Successful Defense and Appeal Strategies for Long-Term Care Facilities

RAC Summit

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- Strategic Appeal Issues - Redetermination
  - 30 days to stop recoupment
  - 120 days to request redetermination
  - 11.375% interest accrues from date of determination
  - Cash flow – can extend repayment for 90 days from the date of determination (includes 60 days for redetermination decisions to be issued)

- Strategic Appeal Issues - Reconsideration
  - 60 days to stop recoupment
  - 180 days to request reconsideration
  - 11.375% interest accrues from date of determination
  - Cash flow – 90+60+60 = 210 days (Includes 60 days for reconsideration decisions to be issued)

- One strategy – appeal all claims within 30 days at first level and within 60 days at second level
- Advantages
  - Cash flow (for a maximum of 210 days from date of determination or 330 days, if reconsideration)
  - Opportunity to reverse decision without impact
- Disadvantages
  - Accrue interest at 11.375%
  - Frantic timetable to assemble appeals

- A Second Strategy – appeal some claims within recoupment limits
  - Based on amount in question?
  - Based on review of the merits?
- A Third Strategy – appeal claims within appeal but not recoupment limits

Additional Defenses and Issues

- Without Fault (Section 1870)
  - Even if overpayment identified provider may still be paid if "without fault" (*i.e.*, no fraud or pattern)
  - 3 year rule (unique counting rule, still applies to the three-year RAC window)

In a May 21, 2009 decision, ALJ Kelton held that:

The initial decision to pay the claim at issue was made by the Fiscal Intermediary on October 3, 2003. The RAC's overpayment assessment letter was dated February 20, 2007, which is over three years after the original decision to pay the claim was made. The overpayment assessment is therefore in violation of 42 C.F.R. section 405.350 and the relevant provisions of the MFMM. As noted above, 42 C.F.R. section 405.350(c) states:

> . . . A provider of services or other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the determination of the carrier, the intermediary, or the Centers for Medicare & Medicaid Service that more than the correct amount was paid was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid.

Kelton Decision continued:

In accordance with these regulations, chapter 3, sections 80 and 80.1 of the MFMM limit recovery of overpayments to the third year following the year in which notice was sent that the amount was paid. According to those sections, "[o]rdinarily, the provider or beneficiary will be considered without fault unless there is evidence to the contrary. In the absence of evidence to the contrary, the FI or carrier will not recover the determined overpayment." Thus, the RAC is limited by contract to a period less than the four fiscal years allowed by section 1893 of the Act.

Kelton Decision continued:

The limits set forth in the MFMM apply a specific time limit upon CMS (and its agents) in pursuing overpayments in cases in which the provider is without fault in creating the overpayment. It is an equitable policy designed to limit the burden on providers who do not commit a "pattern of billing errors," and it carves out a limited set of facts within which the Secretary has decided not to pursue repayment.

Kelton Decision continued:

The overpayment at issue was discovered in 2007, which is subsequent to the third year following the year in which notice was sent that the amount was paid (2003). Pursuant to 42 C.F.R. section 405.350(c) and chapter 3, sections 80 and 80.1 of the MFMM, the appellant/provider is deemed to be without fault for the overpayment when there is no evidence to the contrary. The appeal file contains no evidence showing a "pattern of billing errors" or other similar fault by the provider in this case. Additionally, no such evidence was adduced at the ALJ hearing and the RAC declined to participate in the ALJ hearing process. Therefore, 42 C.F.R. section 405.350(c) and the relevant

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Kelton Decision continued:

Provisions of MFMM would limit recovery in this case to the third year following the year in which the original claim was paid (*i.e.*, not later than December 31, 2006). Inasmuch as the notice of overpayment assessment was issued on February 20, 2007, I find that the attempt to recover overpayment in this case is barred by CMS's own written policy.

Additional Defenses and Issues

- Waiver of Liability (Section 1879)
  - Even if service determined to be not reasonable and necessary, payment could be made if provider or supplier did not know, and could not reasonably have been expected to know that payment would not be made

Additional Defenses and Issues

- Timing of Reopening "Good Cause" 42 C.F.R. 405.980
  - Medicare Appeals Council Decisions involving hospitals and skilled nursing facilities
  - Decisions by Appeals Council and the ALJ lack jurisdiction to decide contested reopenings under the Medicare appeals process
  - Example of recent ALJ decision

In an April 27, 2009 decision, ALJ Trudelle found as follows:

I am not persuaded that this interpretation is correct. To begin, interpreting this regulation in a manner that would immunize a reopening from review is problematic in that, in its absence, there would be no process by which a provider could challenge the legality of a specific contractor reopening. The suggestion has been made that the agency will police abuse of these regulatory requirements on some broad, programmatic basis to ensure complaince. While that may be all well and good, it would leave an individual provider or beneficiary with no opportunity to challenge the lawfulness of a particular reopening. A contractor could utterly fail to satisfy the regulatory timeliness or good cause requirements without any review available to the provider or beneficiary of the specific facts of the case. Such a disregard of due process considerations cannot have been intended.

Trudelle Decision continued:

It is further suggested that there are no due process rights to administrative review of a decision to reopen, given that a contractor's decision to reopen is final and not subject to review. It seems unlikely, however, that the agency would establish specific timeframes and bases for reopening if it did not intend to have decisions made under those regulations reviewable in the administrative process established for review of contractor decision-making on the merits of medical claims. A far better explanation, and one more consistent with pertinent judicial precedent, due process concerns, and plain common sense, is that the regulation barring appeals shields only the discretionary

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Trudelle Decision continued:

decision whether or not to reopen. It merely confirms that providers and beneficiaries do not have a right to a reopening. [*fn. See Califano v. Sanders*, 430 U.S. 99 (1977); and *Your Home Visiting Nurse Services, Inc. v. Shalala*, 525 U.S. 499 (1999)], both of which stand for the proposition that denial of a request for reopening is not appealable.] The foreclosure of review, therefore, should be construed as limited to the discretion that Congress granted to the agency to decide whether to reopen a claim. It should not be extended to deny a provider or beneficiary the right to challenge the lawfulness of a reopening,

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Trudelle Decision continued:

particularly where there are extant regulations that list very specific timeliness and procedural requirements. Under a proper reading of these regulations, once a decision has been made to exercise the discretion to reopen, there follows a non-discretionary obligation to obey The reopening regulations, an obligation that is reviewable for compliance in this administrative process. This interpretation is indeed consistent with the new agency scope of work for RACs, which require adherence to the good cause standards.

. . .

Trudelle Decision continued:

I find and conclude that the RAC made no showing on this record of good cause for late reopening, and, therefore, it has failed to satisfy regulatory requirements as to this issue. The QIC inferred good cause with reference to "a high error rate and/or potential overutilization identified through data analysis," citing Medicare Program Integrity Manual, CMS Pub. 100-8, Section 3.6. The QIC further states: "This claim was selected based on data analysis. Therefore, 'good cause' for the reopening has been established."

Trudelle Decision continued:

Unfortunately for the QIC's rationale, there is absolutely nothing to corroborate these assertions in this record, even if one could make the very difficult leap required from the regulation's definition of good cause to the one included in the agency manual. There is no suggestion in the Manual how a high error rate and/or potential overutilization demonstrates the existence of new and material evidence that was not available at the time of the initial determination. To be perfectly clear, such a data analysis, even if it did exist, would not on its face constitute "good cause" as contemplated in the agency's regulations.

Trudelle Decision continued:

Good cause would have to be demonstrated by clear and persuasive evidence that showed the existence of actual new and material evidence not earlier available. As noted, there is nothing in this record to support the conclusory statement that an unseen and undocumented "data analysis" supports a finding of good cause for the reopening. Nor is it likely that such an analysis would produce new and material evidence, because an analysis of data must be founded upon the data that existed originally. Such an analysis would not produce new evidence, because it merely manipulates the existing data to reach a conclusion predicated on the original records. It is

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Trudelle Decision continued:

an investigational strategy or approach, not a font of new information. It is conceivable that new evidence can flow out of an analysis predicated on the original records; however, as noted, that would require clear and persuasive evidence that explained how the new and material evidence was derived. There is nothing like that in this record.

Additional Defenses and Issues

- Timing of Reopening/"Good Cause"
  - MAC Decision *Palomar Medical Center v. Johnson*, S.D. Cal. No. 3:09-cv-00605-BEN-NLS (S.D. Cal. Complaint filed 3/24/09)
  - Challenges RAC reopening of two year old hospital claim
  - ALJ determined RAC had not shown "good cause" for reopening
  - MAC reversed ALJ finding ALJ lacked jurisdiction to determine whether reopening was lawful
  - Court challenge to jurisdictional argument and due process
  - CMS Transmittal 1671 (February 16, 2009) – RAC data analysis is "good cause" and ALJ has no jurisdiction

Additional Defenses and Issues

- Credentials of reviewer
  - Can request a copy of credentials
  - Medical Director
  - Coding Experts

Additional Defenses and Issues

- Review criteria used
  - Must be Medicare policy, National Coverage Determinations, Local Coverage Determinations
  - What was in effect at time
  - Is Medicare policy applied correctly
  - Can any of the coverage determinations be used as a defense?
- Incorrect application of statutes
  - Medical records standards
  - Physician testimony/declaration
  - Standard of care evidence
  - Peer-reviewed science

Additional Defenses and Issues

- Sampling
  - Extrapolation PIM (CMS Pub100-08) Chapter 3
  - 3.10.1-3.10.11.2
  - Challenge statistical analysis