Latest Developments in Medicare and Medicaid Audits: MICs, MACs, RACs and ZPICs

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THE CURRENT AUDIT LANDSCAPE:
Focus on Home Health & Hospice Providers

- The Federal government has zeroed in on Medicare spending on home health and hospice services.
  - MACs and ZPICs have targeted home health and hospice providers for many years, but home health and hospice providers should prepare for audits from RACs and MICs.

THE CURRENT AUDIT LANDSCAPE

- CMS contractors in the current audit landscape
  - Medicare Administrative Contractors (MACs)
  - Zone Program Integrity Contractors (ZPICs)
  - Recovery Audit Contractors (RACs)
    - Medicare RACs & Medicaid RACs
  - Medicaid Integrity Contractors (MICs)
Medicare Administrative Contractors (MACs)

• Pursuant to Medicare Prescription Drug, Improvement and Modernization Act of 2003, CMS is transitioning and consolidating the roles of intermediaries and carriers into MACs
• MACs are assuming all functions of the current intermediaries and carriers
• Provider services will be simplified by having a single MAC process both its Part A and Part B claims

Zone Program Integrity Contractors (ZPICs): What do they do?

• CMS is in the process of transitioning the functions of Program Safeguard Contractors (PSCs) to ZPICs
• PSCs and ZPICs are responsible for preventing, detecting and deterring Medicare fraud.
  • Different from the Medical Review program which is primarily concerned with preventing and identifying errors
  • PSCs and ZPICs request medical records and conduct medical review to evaluate the identified potential fraud
  • PSCs and ZPICs may also refer to the OIG and DOJ for further investigation
• Consideration: Role of MAC versus ZPIC in a ZPIC audit

Recovery Audit Contractors

Who are the RACs?

• Region A: Diversified Collection Services, Inc.
  • Working in CT, DE, DC, MA, MD, NH, NJ, NY, PA, RI, and VT
  • www.dcsrac.com
• Region B: CGI Technologies and Solutions, Inc.
  • Working in KY, IL, IN, MI, MN, OH and WI
  • http://racb.cgi.com
• Region C: Connolly Consulting, Inc.
  • Working in AL, AR, CA, FL, GA, IA, KS, ME, NC, NM, OK, SC, TN, TX, VA, and WV
  • www.connollyhealthcare.com/RAC
• Region D: HealthDataInsights, Inc.
  • Working in AK, AZ, CA, ID, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, Guam, American Samoa, and Northern Mariana
  • http://racinfo.healthdatainsights.com/home.aspx
RAC New Statement of Work

Published September 12, 2011

• Semi-Automated Reviews:
  – Identification of billing aberrancy through an automated review
  – Notification letter sent to provider explaining potential billing error that is identified

• RACs must complete complex review within 60 days of receipt of medical records or documentation or will not receive a contingency fee

• RACs must provide support to CMS throughout the administration of the appeals process and where applicable, during an appeal to federal district court

THE FOCUS OF CURRENT RAC AUDITS

RAC Approved Issues

• One area of concern revealed in the Demonstration Project was whether the RACs properly interpreted Medicare criteria and made inaccurate overpayment determinations

• In response, CMS created the “new issue review” process and contracted with an independent entity to serve as the RAC Validation Contractor

THE FOCUS OF CURRENT RAC AUDITS

RAC Approved Issues

• New Issue Review Process
  • The RAC must submit information about a new issue it would like to review to CMS
  • CMS will review the issue and determine whether the RAC may proceed or whether it must first be reviewed by the RAC Validation Contractor
  • If referred to the RAC Validation Contractor, the RAC will provide the Validation Contractor with a small sample of claims and medical records, if necessary
  • After evaluating the issue, the RAC Validation Contractor will issue a recommendation to CMS as to whether the RAC should be permitted to proceed with a full-scale review

• Key Consideration: Can providers impact new issues?
THE FOCUS OF CURRENT RAC AUDITS

Home Health RAC Approved Issues

- **Region C: Incorrect Billing of Home Health Partial Episode Payment Claims**
  - **States affected:** AL, AK, CO, FL, GA, IA, LA, MS, NM, NC, OK, Puerto Rico, SC, TN, TX, Virgin Islands, VA, WV
  - **Description:** Incorrect billing of Home Health Partial Episode Payment (PEP) claims identified with a discharge status 06 and another home health claim was not billed within 60 days of the claim from date. Additionally, MCO effective dates are not within 60 days of the PEP claim.

- **Region C: Hospice Related Services – Part B**
  - **States affected:** AL, AR, CO, FL, GA, IA, LA, MS, NM, NC, OK, PR, SC, TN, TX, VI, VA, WV
  - **Description:** Services related to a hospice terminal diagnosis provided during a hospice period are included in the hospice payment and are not paid separately.

- **Region D: Hospice Related Services – Part B and Part A**
  - **States affected:** AK, AZ, CA, HI, ID, KS, MO, MT, ND, NE, NV, OR, WY, SD, UT, WA, Guam, American Samoa, Northern Marianas
  - **Description:** Services related to a hospice terminal diagnosis provided during a hospice period are included in the hospice payment and are not paid separately.

The Focus of Current RAC Audits

Hospice-Related RAC Approved Issues

- **Region C: Hospice Related Services – Part B**
  - **States affected:** AL, AR, CO, FL, GA, IA, LA, MS, NM, NC, OK, PR, SC, TN, TX, VI, VA, WV
  - **Description:** Services related to a hospice terminal diagnosis provided during a hospice period are included in the hospice payment and are not paid separately.

Medicaid RACs

- **February 1, 2011:** CMS Bulletin
  - Clarified that states will not be required to implement their RAC programs by the proposed implementation date of April 1, 2011.

- **Previous Bulletin (issued October 1, 2010) and Proposed Rule (issued November 10, 2010) called for state programs to be fully implemented by April 1, 2011 (absent an exception)**

- **September 16, 2011:** CMS publishes Final Rule

- **January 1, 2012:** States required to have implemented their Medicaid RAC programs
Medicaid RACs

Medicaid RAC Final Rule

• Eligibility requirements for Medicaid RACs
  – Entity must display to the state that it has the technical capability to carry out the Medicaid RAC tasks.
    • Examination of entity’s trained medical professionals in good standing with state licensing authorities
  – Entity must hire or maintain a minimum of 1.0 full-time equivalent Contractor Medical Directors who is either a M.D.
    or a D.O. in good standing with licensing authorities and has experience in relevant work.
  – Entity must hire certified coders unless the state determines that this is not necessary.

• The Final Rule does not require states to provide coding/billing guidelines to providers.
  – Will this omission hinder proactive compliance efforts?
  – Possible defenses as a result of no coding/billing guidelines?

• The Final Rule does require Medicaid RACs to provide minimum customer service measures and to not audit claims that have already been or are currently being audited.
  – No specific mechanism was imposed on the states to prevent duplication of efforts.
  – Will states use a Data Warehouse technique?

Medicaid RACs

• Funding
  • States’ costs to carry out the Medicaid RAC program (establish, operate and appeals process) will be shared by the federal government at the 50% administrative rate applied to all Medicaid expenditures.
  • States are required to determine the contingency fee rate to be paid to Medicaid RACs.
    • Must not exceed the highest contingency rate set in the Medicare RAC program (currently 12.50%).
    • Anything in excess will be paid using state-only funds.
Medicaid RACs

- **Scope of Medicaid RAC Audits**
  - CMS will not issue oversight provisions regarding medical necessity reviews for the Medicaid RAC program.
    - Medicaid RAC medical necessity reviews will be performed within the scope of state laws and regulations.
  - CMS will encourage states to form review teams for Medicaid RACs similar to the Medicare RAC program’s “New Issue Review Board.”
  - **Absent from the Final Rule**: a requirement that states require advanced approval of medical necessity reviews.

Medicare RACs v. Medicaid RACs

**Key differences:**

- **Funding**
- **Authorization of the RAC programs**
- **Control over the RAC programs**
  - Medicaid RAC Final Rule: focused on flexibility for states

Medicaid Integrity Program v. Medicaid RACs

- Medicaid RAC final rule strongly asserted that the program is different from the MIP:
  - **Role/Purpose**
    - RACs: identify payment errors; state issues
    - MICs: identify and prevent fraudulent practices; regional/federal issues
  - **Organization**
    - Medicaid Integrity Program ("MIP"): has three types of contractors.
    - MICs are federal contractors and organized regionally
    - MICs are **not** paid on a contingency fee
Medicaid RACs

Post-Medicaid RAC Audit
  • Re-Billing a Claim:
    • States have discretion whether to allow claims to be re-billed and the requirements for re-filing, consistent with state law, regulation and policy.
  • Medicaid RACs Reopening Claims:
    • State discretion: states have different administrative appeal processes, thus CMS will not require states to comply with the reopening regulations as set forth in the Medicare RAC program.
  • Collection of overpayments:
    • RAC contingency fee based on the overpayments recovered, rather than those simply identified.

Medicaid RACs

Post-Medicaid RAC Audit (continued)
  • Collection of overpayments
    • RAC contingency fee based on the overpayments recovered, rather than those simply identified.
    • A state may pay the contractor once the overpayment is identified and recovered, regardless of any subsequent provider appeal, but if the provider is successful during the appeals process the contractor must return the applicable portion of the contingency fee.
    • A state may also choose to pay the RAC its contingency fee after any and all provider appeals are fully adjudicated.

Medicaid RACs

Impact of Medicaid RACs
  • In the Final Rule CMS estimated that in 2012 the Medicaid RAC program will save the federal government $60 million and state governments $50 million.
  • Aggregate net savings of $2.13 billion for FYs 2012 through 2016.
  • The Final rule did not project any expected impacts of the Medicaid RAC program on Medicaid healthcare providers.
Medicaid Integrity Contractors (MICs)

- Hired contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues
- Provide effective support and assistance to States in their efforts to combat Medicaid provider fraud and abuse
- By the end of FY2010, 947 audits were underway in 25 states and MIG efforts had identified an estimated $10.7 million in overpayments. Medicaid Integrity Report to Congress, 2010

Medicaid Integrity Contractors (MICs)

- Section 6034(e)(3) of the Deficit Reduction Act 2005 mandated the creation of the Medicaid Integrity Program (MIP)
  - Under MIP, CMS hires contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers on Medicaid program integrity issues
  - CMS will support and assist the states in their efforts to combat Medicaid fraud and abuse
- MIP is operated under the jurisdiction of the Center for Medicaid & State Operations (CMSO)

Medicaid Integrity Contractors (MICs)

- Review MICs
  - Review and select providers for audits with a 5 year look back period
- Audit MICs:
  - Request for Records & Documentation of Findings
    - 30 days to provide records
    - All audit findings must be supported by adequate documentation
Medicaid Integrity Contractors (MICs)

- Audit MICs: Audit Report Process
  - Audit MIC sends provider a notification letter.
  - If the Audit MIC believes that an overpayment exists, it will prepare a draft report which will be reviewed by the provider and the state.
  - The provider has an opportunity to comment on the report.
  - CMS prepares a second draft report, then finalizes the report and sends it to the state.
  - The state pursues collection of the overpayment from the provider.

- MICs are not tasked with collecting overpayments
- Federal government collects its share directly from the state and the state is responsible for recovering the overpayment from the provider
- Like the RAC program, payments to providers may be recouped once an overpayment is identified. Not so fast…

- MIC Fraud Referrals
  - If an Audit MIC identifies potential Medicare or Medicaid fraud, it must simultaneously and immediately make a fraud referral to the Medicaid Integrity Group (MIG) or the Office of Inspector General for the Department of Health and Human Services (OIG). Medicaid Program Integrity Manual, 100-15, Ch. 10, § 10020.
  - The OIG has 60 days to determine whether to accept the referral.
Recent Developments Impacting Home Health and Hospice Providers

- February 16, 2012 CMS Published a Proposed Rule proposing:
  - A ten year look back period for all Medicare claims (as opposed to the current four year look back period) (Proposed 42 C.F.R. 405.980(b))
  - A definition for when an overpayment is “identified”: the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. (Proposed 42 C.F.R. 401.305(a)(2))

Home Health and Hospice Medicare Compliance: Face-to-Face Requirements

- The Patient Protection and Affordable Care Act (PPACA) implemented face-to-face requirements for home health and hospice providers.

- **Home Health**: the certifying physician must document that s/he or a non-physician practitioner working with the physician has seen the patient within 90 days prior to the start of care or within 30 days after the start of care.
  - **Considerations**: Post-payment audit denials for F2F prior to implementation date; documentation of F2F.

- **Hospice**: A hospice physician or nurse practitioner must have a face-to-face encounter with a hospice patient prior to the patient’s 180th-day recertification and each subsequent recertification. The encounter must occur within 30 calendar days prior to the start of the hospice patient’s third benefit period.
Home Health and Hospice Medicare Compliance: Terminality Certification

• For the first 90-day period of hospice coverage, by the end of the third day the hospice must obtain oral or written certification of the terminal illness by:
  – The medical director of the hospice or the physician member of the hospice interdisciplinary group (IDG) and the individual's attending physician, if they have one.
  – No one other than a medical director or director of osteopathy may certify or re-certify a terminal illness.

• Terminally ill: medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course.

Home Health and Hospice Medicare Compliance: Terminality Certification

• The written certification must include:
  • Statement that the individual's medical prognosis is that their life expectancy is 6 months or less if the terminal illness runs its normal course;
  • Specific findings and other documentation supporting a life expectancy of 6 months or less; and
  • The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers.
  • The physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.

Key Audit Risk Issues for Home Health

• Homebound
• Skilled services
• Physician certification/recertification
• Performance of services that were not ordered
• Expectation of improvement: hindsight standard
Key Audit Risk Issues for Hospice

- Physician Certification
- Timing and Content
- Covered services
- Services provided consistent with plan of care
- Inpatient
- Nursing Homes

Effective Home Health & Hospice Compliance Measures

- Objectively review documentation practices to verify compliance with Face-to-Face Documentation and Terminal Illness Certification Requirements.
- Establish proactive protocols for reviewing cases:
  - Documentation enhancement
  - Periodically review policies
  - Implement monitoring protocols

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

OVERVIEW
- Rebuttal
- Discussion period
- Redetermination
- Reconsideration
- Administrative Law Judge Hearing
- Medicare Appeals Council (MAC)
- Federal District Court
SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Rebuttal and Discussion Period
• Engaging in rebuttal or the discussion period does not extend the provider's appeal deadlines
• The rebuttal and discussion periods are avenues outside of the Medicare appeals process

Rebuttal
• Providers may file a rebuttal statement within 15 calendar days of receiving the results of a post-payment review
• The statement should address why the suspension, offset or recoupment should not take effect on the date specified in the notice
• The contractor must make a written determination within 15 days

Discussion Period
• Discussion period begins on:
  • The date of the demand letter for automated reviews
  • The date of the review results for complex reviews
• Discussion period ends on the date recoupment occurs
• To engage in a discussion, providers must notify the RAC in writing
• Providers can use this opportunity to:
  • Discuss and challenge the denial rationales
  • Obtain clarification on how the RAC made its determination

Redetermination
• After an initial determination, a provider has 120 days to file a request for redetermination
  - Request for redetermination must be filed within 30 days after the date of the first demand letter to avoid recoupment of the overpayment
  - Recoupment begins on the 41st day after the date of the demand letter
• The contractor has 60 days from the date of the redetermination request to issue a decision
  - Providers may submit additional evidence after the request is submitted, and the contractor may extend the 60 day decision-making time period by 14 days for each submission.
SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Reconsideration

- Once the contractor issues a redetermination decision, a provider has **180 days** to file a request for reconsideration.
  - Request for reconsideration must be filed within **60 days** after the redetermination decision in order to avoid recoupment of the overpayment. **Recoupment begins** on the 76th day after the redetermination decision.

Reconsideration - Key Considerations:

- Full and early presentation of evidence requirement
- Submission of additional evidence, 14 day extension of time period for decision
- Reviewer credentials

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Administrative Law Judge (ALJ) Hearing

- A provider must file a request for an ALJ hearing within **60 days** of the QIC's reconsideration decision.
- Amount in controversy requirement must be met.
- ALJ hearing may be conducted in person, by video-teleconference (VTC), or by phone.
- CMS will recoup the alleged overpayment during this and following stages of appeal.
Contractor Participation in ALJ Hearing

The nature of the contractor's involvement in the hearing often is impacted by how they choose to participate. (42 CFR § 405.1020)

- Two Options for Participation:
  - Party
  - Non-Party Participant (more common)

- As non-party participants contractors may not:
  - Call witnesses
  - Cross-examine a provider's witnesses
  - Be called by the provider as a witness

- As non-party participants contractors may:
  - File position papers
  - Provide testimony to clarify factual or policy issues of the case

**Notice Requirements for Contractors**: 10 days after receiving the notice of hearing (42 CFR § 405.1010(b))

SUCCESSFUL APPEAL STRATEGIES

The Medicare Appeals Process

Medicare Appeals Council (MAC)

- A provider dissatisfied with the ALJ decision has 60 days to file an appeal to the Medicare Appeals Council (MAC)
  - Use of past Medicare Appeals Council cases:
    - http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/mac_de cisions.html
    - http://www.hhs.gov/dab/macdecision/
  - Examples:
    - In the Case of Solati Hospice Care, LLC, Decided June 3, 2011.
    - In the Case of E.P. (Beneficiary), Decided March 29, 2011.

Federal District Court

- A provider must submit an appeal to the federal district court within 60 days of the date of the MAC decision
- Amount in controversy requirements must be met: $1,350

SUCCESSFUL APPEALS STRATEGIES

Audit Defenses

- Provider Without Fault
- Waiver of Liability
- Treating Physician's Rule
- Challenges to Statistics
SUCCESSFUL APPEALS STRATEGIES
Audit Defenses

Provider Without Fault

- Section 1870 of the Social Security Act
- Once an overpayment is identified, payment will be made to a provider if the provider was without “fault” with regard to billing for and accepting payment for disputed services
  - Definition of fault
  - 3 Year Rule

- MAC Cases: In the case of Comprehensive Decubitus Therapy; In the case of Whidbey General Hospital

SUCCESSFUL APPEALS STRATEGIES
Audit Defenses

Waiver of Liability

- Section 1879(a) of the Social Security Act
- Under waiver of liability, even if a service is determined 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.

- MAC Cases: In the case of Baptist Healthcare

SUCCESSFUL APPEALS STRATEGIES
Audit Defenses

Treating Physician’s Rule

- The treating physician rule, as adopted by some courts, reflects that the 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.
SUCCESSFUL APPEALS STRATEGIES
Audit Defenses

Treating Physician’s Rule
- CMS Ruling 93-1: With respect to Part A Claims – CMS Ruling 93-1 states that treating physician opinion is evidence, but not presumptive, so need to make a case specific argument why physician’s opinion is the best evidence.
- 42 C.F.R. § 482.30 - Conditions of Participation: Utilization Review
  - Providers should always argue that the opinion of the treating physician is the best evidence.
- MAC Case: In the case of BionCare Medical Technologies, Inc

SUCCESSFUL APPEALS STRATEGIES
Challenges to Statistics

Section 935 of MMA:
- Limitations 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...
  - There is a sustained or high level of payment error; or
  - Documented educational intervention has failed to correct the payment error.
- The guidelines for conducting statistical extrapolations are set forth in the Medicare Program Integrity Manual, Ch. 8, § 8.4
- MAC Case: In the case of Transyd Enterprises, LLC

SUCCESSFUL APPEAL STRATEGIES
Arguing the Merits

- Merit-based arguments include:
  - Medical necessity of the services provided
  - Skilled Services
  - Terminal diagnosis
- To effectively argue the merits of a claim:
  - Draft a position paper laying out the proper coverage criteria
  - Summarize submitted medical records and documentation
  - If relying on medical records in an ALJ hearing:
    - Organize using tabs, exhibit labels and color coding
    - Use graphs and medical summaries to assist in the presentation of evidence
SUCCESSFUL APPEAL STRATEGIES
Arguing the Merits

• Clinical Arm – Involvement of Experts
  • Clinical component
    • Expert opinions (affidavits and in-person testimony)
    • Integration of high quality literature review
    • College, society standards
    • LCDs – locally and nationally

Questions?

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