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MDS Alert

MEDICARE: Don't Rack Up Unfair RAC Denials: Follow These 6 Rules for Appealing Payment Recoupments

Even if you're dead wrong on an issue, check out this often overlooked escape hatch.

RAC denials can be disheartening,but before you proceed with an appeal, check out these potential pitfalls and tips for winning.

Rule No. 1: Know who you are up against. "RACs aren't likely to deny anything where they don't believe they have say a 90 percent chance of recovering money," says **Pauline Franko, MSCP, PT,** principal of Encompass Consulting & Education in Tamarac, Fla.

And, "you can figure the RAC is going to fight tooth and nail to make sure a denied claim stays denied upon appeal," says **Victor Kintz, MBA, CHC, LNHA, RACCT, CCA,** managing director of operations for the Polaris Group based in Tampa, Fla. That's because, "the outcome will affect whether or not they will be paid for the work done on that claim."

Rule No. 2: If you think you're right, however, fight. Providers should decide whether to appeal on a case-by-case basis, says Kintz. But speaking generally , Kintz notes that if a provider delivereda covered service and documented it -- "and the RAC or another post-payment audit group says [the provider] billed Medicare incorrectly" -- he would not want to admit that by not appealing.

Good point: "If you don't appeal, you have been put on notice that you did something deemed to be wrong," observes attorney **Amy Fehn,** with Wachler & Associates PC in Royal Oak, Mich**.** And "if you don't fight it, you should arguably change your practice patterns."(Fehn notes, however, that it isn't necessarily an admission of wrongdoing if you don't appeal.)

Rule No. 3: Beware blanket appeal tactics. Appealing every RAC denial in an effort to "clog up the system" can backfire, cautions **Tim Johnson,** executive director of Castle Rock Medical Group in Denver. That approach can put the provider in the position of facing **"**potential fraud allegations" by maintaining that everything they are doing is OK and continuing their current practices. "You want to change your operations to adhere to CMS payment criteria," he stresses.

Rule No. 4: Don't count yourself out due to lack of solid documentation. You can summarize services provided but not documented in a late entry and/or put the information in a cover letter, advises Franko. Also, "look at other ways to validate that you provided a service that wasn't documented properly." For example, a SNF could show that the patient signed into the therapy gym for services, she notes.

Rule No. 5: Before you cry 'mea culpa,' consider other ways to prevail. Even if you are completely wrong on an issue, take a closer look to see if you can get off the hook. "We advise looking at every angle before a provider throws in the towel and pays the money back," says Fehn. For example, "did the RAC go back too far?"she asks.

Perhaps the RAC could legitimately reopen the claim, "but did they have good cause to revise it?" Fehn asks. She also points to "waiver of liability and provider without fault arguments," where you examine the guidance that the provider had from CMS on the issue at the time. "The guidance may be clear now to show that the provider did something wrong, but it might not have been so clear at the time" the provider rendered the services, she points out.

Rule No. 6. Take your appeal to the administrative law judge, if needed. "We have the greatest success at the administrative law judge level," notes Fehn. "So to just say you are going to appeal to the reconsideration level means you are missing your best opportunity" at prevailing upon appeal. Kintz agrees that "getting in front of a human to plead your case is where a lot of denials get overturned."

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