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Appeals of RAC Denials

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RAC APPEALS PROCESS

- Rebuttal - Discussion
- Five Levels of Appeal

First Level	Redetermination
Second Level	Reconsideration
Third Level	Administrative Law Judges
Fourth Level	Medicare Appeals Council/Departmental Appeals Board
Fifth Level	United States District Court

Third Level of Appeal – ALJ Hearing (42 CFR 405.1000 *et seq.*)

- A party may request a hearing before an ALJ by filing a written request with the entity specified by the QIC within 60 days of receipt of the QIC's reconsideration decision.

- An appellant must send notice of the request for an ALJ hearing to all other parties;

- The amount in controversy (AIC) requirement for an ALJ hearing in 2009 is $120. Claims may be aggregated to meet the AIC requirements. A party must specifically request the aggregation of claims to meet the AIC requirement.

- Aside from oral testimony, an ALJ will only consider evidence previously submitted to the QIC or at a lower level of review absent a finding of "good cause" for the late submission.

ALJ Procedures

- An ALJ is required to send written notice of the hearing date and location to the parties at least 20 days prior to the scheduled hearing.

- An ALJ may request that CMS or a Medicare contractor participate in the hearing.

- An ALJ is required to establish a "complete record" of the evidence in a case. A party may review the record at the hearing, or if no hearing is held, at any time before the ALJ's decision is issued. A party has the right to request and receive a copy of all or part of the record, including a tape recording of any oral proceedings, and may be required to pay associated costs.

ALJ Decision

- The ALJ is required to apply CMD rulings and NCDs and give substantial deference to LCDs and CMS Manuals.

- The ALJ is required to issue a decision within 90 days from the date that OMHA received the hearing request. If the ALJ cannot issue a decision within this time period, the ALJ shall advise an appellant of the right to escalate the case to the Medicare Appeals Council (MAC).

- An ALJ decision is binding unless reversed or modified by the MAC or a Federal Court.

Fourth Level of Review – Medicare Appeals Council (MAC) (42 CFR 405.1100 *et seq.*)

- A party may request review by the MAC within 60 days of receipt of the ALJ decision. The request must be in writing and state the issues and findings that are being appealed.
- The MAC has the authority to assume jurisdiction of a case upon request of CMS or a contractor under its "own motion" authority.
- The MAC's review is de novo.
- The MAC's review is limited to review of the record before the ALJ (both oral testimony and evidence). Generally, there is no appearance or oral argument before the MAC.

MAC Decision

- The MAC will either affirm, modify, or reverse the ALJ's decision, or remand the case to the ALJ for further proceedings.

- The MAC is required to issue a determination within 90 days. If the MAC cannot issue a decision within 90 days, it will advise the appellant of the right to escalate the case to Federal District Court.

Recent MAC Decisions

- www.hhs.gov/dab/macdecisions
  - In re Critical Care of North Jacksonville issued on February 29, 2008
  - In re Memorial Hospital of Long Beach issued on July 23, 2008
  - In re Providence St. Joseph Medical Center issued on July 23, 2008
  - The MAC under its "own motion" authority reviewed several ALJ decisions holding that a Medicare Recovery Audit Contractor (RAC) had improperly reopened an overpayment determination beyond the one year period specified in 42 CFR 405.980(b)(2) without an evidentiary showing of "good cause."
  - The MAC determined that neither an ALJ nor the MAC has the authority to review a Medicare contractor's decision to reopen a claim. The MAC held that enforcement of the regulatory reopening standard rests solely with the CMS process for evaluating and monitoring Medicare contractors.
  - The MAC remanded the cases back to an ALJ for further proceedings and decisions.

Fifth Level of Review – Federal Court

- A party has the right to request review by a Federal District Court within 60 days of receipt of the MAC's decision. Extensions of time are generally provided by the MAC if such a request is filed prior to the end of the 60 day period.

- The required amount in controversy to request Federal District Court review in 2009 is $1220.

- The evidence considered by a Federal District Court is limited to the administrative record certified by the MAC.

Federal Court of Appeals Decision

- On October 6, 2008, the U.S. Supreme Court denied a petition for a writ of certiorari filed in the case of Maximum Comfort, Inc. v. Leavitt seeking review and reversal of a decision by the U.S. Court of Appeals for the Ninth Circuit.
- On December 21, 2007, the Court of Appeals in reversed a Federal District Court decision, and upheld the prior decision of the MAC holding that claims for power wheelchairs were not payable without adequate supporting documentation. 512 F. 3d 1081 (9th Cir. 1007).
- The Court of Appeals held that the Medicare program "may require, as a condition of reimbursement to an equipment supplier, information in addition to that provided by the certificate of medical necessity."
- The U.S. Supreme Court's denial of review in the Maximum Comfort case resolves the legal debate about whether a certificate of medical necessity may be the sole basis for determining Medicare coverage and payment of expensive durable medical equipment.
- Three courts of appeal have now affirmed the principle that supporting medical documentation, in addition to a certificate of medical necessity, may be required to establish Medicare coverage. *See* Gulfcoast Medical Supply, Inc. v. Secretary, Department of Health and Human Services, 468 F.3d 1347 (11 Cir. 2006); MacKenzie Medical Supply, Inc. v. U.S. Department of Health and Human Services, 506 F.3d 341 (4th Cir. 2007).

Legal Support

- It is important to assess the legal basis for appealing the denial of payment for the claims at issue. The supporting law, regulations, CMS Rulings, Policy Manuals, Program Issuances, and NCDs/LCDs need to be considered in making a determination regarding appeal.

Supporting Documentation

- It is important to review the underlying medical documentation to determine whether it adequately supports the claims for Medicare payment. Sufficient and persuasive documentation is necessary to sustain an appeal. **See** section 1833(e) of the SSA.

Resources Needed to Support an Appeal

- In developing an appeal strategy, it is important to determine whether there are sufficient resources available to effectively undertake an appeal. A provider/supplier may need substantial resources at the lower levels of the appeals process to properly establish the basis for payment of the claims, and create the record for higher levels of review. Evidence submitted at the first two levels of appeal will establish the record for levels three through five. Sufficient resources must be allocated to developing a complete evidentiary record prior to the QIC's issuance of a reconsideration decision.

Cost/Benefit Analysis

A cost/benefit review should be undertaken when considering whether or not to appeal a denial of coverage. An appeal depends on:

- The number of claims;
- The type and value of claims, i.e., the amount of Medicare payment at issue.
- The supporting law, regulations, policies.
- The supporting medical documentation
- The amount of time and resources needed for the appeal.