Behind the Battle Lines: Strategies for Defending against Medicare and Medicaid Contractor Claims Denials and Statistical Sampling and Extrapolation

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Overview

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

Current Enforcement Environment
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


Medicaid RACs

- Contracts with state Medicaid agency
- Typically paid on contingency
- Must have a licensed medical director and certified coders
- States determine record limits, medical necessity reviews and extrapolation
- National 3 year look-back
**RAC-Like Auditors**

- Medicare Advantage and commercial insurance doing RAC-like audits
- 20% Medicare beneficiaries enrolled in Medicare Part C
- Medicare Advantage plans have different appeals processes

**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

ZPICs

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

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

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

MICs

Current MIC Audit Targets

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<thead>
<tr>
<th>Physicians/Practitioners</th>
<th>DME</th>
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<tr>
<td>Home Health/</td>
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<tr>
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<td>Nursing Facility</td>
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| Transportation/          |     |
| Ambulance                |     |
| Lab/X-ray                |     |
| Pharmacy                 |     |
| 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

- 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

Medicare Appeal Process

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 underpayment
- Estimating the overpayment


### 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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