Advanced Audit & Facilitation Workshop for Part A and B Providers and Suppliers

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CMS Audit Contractors

- Medicare Administrative Contractors (MACs)
- Zone Program Integrity Contractors (ZPICs)
- Recovery Audit Contractors (RACs)
  - Medicare RACs & Medicaid RACs
- Office of Inspector General (OIG) audits
- Supplemental Medical Review Contractors (SMRCs)

Medicare Administrative Contractors (MACs)

- Primary operational contact between CMS and providers
- Regional jurisdiction
- Manage policy and payment related to reimbursement
- Local coverage determinations (LCDs)
- Perform Medical Review
- Identify and correct improper payments
- Recoupment of overpayments
- Provider outreach and education
Zone Program Integrity Contractors (ZPICs)
- Focus on detection & prevention of Medicare fraud
- Different from the Medical Review program, which is primarily concerned with preventing and identifying errors
- ZPICs request medical records and conduct medical review to evaluate the identified potential fraud
- Forward findings to MAC for overpayment recoupment actions
- Ability to initiate payment suspensions and provider exclusions
- ZPICs may also refer to the OIG and the Department of Justice (DOJ) for further investigation

Recovery Audit Contractors (RACs)
- The RACs mission is to identify and correct Medicare improper payments through detection and collection of overpayments made on claims of healthcare
- Paid on contingency fee basis
- Who are the RACs?
  - Region A: Performant Recovery
  - Region B: CGI Federal, Inc.
  - Region C: Connolly, Inc.
  - Region D: HealthDataInsights, Inc.

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.
Office of Inspector General (OIG) Audits

- Conducts criminal, civil and administrative investigations of fraud and abuse
- Individual provider audits
- Draft report and opportunity for response
- Final report published on OIG website
- Recommend overpayment recovery to CMS
- CMS directs the MAC to recoup overpayments

Supplemental Medical Review Contractor (SMRC)

- Strategic HealthSolutions, LLC
- Conducts nationwide medical review as directed by CMS
- Medical review performed on Part A, Part B, and DME providers and suppliers
- Focus of SMRC’s review may include, but is not limited to, vulnerabilities identified by:
  - CMS internal data analysis
  - Comprehensive Error Rate Testing (CERT) program
  - Professional organizations
  - Federal oversight agencies
- MACs initiate claim adjustments and/or overpayment recoupment actions

Types of Medicare Audits

- Post-payment reviews
  - Recoupment of overpayments
- Prepayment reviews/ADRs
  - Conducted prior to payment
- Probe reviews
  - Small sample size of claims
  - Pre or post payment review
- Statistically projected audit (extrapolation)
  - Statistical sampling is used to calculate and project (i.e., extrapolate) the amount of overpayment(s) made on claims.
  - Claims are reviewed from a statistical random sample, the results of which are then extrapolated to the universe of claims during a given time period to determine the overpayment amount.
ZPIC Audit Letter Examples

Example #1

AdvanceMed has determined it is likely that you have been overpaid for services provided from May 1, 2009 through the current date based on the review of the documentation submitted for medical review dated January 1, 2008 through April 30, 2009. . . AdvanceMed is requesting that [provider] conduct an internal audit to determine the accuracy of the claims billed. If research determines the claim/patient is incorrect, please process claim adjustments and arrange repayment with [the Medicare Administrative Contract].

Example #2

In addition to the claims that were identified by the medical review as paid in error, AdvanceMed is requesting a self audit of the remainder of claims for these beneficiaries as well as your total population of patients. . . The purpose of this audit is to identify any Medicare claims paid inappropriately. AdvanceMed would like to provide you with this opportunity to identify claims that were inappropriately billed and rectify these claims by submitting a voluntary refund to the Medicare program.

Medicare Appeals Process

• Rebuttal and Discussion Period
• Redetermination
  • Appeal deadline: 120 days (30 days to avoid recoupment)
  • Reconsideration
    • Appeal deadline: 180 days (60 days to avoid recoupment)
  • Full and early presentation of evidence requirement
• Administrative Law Judge Hearing
  • Appeal deadline: 60 days
  • CMS will recoup any alleged overpayment during this and following stages of appeal
• Medicare Appeals Council (MAC)
  • Appeal deadline: 60 days
• Federal District Court
  • Appeal deadline: 60 days

Medicare Appeals Process

ALJ Request Requirements (42 C.F.R 405.1014)
1. Beneficiary name, address and HICN
2. Name and address of appellant (if not beneficiary)
3. Name and address of designated representatives (if appropriate)
4. Medicare Appeal Number (assigned by QIC)
5. Date(s) of service
6. Reasons for disagreement with QIC’s decision
7. Statement of any additional evidence to be submitted and the date it will be submitted
Medicare Appeals Process

Best practices for ALJ appeals:
- Prominently list Medicare Appeal Number on your request
- Ensure beneficiary information matches Medicare Appeal Number
- List beneficiary’s full HICN
- Include first page of QIC decision or prominently list full name of QIC
- Document Proof of Service to other parties
- Do not submit courtesy copy to QIC
- Submit only one request per Medicare Appeal Number
- Mail request via tracked mail to OMHA Central Operations
- Do not submit evidence already submitted to lower level
- Do not attach evidentiary submissions or submit additional filings to OMHA Central Operations
- Wait until an ALJ is assigned and submit directly to ALJ

OMHA Case Processing Manual:
- Important resource for parties appealing to the ALJ level

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))

Audit Defense 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
    - CMS program manuals
    - National coverage determinations (NCDs)
    - Local coverage determinations (LCDs)
    - Summarize submitted medical records and documentation

Use of experts:
- Coding experts
- Medical experts
- Statisticians
Audit Defense Strategies

- Challenge to statistics
  - Cannot challenge the substance of the finding of "sustained or high rate of error," but can challenge whether a finding was made.
- Waiver of liability
  - 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.
- Provider without fault
  - 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.

Current Audit Appeals Landscape
Reforms & Initiatives

Audit Appeals Landscape

- As of February 2015, ALJ appeals had been pending for an average of 572 days.
- Office of Medicare Hearings and Appeals (OMHA) receives as many or more appeals every two months than it can process in a full year.
- "[F]igures suggest that at current rates, some already-filed claims could take a decade or more to resolve."
- OMHA workload – appeal receipts
  - 2015 – 240,373
  - 2014 – 474,065
  - 2013 – 364,151
  - 2009 – 40,831
Judicial Relief re: Appeals Backlog


- AHA sought a writ of mandamus compelling HHS to act within the specified appeal time frames.
  - “[A]ll shall conduct and conclude a hearing . . . and render a decision . . . by not later than the 90-day period beginning on the date a request for hearing has been timely filed” 42 U.S.C. § 1395ff(d)(1)(A).
- District court concluded mandamus relief was unwarranted.
- Reserved and remanded by United States Court of Appeals for the District of Columbia Circuit.
  - “[C]ommon sense suggests that lengthy payment delays will affect hospitals’ willingness and ability to provide care.”
  - Statute imposes a clear duty on HHS to comply with the statutory deadlines; statute gives AHA a corresponding right to demand compliance with the deadlines, and exclusion is an inadequate alternative remedy in the circumstances of this case.
  - “In the end, although courts must respect the political branches and hesitate to intrude on their resolution of conflicting priorities, our ultimate obligation is to enforce the law as Congress has written it. Given this, and given the unique circumstances of this case, the clarity of the statutory duty likely will require issuance of the writ if the political branches have failed to make meaningful progress within a reasonable period of time—say, the close of the next full appropriations cycle.”

Judicial Relief re: Appeals Backlog


- District court awarded Hospice Savannah a temporary restraining order (TRO) enjoining HHS from withholding, recouping, offsetting, or otherwise failing to pay any current Medicare receivables.
- Substantial likelihood of success on the merits based on a “questionable extrapolation.”
- Hospice Savannah will be irreparably harmed by being forced to close and being unable to provide ongoing care to current hospice patients who by definition are terminally ill and disabled.
- Little or no risk to HHS because, at worst, the TRO will only defer its ability to pursue collection efforts.
- Public has an interest in seeing that terminally ill patients continue to have access to Hospice Savannah’s services.

Legislative Relief re: Appeals Backlog

- Senate Bill 2368, Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015 (AFIRM)
  - Introduced in Senate on December 8, 2015.
  - Purpose: “Increase coordination and oversight of Medicare claims review contractors, implement new strategies to address the growing number of review contractor determination appeals, reduce review burdens on providers, and give review contractors the tools necessary to better protect the Medicare Trust Fund.”
  - Appropriates an additional $127 million per year from the Medicare Trust Funds (OMHA to receive $125 million and DAB to receive $2 billion).
Legislative Relief re: Appeals Backlog

- AFIRM’s reforms to Medicare audit process:
  - Prohibit recovery audits from conducting patient status reviews more than 6 months after DOS if claim submitted within 3 months of DOS
  - Encourage Part B rebilling within one-year timely filing limit
  - Establish CMS Ombudsman for Medicare reviews and appeals
  - Identify, investigate, and assess resulting complaints and inquiries regarding Medicare review or the Medicare appeals process
  - Request OMB’s reports to Secretary of U.S. Department of Health and Human Services (HHS)
  - Establish and implement by 4/1/16 a system to track a provider’s denial rate as a percentage of the claims audited and final determination of appeals by type of issue
  - Supplemental providers with a low error rate from RAC and MAC audits would be temporarily exempted from RAC and MAC post-payment audits
  - Tie a review entity’s accuracy rate with Medicare law, policies and program instruction to its ability to request medical records
  - Example: review entities with a 95% accuracy rate or less may be limited in their ability to request medical records
  - Require the QIO (QIOs) to review medical records before conducting or approving audits conducted or approved by medical doctors knowledgeable of relevant Medicare laws, policies and program instructions

Legislative Relief re: Appeals Backlog

- AFIRM’s reforms to Medicare appeals process:
  - Implement Medicare magistrate
  - Permit decisions on the record without a hearing if no material issues of fact in dispute and if ALJ or magistrate determines there exists “binding authority” that controls the decision in the matter under review
  - Favorable or unfavorable determinations
  - Require OMB to initiate ADR processes
  - Permit review at any level of appeal to consolidate more than one pending request for appeal into a single appeal in certain situations
  - Require the OMB, magistrate, ALJ or DAB to remand an appeal to the MAC for redetermination if the appellant submits new evidence at a subsequent level of appeal
  - Exceptions: reviewer inadvertently omits evidence from the administrative record at lower level; new findings issued on appeal; other circumstances as determined by the Secretary of HHS
  - What about preventing remand and subsequent remand?

Update on RACs

- On June 4, 2015, CMS withdrew the Requests for Quotes for the next round of Recovery Auditor contracts.
- RACs were legislatively prohibited from auditing short stay observation services until September 30, 2015.
- CMS announced that RACs would no longer audit short stays; beginning on October 1, 2015, Quality Improvement Organizations (QIOs) took responsibility for inpatient status reviews. Beginning on January 1, 2016, QIOs and Recovery Auditors began conducting patient status reviews in accordance with policy changes finalized in the OPPS rule and effective in calendar year 2016.
New RAC Program Enhancements

Effective May 15, 2015

- Required to maintain an overturn rate of less than 10% at the first level of appeal
- Failure will result in CMS placing the RAC on a corrective action plan, that could include decreasing the ADR limits, or ceasing certain reviews until the problem is corrected.
- Required to maintain an accuracy rate of at least 95%.
- Failure will result in a progressive reduction in ADR limits.
- Limited the look-back period to 6 months from the date of service for patient status reviews in cases where the hospital submits the claim within 3 months of the date of service.
- Incrementally apply the ADR limits to new providers under review.

Effective January 1, 2016

- ADR limits are diversified across all claim types of a facility (e.g., inpatient, outpatient) to ensure that a provider with multiple claim types is not disproportionately impacted by a RAC's review in one claim type.
- ADR limits based on a provider's compliance with Medicare rules.
  - Providers with low denial rates will have lower ADR limits while providers with high denial rates will have higher ADR limits.
  - ADR limits will be adjusted as a provider's denial rate decreases.

Executive Relief: OMHA Initiatives

- Programmatic Initiatives
  - New field office in Kansas City
  - OMHA adjudication manual
  - Statistical Sampling Initiative
  - SCF Pilot Program
  - Senior Attorney Hearing Waivers Pilot
- Process Management Attorney
- IT Initiatives
  - ALJ Appeal Status Information System (AASIS)
  - OMHA website which allows applicants to electronically confirm the status of pending appeals
  - Electronic Case Adjudication and Processing Environment (ECAPE)

Release Schedule:
- June 2016 – Phase 1 (electronic filing of request for ALJ hearing, submission of electronic evidence and review appeals status)
- Late Winter 2016/Early Spring 2017 – Phase 2 (appeals adjudication)
- Spring 2017 – Phase 3 (electronic access to files and communication with OMHA)

Don’t Wait, Facilitate
(but it takes three to tango)
Settlement Conference Facilitation (SCF) Pilot

- Designed to bring CMS and Appellant together to discuss the potential of a mutually agreeable resolution for claims appealed to the ALJ
- If a settlement cannot be reached, claims return to ALJ appeal level

Phase I (Implemented in June 2014)
- Medicare Part B claims appeals
- For ALJ hearing requests filed in 2014
- Resolved over 2,600 unassigned Part B ALJ Appeals
- Equivalent of more than two ALJ teams in one year

SCF Expansion
- Phase II – October 2015
- Phase III – February 2016

Settlement Conference Facilitation (SCF) Expansion

Phase II Eligibility Requirements
- Medicare Part B claims appeals
- The request for hearing must not be scheduled for an ALJ hearing (no Notice of Hearing)
- The request for hearing must have been filed by September 30, 2015
- Part B QIC reconsideration (not dismissals)
- Appellant must be a provider or supplier > NPI
- The beneficiary must not have been found liable after the initial determination or participated in the QIC reconsideration
- Jurisdictional requirements for ALJ hearing met (timely, amount in controversy)
- At least 20 claims must be at issue or at least $10,000 in controversy if fewer than 20 claims are involved
- Each individual claim must be $10,000 or less
- For the purposes of an extrapolated statistical sample, the extrapolated amount must be $100,000 or less
- There cannot be an outstanding request for OMBAs statistical sampling for the same claims

Phase II Eligibility Requirements (cont.)
- The request must include all of the appellant’s pending appeals for the same item or service at issue that meet the SCF criteria
- Appellants may not request SCF for some but not all of the items or services included in a single appeal.
- The appealed claim(s) must not involve services, drugs, or biologicals billed under unlisted, unspecified, unclassified, or miscellaneous healthcare codes
- Equipment or items (excluding drugs or biologicals) which are billed under unlisted, unspecified, unclassified, or miscellaneous healthcare codes are eligible for SCF
- The appellant has not filed for bankruptcy and/or does not expect to file for bankruptcy in the future
SCF Phase II: Part B Claims

- Physicians and group practices
  - Evaluation and management (E/M) denials and down-codes
  - Frequency of visits
  - Incident-to services
- Physical/occupational therapists
  - Certification timeliness
  - Therapy services above cap threshold
- Ambulance
  - Non-emergency transports to dialysis facilities
- Laboratory
  - Radioallergosorbent testing (RAST) without medically necessary diagnosis
  - Toxicology testing

SCF Expansion: Phase III

Phase III Eligibility Criteria

- All Part A provider types are eligible
- The request for hearing must not be scheduled for ALJ hearing (no Notice of Hearing)
- The request for hearing must have been filed on or before December 31, 2015
- Part A QIC reconsideration (not dismissals)
- The claims at issue are covered under Medicare Part A law and policy
- Appellant must be a provider = NPI
- No beneficiary liability after initial determination or participation at QIC reconsideration
- Jurisdictional requirements for ALJ hearing met (timely, amount in controversy)
- At least 50 claims must be at issue and at least $20,000 must be in controversy
- Each individual claim must be $100,000 or less
- There cannot be an outstanding request for OMBHA statistical sampling for the same claims

SCF Expansion: Phase III (cont.)

- The request must include all of the appellant’s pending appeals for the same item or service at issue that meet the SCF criteria
- Appellants may not request SCF for some but not all of the items or services included in a single appeal
  - For example, if an individual appeal has at issue hospice claims and skilled nursing facility claims, an appellant may not request that the hospice claims go to SCF, but the skilled nursing facility claims go to hearing
- The appellant has not filed for bankruptcy and/or does not expect to file for bankruptcy in the future
SCF Phase III: Hospitals

- Claims that were eligible for the CMS Part A Hospital Appeals Settlement option ("68% Settlement") are ineligble regardless of whether the provider participated in the 68% Settlement

- 68% Settlement eligibility criteria:
  (a) The claim was denied by an entity which conducted review on behalf of CMS;
  (b) The claim was not for services or items furnished to a Medicare Part C enrollee;
  (c) The claim was denied based upon an inappropriate setting determination (a "patient status" denial);
  (d) The first day of admission was before October 1, 2013;
  (e) The hospital timely appealed the denial;
  (f) As of the date the administrative agreement was executed by the hospital and submitted to CMS the claim was either still pending at the Medicare Administrative Contractor (MAC), QIC, AL or DAB level of the hospital hadn't yet exhausted its appeal rights, and
  (g) The hospital did not receive payment and/or bill for the service as a Part B claim.

SCF Phase III: Hospitals

- 68% Settlement was limited to acute care and critical access hospitals
  - Hospitals that were ineligible for the 68% Settlement, but are eligible for SCF Phase III:
    - Psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPPS)
    - Inpatient Rehabilitation Facilities
    - Long Term Care hospitals
    - Cancer hospitals
    - Children's hospitals
  - Acute care and critical access hospitals with pending FCA litigation or investigations

- 68% Settlement was limited to "patient-status" appeals
  - Hospital claims that were ineligible for the 68% Settlement, but may be eligible for SCF Phase III:
    - DRG denials
    - Underlying service not medically necessary and reasonable in any setting
    - Insufficient documentation of conservative treatment prior to a surgical procedure

SCF Phase III: Home Health Agencies

- Beginning April 1, 2011, regulations required physicians document a "brief narrative" explaining how the circumstances of the face-to-face encounter supported the beneficiary’s homebound status and need for skilled services
- NAHC challenged HHS’s authority to enforce the brief narrative requirement
- Court upheld HHS’s authority to require the brief narrative; however:
  - Does not allow for denials simply because of poor word choice, grammar, or sentence structure
  - Would be invalid if it permitted a reviewer to deny a claim on the basis of inadequate documentation because the reviewer disagreed with the physician’s clinical findings
- HHS largely eliminated the narrative requirement for certification periods beginning on or after January 1, 2013
- Voluminous brief narrative technical denials with certification periods between April 1, 2011 – January 1, 2013
- Judicial gloss may make these cases good candidates for SCF
SCF Phase III: Hospices

- RAC Approved Issues
  - Extensive length of stay
  - Excessive units of physician services
- OIG Work Plan (FY 2016)
  - Focus on the appropriateness of hospices' general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care
  - Common Medicare hospice audit risk areas
  - Documentation does not support terminal prognosis of six months or less
- Hospice recertification requirements

SCF Phase III: Skilled Nursing Facilities (SNFs)

- CMS Press Release (March 2016) with SNF Utilization and Payment Data
  - Included information on two categories of RUGs that will likely be a focus of Medicare contractor audits: Ultra-high (RU) and Very high (RV) rehabilitation RUGs.
  - CMS found that for these two RUGs, the amount of therapy provided is often very close to the minimum amount of minutes needed to qualify a patient for these categories
- Common Medicare SNF audit risk areas
  - Billing inaccurate RUG levels
  - Medical review of therapy claims exceeding $3,700 threshold
  - Consolidated billing
  - Lack of documentation to support skilled services

SCF Process

- Step 1: Provider completes Medicare Part A and/or Part B Expression of Interest requesting that OMHA run a preliminary report of its pending ALJ appeals and initiate the SCF process
  - Alternatively, OMHA may initiate a preliminary report on its own initiative or at the request of CMS

SCF Expression of Interest - Terms and Tips

- OMHA will not accept electronic signatures
- Email the completed Expression of Interest in PDF format to OMHA.SCF@hhs.gov
- Separate providers that are related business entities can combine multiple provider numbers into the same expression of interest.
- Failure to protect beneficiaries' private data will result in rejection of appeals from SCF process
  - Beneficiary first or last name or initial, address, truncated health insurance claim number
SCF Process (cont.)

- **Step 2**: OMHA forwards the preliminary report to CMS
  - CMS has 15 days to determine whether it will participate
- **Step 3**: If CMS indicates it will participate, OMHA completes an SCF spreadsheet of all eligible appeals
  - OMHA will notify ALJ teams at this time to stop processing the claims
- **Step 4**: OMHA sends provider a SCF Preliminary Notification and the SCF spreadsheet
- **Step 5**: Provider has 15 days from receipt to file a complete SCF Request package:
  - (1) Request for SCF form,
  - (2) Agreement of Participation form,
  - (3) SCF Request spreadsheet (with all appellant columns completed)
SCF Process (cont.)

SCF Agreement of Participation - Terms and Tips

- An individual authorized to sign a binding settlement agreement must be present at the SCF conference; otherwise, the conference will be closed.
- Provider agrees it will not separately contact any individual within any division of CMS or its contractors regarding any claims under SCF review throughout the duration of the SCF process.
- Every individual attending the SCF conference must sign the SCF Agreement of Participation form (failure to do so results in rejection of provider’s request for SCF).
- Confidentiality provisions of Administrative Dispute Resolution Act apply to the SCF conference.
  - Protected: private communications (written and oral) between a party and the facilitator.
  - Exceptions: communications with the other party present; information concerning fraud, criminal activity, threats of imminent harm; disclosure required upon court order (prevent harm to public, health and safety; establish violation of law; manifest injustice).
SCF Process (cont.)

SCF Spreadsheet - Terms and Tips
- Submit SCF Spreadsheet electronically in Excel format (.xlsx)
- Do not add columns, remove columns or edit column headers
- Failure to follow directions will result in rejection of SCF request package

SCF Process (cont.)

SCF Request Package - submission tips
- A complete SCF Request package contains:
  - (1) Request for SCF form, (2) Agreement of Participation form, and (3) SCF Request Spreadsheet (with all appellant columns completed)
  - Electronic submission of all materials on a flash drive or CD is mandatory
  - OMHA does not accept electronic signatures
  - Submit Request for SCF form and Agreement of Participation form in PDF format (with original signatures)
  - SCF Request Spreadsheet must be sent in Excel format (.xlsx)
  - Mail the complete SCF Request Package via US Postal Service, non-signature to:
    U.S. Department of Health and Human Services
    Office of Medicare Hearings and Appeals
    Settlement Conference Facilitation Program
    500 Leesburg Pike
    Suite 1910
    Falls Church, VA 22041
SCF Process (cont.)

- **Step 6:** OMHA issues confirmation notice to provider and CMS
- **Step 7:** Pre-settlement conference call with provider, CMS, and OMHA facilitators
  - Scheduled approximately four weeks after issuance of confirmation notice
- **Step 8:** Settlement conference conducted
  - Scheduled approximately three to four weeks after pre-settlement conference call

SCF Process (cont.)

SCF Settlement Agreement—Terms and Tips

- If settlement is reached, the settlement agreement must be signed the day of the settlement conference
- Terms of OMHA's Settlement Agreement are non-negotiable “in any form or fashion”
- Read the Settlement Agreement:

SCF Process (cont.)

SCF Settlement Agreement—Terms and Tips (cont.)

- CMS will not perform claim-by-claim adjustments or reprocessing; payments will be made according to CMS usual business practices (recoupment and/or offset)
- Settlement payments are a "percentage term"
  - For example, the parties could agree CMS will pay 50% of the approved amount on the claims listed in the SCF Request Spreadsheet
- Settlement of pre-payment claims:
  - % of the Medicare approved amount, less the applicable deductible and/or co-insurance, if any
  - If down-coding involved, the amount already paid by Medicare is subtracted from the above calculated amount
- Settlement of post-payment claims:
  - % by which CMS will reduce the overpayment(s) at issue
  - CMS will issue payment (EFT or check) within 120 days from the later of:
    - The effective date of the Settlement Agreement; or
    - Agreement on the calculation of the Medicare net amount (after applicable reductions for pre-payment details and/or the recalculation after the percentage reduction for post-payment details)
SCF Process (cont.)

SCF Settlement Agreement– Terms and Tips (cont.)

- Settlement Agreement releases CMS from full liability on the claims settled
- Settlement Agreement does not release provider from any claims arising under criminal law, False Claims Act, Civil Monetary Penalties Statute, common law fraud
- Settlement Agreement releases "any and all rights to further administrative review, judicial review or waiver of recovery" regarding the settled claims
- Provider agrees to withdrawal of pending ALJ hearing requests on the settled claims; ALJ dismissal orders for the withdrawn claims will be issued

SCF Process (cont.)

SCF Settlement Agreement– Terms and Tips (cont.)

- "No Admission – This agreement does not constitute an admission of fact or law by the Settlement Parties and shall in no way affect the rights, duties, or obligations the Settlement Parties may have with respect to other issues not covered by this agreement. This agreement does not constitute an admission of liability by Provider/Supplier or CMS.” See OMHA SCF Settlement Agreement Template

SCF Process (cont.)

SCF Settlement Agreement– Terms and Tips (cont.)

- No findings of fact or conclusions of law; claims remain denied
  - "Per CMS, the claims will remain denied in Medicare’s systems” See OMHA SCF Pilot Fact Sheet
  - Appellant cannot seek further reimbursement from the beneficiary
  - Reimbursement from secondary payers will depend upon the secondary payers’ payment policies.
  - What about ‘downstream’, claims?
  - Example: A surgical claim is settled, but remains denied. What about the anesthesia claim?
  - CMS acknowledges this issue and is looking into possible ways to allow for payment of these types of claims in the future.
SCF Process - Overview

SCF: Best Practices
- Position paper
- Expert testimony
- Sampling of claims

SCF: Strategic Approach
Key Considerations
- One-day time period for settlement conference
- SCF process is voluntary for all parties until execution of settlement agreement
- Pre-settlement conference: SNFs/Hospitals with Part A and Part B claims— if submit Part A and Part B EOI forms in one email, perhaps can resolve all claims at one mediation session
- Know your numbers
  - Dollar value at issue
  - Pre-payment (denials) - % of Medicare approved amount less the applicable deductible and/or coinsurance
  - Pre-payment (denial ceiling) - the amount already paid by Medicare is subtracted from preceding calculated amount
  - Post-payment - % by which CMS will reduce the overpayment(s) at issue
  - Past ALJ success rate; projected future ALJ success rate
  - Costs of ALJ hearings
  - # of ALJ appeal requests
  - Internal resources (e.g., employee participation)
  - External resources (e.g., experts, attorney fees)
  - Time value of money
  - Certainty value of settlement
  - Interest on recouped claims ("935 interest")
SCF: Strategic Approach

Key Considerations
- 42 CFR 405.378(j) – When an overpayment is reversed in whole or in part by an ALJ, the provider is entitled to interest on the principal claim amount for the time period in which CMS had possession of the funds ("935 interest")
- SCF Standard Settlement Terms – CMS will not pay interest to Provider/Supplier pursuant to 42 CFR § 405.378(j) as there will be no Administrative Law Judge decision
- Provider waives ability to receive 935 interest on the recouped funds (post-payment audits)
- How much 935 interest is at issue for provider’s claims?
- Interest paid by provider

SCF: Strategic Approach

“935 Interest” Example
- Value of SCF claims - $100,000
- Interest rate – 9.75% per annum on principal
- Total time CMS held recouped funds – 3 years

- ’935 interest” at issue - $29,250

- Carefully consider “935 interest” when determining acceptable settlement amount

SCF: Strategic Approach

Key Considerations
- How strong are your claims on the merits?
  - Strong cases = money left on the table?
  - Previous ALJ success rate for similar claims
- Dismissal of appeal, if settled
- Claims remain denied, if settled
  - Will not improve provider’s error rate
  - Cannot seek further reimbursement from beneficiary
    - E.g., if settled at 65% payable amount, cannot request 65% of copay
  - Secondary payor issue
Interplay Between Audits and Other CMS Program Integrity Tools

Interplay Between Overpayments and Audits

42 CFR § 401.305 - Requirements for reporting and returning of overpayments

- **Deadline for reporting and returning overpayments**: A person who has received an overpayment must report and return the overpayment by the later of either of the following:
  - The date which is 60 days after the date on which the overpayment was identified
  - The date any corresponding cost report is due, if applicable

- **Enforcement**: Any overpayment retained by a person after the deadline for reporting and returning the overpayment is an obligation for purposes of [the False Claims Act]

- **Lookback period**: An overpayment must be reported and returned if a person identifies the overpayment within 6 years of the date the overpayment was received

- **Definition of “Identified”**: A person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. A person should have determined that the person received an overpayment and quantified the amount of the overpayment if the person fails to exercise reasonable diligence and the person in fact received an overpayment.

60-Day Final Rule

[The contractor or government audit may be for a limited time period. If the provider or supplier confirms the audit’s findings, then the provider and supplier may have credible information of receiving a potential overpayment beyond the scope of the audit if the practice that resulted in the overpayment also occurred outside of the audited timeframe. In such situations, providers and suppliers will need to conduct reasonable diligence within the lookback period of this rule . . . In Fed. Reg., 80 Fed. Reg. at 7667 (Feb. 19, 2015)]

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. Id. at 7672.
Interplay Between Overpayments and Audits

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The provisions of this final rule establish that a person has the responsibility to conduct an investigation in good faith and a timely manner in response to obtaining credible information of a potential overpayment and to return identified overpayments by the deadline set forth in §401.305(b). This responsibility exists independent of the appeals process for contractors’ overpayment determinations. 81 Fed. Reg. 7654 at 7667 (Feb. 12, 2016)

If the provider appeals the contractor identified overpayment, the provider may reasonably assess that it is premature to initiate a reasonably diligent investigation into the nearly identical conduct in an additional time period until such time as the contractor identified overpayment has worked its way through the administrative appeals process. Id at 7667.

If the MAC notifies a provider of an improper cost report payment, the provider has received credible information of a potential overpayment and must conduct reasonable diligence on other cost reports within the lookback period to determine if it has received an overpayment. Id at 7667.

Interplay Between Overpayments and Audits

Settlement Conference Facilitation (SCF)

- "No Admission – This agreement does not constitute an admission of fact or law by the Settlement Parties and shall in no way affect the rights, duties, or obligations the Settlement Parties may have with respect to other issues not covered by this agreement. This agreement does not constitute an admission of liability by Provider/Supplier or CMS.” See OMHA SCF Settlement Agreement Template

- "Per CMS, the claims will remain denied in Medicare's systems and new remittance notices will not be issued.” See OMHA SCF Pilot Fact Sheet

Interplay Between Overpayments and Audits

- 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.

- 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
Interplay Between Overpayments and Audits

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Determinations by the Secretary with respect to liability for non-covered items or services under section 1879 of the Act are independent from the obligations of providers and suppliers under section 1128J(d) of the Act to report and return overpayments received by a provider or supplier. Moreover, determinations in accordance with section 1879 of the Act are CMS determinations; section 1879 of the Act is not applicable to the provider’s or supplier’s own assessment of whether funds are an overpayment. We believe it is inappropriate for providers or suppliers to make determinations regarding their own knowledge of noncoverage or whether they were the cause of an overpayment in lieu of reporting and returning an identified overpayment as required by this rule. 81 Fed. Reg. 7654 at 7666

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Interplay Between Revocations and Audits

**42 C.F.R. § 424.535(a)(8)(ii)**

(a) Reasons for revocation. CMS may revoke a currently enrolled provider or supplier’s Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

(8) Abuse of billing privileges.

Abuse of billing privileges includes either of the following:

(ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.

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Interplay Between Revocations and Audits

- “A provider or supplier’s claim denial that has been both—(i) fully (rather than partially) overturned on appeal; and (ii) finally and fully adjudicated will be excluded from our consideration in determining whether the provider or supplier’s Medicare billing privileges should be revoked under § 424.535(a)(8)(ii).” 79 Fed. Reg. 72500 at 72513 (Dec. 5, 2014)

  - “Finally and fully adjudicated” means that—(i) the appeals process has been exhausted; or (ii) the deadline for filing an appeal has passed. [id]

- “[W]e do not believe a claim denial that fails to meet both of these requirements should be excluded from our review for two reasons. First, excluding claims that are currently being appealed could encourage providers and suppliers to file meritless appeals simply to circumvent the application of § 424.535(a)(8)(ii). Second, merely because a claim is under appeal does not necessarily mean it will be overturned.” [id]

- Impact of SCF?
Questions?

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