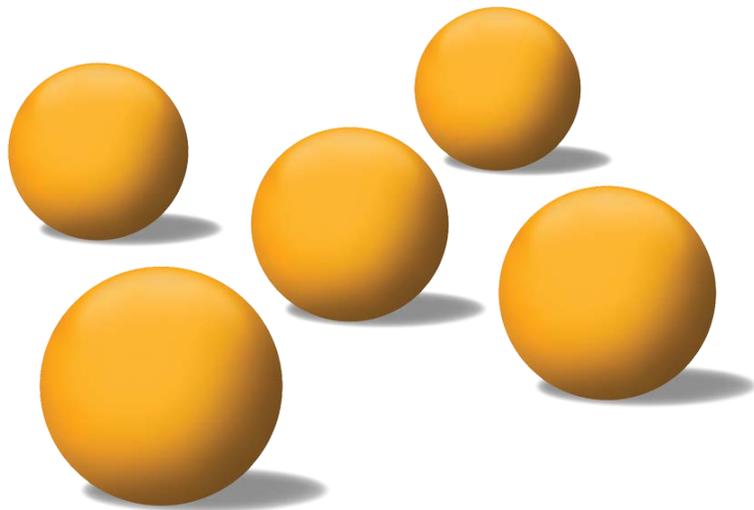


How To Appeal and Win a Medicare Audit



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Statistics

- In FY 2012, RACs recovered \$2.3 Billion in Medicare overpayments
- In FY 2012, RACs identified \$109 Million in Medicare underpayments
- Bulk of overpayments involved inpatient hospital claims, and in particular, so-called "short-stay" admissions
- Every \$1 the U.S. Government spends in combating Medicare and Medicaid fraud results in \$7.90 back to the Government



Alphabet Soup of Audit Programs

- RAC – Recovery Audit Contractors
- CERTs – Comprehensive Error Rate Testing Contractors
- MICs – Medicaid Integrity Contractors
- MACs – Medicare Administrative Contractors – replace carriers and fiscal intermediaries and process both Part A and Part B claims
- ZPICs – Zone Program Integrity Contractors



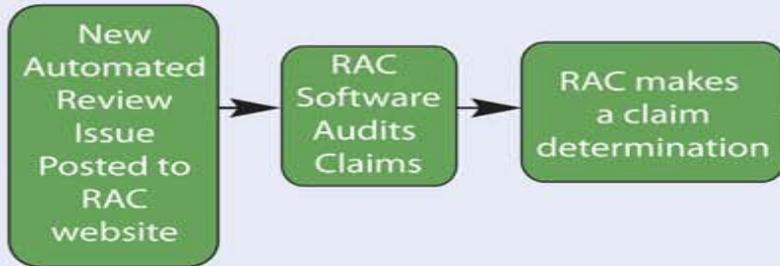
Information on RACs

- Can only review claims three (3) years back
- Paid on a contingency fee (9%-12.5%); higher for DME claims (14%-17.5%)
- PPACA expands RAC to cover Medicare Parts C and D and Medicaid
- Connolly RAC for Alabama – www.connolly.com/healthcare/pages/CMSRACProgram.aspx
- New RAC contracts with CMS up for bid

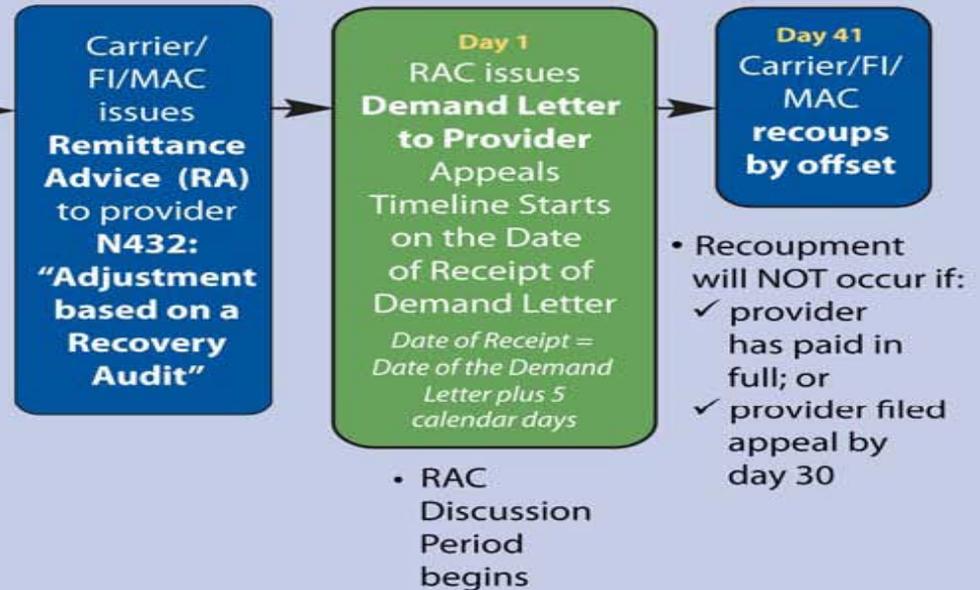


RAC Review & Collection Process

Automated Review



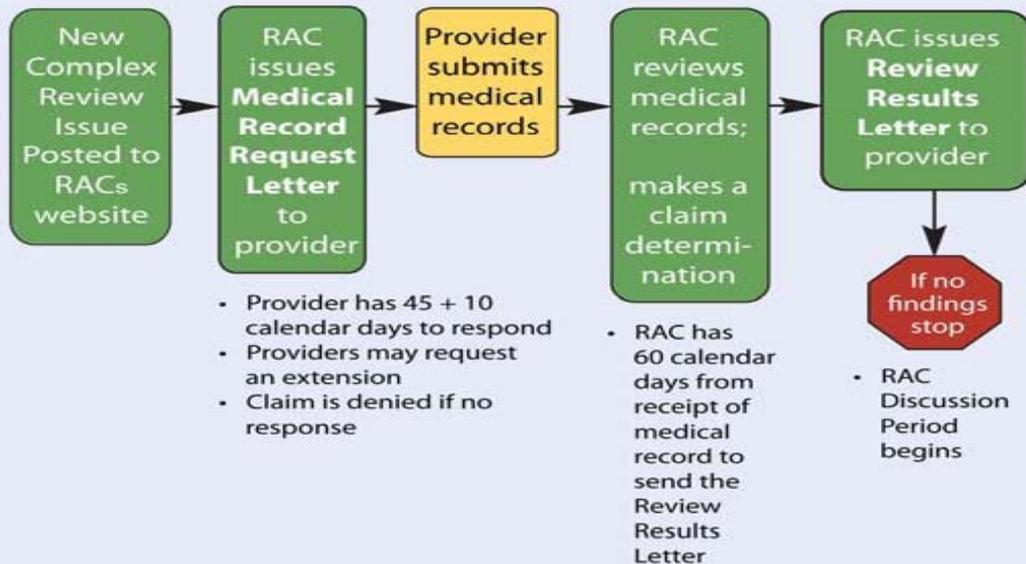
The Collection Process



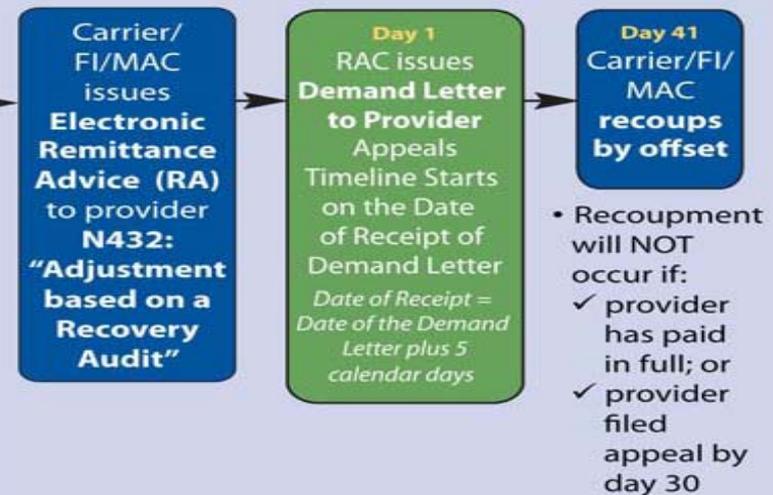


RAC Review & Collection Process

Complex Review



The Collection Process





Information on ZPICs

- Target potential fraud
- May audit all Medicare claims of a provider
- Uses both pre- and post-pay audits
- Generally don't use random audits. Auditors already have an idea of what they are investigating
- May refer cases directly to the DOJ, OIG, US Attorney and other law enforcement agencies
- May use statistical sampling
 - Must determine a sustained high level of payment error, or
 - Educational intervention has failed to correct problem
 - Meaning of "high error rate"?
- Can suspend Medicare payments



Make Your Practice a "Low" Target for an Audit

1. Educate yourself on audit issue
 - review Connolly website
 - review OIG Annual Work Plan (<http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf>)
 - review Medicare Quarterly Provider Compliance Newsletter (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf)
 - review MedLearn articles
 - Network/Seminars
2. Review payor reports and look for outliers
3. Conduct billing audits — use third-party
4. Appeal denials — otherwise can be viewed as an "easy" target
5. Compliance Plan — develop culture of compliance



If Your Practice is Audited

1. Obtain copies of audit request
2. Keep copies of all information provided to Medicare
3. Look for "themes" in chart requests
4. What can you learn from the audit?



If Your Practice is Hit with an Overpayment Demand

1. Determine if an overpayment demand is valid — if so refund money
2. If not valid...Appeal!
 - According to AHA, Q4 2013 Report, Hospitals appealed 49% of all RAC denials, with a 64% success rate

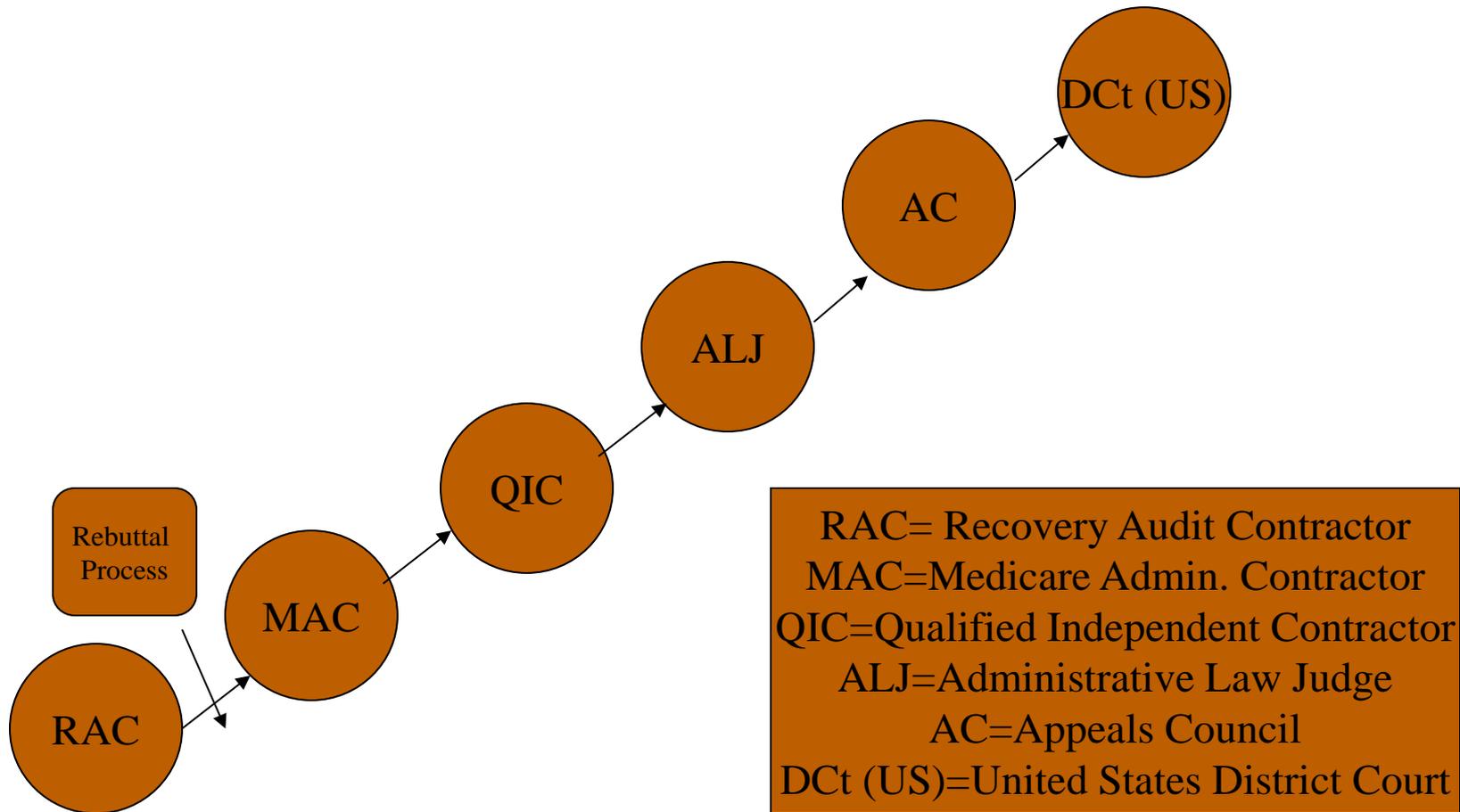


Starting the Appeal Process

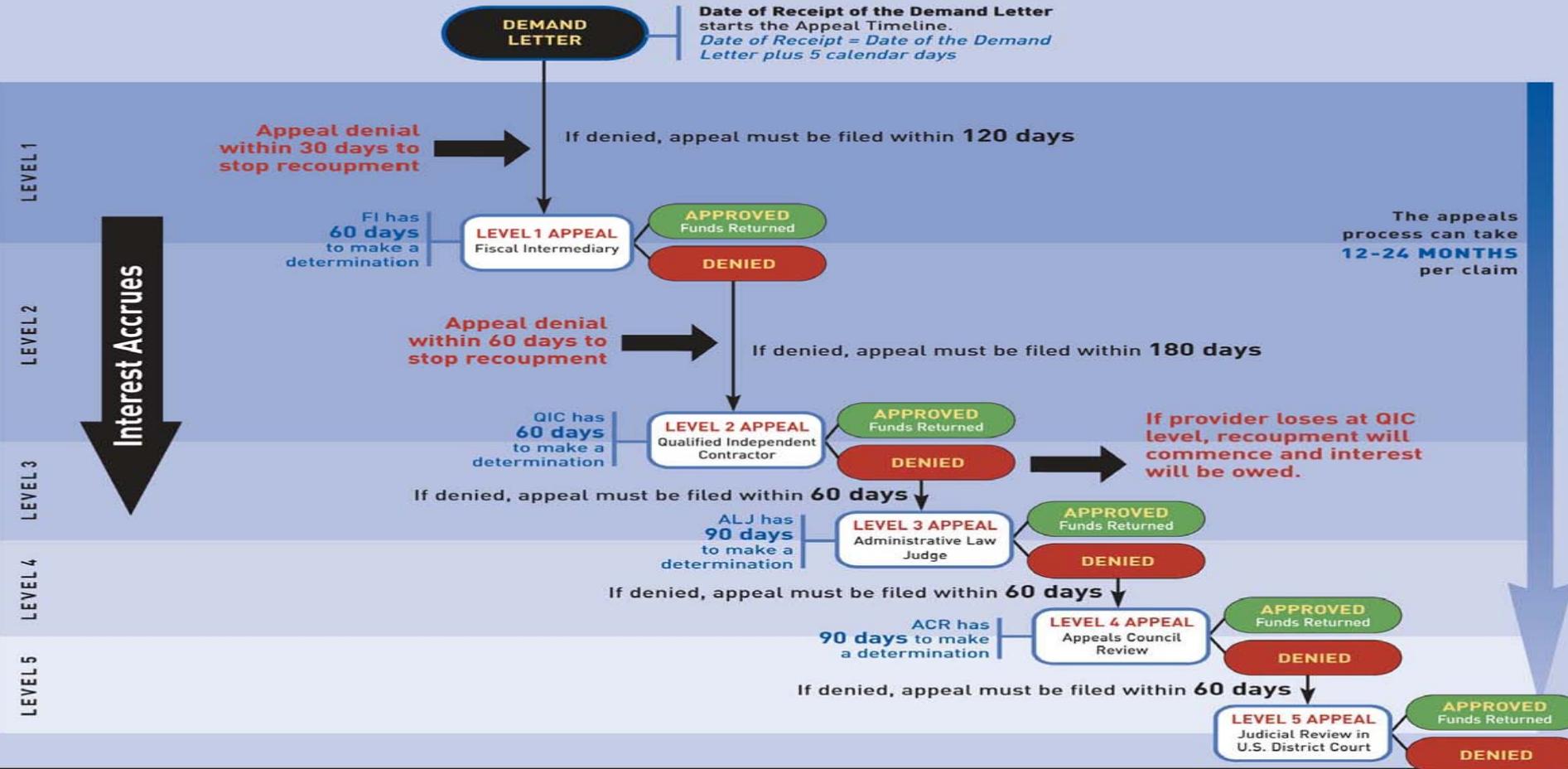
- Demand Letter includes:
 - Denied amount
 - Basis for the denial
 - Repayment options
 - Provider's appeal rights



The Medicare Appeals Process



MEDICARE APPEALS PROCESS





What is the Rebuttal Process?

Medicare will offer a provider a "period of rebuttal" for all denied claims. During the rebuttal period, the provider may provide additional information or documentation to Medicare for its consideration.

- The rebuttal period is NOT part of the formal Medicare Appeals process.
- Engaging in the rebuttal period does NOT preclude recoupment by Medicare for an overpayment. Only qualifying formal appeals may postpone recoupment.
- A provider must submit a rebuttal statement within 15 days of the demand letter.
- The appeals clock is not put on hold for the rebuttal period and will run simultaneously from the date of the demand letter. For example, if a provider wishes to stop recoupment, it should simultaneously file an appeal with the Medicare Administrative Contractor ("MAC") at the same time it is filing a rebuttal.



Repayment Options

- Providers may repay in several ways:
 - Within 30 days of the initial demand letter. In this case, interest will not accrue.
 - Provider may request an extended repayment schedule.
- If not repaid or appealed within 30 days of the initial demand letter the MAC will begin recoupment on the 41st day after the demand letter.



Interest

- Avoided by:
 - Paying the denied amount in full within 30 calendar days of the demand letter.
 - Win on appeal.
- Assessed:
 - Interest will accrue from the date of the demand letter to the date the denied amount is recouped or paid.
 - Assessed on 30-day increments. If payment is made before day 30 no interest for that period.
 - Interest Rate is the higher of the "current value of funds rate" or the "private consumer rate". These are updated quarterly. For example, the current interest rate is 10.125%.



Level 1 - Redetermination

- Filed with MAC.
- File within 120 days of receipt of demand letter.
- However, to avoid recoupment a provider must file an appeal within 30 days following the demand letter.
- Provider may submit new evidence to support claims.
- MAC has 60 calendar days from receipt to mail its Redetermination Decision.



Level 2 - Reconsideration

- Filed with the Qualified Independent Contractor (QIC).
- Must file within 180 calendar days of receipt of the Redetermination Decision.
- However, in order to extend the stay of recoupment through this level, a provider must file an appeal within 60 calendar days of the date of the Redetermination Decision.
- *Last stage, absent good cause, to present new evidence during entire appeal process.*



Level 2 - Reconsideration

- QIC may disregard LCDs and manual instructions, but must give substantial deference to these policies if they are applicable to the particular case.
- QIC must issue its decision within 60 calendar days of receiving the request for Reconsideration. If the QIC fails to issue its decision within 60 days, the QIC must give the provider the option to (1) wait for the QIC to issue a decision or (2) "escalate", i.e. request that the appeal advance to the next level, an ALJ hearing.
- If the QIC rules against a provider recoupment will resume after the 30th day following the QIC's decision letter.



Level 3 – Administrative Law Judge ("ALJ")

- Claim must meet established threshold; 2014 = \$140.00
- Filed within 60 calendar days from date of receipt of the QIC's Reconsideration decision
- Generally, no new evidence accepted. However, can argue "good cause" exception
- Effective July 2013, all new request for an ALJ hearing suspended due to huge backlog (357,000 hearing requests and only 65 ALJs)



Level 3 – Administrative Law Judge

- ALJ has 90 calendar days from receipt of the request for a hearing to render a decision. (A provider may request an "escalation" to the Appeals Council if ALJ fails to render a timely decision.) There are a host of reasons that the ALJ's 90-day deadline will be extended
- ALJ decisions must be based on statute, regulations, CMS rulings and national coverage determinations. Rulings means CMS' formal pronouncements, which are the decisions made by the CMS Administrator that serve as precedent - final opinions, orders, statements of policy and interpretation. Rulings can be found at <http://www.cms.hhs.gov/Rulings/CMSR/list.asp#/TopOfPage>
- ALJs must give substantial deference to LCDs, manual instructions and program guidance, but may choose not to follow given sound rationale.



Arguing a Case to an ALJ

- Hearings are by oral testimony, and typically conducted by telephone. Hearings involve CMS, the provider, legal counsel, clinical experts and any other participants arranged by the provider.
- If appeal is successful at this level, the provider may have already paid interest on funds recouped. However, the payment and interest recouped from the provider will be refunded to the provider.



ALJ Hearing Standard of Review

An ALJ acts as an independent finder of fact in conducting a hearing. Unless the ALJ dismisses the hearing, the ALJ will issue a written decision that gives the findings of fact, conclusions of law, and the reasons for the decision. The decision must be based on evidence offered at the hearing or otherwise admitted into the record.

- ALJ rulings now running approximately 6-10 months following hearing



ALJ Hearing Principles of Law

Pursuant to § 1862(a) of the SSA, "Notwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services -- (1)(A) which... *are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member....*"

§ 1833(e) of the Act states that "no payment shall be made to any provider of services or other person under this part unless *there has been furnished such information as may be necessary in order to determine the amounts due such provider ...*"



Strategies for ALJ Hearings

There are several strategies that can be used in the ALJ appeals process. These strategies involve effectively advocating the facts/merits of the underlying services as well as legal defenses such as:

- The Treating Physician rule
- Provider Without Fault
- Reopening Regulations
- Attack statistical sampling



Argue the Merits

Advocating the merits of a claim involves drafting a position paper that outlines the factual and legal arguments that support payment of a disputed claim. The position paper may include the use of medical summaries, references to the medical record, affidavits by physicians including the treating physician and/or specialist, illustrations, and other types of charts or graphs depicting the claims at issue.



Treating Physician Rule

- The "treating physician rule" involves the principle that a treating physician's determination that a service is medically necessary is entitled to extra weight because the treating physician is inherently more familiar with a patient's medical condition than a retrospective reviewer.



Provider Without Fault

- By statute, in the absence of evidence to the contrary, a provider is deemed to be without fault when an overpayment is discovered after the third calendar year following the year in which notice of the payment was sent to the provider. See 42 U.S.C. § 1395gg; see also 42 C.F.R. § 405.350. For example, if a payment was made in 2010, the third calendar year thereafter is 2013, and overpayments discovered after 2013 are presumed to be made without fault.
- Generally, a provider is considered "without fault" if it exercised reasonable care in billing for and accepting payment. See Medicare Financial Management Manual (CMS 100-06), Chapter 3, Section 90. To exercise reasonable care, the provider must comply with all Medicare regulations, make a full disclosure of all material facts, and on the basis of the information available, have a reasonable basis for assuming the payment was correct. *Id.* Therefore, in order to overcome the statutory presumption that a provider was "without fault" due to the passage of time, CMS must prove that the provider did not exercise reasonable care in billing for and accepting payment.



Reopening Regulations

Medicare regulations recognize that, in the interest of equity, Medicare providers and suppliers must be able to rely on coverage determinations. Accordingly, the Medicare regulations place restrictions upon the permissible timeframe for reopening determinations. According to the federal regulations governing the Medicare appeals process, once an initial determination to pay a claim has been made, the claim can be only reopened for review within a certain time period.

Pursuant to 42 C.F.R. § 405.980 (b), a contractor may reopen and revise its initial determination:

- Within 1 year from the date of the initial determination for any reason;
- Within 4 years of the date of the initial determination for good cause as defined in 405.986.
- At anytime if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.



Attack Statistical Sampling

In some post-payment audits, CMS will audit a small sample of a provider's records and, if it finds an overpayment, CMS will extrapolate the overpayment to the provider's entire Medicare patient population. There are sets limits regarding when statistical extrapolation may be used, and the Medicare manuals establish guidelines for CMS to follow when performing an audit based upon a statistical sample. If an extrapolation is flawed, it may be successfully challenged, bringing the total dollars at issue to the "actual" alleged overpayment, and not the extrapolated alleged overpayment.



Attack Statistical Sampling (Cont'd)

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.



Level 4 – Medicare Appeals Council ("AC")

- Initiated in 1 of 3 ways:
 - Provider may initiate after an unfavorable ALJ ruling within 60 calendar days of date of the decision.
 - CMS may request a AC review within 60 days of the ALJ ruling (the AC may decline request).
 - The AC, upon its own motion, may elect to review the ALJ's decision, which must be initiated within 60 days of the ALJ decision.



Level 4 – Medicare Appeals Council ("AC")

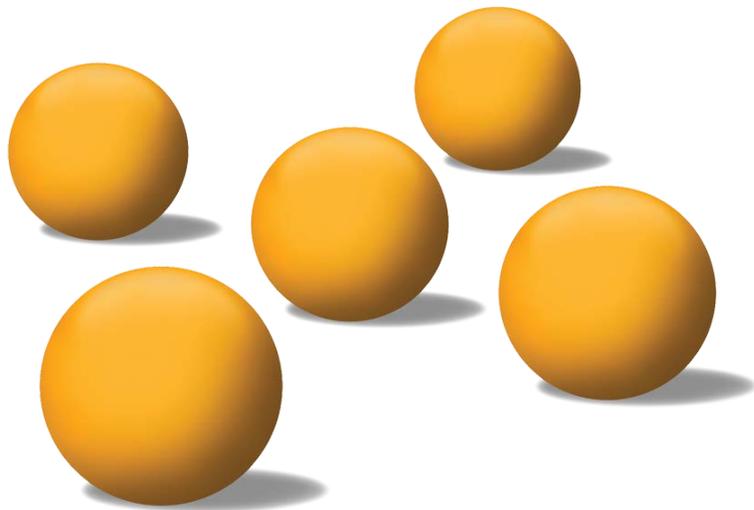
- The AC has 90 days to render a decision, which may be delayed for one of several grounds. A provider may escalate its appeal to the 5th level, federal district court, if the AC fails to render a decision by the appropriate deadline.
- Generally not an evidentiary hearing, but rather based on the administrative record, including the oral argument transcript with the ALJ.
- De novo review – meaning the AC reviews the ALJ decision as an entirely new examination of all facts of the case without giving any deference to any prior determinations.
- Prior AC decisions are located at <http://www.hhs.gov/dab/macdecision>



Level 5 – Federal District Court

- 60 days from receipt of the AC decision to file a request for judicial review
- Value of claim must exceed monetary threshold, 2014 = \$1,400.00
- No time frame for Court to issue a decision

Questions?



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