Overview

- Current Enforcement Environment
- Contractor Landscape
- Responding to Audits
- Appealing Unfavorable Audit Results
- Responding to the Use of Statistical Sampling
Current Enforcement Environment

- Increased fraud enforcement
- Predictive modeling to target outliers and data anomalies
- Increased cooperation of public and private payors
- Move toward proactive enforcement
  - Prepayment audits
  - Payment suspensions
  - Provider exclusions and revocations
Current Enforcement Environment

• Continued use of private contractors for claims review and benefit integrity
• Medicare Contractors
  – Recovery Audit Contractors (RACs)
  – Medicare Administrative Contractors (MACs)
  – Zone Program Integrity Contractors (ZPICs)
  – Unified Program Integrity Contractors (UPICs)
• Medicaid Contractors
  – Recovery Audit Contractors (M-RACs)
  – Medicaid Integrity Contractors (MICs)
RACs

Claims Review

• Review claims on post-payment basis based upon approved audit issues
  – Automated reviews
  – Complex reviews
• Uses same Medicare policies as MACs including LCDs, NCDs and Medicare Manuals
• Areas of focus chosen based on data mining techniques, OIG / GAO reports, CERT reports, and experience and knowledge of staff

<table>
<thead>
<tr>
<th>Medicaid RACs</th>
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<tr>
<td>• Contracts with state Medicaid agency</td>
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<td>• Typically paid on contingency</td>
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<td>• Must have a licensed medical director and certified coders</td>
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<td>• States determine record limits, medical necessity reviews and extrapolation</td>
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<td>• National 3 year look-back</td>
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<th>RAC-Like Auditors</th>
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<tr>
<td>• Medicare Advantage and commercial insurance doing RAC-like audits</td>
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<td>• 20% Medicare beneficiaries enrolled in Medicare Part C</td>
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<td>• Medicare Advantage plans have different appeals processes</td>
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Prepayment Demonstration Project

• Currently in process
• States subject to review
  – Fraud and error-prone states (FL, CA, MI, TX, NY, LA, IL)
  – States with high volumes of inpatient stays (PA, OH, NC, MI)
• Focus on claims with high improper payment rates

Prepayment Demonstration Project

• Record request issued by MAC
• Record response due within 30 days
• Results sent to providers by RACs within 45 days
• No discussion period but providers have appeal rights
Current Status

- Procurement process for award of new RAC contracts
- Appeals developments
- Grassroots and legal efforts for reform

MACs
MACs Are . . .

- Responsible for:
  - Provider enrollment
  - Processing claims
  - Auditing providers
- Authorized to make Local Coverage Determinations (LCD)
  42 USC 1395kk-1(a)(4)
- Re-bid every five (5) years
  42 USC 1395kk-1(b)(1)(B)

MAC Audits

- Conducting data analysis comparing providers to peers
- Outliers receiving audit requests
- High error rates can result in:
  - Prepayment reviews
  - Postpayment audits
  - Payment suspensions
Zone Program Integrity Contractors (ZPICs)

- Consolidation of PSCs and MEDICs
- Coordination of claims processing and benefit integrity activities
- Ensure integrity of ALL Medicare-related claims
  - Parts A, B, C, D, Home Health, DME, Hospice and coordination of Medi-Medi data matches
- Use “innovative data analysis methodologies” for early fraud detection and prevention

Source: Chapter 4 – Benefit Integrity; Medicare Program Integrity Manual; available at: http://www.cms.gov/manuals/downloads/pim83c04.pdf
ZPIC Responsibilities

- Fraud case development
- Fraud complaint processing
- Provider education related to fraud investigations
- Ability to initiate payment suspensions and provider exclusions

Source: Chapter 4 – Benefit Integrity; Medicare Program Integrity Manual; available at: http://www.cms.gov/manuals/downloads/pim83c04.pdf

ZPIC Audits

- Unannounced or limited notice
- Review of claims
  - Prepayment or post payment
    - Potential for payment suspension
  - Probe sample or statistical sampling and extrapolation
- Employee or beneficiary interviews
- Requests for self audits

Source: Chapter 4 – Benefit Integrity; Medicare Program Integrity Manual; available at: http://www.cms.gov/manuals/downloads/pim83c04.pdf
ZPIC Triggers

- Aberrant patterns
  - Statistical deviations from the norm
  - Changes in facility’s historical patterns
  - High utilization (e.g., RU/RV therapy)
  - High cost services or items

Audit Results

- Referral to law enforcement
- Forward findings to MAC for overpayment recoupment action
- Provider education

Source: Chapter 4 – Benefit Integrity; Medicare Program Integrity Manual; available at: http://www.cms.gov/manuals/downloads/pim83c04.pdf
Current MIC Audit Targets

Physicians/Practitioners | DME
Home Health/ | Transportation/
Skilled Nursing | Ambulance
Hospice | Lab/X-ray
Hospital | Pharmacy
Nursing Facility | Renal Dialysis
How Are Providers Selected For Audit?

• MICs select based on data analysis by other CMS contractors and/or referrals from state agencies
• Efforts to ensure that MIC audits do not duplicate state MA audits or interfere with potential law enforcement investigations
• *No MIC audit is “random”*

What Are the MICs Looking For?

• Did Medicaid pay for a “covered service?”
• Was the service actually provided?
• Was the service properly billed?
• Was the service properly documented?
• Was the service reimbursed appropriately according to state policies, rules and regulations?
UPICs

UPIC Objectives

- Implement a “holistic and coordinated Medicare/Medicaid program integrity strategy”
- Strengthen CMS’ national oversight of contractor work
- Consolidate integrity audits now being done by MACs and ZPICs
- Create a more seamless and “rigorous” program integrity strategy
UPIC Activities

- Extensive use of sophisticated analytics
- Standardized system for case management
- Facilitation of exchange of information between the public and private sectors
- Expected outcomes
  - Administrative sanctions
  - Prepayment reviews
  - Referrals to law enforcement

UPIC Activities

- Identify and prioritize leads
- Data analysis and management of leads
- Conduct investigations
- Protect program dollars
- Identify Medicare and Medicaid overpayments
- Provide support to CMS, law enforcement, and administrative appeals process
Responding to Audits

Preparation Before Audits

• Implement effective compliance program.
  – Understand billing requirements.
  – Develop policies and procedures related to billing requirements.
  – Train staff on policies and procedures.
Internal Audits and Monitoring

• Conduct periodic internal audits
• Review denied claims for legitimacy, rebuttal or appeal—root cause analyses
• Identify and fix any internal control or procedural deficiencies
• Refile corrected claims where appropriate
• Consult with counsel as necessary
• **Remember the 60 Day Repayment Rule**

Responding to Audits

• Provide **complete** documentation
  – Review of records before submission
  – Potential supplementation of records
• Don’t rush the process BUT meet deadlines
• Don’t sign statements certifying completeness of records until confirming that all documents have been provided
• Retain or request a copy of all documents provided to contractor
Appealing Unfavorable Audit Results

Medicare Appeal Process

- Redetermination from the MAC
- Reconsideration from a Qualified Independent Contractor
- Appeal to an Administrative Law Judge
- Appeal to the Medicare Departmental Appeals Board
- Appeal to a federal district court

Source: 42 C.F.R. Part 405, Subpart I
Medicaid Appeal Process

- Generally governed by State law
- Certain Medicaid appeals governed by Federal regulations
  - Medicaid RACs
  - Nursing facilities and intermediate care facilities for individuals with intellectual disabilities

Tips for Appeals

- Develop multi-disciplinary appeals team
- Establish tracking system to ensure timely appeals
- Review EVERY claim for possible appeal at EVERY level
  - Procedural – Did the contractor follow rules?
  - Substantive – Was claim medically necessary?
Tips for Appeals

• Consider Legal Defenses
  – Provider Without Fault (SSA Section 1870)
  – Waiver of Liability (SSA Section 1879(a))
  – Treating Physician’s Rule
  – Reopening Regulations
  – Constitutional Challenges

Tips for Appeals

• When submitting appeal:
  – Obtain internal and external reviews (medical, coding, statistical) as appropriate
  – Develop position paper with supporting medical records and expert opinions
Beware of Recoupment

• Medicare Recoupment
  – Redetermination
  – Reconsideration
  – Subsequent levels of appeal
• Medicaid Recoupment
  – Dictated by each State’s laws

Source: 42 C.F.R. Part 405, Subpart C

Responding to the Use of Statistical Sampling
Use of Statistical Sampling for Overpayment Estimation

- Medicare and Medicaid Audits
- OIG Self-disclosure Protocol
- OIG Compliance Audits
- Internal Compliance Audit
- Calculation of Damages in FCA Case?

Legal Basis for Statistical Sampling for Overpayment Estimation

“The use of statistical sampling to project an overpayment…does not deny a provider or supplier due process. Neither the statute nor regulations require that a case-by-case review be conducted in order to determine that a provider or supplier has been overpaid and to determine the amount of overpayment.”

HCFA Ruling 86-1
Legal Basis for Statistical Sampling for Overpayment Estimation

Statistical sampling does not violate due process “so long as extrapolation is made from a representative sample and is statistically significant.”


Performance of Statistical Sampling and Extrapolation

• A Medicare contractor may not use extrapolation to determine overpayment amounts…unless…
  – There is a sustained or high level of payment error; or
  – Documented educational intervention has failed to correct the payment error

42 U.S.C. § 1395ddd(f)(3)
Performance of Statistical Sampling and Extrapolation

• Sustained or high level of payment error can be determined by:
  – Error rate determined by MR unit, ZPIC
  – Probe samples
  – Data analysis
  – Provider/supplier history
  – Information from law enforcement investigations
  – Allegations of wrongdoing by current or former employees of provider or supplier
  – Audits or evaluations conducted by the OIG

Source: Chapter 8 – Benefit Integrity; Medicare Program Integrity Manual; available at:

Performance of Statistical Sampling and Extrapolation

• Major Steps
  – Selecting the provider or supplier
  – Selecting the period to be reviewed
  – Defining the universe, the sampling unit, and the sampling frame

Source: Chapter 8 – Benefit Integrity; Medicare Program Integrity Manual; available at:
Performance of Statistical Sampling and Extrapolation

- Major Steps (cont.)
  - Designing the sampling plan and selecting the sample
  - Reviewing each of the sampling units and determining if there was an overpayment or under payment
  - Estimating the overpayment

Source: Chapter 8 – Benefit Integrity; Medicare Program Integrity Manual; available at: http://www.cms.gov/manuals/downloads/pim83c08.pdf

Defending Against Extrapolation Results

- No administration or judicial review of determination of high level of payment error BUT determination must be made
- Failure to follow one or more requirements in Benefit Integrity Manual does not necessarily affect validity
- Not sufficient to argue better or more precise methods are available
Defending Against Extrapolation Results

• Can challenge validity of sampling methodology based on “the actual statistical validity of the sample as drawn and conducted”
• Test: Was the sample statistically valid?

Defending Against Extrapolation Results

• Procedural Challenges
  – Did the contractor follow the guidelines?
    • Medicare: MPIM
    • Medicaid: State Requirements
  – Were allowed claims included in overpayment sample calculation?
  – Were calculations performed correctly in the audit and at each level of appeal?
Defending Against Extrapolation Results

• Substantive Challenges
  – Likely need a statistician
    • Where can you find one?
  – “One size does NOT fit all.”
  – It is not your job to explain how it should be done.

Defending Against Extrapolation Results

• Examples of Substantive Challenges
  – Is the sample representative?
  – Is the sample statistically significant?
    • Is the sample size reliable?
    • Is the sample within the required precision and confidence levels?
Defending Against Extrapolation
Results

• Obtain all documentation related to sampling calculations
  – Consider provider’s prior audit history
• Know appeal timelines and requirements for each level
• Understand reasons for denial at each level
• Present reasons in written protest or position paper
• Prepare for oral testimony at hearing

Questions

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