STRATEGIC MANAGEMENT

RAC APPEALS PROCESS

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AGENDA

- RAC Program Background
- RAC Determinations
- RAC Appeals Process

RACs

- Recovery Audit Contractors were implemented to enhance and support Medicare's ongoing efforts to identify and correct improper payments in the Medicare fee-for-service program.

- Responsibilities:
  - Conduct data analysis.
  - Review medical records to further analyze claims.
  - Identify and correct improper payments.

WHAT DO THE RACs LOOK AT?

- Improper Payments
- Inpatient Target Areas
  - Short stay claims
  - Debridement
  - Back pain
  - Outpatient vs. inpatient surgeries
  - Transfer patients

RAC RECOVERY

- Hospitals accounted for 92% - 94% of overpayments collected by RACs.
- FY 2006 RACs identified $299.5 million in improper payments.
- FY 2007 RACs identified $371.5 million in improper payments.
- Permanent RAC program will start this year and will be nationwide by 2010.

RAC DEMONSTRATION

Overpayments by Error Type	
Medically Unnecessary	40%
Incorrectly coded	35%
Insufficient Documentation	8%
Other	7%

RAC DEMONSTRATION

Top Services with Overpayments	
Inpatient Hospital	• Surgical Procedures in Wrong Setting • Excisional Debridement • Cardiac defibrillator implant in wrong setting • Treatment for heart failure and shock in wrong setting • Respiratory system diagnoses with ventilator support
Inpatient Rehab Services Overpayments	• Services following joint replacement • Services for miscellaneous conditions
Outpatient Hospital	• Neulasta • Speech-language pathology services • Infusion Services

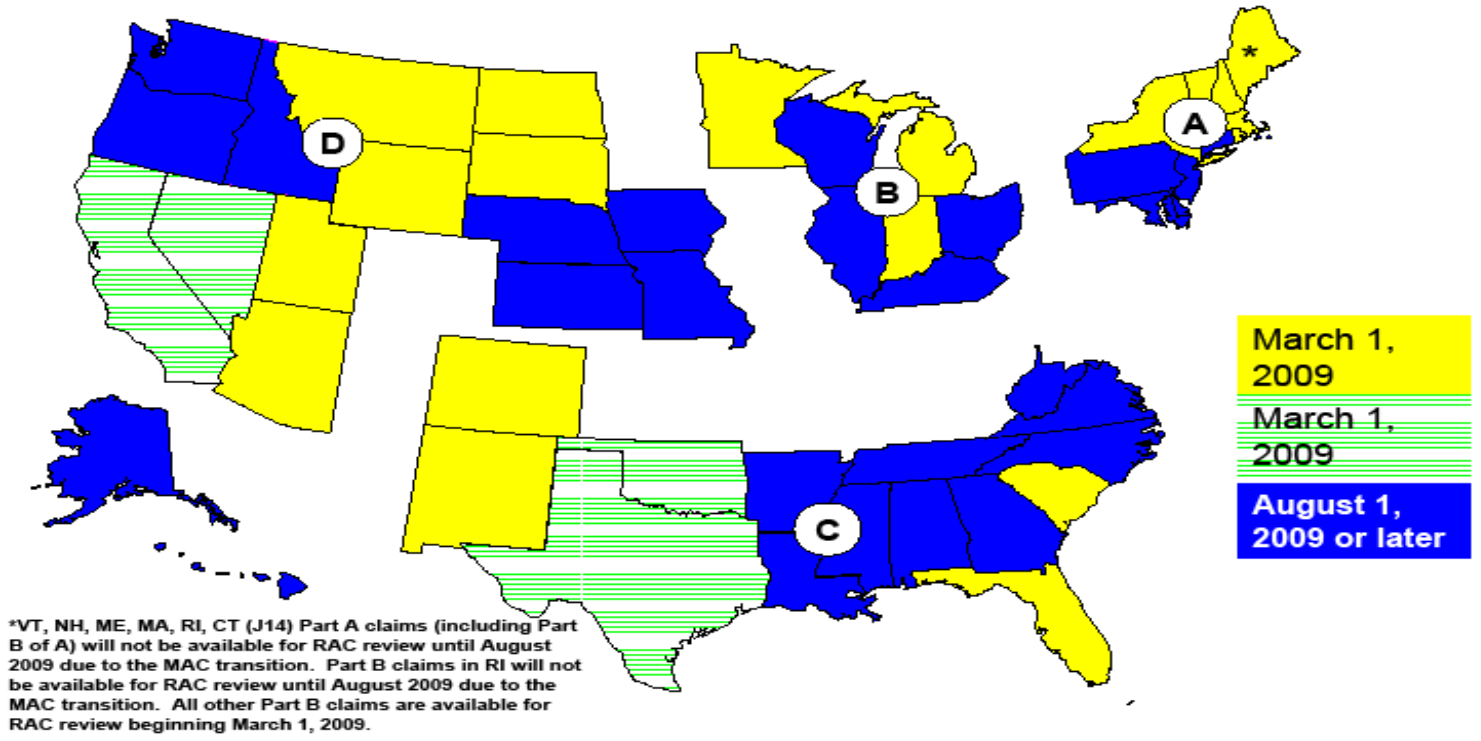
NATIONWIDE PERMANENT PROGRAM

- Permanent RACs announced 10/06/2008

- New RACs
  - Selected under full and open competition.
  - Paid on a contingency fee basis for both the overpayments and underpayments they find.
  - Delay due to a protest filed with the GAO resolved on February 4, 2009.
  - New expansion schedule announced by CMS on February 10, 2009.
  - Phase I – March 1, 2009; Phase II – August 1, 2009.

RAC SCHEDULE

RAC Phase In Schedule



*VT, NH, ME, MA, RI, CT (J14) Part A claims (including Part B of A) will not be available for RAC review until August 2009 due to the MAC transition. Part B claims in RI will not be available for RAC review until August 2009 due to the MAC transition. All other Part B claims are available for RAC review beginning March 1, 2009.

RAC REVIEWS

1. Automated Review
   - Use data analysis to determine improper payments.
   - Do not involve a review of medical records.
   - Consume less resources than a complex review and are conducted more frequently.

2. Complex Review
   - Use medical records to further analyze the claim when data analysis is insufficient.
   - Identify discrepancies between the medical records and the claim.

RAC DETERMINATIONS

1. Automated Review
   - Notify providers only when they find overpayments.

2. Complex Review
   - Sends the hospital a determination letter with its overpayment or underpayment findings.

DETERMINATION: UNDERPAYMENT

- RAC notifies the fiscal intermediary (FI), Carrier, or Medicare Administrative Contractor (MAC) to validate the findings.
- FI, Carrier, or MAC will pay the provider by adjusting the claim.
- Provider is only notified if the RAC conducted a complex review.

DETERMINATION: OVERPAYMENT

- Provider notified of all initial determinations involving overpayments through a *Demand Letter*.

- Demand Letter must include the following:
  - Provider's identity
  - Reason for the review
  - List of claims, with findings, reasons for any denials, and amount of the overpayment for each claim
  - Explanation of Medicare's right to charge interest on unpaid debts
  - Instructions on paying the overpayments
  - Explanation of the provider's right to submit a rebuttal statement and/or an appeal

COLLECTING OVERPAYMENTS

- Recoupment
  - Reduce current or future reimbursements.
  - Begins 41 days after date on Demand Letter.
  - Can be stopped if provider files a formal appeal within 30 days of determination date.

- Repayment
  - Full payment
  - Payment Plan

RAC DETERMINATIONS

- Be sure to review the RAC's findings.
- Ensure coverage, coding, and/or payment policies were accurately applied.
- Determine organization's next steps: recoupment or appeal.

RAC APPEALS PROCESS

- Similar to the current Medicare claims appeals process.
  - Main difference: Prior to filing an appeal, providers can file a rebuttal.
- RAC appeals process applies to inpatient and outpatient claims.
- Provider's full appeal rights are explained in the Demand Letter.

RAC APPEALS PROCESS

- Rebuttal

- Five Levels of Appeal

First Level	Redetermination
Second Level	Reconsideration
Third Level	Administrative Law Judge
Fourth Level	Medicare Appeals Council/Departmental Appeals Board
Fifth Level	United States District Court

REBUTTAL

- Request for the RAC to re-evaluate their initial determination.
- Must be filed within ***15*** calendar days of the date on the Demand Letter.
- Does not stop the recoupment process.
- Does not “stay” the timeframe for filing an appeal.

FIRST LEVEL OF APPEAL

- Redetermination.
- Filed with the FI/Carrier/MAC.
- Must be filed within ***120*** calendar days of the date on the Demand Letter.
- Stops the recoupment process if the appeal is filed within ***30*** days of the Demand Letter.
- FI/Carrier/MAC must render a decision within ***60*** days of receipt of the request.

SECOND LEVEL OF APPEAL

- Reconsideration.
- Filed with a Qualified Independent Contractor (QIC).
- Must be filed within ***180*** days of the redetermination.
- The submission of *all* documentation is critical at this level.

THIRD LEVEL OF APPEAL

- Administrative Law Judge (ALJ).
- Request must be filed within ***60*** days of the QIC's reconsideration decision.
- Amount of the claim in question must be at least $120 ("amount in controversy").
- ALJ required to issue a decision in 90 days.

FOURTH LEVEL OF APPEAL

- Medicare Appeals Council (MAC)/Departmental Appeals Board (DAB).
  - Independent review agency of HHS.
- Request must be filed within ***60*** days of the ALJ decision.
- No new evidence allowed.
- DAB must render a decision in 90 days.

FIFTH LEVEL OF APPEAL

- Judicial review in Federal District Court
- Request must be filed within ***60*** days of the DAB's decision.
- Amount in controversy must be at least $1,180.

RECAP

Five Level s of Appeal	Reviewer	Provider Timeline
Redetermination	FI/Carrier/MAC	120 days from initial determination
Reconsideration	QIC	180 days from the redetermination
Hearing by the ALJ	Administrative Law Judge	60 days from the QIC decision
Departmental Appeals Board	DAB/Medicare Appeals Council	60 days from the ALJ decision
Judicial review by the Federal district courts	U.S. District Court	60 days from the DAB's decision

EFFECTIVE APPEALS STRATEGY

- Three main pillars:
  1. Focus on the Re's – *re*determination and *re*consideration
  2. Structure and Coordination
  3. Decision Criteria

EFFECTIVE APPEALS STRATEGY

1. Focus on the *Re's*
   - *Re*determination
   - *Re*consideration
   - Review
   - Documentation
   - FACTS

EFFECTIVE APPEALS STRATEGY

2. Structure and Coordination
   - Involve the right departments
   - Involve legal counsel
   - Consider outside vendors
   - Consider software tracking tools

EFFECTIVE APPEALS STRATEGY

3. Decision Criteria
   - Benefit vs. cost of the appeal
   - Availability of resources
   - Quality of medical records, charts and other documentation
   - Type of denials

TRACKING

- Use a tracking tool to track information the following appeals information:
  - Number of denied claims
  - Results of the audit
  - Types of denials
  - Date of reimbursement or recoupment by CMS
  - Amount of the reimbursement or recoupment
  - Timelines
  - Status of all appeals
  - Dates of all appeals
  - Basis of all appeals
  - Appeal outcomes
  - Financial impact to the organization

APPEALS STATISTICS

Number of claims with overpayment determinations	525, 133
Number of claims where provider appealed (any level)	118,051
Number of claims with appeal decisions in provider's favor	40,115
Percentage of appealed claims with a decision in provider's favor	34.0%
Percentage of claims overturned on appeal	7.6%

Source: The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration, January 2009.

PERMANENT RAC PROGRAM

- More transparent
- List types of issues undergoing review on each of the RACs' Web sites
- Each RAC will also employ a full-time medical director to help in the review of claims
- RAC Validation Contractor (RVC)
- Need for an effective review and appeal strategy