Medicare Post Payment Claim Audits (RACs, ZPICs, and Other Tools)

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CMS Post Payment Audit Toolbox

- RACs
- ZPICs
- UPICs
- Automated Audit Tools (IUR)
The Creation of the RACs

• Demonstration Project: March 2005 – March 2008
  • Implemented under the Medicare Modernization Act of 2003
  • Covered six states
  • Purpose – to determine if RACs could effectively identify improper payments under Medicare
  • Results – identified $1.03 billion in improper payments

• Nationwide Expansion: January 2010
  • Authorized by the Tax Relief and Health Care Act of 2006
  • Requires annual report on RAC performance and effectiveness
Nationwide RAC Assignments

• There are four RACs across the country:
  • Region A: Performant Recovery Inc.
    • CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT
  • Region B: CGI Technologies and Solutions Inc.
    • IL, IN, KY, MI, MN, OH and WI
  • Region C: Connolly Consulting Associates Inc.
    • AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, SC, TN, TX, US VI, WV
  • Region D: HealthDataInsights Inc.
    • AK, American Samoa, AZ, CA, Guam, HI, IA, ID, KS, MO, MT, NB, ND, NV, OR, SD, UT, WA, and WY
RAC Statement of Work

- Reviews are limited to a 3-year “look-back” period
- Claims are audited based on a “targeted review”
- RACs must employ RNs, therapists, certified coders and a CMD
- Audit issues must be pre-approved by CMS and posted to the RAC’s website
- RACs are paid on a contingency basis (from 9% - 12.5%) but must return their fee when they lose at any level of appeal
Other interesting tidbits: RACs...

- are not permitted to educate providers on Medicare policy
- are required to collaborate with other CMS contractors
- meet quarterly with ZPICs to discuss fraud referrals and trends
- cannot require electronic submission of medical records
- must complete complex reviews within 30 days of receipt
- must offer a discussion period to providers
- can be required by CMS to “rework claims” that were improperly adjusted due to misinterpretation of CMS payment or coverage policies
The RAC Statement of Work

• Objectives of RACs are to:
  • Detect and correct past improper payments
  • Audit claims from fee for service providers
  • Assist CMS with actions to prevent future improper payments

• RACs conduct three types of reviews:
  • Automated
  • Semi-Automated
  • Complex
The RAC Statement of Work

• Automated Reviews
  • When there is certainty that a service is not covered or is incorrectly coded based on a written Medicare guideline
  • Claim determinations are made at the system level

• Semi-Automated Reviews
  • System level finding of a billing aberrancy with “a high index of suspicion”
  • Notification letter allows the provider 45 days to dispute
  • Human intervention occurs if the provider disputes the findings
The RAC Statement of Work

• Complex Reviews
  • Used when:
    • There is a high probability that the service is not covered or is incorrectly coded; or
    • There is no written Medicare guideline
  • Requires human review of the medical record
  • Denials are not to be based on minor omissions if the medical record supports coverage/medical necessity
RAC Statement of Work

• Complex Review Determinations
  • Rationale must be clearly supported
  • Rationale must include:
    • Detailed description of the Medicare policy/rule that was violated
    • State whether violation resulted in improper payment
    • Each rationale must be specific to the claim under review
The RAC Statement of Work

• Types of Complex Review Determinations
  • Coverage/Medical Necessity Determinations
    • Must be made by a RN or therapist
  • Coding Determinations
    • Must be made by certified coders
  • Individual Claim Determination
    • Made when there is no applicable written Medicare guideline
    • Reviewer must “utilize appropriate medical literature and apply appropriate clinical judgment”
    • CMD must be actively involved
RAC Statement of Work

• How RAC Decisions are Communicated
  • By a Review Results Letter within 30 days of receipt
  • Provider may request to open a discussion period
  • RAC must respond within 30 days
  • RACs must use web portal so providers can track audit progress
• RAC sends the final decision to the provider’s MAC
• Overpayment Demand Letters are issued by the MAC
Common RAC Issues for SNFs (CR)

- Part B issues
  - Therapy claims in excess of $3,700 threshold
- Part A issues
  - SNF stay preceded by psychiatric hospital stay
  - Claims for hospice enrollees with condition code 07 (i.e., unrelated services)
  - Units in excess of PPS assessment maximum
  - MDS coding validation
  - Services not medically necessary
Annual Reporting of RAC Results

- Annual Report to Congress on RAC
  - Information on identified overpayments and underpayments
  - Evaluation of the comparative performance of the RACs
  - Amount of savings to the Medicare program
  - Most recent report issued February 5, 2013 for FY 2011
Annual Reporting of RAC Results

  - Identified $939.3 million in improper payments
  - Returned $488.2 million (net of underpayments, appeals, contingency fees, and costs)
  - Independent “validation contractor” determined a cumulative RAC accuracy score of 90% or more
  - 6.7% of overpayment determinations were appealed
  - 43.6% of appeals were overturned
Other Reports on RAC Results

- OIG Report Issued August 2013 (OEI-04-11-00680)
  - To evaluate CMS actions to address:
    - Improper payment vulnerabilities
    - Referrals of potential fraud
    - Oversight of RACs
  - Scope encompassed FY 2010 and FY 2011
  - Findings:
    - 50% of RAC audited claims resulted in improper payments
    - No assessment of CMS actions to address program vulnerabilities
    - Six RAC referrals of potential fraud were not addressed
    - No metrics to assess RAC performance on all contract requirements
Historical Problems with RACs

- Skilled Nursing Facility Issues
  - Flawed logic in semi-automated edits
  - Boiler plate non-specific denial rationales for complex reviews
  - Erroneous statements of “fact” in denial rationale
  - Inability of provider to access clinical reviewer or management
  - Ineffective problem resolution through customer service
  - Apparent lack of SNF PPS expertise in clinical reviewers
  - No contact information on website
Continuing Evolution of the RACs

• Expansion of RACs to Other Payers: In Process
  • Authorized by PPACA
  • RACs will cover Medicaid, Medicare Part D, and Medicare Advantage

• Realignment of RACs
  • There will be four Medicare Part A/B RACs and one national DME and Home Health/Hospital RAC
  • Procurement process began in May 2013
  • Contracts to be awarded in 2014
  • Demonstration project underway for Pre-Payment RAC reviews
Continuing Evolution of the RACs

• Pre-Payment RAC Demonstration (in Process)
  • Audits claims with historically high rates of improper payments
    • Includes 7 states with high numbers of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, and IL)
    • Includes 4 states with high volume of short inpatient hospital stays (PA, OH, NC, and MO)
  • MACs apply the pre-payment edits and request the records
  • RACs conduct the reviews and issue the review results letter
  • No discussion period is permitted
  • Usual appeal rights apply
Continuing Evolution of the RACs

- Pre-Payment RAC Demonstration (In Process)
  - Beginning September 2012 included:
    - Various hospital inpatient DRGs
    - Reviews were stopped indefinitely as of October 2013
  - New pre-payment edits implemented January 2014, including:
    - SNF coding validation
    - HHAs medical necessity and coverage criteria
    - HHA skilled nursing length of stay
  - Intended to prevent improper payments vs. “pay and chase”
ZPIC Authorization / Purpose

- Detect fraud or improper utilization - 42 USC 1395ddd (b) (1)
- Successor to Program Safeguard Contractors (PSCs)
- “primary task … is to identify and stop potential fraud” – PIM 1.7, 4.2
- Conduct pre- and post-payment audits
- Use statistically valid sampling and overpayment extrapolation
- Refer overpayments to MACs for recovery
- Suspension Authority/OIG Referrals
- Referrals to law enforcement
ZPIC Responsibilities / Activities

- Identify program vulnerabilities
- Recommend areas for outreach and education to MAC
- Perform data analysis
- Request financial records and other corporate data
- Conduct onsite visits and staff interviews
- Refer pre-payment and auto-denial edits to MAC
- Withhold payments
- Refer “recalcitrant” providers to CMS
ZPIC Activities

- ZPIC activities do not include:
  - Provider outreach and education
  - Recouping overpayments
  - Medical review not for integrity purposes
  - Complaint screening
  - Claim appeals of ZPIC decisions
  - Auditing of provider cost reports
Your Neighborhood ZPIC

ZPIC Zones

Zone 1
Zone 2
Zone 3
Zone 4
Zone 5
Zone 6
Zone 7

AdvanceMed
AK, WA, OR, MT, ID,
WY, UT, AZ, ND, SD,
KS, IA, MO and NE

Health Integrity
CO, NM, OK and TX

AdvanceMed
AL, AR, GA, LA, MS,
NC, SC, TN, VA and WV

SafeGuard Services
FL, PR and VI

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CPAs & Healthcare Consultants
ZPIC Scope Includes

- Part A providers
  - Hospitals
  - SNFs
  - HHAs
  - Hospice
- Part B
  - Physicians
  - DMEPOS suppliers
- ZPIC zones are based on MAC jurisdictions
- Five states are considered “Hot Spots”
  - CA, FL, IL, NY, and TX
  - Aligned with Program Integrity Field Offices
Historical Problems with ZPICs

- Broad authority to conduct investigative activities
- Lack of industry specific regulatory expertise
- Improper citations to support adjustments
- Unreasonable denial rates
- Lack of accountability to providers for decisions
- Inaccessibility of medical record reviewers to providers
- Overly burdensome documentation production requests
- Simultaneous use of post- and pre-payment reviews
What is next? **UPICs**

- Unified Program Integrity Contractor (UPIC)
  - Objectives are to:
    - 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
  - Several (5 – 15) regional contractors are anticipated
  - RACs will not be affected
  - MACs will limit their audits to routine issues
  - Preliminary meeting held on July 26, 2013
Unified Program Integrity Contractor (UPIC)

- Anticipated UPIC activities
  - Identify and prioritize leads
  - Data analysis and managing leads
  - Conduct investigations
  - Protect program dollars
  - Identify Medicare and Medicaid overpayments
  - To provide support to:
    - The Administrative Appeals Process
    - CMS
    - Law enforcement
Unified Program Integrity Contractor (UPIC)

- Expected outcomes
  - Administrative sanctions
  - Prepayment reviews
  - Referrals to law enforcement
- Extensive use of IT and sophisticated analytics
- Standardized system for case management
- Will facilitate exchange of information between the public and private sectors
Other Types of Post-Payment Audits

• Comprehensive Error Rate Testing (CERT)
  • CERT conducts random audits annually
    • Are **not** targeted reviews
    • Are **not** based on data mining or predictive analysis techniques
  • CERT reviews are:
    • Conducted based on stratified random sampling of Medicare claims
    • Encompass claims submitted to Part A/B and DME MACs
    • Used to calculate national, service-specific, and MAC-specific estimated rates of improper payments
  • 2012 Medicare FFS improper payment rate was 8.5 percent or $29.6 billion in improper payments
Other Types of Post-Payment Audits

• Supplemental Medical Review Contractor (SMRC)
  • Performs nationwide medical review at CMS’ direction
  • Goals are to:
    • Lower improper payment rates; and
    • Increase efficiencies of Medicare and Medicaid medical review functions
  • Contract awarded to StrategicHealthSolutions, LLC
  • Scope of reviews:
    • Part A, Part B, and DME providers and suppliers
    • Focus will include areas of program vulnerabilities
  • 15 Projects are identified on the SMRC website
Other Types of Post-Payment Audits

- SMRC Planned Projects
  - Project “Y1P1” (Completed)
    - Identified 60% error rate in payment for Power Mobility Devices
  - Two other projects relate to Part B therapy:
    - Project “Y1P5” (in process)
      - Dates of Service from 08/2012 – 03/2013
      - Therapy that stopped or paused just under the therapy cap
    - Project “Y1P9” (in process)
      - Claims in NY, NJ, and CT in 10/2012 and 11/2012
      - Billing continued despite the effects of Hurricane Sandy
New Tool: IUR

• Informational Unsolicited Response
  • Born from fact that on pre-payment basis, CMS utilizes a structured database to question or cross-check claims on a number of factors
  • CMS has broad authority pre-payment to reject claims

• Now IUR applying Pre Payment Logic to Post Payment Claims – Automated Program
  • Run Through CMS Payment Database
  • Constitutes Reopening, But Without Notice/Response
  • MACs Deny They Are Doing It (But CRs Show)
  • Results in Remittance Advice w Code Notice Only
Example: “Incarcerated” Beneficiaries

- In November 2012, OIG Report says Medicare Providers Billed for $30M of Claims for Beneficiaries Later Shown as “Incarcerated” (Should Not Be Paid)
- Fact is that Social Security database is often wrong / slow, so SS status may change after claim paid
- Implicates thousands of claims from hospice, home health, to doctor, to skilled nursing, to hospital
- Rather than have MACs reopen 1 by 1, Medicare instructs Contractors to modify payment retroactively, check all claims, and recover funds
- Results Posted as Remittance Advice Reductions with Codes Only
IUR Problem

- **Sounds Efficient But:**
  - Fails to Give Provider Advance Notice
    - No opportunity to submit evidence before decision
  - Fails to Consider Provider No Fault
  - No statutory safeguards
    - No hold on recoupment
    - No response / rebuttal rights
    - Appeal Rights (now acknowledged, but no notice)

- **Utilization**
  - More than 10 IURs in Past Year
Other IURs

- Hospital / Hospice Cross Over
- Ambulance Utilization
- Unlawfully Present Beneficiaries
- Hospice Drug Issues - Analgesics
- More than a Dozen Change Requests and Growing
Notification of Audit

- **ZPICs**
  - Required to give 30 days notice, ask for records (most cases)

- **RACs**
  - Required to give notice / ask for information

- **IUR (Automated)**
  - CMS assumes (perhaps incorrectly) that it needs no information other than what is in its database, so no notice is given until automated audit is complete
Outcomes from Audits

• Recoupment of payment
• Provider can be placed on 100% pre-payment and stop billing (getting off based on approval-denial %)
• Refer to enforcement agencies
• Revocation of participation in Medicare program
  • CMS now indicating that providers that cannot escape TMR will be terminated
ZPIC Audit Findings

- Reported by ZPIC in letter and data CD
- Adopted by MAC immediately into demand
- First Chance: Rebuttal Opportunity
  - Immediately to ZPIC
  - 15 days only (42 USC 1395ddd(7)(B)(iii))
  - Supply missing Documentation
  - Insist upon specifics (42 CFR 405.921; PIM 3.6.4)
Automated IUR

- IUR results only appear on remittance advice notices
- Billing will see a prior patient name, an offset, and a code, no detailed explanation
  - Arguably contrary to statutory notice requirement
  - Contrary to recoupment hold on post payment audit
- Providers Must Call and Ask MACs for Detail
- Appeal Rights Exist, But Not Stated On RA
Management of Audits/Denials/Appeals

- Establish ADR/Denial team
  - Track all medical record requests, decisions and appeals
  - Conduct multi-disciplinary review of records prior to submission
  - Compile complete medical record package
    - Do not limit submission to items listed in request letter
    - Include all information necessary to support claim (even documents outside claim period and those from other providers)
    - Ensure package is well-organized
  - Retain a copy of medical record submission
  - Consider Bates stamping records prior to submission
  - Maintain evidence of timely delivery (FedEx receipts, etc.)
Five Levels of Appeals - Persevere

First Level – Redetermination (Medicare Administrative Contractor) –
Medicare Administrative Contractor (MAC) make initial review. Must be filed within 120 days of initial determination.

Second Level – Reconsideration (Qualified Independent Contractor) –
Qualified Independent Contractor (QIC) review may be sought within 180 days of the MAC redetermination. Not many wins at this level! Must have evidence in the record by this stage. Decisions required in 60 days.

Third Level – Administrative Law Judge Hearing –
Providers entitled next to hearing before an Administrative Law Judge (ALJ). ALJ review must be sought within 60 days. Actual justice available here.

Fourth Level – Medicare Appeals Council (MAC)
A fourth level appeal request may be filed with the Departmental Appeals Board (DAB) / Medicare Appeals Council (MAC). Requests for a MAC review must be filed within 60 days of receipt of the ALJ’s decision. ZPIC and CMS will often appeal adverse ALJ decisions.

Providers that win at ALJ must remember to preserve arguments at next level.
The Appeals Council is home territory for CMS; providers lose here.

Fifth Level – U.S. District Court Review
Providers may file suit in District Court, but forget about medical necessity at this level.
If going to District Court, bring a good legal argument. Judges are not medical experts.
Post Finding Appeal Tips

- Carefully Review Findings
  - Medical Statements buried in Claim Line Denial Docs Running Thousands of Pages

- File Separate Redetermination Requests on Each Patient Denial in the Sample

- Double Check Completeness of Documentation
  - Obtain Third Party Records (Hospitals/Treating Physicians)

- Retain Statistics Expert

- Pay Attention to Inconsistent Findings
QIC Issues

- Must Have All Arguments / Data In By This Point
- QICs Facing Delays
  - May Get Notice of Right To Bypass
  - May Want to Wait For QIC Decision
    - Chance of Prevailing
    - Recoupment Hold
ALJ – Justice Available Here (Eventually)

- ALJ’s Are Best Chance
  - 56% Reversal Rate for Providers
  - Don’t Like ZPIC Technical Denials
  - Focus On Reasonable and Necessary, Nothing Else
  - Willing To Examine Statistical Validity

- OIG Study:
  - Providers file “too many” appeals
  - Suggests implementing fees
  - Planning to re-educate ALJs

- ALJ System Broken
  - 350,000 Claims Pending Before 65 ALJs (5,000 each)
  - 2.5 Year Delay; All Kinds Of New Auditors / No New ALJs
Recoupment / Interest Issues

- Congress precludes recoupment until both redetermination and reconsideration complete (42 USC 1395ddd(f)(2)(A)) (IUR Violates This)
- But CMS short-circuits statutory appeal timing by requiring quick redetermination and reconsideration requests (41 days / 60 days)
- IUR Ignores These Recoupment Restrictions
- Significant time pressure on provider - TIPS
- Interest accrues meanwhile at 10.25% (highest US government rate on the books)
Hospice Medical Necessity – Old School

Clinical Judgment of Doctors Entitled to Deference

LCD Provide Objective Criteria

Partial Denials Vulnerable

CMS Said Hospice Won’t Be Punished for LOS

Decline Not Required

Death of Patient as Evidence
New Hospice Issue – Related Care

- Nature of Hospice Benefit
  - Patient Chooses Palliative over Curative
  - Waives “Related” Curative Treatment
  - Hospice to Provide All “Related” Care

- Patient May Still Receive All “Unrelated” Care
  - Break an Arm, Infections, Diabetes Treatment, Dialysis
  - Long History of CMS Discretion to Providers

- Different Tune Now
  - MEDPac Says $15B Hospice + $1B Unrelated (2012)
  - Drugs/Hospitalizations (Part D Rejections in 2014)
  - Even Vaccinations (Rescinded)
  - CMS Wants This Money Back

- CMS Sees Value In More Simple Analysis

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Face to Face: Hospice/Home Health

- 2011 ACA Required F2F Visits for:
  - Hospice after first 2 benefit periods
  - Home Health for first benefit period
- Made Visit “Condition of Payment”
  - Courts have said no denials for things not a “condition of payment”
- CMS Has Adopted Detailed Regulations as to:
  - Timing, Documentation, Nature of F2F Visits
- Ripe Audit Area
  - Palmetto Reports >50% Denials of HH for F2F
F2F Issues

- Key: Visit Must Occur + Timely
- Secondary Technical Issues
  - Documented Correctly:
    - Form, attestation, signature, dates, benefit periods
- Audits Are Not Complex – Key Point
  - MACs / RACs / ZPICs
    - Simple to Review
    - More Objective Findings
- Problem
  - Rife With Improper Technical Denials
Home Health Medical Appeal Notes

- OASIS system provides objective rating
- ZPICs don’t understand this rating and make arbitrary adjustments
- ZPIC focus on numbers of visits but ignore OASIS authorization coding
- ZPICs don’t understand visit payment cliffs for skilled nursing or therapy
- ZPICs fail to explain basis for denials
Legal Arguments

- Technical Denials Improper
  - US Code/PIM says denials must be on necessity
  - Courts say payment denial must be material
  - Excessive Fines Argument

- Deference to Medical Professionals

- Hindsight

- No Fault Argument
  - Providers Arguably Protected When Not At Fault
    - But CMS Ignores This Rule
Statistical Extrapolation

- **Improper Extrapolation**
  - Congress said Secretary must authorize Contractor use of extrapolation; but ZPICs do this on their own

- **ZPIC (Bad) Habits**
  - Choose same sample size always = 30
  - Variance in overpayment size undermines reliability
  - Universe size may not always justify sampling

- **Offsets**
  - Hospice Cap Liability

- **Need an Expert to Rebut (Start Early)**
THANK YOU