National Healthcare Compliance Audioconference

RAC Audit Appeals: Strategies and Defenses for Overturning Hospital RAC Denials

The Medicare Appeals Process

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The Medicare Appeals Process

- **120 days** to file a request for redetermination
  - *30 days to avoid recoupment*
- **180 days** to file a request for reconsideration by a QIC
  - *60 days to avoid recoupment*
- **60 days** to file a request for an Administrative Law Judge (ALJ) hearing
  - *CMS will recoup the alleged overpayment during this and subsequent stages of appeal*
- **60 days** to file an appeal to the Medicare Appeals Council (MAC)
- **60 days** to appeal to the federal district court
  - Note: Amount in controversy requirements must be met at the Administrative Law Judge hearing stage and federal district court stage.

First Level of Appeal: Redetermination
(42 CFR §§ 405.940-.958)

- **Timeframe:** Providers must file requests for redetermination within **120 calendar days** of receiving the initial determination (or within **30 days** to avoid recoupment)
  - *Issue in the RAC demonstration – Medicare providers did not always receive notice of denial from the RACs*
- No amount in controversy requirement
- Must be submitted in writing

Redetermination Timeframe

- Contractors are required to act within 60 days of receiving the request for redetermination.
- 60 day limit is extended up to 14 days each time additional evidence is submitted after the filing of the request for redetermination.
  - 42 C.F.R. §§ 405.946-.950

Second Level of Appeal: Reconsideration

(42 CFR §§ 405.960-.978)

- Providers who are dissatisfied with a redetermination may file a request for QIC reconsideration
- Providers must file requests for reconsideration within **180 calendar days** (or within **60 days** to avoid recoupment)
- No amount in controversy requirement
- Note: Absent good cause, failure to submit evidence prior to the issuance of the notice of reconsideration precludes consideration of the evidence at subsequent levels of appeal.

Reconsideration
On-the-Record Review

- "On-the-record" review as opposed to an in-person hearing

- On-the record review consists of a review of the initial determination, the redetermination and all issues related to the payment of the claim.

  - 70 Fed. Reg. 11447-48.

Reconsideration
Reviews Involving Medical Necessity

- If the initial determination involves the issue of whether an item or service was reasonable and necessary for the diagnosis or treatment of injury or illness, then the QIC's reconsideration must involve consideration "by a panel of physicians or other appropriate health care professionals, and be based on clinical experience, the patient's medical records, and medical, technical, and scientific evidence of record to the extent applicable."

  - 42 C.F.R. § 405.968 (a).

Reconsideration Binding Authority

- Bound by National Coverage Decisions, CMS rulings, and applicable laws and regulations.
- Not bound by Local Coverage Decisions, Local Medical Review Policies, or CMS program guidance such as program memoranda and manual instructions.
  - While not bound by these authorities, the QIC gives substantial deference to these policies if applicable to the particular case.
  - 42 C.F.R. § 405.968 (b); 70 Fed. Reg. 11447.

Reconsideration
Full & Early Presentation of Evidence

- Absent good cause, failure of a provider to submit evidence, including documentation requested in the notice of redetermination, prior to the issuance of the notice of reconsideration, precludes subsequent consideration of the evidence.
  - 42 C.F.R. § 405.966.

Reconsideration Timeframe

- The QIC is required to act within 60 days of receipt of the request for reconsideration.
- The QIC may extend the 60 day timeframe up to an additional 14 days each time the provider submits additional evidence after filing the reconsideration request.
- If the QIC fails to render its reconsideration decision within the required timeframe, a provider may request an ALJ hearing.
  - *Recent OIG Report found that Part B QICs did not meet the 60 day timeframe 58% of the time.*
- A provider must notify the QIC in writing of the decision to escalate the case to an ALJ.
  - 42 C.F.R. § 405.970.

Third Level of Appeal: ALJ Hearing
(42 CFR §§ 405.1000-.1064)

- A provider dissatisfied with a reconsideration decision may request an ALJ hearing.
- A provider must file request for ALJ hearing within **60 calendar days** of receiving QIC reconsideration decision.
- Amount in controversy requirement

ALJ Hearing
Video-Teleconferencing (VTC)

- ALJ hearings may be conducted in-person, by video-teleconference (VTC) or by phone.

- The Final Rule requires ALJ hearings be conducted by VTC if the technology is available.

  - 42 C.F.R. § 405.1020 (b).

ALJ Hearing
Discovery

- Discovery is only permitted when CMS elects to participate in the hearing as a party.
  - However, providers can make a FOIA request for a copy of a QIC's notes and can request an ALJ's hearing file.
  - 42 C.F.R. § 405.1037.
- CMS or its contractors may participate in ALJ hearing without necessarily joining as a party
  - 42 C.F.R. § 405.1010.
- CMS or its contractors may be a party to a hearing
  - 42 C.F.R. § 405.1012.

ALJ Hearing
Binding Authority

- Bound by National Coverage Decisions, CMS rulings, and applicable laws and regulations.
- Not bound by Local Coverage Decisions, Local Medical Review Policies, or CMS program guidance such as program memoranda and manual instructions.
  - While not bound by these authorities, ALJs give substantial deference to these policies if they are applicable to the particular case.
  - 42 C.F.R. § 405.1062.

ALJ Hearing
Statistical Sampling

- When an appeal from the QIC involves an overpayment in which the QIC relies upon a statistical sample in making its decision, the ALJ must base his or her decision on a review of all claims in the sample.
  - 42 C.F.R. § 405.1064.

ALJ Hearing Timeframe

- Generally, ALJ is required to act within 90 days of of receiving the request for the ALJ hearing.
- A provider who timely files for an ALJ hearing, and whose appeal is still pending after the adjudication time period has ended, has the right to request that the case be escalated to MAC review.
- A provider must exercise his or her right to request escalation in writing.
  - 42 C.F.R. § 405.1016.

Medicare Appeals Council (MAC) & Judicial Review

(42 CFR § § 405.1100-.1140)

- Absent good cause, a provider must file a request for MAC review within **60 calendar days** of receiving the ALJ's decision or dismissal.
- A party does not have the right to seek MAC review of an ALJ's remand to the QIC or an ALJ's affirmation of a QIC's dismissal on a request for reconsideration.
  - 42 C.F.R. §450.1102.

MAC Review

- No hearing
- De novo review
  - 70 Fed. Reg. 11467.

- The MAC may decide on its own motion to review a decision or dismissal by an ALJ.
- CMS or any of its contractors also may refer a case to the MAC any time within 60 days after the date of an ALJ's decision or dismissal of a case, if in its view the decision or dismissal contains an error of law material to the outcome of the claim or presents a broad policy or procedural issue that may affect public interest.
  - 42 C.F.R. § 405.1110.

MAC Review

- Requirements for Request for MAC Review:
  - The request must identify the parts of the ALJ action with which the party disagrees and explain the reasons for disagreement.
  - Unless the request is from an un-represented beneficiary, the MAC will limit its review to those exceptions/issues raised by the appellant in the written request for review.
    - 42 C.F.R. § 405.1112.

MAC Review
Written Statement & Oral Argument

- **Written Statements:** Upon request, the MAC will grant the parties a reasonable opportunity to file briefs or other written statements.
- **Oral Argument:** A party may request to appear before the MAC to present oral argument on the case. The MAC will grant such a request if it decides that the case raises an important question of law, policy, or fact that cannot be readily decided based on the written submissions alone.
  - 42 C.F.R. § 405.1120-24.

MAC Review Timeframe

- The MAC acts within 90 days of receiving the request for review unless extended due to escalation from the ALJ hearing.
- If the MAC fails to act within 90 days, the appellant may request that the appeal, other than an appeal of an ALJ dismissal, be escalated to federal district court.
  - 42 C.F.R. §§ 405.1100; .1132.

Judicial Review
Federal District Court

- **60 calendar days** after receipt of MAC notice of decision to file for judicial review.
- Amount remaining in controversy must meet requirement.
- A court may not review a regulation or instruction that relates to a method of payment under Medicare Part B if the regulation or instruction was published or issued before January 1, 1991.
- In a federal district court action, the findings of fact by the Secretary of HHS, if supported by substantial evidence, are deemed conclusive.
  - 42 C.F.R. § 405.1136.

Legal Issues Arising in the Demonstration Program

- Under the Demonstration Program the RACs were provided a 4-year look back period
  - Provider without Fault considerations
- Appeals challenging proper reopening of claims
  - *See* recent MAC decision of *Critical Care of North Jacksonville v. First Coast Service Options, Inc.*
  - *See* Complaint in *Palomar Medical Center v. Department of Health and Human Services*, No. 09-CV-0605-BEN-NLS (S.D. Cal. Mar. 24, 2009).
- Notice issues
  - Providers did not always receive proper notice from the RACs of claim denials, contrary to Statement of Work.
- QIO
  - Potential issue if discrepancy between QIO and RAC findings – Waiver of Liability, Provider without Fault
- Inpatient vs. Outpatient Observation

Legal Defenses

- Provider without Fault
- Waiver of Liability
- Treating Physician's Rule
- Challenges to Statistics
- Reopening Regulations

Questions?

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