LEGAL ISSUES IN THE RAC AUDIT AND APPEAL PROCESS

presented by

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LEGAL BACKBONE OF THE RAC PROCESS

- **CONGRESSIONAL ACTIONS**
  - **IMPROPER PAYMENT INFORMATION ACT OF 2002**
    - **Required federal agencies to measure improper payment rates, with a focus on identifying mistakes which change the payment amount**

- **MEDICARE MODERNIZATION ACT ("MMA") OF 2003, SECTION 306**
  - **Directed CMS to conduct a three year demonstration postpayment review program commencing in March 2005**
  - **Focused on a handful of states, principally California, New York, and Florida**
  - **Contingency fee compensation**

- **TAX RELIEF ACT OF 2006, SECTION 302**
  - **Made the RAC program permanent**
  - **Expanded the RAC program to all states by 1/1/10**

- **CONGRESSIONAL INACTION**
  - **H.R. 4105: THE MEDICARE RECOVERY AUDIT CONTRACTOR PROGRAM MORATORIUM ACT OF 2007**
    - **Would have imposed a one year moratorium on the RAC program expansion to permit evaluation before going national**
    - **No action and not re-introduced this year**

- **BUT, GAO STUDY REQUESTED BY CONGRESS LAST JULY**
  - **GAO asked to examine the changes implemented in response to lessons learned from the pilot and the incorporation of these changes into the nationwide rollout, including:**
    - **Provider outreach and actions the Agency has taken to prevent future improper payments in areas identified by the RACs**
    - **Coordination and interaction with other Medicare contractors**
    - **CMS oversight of auditing efforts**
    - **CMS oversight of the interactions between RACs and providers done to quantify and minimize the total burden of compliance**

LEGAL ISSUES RELEVANT TO THE RAC AUDIT AND APPEAL PROCESS

- **ARE RACs AUTHORIZED BY CONGRESS TO REVIEW MEDICAL NECESSITY?**
- **MEDICAL NECESSITY DISPUTES USUALLY CONCERN SUBJECTIVE DECISIONS ABOUT:**
  - **ADEQUACY OF DOCUMENTATION**

    OR
  - **APPLICABLE STANDARD OF CARE**
- **QUALIFIED DECISION MAKERS?**
- **BATTLE OF EXPERTS**

- **ARE RAC REVIEWS UNCONSTITUTIONAL AS A RESULT OF THE CONTINGENCY FEE COMPENSATION PAID TO RACs?**

- **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**

- **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**

- **PREEMPTIVE ACTIONS BY THE PROVIDER**
  - **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**
  - **SELF-DISCLOSURES TO THE OIG VS VOLUNTARY REFUNDS**
    - **CORRECTIVE ACTIONS TO MINIMIZE FUTURE IMPACT**

- **RECOUPMENT TIMING AND INTEREST WHILE ON APPEAL**
  - **NO RECOUPMENT DURING THE FIRST TWO LEVELS OF APPEAL IF APPEAL PRIOR TO STANDARD TIME FOR RECOUPMENT BY FI, CARRIER OR MAC**
  - **BUT A LARGE PERCENTAGE OF SECOND LEVEL APPEAL DECISIONS ARE NOT RENDERED WITHIN THE REQUIRED TIME FRAME**
    - **PROVIDER MAY REQUEST AN ALJ HEARING**
    - **BUT PROVIDER DID NOT PREVAIL AT THE SECOND LEVEL?**

- **IF PROVIDER FAILS TO PREVAIL AT THE SECOND LEVEL**
  - **PAY THE PIPER IF CLAIM STILL DENIED AFTER THE FIRST TWO LEVELS OF APPEAL**
    - **REPAY THE CLAIM**

      plus
    - **PAY THE ACCRUED INTEREST**

OTHER CHALLENGES TO RAC REOPENINGS

- **MERITS OF THE CLAIM VERSUS DEFENSES AGAINST CLAIM DENIAL**

- **MERITS OF THE CLAIM**
  - **Payment of the claim is supported by applicable authorities/Denial is not supported by any published Medicare authority**
    - **Medicare statute or regulation**
    - **Interpretations in the Medicare Manuals**
    - **National and Local Coverage Decisions**
  - **RAC reviewer not qualified**

- **DEFENSES AGAINST CLAIM DENIAL AND RECOUPMENT**
- **REOPENINGS**
  - **42 C.F.R.405.986**
    - **INITIAL CLAIM DETERMINATION MAY BE REOPENED:**
    - **WITHIN 1 YEAR FOR ANY REASON**
    - **WITHIN 4 YEARS ON A SHOWING OF "GOOD CAUSE"**
    - **AFTER 4 YEARS ON A SHOWING OF FRAUD OR SIMILAR FAULT**

- **CMS "CLARIFICATIONS" TO "GOOD CAUSE" FOR REOPENINGS IN MEDICARE CLAIMS PROCESSING MANUAL, CHAPTER 34, SECTIONS 10.11-10.11.3: EFFECTIVE FEBRUARY 16, 2009**
  - **CONCERNS "NEW AND MATERIAL EVIDENCE" DISCOVERED WHICH WAS NOT KNOWN AT THE TIME OF THE ORIGINAL PAYMENT DETERMINATION**

- **AS CLARIFIED, IS THERE AN EXPANSION OF "GOOD CAUSE" CONCEPT FOR REVIEWING AND REOPENING DETERMINATION AS TO WHAT WAS NOT KNOWN AT THE TIME OF THE ORIGINAL DETERMINATION?**
  - **USE OF OIG WORKPLANS TO IDENTIFY AREAS WITH HIGH PROBABILITY OF OVERPAYMENT RISK?**
  - **USE OF DATA MINING TO IDENTIFY RISK AREAS?**
- **"CLARIFICATION" OR "SUBSTANTIVE CHANGE" IN THE GOVERNING REGULATION ?**

- **EVIDENCE ON WHICH THE ORIGINAL PAYMENT DETERMINATION ON ITS FACE SHOWS A “CLEAR ERROR” WAS MADE AT THE TIME OF THAT ORIGINAL DETERMINATION**

- **ALJs OVERTURNED RAC DENIAL ON THAT GROUNDS THAT THE RAC REOPENINGS LACKED “GOOD CAUSE”**

- **OWN MOTION REVIEWS BY MAC**
  - **Medicare Appeal Council (MAC) undertaking reviews of ALJ rulings that reversed RAC denials based on the RAC's failure to demonstrate good cause to reopen claims paid more than 1 year ago.**
    - **In the case of Memorial Hospital of Long Beach - July 2008**
      - **MAC remanded the case to the ALJ based on an "error of law" material to the outcome of the claim.**

- **The MAC found:**

  1. As to the 4 year reopening limit, the Reopening Date = the Date of the Record Request, not the Date of the Overpayment Letter

  2. There is no evidentiary or "burden of proof" standard for good cause determinations for reopening

  3. MACs lack jurisdiction to review the RAC's good cause determination

  4. The ALJ had to make a determination on the coverage issues related to the claims prior to applying the waiver of liability provisions

- **EVEN IF THE PROVIDER IS DETERMINED TO HAVE RECEIVED AN OVERPAYMENT, REPAYMENT MAY BE EXCUSED**
  - *** PROVIDER WITHOUT FAULT DOCTRINE**
- **PAYMENT WILL BE MADE IF THE PROVIDER WAS WITHOUT FAULT AS TO BILLING FOR AND RECEIVING PAYMENT FOR THE SERVICES**

- **“FAULT” =**
  - **AN INCORRECT STATEMENT THAT THE INDIVIDUAL KNEW OR SHOULD HAVE KNOWN WAS INCORRECT; OR**
  - **FAILURE TO FURNISH INFORMATION THAT THE INDIVIDUAL KNEW OR SHOULD HAVE KNOWN TO BE MATERIAL; OR**
  - **ACCEPTANCE OF A PAYMENT THAT HE KNEW OR COULD HAVE BEEN EXPECTED TO KNOW WAS INCORRECT**

- **AND A PROVIDER MAY BE DEEMED TO BE WITHOUT FAULT, ABSENT EVIDENCE TO THE CONTRARY, IF THE OVERPAYMENT IS FOUND AFTER THE THIRD CALENDAR YEAR FOLLOWING THE YEAR OF PAYMENT**
  - **Medicare Financial Management Manual, Chapter 3, Sections 80 and 90**

***WAIVER OF LIABILITY DOCTRINE**

- **APPLIES TO MEDICAL NECESSITY AND CUSTODIAL CARE DETERMINATIONS**
  - **42 U.S.C. 1395pp**
- **EVEN IF A SERVICE IS DETERMINED TO BE NOT REASONABLE AND NECESSARY, PAYMENT MAY STILL BE RETAINED IF THE PROVIDER DID NOT KNOW, AND COULD NOT REASONABLY HAVE BEEN EXPECTED TO KNOW THAT PAYMENT WOULD NOT BE MADE**
- **REVIEW OF RELEVANT MAC, INTERMEDIARY AND CARRIER PUBLICATIONS AND OTHER COMMUNICATIONS WITH THE PROVIDER**

*** TREATING PHYSICIAN RULE**

- **COURT DEVELOPED RULE THAT THE TREATING PHYSICIAN'S DETERMINATION THAT A SERVICE IS MEDICALLY NECESSARY IS BINDING UNLESS REBUTTED BY SUBSTANTIAL EVIDENCE AND STILL ENTITLED TO GREAT WEIGHT, EVEN IN THE LIGHT OF SUBSTANTIAL EVIDENCE**
- **THE TREATING PHYSICIAN HAS FIRST HAND FAMILIARITY WITH THE PATIENT'S CONDITION WHICH A REVIEW OF THE MEDICAL RECORD ALONE MAY NOT PROVIDE**

TO APPEAL OR NOT TO APPEAL, THAT IS THE QUESTION

- **COST OF APPEAL VERSUS**
  - **A. IMMEDIATE BENEFIT AS TO THE INDIVIDUAL CLAIM DENIALS THAT MIGHT BE APPEALED**

    OR
  - **B. COMPLIANCE REPERCUSSIONS FROM NOT CHALLENGING THE DENIALS**

- **IMMEDIATE BENEFIT?**
  - **FAILURE TO RESPOND = NOT REASONABLE AND NECESSARY BASED ON A LACK OF DOCUMENTATION**
  - **IF AN OVERPAYMENT DETERMINATION WAS MADE BECAUSE THE PROVIDER FAILED TO RESPOND TIMELY TO A MEDICAL RECORD REQUEST, APPEALING MAY RESULT IN CMS INSTRUCTING THE RAC TO REOPEN THE DENIAL AND ASSESS THE MEDICAL RECORD, IF THE CONDITIONS LISTED IN CMS MANUAL 100-04, CHAPTER 34, SECTION 10.3 APPLY**

- **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**

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

- **STILL COULD LOSE**
  - **LOSE PAYMENT FOR CLAIM**

    PLUS
  - **LOSE INTERNAL AND EXTERNAL RESOURCE COSTS**

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**

- **BAD 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**

- **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**