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## RESPONDING TO RACS: Limits on RACs' Medical Record Requests and Proper Methods for Appealing RAC Audit Determinations

The Centers for Medicare & Medicaid Services (CMS) has awarded contracts to four Recovery Audit Contractors, commonly referred to as "RACs", to carry out CMS's recovery audit program. The contracts charge the RACs with the task of protecting the Medicare Trust Fund by identifying improper Medicare underpayments and overpayments, and, ultimately, fighting fraud and abuse in the Medicare program. CMS has the authority to implement its recovery audit program through two statutory sources: (1) the Medicare Modernization Act of 2003, which authorized CMS to perform a 3-year demonstration project with the RACs and (2) the Tax Relief and Healthcare Act of 2006, which authorized CMS to implement a permanent and nationwide RAC program by January 2010.

The goal of the program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. Improper payments may be overpayments or underpayments. Underpayments can occur when health care providers submit claims for a simple procedure but the medical record reveals that a more complicated procedure was actually performed. Overpayments can occur when health care providers submit claims that do not meet Medicare's coding or medical necessity policies.

Based on the authority provided in the Medicare Modernization Act of 2003 and the Tax Relief and Healthcare Act of 2006, CMS has made the contro-

versial decision to pay RACs on a contingency fee basis for the collection of overpayments made by CMS to health care providers. If the RACs lose at any level of appeal, however, the RAC must return the contingency fee. CMS will retain a portion of the recovered funds and make them available to CMS's program management account to fund the activities conducted under the Recovery Audit Program. As for underpayments discovered by the RACs, CMS has the authority to pay the RACs "such amounts as the Secretary may specify for identifying underpayments."

RACs will review claims on a post-payment basis and will use the same payment policies as the Carriers, FIs, and MACs (i.e., NCDs, LCDs and CMS Manuals). RACs are permitted to look back three years from the date the claim was paid. Initially, however, RACs will not be able to review Medicare claims paid prior to October 1, 2007.

### RACs & Reviews

Within the Recovery Audit Program, U.S. states and territories are grouped into regions designated as Regions A, B, C, & D. Connolly Consulting Associates, Inc., of Wilton, Connecticut, (Connolly) will serve as the RAC for Region C, which includes Alabama, as well as Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia, Puerto Rico and the U.S. Virgin Islands.

The RACs may conduct automated reviews or complex reviews of CMS-approved issues. An automated review occurs when a RAC makes a claim determination at the system level without human review of the medical records. A RAC may use automated review when making coverage and coding determination when (1) there is certainty that the service is not covered or is incorrectly coded and (b) a written Medicare policy, article or sanctioned coding guideline exists. A complex review occurs when a RAC makes a claim determination using "human review" of the medical record. A RAC may use complex review when (a) the requirements for automated review are not met; (b) there is a high probability (but not certainty) that a service is not covered; or (c) no Medicare policy, article or sanctioned coding guideline exists.

### CMS-Approved Issues

A RAC, however, may not conduct an automated review or a complex review of just any coverage or coding determination. Rather, CMS must approve the areas or issues to be reviewed by the RACs. The approved issues are to be posted on the RAC website before widespread review begins. Previous review issues have included incorrect overpayment or underpayment amounts, non-covered services (including services that are not reasonably necessary), incorrectly coded services, duplicate services and Evaluation and Management Services and level of care. RACs will also be able to inves-

tigate issues already highlighted by the Office of Inspector General, the General Accountability Office and certain comprehensive error rate testing reports. Alabama's RAC, Connolly Healthcare, has dedicated a portion of its website to listing the CMS-approved provider issues for Region C. Initially, Connolly will review the following CMS-approved issues:

1. Blood Transfusion: CPT codes 36430, 36440, 36450, and 36455 (excluding claims with any modifiers) should be billed as one (1) per session, regardless of the number of units transfused on that date of service.

2. Untimed Codes: CPT Codes (excluding modifiers KX, and 59) where the procedure is not defined by a specific timeframe (untimed codes), the provider should enter a one (1) in the units billed column per date of service.

3. IV Hydration Therapy: Based on the definition of CPT 90760 (excluding claims modifier-59), the maximum number of units should be one (1) per patient per date of service. Beginning January 1, 2009, code 90760 was replaced with code 96360.

4. Bronchoscopy Services: CPT Codes 31625, 31628 and 31629 should be billed with a maximum number of units of one (1) per patient per date of service (excluding claims with modifier 59) should only be reported with one unit per date of service.

5. Once in a lifetime procedures: By virtue of the description of the CPT code, these codes can be performed only once per patient lifetime.

6. Pediatric codes exceeding age parameters: Newborn/Pediatric CPT codes being applied/billed for patients which exceed the age limit defined by the CPT code.

7. J2505: Injection, Pegfilgrastim, 6 mg: By definition HCPC Code J2505 represents 6 mg per unit. The code should be billed at one (1) unit per patient per date of service. In addition to determining the issues that RACs may review, CMS has limited the number of medical records a RAC may request from a provider.

### Limitations on Medical Records Requests

CMS's limits on medical records requested in the remainder of this fiscal year will be based on (1) the claim volume (in the 2008 calendar year) of the health care provider, and (2) the type of health care provider from whom the records are requested. It is important that health care providers know the maximum amount of medical records that a RAC is permitted to request.

Every 45 days, the RACs may request up to 10% of the average monthly Medicare claims (or a maximum of 200 Medicare claims) from inpatient hospitals, inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and hospices. For example, a local community hospital that had 1,200 Medicare paid claims in fiscal year 2008 would divide its paid Medicare claims (1,200) by 12 (months in a year) to determine that a monthly average of 100 Medicare paid claims per month. Applying the formula to this example, 100 Medicare-paid claims per

month multiplied by 10% would equal a limit of 10 medical records per 45 day period that the RAC could request from the local community hospital.

RACs may request up to 1% of the average monthly Medicare paid services per 45 days from other Part A billers, (such as Outpatient Hospitals, Home Health, etc.) with a maximum of 200 medical records that can be requested per 45 day period. For example, an outpatient hospital that had 360,000 Medicare paid services in fiscal year 2008 would apply the formula as follows: 360,000 (Medicare paid services in fiscal year 2008) divided by 12 (months in a year) equals an average of 30,000 (Medicare paid services per month) multiplied by 1% equals 300 medical records per 45 day period. Despite this calculation, CMS has capped the amount of records from these providers to no more than 200 medical records per 45 day period for outpatient hospitals and other Part A billers.

When reviewing a solo practitioner's Medicare claims, a RAC may only request up to 10 medical records per 45 day period. When reviewing a physician group practice of 2 to 5 individuals, 20 medical records may be requested per 45 day period. For group practices with 6 to 15 individuals, 30 medical records may be requested per 45 day period and for groups of 16 individuals or more, RACs may request 50 medical records per 45 day period. RACs may request up to 1% of the average monthly Medicare paid services per 45 days from other Part B billers, (such as DME, Ambulance, Clinical Laboratories, etc.) with a maximum of 200 medical records that can be requested per 45 day period.

Providers have 45 calendar days to

respond to a medical records request by submitting copies of the medical records to the RAC. An extension may be granted, however, if the request is made within the 45-day response period. Importantly, if the provider does not respond to a request for medical records within the 45-day response period, the RAC may deem the claim to be an overpayment.

In some cases, RAC requests for medical records could impose a financial burden on providers having to make copies of large volumes of medical records. According to CMS, RACs will be required to reimburse PPS providers and Long Term Care providers for photocopy charges associated with reproduction of medical records for RAC audits. Instead of requiring facilities to submit vouchers requesting repayment from RACs, the RACs will automatically issue payments to the providers on a monthly basis for photocopying charges. RACs should issue payments for the copying charges within 45 days of receiving copies of the medical records. RACs are not required to pay other health care providers for photocopy charges, but have the discretion to do so. RACs are permitted to accept imaged medical records on CD or DVD.

#### Proper Payment and Appeal Methods

RACs will review claims on a post-payment basis and will use the same collection policies as the Carriers, FIs, and MACs (i.e., NCDs, LCDs and CMS Manuals). If a provider agrees with its RAC's determination of overpayment, it can simply pay the amount owed by check or allow recoupment from future payments from CMS. The provider may

also apply pay via an installment plan. RACs will be permitted to approve provider payment installment plans of up to 12 months in length. When providers request installment plans with timeframes of more than 12 months, RACs will send its recommendations regarding those plans to the appropriate regional offices. The regional offices will review and forward recommended installment plans with timeframes of more than 36 months to Central Office for approval. RACs cannot deny the request for an installment plan request, but they may recommend denial.

If, however, the provider disagrees with the RAC's determination, it may participate in the Medicare Part A and Part B Administrative Appeals Process, which is a five-step appeals process. The first level of appeal involves a redetermination. A redetermination is an examination of a claim by a different Carrier, FI, or MAC than the one who made the initial determination on the claim. The provider appealing the initial decision has 120 days from the date of receipt of the initial claim determination to file an appeal.

In addition to this 120-day timeframe, RAC audits provide for "RAC Discussion Period". The RAC Discussion Period is a 15-day period during which the provider may send the RAC a discussion letter rebutting the RAC's determination, requesting a meeting regarding the RAC's determination, and/or seeking to learn more about the RAC determination. The 15-day period begins when the provider receives a Demand Letter for an automated review or when the provider receives the Review Results Letter for a complex review.

It is important to note that the RAC Discussion Period does not lengthen the 120-day timeframe that a provider has to file its initial first level appeal.

The second level of appeal consists of a reconsideration of the claims determination. A reconsideration must be filed within 180 days of receipt of the decision on redetermination. A Qualified Independent Contractor (QIC) will conduct this level of appeal, which will consist of panel of physicians or other health care professionals conducting an independent review of medical necessity issues. The QIC will send its decision to all of the parties within 60 days of its receipt of the request for reconsideration. Importantly, CMS has stated that any evidence noted in the redetermination as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the reconsideration decision. Evidence that is not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal.

If a party to the RAC audit decision is still dissatisfied and desires to appeal the RAC's decision further, it may request a hearing before an Administrative Law Judge (ALJ)—the third level of appeal—within 60 days of receipt of the reconsideration decision. There must be at least \$120 remaining in controversy in order to request such an ALJ hearing. The ALJ will issue its decision within 90 days of his or her receipt of the hearing request. If a party is still dissatisfied, the party may ask the judge to escalate the case to the next level of appeal.

The fourth level of appeal requires

the appellant to request a review by the Appeals Council within 60 days of receipt of the ALJ's decision. The Appeals Council will issue its decision within 90 days of receipt of the appeals request. If a party remains dissatisfied with the result, the aggrieved party may request that the Appeals Council escalate the matter to the next level of appeal, the U.S. District Court. Within 60 days of receipt of the Appeals Council's decision, an aggrieved party may initiate the fifth level of appeal by appealing the matter to a U.S. District Court so long as at least \$1,180 or more remains in controversy.

Connolly was authorized to begin conducting RAC audits in Alabama no earlier than August 1, 2009; provided Connolly had performed Provider Outreach in the state, to instruct providers on the Recovery Audit Program. CMS and Connolly have already performed Provider Outreach for hospitals and a joint CMS/Connolly teleconference for physicians and other Part B Suppliers was scheduled for September with the assistance of the Medical Association for the State of Alabama. Regardless of whether the Provider Outreach has taken place yet, CMS recommends that providers begin now to prepare for RAC audits. Health care providers that might be reviewed include hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers and any other provider or supplier billing Medicare Parts A and B.

CMS recommends that providers do the following:

a. Providers may conduct an internal

assessment to identify whether the practice is in compliance with Medicare billing rules. Providers should identify and implement any corrective action necessary for compliance.

b. Contact the RAC via telephone or via email and provide the RAC with the contact information of the individual who will be responsible to responding to Medical Records Request letters.

c. When necessary, check on the status of the medical records to confirm that the RAC received them.

d. When necessary, appeal the RAC decision. Remember - the Medicare Appeals Process remains the same. Providers should be mindful of the deadline for filing an appeal even though it has initiated discussions with the RAC.

Health care providers should be formulating a plan for participating in RAC audits, supplying medical records to RAC auditors, and if necessary, appealing from RAC audit decisions. Sirote's Health Care Practice Group stands ready to assist you in creating a streamline process for handling RAC audits, medical record requests, claims, payments and appeals. **C**

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