Recovery Audit Contractors:

The Basics of the Five-Stage RAC 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 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 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.

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.

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

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 (2nd 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); *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
Treating Physician Rule

- **CMS Ruling 93-1:** With respect to Part A Claims – CMS Ruling 93-1 states that treating physician opinion is evidence, but not presumptive, so need to make a case specific argument why physician's opinion is the best evidence.
  - No similar CMS rulings with respect to Parts B, C, or D
- **42 C.F.R. § 482.30 -** Conditions of Participation: Utilization Review
- Providers should always argue that the opinion of the treating physician is the best evidence.

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
  - *See* MAC decision of
    - *Critical Care of North Jacksonville v. First Coast Service Options, Inc.*
    - *In re Providence St. Joseph Medical Center v. United Government Services, LLC*
    - *In re Memorial Hospital of Long Beach v. PRG Schultz*
  - *See also* Complaint in *Palomar Medical Center v. Department of Health and Human Services*, No. 09-CV-0605-BEN-NLS (S.D. Cal. Mar. 24, 2009).
  - Note also ALJ decisions permitting challenge of good cause for reopening.

Current Legal Issues

- Inpatient Short Stay Denials
- Inpatient Rehabilitation Facility Denials

Current Legal Issues
Inpatient Short Stay Denials

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
  - Medicare rules do not adequately distinguish between inpatient services (Part A) and observation services (Part B).
  - Decision to admit: complex medical judgment

Current Legal Issues
Inpatient Short Stay Denials

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

Current Legal Issues
Inpatient Short Stay Denials

- 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. Providers are barred from doing so under the permanent RAC program.

Current Legal Issues
Inpatient Short Stay Denials

Current developments regarding obtaining reimbursement for outpatient services when inpatient services are denied:

- FAQ 9462 – December 2, 2008
- Meeting with CMS – July 28, 2009
- MAC decisions
  - *UMDNJ – University Hospital v. Riverbend GBA*
- ALJ decisions

Current Legal Issues
Inpatient Rehab Denials

In Patient Rehab Denials

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

Questions?

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