Medicare Audits and Appeals: Current Status and Trends

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Peter W. Thomas
Peter.Thomas@ppsv.com

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Topics

• Contractor Update
• Audit Reform
• Appeals Refresher
• Overpayments, Recoupment and Interest
• ALJ Hearing Delay
• IRF Quality Reporting Program
Multiple Contractors Continue to Target Providers

- Medicare Administrative Contractors
- Recovery Audit Contractors
- Comprehensive Error Rate Testing contractor
- Zone Program Integrity Contractors
- Supplemental Medical Review Contractor
- Universal Program Integrity Contractor
Recovery Audit Contractors

• Now referred to as “Recovery Auditors”
• Focused on recovery of overpayments and underpayments (but only 3%)
• RACs are the only Medicare contractor paid on a contingency fee basis
  • Contingency fee ranges from 9.5% to 12.5%
  • Highly incentivized to recover improper payments
RAC Pause and Transition

• RAC audit pause implemented as transition to new RAC contracts are being awarded

• No more ADRs permitted until new contracts awarded and transition complete

• All claim adjustments supposed to have been completed by June 1, 2014
Proposed Changes to the RAC Program

• Changes to the Discussion Period
  – Dedicated 30-day discussion period before submission of denial to MAC
  – Confirmation of receipt of discussion request required within 3 days

• Revised ADR limits to be used, based in part on claim type

• ADR limits to be adjusted based on provider’s denial rate (i.e., low denial rate equals lower ADR limit)
Proposed Changes to the RAC Program

- RACs will not be paid contingency fee until QIC has rendered appeal decision (if applicable)
- Proposed changes were challenged by one of the former RACs—legal challenge pending in federal court but probably won’t significantly delay the award of new RAC contracts
- At least one new RAC will be selected as one of the existing RACs did not submit a bid for a new contract
Senate Approps Bill Addresses Appeals System

• Senate appropriators push CMS towards improving the backlogged Medicare appeals process

• Language included in the fiscal 2015 HHS Approps spending report urges the agency to insert consistency into all levels of the appeals process and seek congressional help if needed to eliminate the backlog, in order to reform what many stakeholders view as a broken appeals process.

• Language specific to this issue can be found on pages 139 and 170 of the FY 2015 LHHS Subcommittee reported bill, which is available on the Senate Committee on Appropriations website: http://www.appropriations.senate.gov/news/fy15-lhhs-subcommittee-reported-bill-and-draft-report
Comprehensive Error Rate Testing

- Purpose is to measure the performance of the contractors
  - Establish the claim payment error rate
  - Used to evaluate the efficiency of the contractor
- Random claim audits
- Still result in overpayment/refund request for providers and suppliers
- CERTs put pressure on other contractors and CMS to take a hard line on auditing, fueling prob.
Zone Program Integrity Contractor

- ZPICs established in 2008 to replace Program Safeguard Contractors
- Segregated into 7 zones throughout U.S.
- Focused on identifying and preventing fraud and abuse
- Frequently use extrapolation of a sample and impose huge overpayment demands
- When ZPICs call, you know it is serious
Supplemental Medical Review Contractor

- Established in June/July of 2013
- Single Contractor – StrategicHealthSolutions
- Tasked with re-auditing claims that have already been subject to review
- Designed to focus on areas of high vulnerability
SMRC Project Y1P6

• Based on previous OIG audit of IRFs
• Covered services provided in 2010, 2011 and 2012
• 186 claims audited
  – Unclear how many IRFs were included in review
  – 22 beneficiaries had multiple claims audited
  – 167 claims denied
  – 90% error rate identified
• Denials primarily based on documentation issues
  – Preadmission screening and post-admission physician evaluation were major issues
  – Unclear whether medical necessity of care was questioned
  – Improvements noted in the records for the later dates of service
Unified Program Integrity Contractors

• UPICs – new contractor being developed
• Request for Information issued by CMS – initial stages only
• Designed to replace ZPICs and Medicaid Integrity Contractors (MICs to be phased out)
• Will take over program integrity responsibilities of MACs
  • MACs will retain payment processing responsibilities
  • Unclear how much auditing authority MACs will retain
• To operate on a regional basis
• Will not replace RACs
OIG Audits

• OIG has increased its activity in hospital auditing
• Focused primarily on issues related to short-stay admissions for acute care services
• OIG work plan for FY 2014 does not include IRF issues
• However, SMRC audit results could increase scrutiny
Audit Reform Proposed

• H.R. 1250 – The Medicare Audit Improvement Act of 2013
  – Introduced by Sam Graves (R-Mo.), with 10 other co-sponsors
  – Designed to improve RAC operations, mainly for Part A providers
  – Also meant to increase efficiency and transparency of other Medicare contractors
  – Identical bill introduced in Senate (S. 1012) by Roy Blount (R-Mo.)

• Multiple Congressional letters and hearings have been sent/held on this issue in recent months
  – Many members of Congress indicate concern about the impact of audits on the provider community, especially with respect to RACs
  – Focus remains on preventing fraud, waste and abuse in the Medicare program
Provider Relations Coordinator

• New position established by CMS to help address large-scale problems experienced by providers during RAC and MAC audits

• Latesha Walker
  – RAC@cms.hhs.gov (for Recovery Auditor review process concerns/suggestions)
  – MedicareMedicalReview@cms.hhs.gov (for MAC review process concerns/suggestions)
Appealing Claim Denials

• Subject to defined set of procedures
• 5 basic levels in administrative appeals process, but three are most important
  – Redetermination
  – Reconsideration
  – ALJ Review
• Supplemented by RAC discussion period and MAC rebuttal process
When to Appeal

• Most denials can—and should—be challenged through the appeal process

• When an appeal should NOT be filed:
  • Non-covered services
  • Patient not eligible for Medicare or Medicare
  • Denial for violation of timely filing requirements
  • If you agree with the decision following self-review of the claim
Appeals Process Details

• Filing deadlines run from the date of the demand letter or most recent appeals decision letter, in full calendar days

• **Discussion Period**
  – Only applicable to RAC audits
  – File with RAC before recoupment or appeal

• **Rebuttal**
  – Submitted to MAC
  – Should not raise appeal issues but arguments about why money should not be recouped

• Discussion and Rebuttal are separate from appeals process and do not delay filing deadlines
Requests for Appeal

• Forms available at each level of appeal
• Appellants encouraged to use the forms but also consider submitting separate written letter or brief in support of position
• Include all documentation at first two levels of appeal: no new documents may be submitted after QIC level without “good cause”
• Include copies of decision letters from prior level
• Address the reasons for denial from the previous decision-maker in the letter or brief
Maximizing the Appeals Process

• Establish process to track all ADRs, your responses, appeals at every level, and all deadlines so you don’t lose appeal rights
• Make decision on whether to stay recoupment in future appeals and adhere to timelines
• Designate single PoC within your office for audit and appeals tracking/correspondence
• Always use delivery method that can be tracked and delivery verified
Common Reasons for Denial

- **“Technical” Denials**
  - Missing/unsigned/late PAS, admission orders, PAPE
  - Late submission of IRF-PAI data
  - Failure to document presence of necessary personnel at team meetings

- **Medical Necessity Denials**
  - No need for physician supervision at inpatient level
  - Could have been treated in “less intensive setting”
  - Patient’s medical needs not “complex” enough to warrant IRF level of care
  - Therapy needs not sufficient to require intensive program of therapy services
  - Stable/unstable
  - Care required by patient was “routine”
“Technical” Denials and Appeals

• Failure to meet deadlines for completing paperwork can result in denials

• Difficult to appeal because of the “technical nature” of the denial, but equity arguments before ALJ have not been systematically tested

• For those claim denials occurring under the new criteria, majority are not based on pure medical necessity but rather documentation issues

• Important Considerations for EMR Users:
  • Be certain that, when printed for submission to auditor, the records contain all the required fields, especially dates and signatures
  • If using electronic signatures, make sure they truly satisfy the requirements – simple typed names are not sufficient
Return of Alleged Overpayments

- Repayment vs. Recoupment
- What is “recoupment”?
  - Defined as repaying outstanding Medicare debt through reduction of present and future Medicare payments
  - Frequently referred to as “offset”
  - Begins 41 days after initial demand letter issued unless stayed
  - Often incurs interest
  - Request for immediate offset is permissible to avoid interest
- Extended repayment plans may be requested but inability to repay timely must be documented
Limiting Recoupment

• Suppliers may stay recoupment at the redetermination and reconsideration levels of appeal

• Abbreviated deadlines for filing appeals:
  • Must file for redetermination (1st level) within 30 days
  • Must file for reconsideration (2nd level) within 60 days
  • Recommended that appeals specifically request that recoupment be stayed
  • If recoupment only stayed during redetermination, offset will begin as early as Day 61 after redetermination decision has been issued

• Recoupment through offset will occur following a QIC denial, regardless of appeal to ALJ

• Interest continues to accrue during stay

• What if CMS recoups despite your request for a stay?
Interest

• Interest rate is usually quite high – currently 9.625%, but frequently exceeds 10%
• Always accrues as simple interest on principal only – no interest on interest
• Any interest paid to CMS is to be refunded upon favorable appeal
• Full refund to CMS yields no interest payments
• Refund through recoupment *does* trigger interest
Interest

• If provider repaid CMS through offset following a stay on recoupment, entitled to interest on recouped amounts after favorable decision at the ALJ level of appeal (or higher)

• For every full 30-day period between the date of recoupment and the date of the favorable decision based on the interest rate in effect at time of favorable decision

• Interest may also be due to all providers if the contractor does not repay within 30 days of the favorable decision, for each full 30-day period
ALJ Hearing Delay

• Due to appeals backlog, OMHA has delayed assignment of all appeals filed after July 15, 2013
• Delay originally set for two years, but approximately 5.3 year wait expected for claims most recently filed
• Appeals filed by beneficiaries are given priority
• Procedures are being developed to help streamline appeals process
  – Electronic tracking and (eventually) filing of appeals
  – Pilot projects for Part B claims started
• 7 new ALJ teams added to new Kansas City Field Office to help address backlog – should begin hearing appeals in Q4 2014.
Strategies for Handling Delay

- Consider having beneficiary file appeal
  - Still subject to some delay but given priority
  - Must have a willing and able beneficiary
  - Likely to require higher level of administrative or attorney involvement to handle beneficiary’s participation and avoid potential complications or miscommunication
Strategies for Handling Delay

• Exercise limitation on recoupment
  – If limitation on recoupment is triggered during the 1st and 2nd levels of appeal, then interest accrues in favor of provider once overpayment is recouped through offset
  – While provider is given less time to file appeals, accrual of interest during significant delay at ALJ level is some small comfort
  – Caution: Obtaining payment of interest can be challenging so KNOW YOUR RIGHTS
Important Considerations During the Delay

• OMHA is looking for any way possible to ease the burden on the ALJs

• Providers must be extra vigilant to follow all appeal requirements (and even recommendations) to the letter to avoid the risk of dismissal of appeals

• Risk areas:
  – Appointments of representative
  – Notice to beneficiaries
  – Inclusion of all information required under regulation and manual provisions
  – Use of recommended appeals forms
AHA Suit Challenging ALJ Delay

- American Hospital Association (AHA) and 3 hospitals filed suit in D.C. federal district court on May 22, 2014
- Suit argues that OMHA delay violates statutory duty to decide ALJ appeals within 90 days
- Seeks “mandamus,” which is a court order directing a federal officer or agency to comply with a clear duty
- FAIR Fund will file amicus brief: Looking for hospitals willing to share the impact of appeals
AHA Suit Challenging ALJ Delay

• AHA has already filed its motion for summary judgment, *before* HHS answers the complaint
  – This is a highly unusual step
  – AHA states that this is necessary because the issue is so time sensitive

• HHS’s response is due by September 11, 2014
IRF Quality Reporting Program (QRP)

• Affordable Care Act requires IRFs to submit data to CMS (through CDC) on specified quality measures
• Beginning in FY 2014, IRFs that fail to submit quality data as specified by CMS are assessed a 2% reduction in the annual IRF payment update
• CMS implemented the IRF QRP for CY 2013, which would be used for FY 2014 payments
• CMS announced that IRFs would be required to submit data on two quality measures:
  1. Catheter-Associated Urinary Tract Infection (“CAUTI”); and
  2. Pressure Ulcers that are New or Have Worsened
• CMS would impose any corresponding 2% reduction to the annual increase factor on non-compliant IRFs in FY 2015
Several IRFs have received Notices of Non-Compliance from CMS

- Annual payment update to be reduced by 2%
- This translates into huge demands for payment
- CAUTI data appears to be a particular issue
- Possible software problem at CDC
  - IRFs claim to have submitted all data
  - But CDC database does not reflect full submission
Appealing Adverse IRF QRP Findings

• Reconsideration – filed with CMS within 30 days of receiving notice

• Provider Reimbursement Review Board (PRRB)
  • If reconsideration unfavorable, can appeal to PRRB
  • Same entity that hears cost report appeals
  • Extremely backlogged, appeals likely to be delayed for years
Questions?

Contact Peter Thomas, J.D.
Powers Pyles Sutter & Verville, P.C.
202-466-6550
Peter.Thomas@ppsv.com
www.ppsv.com