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Recovery Audit Contractors And Medicare Audits: *What Can Hospitals and Health Systems Expect as the RAC Program Expands Nationwide?*

Andrew B. Wachler, Esquire
Abby Pendleton, Esquire
Jessica L. Gustafson, Esquire
Wachler & Associates PC
Royal Oak, MI

Introduction

Get ready: the Centers for Medicare and Medicaid Services (CMS or Medicare) Recovery Audit Contractor (RAC) program has been made permanent and is expanding nationwide. All Medicare providers and suppliers should begin to prepare now for increased Medicare scrutiny. Hospitals and health systems nationwide can expect RAC auditing activity and overpayment requests beginning in 2009, and providers in nineteen states can expect this activity to begin as soon as February 2009. This Member Briefing will provide a history and overview of the RAC program and will provide guidance to legal counsel representing hospitals and health systems that soon may find themselves subject to RAC audits.

Recovery Audit Contractors

The RAC Demonstration Program

Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) mandated that the Secretary of the Department of Health and Human Services (HHS) conduct a three-year demonstration program using RACs to determine whether the use of RACs would be a cost-effective way to identify and correct improper Medicare payments. Section 306(b)(1) of the MMA directed HHS to conduct the RAC

demonstration program at least in the two states with the highest Medicare expenditures. In compliance with this directive, in 2005 the RAC demonstration program began in California, Florida, and New York—the three states with the highest Medicare expenditures. In 2007, CMS expanded the program to include Arizona, South Carolina, and Massachusetts.[1] There were two types of RACs in the demonstration program: Claim RACs and Medicare Secondary Payor (MSP) RACs.[2] The RACs were tasked with identifying and recouping Medicare overpayments and identifying underpayments, and were compensated on a contingency-fee basis based upon the principal amount collected from and/or returned to the provider or supplier.[3] The RAC demonstration program concluded on March 27, 2008.[4]

From CMS' perspective, the RAC demonstration was a "cost-effective" program.[5] The RACs identified and collected more than $1.03 billion in improper payments over the course of the demonstration. According to CMS, factoring in the underpayments identified and returned to providers and suppliers, the claims overturned on appeal,[6] and the operating costs of the demonstration program, the RAC program was successful in returning $693.6 million to the Medicare Trust Funds.[7] CMS estimates that

[1] "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 1, June 2008, *available at* www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[2] "Claim RACs" review Medicare claims to attempt to identify improper payments made in violation of Medicare policy. "MSP RACs" attempt to identify payments improperly paid by Medicare that should have been paid by a different health insurance company. "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 1, June 2008, *available at* www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[3] Section 306(a)(1) of the MMA.

[4] www.cms.hhs.gov/RAC/02_ExpansionStrategy.asp#TopOfPage.

[5] "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 14, June 2008, *available at* www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[6] As of June 30, 2008, there was an additional $12 million in claims still involved in the appeals process at the Administrative Law Judge stage. There also may be a significant number of claims still involved in the appeals process at the reconsideration stage of appeal. *See* "The Medicare Recovery Audit Contractor (RAC) program: Update to the Evaluation of the 3-Year Demonstration," at p. 14, September 2008, *available at* www.cms.hhs.gov/RAC/Downloads/Appealupdatethrough63008ofRACEvalRept.pdf.

[7] CMS further acknowledged additional costs associated with the RAC demonstration program, such as the increased costs to the Qualified Independent Contractors (QICs) and Administrative Law Judges (ALJs) responsible for processing second- and third-stage appeals. CMS stated that it was "unable to quantify these costs." *See* "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 14, June 2008, *available at* www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

the RAC demonstration program only cost approximately 20 cents for each dollar returned to the Medicare Trust Funds.[8]

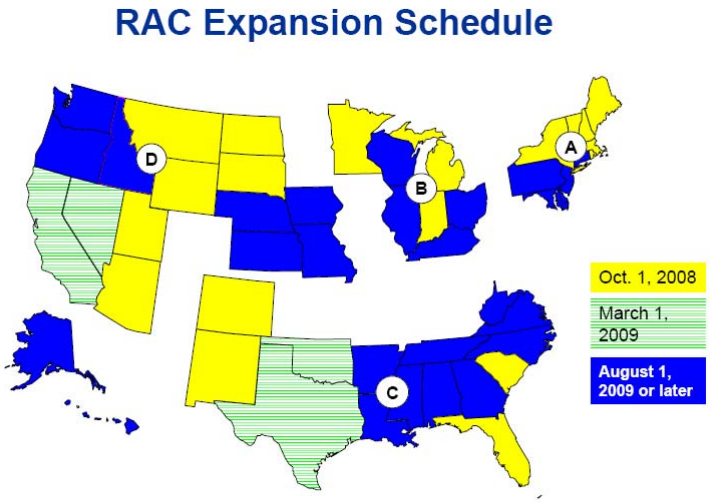
RAC Permanent Program

Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC program permanent and required its expansion nationwide by no later than 2010.[9] CMS already has begun to move forward with this expansion. According to its most recently published "Expansion Schedule," CMS expanded to nineteen states by October 1, 2008, four more states by March 1, 2009, and the remaining states by August 1, 2009 or later.[10]

On October 6, 2008, CMS announced the names of the RAC vendors for the permanent program and identified the initial states for which each will be responsible:

- Diversified Collection Services Inc., of Livermore, CA is the RAC for Region A, including Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and New York;
- CGI Technologies and Solutions Inc. of Fairfax, VA is the RAC for Region B, including Michigan, Indiana, and Minnesota;
- Connolly Consulting Associates Inc. of Wilton, CT is the RAC for Region C, including South Carolina, Florida, Colorado, and New Mexico; and

[8] *Id.* at p. 15.
[9] Section 1893(h) of the Social Security Act, 42 U.S.C. § 1395ddd.



[10] RAC Expansion Schedule, *available at* www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf.

- HealthDataInsights Inc. of Las Vegas, NV is the RAC for Region D, including Montana, Wyoming, North Dakota, South Dakota, Utah, and Arizona.[11]

Before the RACs begin auditing in the permanent program, the RACs will hold "Town Hall"-type outreach meetings, at which the RACs will meet with representatives from CMS and with Medicare providers and suppliers. Of particular interest to hospitals and health systems, these outreach meetings originally were scheduled to be coordinated through state hospital associations specifically (and not to other provider groups), indicating the RACs' intended focus on hospitals and health systems.[12] The outreach meetings were scheduled initially to take place beginning in November and December 2008. However, due to protests initiated by two companies that unsuccessfully bid to become RACs for the permanent program, the outreach meetings have been delayed, possibly until February 2009.[13] Soon after these outreach meetings are completed, hospitals and health systems in the first nineteen states (listed above) can expect to receive requests for medical records and/or overpayment demand letters from the RACs.[14]

How Do RACs Identify Improper Payments?

Although the RACs are tasked with identifying underpayments in addition to overpayments, the vast majority of the improper payments identified by the RACs during the demonstration program were overpayments, and it is the process of identifying and recouping alleged overpayments that is of particular significance to Medicare

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[11] *Id.* Note that the RAC Expansion Schedule indicates the four RAC regions, labeled A, B, C and D.
[12] *See* RAC Provider Outreach Schedule, *available at* www.cms.hhs.gov/RAC/Downloads/RAC%20Provider%20Outreach%20Schedule%20for%201st%20Wave%20States.pdf (last accessed Nov. 16, 2008).
[13] In early November 2008, two companies that unsuccessfully bid for contracts under the permanent RAC program, PRG Schultz (the RAC for California during the RAC demonstration program) and Viant Inc., filed formal protests of the RAC contract awards with the Government Accountability Office (GAO) under the Competition and Contracting Act of 1984 (CICA). As a result of these protests, CMS imposed an automatic stay of all contract work of the RACs, pending a decision by the GAO. Under CICA, the GAO must issue its decision on the protests within 100 days. Therefore, the RAC contracts and all work performed thereunder may be in abeyance until February 2009. *See* www.cms.hhs.gov/RAC (last accessed Nov. 11, 2008) and www.gao.gov. Interested persons can access the status of these protests from the GAO's website. *See* www.gao.gov/legal/index.html.
[14] 2008 RAC Fact Sheet, *available at* www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3292&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

providers.[15] RACs are permitted to attempt to identify improper payments resulting from error, non-covered services (including services denied as not medically necessary), incorrectly coded services (including DRG miscoding), and duplicate services.[16] Pursuant to Section 935 of the MMA[17] and the RAC Statement of Work,[18] RACs are prohibited from selecting claims at random to review. Instead, RACs must use proprietary "data analysis techniques" to determine claims likely to contain overpayments—a process known as "targeted review."[19]

RACs engage in two types of claim reviews in order to identify improper payments: "automated review" and "complex review." An "automated review" is a review of claims data without a review of the records supporting the claim. Generally speaking, RACs may conduct automated reviews only in situations where there is both (a) a certainty that the service is not covered or is incorrectly coded, and (b) a written Medicare policy, article, or coding guideline applicable to the claim. RACs also may use automated review, even if there is no specific Medicare policy, article, or coding guideline on point; in some "clinically unbelievable" situations,[20] or when identifying duplicate claims and/or pricing mistakes.[21] On the other hand, a "complex review" consists of a review of

[15] Over the course of the three-year demonstration, the RACs identified and collected $992.7 million in overpayments and ordered repayment of just $37.8 million in underpayments to Medicare providers and suppliers. Thus, approximately 96% of the alleged improper payments identified were overpayments, as opposed to underpayments. "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 15, June 2008, *available at* www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[16] *See generally* "Statement of Work for the Recovery Audit Contractor Program," *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[17] 42 U.S.C. § 1395ddd.

[18] *See* "Statement of Work for the Recovery Audit Contractor Program" at p. 6, *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[19] *Id.* at pp. 8-9.

[20] A "clinically unbelievable" situation is one where "certainty of noncoverage or incorrect coding exists but no Medicare policy, Medicare articles, or Medicare-sanctioned coding guidelines exist." In these cases, the RAC may ask CMS to approve automated review. However unless CMS specifically approves an issue for automated review, the RAC must use complex review to make such determinations. *See* "Statement of Work for the Recovery Audit Contractor Program" at p. 18, *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[21] *Id.* at pp. 17-18.

medical or other records, and is used in situations where there is a high probability (but not a certainty) that a claim includes an overpayment.[22]

More specifically, the RAC "complex review" process is as follows:

- To obtain the medical records necessary to conduct claim reviews, RACs are authorized to (a) visit the provider's location to view and/or copy medical records or (b) request that the provider mail, fax, or otherwise securely transmit the records.[23] During the RAC demonstration program, some providers felt unduly burdened by the volume of records requests received from the RACs. In an effort to address this concern, CMS imposed limits on the number of records RACs may request per forty-five-day period in the RAC permanent program. For example, with respect to inpatient hospital claims, the RAC may request as many as 10% of the hospital's average monthly paid claims per forty-five days.[24] However, regardless of the hospital's average monthly paid claims, the RAC may request no more than 200 records per forty-five days.[25]

  It is essential that providers timely respond to a RAC's requests for medical records. If a RAC does not receive requested medical records within forty-five days, it is authorized to render an overpayment determination with respect to the underlying claim.[26] If the provider appeals this type of denial, "the appeals department **may, at CMS direction,** send the claim to the RAC for reopening under certain conditions . . . "[27] Significantly, the carrier or intermediary is not required to send the claim to the RAC for reopening. Thus, providers failing to timely respond to a RAC's medical records request could lose appeal rights with respect to such claims.

- Once requested medical records are received, the RAC will conduct its review of the claim. In conducting reviews, RACs are required to comply with National Coverage Decisions (NCDs), Coverage Provisions in Interpretive Manuals, national coverage and coding articles, Local Coverage Decisions (LCDs), and local coverage and coding articles in their respective jurisdictions.[28] The RACs also are authorized to develop internal guidelines to assist their reviewers to conduct claims reviews consistently with NCDs and LCDs.[29]

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[22] *Id.*
[23] *Id.* at p. 11.
[24] For example, if a hospital submitted 12,000 paid claims in 2007, than this hospital's average monthly paid claims would be 1000 claims. Ten percent of this figure is 100. Therefore, the RAC would be permitted to request 100 medical records per forty-five-day period. *Id. See also* "RAC Medical Record Request Limits," *available at* www.cms.hhs.gov/RAC/Downloads/RAC%20Medical%20Record%20Request%20Limits.pdf.
[25] *Id.*
[26] *See* "Statement of Work for the Recovery Audit Contractor Program" at p. 13, *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.
[27] *Id.* at p. 20 (emphasis in original).
[28] *Id.* at p. 16. As will be discussed in greater detail later in this article, Medicare providers and suppliers subject to RAC audits during the demonstration complained that the RACs failed to abide by Medicare policies in conducting claim reviews in multiple situations.
[29] *Id.* at p. 17.

- Generally speaking, a RAC must complete complex reviews within sixty days from receipt of the requested medical records.[30] Following its review, the RAC will issue a letter to the provider setting forth the findings for each claim and notifying the provider of its appeal rights.[31] Alleged overpayments identified by RACs may be appealed through the uniform Medicare appeals process.

Provider Concerns with the RAC Demonstration Program and Resulting Changes Made in the Permanent Program

During the course of the demonstration program, Medicare providers and suppliers raised significant concerns with certain aspects of the program. CMS has made efforts to address these concerns and adopted numerous changes to be implemented in the permanent program. Some of these changes include the following:

- Under the RAC demonstration program, RACs were permitted to reopen claims up to four years following the date of initial payment. Some providers argued that this four-year look-back period was too long and violated the "provider without fault" provisions of the Social Security Act. Under the permanent RAC program, the RACs have a three-year maximum look-back period, and in all cases may not review claims paid prior to October 1, 2007.[32] The RAC Statement of Work specifically acknowledges that a look-back period greater than three years may give rise to provider without fault arguments, stating, "In addition, a provider can be found without fault if the overpayment was determined subsequent to the third year following the year in which the claim was paid. Providers may appeal an overpayment solely based on the without fault regulations. Therefore, the RAC shall not identify an overpayment if the provider can be found without fault."[33]
- Under the RAC demonstration program, the RACs were not required to employ a physician medical director or coding expert. However, under the permanent program, the RACs are required to employ a contractor medical director (CMD) who is a doctor of medicine or doctor of osteopathy, and arrange for an alternate CMD in the event that the CMD is unavailable for an extended period. The CMD is not required to assist with the record review process, but will provide other services, such as providing guidance to RAC staff regarding the interpretation of Medicare policy.[34] Additionally, the CMD must meet with a provider who requests to speak

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[30] *Id.* at p. 19.
[31] *Id.* at p. 22.
[32] *See* "Statement of Work for the Recovery Audit Contractors Participating in the Demonstration" at p. 6, and "Statement of Work for the Recovery Audit Contractor Program" at pp. 7-8, *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.
[33] *See* "Statement of Work for the Recovery Audit Contractor Program" at p. 8, *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.
[34] Legal counsel representing Medicare providers and suppliers subject to RAC audits may find it advantageous to meet with the CMD to advocate on behalf of their clients and gain insight regarding claim denials.

with him or her regarding claim denials. Additionally, in the RAC permanent program registered nurses or therapists are required to make coverage determinations involving medical necessity, and certified coders are required to make coding determinations.[35]

- During the RAC demonstration program, RACs were compensated on a contingency-fee basis, based on the principal amount of collection or the amount paid back to a provider or supplier. This fee structure could incentivize the RACs to aggressively deny claims, and led to the perception among some Medicare providers and suppliers that the RACs were acting as "bounty hunters." The RACs kept their contingency fees if denials were upheld at the first stage of appeal (i.e., redetermination stage), regardless of whether the provider or supplier prevailed at a later stage in the appeals process. Over the course of the three-year demonstration, the RACs earned $187.2 million in contingency payments (or approximately 14.4% of all alleged improper payments identified).[36] While the RACs continue to be compensated on a contingency-fee basis in the permanent program, in a significant change from the demonstration, if a provider files an appeal disputing an overpayment determination and wins this appeal at any level, the RAC is not entitled to keep its contingency fee and must repay CMS the amount it received for the recovery.[37] The RAC contingency fees for the permanent program range from 9% to 12.5%, depending on the particular RAC.[38]

Despite the fact that CMS has acknowledged these and other concerns raised by Medicare providers and suppliers during the RAC demonstration program, and has taken steps to address provider and supplier concerns in the permanent program, it is nonetheless CMS' belief that most Medicare providers and suppliers generally were satisfied with the RAC demonstration program.[39] However, certain advocacy groups and

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[35] *See* "Statement of Work for the Recovery Audit Contractors Participating in the Demonstration" and "Statement of Work for the Recovery Audit Contractor Program" at pp. 19 and 35, *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[36] "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 3, June 2008, *available at* www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[37] *See "*Statement of Work for the Recovery Audit Contractors Participating in the Demonstration" at p. 13, and "Statement of Work for the Recovery Audit Contractor Program" at pp. 42-43, *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[38] The contingency fee for Region A is 12.45%, Region B is 12.5%, Region C is 9%, and Region D is 9.49%. www.fbo.gov/index?s=opportunity&mode=form&id=5c8c7d4b00249ba579d4d77d64bd0aea&tab=core&_cview=1&cck=1&au=&ck

[39] A Gallup Organization telephone survey performed during Summer 2007 found that:
- 71% of poll respondents believed RAC reviewers to have correctly applied Medicare policies in conducting reviews, and
- 74% of poll respondents felt that CMS' efforts to recoup alleged overpayments were fair and reasonable.

Medicare providers and suppliers strongly and vocally disagree, and believe that during the course of the demonstration program, RAC reviewers violated Medicare providers' and suppliers' rights by failing to appropriately apply Medicare policies in conducting claim reviews and improperly recouping alleged overpayments.

1. Concerns raised by the California Hospital Association:

For example, the California Hospital Association (CHA) has claimed that the RAC operating in California during the demonstration program failed to appropriately apply Medicare policies in its reviews of both (1) inpatient rehabilitation facility (IRF) claims and (2) inpatient hospital short-stay claims.

- With respect to IRF claims, during the demonstration program, the RAC assigned to California denied 5,237 IRF claims for the reason that care should have been rendered in a less intensive setting (i.e., "wrong setting" denials).[40] CHA actively communicated to CMS its concerns that the RAC was not appropriately applying Medicare policy in reviewing these claims. In response to CHA's concerns, in September 2007, CMS "paused" the RAC's authority to further review IRF claims and commissioned a different and independent contractor to review a sampling of IRF claims previously reviewed by the RAC. The independent contractor disagreed with approximately 40% of the determinations made by the RAC. In response to this finding, CMS stated that, "It became clear that, with respect to IRF reviews in California, CMS contractors were not consistently applying Medicare policy for IRF services." CMS then provided training to all contractors reviewing IRF claims in California, and instructed the RAC to re-review all of the claims it had previously denied using the medical review procedures taught in the training. Of the 5,237 total IRF claims initially denied, the RAC overturned over 27% (1,454 claims) of its previous denials upon re-review. These cases amounted to approximately $14 million.[41]

- With respect to inpatient hospital short-stay claims, the RAC denied many claims for the reason that the services should have been billed as if the patient were an outpatient, rather than as "inpatient" hospital services. Based upon communications with its members, CHA discovered that the RAC based many of these denials upon InterQual Level of Care criteria, which have not been adopted by Medicare and did

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Notably, this Gallup Organization survey took place before much of the RAC recoupment activity took place. The majority of claim denials made during the RAC demonstration program were made between January 2008 and March 2008. *See* "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at Appendix C, June 2008, *available at* www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[40] *Id.* at p. 49.

[41] *Id.*

not base its reviews upon published Medicare policy.[42] Additionally, where the RAC found that the patient did not qualify to be an "inpatient," the RAC denied payment for the services rendered altogether and did not provide credit for an appropriate outpatient bill. In response to its communications with CHA regarding this issue, during the RAC demonstration program, CMS permitted Medicare providers to re-bill these claims as outpatient observation services. At this time, it is unclear whether this opportunity will be granted in the permanent program.[43]

2. AnMed Health v. Leavitt:

In addition to concerns raised by CHA, hospitals and health systems in South Carolina also have expressed dissatisfaction with the RAC program. On July 3, 2008, a complaint filed jointly by thirty-two South Carolina hospitals asserted that CMS improperly recouped $30 million in alleged overpayments. The complaint alleged specifically that CMS wrongfully recouped RAC-identified overpayments before plaintiff hospitals had received decisions at the reconsideration level of appeal, contrary to Section 935 of the MMA.[44] Section 935 of the MMA generally mandates that CMS refrain from taking recoupment action until a decision is rendered at the reconsideration stage of appeal.[45] In fact, in most cases the intermediary recouped the RAC-identified overpayments before or at the same time that it provided notice to the providers of the alleged overpayments (and thus before the providers had any opportunity to appeal). The complaint further alleged that CMS allowed the RAC to apply different standards for

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[42] Medicare's guidance regarding inpatient hospital admissions is set forth in the CMS Internet Only Publication (100-02), Medicare Benefit Policy Manual, Chapter 1, § 10. Notably, InterQual Level of Care criteria are published by a private company, McKesson Health Solutions LLC, not by Medicare, and have not been formally adopted or even referenced by Medicare by way of published guidance documents.

[43] With respect to this issue, CMS stated, "During the RAC demonstration, CMS waived the 'timely claim filing' limits and allowed hospitals to resubmit claims for outpatient ancillary services in these situations. CMS is exploring whether it is possible to continue this waiver during the RAC permanent program." "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 25, June 2008, *available at* www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[44] Section 935 of the MMA requires the following:

> In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), **the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered.** If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved. Section 1893(f)(2)(A) of the Social Security Act, 42 U.S.C. § 1395ddd (emphasis added).

[45] *Id.*

evaluating medical necessity than it required the providers to use. At the time of this publication, the U.S. District Court for South Carolina is considering CMS' motion to dismiss this action based upon lack of subject matter jurisdiction.[46]

Significantly for Medicare providers, suppliers, and their legal counsel, despite the language of the MMA, in a recent MLN Matters article CMS has taken the position that it is not required to refrain from recouping alleged overpayments at all times before an appellant receives a reconsideration decision. It is the position of CMS that it may engage in recoupment and withhold activities following an overpayment determination before a first level appeal (i.e., request for redetermination) is filed. Following an unfavorable redetermination decision, it is the position of CMS that it may engage in recoupment and withhold activities before a request for second level appeal (i.e., request for reconsideration) is filed.[47]

3. Medicare Recovery Audit Contractor Moratorium Act of 2007:

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[46] *See generally AnMed Health v. Leavitt,* docket number 8:2008cv02453.

[47] *See* MLN Matters Number MM6183, related to CR Transmittal #: R141FM, effective September 29, 2008, *available at* www.cms.hhs.gov/MLNMattersArticles/downloads/MM6183.pdf. In summary, the MLN Matters article states the following:

- Once an Intermediary or Carrier renders an unfavorable initial determination, withholding will begin on the forty-first day following the date of the demand letter, unless the Intermediary or Carrier receives the Medicare provider's or supplier's request for redetermination within thirty days from the date of the demand letter. Once the Intermediary or Carrier receives a request for redetermination, Medicare will cease withhold activities, but interest will continue to accrue. Significantly, under the Medicare appeals regulations, following an adverse initial determination, a provider has 120 days to appeal. If a provider chooses to utilize this entire timeframe, it must be prepared for withholding to begin on the forty-first day following the date of the demand letter.
- If the Intermediary or Carrier issues a partially favorable or unfavorable redetermination decision, then the Intermediary or Carrier may begin withholding funds beginning as soon as sixty-one days after giving notice, unless the QIC first receives the provider's 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. Notably, pursuant to the federal regulations governing the Medicare appeals process, a provider has 180 days from the date of redetermination decision to file its request for reconsideration.
- If the qualified independent contractor issues a partially favorable or unfavorable reconsideration decision, the Intermediary or Carrier may begin recoupment, regardless of whether the provider subsequently proceeds to the third stage of appeal and requests an Administrative Law Judge hearing.

During the entire appeals process interest will continue to accrue, even if Medicare suspends its recoupment activities. As a practical matter, legal counsel representing hospitals and health systems subject to RAC or other Medicare audits should keep CMS' recoupment policy in mind, as some providers may wish to file appeals before the timeframe for appeal has elapsed to ensure that CMS does not initiate a withhold for cash flow purposes. In addition, because interest continues to accrue on overpayment determinations during the appeals process, some providers may wish to file appeals early to avoid accruing additional interest.

On November 7, 2007, H.R. 4105, the "Medicare Recovery Audit Contractor Moratorium Act of 2007," was introduced to Congress. If enacted, H.R. 4105 would direct HHS to enact a one-year moratorium of the RAC program, during which time (1) CMS would further evaluate the RAC program for Congress; and (2) the Comptroller General would prepare a report to Congress on the use of RAC auditors.[48] H.R. 4105 has strong support from Medicare provider and supplier groups, including the American Medical Association,[49] American Hospital Association,[50] and the California Hospital Association.[51] As of the date of this publication, H.R. 4105 has been referred to the House Ways and Means Committee and the House Energy and Commerce Committee for deliberation; however, the Committees have not yet issued reports, and no votes have occurred.[52]

Despite the concerns raised with the RAC demonstration program, CMS is moving forward with the nationwide RAC expansion, and hospitals, health systems, and their legal counsel must be prepared. Although CMS has adopted changes to the RAC program to be implemented in the permanent program, Medicare provider and supplier concerns remain. The RACs continue to be compensated on a contingency-fee basis, which has the strong potential to compromise the objectivity of the RAC auditors and incentivize the RAC auditors to aggressively review and deny claims. Legal counsel must be cognizant of this potential bias and must work proactively to hold the RAC auditors to the requirements of existing statutes, regulations, and Medicare policy guidance. This could mean establishing communications with RACs and with CMS

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[48] H.R. 4105--110th Congress (2007): Medicare Recovery Audit Contractor Program Moratorium Act of 2007, *available at* www.govtrack.us/congress/bill.xpd?bill=h110-4105&tab=summary.
[49] "Statement of the American Medical Association to the Committee on Small Business Subcommittee on Regulations, Health Care and Trade, United States House of Representatives, Regarding the Impact of the Centers for Medicare and Medicaid Services (CMS) Regulations and Programs on Small Health Care Providers," presented by William Dolan, M.D. on May 14, 2008, *available at* www.house.gov/smbiz/hearings/hearing-05-14-08-CMS-Regulations/Dolan.pdf.
[50] "Testimony of the American Hospital Association before the Committee on Small Business of the U.S. House of Representatives, Improving the Paperwork Reduction Act for Small Businesses," February 28, 2008, presented by Linda Brady, M.D. on February 28, 2008, *available at* www.house.gov/smbiz/hearings/hearing-02-28-08-paperwork/testimony-02-28-08-AHA.pdf.
[51] Dauner, Duane, "California Hospitals Support House Legislation to Suspend Controversial Medicare Auditing Program," PR Newswire, November 7, 2007, *available at* insurancenewsnet.com/article.asp?n=1&neID=200711081680.2_26c1002c85f3b5a1.
[52] H.R. 4105--110th Congress (2007): Medicare Recovery Audit Contractor Program Moratorium Act of 2007, *available at* www.govtrack.us/congress/bill.xpd?bill=h110-4105&tab=summary.

when problems are identified (as exemplified by CHA during the demonstration program); utilizing the court system (e.g., *AnMed Health v. Leavitt*); and/or engaging in political activism (e.g., H.R. 4105).

RAC Planning and Compliance

Especially at the beginning of the RAC permanent program, it is CMS' belief that the RACs will focus their auditing activities mainly on hospitals and health systems.[53] Although providers and suppliers cannot stop RAC audits from happening, they can immediately put in place systems for tracking record requests and timely responding, and they can implement appropriate compliance programs and make efforts to understand available audit defenses. Specifically, hospitals and health systems should begin to get systems in place now for:

- Responding to record requests within the required timeframes;[54]
- Internally monitoring protocols to better identify and monitor areas that may be subject to review;
- Implementing compliance efforts, including, but not limited to documentation and coding education; and
- Properly working up appeals to challenge denials in the appeals process. With regard to medical necessity and similar denials, this will certainly entail physician involvement.

Although the areas that will be subject to review during the permanent RAC program cannot be predicted with certainty, reviewing the types of denials made during the RAC demonstration program and reviewing other guidance, such as the Office of Inspector

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[53] According to CMS:

> Approximately 85 percent of the overpayments collected by the Claim RACs were from inpatient hospitals . . . . Several factors may explain the Claim RACs' relatively high rate of improper payment identifications in the inpatient hospital settings. Because the Claim RACs were paid on a contingency fee basis, they establish their claim review strategies to focus on high-dollar improper payments, like inpatient hospital claims, which gave them the highest return with regard to the expense of reviewing the claim and/or medical record. CMS anticipates that the permanent RACs will adopt a similar strategy at first.

*See "*The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 18, June 2008, *available at* www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[54] Providers who are not prepared for the potential large volume of record requests could find themselves facing denials for failure to timely respond. Providers who fail to follow the required response procedures could lose their appeal rights with respect to these denials.

General (OIG) Work Plan, are helpful tools for Medicare providers and suppliers to identify potential target areas for the RACs operating in the permanent program.

During the RAC demonstration program, the vast majority of claim denials (85%) involved inpatient hospital claims, 6% involved IRF services, 4% involved outpatient hospital claims, and the remaining denials involved the claims of physicians, skilled nursing facilities, durable medical equipment suppliers, and ambulance, laboratory, or other providers.

Regarding hospital claim denials, the following services resulted in the greatest alleged overpayments:[55]

Type of Provider	Description of Item or Service	Amount Collected, Less Cases Overturned on Appeal (in Millions of Dollars)	Number of Claims With Overpayments, Less Cases Overturned on Appeal	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

[55] "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 38, June 2008, *available at* www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

Type of Provider	Description of Item or Service	Amount Collected, Less Cases Overturned on Appeal (in Millions of Dollars)	Number of Claims With Overpayments, Less Cases Overturned on Appeal	Location of Problem
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

With respect to inpatient hospital claims specifically, the RACs alleged that these claims accounted for $828.3 million in improper payments. Approximately 36% of these claims were denied due to incorrect coding. Another 41% were denied because the RACs found that the services were provided in a medically unnecessary setting (i.e., "wrong setting" denials).[56]

Across all provider and supplier types, the denials made during the demonstration program were made for the following reasons:

- 35% as a result of incorrect coding;
- 40% for not meeting Medicare's medical necessity criteria; and
- 8% because of "no/insufficient documentation" (meaning the RAC requested the information but the entity did not respond timely or completely).
- 17% for "other" reasons, including that claims were paid based upon outdated fee schedules, duplicate claims, etc.[57]

Additionally, hospitals and health systems should be cognizant of other Medicare guidance identifying areas of increased scrutiny. For example, each year the OIG publishes a Work Plan document setting forth various projects to be addressed during the upcoming fiscal year, including areas of planned audit activity. The OIG has identified the following as areas to be addressed during fiscal year 2009, among others: IRF payments, payments for diagnostic x-rays in hospital emergency departments, and

[56] *Id.* at 18.
[57] *Id.* at pp. 1 and 19.

coding and documentation changes under the Medicare Severity Diagnosis Related Group (DRG).[58]

Hospitals and health systems can expect to see the RACs focus on the areas of scrutiny set forth above. Hospitals and health systems are advised to adopt and implement compliance policies and procedures to address these and other areas of Medicare scrutiny now—before the RACs begin nationwide auditing.

Strategies for Successfully Appealing Claim Denials and Medicare Audit Determinations

The Medicare Appeals Process

If a Medicare provider or supplier receives a claim denial or a finding of overpayment is made as a result of a RAC review, this denial will be subject to the uniform Medicare Part A and Part B appeals process.[59] The five-stage appeals process is as follows:

- Redetermination;
- Reconsideration;
- Administrative Law Judge (ALJ) hearing;
- Medicare Appeals Council (MAC) review; and
- Federal district court review.

Hospitals and health systems subject to RAC or other Medicare audits and claim denials should understand that many strategies exist that can be employed in the appeals process to effectuate successful results.[60] These strategies involve effectively advocating the merits of the underlying claim and employing legal defenses.

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[58] www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf.

[59] The regulations governing this process are contained at 42 C.F.R. § 405.900 *et seq.* The Medicare appeals process described herein was effective May 1, 2005, for claim denials and unfavorable audit determinations issued by Medicare and its contractors.

[60] Based upon the information it had available at the time of publication of the Update to the Evaluation of the 3-Year Demonstration document (Update) (current through Aug. 31, 2008), CMS found that providers had chosen to appeal only 22.5% of RAC determinations. Thirty-four percent of those appealed claims had been decided in a provider's favor. Of all RAC overpayment determinations, only 7.6% were overturned on appeal. See "The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration," at p. 4, January 2009, *available at* www.cms.hhs.gov/RAC/Downloads/AppealUpdatethrough83108ofRACEvalReport.pdf

Advocating the Merits

When advocating the merits of a claim, it is useful to draft a position paper outlining the factual and legal arguments in support of payment for a disputed claim. Other strategies that can prove successful include the use of medical summaries, illustrations, and color-coded charts or graphs depicting the claims at issue that are user-friendly for the decision maker. Additionally, in most cases it is advantageous to engage the services of a qualified expert, particularly when an audit or claim denial involves issues of medical necessity. The use of expert testimony becomes particularly important because RACs are specifically tasked to assist CMS with support of overpayment determinations throughout the appeals process[61] and likely will accomplish this task through participation in ALJ hearings—providing expert witness testimony of its own.

Audit Defenses

In addition to advocating the merits of a claim through various techniques, certain legal defenses are available. Defenses that have proved valuable for providers and suppliers challenging Medicare audit determinations include: arguing the "Waiver of Liability" defense; arguing the provider is without fault; invoking the treating physician rule;

However, these appeals statistics are premature and potentially misleading to providers and suppliers. The vast majority of the RAC denials were made in the final three months of the program (January through March 2008.) See "The Medicare Recovery Audit Contractor (RAC) Program: Evaluation of the 3-Year Demonstration," at Appendix C p. 33. Thus, at the time CMS published its Update, many of the claims that had been appealed remain in various stages of the appeals process, and may still be overturned.

Additionally, the data that exists is incomplete. The Update acknowledges that RAC claims information was not closely tracked during all stages of the appeals process. Specifically, at the time of publication of the Update, CMS did not know the number of appeals pending at the first stage of appeal. In addition, during the RAC demonstration program the Qualified Independent Contractor (QIC) appeals system did not track the affiliated RAC who reviewed each initial claim. CMS attempted to identify claims initially denied by RACs at the QIC level by matching the RAC jurisdiction with the location of the provider; however, CMS acknowledged that errors could result if the billing provider and the rendering provider were in different locations, in cases of chain providers and/or if data entry errors occurred.

The Update document does not contain enough information to replicate CMS' findings, so it is unclear whether CMS' findings are accurate. For example, although the Update contains information regarding the number of claims appealed to the intermediary, QIC, Administrative Law Judge (ALJ), and Medicare Appeals Council (MAC), the Update does not contain information regarding the results at each level of appeal, only results at "all levels." Because so much data is unknown, it is impossible to ascertain whether CMS's conclusions are accurate.

[61] *See* "Statement of Work for the Recovery Audit Contractor Program" at p. 38, *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

challenging the statistical extrapolation (if one was involved); and challenging the timeliness of the audit and/or claim denial.

1. Waiver of Liability

Pursuant to the Medicare "waiver of liability" defense, providers and suppliers may be entitled to payment for claims deemed not reasonable and necessary by CMS or its contractors during an audit. The statutory authority for waiver of liability is set forth in Section 1879(a) of the Social Security Act.[62] The waiver of liability defense generally applies only to determinations that a service was not medically necessary. Under waiver of liability, even if a decision maker finds a service 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. Therefore when challenging an audit determination, providers and suppliers must have access to all relevant CMS communications with the provider and supplier community generally (e.g., statutes, regulations, NCDs, LCDs, etc.) and with the particular provider or supplier that would provide notice that payment would not be made. For example, in situations where a provider or supplier receives an overpayment demand, if the provider or supplier had been previously subject to claim reviews, a RAC audit, or other Medicare audit where similar claims were approved, then these decisions can be used to demonstrate that the provider or supplier did not have reason to know payment would not be made in a same or similar case.

[62] *See* 42 U.S.C. § 1395pp, which states the following:

(a) Where--

[1] a determination is made that, by reason of Section 1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g), payment may not be made under Part A or Part B of this title for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1842(b)(3)(B)(ii); and

[2] both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have expected to know, that payment would not be made for such items or services under Part A or B,

then to the extent permitted by this title, payment shall, notwithstanding such determination, be made for such items or services … as though section 1862(a)(1) and section 1862(a)(9) did not apply and as though the coverage denial described in subsection (g) had not occurred.

See also Medicare Claims Processing Manual (CMS-Pub. 100-04), Chapter 30, § 20.

2. Provider Without Fault

The "provider without fault" defense may be employed in the case of post-payment review denials, such as RAC denials. The Medicare provider without fault provisions—Section 1870 of the Social Security Act—state that payment will be made to a provider if the provider was without "fault" with regard to billing for and accepting payment for disputed services.[63]

As a general rule, a provider or supplier will be considered without fault if it exercised reasonable care in billing for and accepting payment, i.e., the provider complied with all pertinent regulations, made full disclosure of all material facts, and on the basis of the information available, had a reasonable basis for assuming the payment was correct.[64]

In addition, as further discussed herein, providers and suppliers will be deemed to be without fault—in the absence of evidence to the contrary—if an overpayment was discovered subsequent to the third calendar year after the year of payment.[65] As noted herein, under the RAC demonstration program RACs were permitted to reopen claims

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[63] Pursuant to 42 U.S.C.§ 1395gg:

(a) Any payment under this title to any provider of services or other person with respect to any items or services furnished to an individual shall be regarded as payment to such individual.

(b) Where -

(1) more than the correct amount is paid under this title to a provider of services . . . and the Secretary determines . . . that such provider of services . . . was without fault with respect to the payment of such excess over the correct amount . . .

(2) proper adjustments shall be made . . .

[S]uch provider of services . . . shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary's determination that more than such 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; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.

(c) there shall be no adjustment provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payments have been made . . . with respect to an individual who is without fault . . .

[64] Medicare Financial Management Manual (CMS Pub. 100-06), Chapter 3, § 70.3.

"Fault," for purposes of the provider without fault provision, is defined as follows:

(a) An incorrect statement made by the individual which he knew or should have known to be incorrect; or

(b) Failure to furnish information which he knew or should have known to be material; or

(c) With respect to the overpaid individual only, acceptance of a payment, which he knew or could have been expected to know, was incorrect.

See 20 C.F.R. § 404.507 (2007).

[65] Medicare Financial Management Manual (CMS-Pub. 100-06), Chapter 3, §§ 80 and 90.

up to four years following the date of initial payment.[66] Many providers and suppliers successfully argued that this four-year look-back period violated the "provider without fault" provisions of the Social Security Act. Under the permanent RAC program, the RACs have a three-year maximum look-back period, and in all cases may not review claims paid prior to October 1, 2007.[67]

3. Treating Physician Rule

It may be appropriate in many audit settings to assert the "treating physician rule." The treating physician rule, as adopted by some courts, reflects that a 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.[68] For example, the treating physician rule may prove effective in situations where hospitals and health systems are appealing short-stay inpatient hospital claims denied because the services were provided in the "wrong setting" and care should have been provided as outpatient observation. Under Medicare policy guidance, only a physician is qualified to render a determination that an inpatient admission is appropriate.[69] As noted above, RACs utilize the services of registered nurses to conduct claim reviews involving medical necessity determinations, including "wrong setting" denials. Hospitals could effectively reference the treating physician rule to demonstrate that the treating physician's medical judgment

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[66] *See* "Statement of Work for the Recovery Audit Contractors Participating in the Demonstration" at p. 6, *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[67] *See* "Statement of Work for the Recovery Audit Contractors Participating in the Demonstration" at p. 6, and "Statement of Work for the Recovery Audit Contractor Program" at pp. 7-8, *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[68] Authorities that have addressed this issue include: *State of N.Y. v. Sullivan,* 927 F.2d 57, 60 (2d Cir. 1991); *Klementowski v. Secretary of HHS,* 801 F.Supp 1022 (W.D.N.Y. 1992); *Gartman v. Secretary of HHS,* 633 F.Supp. 671, 680-82 (E.D.N.Y. 1986); *Wickline v. California*, 228 Cal. Rptr. 661 (Cal. Ct. App. 1986); *Breeden v. Weinberger,* 377 F. Supp. 734 (M.D. La. 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 (2d Cir. Dec. 17, 1980); and *Stearns v. Sullivan*, NO 88-2756-Z, CCH Medicare/Medicaid Manual, ¶ 38,273 (D.C. Mass. 1989).

[69] The Medicare Benefit Policy Manual specifically states, "The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient." CMS-Pub. 100-02, Chapter 1, § 10.

as to the medical necessity of the services provided should prevail absent substantial contradictory evidence.

4. Challenges to Statistics

In many post-payment audits, CMS will audit a small sample of a provider's or supplier's records, and if it finds an overpayment, CMS will extrapolate the overpayment to the provider's or supplier's entire patient population. The MMA sets limits regarding when statistical extrapolation may be used, and the Medicare manuals establish guidelines for CMS to follow when performing an audit based upon a statistical sample. If an extrapolation is flawed, it may be successfully challenged, bringing the total dollars at issue to the "actual" alleged overpayment, and not the extrapolated alleged overpayment.

Pursuant to Section 935 of the MMA:

> (1) LIMITATION 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 –
>
> (A) there is a sustained or high level of payment error; or
>
> (B) documented educational intervention has failed to correct the payment error.[70]

CMS guidelines for 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). Notably, the RACs are authorized to use extrapolation, provided that they adhere to the above-referenced statute and Manual provisions.[71] CMS and its contractors must follow these guidelines in conducting statistical extrapolations. If it fails to do so, a Medicare provider may have success challenging the validity of the extrapolation. For example, if CMS were to conduct an audit and find an "actual" overpayment of $25,000, and then extrapolate this amount to a figure of $1.5 million, the use of a qualified statistician expert witness could assist the provider to successfully challenge this suspect statistical extrapolation. An Administrative

[70] Section 1893(f)(3) of the Social Security Act, 42 U.S.C. § 1395ddd (emphasis added).
[71] *See* "Statement of Work for the Recovery Audit Contractor Program," at p. 24, *available at* www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

Law Judge could find the methodology of the statistical extrapolation to be in error and overturn the extrapolation.

5. Reopening Regulations

Medicare regulations place restrictions upon the allowable timeframe for reopening initial determinations. The RACs are required to adhere to these regulations in conducting claim reviews.[72] Pursuant to 42 C.F.R. § 405.980(b), a contractor may reopen and revise its initial determination:

1. Within one year from the date of the initial determination for any reason.
2. Within four years of the date of the initial determination for good cause as defined in Sec. 405.986.
3. At any time if there exists reliable evidence as defined in Sec. 405.902 that the initial determination was procured by fraud or similar fault as defined in Sec. 405.902.
4. At any time if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.

Pursuant to 42 C.F.R. § 405.986, "good cause" may be established when:

1. There is new and material evidence that—
    i. Was not available or known at the time of the determination or decision; and
    ii. May result in a different conclusion; or
2. The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.[73]

Further, according to the Medicare Financial Management Manual, "If an overpayment is determined based on a reopening outside of the above parameters, the FI or carrier will not recover the overpayment."[74]

[72] *Id.* at p. 6.
[73] *See also* Medicare Claims Processing Manual (CMS-Pub. 100-04), Chapter 29, § 90 and Medicare Financial Management Manual (CMS-Pub. 100-06), Chapter 3, § 80.1.
[74] Medicare Financial Management Manual (CMS-Pub. 100-06), Chapter 3, § 80.1.

Although, during the RAC demonstration program, some Medicare providers and suppliers successfully challenged reopenings under these regulations, a recent MAC decision has found that the ALJs and the MAC lack jurisdiction to consider challenges to reopenings under the Medicare appeals process.[75] Although Medicare administrative appeal decisions have no precedential value,[76] certain ALJs have taken the position that as a result of this MAC decision, they may no longer consider the argument that a reopening was conducted in violation of the above-cited regulations. Nonetheless, an argument remains that even if a provider or supplier may not challenge the Medicare contractor's authority to "reopen" a claim, they may still be able to challenge the carrier's or intermediary's decision to "revise" that claim following the reopening.

Conclusion

Hospitals and health systems nationwide should prepare now for increased Medicare scrutiny as the RAC program expands nationwide. Providers should act now to evaluate their compliance with Medicare policies and guidelines. Should a hospital or health system be subject to a RAC or other Medicare audit, effective strategies are available that can be successfully employed in the appeals process to defend Medicare audits.

[75] *Critical Care of North Jacksonville v. First Coast Serv. Options, Inc.*, decided February 29, 2008.
[76] *See e.g.,* 70 Fed. Reg. 11449 (Mar. 8, 2005).