

# Recovery Audit Contractors:

## *Appeals Strategies*

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# Current Legal Developments

- ◆ Automatic Stay of RAC program
- ◆ Medicare Recovery Audit Contractor Program Moratorium Act of 2007, H.R. 4105
- ◆ *AnMed Health et al. v. Leavitt et al.*, docket number 8:08-CV-02453-HFF (D. SC)
- ◆ MLN Matters MM6183 (Sept. 29, 2008)
  - Timeframes for recoupment
- ◆ MLN Matters MM6131 (Jan. 1, 2009)
  - Denials for non-compliance with physician self-referral prohibition
- ◆ Medicaid Integrity Plan (MIP)
- ◆ California RAC Experience

# Automatic Stay of RAC program

- ◆ CMS imposed an automatic stay of the contract work of the four RACs. This action is the result of protests filed to the General Accountability Office (GAO) by Viant, Inc. and PRG Schultz International, Inc., two unsuccessful bidders for RAC contracts.
  - 100 days to issue decision
  - RACs will likely begin auditing in February 2009

# The Recovery Audit Contractor Program Moratorium Act of 2007, H.R. 4105

- ◆ Directs the Secretary of the Department of Health and Human Services (HHS) to effect a one-year moratorium of the RAC program, during which time:
  - CMS will evaluate the program for Congress
  - The Comptroller General will prepare a report to Congress on the use of RAC auditors.

# *AnMed Health et al. v. Leavitt et al.*

- ◆ A complaint filed by 32 South Carolina hospitals on July 3, 2008 alleges that:
  - CMS improperly recouped \$30 million in alleged overpayments before plaintiff hospitals filed requests for reconsideration, contrary to Section 935 of MMA. **In most cases, the intermediary recouped payment simultaneously with or before notice letters were sent to providers;**
  - CMS allowed the RACs to apply different standards for evaluating medical necessity than it requires the providers to use.

# MLN Matters MM6183

## (Sept. 29, 2008)

### Recoupment

- ◆ After the Intermediary or Carrier makes an unfavorable initial determination, withholding may begin on the 41<sup>st</sup> day following the date of the demand letter, unless a request for redetermination is received within 30 days from the date of the demand letter.
  - *Once a provider files a request for redetermination, Medicare will cease its withhold activities.*
- ◆ After the Intermediary or Carrier makes an unfavorable redetermination decision, withholding may begin 61 days, unless the provider first appeals a request for reconsideration.
  - *The Intermediary or Carrier may not initiate, and must cease, recoupment once a valid and timely request for reconsideration has been filed.*
- ◆ After the Intermediary or Carrier makes an unfavorable reconsideration decision, withholding may begin.

# MLN Matters MM6131

## (Jan. 1, 2009)

### Denial for Stark violations

- ◆ Institutes a new denial code to be used when claims are denied because of non-compliance with the physician self-referral prohibitions
- ◆ Denial code will be used when a claim is denied because a physician (or one or more of their immediate family members) has a financial interest in a DHS provider and fails to meet one of the statutory exceptions
- ◆ Violations of physician self-referral laws are punishable by:
  - Denial of payment for all DHS claims
  - Refunds of amounts collected for DHS claims
  - Civil money penalties for knowing violations.

# Medicaid Integrity Plan

- ◆ Established by the Deficit Reduction Act of 2005 (DRA)
- ◆ Directs HHS to enter into contracts to carry out activities, including:
  - Review of actions of individuals or entities furnishing items for services for which Medicaid payments were made
  - Audit of claims for payment for items or services rendered for which a Medicaid payment was made
  - Education of service providers, managed care entities and beneficiaries
- ◆ Authorizes the use of Medicaid Integrity Contractors (MICs) to identify overpayments – Like Medicare RACs but for Medicaid.



# The California Experience

- ◆ Pursuant to the Statement of Work, RACs are bound by Medicare regulations, NCDs, LCDs and other Medicare policies in conducting reviews.
  - **IRF services** – Medicare contractors (including RACs) found to have used inconsistent criteria when reviewing IRF claims. The RAC’s authority to review IRF claims “paused,” and re-review of all denials was performed.
    - Approximately 27% of IRF claim denials reversed on re-review.
  - **Inpatient hospital “short stay” cases** – RAC reviews were based upon InterQual criteria, rather than Medicare policy.

# The California Experience cont'd.

- ◆ Inpatient hospital “short stay” cases
  - Many of these claims were denied for the reason that care could have been provided at the observation level of care, rather than the inpatient level of care
  - These claims were denied outright, and were not re-coded to the observation level of care by the RACs
  - During the demonstration program, providers were permitted to re-bill denied claims at the observation level. It is unclear whether this will be an option under the permanent RAC program.
  - Code 44 issue

# The California Experience cont'd.

## CHA concerns with RAC Evaluation Report

- ◆ Appeals data is premature
  - Many claims still in the appeals process
  - Many claims included in the Evaluation Report will be re-billed.
- ◆ Evaluation Report states that each RAC had a physician medical director, which was not true until May 2007.
- ◆ Provider satisfaction survey not reflective of CA experience.

# 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.*
- ◆ 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

# Can Medicare providers avoid RAC audits and claim denials?

- ◆ Maybe Not – However, providers can limit exposure for take-backs by enacting solid compliance measures and ensuring appropriate administrative systems are in place to address the challenges posed by the RACs.

# Compliance

- ◆ Identify and monitor areas that may be subject to review;
  - OIG Work Plan
  - Areas scrutinized in the RAC demonstration program
- ◆ Develop and implement effective processes to respond to record requests and prepare for appeals, if necessary.

# Compliance

## Areas subject to review in the RAC demonstration

- ◆ 85% of claim denials involved inpatient hospital claims;
  - Of these, 41% were “wrong setting” denials
- ◆ 6% of claim denials involved IRFs;
- ◆ 4% of claim denials involved outpatient hospitals;
- ◆ The remaining claims involved the claims of physicians, skilled nursing facilities, durable medical equipment suppliers, and ambulance, laboratory or other providers.
- ◆ *See CMS RAC Demonstration Evaluation Report, available at <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf>.*

# Compliance

## Areas subject to review in the RAC demonstration

**Top Services with RAC-Initiated Overpayment Collections (Net of Appeals)  
Cumulative Through 3/27/08, Claim RACs Only**

Type of Provider	Description of Item or Service	Amount Collected Less Cases	Number of Claims with Overpayments	Location of Problem
Inpatient Hospital	Surgical procedures in wrong setting (medically unnecessary)	88.0	5,421	NY
	Excisional debridement (incorrectly coded)	66.8	6,092	NY, FL, CA
	Cardiac defibrillator implant in wrong setting (medically unnecessary)	64.7	2,216	FL
	Treatment for heart failure and shock in wrong setting (medically unnecessary)	33.1	6,144	NY, FL, CA
	Respiratory system diagnoses with ventilator support (incorrectly coded)	31.6	2,102	NY, FL, CA
Inpatient Rehabilitation Facility	Services following joint replacement surgery (medically unnecessary)	37.0	3,253	CA
	Services for miscellaneous conditions (medically unnecessary)	17.4	1,235	CA
Outpatient Hospital	Neulasta (medically unnecessary)	6.5	558	NY, FL
	Speech-language pathology services (medically unnecessary)	3.2	24,991	NY, CA
	Infusion services (medically unnecessary)	2.3	19,271	CA
Skilled Nursing Facility	Physical therapy and occupational therapy (medically unnecessary)	6.8	77,911	CA
	Speech-language pathology services (medically unnecessary)	1.6	3,012	CA
Physician	Pharmaceutical injectables (incorrect coding)	5.8	18,930	NY, CA
	Neulasta (medically unnecessary)	3.0	56	NY
	Vestibular function testing (other error type)	1.4	13,805	FL
	Duplicate claims (other error type)	1.0	11,165	CA
Lab/Ambulance/Other	Ambulance services during a hospital inpatient stay (other error type)	2.9	13,589	FL, CA
Durable Medical Equipment	Items during a hospital inpatient stay or SNF stay (other error type)	4.8	38,257	NY, FL, CA



# 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 following 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 §§ 405.940-58)

- ◆ Providers must file requests for redetermination within 120 calendar days from 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

- ◆ The contractor must mail or otherwise transmit notice of its redetermination decision within 60 calendar days of receiving the request.
- ◆ The contractor may extend the 60 day timeframe an additional 14 days if the provider submits additional evidence after filing the redetermination request.
  - 42 CFR § 405.950.

# Second Level of Appeal: Reconsideration (42 CFR §§ 405.960-78)

- ◆ 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

# 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

- ◆ Medical necessity reviews must be performed “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 CFR § 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.
  - 42 CFR § 405.968 (b); 70 Fed. Reg. 11447.

# Reconsideration

## Full and 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 CFR § 405.966.



# Reconsideration Timeframe

- ◆ 60 days to act
  - ◆ The QIC may extend the 60 day timeframe an additional 14 days if 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.*
    - *Notice issues (authorized representative, etc.)*
- 42 CFR § 405.970.

# Third Level of Appeal: ALJ Hearing (42 CFR §§ 405.1000-64)

- ◆ A provider dissatisfied with a reconsideration decision may request an ALJ hearing
- ◆ 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 CFR § 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 CFR § 405.1037.
- ◆ CMS or its contractors may participate in an ALJ hearing without necessarily joining as a party
  - 42 CFR § 405.1010
- ◆ CMS or its contractors may be a party to a hearing
  - 42 CFR § 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.
  - 42 CFR § 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 CFR § 405.1064.

# ALJ Hearing Timeframe

- 90 days to act
- A provider who timely files for an ALJ hearing, and whose appeal continues to be pending after the adjudication time period has ended, has the right to request that the case be escalated for MAC review
  - ◆ 42 CFR § 405.1016.

# Medicare Appeals Council (MAC) and Judicial Review stages (42 CFR § § 405.1100-40)

- ◆ 60 days to file MAC review
- ◆ 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.
  - 70 Fed. Reg. 11467.



# MAC Review

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

# MAC Review

- ◆ 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 sixty (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 CFR § 405.1106-10.

# 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 CFR § 405.1112.

# MAC Review

## Written Statement and 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.
  - 42 CFR § 405.1120-24.

# MAC Review Timeframe

- ◆ 90 days to act
- ◆ 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 CFR § 405.1132.

# Federal District Court

- ◆ 60 days to file
- ◆ 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 CFR § 405.1136.

# Strategic Approaches to Audits

- ◆ Arguing the Merits
- ◆ Audit Defenses

# Arguing the Merits

- ◆ Preparation of Rationales (Position Paper)
- ◆ Impact of NCDs and LCDs
- ◆ Expert Involvement
- ◆ Reviewer Credential Issues



# Audit Defenses

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

# Audit Defenses

## Provider without Fault

- ◆ Section 1870 of the Social Security Act
- ◆ Once an overpayment is identified, payment will be made to a provider if the provider was without “fault” with regard to billing for and accepting payment for disputed services
  - Definition of fault
  - 3 Year Rule

# Audit Defenses

## Waiver of Liability

- ◆ Section 1879(a) of the Social Security Act
- ◆ Under waiver of liability, even if a service is determined to be not reasonable and necessary, payment may be rendered if the provider or supplier did not know, and could not reasonably have been expected to know, that payment would not be made.

# Audit Defenses

## Treating Physician Rule

- ◆ The treating physician rule, as adopted by some courts, reflects that the treating physician's determination that a service is medically necessary is binding unless contradicted by substantial evidence, and is entitled to some extra weight, even if contradicted by substantial evidence, because the treating physician is inherently more familiar with the patient's medical condition than a retrospective reviewer.
  - Authorities that have addressed this issue include: *State of N.Y. v. Sullivan*, 927 F.2d 57, 60 (2<sup>nd</sup> Cir. 1991); *Klementowski v. Secretary of HHS*, 801 F.Supp 1022 (1992); *Gartman v. Secretary of HHS*, 633 F.Supp. 671, 680-82 (E.D. NY 1986); *Wickline v. California*, 228 Cal. Rptr. 661 (Cal. App. 2d Dist. 1986); *Breeden v. Weinberger*, 377 F.Supp. 734 (1974); *Collins v. Richardson*, Medicare/Medicaid Manual, ¶26,500 (Iowa, 1972); *Pillsums v. Harris*, CCH, Medicare/Medicaid Manual, ¶309,080 (CA 1981); *Handerson v. Harris*, No: 80 8066, Slip Opinion at 622 (2nd Cir., 12/17/80); and *Stearns v. Sullivan*, NO 88-2756-Z, CCH Medicare/Medicaid Manual, ¶38,273 (D.C. Mass 1989).

# Audit Defenses Challenges to Statistics

- ◆ Section 935 of the MMA
- ◆ The guidelines for conducting statistical extrapolations are set forth in the Medicare Program Integrity Manual (CMS Pub. 100-08), Chapter 3, §§ 3.10.1 through 3.10.11.2

# Audit Defenses

## Reopening Regulations

- ◆ 42 C.F.R. §405.980
  - *But See* recent MAC decision of *Critical Care of North Jacksonville v. First Coast Service Options, Inc.*
  - Note also recent ALJ decisions permitting challenge of good cause.

# RAC Appeal Experiences

- ◆ Inpatient Rehabilitation Facility Denials
- ◆ Inpatient Short Stay Denials

# IRF Denials

## Effective Appeal Strategies

- ◆ Many IRF denials are for the reason that the care provided could have been provided in a Skilled Nursing Facility (“SNF”), rather than an IRF.



# IRF Denials

## Effective Appeal Strategies

- ◆ Standards
  - Medicare Benefit Policy Manual (CMS Pub. 100-02), Chapter 1, Section 110
  - HCFA Ruling 85-2
- ◆ Arguing the merits
- ◆ Importance of expert involvement

# Inpatient Short Stay Denials

- ◆ In the demonstration program, the RACs denied many inpatient short stays (e.g. one day stays), for the reason that the inpatient level of care was inappropriate, and care could have been rendered at the outpatient level.
  - In the RAC demonstration program, providers were permitted to re-bill these services as observation services.
  - It is unclear whether re-billing will be permitted in the permanent RAC program.

# Inpatient Short Stay Denials Effective Appeal Strategies

- ◆ Standards
  - Medicare Benefit Policy Manual (CMS Pub. 100-02), Chapter 1, § 10
    - RAC's inappropriate use of InterQual criteria as a basis for denial
  - Medical necessity criteria in 42 C.F.R. §411.406 (e), HCFR Ruling 95-1
- ◆ Arguing the merits
- ◆ Importance of expert involvement
- ◆ Code 44 issue

# Hospital Condition of Participation: Utilization Review

- ◆ Pursuant to 42 C.F.R. § 482.30, all hospitals must have in place a utilization review (“UR”) plan, which ensures that the requirements of the regulation are fulfilled. These requirements may be filled either by the hospital directly through its policies, procedures, and UR committee or through a QIO that has assumed binding review for performing such tasks. If the UR committee maintains the responsibility to fulfill the required UR functions:
  - A UR committee consisting of two or more practitioners carry out the UR function. At least two members of a hospital’s UR committee must be doctors of medicine or osteopathy, and the other members may be any of the other types of practitioners specified in the regulation.
  - The determination that an admission or continued stay is not medically necessary must be made either by (i) one member of the UR committee if the practitioner(s) responsible for the care of the patient either concurs with the determination or fails to present their views when afforded the opportunity, or (ii) two members of the UR committee in all other cases.
  - The UR committee must consult with the practitioner(s) responsible for the care of the patient and allow them to present their views before making a determination.
  - If the UR committee determines that an admission is not medically necessary, the committee must give written notification, no later than 2 days after the determination, to the hospital, the patient, and the practitioner responsible for the care of the patient.
- ◆ A review of an inpatient admission may be performed before, at or after an admission
  - Code 44

# Questions?

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