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FAST BREAK: MEDICARE APPEALS

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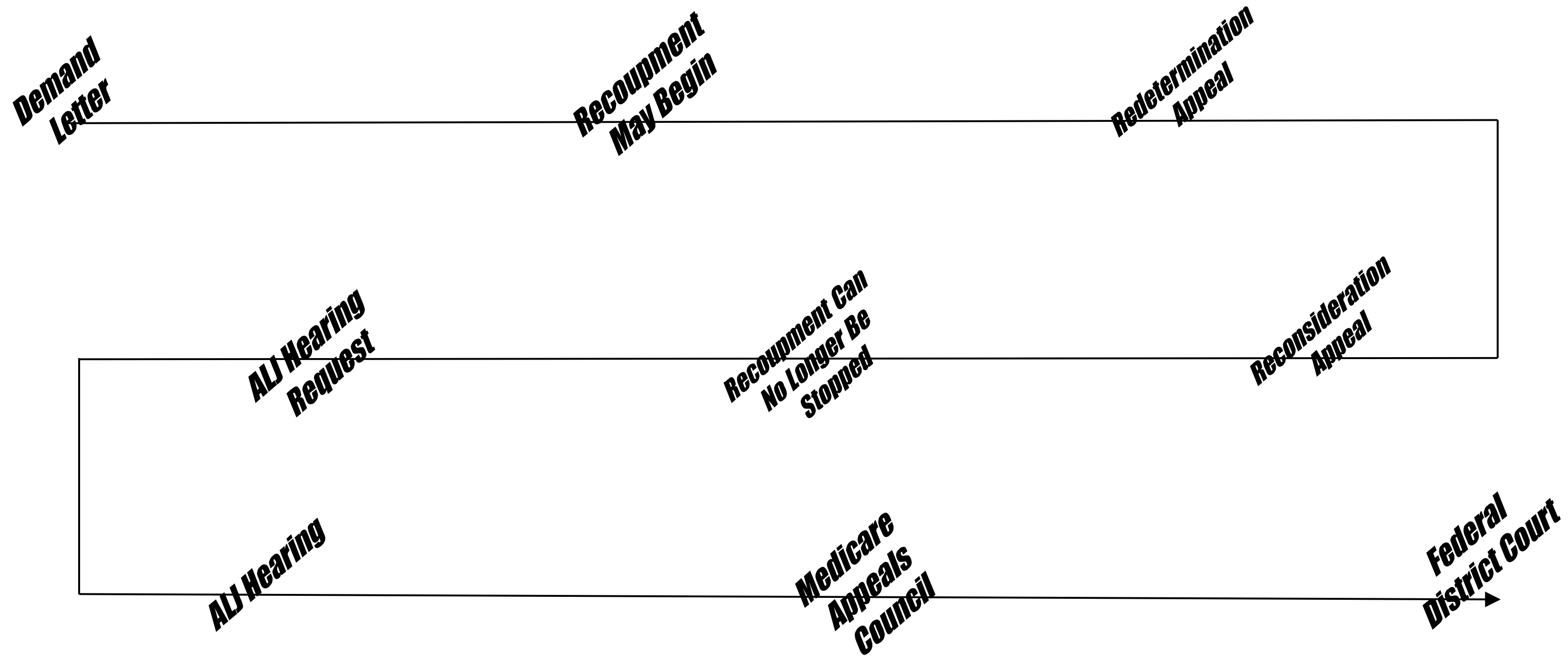
Topics for Today

- The 5 Stages of Medicare Appeals
- Documentation and Evidence
- Recoupment and Interest
- ALJ Hearings
- Tips for Successful Appeals

Overview of the Process



Redetermination

- Must be filed within 120 days of receipt of demand letter
- Submitted to Medicare Administrative Contractor
- Recoupment is stopped when redetermination is filed
- Review generally upholds prior determination
  - Very few claims overturned at redetermination stage
- Expect a redetermination decision approximately 60 days from filing

Reconsideration

- Must be filed within 180 days of receipt of redetermination decision
- Submitted to the Qualified Independent Contractor (QIC)
- Recoupment is stopped when reconsideration is filed
- Review generally upholds prior determination, although chance for greater success
  - Although independent from MAC, QIC generally concurs with MAC determination
- Expect a reconsideration decision approximately 60 days from filing
- Last stage to submit documentation and evidence without “good cause”

Administrative Law Judge Hearing

- Must be filed within 60 days of receipt of reconsideration decision
- Submitted to the Office of Medicare Hearings and Appeals (OMHA)
- Recoupment can no longer be stopped
- ALJ hearings offer first opportunity for real-time presentation of arguments and evidence in a "quasi-trial" setting
- Expect this stage to take between 2 – 4 years

Medicare Appeals Council Review

- Must be filed within 60 days of receipt of ALJ decision
- Submitted to the Medicare Appeals Council of the Departmental Appeals Board
- Focus is largely on legal issues
  - ALJ violations of law or HHS policy
  - Abuse of discretion
  - Substantial evidence
- Expect this stage to take approximately 1 year
- The Administrative QIC (AdQIC) often recommends that the Council take up on its own motion cases where the ALJ relies on a legal basis to reduce or eliminate provider liability

Federal District Court

- Must be filed within 60 days of receipt of Council decision
- Submitted to the local district court
- Council decision represents final agency action
- Again, focus is largely on legal issues
  - HHS violations of regulation, statute, or Constitution
- Although trial court is not the finder of fact in this circumstance, courts generally hear from witnesses and accept oral argument
  - Process is government be Federal Rules of Civil Procedure

Rebuttal

- Chance to offer rebuttal at first stages of process as to why recoupment should not occur
- Due 15 days after demand letter/redetermination decision issued
- Rebuttal very rarely successful
- Only applies to recoupment, not validity of overpayment

Documentation and Evidence

"If it wasn't documented, it wasn't done."

- Unlike civil or criminal fraud matters, importance of intent limited
  - Similarly, testimony and non-documentary evidence have limited utility
- Instead, contractor focus is on whether the documentation supports the claim
  - ALJs may give some additional weight to non-documentary evidence, particularly on issues of medical necessity, but documentation must still be reasonably fulsome

Documentation and Evidence

- Documentation and other evidence (such as attestations and affidavits) must be submitted before the QIC renders its decision
  - Otherwise an ALJ must find "good cause" for allowing additional evidence into the record

- Providers may and should supplement the record sent to a ZPIC/UPIC/RAC with other records as they become available
  - Consider supporting records from other care providers (subject to HIPAA)
  - While case/claim summaries aren't "evidence," consider preparing them early in the process so that each level of review has the benefit of them

ALJ Hearing Process

- Best (and often only) shot at significantly overturning overpayment determination
- Challenges typically made on three fronts:
  - Factual – documentation supports claims
  - Legal – waiver/limitation on liability arguments
  - Statistical – if extrapolation involved, extrapolation and sampling are invalid
- ALJ hearings are typically contested proceedings
  - Role of CMS and contractors as "parties" v. "participants"

ALJ Hearing Process

- Current backlog at ALJ level
  - Substantial delay (multi-year)
  - OMHA and CMS exploring ways of remediating backlog
    - Mediation
    - Sampling

- Pre-hearing conferences
  - Narrowing issues

ALJ Hearing Process

- Preparation for ALJ hearing
  - Expert witnesses (statistician, physicians, clinical reviewers)
  - Review and preparation of critical documentation
- Typically conducted via phone or video-conference
- Generally, few hours to full day hearing
- ALJs have significant discretion in conduct of hearing and decision-making

Recoupment and Interest

- Recoupment also known as withholding or offset
- Recoupment refers to right of contractor to apply future Medicare payments to existing overpayments
- Recoupment can begin 41 days after demand letter issued
  - But two chances to stop recoupment by filing redetermination and reconsideration appeals
  - However, recoupment may begin again 30 (redetermination) or 60 (reconsideration) days after decision is issued
- Extended repayment plans

Recoupment and Interest

- Interest accrues on overpayments 31 days after date of demand letter
- Medicare interest rate varies quarterly but has remained around 10% for last several years
- Interest does not accrue if overpayment paid within 30 days
- Providers successful at ALJ level of appeal can receive interest on principle amounts paid (but not on interest they paid) at the Medicare interest rate

Tips for Successful Appeals

- Don’t rely solely on legal or statistical arguments to avoid liability

- Attack each basis for denial in initial, redetermination, and reconsideration decisions
  - More difficult now for contractors to assert new denial reasons midway through process
  - Remediate technical denials as early in process as possible
  - Apply LCDs if available and favorable

- While focus is on ALJ appeal, preparing defenses early gives a chance that earlier levels of appeal will be favorable

Tips for Successful Appeals

- Use of outside clinical experts important but also rely on internal resources (certifying or performing physician, etc.)
  - ALJs appreciate hearing the perspective of the rendering provider

- Don’t neglect regulatory requirements for notifying other parties
  - While jurisdiction and regulation compliance issues aren’t often used to dismiss a case, they may become more prevalent in the future

- Ensure review of Medicare primary sources (regulation, Medicare Benefit Policy Manual, or Medicare Claims Processing Manual) – contractors often misstate these or only rely on their interpretation
  - ALJs not bound by LCDs or other contractor interpretations

Thanks!

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Jake Harper represents a variety of health care providers in government audits and investigations and provides regulatory and compliance counseling on reimbursement and fraud and abuse matters. In addition to defending providers in DOJ and OIG investigations on Stark, AKS, exclusion, and false billing matters, Jake maintains an active appeals practice, including representing health care providers before the PRRB and ALJs at the Office of Medicare Hearings and Appeals.

Join us next month!

Please join us for next month's Fast Break continuing our discussion of Medicare appeals:

"*Fast Break:* Congress and Healthcare – What Just Happened and What it Means for 2018"

with Susan Feigin Harris and Kathy Rubinstein

- Wednesday, January 17, 3:00 PM (EST)