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DOCTORS Rx

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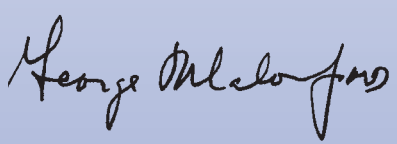
A Letter from the Chair of the Board

Dear Colleague:

The Recovery Audit Contractor (RAC) program was created through the Medicare Modernization Act of 2003 to identify and recover improper Medicare payments paid to health care providers under fee-for-service Medicare plans.

This issue of Doctors RX *will provide you with an understanding of what to expect if an auditor comes to call as well as steps to avoid the visit in the first place.*



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Chair of the Board
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The RAP on RAC

An all-too-familiar story:

A practice is handed a bill in the amount of four million dollars after an audit by a Medicare contractor alleging overpayments. The practice challenged the audit and proved that the contractor made a mistake interpreting medical coding.

The good news? The four million was reduced to $2,810.

The bad news? It took the practice two years to rectify the mistake at a cost of $350,000.

What is going on here?

With ever-increasing pressure on both governmental and private payers to reduce health care costs, it is inevitable that payers will continue to find ways to identify overpayments and to demand that Physicians repay these amounts.

To that end, the Centers for Medicare and Medicaid Services (CMS) have embarked upon a system of reimbursement and recoupment of services covered by Medicare. This system has been named the Recovery Audit Program (RAP). The program initially applied to payments under Medicare Parts A & B and, with the passage of the Affordable

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Care Act, has been expanded to cover Part C (Medicare Advantage), Part D (Medicare Prescription Drugs Program), and state Medicaid programs as well.

The RAP has been charged with the following mission statement:

> The Recovery Audit Program's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.

The RAP utilizes the services of four private contractors; one for each region of the country. A Recovery Audit Contractor (RAC) is paid on a commission basis to review Medicare payments for the purpose of identifying both overpayments and underpayments for medical services. Currently, in the State of Maryland and the District of Columbia, those commission-based payments are going to Performant Recovery, Inc. Performant's contingency fees may range from nine to 12 percent of fees recovered for matters not involving non-durable medical equipment and up to 17.5 percent for recovery of fees associated with durable medical equipment. In the State of Virginia, Connelly Consulting is the designated contractor. The CMS requires that employees of RACs include a medical director, clinical professionals, and certified coders.

Review Criteria – From Automated to Complex, and Everything in Between

RAC auditors have employed a three-tiered review system that divides claims into three categories: (1) Automated; (2) Semi-Automated; and (3) Complex.

Automated claims do not involve a review of medical records by an auditor. They involve only a review of coding and coverage issues. For a claim to be labeled Automated, two criteria must be met:

1. There must be *certainty* that the service is not covered or that it was incorrectly coded; and
2. There is an applicable, written Medicare Policy, Medicare article or Medicare-sanctioned coding guideline such as a CPT statement, etc.

You may also see automated reviews of such items as duplicate claims or pricing mistakes that do not involve clinical correlation.

If one or both of these elements is absent, then the matter is treated as Complex, which means it will involve a review of the medical records.

In matters subject to Complex review, the medical chart is reviewed for the specific purpose of determining whether overpayment or underpayment was made by CMS for the services described in the chart. According to CMS guidelines, Complex medical reviews are used in cases involving "a high probability (but not certainty) that the service is not covered or where no Medicare policy, Medicare article or Medicare-sanctioned coding guideline exists." In these situations, the practitioner will receive a letter requesting that a copy of the medical record be provided to the auditor for purposes of the review.

Within the broad heading of Complex reviews, the auditor may perform an individual claim determination that, according to CMS guidelines, may involve review of medical literature, and the broad range of available evidence. (See, Implementation of Recovery Auditing at the Centers for Medicare and Medicaid Services, Fiscal Year 2010 Report to Congress.)

In the event of a Complex review, CMS guidelines require that the review be completed within 60 days from the receipt of the medical records. That said, the auditor may request a waiver of the 60-day time frame.

Finally, your fee payment may be subject to a Semi-Automated review. Such a review may be conducted in two parts. The auditor will make a threshold determination as to the existence of a billing anomaly through the automated review method. If such an anomaly is identified, a notification letter is sent to the practitioner describing the anomaly and requesting that the practitioner provide documentation to support the fee within 45 days.

If no such documentation is provided, the practitioner will receive a demand letter for reimbursement of overpayment. Conversely, if the practitioner sends appropriate documentation that supports the fee and dispels the notion of an anomaly, the case will be closed.

If you are wondering, at this point, how the review audit contractors make a determination as to which fees will be audited and which will not, CMS has reported to Congress that *random reviews* will not be used for the purpose of identifying cases in which practitioners will be requested to submit medical records. Instead, the auditors will use a *targeted review* process. According to CMS, the recovery auditor "may not target a claim solely because it is a high dollar claim." Conversely, the auditor may "target a claim because it is high dollar and contains other information" that causes the auditor to suspect that an overpayment has occurred.

Finally, CMS has assured Congress that auditors will not review payments older than three years.

Appeals Process

Just because the auditor says you made a mistake or were paid in error doesn't make it true. If you find that you are the subject of a review and overpayment has been demanded, you may appeal that determination. The appellate process consists of five steps:

1. A claims processing contractor is asked to perform a Redetermination of the demand.
    - You will have a deadline of 120 days from the date of the initial determination that there has been an overpayment within which to submit your appeal.
    - According to CMS guidelines, your appeal should be decided within 60 days.
2. A Qualified Independent Contractor is asked to perform a Reconsideration.
    - This appeal must be filed within 180 days of the date of the Redetermination Notice. (Please note – the time period does not begin on the day you receive the Notice; it has already begun as of the date on the Notice.)
    - CMS Guidelines, again, call for a determination of your appeal within 60 days.
3. The matter is submitted to a hearing before an Administrative Law Judge.
    - This level of appeal requires a minimum amount of $130 in dispute. You will be required to file a request for a hearing within 60 days of your Reconsideration Notice.
    - CMS guidelines call for resolution of this level of appeal within 90 days. So far, that time limit has been elusive.
4. The matter is reviewed by an Appeals Council.
    - You will be bound by a deadline of 60 days from the date of your Administrative Law Judge ruling within which to request a review by an Appeals Council. The request must be processed within 90 days of receipt.
5. A federal district court performs a final judicial review.
    - This final level of appeal requires an amount in controversy of at least $1,300 and must be filed within 60 days of the Appeals Council's notice.

CMS guidelines contain no deadline within which the Courts are required to make a decision. Throughout the appeals process, it is critical that you submit the necessary documents on a timely basis.

Note: Once the RAC is notified of the appeal request, the RAC shall stop all recovery efforts and confirm the appeal request with the CMS Project Officer or its delegate. After the Reconsideration level of the appeal process is adjudicated, the RAC shall resume recovery efforts if the decision was not favorable to the provider.

Suspension of Appeals

To no one's great surprise, this process has resulted in a fairly significant backlog of appeals. This, in turn, has prompted the Chief Administrative Law Judge, The Honorable Nancy J. Griswold, to issue a Memorandum to Medicare appellants on December 24, 2013, in which the following statement was made:

> Due to the rapid and overwhelming increase in claim appeals, effective July 15, 2013, OMHA [Office of Medicare Hearings and Appeals] temporarily suspended the assignment of most new requests for an Administrative Law Judge Hearing to allow OMHA to adjudicate appeals involving almost 357,000 claims for Medicare services and entitlements already assigned to its 65 Administrative Law Judges.

Judge Griswold also indicated in the Memorandum that she does not expect general assignments to Administrative Law Judges to resume for at least another two years. Once the assignments resume, appellants can expect the post-assignment hearing times to exceed six months.

Judge Griswold has also indicated that this step has been necessitated by the rather dramatic increase in the number of appeals that have reached the level of an Administrative Law Judge over the past two years. She has cited specific figures of a backlog of 92,000 claims two years ago that has blossomed into a rather stunning 460,000 claims awaiting review by an Administrative Law Judge. According to her Memorandum, two years ago, her Central Operations Division was receiving some 1,250 appeals per week; in December, 2013, the Division received approximately 15,000 appeals per week.

These figures do not bode well for the smooth resolution of claims subject to appeal beyond the Qualified Independent Contractor's Reconsideration stage.

Be in the Know

Given the historic delay in completing appeals even prior to Judge Griswold's suspension of new case assignments, and certainly in light of the suspension of the appellate process at the Administrative Law Judge level, a practitioner is best advised to apply a healthy dose of preventative medicine to the billing and coding process to avoid the necessity of an appeal from the outset. In this regard, CMS has published a list of top issues per region that have been identified by the regional auditors. The following issues have been tagged in the mid-Atlantic region:

1. Medical necessity review – renal and urinary tract disorders, resulting in 2,226 claims in the fiscal year 2011 equal to approximately $15,000,000 with a mean claim amount of more than $6,700.

2. Medical necessity review – acute inpatient admission, neurological disorders, resulting in almost 3,000 claims in the fiscal year 2011 accounting for more than $11,000,000 in payments with a mean claim average of more than $3,800.

3. MS-DRG validation – diseases and disorders of the circulatory system, resulting in more than 2,100 claims with a dollar equivalent of more than $10,000,000 in payments and a mean claim amount of more than $4,800.

4. MS-DRG validation – severe sepsis, accounting for 2,100 claims equivalent to just under $9,000,000 in payments with a mean claim amount of more than $4,100.

Some Good News

In the face of numerous complaints, CMS announced a "pause" in RAC audits – ostensibly in preparation for the procurement of the next round of RAC contracts. It is not clear how long the pause will be. According to CMS, RACs can continue to conduct automated reviews (reviews that do not require soliciting medical record documentation from providers) through June 1, 2014. Additionally, in light of these complaints, CMS says it plans to "refine and improve" the Medicare Recovery Audit Program.

CME Test Questions

Instructions for CME Participation

CME Accreditation Statement – MEDICAL MUTUAL Liability Insurance Society of Maryland, which is affiliated with Professionals Advocate® Insurance Company, is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for Physicians.

CME Designation Statement – MEDICAL MUTUAL Liability Insurance Society of Maryland designates this enduring material for a maximum of one (1) *AMA PRA Category 1 Credit.*™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Instructions – to receive credit, please follow these steps:

1. Read the articles contained in the newsletter and then answer the test questions.
2. Mail or fax your completed answers for grading:

   Med•Lantic Management Services, Inc.
   225 International Circle
   P.O. Box 8016
   Hunt Valley, Maryland 21030
   Attention: Risk Management Services Dept.

   Fax: 410-785-2631

3. One of our goals is to assess the continuing educational needs of our readers so we may enhance the educational effectiveness of the *Doctors RX*. To achieve this goal, we need your help. You must complete the CME evaluation form to receive credit.
4. Completion Deadline: September 1, 2014
5. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you.

1. The Recovery Audit Program (RAP) is administered by the Centers for Medicare and Medicaid Services (CMS) but utilizes the services of private Recovery Audit Contractors (RAC).

   A. True B. False

2. The RAP covers which of the following?

   A. Medicare parts A & B
   B. Medicare parts A, B, C and D
   C. Medicare parts A through D, as well as state Medicaid programs
   D. Medicare, Medicaid and most private insurance payors

3. RACs are paid on a commission basis to review Medicare payments for the purpose of identifying:

   A. Overpayments
   B. Underpayments
   C. Both overpayment and underpayments
   D. All overpayments and underpayments that are deemed kickbacks

4. RACs may collect contingency fees for up to 50 percent of fees recovered for matters not associated with durable medical equipment.

   A. True B. False

5. Automated reviews under the RAP require that medical records under review be automatically sent electronically to the auditors.

   A. True B. False

6. RAC auditors have a lookback period of three years from the paid claim date.

   A. True B. False

7. CMS guidelines require complex reviews be completed within a 30-day time frame.

   A. True B. False

8. The time frame to submit an appeal for the claims contractor to perform a Redetermination of the demand is 120 days from the date of the initial determination that there has been an overpayment.

   A. True B. False

9. The appeal process consists of five steps: Redetermination, Reconsideration, hearing before an Administrative Law Judge, review by Appeals Council, federal district court review.

   A. True B. False

10. CMS guidelines require the Courts to make a decision within:

    A. 60 days of their review
    B. 90 days of their review
    C. 120 days of their review
    D. There is no deadline specified

CME Evaluation Form

Statement of Educational Purpose

Doctors RX is a newsletter sent twice each year to the insured Physicians of MEDICAL MUTUAL/Professionals Advocate.® Its mission and educational purpose is to identify current health care related risk management issues and provide Physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:
1) Gain information on topics of particular importance to them as Physicians,
2) Assess the newsletter's value to them as practicing Physicians, and
3) Assess how this information may influence their own practices.

CME Objectives for "The Rap on RAC"

Educational Objectives: Upon completion of this enduring material, participants will be better able to:
1) Demonstrate knowledge of the RAC process and its intent,
2) Understand the five levels of appeals, and
3) Apply preventive medicine by auditing your own billing/coding processes.

	Strongly Agree				**Strongly Disagree**
Part 1. Educational Value:	5	4	3	2	1
I learned something new that was important.	❑	❑	❑	❑	❑
I verified some important information.	❑	❑	❑	❑	❑
I plan to seek more information on this topic.	❑	❑	❑	❑	❑
This information is likely to have an impact on my practice.	❑	❑	❑	❑	❑

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

_____

_____

_____

Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature: _____ Date: _____

Part 4. Identifying Information: Please PRINT legibly or type the following:

Name: _____ Telephone Number: _____

Address: _____

_____

_____

_____

How to Protect Yourself

With increased concern over the cost of health care and with the availability of Physician data, Physicians **must** expect and prepare for claims audits and reviews. What can you do to mitigate your risk?

To begin with, you can make certain that you are familiar and up-to-date with all service coding systems utilized by CMS in submitting your service fees. In addition, you can assess your risk for an audit by comparing your utilization of codes with that of your peers. You should endeavor to ensure that your records clearly and unambiguously communicate your assessments, your examinations, your judgment and your justifications for treatment and therapies.

There are additional recovery audit materials that are available on several government web sites where you can educate yourself on the issues most likely to result in a finding of overpayment. These sites include:

- www.cms.hhs.gov/cert
- oig.hhs.gov/oei/reports/oei-04-11-00680.asp

You can also visit "www.cms.gov" and search for "RAC Recent Updates" for the latest news on the Recovery Audit Program.

Finally, you should consider designating a member of your staff to serve as the Recovery Auditor's contact person and ensure that the Recovery Auditor has direct access to that person. Make sure your staff has the email address of the Recovery Auditor: RAC@cms.hhs.gov.

These measures may not ensure that your encounters with the process are hassle-free, but they can certainly help get you back to where you belong – devoting your maximum time and attention to patient care.

Tips to Prevent a RAC Audit

- Code correctly on the front end.
- Review what CMS has to say about the RAC process and what it may be focusing on.
- Learn the rules regarding billing for mid-level providers.
- Obtain training on what you and your staff don't know.
- Annually audit your coding/billing department, billing service or third-party vendor.

Doctors RX

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Numbers you should know!

Home Office Switchboard	410-785-0050
Toll Free	800-492-0193
Incident/Claim/ Lawsuit Reporting	800-492-0193
Risk Management Education Program Info	ext. 215 or 204
Risk Management Questions	ext. 224 or 169
Main Fax	410-785-2631
Claims Department Fax	410-785-1670
Web Site	mmlis.com proad.com

Reminder: Regular Software Updates Can Protect Your Practice

With the "Heartbleed" computer vulnerability in the news recently, it's important to remember that regular updates to your software can help prevent the corruption or breach of data from your EHR systems or networked computers within your practice. Physicians are encouraged to conduct regular assessments of their office computers and EHR systems, including vulnerability scans. In the event any vulnerabilities are found, they should be addressed with patches and software updates as soon as possible. There are web resources available that can be used to track known vulnerabilities, such as the NIST Vulnerability Database (https://nvd.nist.gov) and the MITRE CVE list (http://cve.mitre.org/cve/index.html).

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