BACK TO SCHOOL WITH GOVERNMENT AUDITS

Prepared and Presented by:

Julie B. Mitchell, J.D., LL.M.

Philip J. Chapman, J.D.

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25% OF HEALTHCARE SPENDING IS ACCOUNTED TO WASTE

- Failure of Care Delivery: $165.7 B
- Failure of Care Coordination: $78.2 B
- Overtreatment or low-value care: $101.2 B
- Pricing Failure: $240.5 B
- Fraud and Abuse: $83.9 B
- Administrative Complexity: $265.6 B

EFFECT OF COVID19 ON 2020 FEDERAL SPENDING

- As of March 1, 2021, an estimated $5.3 Trillion has been spent in response to COVID19
- Families First Coronavirus Relief Act (FFCRA) authorized 6.2% increase in federal match rate
- CARES Act-- $2.2 trillion stimulus, with $463B devoted to Health and Human Services

HOW LONG WILL MEDICARE & SOCIAL SECURITY LAST?

- Total Medicare expenditures increase at a faster pace than either workers' earnings or the economy overall. Total Medicare and Social Security expenditures were $1.99 Trillion in 2020. That is over $100 billion more than in 2019.
- Pre-COVID 19, The Medicare Hospital Insurance Trust Fund (Part A) was projected to be exhausted by 2026. Post-2020 data shows fund will be exhausted by 2024.
- The Social Security Trust Fund is projected to be exhausted in 2035.

"The fraud control game is dynamic, not static. Fraud control is played against opponents: opponents who think creatively and adapt continuously and who relish devising complex strategies; this means that a set of fraud controls that is perfectly satisfactory today may be of no use at all tomorrow, once the game has **progressed a little."**

- Malcolm K. Sparrow

OIG REPORTS:
OCT. 1, 2020 – MAR. 31, 2021

Statistic	10/1/2020-3/31/2021
Audit Reports Issued	75
Evaluations Issued	20
Expected Audit Recoveries	$566.46m
Potential Savings	$919.97m
New Audit and Evaluation Recommendations	228
Expected Investigative Recoveries	1.37b
Criminal Actions	221
Civil Actions	272
Exclusions	1,036

ATTEMPTS AT REDUCING WASTE

- HIPAA (Health Insurance Portability and Accountability Act of 1996)
- BIPA (Benefits Improvement & Protection Act 2000)
- MMA (Medicare Modernization Act 2003)
- DRA (Deficit Reduction Act 2005)
- Tax Relief & Healthcare Act 2006
- PPACA (Affordable Care Act 2010)

PAYMENT RECAPTURE AUDITS

- On March 20, 2010, President Obama issued a Presidential Memorandum that directed all executive departments to expend their use of payment recapture audits to the fullest extent permitted by law

THE GOVERNMENT'S TOOLKIT

- MAC
- RAC
- UPIC
- CERT
- OIG
- DOJ
- FBI
- PERM
- M/M PROGRAM INTEGRITY
- MFCU
- STATE AUDITS
- SMRC
- SURVEY

MISSISSIPPI HEALTH CARE FRAUD

- Mississippi is the #1 hotspot for hospice fraud in the United States
- Mississippi compounding pharmacies bill TriCare millions for unnecessary pain cream
- Mississippi's MFCU is opening more than seven (7) new cases a week
- State Auditor unveils waste in Medicaid with 5% of those receiving Medicaid benefits actually ineligible

WHO IS AUDITING YOU?

Overview of the current auditors for CMS

MEDICARE/MEDICAID INTEGRITY PROGRAM

- As of December 28, 2015, HHS has been utilizing contractors to "promote the integrity of the program" by determining whether fraud, waste, or abuse has occurred or is likely to occur.
- For Medicaid, found in 42 USCA § 1396U-6
- For Medicare, found in 42. USCA 1395ddd

TYPES OF AUDITORS

- Medicare Administrative Contractors (MACs)
- Recovery Aduit Contractors (RACs)
- Supplemental Medical Review Contractor (SMRC)
- Comprehensive Error Rate Testing (CERT)
- Unified Program Integrity Contractors (UPICs)
- Payment Error Rate Measurement (PERM)

MEET THE MACS

- Novitas Solutions, Inc. (A/B)
- CGS Administrators, LLC (DME)
- Palmetto GBA (HH&H)

CGS
A CELERIAN GROUP COMPANY

PALMETTO GBA
A CELERIAN GROUP COMPANY

MACS

- Medicare Administrative Contractors
- Private health care insurer that processes claims for Medicare Fee-For-Service Beneficiaries
- Replaced carriers and intermediaries
- Handle pre- and post-pay audits
- Administer Targeted Probe and Educate (TPE)
- Provide education
- Handles 1st level appeals of any Medicare audits
- In FY 2020, MACs processed more than 1.1 billion FFS Medicare claims

MEET THE RAC

- Region C– Cotiviti Healthcare (Mississippi's Auditor)

COTIVITI

RACS

- Recovery Audit Contractors, or RACs
- ID and correct Medicare past improper payments through post-pay audits
  - non-fraud auditors
- Paid on a contingency fee basis for recovering or returning overpayments/underpayments
- CMS suspended RAC audits during COVID-19, but audits resumed August 3, 2020

MEET THE SMRC

- Only one nationwide—Currently, Noridian Health Care Solutions

noridian
Healthcare Solutions

SMRC

- Supplemental Medical Review Contractor
- Works to reduce improper Medicare payment rates and protect Medicare Trust Fund via post-pay medical reviews and data analysis
- Service-specific medical reviews of Part A, Part B, and DMEPOS claims

CERT

- Comprehensive Error Rate Testing
- Each year, performs post-pay review of statistically valid stratified random sample of Medicare FFS claims to determine if paid correctly
- Claims randomly selected
- In FY 2020, Medicare FFS estimated improper payment rate of 6.27% ($25.74 billion)
- CMS suspended/put on hold CERTs during COVID-19 Public Health Emergency, but CERTs resumed August 11, 2020

MEET THE UPICS

- **Southwestern Jurisdiction**
  - **CO, NM, OK, TX, AR, LA, MS**
  - **Qlarant**
- Mid-Western Jurisdiction
  - IA, IL, IN, KS, KT, MI, MN, MO, NE, OH, WI
  - CoventBridge Group
- Northeastern Jurisdiction
  - ME, VT, NH, MA, RI, CT, NY, PA, NJ, DE, MD, DC
  - SafeGuard Services LLC
- South-Eastern Jurisdiction
  - WV, VA, NC, SC, TN, AL, GA, FL
  - SafeGuard Services LLC
- Western Jurisdiction
  - AK, AZ, CA, HI, ID, MT, NV, ND, OR, SD, UT, WA, WY
  - Qlarant

UPICS

- Unified Program Integrity Contractor
- Effective July 21, 2020, UPICs were added to listed CMS Contractors
- Replaced ZPICs, PSCs, and MICs
- Performs fraud, waste, and abuse detection, deterrence, and prevention for Medicare & Medicaid claims processed by the United States

PERM

- Payment Error Rate Measurement
- Measures improper payments in Medicaid and CHIP
- PERMS were paused during COVID19, but have resumed as of August 11, 2020

MEET THE MEDICAID RAC

- LaunchPoint Ventures dba Discovery Health Partners

DISCOVERY
HEALTH PARTNERS

MEDICAID RAC

- PPACA requires Medicaid agencies to contract with at least one Recovery Aduit Contractor (RAC) to identify and recovery overpayments and to identify underpayments
- Same responsibilities as Medicare RACs

A NOTE REGARDING RELIEF FUND AUDITS

- CARES Act funds will likely be subject to audits
- HHS has not yet detailed which entity will be responsible for audits or how recoupment will work
- HHS has stated that it "will have significant anti-fraud monitoring of the funds distributed, and the [OIG] will provide oversight… to ensure Federal dollars are used appropriately."
- In MS, State Auditor Shad White, stated on August 5, 2020, that he intends to audit over $1.25 billion sent to MS as part of the CARES Act.

OIG WORK PLAN 2020-2021

- Audit of Medicare Emergency Department Evaluation and Management Services
- Data Snapshot: Review of Beneficiaries relationship with providers for Telehealth Services
- Accuracy of Place of Service Codes on Claims for Medicare Part B Physician Services when beneficiaries are Inpatients under Part A
- Impact of Expanding the Hospital Transfer Payment Policy for Early Discharges to Post-acute Care
- Audit of CARES Act Provider Relief Funds—Payments to healthcare providers that applied for general distribution under phases 1, 2, and 3
- Meeting the challenges presented by COVID19: Nursing Homes
- Audit of the effectiveness of HHS's Governance to ensure hospitals implement measures to prevent, detect, and recover from cyberattacks
- Audit of Home Health Services provided as telehealth during the COVID19 Public Health Emergency
- Audit of CARES Act Provider Relief Funds—General and Targeted Distributions to hospitals
- Results of UPICs' benefit integrity activities
- Swing-Bed services at Nationwide Critical Access Hospitals

OIG WORK PLAN 2020-2021

- Medicare needs better controls to prevent Fraud, Waste, and Abused related to Orthotic braces
- Medicare Part D payments during covered Part A SNF stay
- Audits of Medicare Part B Telehealth Services during the COVID19 Public Health Emergency
- Home Health Agencies' challenges and strategies in responding to the COVID19 Pandemic
- CMS oversight of the Two-Midnight Rule for Inpatient Admissions
- Nursing homes' compliance with facility-initiated discharge requirements
- Medicare Telehealth Services during the COVID19 Pandemic: Program Integrity Risks
- Joint work with state agencies
- Use of Medicare telehealth services during the COVID19 pandemic
- Audit of Medicare payments for inpatient discharges billed by hospitals for beneficiaries diagnosed with COVID19

THE AUDIT PROCESS

WHAT TRIGGERS AN AUDIT?

- Services are not medically necessary
- Lack of documentation
- Improper coding
- Processing and administrative errors
  - Did not include certifying physician signature
  - Encounter notes did not support eligibility
  - Documentation does not meet medical necessity
  - Missing or incomplete initial certification or recertification

OTHER AUDIT TRIGGERS

- Complaints
  - Patient/family member
  - Competitor
  - Anonymous sources
- Employee whistleblowers
- Referrals—survey or contract agency

WHAT TO DO AFTER YOU RECEIVE A DEMAND LETTER

- The Contractor will notify the provider of an improper payment determination (overpayment or potentially a fraudulent payment) by submission of a demand letter.
- Provider then has four options:
  - Pay the overpayment by check
  - Allow recoupment of the overpayment from future CMS payments
  - Request or apply for extended repayment plan
  - Appeal

THINGS TO KEEP IN MIND

1. Be aware of Medicare's right to audit you, so stay cooperative
2. Stay on top of requests for information and document all aspects of the audit
3. Ensure all records requested by auditor are provided timely and sufficiently
4. Never change, alter, or modify any of the requested records
5. Double check and investigate the claims being audited
6. ALWAYS consult with experienced counsel before responding to an audit notification

UNDERSTANDING THE APPEALS PROCESS FOR AUDITS

Outlining the Medicare and Medicaid Appeals Process

TO APPEAL OR NOT TO APPEAL— CONSIDERATIONS FOR PROVIDERS

- Do you have the time?
- Can you afford to appeal?
- Can you afford NOT to appeal?
- Do you have a benchmark for how far you want to appeal?
- Will you outsource or appeal in house?

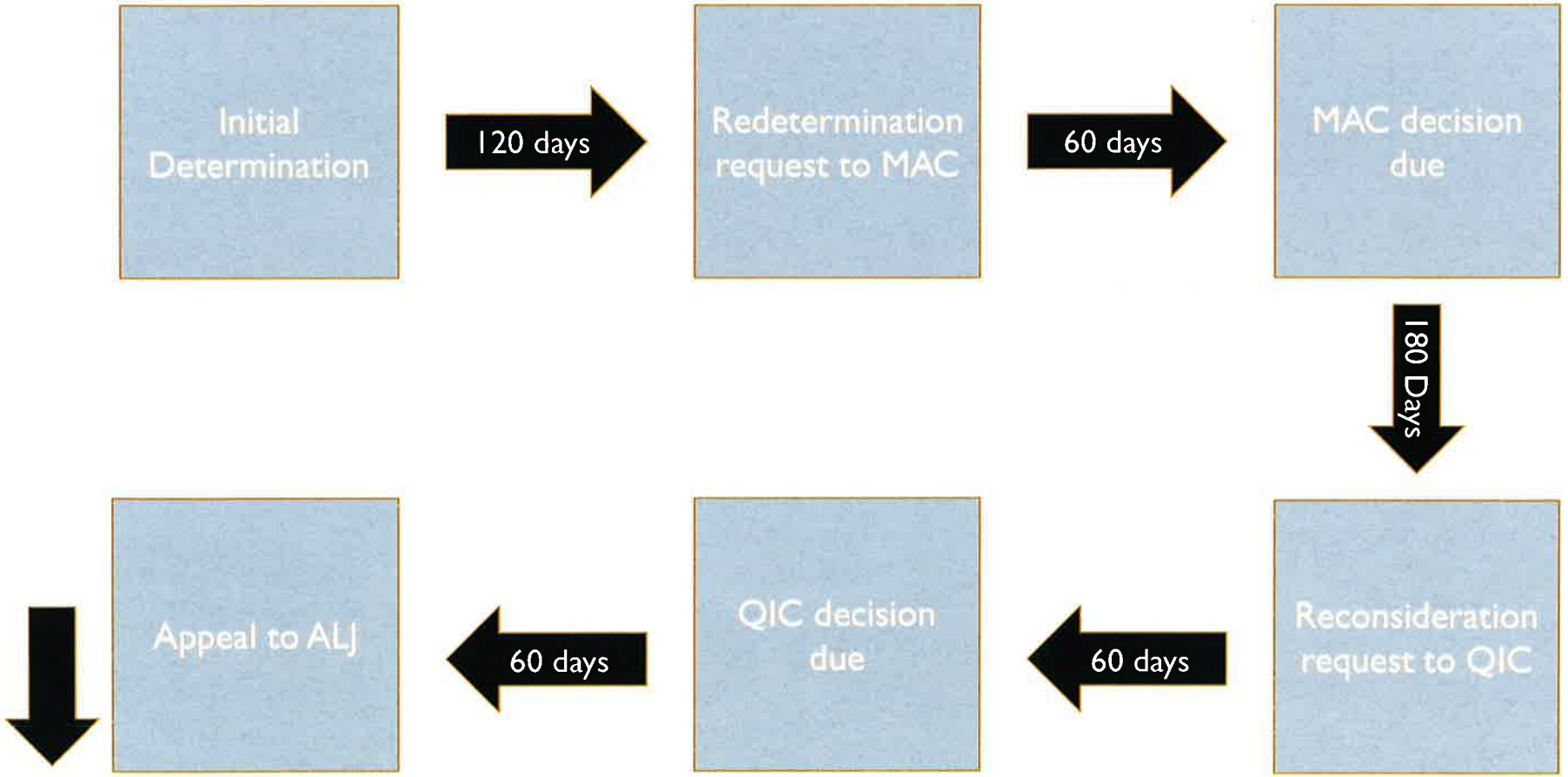
BASIC PROCEDURE

- The Medicare Appeals Process follows the same basic procedure as MACs, RACs, SMRC, UPICs, and CERT.
- There is a five (5) level appeal process
- Distinguishing characteristic for a RAC appeal is the inclusion of a "Discussion Period"
- Medicaid Process for UPICs is a little different

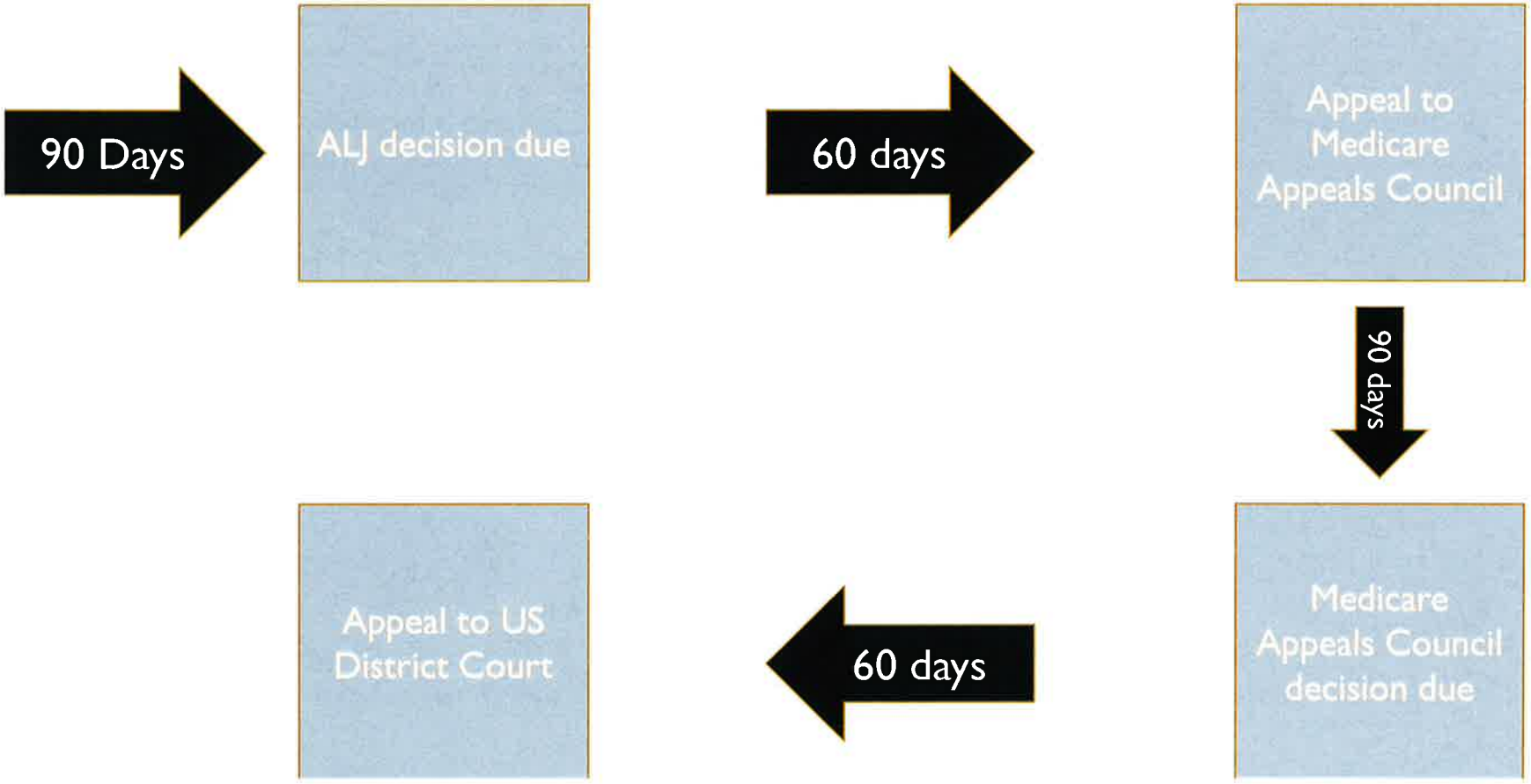
APPEALING A MEDICARE DENIAL

	Level One	Level Two	Level Three	Level Four	Level Five
Type of Appeal	Redetermination (Medicare Administrative Contractor [MAC])	Reconsideration (qualified independent contractor [QIC])	Administrative Law Judge	Medicare Appeals Council (Council)	Federal Court Review
Time Limit of Filing Appeal	120 days from date of receipt of the initial determination	180 days from the date of receipt of the redetermination decision	60 days from the date of receipt of the reconsideration (QIC decision) 90 days to rule	60 days from the date of receipt of the ALJ decision	60 days from date of receipt of the Council decision
Amount in Controversy (monetary threshold to be met)	No Minimum (none)	No Minimum (none)	For requests filed on or after 1/1/2021, at least $180 remains in controversy	No Minimum (none)	As of 2021, at least $1,760 remains in controversy

APPEALS PROCESS FLOWCHART



APPEALS PROCESS FLOWCHART



REDETERMINATION

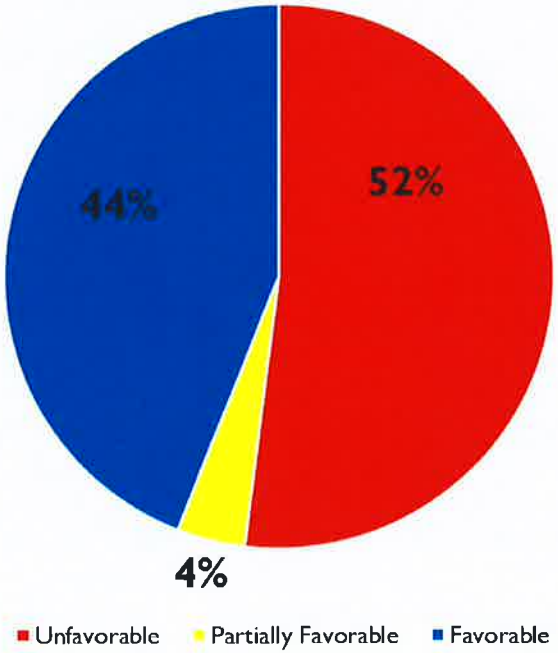
- First level of appeal (MACs)
- The provider may appeal within 120 days from the date the provider receives a demand letter
- Recoupment may begin on the 41st day after the date of demand letter
- Once initiated, recoupment will stop upon receipt of a valid request for redetermination. However, to avoid any recoupment, the Provider must appeal within 30 days of the date of the demand letter.
- Redetermination must be requested in writing.

REDETERMINATION OUTCOMES

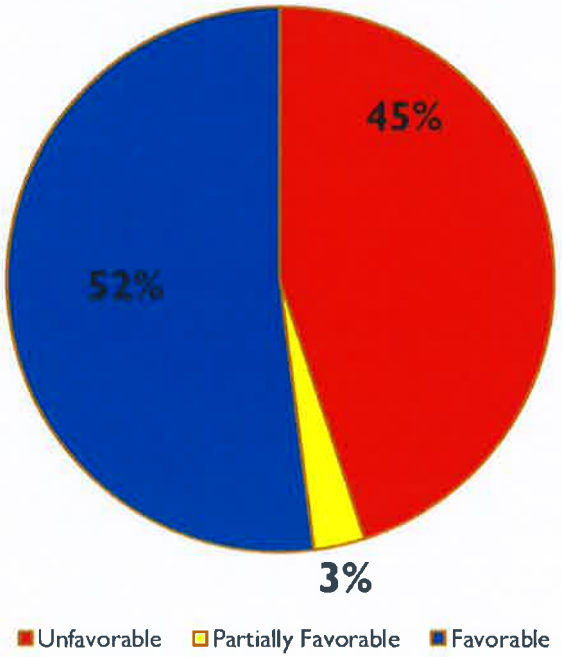
- Possible outcomes
  - Full Reversal (Favorable)
  - Partial Reversal (Partially Favorable)
  - Full Affirmation (Unfavorable)
- The MAC must render its decision within 60 days of the date the appeal is filed

REDETERMINATION DISPOSITIONS IN 2020

Part A Redeterminations



Part B Redeterminations



RECONSIDERATION

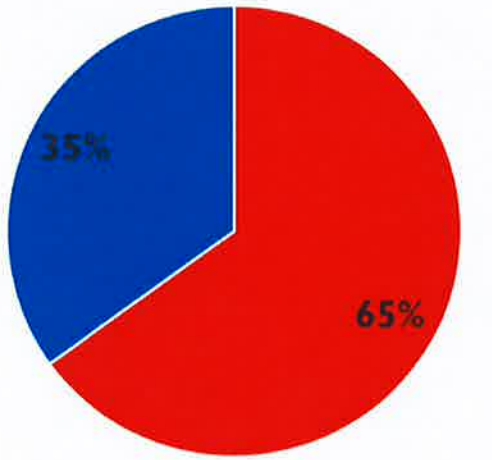
- Second level of appeal
  - Qualified Independent Contractor (QIC)
- The provider may appeal a redetermination within 180 days of receipt of the MAC's decision.
  - If the provider appeals the redetermination within 60 days, recoupment is stayed.
  - Otherwise, recoupment begins on the 76th day after the redetermination decision.
- Submission of additional evidence

RECONSIDERATION OUTCOMES

- Possible outcomes on the overpayment:
  - Full reversal (Favorable)
  - Partial reversal (Partially Favorable)
  - Full affirmation (Unfavorable)
- The QIC has 60 days from the date the appeal is filed to render its decision.

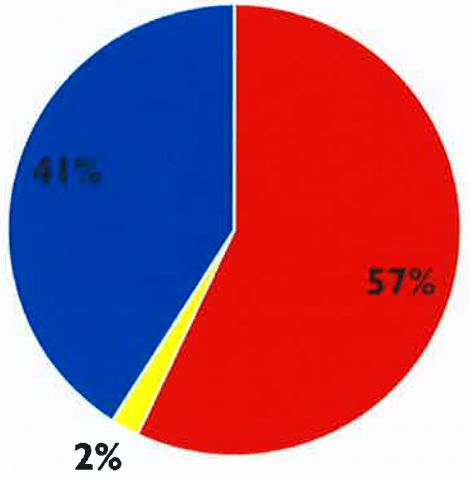
RECONSIDERATION DISPOSITIONS IN 2020

Part A Reconsiderations



■ Unfavorable ■ Partially Favorable ■ Favorable

Part B Reconsiderations



■ Unfavorable ■ Partially Favorable ■ Favorable

RECOUPMENT AFTER RECONSIDERATION

- Medicare Contractors can initiate or resume recoupment until the debt is satisfied in full, immediately upon receipt of the QIC's decision or dismissal notice of a provider's request for reconsideration, regardless of a subsequent appeal to the administrative law judge and all further levels of appeal.

ADMINISTRATIVE LAW JUDGE

- Third level of appeal
- The provider may appeal a reconsideration within 60 days of receipt of the QIC decision.
- For 2021, the amount in controversy must be at least $180.
- The ALJ must conduct a hearing and render a decision within 90 days of the date the appeal is filed.
  - The hearing may be in person, by video teleconference, or by telephone.

ALJ BACKLOG

- As of November 1, 2018, there was a backlog of 426,594 pending appeals at the ALJ level with providers waiting up to 5 years for ALJ decision.
- On that date, federal district court in *AHA v. Azar* ordered HHS to reduce backlog by 49% by the end of FY 2020, by 75% by the end of 2021, and to clear it entirely by the end of 2022.
- As of March 26, 2021, a total of 131,961 appeals remain pending, which is a 69% reduction of the ALJ's backlog.

MEDICARE APPEALS COUNCIL

- Fourth level of appeal
- Medicare issues are heard by the Medicare Appeals Council within the Departmental Appeals Board (DAB)
- The Provider may appeal an ALJ decision to the DAB within 60 days of receipt of the decision.
- The DAB must render a decision or remand to the ALJ within 90 days.
- Backlog here too

UNITED STATES DISTRICT COURT

- Fifth level of appeal
- The provider may appeal an adverse DAB decision to the appropriate U.S. District Court within 60 days of receipt of the DAB decision.
- For 2021, the amount in controversy must be at least $1,760.00.
- District Court review may take 90 days or more.

REBUTTAL STATEMENT & DISCUSSION PERIOD (PRIOR NOTICE SITUATIONS ONLY—RAC/UPIC)

- Provider may submit a rebuttal statement within 15 days of receiving a determination latter
- From receipt of the determination letter until the date of recoupment, there is a Discussion period
  - Neither stays the appeals deadline
  - Discussion period requires notification to the RAC in writing
- Usefulness of Rebuttal Statement & Discussion Period
  - Address obvious error
  - Opportunity for submission of additional documentation
  - Open dialogue
  - Informal discovery
  - Negotiate extended payment plan

NOTE ON EXTENDED PAYMENT PLANS

- Repayment plans are a useful tool for providers who consider appealing the RAC determination
- The Medicare rate of interest applies to extended payment plans.
  - As of January 19, 2021, the interest rate for Medicare overpayments and underpayments is 9.625%
  - Interest accrues on overpayment from the 30th day after the demand letter
  - If the provider wins on appeal, funds recouped are repaid with interest

APPEALING A MEDICAID APPEALS PROCESS (MS)

- Providers may appeal any overpayment determination as provided by state law.
- The Mississippi Medicaid appeals process is set forth in Title 23, Chapter 300 of the Miss. Admin. Code.

MS MEDICAID APPEALS

- A provider may request a formal hearing within 30 days after a final administrative decision.
  - A request for hearing must be in writing and must explain the facts that support the provider's position and the reasons the provider believes it has complied with Medicaid regulations.
  - The provider should attach any available documentation supporting the provider's position.

MS MEDICAID APPEALS

- The Executive Director of the Division of Medicaid shall notify the provider in writing by certified mail, return receipt requested at least 30 days in advance of the date the matter has been set for hearing.
- The Executive Director shall designate one member of DOM staff as hearing officer.
  - The hearing officer may issue subpoenas, administer oaths, compel the attendance and testimony of witnesses, require production of documents and other evidence, take depositions, and do all other things within the law which may be necessary to enable him to discharge his duties.

MS MEDICAID APPEALS

- The provider may be assisted by counsel and may present and examine evidence and witnesses.
- The hearing officer must make a written recommendation, including findings of fact, to the Executive Director within 60 days after the hearing
- Appeals of Medicaid Decisions must be filed in Hinds County Chancery Court, 1st Judicial District, within 60 days of receipt of decision via certified mail

CONSIDERATIONS FOR PROVIDERS

WHAT IF YOU LOSE THE APPEAL?

- Did you attempt to recover the cost of services from the beneficiary?
- Did you notify the beneficiary with an Advance Beneficiary Notice if it was questionable that services would be covered?

BE THOROUGH WHEN GATHERING DOCUMENTS AND OTHER EVIDENCE FOR SUBMISSION

- If you wait to introduce evidence until later levels of appeal, you may be limited as to what evidence you are allowed to introduce
- E.g., at the ALJ level, you must have *good cause* to introduce new evidence

AUDIT DEFENSES

ATTACK THE CONTRACTOR'S STATISTICAL METHODS

- Medicare contractors are limited in their ability to use extrapolation to instances in which 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
- Guidelines for extrapolations are set forth in Chapter 3, sections 3.10.1 through 3.10.11.2 of the Medicare Program Integrity Manual
  - Expert witness a must

PROVIDER WITHOUT FAULT

- Section 1870 of the Social Security Act provides that 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.
- What does it mean to be "without fault"?

TREATING PHYSICIAN RULE

- States that the treating physician is in the best position to make medical necessity determinations because he is most familiar with the patient's condition.
- The treating physician's determination that a service is medically necessary is binding unless contradicted by substantial evidence and is even entitled to extra weight even if contradicted by substantial evidence.
- CMS Ruling 93-1 (applicable to Part A claims) states that the treating physician's opinion is evidence, but not presumptive, so the provider must make an argument as to why the physician's opinion is the best evidence.
- This defense has been largely eroded

WAIVER OF LIABILITY

- Section 1879 of the Social Security Act provides that providers may be entitled to payment for claims deemed not reasonable and necessary if the provider did not know or have reason to know that payment would not be made.

REOPENING REGULATIONS

- Medicare regulations provide that once an initial determination has been made, the claim can be reopened for review only within a certain time period

CONTACT

Julie Mitchell J.D.,LL.M.
Hagwood & Tipton, P.C.
Phone: (601) 707-4039
Email: jmitchell@hatlawfirm.com

Philip J. Chapman, J.D.
Hagwood & Tipton, P.c.
Phone: (601) 608-3117
Email: pchapman@hatlawfirm.com