

INSIDE THIS ISSUE:

MEDICARE AND RAC APPEAL PROCESS 1

HEALTHCARE REFORM 1

PRIMARY CARE DOCTORS 2

HAPPY THANKSGIVING 2

PHYSICIAN PAY FORMULA 2

VETERANS DAY 3

QUOTE OF THE MONTH...

“ A winner is someone who sets his goals, commits himself to those goals, and then pursues his goals with all the ability given him. “

MEDICARE AND RAC APPEAL PROCESS

When Medicare claims are denied or a Recovery Audit Contractor (RAC) identifies a previous Medicare overpayment, physicians may initiate an appeal with their Medicare carrier. Appealing a denied claim or RAC audit can be a multi-step process as outlined below.

Claims Reviewed by Recovery Audit Contractors

Medicare continues to use RACs to help identify overpayments. RAC is a Medicare auditing program that utilizes private firms to examine physician, hospital, nursing home, and other claims to find instances in which the government has overpaid providers. Once a RAC determines there has been an overpayment, the physician or hospital is required to reimburse Medicare, even if they plan to appeal the

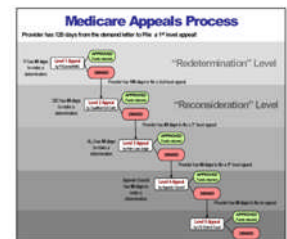
decision. Sometimes this can be large amounts of money. The RACs are paid by Medicare based on the amount of money they recover from physicians or hospitals. Until recently, the RACs have operated in only a few states. However, starting in 2008, the RAC program is being expanded to additional states.

An appeal to a RAC determination is essentially the same as any other Medicare appeal. However, a RAC initial determination is not appealed to the RAC – rather it is appealed to the Medicare carrier (or intermediary, in the case of hospital claims).

Defending a Medicare Overpayment-Documentation

The first line of defense in a Medicare overpayment, whether initiated by the RAC or the Medicare Part B carrier (the organization or company which

is administering Medicare Part B), is having adequate documentation to establish the medical necessity of the service. If the service is



governed by a local or national coverage determination, it is important to review that determination and make sure that the patient met the criteria set forth. For evaluation and management services, the documentation should reflect the level of service billed,

Continued on pg. 3— Medicare and RAC Appeal...

HEALTHCARE REFORM COULD EXTEND INTO 2010

Senate leaders could see health reform slip into next year. Senate Majority Leader Harry Reid waived any lingering deadlines that may have existed for a health reform package, pledging that he would not “be bound by any timelines” and potentially clearing the way for a 2010 end date for the bill.

Talking to reporters off of the Senate floor, Reid said would

make the bill public and allow enough time for everyone—from lawmakers to laymen—to study it. “So we’re going to do this legislation as expeditiously as we can, but we’re going to do it as fairly as we can, also,” he said.

Lawmakers in the Senate continue to wait for the Congressional Budget Office to release its cost assessment of a legislative package shaped by

committee chairmen and submitted by Reid last week. Any legislative step forward first requires the CBO to weigh in. The back and forth between lawmakers and the CBO is typical for any bill, but even more so considering the complexity of the healthcare overhaul package.

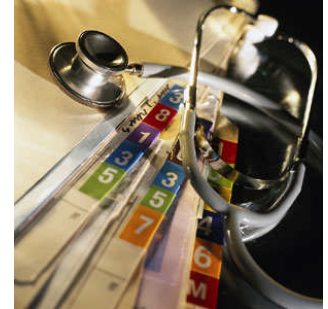
By [Matthew DoBias](#)
Posted: November 3, 2009
Modern Physicians

PROBLEM FACING PRIMERY CARE DOCTORS

A report from The Physicians' Foundation said nearly half of all the nation's primary care physicians plan to stop practicing or reduce the number of patients they see. The survey released by the organization depicts widespread frustration and concern among primary care physicians nationwide, which could lead to a dramatic decrease in practicing doctors in the near future. The survey examined the causes behind the doctors' dissatisfaction, the state of their practices and the future of care. The resulting findings show the possibility of significantly decreased access for Americans in the

years ahead, as many doctors are forced to reduce the number of patients they see or quit the practice of medicine outright. An overwhelming majority – 78 percent – of physicians believe that there is an existing shortage of primary care doctors in the United States today. Additionally, nearly half of them – 49 percent, or more than 150,000 practicing doctors – said that over the next three years they plan to reduce the number of patients they see or stop practicing entirely. The Physicians' Foundation believes the future of primary care could have a significant

impact on the American healthcare debate. The reported reasons for the widespread frustration among physicians include increased time dealing with non-clinical paperwork, difficulty receiving reimbursement and burdensome government regulations. Physicians said these issues keep them from the most satisfying aspect of their job: patient relationships.



Health Resources Publishing's "Directions: Looking Ahead in Healthcare." © 2009, Health Resources Publishing.

HAPPY THANKSGIVING

Wherever you find yourself on this life journey, we wish you a joyous and blessed Holiday Season. As we prepare to celebrate Thanksgiving here in the United States, we know that holidays are

a time of reflection as well as celebration.

From all of us here at American Healthcare Audit Professionals, we wish you a very special Thanksgiving Day for you and your family and loved ones.



PHYSICIANS PAY FORMULA SHOT DOWN

Paying doctors more money is a tough sell even in the best of economic times. The public and its elected officials perceive physicians to be some of the wealthiest people among us regardless of what the data say. Add in the recent recession and the debate over spending almost \$1 trillion on national

healthcare reform, the \$250 billion bill to fix the way Medicare pays doctors was a long shot, if not dead on arrival, in Congress.

The first nail in the bill's coffin was its rejection in the Senate last week. Physicians should not expect to be treated any better in the

House, if it ever comes up for a vote. The American Medical Association should have seen this coming, but it decided to trust the White House. The AMA was one of many organizations and industry sectors that cut a deal with the Obama administration.

Continued on pg. 4— Physician Pay formula...

responsibility to pay	TOTAL BILLED
TYPE OF SERVICE	100
Medical Visit	
Testing / X-ray / Lab	
Surgery	
TOTAL THIS CLAIM	

MEDICARE AND RAC APPEAL...CONTINUED FROM PAGE 1

based on either the 1995 or 1997 evaluation and management coding guidelines. Unfortunately, the first and second levels of appeal are often rubber stamps of the initial determination. However, many cases can be successfully overturned at the Administrative Law Judge (ALJ) level. Therefore, depending on the dollar amount at issue, it may be worth it to pursue the case up to the ALJ level (see below for more information).

First Level of Appeals (Written Requests for Redetermination)

Once the claim denial has been reviewed by the Medicare carrier, it may be appealed by requesting a redetermination of the claim within 120 days of the initial decision. Medicare carriers are required to respond to a request for redetermination within 60 days of receipt. The review determination letter will indicate the carrier's rationale for its decision. If the claim denial is overturned, the carrier must include the appropriate payment with the letter. If the claim denial is upheld, the carrier will provide an explanation. Providers are no longer given the option to appeal a denial via telephone. Carriers may choose to reopen a claim by telephone for clerical errors or omissions only.

Second Level of Appeals (Reconsideration)

If a provider or beneficiary (patient) is dissatisfied with the outcome of the redetermination process a request for a reconsideration may be filed within 180

days. The requests for reconsideration are required to be processed within 60 days by qualified independent contractors (QICs). There is no minimum dollar amount for the claim in controversy to qualify for reconsideration. Requests for reconsideration must be made in writing either on a standard CMS form or the reconsideration request form included with the redetermination. If neither of these forms are used, the request for reconsideration must contain the following items: 1) the beneficiary's name; 2) Medicare health insurance claim number; 3) the specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service; 4) the name and signature of the party or representative of the party; and 5) the name of the contractor that made the redetermination.

Third Level of Appeals (Administrative Law Judge)

If a provider is not satisfied with the result of the reconsideration, a hearing before an ALJ can be requested if the amount in controversy is at least \$110. Requests for a hearing from an ALJ must be filed in writing with the entity specified in the QIC's reconsideration notice and be received within 60 days of its receipt. ALJs are attorneys who work for the Department of Health and Human Services (HHS). Hearings are held in the Office of Medicare Hearings and Appeals (OMHA) field offices around the country. The physician, as well as the beneficiary, typically attends the hearing to present testimony. Following the hearing, the ALJ is required to issue a written ruling. The ruling is due within 90 days from the date that OMHA receives the hearing request. The ALJ's decision is binding unless

revised at a later date by the ALJ, the federal district court, or the Medicare Appeals Council. An ALJ hearing may be conducted either in-person, or through Video teleconference (VTC) or telephone. Most hearings are held by VTC or telephone unless the ALJ determines that there are special or extraordinary circumstances. Written notice of the hearing date and location should be received at least 20 days prior to the scheduled hearing.

Fourth Level of Appeals (Medicare Appeals Council)

The provider may file a request for review with the Medicare Appeals Council if the ALJ's decision is not favorable to the provider. Requests for an Appeals Council review must be filed within 60 days of receipt of the ALJ's decision. The Appeals Council may either modify or reverse the ALJ's decision or send the case back to the ALJ for another hearing. The Appeals Council must issue a determination within 90 days of the review.

Fifth Level of Appeals

If the decision of the Appeals Council is unfavorable to the provider, the final option is to file a suit in federal district court, 60 days from the Appeals Council decision and if the amount in controversy is at least \$1090. This is the last level of appeals available to providers.

This information was provided by
(*American Academy of Physical Medicine & Rehabilitation*)

REMEMBER TO THANK A VETERAN

Remember, if you see a veteran today, or you know one and you haven't done it already, make sure you thank him or her for serving their country...

Remember November 11th is **Veterans Day**.

We salute each and every one of them,
The noble and the brave,
The ones still with us here today,
And those who rest in a grave.
So here's to our country's heroes;
They're a cut above the rest;
Let's give the honor that is due
To our country's very best.



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- *Case Review & Preparation*
- *Expert Witness Testimony*
- *Consulting Services for Attorneys & Healthcare Providers*
- *Worker's Compensation Reviews*

MAKING A DIFFERENCE WHERE IT COUNTS...

PHYSICIAN PAY FORMULA...CONTINUED FROM PAGE 2

Most of them agreed to make some level of financial concession in exchange for supporting a reform proposal that wouldn't be potentially fatal to that particular sector of the industry. Pay up and you'll live. Don't pay and we'll figure out a way to put you out of business.

For its part, the AMA agreed to support President Barack Obama's reform plan in exchange for the passage of a bill that would scrap the current way Medicare pays doctors for care to beneficiaries, and freeze payment rates for 10 years until a new, more equitable payment system would be put in place. But you didn't hear or see Obama stumping for physician payment reform as aggressively or as overtly as he has for his overall healthcare reform plan.

Perhaps he knew physician payment reform was a dead issue, and he didn't want to waste any political capital that he needs for the bigger fight.

Now what's the AMA to do? We would suggest turning its sights on the fatal physician-ownership provisions in the five reform bills pending in Congress. The provisions effectively would put physician-owned hospitals out of business. They would not allow existing facilities to expand. They would not grandfather-in facilities under development. And they would not allow new facilities to be built.

Physician-owned hospitals do wonders for local healthcare markets by adding much-needed competition to those markets. But they also give

entrepreneurial doctors an opportunity to control their own financial fate. If the government isn't going to pay them any more money for treating the poor and the elderly, at least let them own their own business just like every other American has the right to do.

The AMA would be wise to work day and night to strip those reform bills of those provisions and do what it can for its members rather than hoping for something that may never happen at all.

By David Burda
Posted: October 26, 2009
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