THE BASICS OF THE MIC, MAC, & RAC APPEALS PROCESS

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SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

OVERVIEW

- *Rebuttal*
- *Discussion period*
- Redetermination
- Reconsideration
- Administrative Law Judge Hearing
- Medicare Appeals Council (MAC)
- Federal District Court

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

- **Rebuttal and Discussion Period**
  - Engaging in rebuttal or the discussion period (or both) **does** **not** extend the provider's appeal deadlines
  - The rebuttal and discussion periods are avenues outside of the Medicare appeals process
    - Rebuttal and discussion period may be used to create an open dialogue with the contractor or attempt to stop the immediate recovery of an alleged overpayment.

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Rebuttal

- Providers may file a rebuttal statement within 15 calendar days of receiving the results of a post-payment review
- The statement should address why the suspension, offset or recoupment (collectively referred to as the "recovery") should not take effect on the date specified in the notice
  - The statement may be accompanied by other pertinent information
- The contractor must consider the statement and any accompanying evidence and, within 15 days of receiving the statement, make a determination as to whether the facts justify the recovery
  - The contractor must issue a written determination of its findings

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Discussion Period

- Discussion period begins on:
  - The date of the demand letter for automated reviews
  - The date of the review results for complex reviews
- Discussion period ends on the date recoupment occurs
- To engage in a discussion, providers must notify the RAC in writing
- Providers can use this opportunity to:
  - Discuss and challenge the denial rationales
  - Obtain clarification on how the RAC made its determination

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Redetermination

- Once contractor makes an initial determination, a provider has **120 days** to file a request for redetermination
  - Request for redetermination must be filed **within 30 days** after the date of the first demand letter in order to avoid recoupment of the overpayment. Recoupment begins on the 41st day after the date of the demand letter.

- The contractor has 60 days from the date of the redetermination request to issue a decision
  - Providers may submit additional evidence after the request is submitted, and the contractor may extend the 60 day decision-making time period by 14 days for each submission.

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Reconsideration

- Once the contractor issues a reconsideration decision, a provider has **180 days** to file a request for reconsideration
  - Request for reconsideration must be filed **within 60 days** after the redetermination decision in order to avoid recoupment of the overpayment. Recoupment begins on the 76th day after the redetermination decision.

- Key Considerations:
  - Full and early presentation of evidence requirement
  - Submission of additional evidence, 14 day extension of time period for decision
  - Reviewer credentials

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Administrative Law Judge (ALJ) Hearing

- A provider must file a request for an ALJ hearing **within 60 days** of the QIC's reconsideration decision.
- Amount in controversy requirement must be met
- ALJ hearing may be conducted in person, by video-teleconference (VTC), or by phone
- Discovery versus requests for information
  - Discovery is only permitted when CMS or its contractors participate as a party
  - Regardless, providers can submit FOIA requests for information and request to review the QIC file
- CMS or its contractors may participate in the hearing without being a party
- CMS will recoup the alleged overpayment during this and following stages of appeal

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Medicare Appeals Council (MAC)

- A provider dissatisfied with the ALJ decision has **60 days** to file an appeal to the Medicare Appeals Council (MAC)

Federal District Court

- A provider must submit an appeal to the federal district court within **60 days** of the date of the MAC decision
  - Amount in controversy requirements must be met

SUCCESSFUL APPEAL STRATEGIES
The Medicaid Appeals Process

- Provider appeals of MIC audits will be handled through the state appeals process, pursuant to state law.

- The appeal processes for the various states may differ, but they are likely governed by the state's administrative procedures act and will contain an opportunity for a hearing.

THE MEDICAID APPEALS PROCESS
Michigan

- Right to hearing under Administrative Procedures Act
  - Contest Case: MCL §24.271
    - MSA Provider Hearings – Admin. Rules 400.3401-400.3425
    - "Adverse actions" include:
      - Reductions, suspension, or adjustment of provider payments
      - Retroactive adjustments following the audit or review and determination of the daily reimbursement rates for institutional providers
    - Prehearing Conference
    - Bureau Conference

THE MEDICAID APPEALS PROCESS Michigan

- Adverse Action
  - Within 30 days of the bureau conference, the bureau director must decide whether the take adverse action
    - Bureau director may consult with independent professional personnel
  - Prior to taking an adverse action, the provider must receive a a final determination notice

THE MEDICAID APPEALS PROCESS
Michigan

- **Formal Hearing -** Other Considerations:
  - Representation at the hearing
  - Hearing
    - Testimony of witnesses
    - Receive documents relevant and material to subject matter
    - Rules of evidence - as applied in a nonjury civil case
  - Written Statements
    - Upon request, parties have 15 days after the close of the hearing to file written statements in support of their position.

THE MEDICAID APPEALS PROCESS
Michigan

- ALJ prepares a recommended decision
  - In writing, setting forth findings of fact and conclusions of law
- Within 10 days, a party may file exceptions for consideration by the director or hearing authority.
- Final Decision of Director or Hearing Authority
  - Final decision must be rendered within 45 days after ALJ makes recommended decision

THE MEDICAID APPEALS PROCESS
Michigan

- Formal Hearing
  - If provider requests a hearing, adjustment and recovery of the alleged overpayment may not be made until 10 days <u>after</u> the mailing of the hearing decision.
    - *Exception*: if the bureau director determines that the practice set out in the final determination requires immediate action to protect the health, safety or welfare of recipients or the general public.
  - Withhold is limited to not more than 25% of present or future payments

THE MEDICAID APPEALS PROCESS
Michigan

- Settlement Authority
  - Between state and provider
  - Impact on federal-state relationship

THE MEDICAID APPEALS PROCESS
New York

- Department of Health (DOH) monitors NY Medicaid Program
  - Conduct audits
  - Seek restitution for improper payments
- If overpayments are found, DOH will issue a draft audit report, setting forth the items disallowed and the DOH's proposed action
  - Providers have 30 days to submit documentation and/or object to the proposed action
  - After consideration, DOH will issue a final audit report
  - Provider may request an administrative hearing to contest an adverse determination

THE MEDICAID APPEALS PROCESS
New York

- Hearing under Administrative Procedures Act
  - Opportunity for a hearing
    - Present written arguments
    - Present oral argument
  - Complete record of proceeding
    - All records and documents in possession of the agency must be offered and made part of the record
  - Final determination
    - Each agency maintains an index by name and subject of determination

THE MEDICAID APPEALS PROCESS
New York

- Withhold of Payments
  - At option of DOH, overpayments may be recovered by withholding provider's or affiliate's billings
  - DOH may withhold payment in absence of a final audit report when it has reliable information that the person is involved in fraud or willful misrepresentation
  - Withhold will not typically continue for more than 90 days unless a report or notice of agency action is sent to the provider

THE MEDICAID APPEALS PROCESS California

- Claim Denials
  - Request Reconsideration - Claim Inquiry Form (CIF)
    - Request reconsideration within 6 months of date of denial
    - Within 15 days of receipt – Claims Inquiry Acknowledgement will be issued
    - Claim should appear on remittance within 45 days of Claims Inquiry Acknowledgement

THE MEDICAID APPEALS PROCESS
California

- Appeal of claim denial
  - Fiscal intermediary individually reviews each case
  - Within 90 days, providers seeking an appeal must submit a complaint
    - In writing
    - Identifying the claim
    - Describing the disputed action or inaction

THE MEDICAID APPEALS PROCESS California

- Appeal of claim denial – Cont'd:
  - Fiscal Intermediary will
    - Acknowledge written complaint with 15 days of receipt
    - Make decision within 45 days of receipt
      - If FI is unable to make decision within this time frame, the appeal is referred to professional review unit for additional 30 days
  - Fiscal Intermediary will send an Appeal Response Letter explaining appeal determination
  - Judicial remedy available not later than one year after the appeal decision
    - Provider can file suit in local court naming "Department of Health Care Services (DHCS)" as the defendant.

SUCCESSFUL APPEAL STRATEGIES

Arguing the Merits

- Merit-based arguments include:
  - Medical necessity of the services provided
  - Appropriateness of the codes billed
  - Frequency of services

- To effectively argue the merits of a claim:
  - Draft a position paper laying out the proper coverage criteria
  - Summarize submitted medical records and documentation
  - If relying on medical records in an ALJ hearing:
    - Organize using tabs, exhibit labels and color coding
    - Use graphs and medical summaries to assist in the presentation of evidence

SUCCESSFUL APPEAL STRATEGIES
Use of Experts

- Experts such as physicians, registered nurses, coding experts, and inpatient rehabilitation specialists may be helpful in appealing a contractor determination
- Experts can:
  - Assess strength of a case early on and help develop a strategic plan
  - Assist with the interpretation and organization of medical records
  - Provide testimony regarding appropriateness and/or necessity of services
    - Affidavit at redetermination and reconsideration levels
    - Live testimony at ALJ hearing

SUCCESSFUL APPEALS STRATEGIES
Audit Defenses

- Provider Without Fault
- Waiver of Liability
- Treating Physician's Rule
- Challenges to Statistics
- Reopening Regulations
- Regulatory & Constitutional Challenges

SUCCESSFUL APPEALS STRATEGIES
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

SUCCESSFUL APPEALS STRATEGIES
Waiver of Liability

- Section 1879(a) of the Social Security Act
- Under waiver of liability, even if a service is determined not to be 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.

SUCCESSFUL APPEALS STRATEGIES
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).

SUCCESSFUL APPEALS STRATEGIES
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.

SUCCESSFUL APPEALS STRATEGIES

Challenges to Statistics

- Section 935 of the MMA
  - **Limitations on Use of Extrapolation** – A Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise, unless the Secretary determines that –
    - There is a sustained or high level of payment error; or
    - Documented educational intervention has failed to correct the payment error.
- 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

SUCCESSFUL APPEALS STRATEGIES
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.

QUESTIONS?

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