The Audit Landscape: MICs, MACs, RACs and ZPICs

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SETTING THE SCENE: FOCUS ON SKILLED NURSING FACILITIES

• The Federal Government has zeroed in on Medicare payments to Skilled Nursing Facilities as identified in 2010 OIG Report:
  – SNFs increasingly billed Medicare for higher paying RUGs from 2006-2008, even though the OIG states beneficiary characteristics remained the same;
  –Reported that for-profit SNFs were more likely to bill for higher paying RUGs than for nonprofit of government SNFs
  –Recommendations to CMS included:
    • Monitor payments to SNFs;
    • Strengthen monitoring of SNFs that are billing for higher paying RUGs;
    • Follow-up on the SNFs identified as having questionable billing

SETTING THE SCENE: FOCUS ON SKILLED NURSING FACILITIES

• The OIG Work Plan for 2012 stated that it would focus on the extent to which payments to SNFs met Medicare coverage requirements.
• It cited a prior report where 26 percent of claims had RUGs that were not supported by patients’ medical records – the percentage representing $542 million in potential overpayments.
### THE CURRENT AUDIT LANDSCAPE

- CMS contractors in the current audit landscape
  - Medicare Administrative Contractors (MACs)
  - Zone Program Integrity Contractors (ZPICs)
  - Recovery Audit Contractors (RACs)
    - Medicare RACs & Medicaid RACs
  - Medicaid Integrity Contractors (MICs)

### Medicare Administrative Contractors (MACs)

- Pursuant to Medicare Prescription Drug, Improvement and Modernization Act of 2003, CMS is transitioning and consolidating the roles of intermediaries and carriers into MACs
- MACs are assuming all functions of the current intermediaries and carriers
- Provider services will be simplified by having a single MAC process both its Part A and Part B claims

### Zone Program Integrity Contractors (ZPICs): What do they do?

- CMS is in the process of transitioning the functions of Program Safeguard Contractors (PSCs) to ZPICs
- PSCs and 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
  - PSCs and ZPICs request medical records and conduct medical review to evaluate the identified potential fraud
  - PSCs and ZPICs may also refer to the OIG and DOJ for further investigation
Recovery Audit Contractors

Who are the RACs?

- Region A: Diversified Collection Services, Inc.
  - Working in CT, DE, DC, MA, MD, NH, NJ, PA, RI and VT
  - www.dcsras.com

- Region B: CGI Technologies and Solutions, Inc.
  - Working in KY, IL, IN, MI, MN, OH and WI
  - http://racb.cgi.com

- Region C: Connolly Consulting, Inc.
  - Working in AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, SC, TN, TX, VA and WV
  - www.connollyhealthcare.com/RAC

- Region D: HealthDataInsights, Inc.
  - Working in AK, AZ, CA, IA, ID, WA, WY, Guam, American Samoa and Northern Marianas

THE FOCUS OF CURRENT RAC AUDITS

SNF RAC Approved Issues

- Region B: SNF Consolidated Billing
  - States affected: MN, WI, MI, IL, OH and KY
  - Type of Review: Automated Overpayment
  - Description: Services are being billed separately that should be included in the Skilled Nursing Facility consolidated billing. Consolidated billing is when services provided during the resident’s stay in a skilled nursing facility (SNF) are bundled into one package and billed by the SNF. Under the consolidated billing requirement, a Skilled Nursing Facility itself must submit all Medicare claims for the services that its residents receive (except for specifically excluded services).

THE FOCUS OF CURRENT RAC AUDITS

SNF RAC Approved Issues

- Region B RAC “test claims” of “ultra high” therapy scores
  - CMS must approve audit issues before the RACs may pursue them
  - RACs may audit a limited number of “test claims” in order to seek CMS approval of proposed issues
  - The record requests are the result of an OIG report criticizing the handling of Part A charges by SNFs and CMS rulemaking on Part A payments for FY 2013.
**THE FOCUS OF CURRENT RAC AUDITS**

**SNF RAC Approved Issues**

Region D: Skilled Nursing Facility (SNF) Medical Necessity:
SNF stays will be reviewed for documentation of covered services that are medically necessary and reasonable; States affected: All Region D states

Region A: CT Scans, Head and Neck, Incorrect Billing:
Potential incorrect billing of CT scans not supported by medical necessity (NGS LCD 285616); State affected: NY

Region A: CT Scans, Trunk and Extremities, Incorrect Billing:
Potential incorrect billing of CT scans not supported by medical necessity (NGS LCD 28516); State affected: NY

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**Medicaid RACs**

- **January 1, 2012**: States required to have implemented their Medicaid RAC programs
- CMS will not issue oversight provisions regarding medical necessity reviews for the Medicaid RAC program.
- Medicaid RAC medical necessity reviews will be performed within the scope of state laws and regulations.
- The Medicaid RAC Final Rule does not require Medicaid RACs to receive prior approval for medical necessity reviews.

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**Medicaid Integrity Contractors**

- Section 6034(e)(3) of the Deficit Reduction Act 2005 mandated the creation of the Medicaid Integrity Program (MIP)
  - Under MIP, CMS hires contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers on Medicaid program integrity issues
  - CMS will support and assist the states in their efforts to combat Medicaid fraud and abuse
- MIP is operated under the jurisdiction of the Center for Medicaid & State Operations (CMSO)
Medicaid Integrity Contractors

- Review MICs
- Audit MICs
  - 30 days to provide records
  - All audit findings must be supported by adequate documentation

Medicaid Integrity Contractors

- MIC Fraud Referrals
  - If an Audit MIC identifies potential Medicare or Medicaid fraud, it must simultaneously and immediately make a fraud referral to the Medicaid Integrity Group (MIG) or the Office of Inspector General for the Department of Health and Human Services (OIG). *Medicaid Program Integrity Manual, 100-15, Ch. 10, § 10020.*
  - The OIG has 60 days to determine whether to accept the referral.

Compliance Policies on Government/Third Party Payor Investigations

- It is important for skilled nursing facilities to have a policy on cooperation and coordination with government investigations.
- If an employee receives any inquiry, subpoena or other legal document relating to the employer’s business:
  - Notify the Compliance Officer immediately.
    - The Compliance Officer should contact legal counsel.
    - Do not provide false or inaccurate information to a government investigator.
Compliance Policy on Government/Third Party Payor Investigations

• Initial contact with a government investigator:
  – Obtain information specified in compliance program

• On-Site Inquiries
  – Obtain “initial contact” information
  – Contact Compliance Officer
  – Draft memorandum regarding information obtained from the investigator and provide to Compliance Officer

Compliance Policy on Government/Third Party Payor Investigations

• Search Warrants
  – Contact Compliance Officer immediately
  – Compliance Officer will immediately contact legal counsel

• Employees speaking with government investigators:
  – Cannot be prohibited from speaking with government investigators
  – May politely decline to speak with investigators
  – May request legal counsel to be present during an interview

OIG Compliance Program Guidance for Skilled Nursing Facilities

• Components of an Effective Compliance Program:
  – Written policies, procedures and standards of conduct
  – Designated compliance officer
  – Effective training and education
  – Effective lines of communication
  – Enforcement of standards through well-publicized disciplinary guidelines
  – Internal monitoring and auditing
  – Prompt responses to detected offenses and corrective action.
Identified Audit Risk Areas for SNFs

- Billing inaccurate RUG levels
- Consolidated Billing (Region B RAC)
- Lack of documentation to support skilled services
- Illegible signatures on orders and elsewhere in the medical record

RECENT DEVELOPMENTS in the Audit Landscape

• In August 2012, the American Health Care Association’s efforts to persuade CMS to suspend ZPIC prepayment reviews of long term care providers in Florida were successful.
• ZPIC reviews in Florida, for a time, will be conducted on a post payment review basis.
• The cry for action by CMS was the result of the extremely aggressive nature of the ZPIC audits of long term care providers in Florida.

RECENT DEVELOPMENTS in the Audit Landscape

Reporting and Returning Overpayments

• February 16, 2012 CMS Published a Proposed Rule proposing:
  – A ten year look back period for all Medicare claims (as opposed to the current four year look back period) (Proposed 42 C.F.R. 405.980(b))
  – Definition: overpayment is “identified” - the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment. (Proposed 42 C.F.R. 401.305(a)(2))
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

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.

Key Considerations:
- Full and early presentation of evidence requirement
- Submission of additional evidence, 14 day extension of time period for decision
- Reviewer credentials
SUCCESSFUL APPEAL 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

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

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 CFR § 405.1020)
- Two Options for Participation:
  - Party
  - Non-Party Participant (more common)
- As non-party participants contractors may not:
  - Call witnesses
  - Cross-examine a provider's witnesses
  - Be called by the provider as a witness
- As non-party participants contractors 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 CFR § 405.1010(b))

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Medicare Appeals Council (MAC)
- A provider dissatisfied with the ALJ decision has 60 days to file an appeal to the Medicare Appeals Council (MAC)
- Use of past Medicare Appeals Council cases:
  - http://www.hhs.gov/dab/macdecision/

Example: In the Case of Jackson Healthcare, March 26, 2012
- The Council concluded that the ALJ erred in initially requiring a physician's certification of the initial plans of care for therapy services as a condition of coverage. The initial inquiry before the ALJ was not the written certification, but whether therapy services provided were skilled services.
SUCCESSFUL APPEAL 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
  - 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
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.
  • 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 APPEAL 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 APPEAL 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
HANDLING OF PART A AUDITS IN SKILLED NURSING

- Disputes over documentation supporting MDS scores and RUGs levels
- Defense of existing scores/“fall back” position of lower scores
- Impact of O’Connor Hospital case on Part A claims
  - Lower RUG levels
  - Part B therapy as “fall back” alternative for Part A claims
  - Adjustment billing based on “administrative finality”

Questions?

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