



News You Can Use From The Florida Medical Association

RACs Are Coming. Are You Prepared?

The three-year Recovery Audit Contractor (RACs) pilot project is over. On a post-payment basis, RACs identify and correct improper payments for the Centers for Medicare and Medicaid Services. Because the RACs identified Medicare overpayments of more than \$1 billion, Congress passed the Tax Relief and Health Care Act, Section 302 making the RAC program permanent and requiring the U.S. Department of Health and Human Services to expand the program to all 50 states by January 1, 2010. During the demonstration program Health Data Insights (HDI) was the RAC in Florida, but **Connolly Consultant, Inc.** will be the RAC for the permanent program for Region C (which includes Florida).

This article will give you information on the RAC process, including some changes from the pilot program. But the best advice is to get prepared now, do not wait until First Coast Service Options is deducting money on your remittance advice notice for RAC identified overpayments.

The major changes made to the RAC program following the pilot were: each RAC must have a physician medical director and qualified staff, RACs will be limited to a three year “look-back” period but will not be able to review claims paid prior to October 1, 2007, the numbers of medical records requested will be limited, and if the RAC loses at any level of appeal they must return any contingency fees received.

Connolly has indicated they will only accomplish data mining of hospital claims in April 2009. Unless a clear “black and white” overpayment issue is identified concerning physicians, it will probably be mid-summer before physician offices start receiving demand letters.

During April and May 2009, CMS and Connolly will be accomplishing outreach efforts for physicians. They are holding meetings with hospital groups in March. A meeting is set for physicians in Orlando on April 29, 2009. The Florida Medical Association will keep members apprised about planned outreach programs.

What Should You Do Now?

Educate your office and prepare. Either do self evaluations or if concerned about your billing practices, hire an outside entity to review a sample of your records/claims for evaluation. Providers can limit unnecessary hardship and appeals by making sure office coding staff are trained and have current reference materials. Make sure everyone in your office knows who the Florida RAC is [Connolly] and correspondence is addressed immediately. Don't risk demand letters being thrown out because office staff “does not recognize” the sender - this actually happened in several practices during the pilot!

Know Where Previous Overpayments Have Been Found

During the pilot, the top problems that the RACs found when reviewing physician claims were:

- Incorrect coding (ex. for injectable drugs)
- Medical necessity issues (ex. when billing for Neulasta (a drug used to treat white blood cell deficiencies caused by cancer chemotherapy))
- Requirement for tests (ex. Vestibular functioning tests)
- Duplicate claims (ex. Multiple procedures on same patient the same day)

Getting Prepared for the RACs

- Know where previous improper payments have been found, such as those detailed in the OIG, CERT and RAC Demonstration reports. Note that the FMA will send out information from these reports as well as information we receive from physician offices who have received demand letters and other RAC correspondence.
- Know if you are currently submitting claims with improper payments
- Be prepared to respond to RAC medical record requests
- Appeal when necessary (see paragraph/chart on appeals and timelines)
- Learn from your past mistakes

Review of “New Issues”

Another difference in the permanent program is that all “new issues” must be reviewed and approved by CMS before the RACs can act on them. This oversight was put in place by CMS in response to problems reported by providers during the Pilot Project. According to the RAC representatives, “All issues, even those that came to light in the Pilot, must go through the “New Issue” review.” The RAC conducts a review of a small number of charts related to the specific compliance issue and sends a New Issue Review Request to CMS. CMS has 60 days to review the issue and decide on its value and appropriateness. If approved, the “New Issue” is posted to RAC website and RAC can begin Region-wide physician claim reviews. RAC websites will be available as soon as approved by CMS. This will probably occur during the summer.

How Do the RACs Find Overpayments?

RACs use two types of reviews when auditing Medicare claims. Automated reviews occur where RACs are able to clearly recognize improper payments from the database of claims available to the RACs without review of the medical record. An example of an improper payment found from an automated review is a duplicate payment for one claim. Complex reviews, on the other hand, occur where the improper payment may not be apparent by a review of the claims alone and a review of the medical records is necessary to determine whether the payment was appropriate.

RACs must follow all applicable Medicare policies and guidelines when reviewing claims, including National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Unlike fiscal intermediaries, carriers and Medicare Administrative Contractors (MACs), RACs do not develop their own billing and coding guidelines.

Keep Deadlines In Mind

Your practice needs to know the recoupment and appeal rules. Cash flows could be disrupted if you don't act timely when receiving correspondence from the RAC. Review and understand the

chart below, especially the different timelines. Note that the numbers of days you have to respond are calendar days, not business days.

The FMA suggestion is that you have a written audit plan in place with someone responsible for coordinating your practice's responses to RAC requests. This person would be in charge of making sure you respond to RAC's requests in a timely manner, sort of a RAC czar. Create a log to document the RAC request, necessary action required, and action taken, with dates. This person must understand and tell the difference between a RAC and a CERT (Comprehensive Error Rate Testing) audit.

APPEALING A MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) OVERPAYMENT: UNDERSTANDING THE APPEALS PROCESS

If you have received a letter from a Medicare Recovery Audit Contractor (RAC) requesting overpayment(s) and you believe it is incorrect, you may appeal. It is important to understand key deadlines in the appeals process. Outlined below are the steps you should take.

FAST FACTS:

- **Recoupment(s) Halted:** If physician appeals within 30 days of receiving letter requesting overpayment.
- **Interest Accrues:** With or without an appeal 31 days from date physician receives overpayment letter, unless full repayment is made before this time.
- **Max Time to File Initial Appeal:** 120 days

STEP 1: CALL

If you receive an overpayment letter, call your RAC within 15 days from the date you receive it to discuss the overpayment and send any evidence to counter an offset. NOTE: Calling your RAC does not constitute a formal appeal.

STEP 2: APPEAL

If you continue to believe the request for overpayment is unjustified, you must file an appeal. If you do so within 30 days of receipt of the overpayment letter you will avoid a Medicare recoupment action. NOTE: Interest, begins to accrue 31 days from the receipt of the overpayment letter regardless of whether an appeal is filed. No interest accrues if repayment is made within 30 days.

There are five levels of appeal.

1st Level Appeal

→ You have 120 days to file the first appeal which is referred to as a "redetermination." Redeterminations are conducted by Carriers or Medicare Administrative Contractors (MAC). If the overpayment is upheld at the redetermination level, you have 180 days to appeal to the 2nd level. NOTE: While you have 120 days to file the first appeal, you can only avoid a Medicare recoupment action if you do so within 30 days.

2nd Level Appeal

→ Second level appeals are referred to as "reconsiderations." Reconsiderations are conducted by Qualified Independent Contractors (QICs). If the overpayment is upheld at the reconsideration level, you have 60 days to appeal to the 3rd level.

3rd Level Appeal

→ At the third level of appeal, an Administrative Law Judge (ALJ) will review your case. If the overpayment is upheld, you have 60 days to appeal to the 4th level.

4th Level Appeal

→ At the fourth level of appeal, an HHS Department Appeals Board will review your case. If the overpayment is upheld you have 60 days to appeal to the 5th level.

5th Level Appeal

→ At the fifth level of appeal a Federal District Court will review your case.

STEP 3: REFUNDING OVERPAYMENT

If your appeal is upheld and making a repayment in full represents a hardship, ask your RAC if you qualify for an extended repayment plan. NOTE: Interest is waived if an overpayment has been returned within 30 days of final determination.