RAC Appeals – the View from the QIC

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Agenda

- Background
- The new RAC decisions
- QIC review process
- Basis for an appeal
- Questions

Background

The appeals process is now more structured and efficient.

BIPA streamlined the appeal process.

Level of Appeal	Amount in Controversy	Days to File	Entity	Days to Decide
Fifth	$1,220*	60	Federal District Court	
Fourth	$0	60	DAB Review	90
Third	$120*	60	OMHA ALJ Hearing	90
Second	$0	180	QIC Reconsideration	60
First	$0	120	M / AC Redetermination	60
RAC Denial			M / AC Recoupment	

* For 2009

Hearings

What is a QIC?

- Qualified Independent Contractor (QIC)
- Established by BIPA and MMA as independent contractors to perform the second level of appeal on Medicare claims.
- Provides on-the-record review of medical evidence and coverage policy at the time of the service.
- Utilizes a clinical panel to adjudicate claims denied as not reasonable and necessary (R&N).

The New RAC Decisions

There are improvements in the new process.

New controls provide better oversight for RAC audits.

- RACs must employ a staff consisting of nurses, therapists, certified coders, and a physician CMD.
- RACs will offer an opportunity for the provider to discuss the improper payment determination with the RAC (prior to the appeal process).
- CMS will approve issues the RAC wants to pursue prior to widespread claim review.
- Approved issues will be posted to a RAC website before widespread review.
- Detailed review results letter will follow all complex reviews.
- There is a limitation on the number of claims that the RAC can review at any one time.

QIC Review Process

QICs, the second level of appeal, review all the preceding arguments.

QIC's consider a wide range of evidence.

- The administrative record from the redetermination.
- Evidence submitted by the appellant in response to the redetermination letter.
- Notes in the Medicare claims system indicating the RAC issue.
- Applicable contractor or CMS policies.
- Advanced Beneficiary Notice.

QIC review may differ from prior levels

- Denials based on the determination that the services were not reasonable and necessary will be reviewed by a clinical panel.
- QICs and ALJs are not bound by contractor LCDs or CMS manual provisions but must show “substantial deference.”

Basis for an appeal

The burden is on the appellant to demonstrate why it does not owe, or should not be required to pay, money to the Medicare Trust Fund.

What would be a basis for a QIC to reverse the RAC denial?

- There is no overpayment.
- The amount of the overpayment was calculated incorrectly.
- The provider is not liable for repayment.
- The provider is without fault regarding the overpayment.

"There is no overpayment."

- The services are in a defined benefit category.
- The services are reasonable and necessary.
- The services are correctly coded and billed.
- Apply relevant Medicare coverage criteria to the facts of the case.

"The overpayment was calculated incorrectly."

- Services should have been downcoded instead of denied.
- Overpayment determination contained clerical or other errors in calculation.

"An overpayment exists, but the provider is not liable."

- § 1879 of the Social Security Act (the Act) limits financial liability of beneficiaries, providers, practitioners and other suppliers.

- § 1879 applies only to claims that are denied on the basis of:

  - § 1862(a)(1) – items or services are not reasonable and necessary.

  - § 1862(a)(9) – items or services are custodial in nature.

  - § 1879(e) and § 1879(g) – certain administrative issues with hospital and HHA services.

"An overpayment exists, but the provider is not liable." (cont.)

- § 1879 limits liability where the beneficiary and/or provider of services "did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services."

- 42 CFR § 411.406: Provider knowledge is based on experience, actual notice or constructive notice, including:
  - CMS manual issuances and program guidance
  - Contractor bulletins and other written guides and directives
  - Federal Register publications
  - Acceptable standards of practice in the medical community

"An overpayment exists, but the provider was without fault."

- § 1870(b) of the Act
  - Does not define "fault."

- Provider is considered "without fault" when:
  - It made full disclosure of all material facts; **and**
  - On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the FI or carrier's attention. (Pub 100-06, Ch. 3, Section 90)

Some examples of where provider is 'at fault' (Pub 100-06, Ch. 3, Section 90.1)

- The Provider Furnished Erroneous Information or Failed to Disclose Facts That It Knew or Should Have Known, Were Relevant to Payment of the Benefit.
- The Provider Receives Duplicate Payments.
- The Overpayment Was Due to a Mathematical or Clerical Error.
- The Provider Does Not Submit Documentation to Substantiate That Services Billed to the Program Were Covered.

Some examples of where provider is 'at fault' (cont.)

- The Provider Billed, or Medicare Paid the Provider for Services that the Provider Should Have Known Were Noncovered.
  - The policy or rule is in the provider manual or in Federal regulations,
  - The FI or carrier provided general notice to the medical community concerning the policy or rule, or
  - The FI or carrier gave written notice of the policy or rule to the particular provider.
- For Carriers, Items or Services Were Furnished by Practitioner or Supplier not qualified for Medicare reimbursement.

Questions?

Thank you.

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