The ABCs of Medicare Audits and Appeals

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Outline

• Overview of the current Medicare audit programs
• Understanding Medicare audit documentation
• Practical Considerations
  • Responding to an audit request
  • Unfavorable audit determination
• Questions

Introduction: CMS Audit Contracting

• The Social Security Act provides that the Secretary of Health and Human Services (HHS) may perform any of his/her functions directly or by contracting with entities to carry out those functions.
• Contracted functions include:
  • Claims processing
  • Medical review / audits
  • Error rate calculations
  • Benefit integrity (detecting fraud and abuse)
Key Medicare Audit Contractors

- Medicare Administrative Contractors (MACs)
- Comprehensive Error Rate Testing (CERTs)
- Zone Program Integrity Contractors (ZPICs)
- Recovery Audit Contractors (RACs)

Medicare Administrative Contractors (MACs)

Tasked with a number of responsibilities:
1. Claims processing
2. Medical review audits
3. Provider enrollment (Parts A & B)
4. Issuing overpayment demand letters, recoupment
5. First level appeals (redetermination)

MAC Medical Review Audits

- Goal: prevent improper payments, reduce payment error
  - Focus on prevent future improper billing, not necessarily identifying potential fraud and abuse.
  - If MAC uncovers suspected fraud, directed to refer to ZPIC for development
- Often focus on CERT error rates and vulnerabilities identified by the RACs; also use analysis of internal claims data
Medicare Administrative Contractors (MACs)

MAC Medical Review Audits
• Pre-payment and post-payment claim review
• Statistical sampling and extrapolation
• Types of Reviews:
  • Complex – review of medical documentation
  • Non-complex – no review of medical documentation

MACs directed to apply coverage provisions in:
• Social Security Act and regulations
• CMS Rulings
• National Coverage Determinations (NCDs)
• Manual guidance
• Relevant MAC’s Local Coverage Determinations (LCDs)
• Coding guidelines (CPT, ICD-9, HCPCS, CMS coding policies)

• Issue Overpayment Demand Letters
  • Also called “First Request” Letters
  • For MAC audits and audits conducted by other contractors

• First Level Appeals (Redetermination)
  • May be the contractor that conducted the audit, in which case a different reviewer carries out the appeal
Comprehensive Error Rate Testing (CERT)

- Tasked with calculating the Medicare Fee-for-Service improper payment rate
- CERT uses a statistically valid random sample of claims to determine if claims were paid properly under Medicare coverage, coding and billing rules.
- Improper payment rate is not a “fraud rate”

Comprehensive Error Rate Testing (CERT)

- Two CERT contractors:
  - CERT Documentation Contractor
  - CERT Review Contractor
- Claims reviewed by CERT are subject to:
  - Post-payment denials
  - Payment adjustments
  - Other administrative or legal actions
- CERT claim denials may be appealed through Medicare appeals process

Zone Program Integrity Contractors (ZPICs)

- Program Integrity contractors
- Formerly known as Program Safeguard Contractors (PSCs)
- Seven regional “program integrity zones”
- Michigan ZPIC: Cahaba Safeguard Administrators
Zone Program Integrity Contractors (ZPICs)

**Goal:** Identify and develop cases of suspected fraud
- Investigate complaints and allegations of fraud
- Quickly respond to fraud and employ administrative actions
  - Audit claims
  - Initiate payment suspension
- ZPICs utilize:
  - Referrals from MACs and other medical review contractors
  - Data analysis to identify patterns of claim submissions or payments that indicate potential problems

Zone Program Integrity Contractors (ZPICs)

**ZPIC Audits**
- May use pre-payment or post-payment claim review
- Focus of Benefit Integrity reviews:
  - Identifying possible falsification
  - Trend of using higher codes
  - Obvious or nearly identical documentation
  - Evidence of alterations to the records
- ZPICs may (and often do) use statistical sampling and extrapolation

Recovery Audit Contractors (RACs)

**Focus:** Identifying improper payments (not detecting fraud, waste and abuse)
- RAC program began as a demonstration program, was made permanent and expanded nationwide
- Paid on a contingency fee basis
- Four RACs, each responsible for a region covering ¼ of the country
  - Michigan: CGI Federal (RAC Region B)
Recovery Audit Contractors (RACs)

RAC Audits
- Post-payment claim reviews
  - Automated (non-complex)
  - Semi-automated
  - Complex
- September 2012: RAC prepayment review demonstration
  - 11 states with high levels of improper payments/fraud or high claim volumes for hospital inpatient short-stay claims – includes Michigan
  - April 2013: therapy claims added to prepayment demonstration
  - Prepayment review of inpatient short-stay claims were stopped on 10/1/2013; prepayment therapy reviews are ongoing.

Recovery Audit Contractors (RACs)

RAC Audits
- Focus on claims with greatest impact to Medicare Trust Fund
- Incentivized by contingency fee arrangement
- Issue Validation Process before claims can be reviewed
  - CMS or RAC Validation Contractor must review and approve issue
  - Issue must be posted to RAC website
- Three-year look back period

The List Continues...Other CMS Contractors

Depending on the nature of your practice, you may also encounter:
- Quality Improvement Organizations (QIOs)
- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Medicare Drug Integrity Contractor (MEDICs)
- Medicaid Integrity Contractors (MICs)
- Payment Error Rate Measurement (PERM)
The Future of CMS Audit Contractors

Moving toward programs that span across Medicare and Medicaid

• Supplemental Medical Review Contractor (SMRC)
  • Goal: lowering improper payment rates and increasing medical review efficiencies across the Medicare and Medicaid programs
  • Nationwide medical review activities assigned by CMS
  • Current SMRC: StrategicHealthSolutions, LLC

• Unified Program Integrity Contractors (UPICs)
  • Integrate program integrity audits and investigations across Medicare and Medicaid
  • Between 5-15 regional UPICs
  • Expected implementation beginning in FY 2015

Understanding Audit Documentation

Request for Medical Records

• Type of audit will impact the audit documentation you receive
• Pre-payment (claim-by-claim review)
  • Additional Documentation Requests (ADRs)
  • Post-payment
    • Individual claims – ADRs requesting records
    • “Big-box” – list of claims for which medical records are requested

Audit Findings:

• Review Results Letter (post-payment)
  • May be separate from overpayment demand
  • May be accompanied by statistical sampling and extrapolation information
  • May indicate future actions to be taken (prepayment review, larger post-payment review, payment suspension)
• Denial Code on Remittance Advice (pre-payment)
  • Triggers appeal timeframes
Understanding Audit Documentation

Overpayment Demand/First Request Letter
- Issued in post-payment audit
- Letter issued by MAC
- Triggers recoupment and appeal timeframes
- Different from “Intent to Refer” Letter

Practical Considerations – Responding to Records Requests and Denials

Maintaining Contractor Correspondence
- Record Request or ADR Letters
- Review Result Letters
- Overpayment Demand Letters
Maintaining Contractor Correspondence

- Letter Numbers
- Dates of Letters
- Beneficiary Names and HICN (do they match previous letters?)
- Organization with spreadsheets – when was information received and sent – deadline calculation
- If telephone communication with contractors – ask for reference number for your call
- Maintain any email correspondence

Organization of Documents and Medical Records

- Keep exact copies of everything you send!!
- Use of cover sheets (beneficiary name, HICN, date of service at issue)
- Single-sided medical records
- Organization of medical records
- Bates stamped
- Include everything that you think is important!
- Explain documents in medical record if necessary

Inclusion of Identifying Information on Correspondence

- E.g.: NPI, PTAN, Last 5 of Tax ID
- Use of header with information on each page of submission
- Use appropriate CMS forms where applicable (appointment of representative, redetermination form, reconsideration form)
Calendaring Deadlines and Events

- Due dates for medical records requests
- Dates records were submitted
- Due dates for next level of appeal (withhold deadline vs. actual deadline)
- Contractor deadlines (e.g., 60 days for reconsideration/redetermination; 90 days for ALJ and MAC) (note that ALJ MAC are not adhering to that deadline!)

Tracking Submissions

- Note tracking numbers in file and on letters
- P.O. Box vs. Street Address – beware of which carriers can go to P.O. Box and whether signature could cause problems
- USPS Priority is not guaranteed vs. Priority Express guaranteed

Unfavorable Determinations
- What Next
5 Stage Appeal Process

- Redetermination
- Reconsideration
- Administrative Law Judge (ALJ)
- Medicare Appeals Council (MAC)
- Federal District Court

Rebuttal or Discussion Period

- 15 days
- Important to note that it does not extend other appeal deadlines

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.
Reconsideration

- A provider has 180 days to file a request for reconsideration after the contractor issues a redetermination decision.
- Request for reconsideration must be filed within 60 days of the redetermination decision.
- Decision should be issued within 60 days.

Reconsideration - Key Considerations:

- All information must be submitted before the reconsideration decision is issued or will be precluded (absent good cause).
- Submission of additional evidence, 14-day extension of time period for decision.
- Reviewer credentials.

Administrative Law Judge (ALJ) Hearing

- A provider must file a request for an ALJ hearing within 60 days of the QIC’s reconsideration decision.
- The amount in controversy requirement must be met (2014 = $140) – may combine.
- Generally conducted by telephone.
- CMS will recoup the alleged overpayment during this and following stages of appeal.
- Current backlog – years!

Additional Levels of Appeal

- Medicare Appeals Council (MAC)
  - A provider dissatisfied with the ALJ decision has 60 days to file an appeal to the Medicare Appeals Council (MAC).
  - No hearing.

- 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: 2014 = $1,430.
Appeal Strategies – Merit Based Arguments

- Merit-based arguments include:
  - Medical necessity of the services provided

- Medical records play a key role in effective defense of medical necessity claim denials

- Illustrate how medical records meet the documentation guidelines
  - Identify and outline applicable coverage criteria
  - Provide clear, case-specific examples of how guidelines are met
  - Use exhibited medical records

Appeal Strategies – Involvement of Experts

- Clinical Component:
  - Internal clinicians (narratives/attestations/summaries)
  - Outside expert opinions (affidavits and in-person testimony)
  - Integration of high quality literature
  - College, society standards
  - LCDs – locally and nationally

Appeal Strategies – Involvement of Experts

- Coding Component
  - E/M Codes – detailed arguments and spreadsheets regarding reasons why E/M code is appropriate
  - Coding expert can be used to prepare arguments, testify at ALJ and to assist with compliance going forward
Appeal Strategies – Challenge 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

Appeal Strategies – Legal Arguments

- Provider Without Fault
- Waiver of Liability

Questions?

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