Effective Appeal Strategies: What You Need to Know About Audits & Appeals

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Outline

• Types of Contractors who Conduct Audits
• Types of Audits – Key Characteristics
• Understanding Audit Documentation
• Appeals Process
• Effective Appeal Strategies
• Questions

Focus: 3 Key Audit Contractors

• Medicare Administrative Contractors (MACs)
• Unified Program Integrity Contractors (UPICs)
• Recovery Audit Contractors (RACs)
Medicare Administrative Contractors (MACs)

Tasked with: Claims processing, medical review audits, provider enrollment, issuing overpayment demand letters, recoupment, first level appeals (redetermination)

• MACs have authority to review any claim at any time
• Use data and claims analysis; instructed to focus on greatest financial risks to Medicare program

• MACs for Michigan:
  • A/R MAC: Wisconsin Physician Services (WPS)
  • DME MAC: CGS
  • HH+H MAC: NGS

Unified Program Integrity Contractors (UPICs)

• Unified Program Integrity Contractors (UPICs)
  • Integrates program integrity audits and investigations across Medicare and Medicaid (combines functions of and replaces ZPICs, PSCs, and MICs)
  • AdvanceMed received first contract for “Midwestern Jurisdiction” including Michigan and 10 other states. Audits are currently underway.

UPIC Program

Goal: identify and develop cases of suspected fraud

• Benefit integrity: investigate complaints and allegations of fraud
• Quickly respond to fraud and employ administrative actions
  • Audit claims
  • Initiate payment suspension
• Utilize:
  • Referrals from MACs and other medical review contractors
  • Data analysis to identify patterns of claim submissions or payments that indicate potential problems
Recovery Audit Contractors (RACs)

(Note: Also referred to as Recovery Auditors (RAs))

Focus: Identifying improper payments (not fraud, waste and abuse)
- RAC program began as a demonstration program, was made permanent and expanded nationwide
- RACs are paid on a contingency fee basis
- Michigan: Performant Recovery, Inc. (Performantrac.com)

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

Other CMS Contractors

Depending on the nature of your practice, you may also encounter:
- Comprehensive Error Rate Testing (CERT)
- Quality Improvement Organizations (QIOs)
- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Medicare Drug Integrity Contractor (MEDICs)
- Supplemental Medical Review Contractor (SMRCs)
- Payment Error Rate Measurement (PERM)
Important Audit Characteristics

• Complex or non-complex (automated) review
• Pre-payment or post-payment claim review
• Claim-by-claim review or statistical sampling and extrapolation
• Probe reviews

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) or denial on Remittance Advice
• Post-payment
  • Individual claims – ADRs requesting records
  • "Big-box" – list of claims for which medical records are requested

Additional Documentation Requests

• Letter will identify individual pieces of documentation needed to make a determination
• But contractor will consider all documentation submitted
• Submission can be paper or via esMD – www.cms.gov/esMD

Important: Calendar due dates dates for submission of records!

• Date by which records must be submitted
• Date records were actually submitted
• Document method of submission
• Document any extensions granted
Probe Reviews

- When data analysis, reports from other contractors, or complaints indicate a potential error
- Saves resources by first doing a “probe” sample of 20-40 potential problem claims
- Probe can be on pre-payment or post-payment basis

Importance of Appealing Probe Audits

- May not be large monetary amount, but there is value in appealing probe audits.
- Very important to appeal so the “potential problem” is not validated.
- Current challenges at the ALJ make it very important for the best possible work up at the Redetermination and Reconsideration levels of appeal.

You sent in the records...but what next?
Understanding Audit Denial Documentation
Understanding Audit Documentation

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

Notification of Denials on Remittance Advice

- Denial Codes on Remittance Advice
- Easy to miss – and could cause to miss appeal deadlines

Calendaring Deadlines and Events

- 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 Appeals Council)
- *Note that ALJ and Appeals Council are not adhering to that deadline!
Unfavorable Determinations – What Next

5 Stage Medicare 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 must be filed **within 30 days** after the date of the first demand letter to avoid recoupment of the overpayment.
- Recoupment begins on **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

Reconsideration

Once contractor issues a redetermination decision, provider has **180 days** to file a request for reconsideration

- Request must be filed **within 60 days** after the redetermination decision in order to avoid recoupment of the overpayment.
- Decision should be issued within 60 days
- **Note:** All information must be submitted before reconsideration decision is issued or will be precluded (absent good cause)

Administrative Law Judge Hearing

- A provider must file a request for an ALJ hearing **within 60 days** of the QIC’s reconsideration decision.
- Generally conducted by telephone.
- CMS will recoup the alleged overpayment during this and following stages of appeal.
- Current backlog – years!
Recent Efforts to Ease Backlog

Effective March 20, 2017 - Changes include:

- Use of Attorney Adjudicators in cases where:
  - Decisions can be issued without a hearing
  - Review of QIC dismissals
  - Issuing remand to contractors
  - Dismissing requests for hearing when appellant withdraws request
- Designate certain Medicare Appeals Council decisions as precedential
  - Designated decisions will have binding effect
    - Goal: to increase consistency in decision-making across appeals levels
- Limit number of entities (CMS, contractors) that can be a participant/party at a hearing

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

How do I increase my chances of success? – Effective Appeal Strategies
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 – Credentials of Reviewers

- Complex reviews must be completed by physicians, nurses or other licensed health care professionals
- RACs must ensure that the credentials of reviewers are consistent with the requirements in Statements of Work.
- Could be an issue to raise on appeal – if information on reviewer is not readily provided, can try Freedom of Information Act (FOIA) request

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, LCDs – locally and nationally
- Coding Component:
  - E.g., E/M Codes - detailed spreadsheets with reasons why E/M code was appropriate
  - Coding experts can be helpful to prepare written arguments, testify at hearing and to assist with compliance going forward
- Statistics Expert:
  - Evaluate and challenge sampling, extrapolation methodology
### Appeal Strategies – Legal Arguments

- **Provider Without Fault** – applies to post payment audits only
  - If provider exercised reasonable care in billing for and accepting payment
  - Complied with all pertinent regulations, made full disclosure of all material facts and on the basis of information available had reasonable basis for assuming that the payment was correct.

- **Waiver of Liability** – applicable to pre-payment and post-payment denials
  - If provider did not know and could not have been expected to know that payment would not be made for the services at issue
  - Then claim should be paid

### Effective Appeal Strategies

#### Practical Tips for the ALJ Hearing

1. **Utilize CMS forms whenever possible**
   - Helps to reduce errors and increase efficiency for OHMA administrative staff
   - Helps to ensure all required information is included
   - E.g., Request for ALJ Hearing form, Appointment of Representative form

2. **Make the most of your time in the hearing** → Be concise and to the point
   - Outline the facts of the situation
   - Applicable law/regulations/Medicare guidance
   - How you satisfy it

   Figure out “why you should win” and work backwards to explain the reasoning

3. **Send copies of any submissions to “the other side”** (CMS, contractors identified on QIC reconsideration decision or ALJ Notice of Hearing)
4. **Know the procedural requirements for CMS/contractor participation (participant or party) and raise objections when CMS or contractor is not in compliance**
5. **Refer to ALJ as “your honor” and respond respectfully**
Appeal Strategies – Increase Internal Efficiencies

- Proactively create an audit/appeals process for your group/organization
- Identify who is responsible for each specific task in the process
- Create a usable tracking/recordkeeping system
- Institute a process for substantive evaluation of the merits of the case

Questions?

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