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MEDICAL PROFESSIONAL LIABILITY – TRENDS IN CLAIMS AND LEGISLATIVE RESPONSES

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Introduction

The U.S. healthcare system has changed dramatically over the last 30 years and with it so has the medical liability environment. While many have witnessed the changes in the way healthcare is delivered – from the dominance of sole practitioners to the growth of large group practices, and from the advent of managed care to the current focus on Accountable Care Organizations – change has also come to what happens after care is delivered. Over the years there have been substantial increases in the frequency of medical professional liability ("MPL") claims, and dramatic surges in awards to those who have suffered a suboptimal medical outcome (whether the result of negligence or not). There have been several MPL crises (when premiums rise significantly while fewer insurers remain in the market to provide coverage), and, more recently, a sustained period of relative calm in the litigation environment.

This article will examine the trends in MPL claims since 1985, with a particular emphasis on the changing nature of claims and payments in that time frame. In addition, it will examine claims reported to a national MPL repository and the severity of indemnity paid, as well as the cost of defending those claims, and look at how changes in all of these areas have affected both MPL insurers and the healthcare providers that they cover. This article will also review the legislative trends at both the state and federal levels which have resulted from changes in the MPL environment and will address how these trends may foretell future legislative trends in the MPL arena.

Medical Professional Liability Claims Trends[1]

Introduction to the Data Sharing Project

While the MPL environment over the last 30 years has sometimes resembled a roller coaster, PIAA[2] recognized that trends existed, and that collecting claims data would be a critical tool in understanding those trends.

The data by which this article will analyze claims in MPL trends is taken from the PIAA Data Sharing Project ("DSP"). The DSP collects and accumulates claims data from participating domestic member companies of PIAA; its focus is to provide the intelligence

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RESPONDING TO CMS OVERPAYMENT DEMANDS: PRACTICAL STEPS FOR AN APPEAL

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Introduction

The Centers for Medicare & Medicaid Services ("CMS") implemented a national recovery audit program ("Recovery Audit Program") in 2010 in an effort to identify and collect improper Medicare payments while limiting fraud, waste and abuse in the U.S. healthcare system.[1] Since that time, healthcare providers have experienced a barrage of added scrutiny through both pre- and post-payment audits, resulting in the enforcement of billions of dollars in repayment demands imposed by the government. In 2013 alone, over $3.7 billion in overpayments were collected from healthcare providers in the United States.[2] While many providers repay millions of dollars to these recovery auditors (also known as recovery audit contractors, or "RACs"), a growing number are employing successful appeal strategies, allowing them to overcome the government's demands and retain their revenue. This article offers legal, statistical and clinical arguments that may help to maximize the likelihood of successful appeals, with a particular focus on appeals of RAC recoupments.

A key component of the government's efforts to identify and collect overpayments from federal healthcare programs is its reliance on privatized enforcement. The identification and collection of improper payments is conducted on behalf of CMS through a variety of private contractors, including RACs. RACs are compensated on a contingency basis ranging from nine percent to 12.5 percent of money collected from providers, creating a pronounced incentive for RACs to expand their audit efforts.[3] Indeed, Fiscal Year ("FY") 2013 brought a 60 percent increase in the dollar amount of RAC-identified overpayments from FY 2012.[4] Given the financial incentives for RACs and the overwhelming recoveries obtained by CMS, the provider community anticipates a continued surge in audit activity in coming years. The ability to develop a successful appeal is increasingly vital for healthcare providers seeking to retain payments to which they are entitled.

In the face of last year's $3.7 billion in recovered money, CMS data indicates surprisingly few healthcare providers have appealed RAC claims. Only 26 percent of RAC claims were appealed in FY 2012,[5] while less than seven percent were appealed in FY 2011.[6] This is particularly surprising considering the success of such appeals exceeded 47 percent in FY 2011 and 27 percent in FY 2012.[7]

The healthcare industry has collected even more dramatic data related to appeals. The American Hospital Association ("AHA") conducts a quarterly survey of hospitals to collect data about the Recovery Audit Program. In the most recent survey, 1,240 hospitals reported appealing 49 percent of all RAC denials with a startling 67 percent success rate in the fourth quarter of 2013.[8] Given the implications of this data, healthcare providers should think twice before complying with a repayment demand and thoughtfully consider the potential arguments for appeal.

Recovery Programs and Appeal Overview

The expansive privatization of healthcare enforcement began with a pilot program in 2005 to identify and recover improper payments under fee-for-service Medicare plans. Over $900 million was recovered between 2005 and 2008 as a result of the pilot program.[9] Congress expanded the program's scale with the Tax Relief and Healthcare Act of 2006 and created what is known today as the Recovery Audit Program under which RACs operate nationally.[10]

The use of private contractors to identify and collect overpayments has become a key enforcement tool for both Medicare and Medicaid, and these contractors have become increasingly aggressive in monitoring and auditing payments by federal and state healthcare programs. Contractors typically conduct two types of post-payment audits: automated and complex.[11] Automated audits normally detect payment errors through the use of quantitative analysis requiring limited interaction with the provider. Complex audits involve a manual review of records by clinical and statistical experts. These complex audits offer much greater subjectivity for RACs because they are required to review only a sample of claims when evaluating documentation, clinical decision-making and code application. In many cases, RACs extrapolate or project their findings from the sample across a much larger population of payments, even those they did not review. In the AHA's fourth quarter 2013 survey, approximately 97 percent of RAC denials involved complex audits.[12]

While a variety of strategies exist to successfully navigate contractor audits and minimize the rate of overpayments detected, this article addresses the events that occur after alleged overpayments are identified. The process begins with the receipt of a review results letter (complex review) or a demand letter (automated review). These letters indicate

that the RAC has identified overpayments and trigger a demand for repayment. In response to a demand for repayment, a healthcare provider has several levels of appeal rights, each with its own prescribed timeframe, in which they can challenge a RAC's overpayment findings.[13]

The first opportunity the provider has to challenge the alleged overpayment is the discussion period, which provides an informal process for the provider to present additional information to the RAC to explain why the claim should be paid. The discussion period may be the most critical given that one-third of participant hospitals in the AHA survey reported RAC denials reversed through utilization of that period.[14] Providers should recognize that RACs can be open to discussion during this phase, and take advantage of the limited costs associated with initiating such discussions. Hospitals have reported success using the discussion period when it is clear that the RAC missed a key piece of documentation (such as an order) or additional documentation is available to support the claim. Afterward, the formal appeal process may require legal counsel, statistical experts, clinical and coding experts and audit professionals with experience leading defensible reviews. The costs can be substantial, but successful appeals can limit otherwise tremendous repayments, and the dramatic success rates of recent appeals are encouraging.

Legal Strategies for Appeal

When a healthcare provider receives an overpayment demand, there are several legal theories, defenses and strategies that may help the provider successfully challenge alleged overpayments. The arguments discussed herein primarily apply to audits from the Medicare program, but the theories behind these defenses may also be helpful in audits from certain state Medicaid agencies and other payors. Appeals before an administrative law judge ("ALJ"), the third level of a formal appeal are the first instance in which an attorney may be the arbiter; thus it is often the first time significant consideration is given to legal arguments.

Authority to Audit/Scope of Audit

The first argument that an appellant should consider is to challenge the auditor's authority to review the claim. Most Medicare audits are conducted retrospectively, sometimes years after the provider rendered service and after it has been reimbursed by Medicare. A provider can argue that the auditor does not have authority to audit the claim(s) at issue under either the Medicare reopening regulations or the RAC Statement of Work. Medicare's reopening regulations set the following timeframes for reopening a paid claim:

1. Within one year from the date of the initial determination or redetermination for any reason;
2. Within four years from the date of the initial determination or redetermination for good cause as defined in Section 405.986; or
3. At any time if there exists reliable evidence as defined in Section 405.902 that the initial determination was procured by fraud or similar fault as defined in Section 405.902.[15]

For purposes of Medicare audits, the date of the initial determination is the date when a MAC sends an electronic or paper remittance advice to the provider in response to a submitted claim. Generally, CMS contractors use the four-year time period to reopen claims based on "good cause." Good cause is established when "there is new and material evidence that…(1) [w]as not available or known at the time of the determination or decision; and [m]ay result in a different conclusion; or (2) [t]he 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."[16] Unfortunately, a CMS contractor's decision to reopen a claim is final and not subject to appeal,[17] but providers should consider using the discussion period to challenge the contractor's basis for reopening claims under audit. CMS has expressly stated that it enforces a contractor's good cause standards through CMS' evaluation and monitoring of contractor performance, not the administrative appeals process.[18] If claims are outside of the four-year reopening window, providers can challenge the reopening of the claims if the contractor has no evidence of fraud or similar fault.

Additionally, the RACs are bound by a Statement of Work established by CMS.[19] The RAC Statement of Work forbids RACs from attempting to identify overpayments "more than three years past the date of the initial determination made on the claim."[20] The first step in responding to a RAC records request should be to confirm that all of the claims under review are within the three-year window allowed by the Statement of Work. If the claims are more than three years old, the provider can challenge (in writing) the RAC's authority to select the claims.[21]

Waiver of Liability

When designing the Medicare program, Congress acknowledged that administrative finality of Medicare payments was important to both the program and participating providers. Accordingly, it included a limitation of liability in Section 1879 of the Social Security Act ("SSA"),[22] which states, in relevant part:

Where—

1. *a determination is made that*, by reason of Section 1862(a) (1) or (9)…*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*

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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… .[23]

The limitation of liability provision allows a provider subject to post-payment review to argue that even though the contractor may have identified an overpayment, the provider should retain its payment because the provider did not know, and could not reasonably be expected to know, that the payment would later be denied.[24] For purposes of determining the provider's knowledge – actual or constructive – an ALJ or the Medicare Appeals Council ("Council"), the fourth level of appeal, look for the following evidence:

- A Medicare contractor's prior denial of payment for similar or reasonably comparable services;
- Medicare's general notices to the medical community of Medicare payment denial of services under all or certain circumstances, including manual instructions, bulletins, contractor's written guides and directives;
- The services provided were inconsistent with acceptable standards of practice in the local medical community;
- The provider's utilization review committee informed the provider in writing that the services were not covered; or
- A Medicare contractor previously issued a written notice to the provider that Medicare payment for a particular service or item is denied. This also includes notification of Quality Improvement Organization ("QIO") screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue and of medical procedures subject to preadmission review by the QIO.[25]

The limitation on liability defense is best used in cases where there is little or no specific guidance on the Medicare coverage or documentation requirements for a specific service.

In *Baptist Health Care ("Baptist")*, a hospital challenged a RAC's determination that the hospital was inappropriately paid for inpatient stays related to automatic implantable cardioverter defibrillator ("AICD") procedures in 2003, 2005, and 2006.[26] During these years, the AICD procedures were included on Medicare's "inpatient-only list," which includes services and treatments that Medicare generally only considers appropriate when rendered in an inpatient setting.[27] On July 1, 2006, the QIO, in this case Florida Medical Quality Assurance, Inc., ("FMQAI") issued a policy that stated it would no longer "uniformly" allow AICD procedures to be billed as inpatient services, but that it would consider denying routine cases with an anticipated discharge within 24 hours.[28] The Council noted that FMQAI's policy statement put the hospital on notice that its claims could be denied, but only the claims with dates of service after July 1, 2006.[29] For services provided before FMQAI issued its policy, however, the Council agreed with the hospital's limitation on liability defense, stating that until FMQAI issued its policy, the hospital "did not know, and did not have reason to know, that Medicare would not cover automatic implantable cardioverter defibrillators services provided in an inpatient hospital setting.…" The Council overturned the RAC's overpayment determination.[30]

Provider Without Fault

Like the limitation of liability defense, the "provider without fault" defense is a statutory defense based on administrative finality. Section 1870(b) of the SSA states that a provider is "deemed to be without fault" (absent evidence to the contrary) with respect to an overpayment if the overpayment determination is made "subsequent to the fifth year following the year" of the initial determination.[31] If a provider was paid for services in 2008 (or earlier) and has retained the payment until 2014, the provider is now deemed to be "without fault" with respect to any overpayments, unless there is evidence to the contrary. While the statute does not define "without fault," Medicare manual guidance states that a provider is considered to be "without fault" if it exercised reasonable care in billing for, and accepting, the payment, i.e.:

- 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 Fiscal Intermediary or carrier's attention.[32]

In *Comprehensive Decubitus Therapy*, a supplier argued that it was without fault with respect to payments it received for supplies that should have been bundled into the beneficiary's home health benefit.[33] In finding that the supplier was without fault, the Council determined that the following facts demonstrated that the supplier exercised reasonable care in billing for the services: (1) the physician's order for the supplies indicated that the beneficiary was not receiving home health; (2) a progress note stated that the beneficiary had discontinued home health; and (3) the supplier obtained pre-authorization from a Medicare contractor that did not indicate that the beneficiary was receiving home health.[34] Importantly, in this case, the presumptive "without fault" time period had not elapsed, but the provider was able to show it was "without fault" through strong documentation.[35]

Statistical Evaluation of Demands

In addition to legal arguments, healthcare providers should also scrutinize the process and procedures by which a contractor estimates an overpayment amount. Complex audits require a rigorous degree of audit planning to ensure the process is conducted fairly and yields sound and reliable conclusions. This process also necessitates a high degree of statistical competency to ensure that claims are properly sampled and extrapolated to achieve sufficiently precise results. As such, contractors are required to abide by the Medicare Program Integrity Manual ("MPIM"), which includes guidelines on data analysis, statistical sampling, extrapolation, and estimation of overpayments.[36] Successful appeals often highlight a contractor's nonconformance with these guidelines, and several decisions have been rendered regarding these arguments.

Generally Accepted Standards

Statistical sampling and extrapolation, when conducted properly, is a widely accepted method for estimating overpayments. The MPIM requires that any sampling methodology be reviewed by a statistician or a person with equivalent expertise in probability sampling and estimation methods.[37] However, that review alone does not protect statistical analysis and the resulting conclusions from appeal. In fact, a great degree of subjectivity exists when implementing statistical procedures as they relate to these matters. Several appeal decisions have concluded that no "generally accepted standards" exist for the application of sampling.[38] In *King*, which involved RAC overpayment demands, the Council observed that "[w]hile there may well be theories on the 'right way' to conduct a sample, there is no formal recognition of 'generally accepted statistical principles and procedures.'"[39]

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This decision, along with others like it, highlights the difficulty in challenging the subjective methodology of a contractor's statistical analysis. Appeal decisions have consistently shown that successful appellant arguments rest not solely on a contractor's statistical technique, but more broadly on whether the contractor's conclusions are arbitrary and capricious.

Burden of Proof

According to CMS Ruling 86-1, the burden of proof is on the appellant to prove a contractor's statistical sampling methodology was invalid and not on the contractor to establish that it chose the most precise methodology.[40] This ruling, along with a lack of clear industry standards, explains why the Council and federal courts (the last, highest level of appeal) are reluctant to overturn a contractor's methodology without explicit evidence of errors. Multiple decisions have followed this reasoning.[41] In *Border Ambulance Service*, the Council stated that "[a]ppellant's challenges to the sample are not based on demonstrable errors in the sample or reference to specific supporting evidence in the record. Rather, the appellant's arguments are based upon the testimony of its statistical expert and its cross examination of the PSC's [Program Safeguard Contractor's] statistical expert. The appellant's speculative assertions do not satisfy its burden of proving that the statistical sampling methodology at issue is invalid."[42]

While these decisions appear to limit potential challenges to sampling, they also provide a roadmap for arguments that can be successful. A successful argument should be based on data and the facts of the case rather than statistical design alone. Instead of engaging in a "battle of the experts," appellants and their experts should use case facts (i.e., the claims in question) to demonstrate their theories. For example, statistical experts may opine that a particular sample is biased, and therefore not statistically valid. That argument alone may not be successful. Instead, appellants should demonstrate that an unbiased sample would produce materially different results in a comparable audit *in addition to* arguing the theoretical concept of bias. In other words, an appellant may need to perform its own audits using more appropriate data.

Sample Size

A common strategy when appealing an extrapolation involves the sample size and precision of a contractor's conclusions. Since larger sample sizes increase precision, many providers argue a sample size is 'too small' when they believe the conclusions to be invalid. Unfortunately, such arguments yield little success. Once again, the obstacle is that no industry standards exist for appropriate sample sizes. Multiple U.S. District Courts have ruled that no minimum amount exists for sample size, including decisions in *Ratanasen v. California*,[43] *Webb v. Shalala*,[44] and *Pruchniewski v. Leavitt*.[45] However, these decisions give guidance regarding the types of sample size arguments that may succeed. Such arguments should demonstrate that, when performed properly (i.e., with a larger sample), the contractor's audit would have concluded materially different results. Such an argument will more likely deem the contractor's analysis, and resulting conclusions, to be invalid.

Interestingly, the U.S. Department of Health and Human Services Office of Inspector General ("OIG") recently published its own guidance regarding sample size thresholds. In April 2013, the OIG updated its Provider Self-Disclosure Protocol ("SDP"), which allows providers to self-report instances of potential fraud or false billings.[46] The SDP is separate and unique from CMS' own Self-Referral Disclosure Protocol ("SRDP") which applies only to potential violations of the Stark Law.[47] Among other things, the SDP requires the submission of a detailed sampling plan with a sample size of *at least* 100 claims. While this guidance does not apply to CMS contractors for the purposes of recovery audits, the updated SDP should be a reasonable indication of the minimum sample size necessary to generate reliable and precise conclusions, at least for the OIG.

Precision

The relevance of an estimate based on sampling and extrapolation depends on both precision and confidence levels of the conclusion. Precision explains a range of accuracy related to an estimated overpayment amount, while confidence is the degree of certainty that the sample correctly depicts the population. For example, an estimated overpayment amount of $200,000 with a two-sided 90 percent confidence interval and a precision amount of $10,000 would be interpreted to mean the true overpayment is expected to be within $10,000 of the $200,000 estimate with a probability of 90 percent. In other words, there is a 90 percent chance the actual overpayment amount lies within the range of $190,000 and $210,000. Naturally, a more precise conclusion would result in a smaller range of possible overpayment amounts. As such, many appeals argue that contractor estimates do not meet reasonable precision thresholds.

Multiple Council and federal court decisions have confirmed that no specific level of sampling precision is required. Therefore, appellants must show that the contractor's level of precision yields unreasonable results.[48] In *Pruchniewski v. Leavitt*, the Court held that because there is no established standard of precision for this type sampling, the ALJ was correct in concluding that providers, like the plaintiff, must "go further and establish

that the degree of imprecision is such that the extrapolation does not reasonably approach the actual overpayment, that is, it is so imprecise as to be arbitrary and capricious."[49]

While the court did not endorse the appellant's argument, it opened the door for appellants to delve further and demonstrate that a more precise analysis could result in materially different conclusions.

Representativeness and Randomness of Sample

A common argument used by appellants is that the sample is not representative of the population in question. Common causes for such an argument involve unique subsets of claims in which a contractor may only audit certain subsets, while attempting to extrapolate its conclusions across the broader population. Examples could include disproportionate samples of high-dollar claims or a focus on one particular facility or provider (i.e. potentially "rogue" providers). The Council and federal courts have not been persuaded absent a showing that such a lack of representation adversely affected the contractor's conclusions.[50] Once again, the burden of proof lies with the appellant.

Another common area for appeal involves *how* the sample was selected. Contractors typically use statistical software to help select a sample, such as RAT-STATS, which was developed by the government and is commonly used for statistical analysis.[51] While the Council and federal courts have widely held that such software programs are a reliable means of selecting a sample,[52] these programs are only as effective as their operator. Appellants should scrutinize the contractor's work plan to ensure that RAT-STATS was used as intended and that the resulting outputs were properly employed. Errors in the selection of a sample or intentionally including specific claims in an otherwise random selection may result in biased and invalid conclusions.

For instance, in *Sanders*, a case involving RAC overpayment demands, the Council found that "…either the samples themselves were not drawn correctly or the claims were not correctly assigned to the correct stratum in every case consistent with the probability sample design."[53] In part due to this finding of improper sampling, the extrapolation was set aside and overpayments were limited to the actual claims sampled. This case highlights that simply using RAT-STATS does not protect against appeals, much like using a calculator may not prevent a calculation error.

Once again, appeals based on theoretical arguments of invalidity are rarely successful foundations for appeal. Instead, appellants should reperform portions of analysis and demonstrate the existence of material errors when possible. In *Pruchniewski v. Leavitt*, the court found that the plaintiff had failed to present any empirical support for his suggestion that a different stratification would have made a material difference in the overpayment calculation or that the method chosen violated due process or resulted in an unreliable overpayment estimate.[54] Presenting such empirical evidence may have resulted in a successful appeal.

The role of statistical analysis and audit design in both estimating overpayments, and in appealing those estimates, cannot be overstated.

Clinical Role in Appeals

Healthcare providers should also recognize the role of clinical decision-making in successful appeals. The AHA indicated that 61 percent of participating hospitals (752 in total) had successful appeals in the fourth quarter of 2012 after the care in question was determined to be medically necessary.[55] That success rate highlights the need to review RAC determinations with clinical personnel and suggests that some RACs have difficulty evaluating medical records.

Engaging clinical experts in the review of contractor results is essential to properly evaluate the claims in question. In many cases, independent clinical experts are retained to provide opinions about the medical necessity and appropriateness of certain claims, particularly in cases where industry norms differ from clinical standards. Clinical expertise is also a critical skillset to incorporate as audit and statistical professionals scrutinize contractor analysis. Clinicians can often help auditors and statisticians understand where representativeness or sampling design issues may arise, and their involvement helps to develop many of the best appeal arguments.

Conclusion

Healthcare providers continue to face increased scrutiny through the Recovery Audit Program. In the face of this and other audit scrutiny, many providers successfully appealed the results of these recovery audits, contributing directly to their bottom line. In many cases, in-depth legal analysis or additional audit activities will be required to fully explore these avenues.

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Endnotes

1 FY 2012 Report to Congress, Centers for Medicare & Medicaid Services, *Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012 at 11*. Available at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012_013114.pdf.

2 Quarterly Newsletter, Centers for Medicare & Medicaid Services, *Medicare Fee for Service National Recovery Audit Program*, October 1, 2013 –December 31, 2013. Available at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-1st-Qtr-2014.pdf.

3 Centers for Medicare & Medicaid Services, *Medicare Fee-For-Service Recovery Audit Program Myths*, Dec. 17, 2012. Available at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Myths-12-18-12.pdf.

4 Quarterly Newsletter, Centers for Medicare & Medicaid Services, *Medicare Fee for Service National Recovery Audit Program*, July 1, 2013 – Sept. 30, 2013. Available at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-4th-Qtr-2013.pdf.

5 *Supra* note 1.

6 Centers for Medicare & Medicaid Services, *Recovery Auditing in the Medicare and Medicaid Programs for Fiscal Year 2011*, at 10. Available at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY2011-Report-To-Congress.pdf.

7 *Id.*

8 Presentation, American Hospital Association RAC*Trac*, *Exploring the Impact of the RAC Program on Hospitals Nationwide*, March 5, 2014, *available at* www.aha.org/content/14/13q4ractracresults.pdf. The AHA's data does not include rates of appeals by physicians or other providers or suppliers, which may explain the disparity between CMS' and AHA's data regarding rates of appeals. For example, a physician may choose to repay rather than appeal because the overpayment demand is relatively small compared to overpayment demands for inpatient hospital stays, which typically represent thousands of dollars in reimbursement.

9 *Recovery Audit Program*, Centers for Medicare & Medicaid Services, www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/?redirect=/recovery-audit-program (last visited Mar. 25, 2014).

10 Tax Relief and Healthcare Act of *2006, 109th Congress*, H.R.6111.ENR *Washington: Government Printing Office, 2006*. While Congress has expanded the recovery audit program to Medicaid and Medicare Parts C and D, this article focuses on appeals of claim denials under Medicare Parts A and B.

11 RACs are also permitted to use semi-automated reviews, in which the RAC identifies potentially erroneous payments based on claims data and gives the provider an opportunity to provide medical records to substantiate the claim. For example, the semi-automated review process is used when a RAC identifies claims that are "medically unlikely," such as claims for more than three units of incision and drainage of post-operative wound infections. Because these claims are denied in the same manner as an automated review, the AHA combines semi-automated and automated review data in its RACTrac survey.

12 *Supra note* 8.

13 See 42 C.F.R. §§ 405.374-.375; 405.900 *et. seq.* (defining the levels of appeals and time limits applicable to each level). A healthcare provider has several levels of appeal rights, each with its own prescribed timeframe, in which they can challenge a RAC's overpayment findings:

Level 0: Discussion and Rebuttal Period (an informal level);

Level 1: Redetermination, Medicare Administrative Contractor ("MAC");

Level 2: Reconsideration, Qualified Independent Contractor ("QIC");

Level 3: Administrative Law Judge ("ALJ");

Level 4: Medicare Appeals Council (the "Council");

Level 5: Federal District Court

14 *Supra* note 8.

15 42 C.F.R. § 405.980(b).

16 42 C.F.R. § 405.986.

17 42 C.F.R. § 405.926(l).

18 Interim Final Rule with Comment Period, 70 Fed. Reg. 11,420, 11,453 (Mar. 8, 2005); *Sacred Heart Hospital*, 2009 WL 5764303 (H.H.S. Nov. 10, 2009).

19 Centers for Medicare & Medicaid Services, *Statement of Work for the Recovery Audit Program*. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf.

20 *Id.* at 9.

21 Challenging the authority of the RAC to be able to select the claims for review should be done as early in the process as possible, preferably upon receipt of a records request if the claims are outside of the three year window. For automated RAC reviews of claims more than three years old, the provider should use the discussion period (typically performed by fax) to challenge the RAC's authority to audit the claims.

22 42 U.S.C. § 1395pp.

23 *Id.* (emphasis added).

24 The Medicare Appeals Council has held that "the performance of a post payment review itself cannot constitute knowledge of non-coverage of services provided and billed for prior to the assessment of the overpayment." *Baptist Health Care*, 2009 WL 5764270 (H.H.S. June 26, 2009).

25 *Id.* at 4 (citing Medicare Claims Processing Manual §§ 40.1 and 40.1.2, 42 C.F.R. § 411.406, and CMS Ruling 95-1).

26 *Id.* at 1.

27 *Id.* at 5-6.

28 *Id.* at 6.

29 *Id.* at 7.

30 *Id.*

[31] 42 U.S.C. 1395gg. In 2013, the "provider without fault" time period was lengthened from three years to five years by the American Taxpayer Relief Act of 2012, Pub. L. No. 112–240, 126 Stat. 2313 (2013).

[32] Medicare Financial Management Manual (CMS Pub. 100-06), Ch. 3, § 90. Available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c03.pdf.

[33] *Comprehensive Decubitus Therapy, Inc.*, 2009 WL 5788648 (H.H.S. Mar. 13, 2009).

[34] *Id.* at 7-8.

[35] *Id.*

[36] Centers for Medicare & Medicaid Services, *Medicare Program Integrity Manual*, May 27, 2011 at Ch. 8, § 8.4.1.5, Available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c08.pdf.

[37] *Id.*

[38] *Pruchniewski v. Leavitt*, 2006 WL 2331071, (M.D. Fla 2006).

[39] *King*, 2011 WL 6960267 (H.H.S. May 10, 2011).

[40] Program Memorandum Carriers, Centers for Medicare & Medicaid Services, *Use of Statistical Sampling for Overpayment Estimation When Performing Administrative Reviews of Part B Claims*, Jan. 8, 2011. Available at https://cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/B0101.pdf.

[41] *Momentum EMS*, 2010 WL 7232787 (H.H.S. Nov. 22, 2010).

[42] *Border Ambulance Service, LLC*, 2010 WL 7209455 (H.H.S. Nov. 10, 2010).

[43] *Ratanasen v. California*, 11 F.3d 1467 (9th Cir. 1993).

[44] *Webb v. Shalala*, 49 F.Supp.2d 1114 (W.D. Ark. 1999).

[45] *Supra* note 36.

[46] OIG's Provider Self-Disclosure Protocol (April 17, 2013), U.S. Department of Health & Human Services Office of Inspector General, Available at http://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf.

[47] CMS' Self Referral Disclosure Protocol (May 6, 2011), Centers for Medicare and Medicaid Services, Available at www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/6409_SRDP_Protocol.pdf.

[48] *Supra* note 37.

[49] *Supra* note 36.

[50] *Place for Achieving Total Health*, 2010 WL 2895718 (H.H.S. Mar. 3, 2010).

[51] RAT-STATS Statistical Software, Available at http://oig.hhs.gov/compliance/rat-stats/index.asp.

[52] *John v. Sebelius*, 2010 WL 3951465 (E.D. Ark. 2010).

[53] *Sanders*, 2011 WL 6960281, (H.H.S. May 12, 2011).

[54] *Supra* note 36.

[55] *Supra* note 7.