

DETERMINING WHETHER TO APPEAL RAC DENIALS

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RACs USE 2 APPROACHES TO REVIEWING FOR IMPROPER PAYMENTS

I. AUTOMATED REVIEW

- DATA MINING
 - CERTAINTY THAT SERVICE IS NOT COVERED OR IS INCORRECTLY CODED AND
 - A WRITTEN MEDICARE POLICY, ARTICLE OR SANCTIONED GUIDELINE EXISTS

RACs USE 2 APPROACHES TO REVIEWING FOR IMPROPER PAYMENTS (cont'd)



COMPLEX REVIEW

- HUMAN REVIEW OF THE MEDICAL RECORD
 - THE REQUIREMENTS FOR AUTOMATED REVIEW ARE NOT MET (E.G., NO MEDICARE POLICY, ARTICLE OR SANCTIONED CODING GUIDELINES EXISTS)
 - THERE IS A HIGH PROBABILITY (BUT NOT CERTAINTY) THAT A SERVICE IS NOT COVERED

COMPLEX REVIEW

- RACs REQUIRED TO USE MEDICAL LITERATURE AND APPLY APPROPRIATE CLINICAL JUDGMENT
- RAC'S MEDICAL DIRECTOR TO BE INVOLVED IN REVIEWING THE CLAIM DETERMINATIONS
- RAC'S RNS OR THERAPISTS TO MAKE MEDICAL NECESSITY/COVERAGE DETERMINATIONS
- CERTIFIED CODERS TO MAKE CODING DETERMINATIONS
- PROVIDER MAY REQUEST CREDENTIALS OF THE REVIEWERS

DO YOU APPEAL A RAC DENIAL?

- ANY CLEAR MEDICARE RULES, GUIDANCE OR CRITERIA REGARDING THE SERVICE
- STATUS OF SUPPORTING DOCUMENTATION
- CLINICAL STAFF AVAILABILITY AND SUPPORT
- INVOLVEMENT OF OUTSIDE CONSULTANTS/ ATTORNEYS TO ASSIST IN REVIEW OF DENIAL

DO YOU APPEAL A RAC DENIAL? (cont'd)

- EFFECT OF BINDING AUTHORITY ON DIFFERENT APPEAL LEVELS
 - ALJS NOT BOUND BY LOCAL COVERAGE DECISIONS, LOCAL MEDICAL REVIEW POLICIES, OR CMS PROGRAM GUIDANCE; E.G., MANUAL PROVISIONS
- AVAILABILITY OF OTHER LEGAL DEFENSES
- COST VS. BENEFIT OF THE APPEAL

DO YOU APPEAL A RAC DENIAL?

- DOES RAC AUDIT COMPLY WITH RAC CONTRACTUAL REQUIREMENTS?
 - *EXAMPLE:* NO REVIEW OF CLAIMS REVIEWED BY OTHER MEDICARE AUDITORS OR FEDERAL AGENCIES
 - *EXAMPLE:* CANNOT EXCEED CMS ISSUED LIMITS ON NUMBER AND FREQUENCY OF MEDICAL RECORD REQUESTS
 - *EXAMPLE:* DID RACs INVOLVE APPROPRIATE CLINICAL STAFF IN REVIEW
 - *EXAMPLE:* DID RAC APPLY CMS RULES/POLICIES OR ITS OWN SCREENING CRITERIA AND RULES

REBUTTAL TO RAC

- UPON RAC DENIAL: REBUTTAL AND APPEAL OPTIONS
- REBUTTAL TO THE RAC
 - 15 DAYS OF RECEIPT OF RAC DENIAL
 - POSSIBLE USE TO AUGMENT PROVIDER'S UNDERSTANDING OF THE BASIS FOR THE DENIAL AND IN ASSESSING WHETHER TO APPEAL

REBUTTAL TO RAC (cont'd)

- NEW DOCUMENTATION COMES TO LIGHT TO SUPPORT A CLAIM
- REFERENCE ANY MEDICARE AUTHORITY SUPPORTING PROVIDER'S POSITION
- PROVIDER STILL ABLE TO APPEAL, BUT USE OF REBUTTAL PROCESS DOES NOT AFFECT RECOUPMENT OR APPEAL TIME FRAMES

COST VERSUS BENEFITS OF APPEALING

BENEFITS



KEEP/RECOUP CLAIM PAYMENT



MAY HEAD OFF SIMILAR DENIALS, IF SUCCESSFUL



PROACTIVELY APPEALING MAY MAKE THE PROVIDER A LESS DESIRABLE TARGET



PROTECT COMMUNITY REPUTATION



MINIMIZE COMPLIANCE REPERCUSSIONS FROM NOT CHALLENGING DENIALS

- COSTS
 - COST OF ASSESSING THE DENIAL
 - INTERNAL
 - EXTERNAL CONSULTANTS OR LEGAL COUNSEL
 - COST OF PREPARING AND HANDLING THE APPEAL
 - ALJ (THE THIRD LEVEL APPEAL) IS GENERALLY THE MOST FRIENDLY APPEAL LEVEL, BUT DOCUMENTATION EVIDENCE MUST BE COMPLETE BY THE SECOND LEVEL

INTEREST COSTS

- IF APPEAL BEFORE RECOUPMENT, AVOID IMMEDIATE RECOUPMENT
 - *BUT:* PAY THE PIPER INTEREST LATER IF LOSE
 - SECTION 935 OF THE MMA: RECOUPMENT UNLESS REQUEST REDETERMINATION BY THE 30TH DAY AFTER THE DATE OF THE DEMAND LETTER AND UNLESS REQUEST RECONSIDERATION BY THE 60TH AFTER AN ADVERSE REDETERMINATION DECISION
- RECOUPMENT AFTER AN ADVERSE RECONSIDERATION DECISION EVEN IF APPEAL TO THE ALJ

- STILL COULD LOSE
 - LOSE PAYMENT FOR CLAIM
PLUS
 - LOSE INTERNAL AND EXTERNAL
RESOURCE COSTS

- CANNOT WAIT UNTIL ALJ LEVEL TO PUT TOGETHER THE APPEAL
- EARLY PRESENTATION OF EVIDENCE IN THE APPEAL PROCESS
 - CRITICAL NATURE OF RECONSIDERATION LEVEL OF APPEAL
 - ALL OF THE DOCUMENTATION THAT THE PROVIDER/SUPPLIER EXPECTS TO USE FOR THE REST OF THE APPEAL PROCESS MUST BE PRESENTED BY THE RECONSIDERATION APPEAL LEVEL
 - PROVISION OF DOCUMENTATION THEREAFTER SUBJECT TO “GOOD CAUSE” CONSIDERATIONS

GENERAL LEGAL ISSUES RELEVANT TO RAC APPEALS

- ARE RACs AUTHORIZED BY CONGRESS TO REVIEW MEDICAL NECESSITY?

GENERAL LEGAL ISSUES RELEVANT TO RAC APPEALS (cont'd)

- ARE RAC REVIEWS UNCONSTITUTIONAL AS A RESULT OF THE CONTINGENCY FEE COMPENSATION PAID TO RACs?
 - VALIDATION AUDITOR DISAGREED WITH RACS IN 40% OF CASES REVIEWED

OTHER CHALLENGES TO RAC REOPENINGS

- DEFENSES AGAINST CLAIM DENIAL

COMPLIANCE REPERCUSSIONS?

- RACs ARE TO REPORT SUSPECTED FRAUD AND ABUSE
- MMA OF 2003 DID NOT PROHIBIT INVESTIGATIONS BY CMS OF FRAUD AND ABUSE ARISING FROM A RAC OVERPAYMENT DETERMINATION
 - OTHER MEDICARE ENFORCEMENT AGENCIES WILL SEE THE DENIAL STATISTICS

- ERRONEOUS OR QUESTIONABLE RAC DETERMINATIONS MIGHT BE HARDER TO CHALLENGE AT THE BACK END IF THOSE DETERMINATIONS BECOME THE BASIS OF A COMPLIANCE INVESTIGATION
 - IF THE RAC FINDS OVERPAYMENTS OF A SYSTEMATIC TYPE, PROVIDER CORRECTIVE ACTIONS MERITED PARTICULARLY IF DO NOT APPEAL
 - IF DO APPEAL, THERE IS A LEGAL DISPUTE OVER WHETHER ANY KNOWLEDGE OF FALSITY UNDER THE FALSE CLAIMS ACT

- PREEMPTIVE ACTIONS BY THE PROVIDER
 - SELF-DISCLOSURES TO THE OIG, VOLUNTARY REFUNDS AND CORRECTIVE ACTIONS TO MINIMIZE FUTURE IMPACT
 - SELF-DISCLOSURE AND REPAYMENT
 - SHOULD A PROVIDER DISCOVER THAT IT MAY HAVE RECEIVED AN IMPROPER MEDICARE PAYMENT, MAY DECIDE TO MAKE A SELF-DISCLOSURE OR VOLUNTARY REFUND

- **IMPACT ON RAC AUDITS:**
 - **RACs MAY NOT REVIEW CLAIMS THAT ARE UNDER REVIEW BY ANOTHER GOVERNMENT ENTITY**
 - **RAC COMPENSATION IS IMPACTED BY SELF-DISCLOSURES AND VOLUNTARY REFUNDS**

- VOLUNTARY REPAYMENTS
 - MADE TO THE MEDICARE CONTRACTOR
 - NO RAC FEES IN CERTAIN CASES
 - MEDICARE PROGRAM INTEGRITY MANUAL, CHAPTER 4

OTHER CORRECTIVE ACTIONS

- REDESIGNING OR IMPROVING INTERNAL CONTROLS
- EDUCATING AND TRAINING OF RELEVANT PROVIDER STAFF
- ASSURING POLICIES ON DOCUMENTATION CODING AND BILLING ARE UP TO DATE AND COMPLIANT
- PERIODICALLY MONITORING CLAIMS VIA AN INTERNAL AUDIT TO ASSURE THAT DOCUMENTATION, CODING AND BILLING IS BEING DONE APPROPRIATELY

- **RACs CAN EXTRAPOLATE**
 - RACs MUST FOLLOW SECTION 935(a) OF THE MEDICARE MODERNIZATION ACT OF 2003
 - CMS ENVISIONS A RAC USING EXTRAPOLATION IN CASES WHERE THERE WAS EVIDENCE OF A SUSTAINED OR HIGH LEVEL OF PAYMENT ERROR OR DOCUMENTED EDUCATION INTERVENTION BY THE MEDICARE CONTRACTOR