HCCA’s 17th Annual Compliance Institute
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ZPIC, RAC, HIPAA AUDITS IN LTC: ARE YOU READY?

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Recovery Audit Contractors

- Who are the RACs?
  - Region A: Performant Recovery
    - Working in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA
    - www.dcsrac.com
  - Region B: CGI Federal, Inc.
    - Working in IL, IN, KY, MI, MN, OH and WI
    - http://racb.cgi.com
  - Region C: Connolly, Inc.
    - Working in AL, AZ, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and U.S. Virgin Islands
    - www.connollyhealthcare.com/RAC
Recovery Audit Contractors

- **Region D:** HealthDataInsights, Inc.
  - Working in AK, AZ, CA, IA, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, Guam, American Samoa and Northern Marianas
  - [http://racinfo.healthdatainsights.com/home/aspnx](http://racinfo.healthdatainsights.com/home/aspnx)

- What is the RAC?
  - Now called a Recovery Auditor (“RA”)
  - Contingency Fee Contractors
  - Overpayments made by Medicare

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

- Key Consideration: Can providers impact new issues?
Challenges Relating to New RAC Issues

- **Acute Care**: Several medical necessity issues separated by condition
- **Post-Acute Care**
  - IRF – broad issue relating to “reasonable and necessary.”
  - Skilled Nursing – broad issue relating to “medical necessity.”

**CMS Medicare FFS Recovery Audit Program Myths**

**December 17, 2012**

- **CMS Myth**: RACs deny every claim that they review.
  - **CMS Fact**: RACs identify underpayments and overpayments of claims paid under the Medicare program for services for which payment is made under Part A or Part B of title XVII of the Social Security Act.
This is accomplished through review of all claim and provider types and a review of claims providers that have a high propensity for error based on the Comprehensive Error Rate Testing (CERT) program and other CMS analysis.

Improper payments may result from
- Incorrect payment amounts
- Non-covered services (including services that are not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act)
- Incorrectly coded services (including DRG miscoding)
- Duplicate services

CMS Myth: RACs have a contingency fee between 30 and 50 percent.

- CMS Fact: Recovery Auditors are paid based on a contingency fee basis. The amount of the contingency fee is based on the amount of money from, or reimbursed to, providers. The contingency fee is a percentage of the amount of the improper payment.
CMS Fact (cont.): In FY 2009 and 2010, the contingency fees ranged from 9.09 - 12.5%. The fee is paid once the money is recouped or refunded, not when the improper payment is first identified. The Recovery Auditor must return the fee if an overpayment/underpayment is overturned at any level of appeal.

CMS Myth: Every RAC denial is overturned on appeal.

- CMS Fact: The appeals process is a multilevel approach that allows providers to appeal a Recovery Auditor’s overpayment determination. This process is exactly the same for all providers who want to appeal a Medicare claim decision.
CMS Fact: To date, only 2.4% of all claims collected have been both challenged and overturned on appeal. Health care providers have appealed 8,449 claims to date, which constitutes 5% of all claims collected in FY 2010. Monitoring appeals activity is a key part of the Recovery Audit program. CMS will continue to track the Recovery Auditor appeal rates.

CMS Myth: RAC have non-clinicians conduct review of medical records.

CMS Fact: Each RAC employs certified coders, nurses, therapists, and a physician (CMD).

- A Recovery Auditor Organization chart is submitted as part of the proposal and identifies the number of key personnel and the organizational structure of the Recovery Auditor effort.
CMS Myth: RAC create their own policies and are not bound by CMS regulations, NCDs, or LCDs.

- CMS Fact: The Recovery Auditor shall comply with all National Coverage Determinations (NCDs), Coverage Provisions in Interpretive Manuals, national coverage and coding articles, local coverage determinations (LCDs) formerly called local medical review policies (LMRPs) and local coverage/coding articles in their jurisdiction.

- CMS Fact (cont.): NCDs, LMRPs/LCD and local coverage/coding articles can be found in the Medicare Coverage Data Warehouse http://cms.hhs.gov.mcd.overview.asp. Coverage Provisions in Interpretive Manuals can be found in various parts of the Medicare Manuals. In addition, the Recovery Auditor shall comply with all relevant joint signature memos forwarded to the Recovery Auditor by the project officer.
CMS Fact: Recovery Auditors are required to comply with Reopening Regulations located at 42 C.F.R. Section 405.980. Before a Recovery Auditor makes a decision to reopen a claim, the Recovery Auditor must have good cause and must clearly articulate the good cause in New Issue proposals and correspondence (review results letters, ADR, etc.) with providers.

CMS Myth: RACs can review as many claims as they want from a provider.
CMS Fact: CMS continues to work with the provider community to reduce the burden of the review process. In doing so, CMS has limited the look-back period for Recovery Auditor reviews to a maximum of 3 years. This is consistent with CMS’s claims reopening and liability policies. Lastly, CMS has limited the number of additional documentation requests that a Recovery Auditor may request at one time, based on provider size and resources. The CMS continues to work with hospital and medical associations in order to receive and respond to provider concerns and further reduce provider burden.

- The maximum request amount is per campus. The definition of campus is one or more facilities under the same Tax Identification Number (TIN) located in the same area (using the first three positions of the ZIP code). This is different than the definition used for provider-based status.
- Each limit is based on the provider’s prior calendar year Medicare claims volume.
- The maximum number of requests per 45 days is 400.
• CMS Myth: RACs don’t have physicians on staff.
  ➢ CMS Fact: Each Recovery Auditor must employ a minimum of
    one FTE contractor medical director (“CMD”) and arrange for an
    alternate when the CMD is unavailable for extended periods. The
    CMD FTE must be composed of either a Doctor of Medicine or a
    Doctor of Osteopathy who has relevant work and educational
    experience. More than one individual’s time cannot be combined
    to meet the one FTE minimum.

• CMS Fact: All clinicians employed or retained as consultants
  must be currently licensed to practice medicine in the United
  States, and the contractor must periodically verify that the license
  is current. When recruiting CMDs, contracts must give preference
  to physicians who have patient care experience and are actively
  involved in the practice of medicine.
CMS Myth: RACs are focusing complex reviews on Critical Access Hospital claims.

- CMS Fact: Recovery Auditors have not completed any complex reviews on Critical Access Hospital claims.

CMS Fact: Complex review occurs when a Recovery Auditor makes a claim determination utilizing human review of the medical record. The Recovery Auditor may use complex review in situations where the requirements for automated review are not met or the Recovery Auditor is unsure whether the requirements for automated review are met. Complex medical review is used in situations where there is a high probability (but not certainty) that the service is not covered or where no Medicare policy, Medicare article, or Medicare-sanctioned coding guideline exists. Complex copies of medical records will be needed to provide support for the overpayment.
CMS Myth: RACs do not tell anyone what they are reviewing.

- CMS Fact: CMS requires that issues be posted on the Recovery Auditors websites, which improves transparency to the public and the provider community. Recovery Auditors post online CMS-approved issues that may trigger a Recovery Auditors review. CMS recently began posting additional information to our website related to Recovery Auditor recoveries on a quarterly basis.

CMS Fact: Recovery Auditors are required to give the provider a detailed rationale of the improper payment determination.

Following any complex review, Recovery Auditors are required to issue a detailed “review results” letter to the provider outlining any improper payments identified, along with references supporting the determination.
CMS Myth: RACs do not issue detailed result letters.

- CMS Fact: The Recovery Auditor shall clearly document the rationale for the determination. This rationale shall list of the review findings, including a detailed description of the Medicare policy or rule that was violated and a statement as to whether the violation resulted in an improper payment. Recovery Auditors shall ensure that they are identifying pertinent facts contained in the medical record to support the review determination. Each rationale shall be specific to the individual claim under review.

Automated Review – The Recovery Auditor shall communicate to the provider the results of each automated review that results in an overpayment determination. The Recovery Auditor shall inform the provider of which coverage/coding payment policy or article was violated.

Complex Review – The Recovery Auditor shall communicate to the provider the results of every semi-automated and complex review, including cases where no improper payment was identified. In cases where an improper payment was identified, the Recovery Auditor shall inform the provider of which coverage/coding payment policy or article was violated.
CMS Myth: RACs do not issue timely denial letters.
  - CMS Fact: As of January 1, 2012, the Medicare Administrative Contracts (MAC) began issuing the demand (denial) letter to the providers. This was in an effort to increase the time providers had to respond. Since the accounts receivable and demand letter begins interest accrual, includes appeal rights and begins recoupment timeframes, it is imperative that the demand letter be dated the same day as the accounts receivable date.

CMS Myth: RACs outsource all the medical review to staff in India and the Philippines.
  - CMS Fact: Each RAC employs certified coders, nurses, therapists, and a physician (CMD), all within the United States of America.
    - A Recovery Auditor Organization chart is submitted as part of the proposal and identifies the number of key personnel and the organizational structure of the Recovery Auditor effort.
• CMS Myth: RACs deny IRF (inpatient rehab facility) claims because the care could have been given in a less intensive setting.

  CMS Fact: A full denial occurs when the Recovery Auditor determines that: (1) The submitted service was not reasonable or necessary and no other service (for that type of provider) would have been reasonable and necessary, or (2) No service was provided.

• CMS Fact: A partial denial occurs when the Recovery Auditor determines that: (1) The submitted service was not reasonable and necessary; or (2) The submitted service was upcoded (and a lower level service was actually performed) or an incorrect code (such as a discharge status code) was submitted that caused a higher payment to be made; (3) the AC failed to apply a payment rule that caused an improper payment (e.g., failure to reduce payment on multiple surgery cases).
CMS Myth: RACs target providers who are part of CMS demonstrations.

- CMS Fact: Unless otherwise directed by CMS through technical director, the claims being analyzed for this award will all be fee-for-service claims processed in Region ___ regarding of the provider’s or suppliers’ physical location.


**Purpose**

- Prevent improper payments before they are made
- Lower the error rate
- Focus on claims with high improper payment rates
  - Begin with reviews of short inpatient hospital stays
  - To be used for Part B therapy cap

**Overview**

- August 27, 2012 – August 26, 2015
- Applicable to seven fraud and error-prone states (FL, CA, MI, TX, NY, LA, and IL) and four states with high volumes of inpatient stays (PA, OH, NC, and MI)
- Will not replace MAC prepayment review
  - Contractors will coordinate review areas to not duplicate effort
MS-DRGs for Review

- MS-DRG 312 SYNCOPE & COLLAPSE
- MS-DRG 069 TRANSIENT ISCHEMIA
- MS-DRG 377 G.I. HEMORRHAGE W MCC
- MS-DRG 378 G.I. HEMORRHAGE W CC
- MS-DRG 379 G.I. HEMORRHAGE W/O CC/MCC
- MS-DRG 637 DIABETES W MCC
- MS-DRG 638 DIABETES W CC
- MS-DRG 639 DIABETES W/O CC/MCC

Operational Details

- ADRs will come from the FI/MAC
- Providers will have 30 days to send documentation
- Recovery Auditors will review and communicate payment determination to FI/MAC
  - Providers will receive determination within 45 days
  - Recovery Auditors will also send detailed review results letter
For now, limits on prepayment and post-payment reviews won’t typically exceed current post-payment ADR limits

- Providers may appeal the denial
  - Same appeal rights as other denials
- Claims will be off-limits from future post-payment reviews by a CMS contractor

Manual Medical Review of Therapy Claims Above $3,700 Threshold

- The American Taxpayer Relief Act of 2012 (ATRA) was signed into law by President Obama on January 2, 2013. Section
- This law extends the Medicare Part B Outpatient Therapy Cap Exceptions Process through December 31, 2013.
- Section 603 of this Act contains a number of Medicare provisions affecting the outpatient therapy caps and manual medical review (MR) threshold.
The statutory Medicare Part B outpatient therapy cap for Occupational Therapy (OT) is $1,900 for 2013, and the combined cap for Physical Therapy (PT) and Speech-Language Pathology Services (SLP) is also $1,900 for 2013.

This is an annual per beneficiary therapy cap amount determined for each calendar year.

Exceptions to the therapy cap are allowed for reasonable and necessary therapy services.

Per beneficiary, services above $3,700 for PT and SLP services combined and/or $3,700 for OT services are subject to manual medical review.

CMS is not precluded from reviewing therapy services below these thresholds.
The therapy cap applies to all Part B outpatient therapy settings and providers, including:
- Therapists’ private practices
- Offices of physicians and certain non-physician practitioners
- Part B skilled nursing facilities
- Home health agencies (Type of Bill (TOB) 34X)
- Rehabilitation agencies (also known as Outpatient Rehabilitation Facilities-ORFs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Hospital outpatient departments (HOPDs)

In addition, the therapy cap will apply to outpatient hospitals as detected by:
- TOB 12X (excluding CAHs) or 13X
- Revenue code 042X, 043X, or 044X
- Modifier GN, GO, or GP
- Date of service on or after January 1, 2013
Medicare Administrative Contracts (MACs) will conduct prepayment review on claims reaching the $3,700 threshold with dates of service January 1, 2013 to March 31, 2013.

CMS requested MACs conduct these manual medical reviews within 10 days.

At this time, there is no advance request for an exception process.

Effective April 1, 2013, the Recovery Auditors will conduct prepayment review for all claims processed on or after April 1, 2013.

Recovery Auditors will complete two types of review.

- Prepayment review:
  - Claims submitted in the Recovery Audit Prepayment Review Demonstration states will be reviewed on a prepayment basis.
  - These states are Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina and Missouri.
In these states, the MAC will send an ADR to the provider requesting the additional documentation be sent to the Recovery Auditor (unless another process is used by the MAC and the Recovery Auditor).

The Recovery Auditor will conduct prepayment review within 10 business days of receiving the additional documentation and will notify the MAC of the payment decision.

Post-payment Review

In the remaining states, the Recovery Auditors will conduct immediate post-payment review.

In these states, the MAC will flag the claims that meet the criteria, request additional documentation and pay the claim.

The MAC will send ADR to the provider requesting the additional documentation be sent to the Recovery Auditor.

The Recovery Auditor will conduct post-payment review and will notify the MAC of the payment decision.
Section 603(b) of the American Tax Relief Act counts outpatient therapy services furnished in a Critical Access Hospital (CAH) toward a beneficiary’s annual cap and threshold amount using the Medicare Physician Fee Schedule rate.

CAHs are not subject to the therapy cap and threshold amount using the Medicare Physician Fee Schedule rate.

CAHs are not subject to the therapy cap, the manual medical review process, or the use of the KX modifier.

Special Problems with Hospital RAC Audits

- ALJ remand process
  - July 2012 CMS memo allowing ALJs to determine whether to pay Part B payment for denied Part A claims if evidence does not support Part A claim but does at outpatient level.
  - However, Qualified Independent Contractor (“QIC”) determinations are often incomplete in that QIC does not determine whether should be considered for outpatient services.
  - As a result, ALJs are remanding to QICs.
  - QICs have no timeframe to resolve remands

- CMS March 13th – Part A/B rebilling Rulemaking
CMS permits adjustment claims beyond one-year window through an accommodation with the Medicare Appeals Council. Proposed rule says no more once rulemaking finished.

- **Claims accelerations to ALJ**
  - QIC cannot complete review within required timeframe
  - Provider has option to accelerate review to ALJ
  - Concern over remand to QIC (see above)

- **ALJs refusing to decide**
  - Remands
  - Observational/inpatient services
    - Some ALJs say they can only decide if Medicare covered services
    - Cannot decide what type of services
Zone Program Integrity Contractors (ZPICS): What do they do?

- 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
  - ZPICs request medical records and conduct medical review to evaluate the identified potential fraud
  - ZPICs may also refer to the OIG and DOJ for further investigation

RECENT DEVELOPMENTS OF SIGNIFICANCE

- ZPIC audits on post-acute Part A claims with an emphasis on ultra-high therapy scores.
  - Storming through Florida and elsewhere
  - ZPIC audits on Part A claims with an emphasis on ultra-high therapy scores.
  - OIG/DOJ investigations in this area, false claims cases expected
60-DAY RULE

- ACA Requires ID and reimbursement of overpayment within 60 days
  - If not done, overpayment becomes “obligation” for false claims purposes
  - CMS issued proposed rule in February 2012 (NPRM)
    - 10-year “look back”
    - Investigation must be expeditious
    - Other elements and implications

- NPRM applies only to Medicare Part A/B providers and suppliers (together “providers” unless otherwise noted)

- Overpayment retained after deadline under NPRM creates an “obligation” for purposes of the federal FCA

- Providers still potentially liable under other laws even with timely report/repayment
  - Federal FCA
  - Civil Monetary Penalty Law
A person “identifies” an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.

Oddly, statute defines, but does not use, “knowing” and “knowingly”.

CMS believes FCA’s “deliberate ignorance or reckless disregard” standard encourages self-directed compliance.

May impact future rulemaking around compliance programs.

OVERPAYMENT EXAMPLES

- Medicare payments for non-covered services
- Medicare payments in excess of the allowable amount for an identified covered service
- Errors and non-reimbursable expenditures in cost reports
- Duplicate payments
- Receipt of Medicare payment when another payor had the primary responsibility for payment
WHAT DOES “IDENTIFIED” MEAN TO CMS?

- Provider receives an anonymous compliance hotline complaint about a potential overpayment and fails to make a reasonable inquiry into the complaint
- Provider or supplier reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement
- Provider or supplier learns that a patient death occurred prior to the service date on a claim that has been submitted for payment

NPRM EXAMPLES OF “IDENTIFIED”

- Provider or supplier learns that services were provided by an unlicensed or excluded individual on its behalf
- A provider of services or supplier performs an internal audit and discovers that overpayments exist
- A provider of services or supplier is informed by a government agency of an audit that discovered a potential overpayment, and the provider or supplier fails to make a reasonable inquiry
  - Duty to make reasonable inquiry
  - “All deliberate speed”
CHALLENGES FOR PROVIDERS – “IDENTIFIED”

- NPRM definition of “identified” does not address complex overpayment situations
  - Wholly silent about how provider cannot quantify overpayment within 60 days (even with reasonable diligence)
- NPRM does not specify how strong the evidence needs to be to trigger a provider’s “obligation to make a reasonable inquiry”

RELATIONSHIPS WITH OTHER DISCLOSURES

- Receipt of acknowledgment from CMS of SRDP submission suspends obligation to return
  - Does not constitute “report” for purposes of 60-day rule
- CMS seeking comment on how to avoid duplicate reporting under SRDP
Upon acknowledgement of receipt of submission, duty to return suspended

Notice to OIG through OIG SDP also constitutes notice to appropriate parties for purposes of the NPRM

- Timeliness requirements still apply – no additional delay

No clear basis for distinguishing between SRDP and OIG SDP

- Self-disclosure under SRDP would suspend provider’s obligation to return, but not to report, an overpayment
- Self-disclosure under OIG SDP would suspend both a provider’s obligation to return and to report an overpayment
- No legal or policy basis for distinguishing between these two processes
- NPRM would subject providers to duplicative and unnecessary reporting requirements in cases where a provider self-discloses an overpayment to CMS under the SRDP
Refund Process

- Requires reporting of information specified in the regulation
  - Description of the corrective action plan to ensure the error does not occur again
  - The timeframe and the total amount of refund for the period during which the problem existed that caused the refund
  - If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment

- Use of “existing refund process” requires further guidance from CMS
  - Existing voluntary refund forms may not incorporate all of the NPRM’s mandated elements for a report
  - E.g., Palmetto’s current overpayment refund form for Region IX does not provide for at least four of the fields the Proposed Rule mandates:
    - TIN
    - How error was discovered
    - Description of corrective action plan
    - If a statistical sample used, description of the statistically valid methodology used to determine the overpayment
Inability to Repay the Overpayment

- Use Extended Repayment Schedule (formerly “Extended Repayment Plan”)
  - Publication 100-06, Chapter 4, Financial Management Manual
- ERS requests will not be automatically granted
- Significant documentation of financial hardship required
- A bit of a straw man viz. quantification problems

Possible 10-year “Lookback”

- NPRM provides that overpayment must be reported and returned if a person identifies the overpayment “within 10 years of the date the overpayment was received”
  - CMS chose 10-year lookback because this is the outer limit of the federal FCA statute of limitations and will “further our interest in ensuring that overpayments are timely returned to the Medicare Trust Funds.”
Existing Medicare claims reopening regulations
- 4-year lookback where no evidence of “fraud or similar fault”
- 5-year lookback under “fiscal cliff” legislation
- No express limit where evidence of fraud or similar fault” does exist
- Provider already subject to up to 10-year lookback period under FCA

CHALLENGES FOR PROVIDERS UNDER THE NPRM
- No sound basis to expand lookback period to 10 years
- Inappropriately links even simple payment errors with the FCA liability standard
  - 10-year FCA limit intended to address intentional fraud
  - What if FCA settlement based on 6 years?
  - Mere retention of overpayment past 60-day deadline, without more, does not give rise to FCA liability
- What about identifying and offsetting underpayments?
Successful Appeal Strategies
The Medicare Appeals Process

- Overview
  - Rebuttal
  - Discussion Period
  - Redetermination
  - Reconsideration
  - Administrative Law Judge Hearing
  - Medicare Appeals Council (MAC)
  - Federal District Court

- 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
Successful Appeal Strategies

- **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

Successful Appeal Strategies

The Medicare Appeals Process

- **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

- 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.

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Successful Appeals Strategies
The Medicare Appeals Process

- Reconsideration
  - Key Considerations
    - Full and early presentation of evidence requirement
    - Submission of additional evidence, 14 day extension of time period for decision
    - Reviewer credentials
    - Internal or external expert medical necessity review
    - Utilization Review
    - Physician advisors and nurse reviewers
    - Independent experts
Successful Appeals 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 C.F.R. section 405.1020)
    - Two options for participation
      - Party
      - Non-Party Participant (more common)
Successful Appeals Strategies  
The Medicare Appeals Process

- As non-party participants, contracts may not:
  - Call witnesses
  - Cross-examine a provider’s witnesses
  - Be called by the provider as a witness
- As non-party participants, contracts 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 C.F.R. section 405.1010(b))

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*Medicare Appeals Council (MAC)*

- A provider dissatisfied with the ALJ decision has **60 days** to file an appeal to the Medicare Appeals Council
- Use of past Medicare Appeals Council cases:
  - [http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/mac_decisions.html](http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/mac_decisions.html)
  - [http://www.hhs.gov/dab/macdecision](http://www.hhs.gov/dab/macdecision)
  - The MAC overturned an ALJ’s unfavorable findings as they related to beneficiaries’ homebound status.
  - The MAC determined that in the absence of findings that the beneficiary was in fact frequently leaving the home for nonmedical purposes, the ALJ should have found the patients to be homebound.
Successful Appeals Strategies
The Medicare Appeals Process

- 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
    - ALJ erred in applying a “stability presumption” and evaluating a beneficiary’s need for services from the “perspective of hindsight” for a beneficiary receiving home health services.
    - Skilled nursing facility services should not be denied solely because a beneficiary’s condition has no potential to improve because Federal regulations allow skilled services to prevent further deterioration or preserve current capabilities.

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

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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.

- 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 BioniCare 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 Appeals Strategies
Arguing the Merits

- Merit-based arguments include:
  - Medical necessity of the services provided
  - Appropriateness of the codes billed
  - Frequency of services
- 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 Appeals 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

Proposed 60-Day Rule

- ACA Requires ID and reimbursement of overpayment within 60 days
  - If not done, overpayment becomes “obligation” for false claims purposes
  - CMS issued proposed rule in February 2012
    - 10-year “look back”
    - Investigation must be expeditious
    - Other elements and implications
Provider Preparation

- Know where previous improper payments have been found (OIG, CERT, RAC Reports)
- New issues are posted to the web – CMS appeal process
- RAC claim status web interface (2010)
- Detailed review results letter and denial letter following all complex reviews – “discussion period” opportunity/does not impact appeal deadlines

Provider Preparation

- Prepare to respond to RAC medical record requests – 45 day window
- Keep/submit proper documentation – point of contact/team building/organizational issues resolved
- Appeal when necessary - know timelines for appeal AND timelines to stop recoupment (e.g., 120 days v. 30 days for first level appeal and 180 days v. 60 days for second level appeal)
Prepare for RACs/ZPICS

- Establish internal team
- Interdisciplinary Team: Legal, Finance, Clinical, Compliance, IT
- Identify point of contact for internal and external communications
- Develop central tracking mechanisms/database for all - Incoming and Outgoing
- Coordinate the tracking mechanism with communications structure – record reviews, and appeal of recoupment deadlines

Prepare for RACs/ZPICS

- Conduct self audits to identify potential problems
- Participate in trainings and outreach
- Monitor news sources, CMS, associations, and your own reports to stay abreast of trends
- If desired, development of unique forms for appeal levels once issues identified
Responding to Record Requests

- Stamp date and time received
  - 45 calendar days from date of letter
  - Notify if significant discrepancy between date of letter and date of receipt
  - Identify any internal issues in expeditiously getting the mail for processing

- Was the request sent to the right place?
  - Notify Contractor of the contact person with contact information

- Did the Contractor exceed the maximum number of record requests under the circumstances?
Responding to Record Requests

- Copying of Record and Others
  - Ensure entire record is copied
  - Include copies of substantive coverage materials
- Review of all records before they are released
  - Permits early identification of issues
  - Establishes priority for appeals
  - Intensive work

- Has the claim already been subject to audit by another contractor
- Who is this request from?
- Confusion with so many different contractors
Responding to Record Requests

- Document Management?
  - Stamp number (Bates Stamp) on bottom of each page produced
  - Scan everything produced
  - Include cover letter itemizing contents of box of documents or CD
  - Send certified mail or, if regular mail, complete affidavit of service by mail

Responding to Record Requests: Data Management

- Audit ID Number
- Type of Audit
- Reason for Audit (Issue Specific)
- Date of Record Request
- Date Received
- Next Deadline
Responding to Record Requests: Data Management

- Information about the production
- Patient information
- Status of case
- Reimbursement information
- Contractor/State response
- Status at each level of appeal

Determinations

- Stamp the date received
  - Determine appeal period
HIPAA Audits

- HITECH Act of 2009 required OCR to conduct periodic HIPAA compliance audits
- OCR hired KPMG to conduct a pilot audit program during 2011 and 2012
- Pilot program is complete
- OCR evaluating results; has not announced plans for continuing program

Who was Audited?

- 115 HIPAA covered entities
- Selected to provide a broad overview of industry compliance
- Not specifically identified
  - OCR identified initial 20 by type
  - Included a nursing and custodial care facility
What Was Audited?

- Audit protocol on OCR web site:
  http://www.hhs.gov/ocr/privacy/hipaa/enforcement/audit/protocol.html
- Covers
  - Privacy
  - Security
  - Data breach reporting

What is the Process?

- OCR sends introductory letter
- Includes document review and on-site visit
- Draft report provided to covered entity for review and comment, and corrective action plan
- Final report submitted to OCR
What are the Consequences?

- Primarily to allow OCR to determine what types of technical assistance should be developed, and what types of corrective action are most effective.
- Should an audit report indicate a serious compliance issue, OCR may initiate a separate compliance review, which could result in corrective action.
- OCR publishes corrective actions:
- No report of corrective action from audit program.

What Were the Findings?

- OCR released summary of first 20 audits:
- Top privacy issues:
  - Privacy of information concerning deceased persons
  - Disclosures to personal representatives
  - Business associate contracts
  - Disclosures for judicial and administrative proceedings
  - Verification of identity of people requesting PHI
What Were the Findings?

- Top security issues:
  - Training
  - Policies and procedures
  - Ongoing risk assessments
  - Contingency planning
  - User activity monitoring

What is the Future?

- Pilot project completed in 2012
- OCR assessing results
- OCR has said there is a “reasonable likelihood” that the program will continue in 2013
- No plans announced
What Should You Do?

- Update privacy and security policies and procedures
- Ensure business associate contracts are in place
- Perform periodic risk assessments
- Ensure portable devices are secure
- Conduct job-focused privacy and security training
- Be prepared to respond to breaches

Questions?

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