RAC LEGAL DEVELOPMENTS AND STRATEGIES FOR SUCCESSFUL APPEALS

Kathleen Houston Drummy, Esq.

kathydrummy@dwt.com

Davis Wright Tremaine LLP

RACS MUST TARGET CLAIMS FOR REVIEW USING DATA ANALYSIS

- Data mining techniques
- Office of Inspector General ("OIG") and GAO reports
- Comprehensive Error Rate Testing ("CERT") Program reports
- Claims data furnished by CMS (Demonstration Project)

TYPES OF REVIEW

- **<u>Automated Review</u>: If there is a *clear* improper payment, the RAC has no need to evaluate the medical record associated with the claim and merely contacts the provider to collect the overpayment or pay the underpayment.**
- **<u>Complex Review</u>: If it appears *likely* that a claim contains errors, the RAC requests medical records from the provider and reviews the claim.**

THE REVIEW PROCESS

- **RACs must use the same Medicare policies and rules and the same type of review staff used by Medicare claims processing contractors.**
- **Providers may refute an overpayment determination in two ways: an informal rebuttal process or a formal appeal process.**

APPEALS CONCERNING THE RAC DEMONSTRATION

- A large number of the appeals filed by providers in the three year RAC Demonstration challenged medical necessity or coding determinations made by the RAC.
- CMS emphasized in the 2008 Status Report that only a small percentage of RAC determinations were fully or partially overturned on appeal.
- The CMS "success" calculation may be overstated.

REBUTTAL

- Informal opportunity to work with RAC to dispute alleged overpayment finding.
- Provider must submit a rebuttal statement within 15 days of receiving notice of recoupment of an overpayment.
- The RAC considers the rebuttal statement and other relevant evidence in determining whether the decision is justified.
- This process is not a prerequisite to the appeals process and the Provider need not pursue rebuttal.
- Provider may still appeal using the formal appeal process.
- Rebuttal process may assist in decision as to whether to continue to appeal.

MEDICARE APPEALS PROCESS FOR RACS

- **General: RAC determination may be appealed in essentially the same manner as any Medicare appeal.**
- **Exception: The RAC initial determination is appealed to the Medicare contractor that initially paid the claim, not the RAC that made the initial determination.**

FIRST LEVEL OF APPEAL: REDETERMINATION

- **Provider must request redetermination in writing within 120 days of initial determination.**
  - **<u>Exception</u>: At least for Part B overpayment determinations, if the Provider files the notice of appeal within 30 days of initial determination, recoupment is deferred during the first two appeal levels. MMA Section 935(a); CMS Transmittals 322 and 384.**

FIRST LEVEL OF APPEAL: REDETERMINATION *(cont'd.)*

- **Overpayment withholding otherwise starts on day 41**
- **Interest continues to accrue on overpayment during the deferral period**
- **<u>AnMed Health v. Leavitt</u>: Recoupment of Part A Overpayments**

- **There are no minimum requirements for the amount in controversy.**

FIRST LEVEL OF APPEAL: REDETERMINATION *(cont'd.)*

- **Medicare contractor has 60 days from receipt to decide whether to sustain RAC's findings.**
  - **The review determination letter should state the rationale for its decision.**
  - **If the claim denial is upheld, the Medicare contractor will provide an explanation.**
- **The provider cannot expedite the appeal at this level.**

SECOND LEVEL OF APPEAL: RECONSIDERATION

- **Provider must request a reconsideration in writing for a review by a Qualified Independent Contractor ("QIC").**
  - **<u>EXCEPTION</u>: If Provider appeals early to QIC, recoupment again is deferred, at least for Part B overpayment determinations.**
- **There are no minimum requirements for the amount in controversy.**

SECOND LEVEL OF APPEAL: RECONSIDERATION *(cont'd.)*

- **The QIC must process the request for reconsideration within 60 days.**
  - **If the QIC cannot complete its decision in the applicable timeframe, it will inform the appellant of its right to move the case to an administrative law judge.**
  - **<u>Critical</u>: All issues must be raised and all evidence relevant to the appeal submitted to the QIC prior to the issuance of the reconsideration decision. Absent a showing of good cause for late submissions, evidence not submitted at the reconsideration level may be excluded from consideration at later levels.**

THIRD LEVEL OF APPEAL: ADMINISTRATIVE LAW JUDGE ("ALJ") HEARING

- **Provider may request a hearing before an ALJ by filing the request in writing with the entity specified in the notice within 60 days of receipt of the QIC's reconsideration notice.**
- **Appellants must send notice of the ALJ hearing request to all parties to the QIC for reconsideration.**
- **The minimum amount in controversy for calendar year 2009 is $120 (adjusted annually).**

THIRD LEVEL OF APPEAL: ADMINISTRATIVE LAW JUDGE ("ALJ") HEARING *(cont'd.)*

- **Written notice of the hearing date and location should be received at least 20 days prior to the scheduled hearing.**
- **The hearing may be conducted either in-person, through video-teleconference, or by telephone.**
- **The ALJ may only review evidence previously presented at the Second Level of Appeal, absent a finding of good cause.**
- **Oral testimony may be offered.**

THIRD LEVEL OF APPEAL: ADMINISTRATIVE LAW JUDGE ("ALJ") HEARING *(cont'd.)*

- **The ALJ may request that CMS or its contractors participate as a party.**
- **The ALJ must issue a written decision within 90 days from the date that the Office of Medicare Hearings and Appeals receives the hearing request.**
  - **If the ALJ cannot issue a decision in the applicable timeframe, the ALJ will notify the appellant of the right to move the case to the Medicare Appeals Counsel ("MAC").**
- **The ALJ decision is binding unless it is modified or reversed by the MAC or a federal court.**

FOURTH LEVEL OF APPEAL: MAC REVIEW

- **Provider may file a request for review with the MAC within 60 days of receipt of the ALJ's decision. The request must be in writing and must specify the issues and findings that are being contested.**
- **The MAC may review the ALJ's decision on its own motion or at the request of CMS.**
- **There are no minimum requirements for the amount in controversy.**

FOURTH LEVEL OF APPEAL: MAC REVIEW *(cont'd.)*

- **No appearance is required.**
- **The appeal is limited to the record made before the ALJ.**
- **The MAC must issue a determination within 90 days of the review, either modifying, reversing, or remanding the ALJ decision. If the MAC cannot complete its decision in the applicable timeframe, it will inform the appellant of the right to move the case to the federal district for judicial review.**

FIFTH LEVEL OF APPEAL: FEDERAL DISTRICT COURT

- **Provider has a final option to file suit in federal district court within 60 days of receipt of the MAC decision.**
- **The minimum amount in controversy for 2008 is $1180 and for 2009 is $1220.**
- **The evidence presented at the federal district court level is limited to the administrative record.**

APPEAL CONSIDERATIONS

- **In deciding whether to appeal, providers should consider:**
  - **Is there clear Medicare guidance or criteria to support or rebut the RAC's determination?**
  - **Is the clinical documentation adequate?**
  - **Is clinical support available, in particular the treating physician?**

APPEAL CONSIDERATIONS *(cont'd.)*

- **Should outside consultants, including legal counsel, be involved and at what stage in the process?**
- **The cost versus the benefit of appeal?**
  - **Unique, one time issue versus frequent and ongoing issue?**
  - **Case must be fully developed early in the appeal process, so retention of any outside consultants/attorneys similarly should occur earlier.**

RECENT DEVELOPMENTS

- **The MAC has been reviewing and remanding ALJ decisions regarding RAC determinations.**
- **For example, providers have challenged RAC determinations that there was "good cause" for reopening claims beyond one year.**

RECENT DEVELOPMENTS *(cont'd.)*

- **The MAC, on its own motion, has been reviewing ALJ decisions holding that a Medicare contractor improperly reopened claims beyond one year without making an evidentiary showing of good cause. See, e.g., In re Critical Care of North Jacksonville, Medicare Appeals Council, February 29, 2008; In re Memorial Hospital of Long Beach, Medicare Appeals Council, July 23, 2008; In re Providence St. Joseph Medical Center, Medicate Appeals Council, July 23, 2008.**

RECENT DEVELOPMENTS *(cont'd.)*

- **The MAC's remand was based on its determination that neither the ALJ nor the MAC have the jurisdiction to consider a Medicare contractor's decision on whether to reopen a claim or whether the contractor met the "good cause" standard. The MAC concluded that CMS's evaluation and monitoring of contractor performance, not the appeals process, offered the forum for enforcing the "good cause" standard.**

STAY OF RECOUPMENT

- **AnMed Health v. Leavitt, Case No. 8:2008 CV02453 – HFF, U.S. District Court, District of South Carolina: Pending case in which thirty-seven South Carolina hospitals alleged that CMS unlawfully recouped over $20 million in alleged Medicare overpayments, in controvention of MMA 935(a), in the RAC Demonstration project**