

Medicare Audits: Ready or Not, Here They Come

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Hospitals, physician groups and other health care providers who provide services to Medicare beneficiaries (“Providers”) are at risk for increased scrutiny, auditing activity, and, most importantly, overpayment demands from Medicare. The Centers for Medicare and Medicaid Services (“Medicare”) Recovery Audit Contractor Program (“RAC”) has been made permanent, and Medicare providers big and small must prepare now. Most RAC auditors are paid a percentage of overpayments discovered by an audit, so the incentives for RACs to perform audits and demand overpayments from Providers are clear and substantial. RAC audits are sprouting up all over the country, and, as medical providers in a state that has become infamous for allegations of health care fraud, Florida Providers who provide services for Medicare patients are particularly at risk.

Adopting and implementing a compliance program is an appropriate first step to prepare for increased

Medicare scrutiny. Unfortunately, even with appropriate compliance programs in place, Medicare providers and suppliers still may experience overpayment allegations, claim denials, and recoupments. However, defense strategies exist for those who find themselves the subject of a RAC audit. Many of these denials can be successfully appealed through the Medicare appeals process.

How Do RACs Identify Improper Payments?

Although RACs are tasked with identifying underpayments in addition to overpayments, the vast majority of improper payments identified by RACs are, unsurprisingly, overpayments. Accordingly, the process of identifying and recouping alleged overpayments is of particular significance to Providers. RACs are permitted to identify improper payments resulting from error, non-covered Medicare services (including services defined as not “medically necessary”), incorrectly coded services and duplicate services. Put simply, every aspect of a Provider’s Medicare billing is at risk for an audit and

subsequent overpayment demand.

RACs engage in two kinds of claims reviews in order to identify improper payments: (1) “automated review” and (2) “complex review.” An automated review is a review of claims data without a review of records supporting the claim. Conversely, a complex review consists of a review of medical or other records, and is used in situations where there is a high probability that a claim includes an overpayment.

What Do I Do if I Am the Subject of an Audit?

If a Provider or supplier receives a claim denial, or a finding of overpayment is made as a result of a RAC review, this denial will be subject to the Medicare Part A and Part B appeals process. The regulations governing this process are contained in the Federal Register.

The first level of the appeals process is the redetermination. Providers must submit requests for redetermination in writing within 120 calendar days of receiving Medicare’s notice. Notably, the request for redetermination must be filed

within 30 days in order to avoid initial recoupment of the amounts in question by Medicare.

Providers not satisfied with the redetermination decision are permitted to file a request for reconsideration conducted by a third-party Qualified Independent Contractor. This second level appeal must be filed within 180 days, with a 60-day time limit required to avoid recoupment.

The third level of appeal is the Administrative Law Judge (“ALJ”) hearing. A Provider dissatisfied with a reconsideration decision may request an ALJ hearing. The request must be filed within 60 days following receipt of the QIC’s reconsideration decision. In addition, if the QIC fails to render its reconsideration decision within the required timeframe, a provider may request an ALJ hearing.

The fourth level of appeal is the Medicare Appeals Council (“MAC”) Review. The MAC is within the Departmental Appeals Board of HHS. A MAC Review request must be filed within 60 days following receipt of the ALJ’s decision.

A provider also may request a MAC review of the claim if the ALJ fails to render its decision within the required timeframe.

The final step in the appeals process is judicial review in federal district court. A request for review in district court must be filed within 60 days of receipt of the MAC’s decision.

How Do I Avoid an Audit?

Although Providers cannot prevent a RAC audit, they can immediately get systems in place for tracking record requests and timely responding, and they can implement appropriate compliance programs and make efforts to understand available audit defenses. Specifically, Providers and suppliers can begin to prepare for the RACs by dedicating resources to the following:

- Responding promptly and properly to a RAC auditor’s records request;
- Implementing compliance plans and providing billing and coding training to staff members;
- Consistently monitoring

- areas that may be subject to RAC auditor review; and
- Timely putting together the appropriate team needed to affect the appeals process and challenge denials and overpayment allegations.

Increased audit activity by Medicare is unavoidable. Providers and suppliers subject to RAC or other Medicare audits and claim denials should understand that many strategies exist that can be employed successfully in the appeals process to effectuate meaningful results. These strategies involve effectively advocating the merits of the underlying services as well as employing legal defenses, including Medicare’s failure to abide by proper procedure.

Understanding the entire RAC audit process, including deadlines for appeals, is critical to navigating this new compliance landscape. The multi-level appeals process that is part of the RAC program sets up an additional set of arduous hurdles for Providers who find grounds for an appeal once an audit has commenced. ■

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