

Love Letters to and from CMS: Responding to Audits and Overpayments and Making Voluntary Refunds

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& BYRON, P.A.





You Have Mail

- Request for records:
 - MAC
 - PSC, ZPIC, BISC
 - RAC
 - Medicaid
 - Private insurance
 - CERT
 - Subpoena
- Revalidation.
- On-site surveyors (especially DME).

You Have Mail

- Revocation of billing privileges, closing a PTAN.
- PEPPER reports.
- Aberration notices/please do a self-audit.
- PSAVE.
- “Questionnaires,” possibly with a certification.

Take a Letter, Maria....(Or Signed Sealed Delivered, I'm Yours)

- 855 enrollment forms.
- Voluntary Disclosures (at the end of our session).

Case 1

- Physician sees primarily non-verbal patients in ICF/MRs.
- He gathers information from the nursing station, prescribes drugs and orders treatment.
- MAC audits, denies visits entirely.
- Also downcodes E&M encounters.

Case 2: You Can't Make This Up

- New Mexico oncologist hadn't signed his charts.
- Contractors audits. Leaves with original charts.
- Denies all unsigned charts: How do we know the service was provided?

Case 3

- Multi-state IDTF with scans ordered by NPPs.
- Contractor says only physicians can order portable x-rays, relying on a rule from the 1960s.
- Contractor handles each claim as an appeal.

Would This Hit Your Radar?



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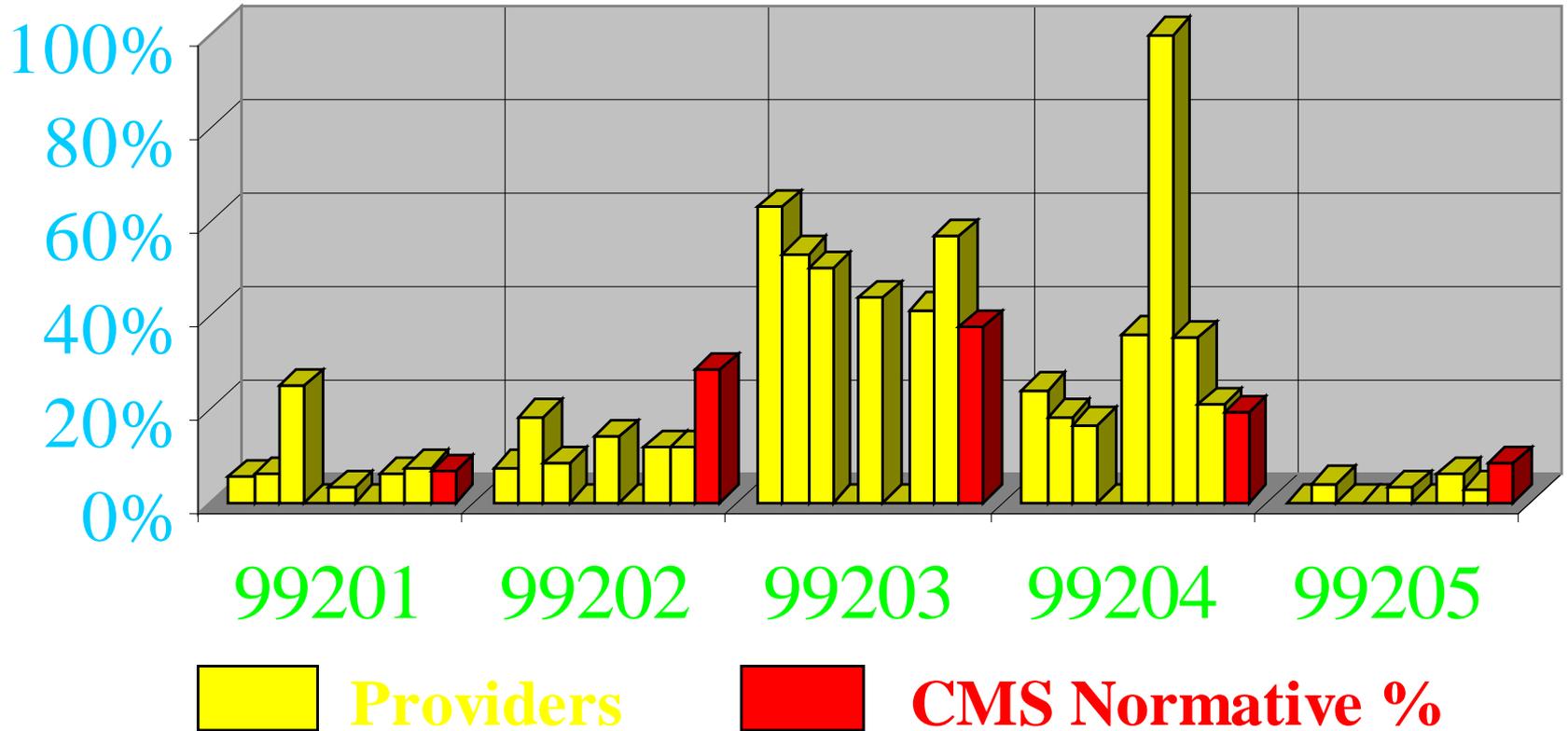
What Can You Do to Prevent an Audit?

- A trick question.
- Get an “Anomalies Happen” bumper sticker.
- Goal: Know that you can defend yourself if you are audited.
- Means: Investigate like an auditor.

What Do You Look for Before an Audit?

- Documentation.
- Code distribution patterns.
 - Variation from the norm.
 - Changes.
- Total Production.
- Bundling.
- Nervous employees: get quarterly certifications!
- Credit Balances.
- RAC issues list.
- OIG Workplan.

ABC COMPANY
Comparison to CMS Norms - New Patient Office Visits
Variance by Specialty - Family Practice

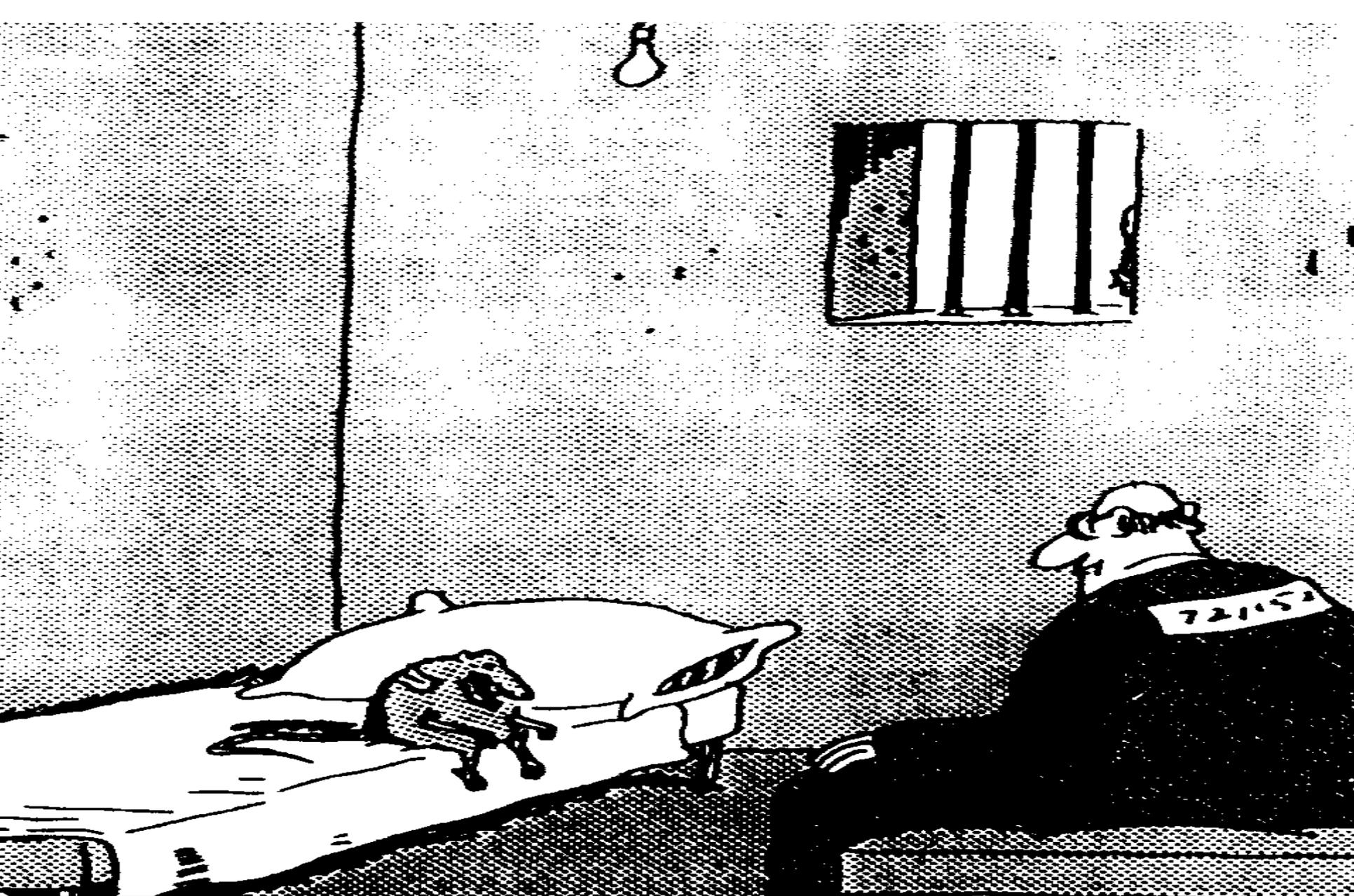


What's Under the Surface?



Even Before the Letter Arrives . . .

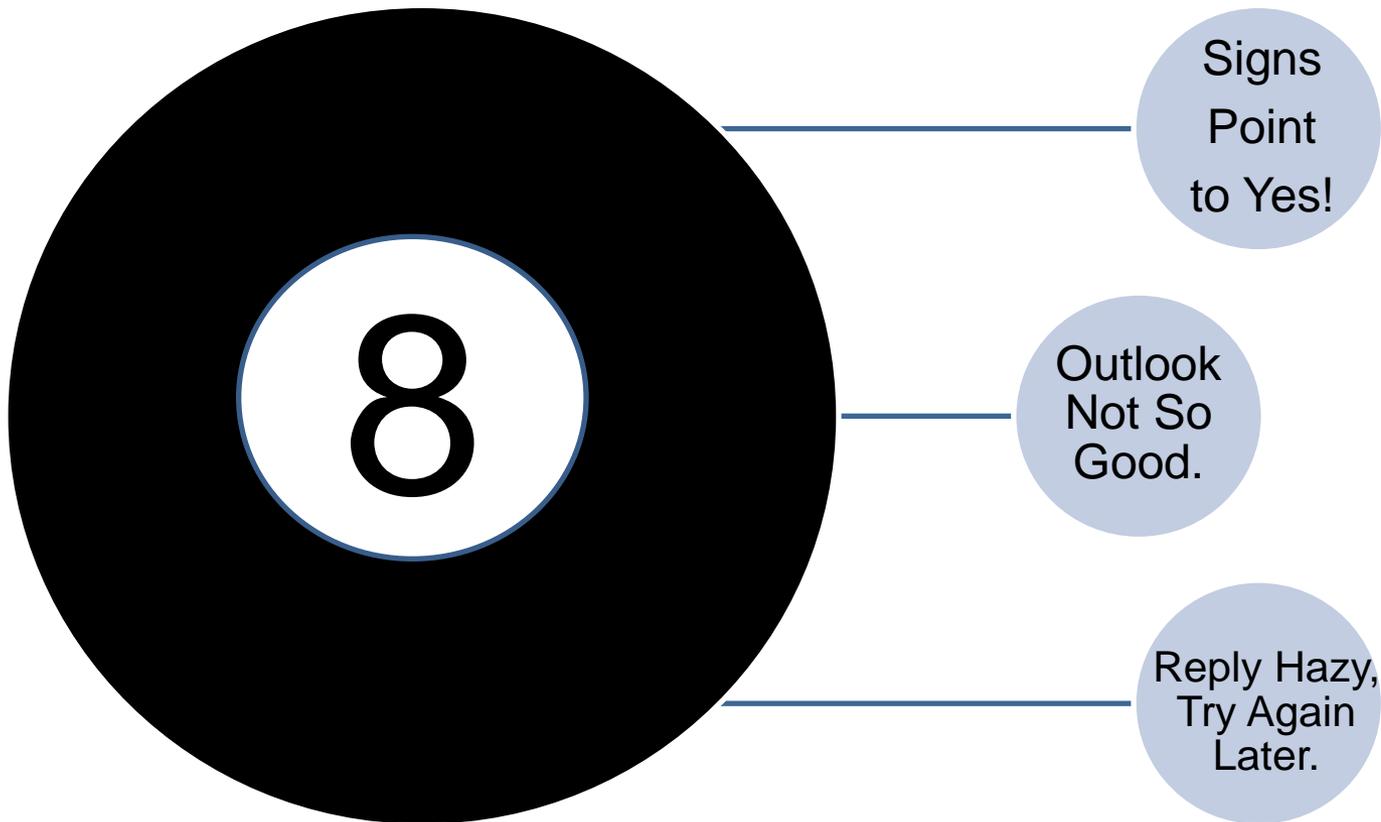
- Educate your staff about directing letters from the government to the correct person in your organization.
- Have a process for opening practitioners' mail.
- Staff should understand that appeals are time sensitive.
- Date stamping.
- Calendar deadlines.
- Envelopes. (Be a packrat!!)



“I would have gotten away scot free if I had just gotten rid of the evidence. ... But, shoot - I’m a packrat.”

How Do You Decide Whether to Appeal?

Keep Calm and Consult Your Magic 8 Ball?



How Do You Decide Whether to Appeal?

- What is the right cost-benefit analysis?
- Is failure to appeal held against you?
- Can you “teach” them by appealing?
- Does appealing put you on their radar?
Does failure to appeal?

Using Counsel

- Start early. Strategy matters.
- Use someone who knows the ropes.
- Using counsel doesn't mean you can't do much of the leg work.
- Create an assembly line. Use a team.
- Understand how privilege works

What is Privileged?

- Attorney-client privilege:
 - Oral and written communications.
 - Communications from the client as well as advice from the attorney and retained agents.
 - Key issue: whether the communication was in furtherance of obtaining legal advice?
- Work product privilege:
 - Materials prepared or assembled at the direction of counsel.
 - Must be in anticipation of potential litigation.

Hiring Consultants

- Consider using work product privilege.
- Discuss the consultant's role; is s/he an advocate or a cop?
- Get references. There are some horror stories.

Initial Determination

- The letter notifying you of an overpayment decision is an “initial determination” that you may appeal.
- Appeal levels:
 - Level 1: Redetermination
 - Level 2: Reconsideration
 - Level 3: Administrative Law Judge
 - Level 4: Medicare Appeals Council
 - Level 5: District Court

Level 1: Redetermination

- You have 120 days from receipt of the initial determination to submit a request for “redetermination.”
 - BUT, to stop recoupment, you must submit the appeal within 30 days after receipt.
- “Receipt” is presumed to be 5 days after the letter date.

Who is Responsible for the Appeal?

- Identify your appeals team.
- Involve a physician early.
 - Treating physician versus reviewing physician?
 - Think ahead to who will testify at the ALJ hearing. Capture the argument early.

Gathering the Record

- Inside versus outside records.
- Defining the relevant time frame.
- The importance of pagination.
- Make (and keep!!) an exact copy.
- Thorough review by the physician.

Presentation of Your Arguments

- What is the best format to present your case?
 - Always include a cover letter.
 - Consider the use of tables or spreadsheets for claim-by-claim arguments.
 - Exhibit books.
 - Bottom line: make it easy for the reviewer to see your arguments and evidence.

Writing the Appeal Letter

- The goal: write one good appeal letter to use at all levels:
 - Redetermination.
 - Reconsideration.
 - Administrative law judge.

Writing the Appeal Letter

- Make it terse.
- Frame the argument using authority (regulation, manual). Don't let the auditor control this!
- Use plain language.
- Include only facts relevant for the standard.

Required Contents of Appeal

- The request **MUST** include:
 - Beneficiary name;
 - Beneficiary Medicare health insurance claim number;
 - Item(s)/service(s) underlying appeal;.
 - Date(s) of service; and
 - Name and signature of party or representative.
- Appointment of Representative form.

Sending the Letter

- Use the address provided in the initial determination.
- Copy the right parties. (Beneficiary!!?)
- Use tracking.
- Call to confirm receipt?

Other Process Issues

- RAC Rebuttal Process.
- Requesting time extensions.
 - Only rare circumstances.
 - Do NOT rely on this.
- Pay outstanding amount? Issues associated with interest.

Level 2: Reconsideration

- You have 180 days from receipt of the redetermination to submit a request for “reconsideration.”
 - BUT, to stop recoupment, you must submit the request within 60 days after receipt.

Level 2: Reconsideration

- This is the last stage to submit new evidence, unless you can show “good cause” to the ALJ.
 - Don’t count on winning a “good cause” argument.
 - What is “new” evidence? Statistics? Testimony?
- The requirements for redetermination request apply to reconsideration.

Stats, Stat?

- Sampling cases present a dilemma.
- Winning on sampling may make an appeal more likely.
- Good statisticians are hard to find/ often expensive.
- MACs statistical “effort” is often laughable.

Sampling Issues

- Sampling unit (claim/patient/line item).
 - Is “paid claims” a fair sample?
- Size.
- Simple versus stratified.
 - Variability.
 - Footballs and fish.
- Precision (.1 vs. .25 vs. .6).
- Confidence intervals.





Level 3: Administrative Law Judge

- 60 days after receipt of the reconsideration to request an ALJ hearing.
- CMS may resume recoupment.
- Amount in controversy requirements.
- Moratorium/litigation.

Level 3: Administrative Law Judge

- What type of review are you requesting?
 - On the record?
 - Telephone, video or in-person?
- Will you call witnesses?

Preparing for the Hearing

- Prepping witnesses
 - Legal standard.
 - Effusive or terse?
 - Cross examination.
 - Is CMS a party?
- Exhibits.

MAC/District Court

- Better if you don't go there.
- MAC: usually on the record; often remands.
- District court: expensive.

Challenging Documentation Denials

- “If it isn’t written, it wasn’t done,” isn’t the law.
- Medicare payment is determined by the content of the service, not the content of the medical record.
- The documentation guidelines are just that: guidelines (although the Medicare contractor won’t believe that).

Role of Documentation: The Law

“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 or other person under this part for the period with respect to which the amounts are being paid or for any prior period.”

- *Social Security Act § 1833(e)*

Role of Documentation: Guidance from CPT and CMS

- The CPT Assistant explains: “it is important to note that these are *Guidelines*, not a law or rule. Physicians need not modify their record keeping practices at all.”
 - *CPT Assistant Vol. 5, Issue 1, Winter 1995*
- Then HCFA, now CMS publicly stated that physicians are not required to use the Documentation Guidelines.

Role of Documentation: Guidance from CMS/HCFA

“Documentation Guidelines for Evaluation and Management Services Questions and Answers

These questions and answers have been jointly developed by the Health Care Financing Administration (CMS/HCFA) and the American Medical Association (AMA) March 1995.

1. Are these guidelines required?

No. Physicians are not required to use these guidelines in documenting their services.

Guidance from CMS/HCFA

However, it is important to note that all physicians are potentially subject to post payment review. **In the event of a review, Medicare carriers will be using these guidelines in helping them to determine/verify that the reported services were actually rendered.** Physicians may find the format of the new guidelines convenient to follow and consistent with their current medical record keeping. Their usage will help facilitate communication with the carrier about the services provided, if that becomes necessary. Varying formats of documentation (e.g. SOAP notes) will be accepted by the Medicare carrier, as long as the basic information is discernible.”

Role Guidance from CMS/HCFA

“6. How will the guidelines be utilized if I am reviewed by the carrier?”

If an evaluation and management review is indicated, Carriers will request medical records for specific patients and encounters. The documentation guidelines will be used as a template for that review. If the documentation is not sufficient to support the level of service provided, the Carrier will contact the physician for additional information.”

How Do We Demonstrate a Service was Performed?

- Ask.
 - The physicians.
 - Others (nurses, receptionists).
 - Secret shopper/shadowing.
- Schedules/time based billing.
- Production data.

Short Stays: Pre 10/1/13 Guidance

Medicare Benefit Policy Manual
(CMS Pub. 100-02)

§ 10 - Covered Inpatient Hospital Services Covered
Under Part A

- An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. **Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.**

Pre 10/1/13 Guidance

- The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24 hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

Pre 10/1/13 Guidance

- Factors to be considered when making the decision to admit include such things as:
- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Pre 10/1/13 Guidance

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

Minor Surgery or Other Treatment - When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

Things to Note

- Expectation-based.
- The idea of intensity of service/severity of illness is absent.
- No reference to InterQual/Milliman or others. Were you sold a bill of goods??
- **WHAT HAPPENS DURING THE STAY DOESN'T REALLY MATTER!**
- The 2 midnight rule is similar.

Appeals

- You can still appeal (and should) denials of short stays with admission dates prior to 10/1/13.
- In fact, the new rule supports appeals of pre-10/1/13 admissions where the physician expected the patient to stay overnight or 24 hours.
- We are getting close to being able to make the “without fault” argument for admission dates prior to 10/1/13.

Medical Necessity Denials

- Use the “treating physician rule.”
- The theory is that the patient’s physician is objective. Therefore, the physician’s opinion receives deference.
- Medicare’s legislative history supports this argument.

The “Treating Physician Rule.”

“It is a well-settled rule in Social Security Disability cases that the expert medical opinion of a patient’s treating physician is to be accorded deference by the secretary and is binding unless contradicted by substantial evidence... This rule may well apply with even greater force in the context of Medicare reimbursement. The legislative history of the Medicare Statute makes clear the essential role of the attending physician in the statutory scheme; ‘the physician is to be the key figure in determining utilization of health services.’” Gartmann v. Secretary of the U.S. Department of HHS, 633 F.Supp. 671, 680-681 (E.D. N.Y. 1986).

The “Treating Physician Rule.”

A carrier is expected to place “significant reliance on the informed opinion of the treating physician” and to give “extra weight” to the treating physician’s opinion. Baxter v. Sullivan, 923 F.2d 1391, 1396 (9th Cir. 1991).

The “Treating Physician Rule.”

- CPM Ch. 30, § 100.2 forbids carriers from recouping an overpayment on the basis of a lack of medical necessity if a situation is ambiguous enough that the carrier requests its own physician consultant to review whether the services are covered.
- This should place the burden of proof on a carrier during an appeal.
- It provides a firm ground for challenging the carrier’s arguments that office visits can be denied as not medically necessary.

Manuals/Guidance Can't Limit Coverage

- 42 USC § 1395hh(a)(1) says nothing other than an NCD may change benefits unless promulgated as a regulation.
- The Rachel Brand memo from January 25, 2018.



U. S. Department of Justice

Office of the Associate Attorney General

The Associate Attorney General

Washington, D.C. 20530

January 25, 2018

MEMORANDUM FOR: HEADS OF CIVIL LITIGATING COMPONENTS
UNITED STATES ATTORNEYS

CC: REGULATORY REFORM TASK FORCE

FROM: THE ASSOCIATE ATTORNEY GENERAL

A handwritten signature in blue ink, appearing to be "RUB", is written over the text "THE ASSOCIATE ATTORNEY GENERAL".

SUBJECT: Limiting Use of Agency Guidance Documents
In Affirmative Civil Enforcement Cases

On November 16, 2017, the Attorney General issued a memorandum (“Guidance Policy”) prohibiting Department components from issuing guidance documents that effectively bind the public without undergoing the notice-and-comment rulemaking process. Under the Guidance Policy, the Department may not issue guidance documents that purport to create rights or obligations binding on persons or entities outside the Executive Branch (including state, local, and tribal governments), or to create binding standards by which the Department will determine compliance with existing statutory or regulatory requirements.

The Guidance Policy also prohibits the Department from using its guidance documents to coerce regulated parties into taking any action or refraining from taking any action beyond what is required by the terms of the applicable statute or lawful regulation. And when the Department issues a guidance document setting out voluntary standards, the Guidance Policy requires a clear statement that noncompliance will not in itself result in any enforcement action.

Manuals/Guidance Can't Limit Coverage

- “Thus, if government manuals go counter to governing statutes and regulations of the highest or higher dignity, a person ‘relies on them at his peril.’ ” Government Brief in Saint Mary’s Hospital v. Leavitt.
- “[The Manual] embodies a policy that itself is not even binding in agency adjudications.... Manual provisions concerning investigational devices also ‘do not have the force and effect of law and are not accorded that weight in the adjudicatory process.’ ” Gov’t brief in Cedars-Sinai Medical Center v. Shalala.

Case 4

- CERT requests records.
- CERT finds overpayment based on an LCD requirement.
- CERT education to contractors includes LCD requirement.
- No such requirement in statute, regulation, NCD, or even manual!

Time Limits On Recovery

- Statutory limits:
 - 1870 (note recent change).
 - 1879.

How does § 1870 work?

- Focus only on the YEAR payment is made.
- Payment made 1/4/13. Can recover 5 years after 2013, so count: 2014, 15, 16, 17, 18. Recovery possible through 12/31/18.
- Payment made 12/31/12. If new provision applies, 2013, 14, 15, 16, 17. Recovery until 12/31/17.
- Note that references to “five years” are very misleading. Simplicity trumps accuracy.

Time Limits On Recovery

- Regulations.
 - Any reason w/in 1 year of determination.
 - Good cause w/in 4 years of determination.
 - Anytime for fraud/similar fault.
- Manuals.

42 C.F.R. § 405.980

(b) A contractor may reopen an initial determination or redetermination on its own motion—

(1) Within 1 year from the date of the initial determination or redetermination for any reason.

(2) **Within 4 years from the date of the initial determination or redetermination for good cause as defined in § 405.986.**

(3) **At any time if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault as defined in § 405.902.**

42 C.F.R. § 405.902

“Similar fault” means “to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled. This includes, but is not limited to, a failure to demonstrate that he or she filed a proper claim”

42 CFR § 411.21 defines a “proper claim” as a “claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or Insurer.”

Time Limit on RACs

- A whole different ballgame. Governed by a different statute and a statement of work.
- Statute is four FISCAL years (10/1) after the year of payment.
- Statement of work is three years. (Three years from the date of payment.)
- Statement of work should carry the day.

If You Are Entitled to Keep the Money...

- “*Overpayment* means any funds that a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title.”

- 42 CFR 401.303

- If the contractor can't reopen the claim, doesn't that mean you are entitled to keep the money?

CMS Disagrees

- “*Comment:* Commenters questioned whether they had a responsibility to go back beyond the 3 years covered in a Recovery Audit Contractor (RAC) audit that identifies overpayments.
- *Response:* Yes, as discussed previously, this final rule clarifies that when the provider or supplier receives credible information of a potential overpayment, they need to conduct reasonable diligence to determine whether they have received an overpayment.

CMS Disagrees

- RAC audit findings, as well as other Medicare contractor and OIG audit findings, are credible information of at least a potential overpayment. Providers and suppliers need to review the audit findings and determine whether they have received an overpayment. As part of this review, providers and suppliers need to determine whether they have received overpayments going back 6 years as stated in this rule. - *81 FR 7672*

Six years from when?

- Remember “identify” includes quantification.
- The six years runs from the date the overpayment is quantified not from the first suspicion of an overpayment.
- Operationally, this may be challenging.

Bottom Line

- The government thinks you must go back six years from when you quantified the overpayment. (Even if the contractor doesn't go back as far!)
- We think they lack the statutory authority for this.
- You must choose the route you are comfortable with.

Self-Disclosure Options

- Contractor refund.
- CMS Self-Referral Disclosure Protocol (Stark).
- OIG Self Disclosure Protocol (Fraud).
- State Medicaid agencies.
- DOJ.
- Why pay a multiplier in a refund?

The Refund Letter

- Do you ever send a “placeholder” letter?
- Who is it from?
- Who is it to?
- How much detail do you provide?
- What about small issues where cost of investigation exceeds overpayment?
- What don't you say?

Dr. C's Letter

- We **recently** discovered that one of our physicians **was committing billing fraud**. She was **not documenting services properly**. We **inadvertently billed for these services**. We did **a statistically valid sample**. We **have corrected the problem**.

The Refund Letter

- “As part of our ongoing compliance process.”
- “More appropriate” is a great phrase.
- “Possible issues.”
- Reserve the right to recant.
- “Level we are confident defending...”
- Beware of “our attorney has told us”
- “Refund” vs. “overpayment.”
- “Steps to improve....”

What Do You Do with Copayments?

- Law is less clear.
- Size matters. (Would you bill the patient if they owed you the same amount?)
- State law.

Do You Rebill or Refund?

- Rebilling generates timely filing issues.
- Refunding leaves bad claims data in the insurer's system.
- For private payors, beware of your contract.
- Refund is the way to go.

How Do Refunds Affect RACs?

- If you have sampled, no one claim has been “refunded.”
- This will be something to watch.
- Note this is an issue even if the audit is on a different problem.
- In any overpayment situation, always look at prior refunds/audits on the same issue.
- (Note tie-in to rebill/refund issue!)

What About Private Payors?

- Contract (and manual??) control.
- Refund requirement is gov. only, but “health fraud” is a federal crime.
- State statute of limitations apply.
- State insurance law.
- Is Medicare Advantage a private payor?

Questions?



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