Everything You Need to Know to Survive RAC and Prepayment Audits

1

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2

Alphabet Soup

- Multiple Types of Audits
  - Pre-Payment
  - Post-Payment
  - CERT Audits
  - RAC Audits
  - ZPIC Audits
  - SMRC Audits
- Although different, results are often the same

3

Pre-Payment Review

- Performed by the DME MAC
- Claim is reviewed prior to adjudication
- Can be random or focused
  - Provider based
  - Service based
- Failure results in claim denial and no payment
- Denied claims may be appealed

4

Pre-Payment Review

- Recent Examples
  - Jurisdiction A
    - Lower limb prostheses with K3 componentry
      - Error rate reduced from 90.2% in 1st quarter of 2012 to 62% in 2nd quarter of 2013
      - Reduced error rate encouraging but not enough to end audits
  - Jurisdiction B
    - LSOs/TLSOs
      - Increased claim submission in the second half of 2012
      - No results published

5

Pre-Payment Review

- Recent Examples
  - Jurisdiction B
    - High Error Rate Procedures
      - Identified Orthotics and Prosthetics
      - Created cash flow crisis for small businesses
      - Positive results lead to limited relief from pre-payment review
  - Jurisdiction C
    - Off the shelf diabetic shoes (A5500)
      - Began in September 2010
      - Error rate has ranged from 72% to 86%

6

Pre-Payment Review

- Recent Examples
  - Jurisdiction D
    - AFOs described by L1960
      - 80% error rate in 1st quarter of 2013
      - 99% error rate in 2nd quarter of 2013
    - LSOs described by L0631 and L0637
      - 85% error rate for both codes in 2nd quarter of 2013
    - Breast Prostheses described by L8030
      - 72 % error rate in 3rd quarter of 2013

7

Post Payment Review

- Performed by the DME MAC
- Claim is reviewed after adjudication
- Can be random or focused
  - Provider based
  - Service based
- Failure results in claim denial and recoupment of payment
- Denied claims may be appealed

8

Post Payment Review

- Post Payment reviews are often triggered by other events
  - CERT audit results
  - OIG reports
  - CMS bulletins

9

CERT Audits

- CERT is an acronym for Comprehensive Error Rate Testing
- Purpose of CERT audits
  - Measure the performance of the contractor
    - Establish the claim payment error rate
    - Used to evaluate the efficiency of the contractor
- Results of CERT audits
  - Overpayment/refund request

10

CERT Audits

- Why are CERT audits important?
  - Identify areas of vulnerability
  - Lead to pre-payment and post payment reviews
  - Failure to respond results in denial
  - While providers are not the target, consequences remain the same

11

RAC Audits

- RAC is an acronym for Recovery Audit Contractor
- Focused on recovery of underpayments and overpayments
- Only Medicare contractor who is paid on a contingency basis
  - Contingency fee ranges from 9.5% to 12.5%
  - Highly incentivized to recover improper payments

12

RAC Audits

- RAC History
  - Medicare Modernization Act created a three year RAC demonstration project
    - Demonstration project resulted in $700 million ins recoveries in 5 states
  - Tax Relief and Healthcare Act of 2006 authorized a permanent nationwide RAC program
    - Almost $5 billion in recoveries since expansion of the RAC program

13

RAC Audits

- RAC Structure
  - Regional
    - Same Jurisdictions as DME MACs
    - Jurisdiction A-Performant Recovery, Inc.
    - Jurisdiction B-CGI Technologies and Solutions, Inc.
    - Jurisdiction C-Connolly Consulting Associates, Inc.
    - Jurisdiction D-HealthDataInsights, Inc.

14

RAC Audits

- RAC Limits
  - Three year “look back”
  - Limits on number of audit requests (ADR) per 45 days
    - tied to supplier’s Tax Id Number
    - Limits set at 10% of all claims submitted in previous calendar year divided by 8. (Round results)
      - 700 claims previous year = 9 audit requests per 45 days
        - (700 *.10) / 8= 8.75 rounded up to 9
    - Cap is 10 ADRs per 45 days
      - Only for specific taxonomy coded suppliers

15

ZPIC Audits

- ZPIC is an acronym for Zone Program Integrity Contractor
- ZPICs established in 2008
- ZPIC contracts are segregated into 7 zones
  - ZPIC for each zone performs audits for all Medicare services including DMEPOS
- ZPICs are focused on identifying and preventing fraud and abuse

16

SMRC

- SMRC is an acronym for Supplemental Medical Review Contractor
- Established in June/July of 2013
- Single Contractor
  - StrategicHealthSolutions, LLC.
- Focus on areas of high vulnerability
  - Currently limited to power wheelchairs

17

How Did We Get Here?

- OIG Report on Lower Limb Prostheses
  - August 2011
  - $43 million in improper payments
  - $61 million in claims with no claims from referring physician
- Dear Physician Letter
  - August 2011
  - Stated that physician documentation is the primary source for establishment of medical necessity

18

How Did We Get Here?

- OIG Report on L0631
  - Utilization almost tripled from 2008 to 2011
  - Medicare reimbursement was 380% of the average acquisition cost
  - 1/3 of suppliers reported no fitting or training
  - 93% of suppliers provided only basic fitting and training instruction

19

What Has Been Done?

- Communication
  - AOPA has sent written correspondence to CMS, the OIG and the DME MACs regarding the reports and subsequent audits triggered by these events
  - AOPA and the O&P Alliance have participated in multiple meeting with CMS staff
  - AOPA has taken its message to Congress

20

What Has Been Done?

- Litigation
  - AOPA filed suit against CMS on May 13, 2013
  - Government filed a motion to dismiss the case
  - AOPA has responded to this motion and has requested the hearing of oral arguments regarding the motion to dismiss
  - Federal Judge will rule on the motion to dismiss in the next several months

21

Basic Overview & General Tips

- Medicare Appeals
  - What can be appealed
  - What cannot be appealed
- The Medicare Appeals Process
  - Review of the five official levels of appeals
  - General Tips/Strategies
- Interact with Referral Sources
  - Documentation before and after the fact

22

Medicare Appeals

- When An Appeal May be Filed
  - Denial of claim as “Not Medically Necessary”
    - Catch all phrase, covers most reasons for denials
- When An Appeal May Not/Should Not be Filed
  - Non-covered services
  - Patient not eligible for Medicare or Medicare is not the payer of record
  - Denial for violation of Timely Claim Filing Limit
  - Agree with the results

23

Medicare Appeals: The Process

- Redetermination
  - First level of appeal
  - Must be filed within 120 days of notice of denial of the initial claim
  - Additional material may be provided to support your claim
  - Performed by the DME MAC
  - No minimum dollar limit
  - Medicare Redetermination Request form (CMS-20027)
    - http://www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf

24

Medicare Appeals: The Process

- Redetermination
  - If you choose not to use the CMS-20027 form, your written request must include:
    - Patient's name and Medicare Number
    - Items for which the redetermination is being requested
    - Specific dates of service
    - Name and signature of the party doing the redetermination
    - Attach any supporting material/documentation
  - Decision is usually made within 60 days of receipt of the request

25

Medicare Appeals: The Process

- Reconsideration
  - Second level of appeal
  - Must be filed within 180 days of receipt of redetermination outcome
  - Additional material may be provided to support your claim

26

Medicare Appeals: The Process

- Reconsideration
  - Performed by the Qualified Independent Contractor (QIC)
    - C2C, Inc.
  - No minimum dollar limit
  - Medicare Reconsideration Request form (CMS-20033)
    - http://www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf

27

Medicare Appeals: The Process

- Reconsideration
  - If you choose not to use the CMS-20033 form, your written request must include:
    - Patient's name and Medicare Number
    - Items for which the reconsideration is being requested
    - Specific dates of service
    - Name of the contractor from the redetermination
    - Explanation for why you disagree w/ the redetermination
    - Name and signature of the party doing the redetermination
    - Attach any supporting material/documentation
  - Decision is usually made within 60 days of receipt of the request
    - If not you may have the ability to escalate to the ALJ

28

Medicare Appeals: The Process

- Administrative Law Judge (ALJ) Hearing
  - Third Level of Appeal
  - Minimum Amount in Controversy (AIC) must be $140
    - Amount remaining before application of coinsurance and/or deductible
  - Must be filed within 60 days of notice of reconsideration outcome
  - Must be filed with the main Office of Hearings and Appeals (Centralized Docketing System)
    - Then assigned to an ALJ
    - Handled by 1 of 4 field offices

29

Medicare Appeals: The Process

- Administrative Law Judge Hearing
  - Medicare ALJ Request form
    - http://www.cms.hhs.gov/cmsforms/downloads/cms20034ab.pdf
  - Or it may be requested in writing
    - Must contain all the information found in the ALJ request form
  - **Typically no additional material may be introduced**
    - **Must have just cause for why new information is being presented**

30

Medicare Appeals: The Process

- Administrative Law Judge Hearing
  - Finding Out How, When and Where the Hearing Will be Held
    - Will receive a Notice of Hearing
      - 20 day window of when the hearing will take place
  - Usually done via videoconference, but you may request a phone hearing or an in-person hearing
  - May also be done as an "on the record" review
    - Decision made by reviewing all information on hand, and no hearing is required

31

Medicare Appeals: The Process

- Administrative Law Judge Hearing
  - Decision is usually made within 90 days of the request for a hearing
    - As of July 15, 2013 wait time for a Notice of Assignment is 10 to 12 months
    - Decision can also be extended
      - Request not filed properly, adding new information, etc.
  - If not you may have the ability to escalate to the next level

32

Medicare Appeals: The Process

- Departmental Appeals Board (DAB)/Medicare Appeals Council (MAC)
  - No minimum dollar amount
  - Must be filed within 60 days of notice of ALJ decision
    - Must be done in writing, suggested to use form DAB-101
    - Must identify the parts of the ALJ results you disagree with and why.
  - Typically only considered if:
    - Abuse of discretion by the ALJ/Broad policy or procedural dispute
    - Actions, findings, or conclusions of the ALJ that the board cannot support

33

Medicare Appeals: The Process

- Departmental Appeals Board (DAB)/Medicare Appeals Council (MAC)
  - Conduct a review of only the issues raised in your request
  - The MAC will consider all of the evidence in the administrative record (what was presented to the ALJ)
  - Respond to request within 90 days
    - Timeframe may be extended

34

Medicare Appeals: The Process

- Judicial Review
  - Final Level of Appeal
  - At least $1,400 must remain in dispute
  - Must be filed within 60 days of notice of DAB/MAC decision
  - Civil Suit in Federal District Court
    - You must be represented by an attorney

35

Medicare Appeals: Basic Tips

- Know what you are Appealing
  - Explanation of specific patient need/Explanation of how the item is different
    - What you may think is obvious is not always so
- Make sure all proper documentation is sent
- Give them a road map
- Respond in a timely manner
- Business decision on how far to go and to refund or not to refund.

36

Submitting/Obtaining Documentation

- Continue to document and obtain documentation
  - Claims history can be used to establish medical necessity, supplemental information
  - Get what you can, focus on key issues
- Work with others
  - PTs, OTs, etc
  - Hospitals, SNFs, etc

37

Submitting/Obtaining Documentation

- Continue to work with the physicians
  - Dear Physician Letter or Office party
  - Attestation Statement
    - To collaborate existing information
- Control what you can control
  - Your documentation is up to date and complete
    - Rxs, Delivery slips, etc
      - Complete and compliant
    - Notes are in order

38

Return of Alleged Overpayments

- Repayment vs. Recoupment
- What is "recoupment"?
  - Defined as repaying outstanding Medicare debt through reduction of present and future Medicare payments
  - Frequently referred to as "offset" (though defined differently)
  - Begins 41 days after demand letter issued unless stayed
  - Often incurs interest
  - Request for immediate offset is permissible to avoid interest
- Extended repayment plans may be requested but inability to repay timely must be documented

39

Limiting Recoupment

- Providers may hold off recoupment at the redetermination and reconsideration levels of appeal
- Abbreviated deadlines for filing appeals:
  - Must file for redetermination within 30 days
  - Must file for reconsideration within 60 days
  - Recommended that appeals specifically request that recoupment be stayed
  - If recoupment only stayed during redetermination, offset will begin as early as Day 61 after redetermination decision has been issued
- Recoupment through offset will occur following a QIC denial, regardless of appeal to ALJ
- Interest continues to accrue during stay
- What if CMS recoups despite your request for a stay?

40

Interest

- Interest rate is usually quite high – currently 10.375%
- Always accrues as simple interest on principal only – no interest on interest
- Any interest paid to CMS is to be refunded upon favorable appeal
- Suppliers who win appeals are sometimes entitled to repayment of interest on amounts repaid to CMS as well

41

Interest

- If supplier repaid CMS through offset, entitled to interest on recouped amounts after favorable decision at the ALJ level of appeal (or higher)
- For every full 30-day period between the date of recoupment and the date of the favorable decision based on the interest rate in effect at time of favorable decision
- Interest may also be due to all suppliers if the contractor does not repay within 30 days of the favorable decision, for each full 30-day period

42

Requests for Appeal

- Forms available at each level of appeal
- Suppliers encouraged to use the forms but also submit separate written letter or brief in support of position
- Include all documentation at first two levels of appeal: no new documents may be submitted after QIC level without good cause
- Include copies of decision letters from DME MAC/QIC and address their reasons for denial in your letter or brief

43

Creating a Persuasive Argument

- Know the documentation requirements for O&P suppliers cold
- Know the applicable Local Coverage Determination (LCD) (if one exists) for the specific item provided
- Explain how each element of the requirements is met and reference specific documentation to support arguments
- Organize and cite documents so reader/decision-maker can easily progress through the argument

44

Asking for an Exception to an LCD

- ALJs are permitted to ignore LCDs if sufficient grounds exist for doing so, though this is rare
- If the service provided is not covered under the rules of an LCD, explain how the specific facts of the claim make it unique
- Provide as much clinical and scientific support for the non-covered use as possible
- Consider retaining an independent expert to provide support for approach
- Physician testimony/corroboration is important

45

How To Secure Necessary Documentation

- Before filing reconsideration request, make sure you have:
  - Copies of physician records
  - Attestations (if necessary), but exercise prudence in documenting
- At ALJ level of appeal:
  - Need to establish "good cause" to submit additional documents
  - Demonstrate attempts to obtain evidence earlier
  - No guarantees that new evidence will be accepted
- Effect of "Dear Physician" letter
  - Can be argued against relatively effectively for items provided pre-August 2011
  - Arguments still possible for items provided after August 2011 but less likely to be effective

46

Getting Necessary Documentation in the Future

- Enhance relationships with physicians and staff who are frequent referral sources
  - Send letter to existing referral sources outlining requirements and explaining need for better records
  - Keep record of PoC at various offices
- Prepare form letter that can be sent to new referral sources
- Train scheduling and reception staff regarding documentation requirements
- Make NO EXCEPTIONS!

47

Maximizing the Appeals Process

- Establish process to track all ADRs, your responses, appeals at every level, and all deadlines so you don't lose appeal rights
- Make decision on whether to stay recoupment in future appeals and adhere to timelines
- Designate single PoC within your office for audit and appeals tracking/correspondence
- Always use delivery method that can be tracked and delivery verified

48

Filing a Request for Appeal

- Use provided forms for filing appeals
- Remember that you are both the "Supplier" and the "Appellant" on all forms
- Give specific contact information for office PoC if possible
- Include cover letter/brief that lists all enclosed items
- Keep copy of everything that is submitted

49

Handling Contact with OMHA

- OMHA now uses centralized docketing system
- After initial submission of request for ALJ hearing, do not send any further submissions until assigned to a specific ALJ
- After first 90 days has passed, if no correspondence, contact OMHA to obtain ALJ assignment (if available)
- Be prepared for a lengthy ALJ process; ALJs routinely violate their regulatory time deadlines
- ALJ level of appeal is the most favorable venue for providers so backlog of cases is growing significantly

50

Notice Requirements

- "Parties" to appeals have certain rights to notice
  - Parties include beneficiaries and suppliers accepting assignment of payment
  - Parties may also include suppliers who did not accept assignment of payment but have obtained assignment of appeal rights
- Redetermination and reconsideration have no special notice requirements

51

Notice Requirements

- Copies of requests for ALJ hearings must be sent to "all parties"
  - Some ALJs require notice to be sent to contractors as well, but not required under the regulations
  - Failure to send notice may result in dismissal of appeal, though this is not permitted under the regulations
- Medicare Appeals Council has same notice requirements as ALJ level of appeal

52

Outside Consultants

- Depending on the number of appeals, dollar value of cases, and whether extrapolation is at issue, consider the use of outside experts:
  - Independent clinical experts
  - Consultants
  - Attorneys experienced in Medicare appeals
  - Statistical Experts – this is only necessary when challenging an extrapolation

53

Limiting Exposure While Providing O&P Care

- Compliance with Medicare policies
  - General requirements
  - LCDs
  - New developments
  - Staff training
- Internal audits
  - O&P practice owner has special obligation to personally check accuracy of claims
  - Random sampling
  - Automatic reminders or internal checks
  - 60-day repayment requirement

54

Advocacy

- OIG Report and Dear Physician letter in August 2011 stimulated major O&P auditing
  - Problem is that prosthetist's records are not given proper weight in the medical necessity determination
- AOPA, NAAOP, the O&P Alliance and others have been actively engaging CMS and Congress ever since
- Consensus is building for changes to:
  - RAC program with its financial incentives
  - Appeals process (eliminate QIC, hire more ALJs, stay recoupment through ALJ decision, enforce reopening regulations, streamline Medicare contractors, etc.)

55

Pending O&P Policy Issues

- Physician documentation template
  - CMS taking page out of power wheelchair book
  - Electronic template is burdensome, too reliant on physician and medical conditions, and not focused on *functional status and potential of the patient*
  - Three Open Door Forums have occurred but CMS not using formal procedures to implement this
  - Fear is that existence of particular conditions in patient record will bar coverage of certain prosthetic componentry

56

Pending O&P Policy Issues (con't)

- CMS is also considering Prior Authorization
  - Differences of opinion on this issue within the O&P profession
  - Pro: It's better to know whether you will be paid than take a gamble with each case
  - Con: It will delay care, there is no guarantee of coverage and payment when claim is actually submitted, and these claims are not protected from RAC and other audits
  - Status at CMS: Pending

57

Pending O&P Policy Issues (con't)

- Competitive Bidding of OTS Orthotics
  - CMS recently published "final" list of what it considers OTS orthotics (over 60 codes)
  - Strong objection from O&P groups conveyed to CMS
  - CMS intends to "explode" codes that contain both OTS and prefabricated orthoses
  - Policy fails to:
    - Adhere to statutory definition of OTS
    - Appreciate clinical involvement and expertise necessary
    - Recognize complexities and unintended consequences

58

QUESTIONS?

59