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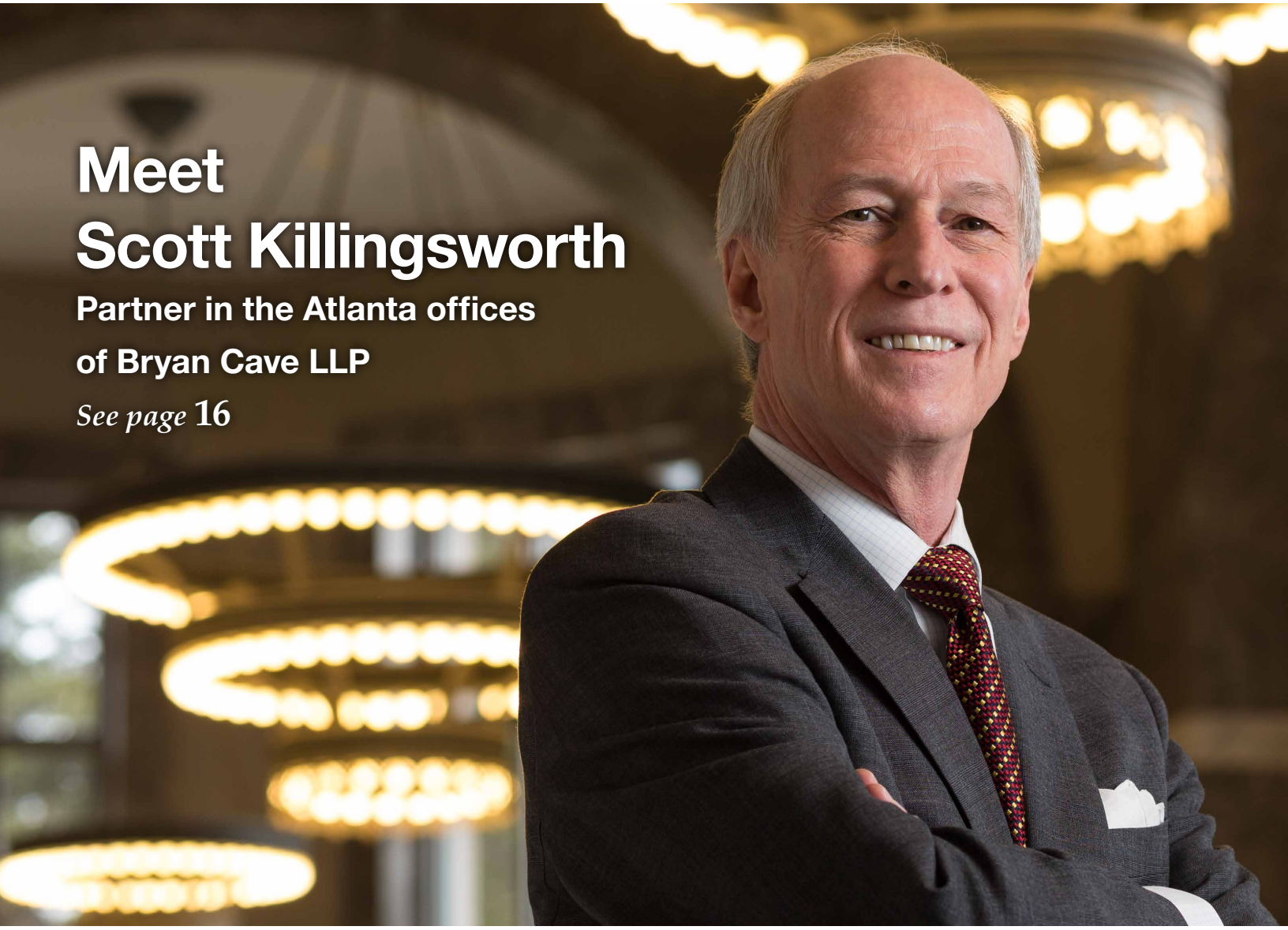

Meet Scott Killingsworth

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by Jason T. Lundy

How does your RAC stack up?

» The RAC program has been very successful in clawing back Medicare payment from providers.
» Providers who persist in their appeals have been successful at overturning RAC payment denials.
» Partially-favorable and favorable decisions mean that services can be billed, even if the inpatient admission criteria is not met.
» Develop a strategy and streamline your process to increase the efficiency of appeals.
» Prioritize which claims will have the greatest return for the effort expended to appeal them.

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Now that the Recovery Audit program (RAC) has been running as a permanent program since January 2010, any provider who has been subject to a RAC audit recognizes a few truths. The RAC program is a claw-back of Medicare payments. It is structured to encourage RAC auditors to cast a wide net and retroactively deny as many Medicare claims as possible. (RAC contractors are paid on contingency based on claims denied, so the more Medicare denials, the bigger the paycheck for the RAC contractors.) The RAC program has been very successful in taking away Medicare payment from providers. According to the American Hospital Association's RACTrac survey, through the third quarter of 2012 RAC contractors have denied $1.1 *billion* in Medicare payments from hospitals who participated in the survey.[1]


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On the other hand, providers can successfully block or overturn the RAC's claw-back. To do so, providers must appeal RAC denials (obviously) and then typically persist through the third level of appeal to an administrative law judge (ALJ). According to the latest RACTrac survey, only 42% of RAC denials are appealed.[2] Of course, every RAC denial not appealed by providers is a victory for the RAC contractors. Additionally, the first two levels of appeal (requests for reconsideration to the Medicare Administrative Contractor, and then requests for redetermination to the Qualified Independent Contractor) are overwhelmingly decided in favor of the RAC contractors. However, the tables turn at the third level of appeal, requests for hearing with an ALJ. For claims that have completed the appeals process, providers have been successful in 74% of cases.[3]

We could spill a lot of ink about how unfair this system is to providers. But unless and until Congress and CMS modify the RAC program (which seems unlikely, given its success and prevailing enforcement mentality), this is the game we have to play. Setting aside the philosophy and emotion of "fairness," we are left with economics: How well can providers keep the Medicare payments that the RAC contractors seek to claw-back? Two factors decide the answer to that question—win rate and efficiency.

How, and how often, do providers win?

Win rate is, quite simply, how often providers are successful against RAC denials. As discussed above, the win rate nationwide is 74%. Most often, the issue in the RAC denial—and therefore the "win" for providers—is Medicare Part A coverage for a hospital inpatient admission. Typically, RAC denials assert that inpatient admission was not medically necessary for

a patient, that the medical care and services could have been provided to the patient in an outpatient or observation setting, and therefore, Medicare payment is not authorized. RAC decisions that are favorable to providers rule that full Medicare Part A payment is appropriate.

Recently, ALJs had also been extending fall-back "wins" to providers, even in cases where the ALJs did not find that inpatient admission was medically necessary. When RAC contractors deny a claim, they attempt to claw-back *all* the Medicare payment. The result is $0 in payment to a provider for the medical treatment and services to the patient. Although the RAC appeals typically argue over the medical necessity for a patient's *inpatient admission*, there is usually no argument that the *medical treatment and services* were medically necessary, which is the pre-condition for Medicare coverage. Recognizing this, ALJs were frequently issuing partially-favorable decisions, ruling that although inpatient admission was not supported, the medical treatment and services should be covered by Medicare and therefore paid as Part B claims and/or under the observation level of care. Compared to the complete denial of Medicare payment sought by RAC contractors, these partially-favorable ALJ decisions were important "wins" for providers.*

After your first, you should never again prepare an appeal from scratch. Each subsequent appeal should stand on the shoulders of its predecessors.

What does a win cost?

The satisfaction of overturning a RAC denial can quickly sour if the effort and expense of the successful appeal eclipses the Medicare payment at issue in the RAC appeal. Avoiding such Pyrrhic victories requires providers to appeal "efficiently" as well as effectively.

A key to efficient RAC appeals is streamlined preparation. But to judge efficiency, providers must also collect cost statistics to calculate a metric for efficiency. If you fall short on the efficiency metric, you need a strategy to optimize the RAC claims you appeal.

Efficient preparation

After your first, you should never again prepare an appeal from scratch. Each subsequent appeal should stand on the shoulders of its predecessors. In my practice, I have developed RAC appeal templates that are always the starting point for an appeal. As these templates have developed and been refined, they are now the substantial foundation for every RAC appeal, needing pointed tailoring to the specific patient's clinical background and medical treatment. These templates streamline preparation of RAC appeals in two ways, having already-established organization and certain substantive sections is a huge head-start, and standardizing the appeals allows a large volume of appeals to be prepared more quickly and easily.

Also, be mindful of your process for preparing RAC appeals. Just like manufacturing microchips or pick-up trucks, there is a tremendous opportunity to use economy of scale to make RAC appeals efficient. After gaining some experience preparing RAC appeals, you will likely find that sitting down to write a RAC appeal takes a fairly consistent amount of time, maybe two or three hours. But much of that time is devoted to getting re-immersed into the RAC rhythm. If you add a couple more hours into your RAC work, you should find that you can accomplish two or three

"additional" RAC appeals. There is a significant advantage for tackling RAC appeals in batches. Likewise, the larger volume of RAC appeals prepared "for the provider as a whole" decreases the marginal effort for each appeal.

A smart plan to capitalize on the repetition and earned experience from a volume of RAC appeals will streamline the process to the point where preparing dozens of RAC appeals is marginally more effort than one-off or spot appeals.

Keeping track

To measure success in RAC appeals, providers need to quantify their win rate and efficiency. Win rate is easy: total dollars in Medicare payments retained due to favorable or partially-favorable decisions. Grading efficiency requires statistics about efforts and expenses for appeals. Primarily, the "cost" of RAC appeals will be the labor in preparing and submitting appeal letters. Calculate this by tracking man-hours spent on appeals and multiplying by an hourly rate. Add in any expenses from consultant or legal fees; these may also be communicated in a hourly-rate format for each appeal or a flat fee to divide across a batch of appeals.

Compare the labor costs for preparing RAC appeals with the total recovery. If it costs an equal amount to appeal RAC denials as the Medicare payments you succeed in keeping through favorable decisions, then you are not really coming out ahead. But how much more in retained payments than costs does it take to say you have a successful RAC appeals system. I have not seen any studies or reports that quantify a comparison between appeal costs and recoveries for providers. I suspect that is due to the fact that the RAC appeals, especially at the ALJ level and beyond, are not yet mature, or because providers have not gathered information to calculate the metric, or reluctance by providers to share such information. However, based on my experience with RAC appeals for several hospital systems, I think a reasonable goal for a successful RAC appeals system is 50% more in Medicare payments recovered/retained compared to a provider's costs of appealing.

A caveat for the recovery-versus-cost metric: Only include final decisions into the calculation. If you appeal a RAC denial at all, you should be prepared to appeal all the way through the ALJ hearing, at least. If an appeal is continuing up the levels from reconsideration to redetermination to ALJ hearing, but you add in the appeal costs for unsuccessful appeals at the early stages without the benefit of the final decision from an ALJ hearing, then your calculations will skew toward higher costs/lower recoveries. To get an honest calculation, only use data from RAC appeals that have come to a final decision. Understand that it will take some time (possibly two years or more) from the RAC demand letter to an ALJ decision. It is wise to judge the efficiency of your RAC appeal system, but a fair judgment comes slowly

Optimization strategy

If you do not have resources to appeal as many RAC denials as you wish, or if you are coming short of a successful recovery-versus-cost metric, you should consider a strategy for selecting the RAC denials to appeal to maximize your appeal efforts. Strategy for prioritizing appeals should weigh three factors:

- Amount of Medicare payment at issue in the RAC claim;
- Strength of evidence and argument for medical necessity; and
- Prevalence of medical treatment and services at issue for the provider.

First, higher dollars at issue in a RAC claim allow for larger recoveries compared to labor costs. The time and effort to appeal a $10,000 RAC denial is likely equivalent to the time and effort for a $1,000 RAC denial. Clearly, pursuing the $10,000 RAC denial will give more bang for

the buck on appeals. If you need a benchmark for prioritizing RAC appeals by claim amount, start with RAC denials of $4,000 or more, then adjust according to your experience.

Second, pursuing appeals on RAC claims for which you have high confidence in the evidence and argument for medial necessity should increase your win rate. As mentioned above, with the high win percentage and availability of partially-favorable recoveries, providers should appeal a substantial portion of their RAC denials. But to determine the last appeals in or out within a batch of claims, favor the appeals that are strong on the merits over long-shots.

Finally, you may see RAC denials about the same issue repeatedly or across-the-board for a particular treatment or service. Appealing a repeat or prevalent denial allows you to exploit the economy of scale and issue a large volume of appeals with decreasing marginal effort for each case.

A provider can set its appeals strategy according to any one of these three factors, or weigh all three to select the optimal RAC claims for appeal.

Considering the high win rate seen at the ALJ hearings through favorable and partially-favorable decisions, providers should feel encouraged to fight back against RAC denials by appealing a substantial portion of the RAC claims. To have a truly successful RAC appeals system, however, a provider cannot just win, but must win efficiently. A thoughtful process for appeals preparation will enable a provider to efficiently appeal a large volume of RAC denials. To judge its efficiency, a provider must compile statistics on its appeal costs and properly compare against its RAC recoveries. If you come up short on an efficiency goal, consider three aspects of a RAC claim to optimize the claims you pursue. Providers can defend against RAC claims successfully, but it takes the willingness to appeal, perseverance through several appeal levels, and a sound appeal strategy.

1. American Hospital Association RACTrac Survey, 3rd quarter 2012, at http://www.aha.org/content/12/121219ractracslides.pdf at page 21.
2. ibid at page 43.
3. ibid at page 43.

* See our June 2013 issue for an update on Ruling CMS-1445-R, which affects the information in this paragraph.