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Understanding Medicare RAC Audits

KNOW WHAT TO DO IF MEDICARE PUTS YOU UNDER REVIEW.

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If you treat Medicare beneficiaries, you will in all likelihood eventually meet one of Medicare's Recovery Audit Contractors, otherwise known as RACs Recovery Audit Contractors are Medicare third-party contractors engaged for the sole purpose of identifying services provided by doctors that do not meet the many documentation requirements now required by Medicare for reimbursement.

It is important to note up front that RACs are compensated based upon the amount of improper reimbursement they identify received by a practitioner as paid by Medicare. Of course, such an incentive drives the RACs to interpret documentation requirements against the practitioner's favor. Another noteworthy factor is that Medicare's bureaucratic process often creates an unbalanced playing field in any RAC dispute. For these reasons, it is imperative that as a provider of services for Medicare beneficiaries, you be aware of your rights and the defenses available to protect your practice should you find yourself under review.

The Review of Records

Typically, a RAC would contact your practice by letter, requesting that you send records to their attention for review. What the RAC is doing is looking at records for which you have already been reimbursed to see where payments may have been made that are not substantiated by your documentation techniques.

The rationale behind the review process is that every time a claim is submitted to Medicare for reimbursement, you are submitting a bill to the government; the government does not confirm receipt of services rendered to the extent that such services are truly verified at the time of payment. Post-payment reviews are a sampling of services rendered to verify fair consideration has been received.

The main problem with post-payment reviews is that documentation requirements for initial and subsequent visits are equivalent to large haystacks; and the closer you look, the more pins you will find in the stack. In this metaphor, the pins represent documentation gaps or errors. At the end of the day, no matter how good your documentation may be, held under a big enough microscope, mistakes may be found.

After you have submitted your records for review, the next step in this process is a letter from the RAC detailing their findings and identifying your documentation errors. This letter will also state an amount of money requested to be returned to Medicare for those services that were paid, but not substantiated.

If you take nothing else from this article, understand the worst thing you can do for your practice is blindly send a check to Medicare upon receipt of your initial RAC determination letter, for several reasons. First, any return of funds will be treated as an admission of fault. Second, errors in documentation regularly identified by RACs are subjective. For the most part, Medicare

documentation requirements are not specific with regards to actual documentation details – general billing guidelines are primarily addressed.

For instance, you may be required to assess qualitatively patient improvement from visit to visit, however, those qualitative measures Medicare would like you to use have not been defined. How are you to know what "qualitative measures" Medicare is looking for if no guidance is provided? This example is a common argument maintained by RACs – that practitioners fail to use appropriate qualitative measures.

The third reason is that as the treating provider, you have defenses available to you to combat such an adverse determination. Fourth, RACs notoriously make mistakes in their reviews. And fifth, you are entitled to be reimbursed for services you have rendered; the truth will set you free!

The Appeals Process

Appealing a RAC determination is a process. There are different appeal stages – the first is a *redetermination* (asking the same party to re-review); the second is a *reconsideration* (asking a new party to review first review again for new results); the third is an *Administrative Law Judge hearing* (asking a judge to look at the whole kit-and-caboodle from scratch); and the fourth is the *Medicare Appeals Council letter* (asking a group of higher-ups to review). Thereafter you are free to pursue a challenge in the court system.

Of course, this is a daunting process for many, one that should not be tackled without legal representation by a health care attorney with experience in these particular matters. (*Note:* Legal fees may be covered entirely by your malpractice carriers under an audit defense allotment.) Further, there is no benefit in not standing up for your right to be reimbursed for valid services rendered.

A common comment we hear from practitioners that always resonates is that health care is the only industry in which the general concept of getting something for free is commonplace. Medicare has a contract with its beneficiaries, and until such time as Medicare no longer is contracted to cover chiropractic services, it is required to honor its contractual agreement to reimburse for those covered services. In short, don't let Medicare bilk you out of payments for services rendered to your patients.

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