Health Care Reimbursement Conundrums Part 1: Government Payors

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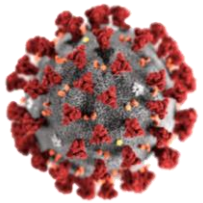
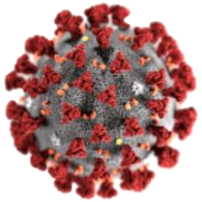
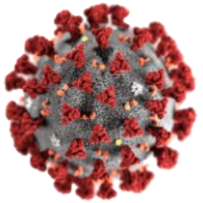
Agenda

We'll cover the following topics with an emphasis on maximizing and retaining payment while ensuring compliance –

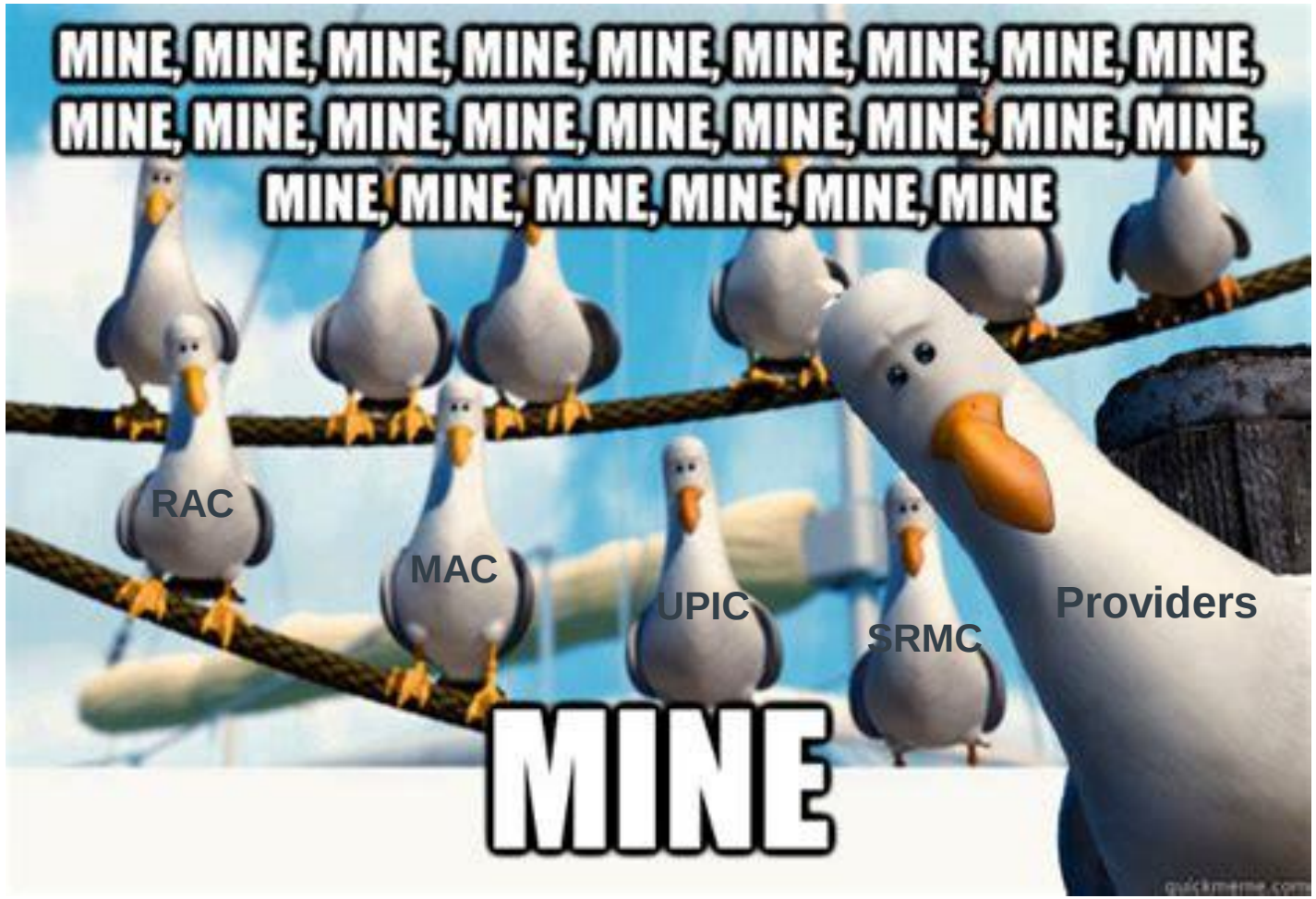






I. Internal Overpayment Reviews
II. The Flip Side – Underpayments & Improper Denials
III. External Audits and Investigations

Importance of Being Strategic & Assertive



Goal

- Particularly in this time of economic distress, goal has to be getting and keeping the ***correct*** payment
- Not every error creates an overpayment
  - Not every auditor will tell you that
- Not every denial or short pay is correct
  - Not every MAC/Medicaid agency/payor will tell you that
- How can legal/compliance teams help their business partners?
  - Assess whether errors identified internally and externally are actually overpayments requiring refund and/or disclosure
  - Assist in efforts to seek full and accurate payment for the medically necessary services your business provides
  - Provide guidance (and sometimes, muscle) in defining or limiting scope of review

Internal Overpayment Reviews

Overpayment Framework

- ACA Section 6402
  - A person who has received an overpayment must report and return the money within 60 days after the date on which the overpayment is "identified" or the date the corresponding cost report is due
  - Failure to do so can result in False Claims Act (FCA) liability
- Final Rule for Medicare A & B – 42 C.F.R. § 401.301
  - Credible information
  - Reasonable diligence
  - Identification and quantification
  - Report and return

Credible Information

- Case Studies
  - Hospital outpatient department leadership notifies compliance that certain procedures were performed without the on-site supervision of a physician.
  - A new EMR system was implemented in 2018. A nurse discovers that the system failed to route verbal orders to physicians for signature.
  - HR notifies a physician clinic that an employed nurse was practicing for a short time without a state license.

Considerations for "Reasonable Diligence" Inquiry

- **Is it really a payment issue**?
- What is the proper scope of the review?
  - Issue areas (e.g., service specific)
  - Time Period (Factual & Legal Limits)
  - Payers
- Who should be involved?
- Should the investigation be conducted under attorney/client privilege?
- What should the process look like?

Is it Really a Payment Issue?

- Some issues/errors may not affect reimbursement
  - Conditions of Participation (CoPs) or Conditions for Coverage (CfCs)
    - Generally, CoPs and CfCs are not conditions of payment
    - Whistleblowers and DOJ continue to bring these cases, however
  - Bundled Payment Environment
    - Even if a portion of a bundled payment not covered, it does not render the whole service non-covered
  - Billing error related to manual provision or other sub-regulatory guidance
    - Generally, manuals are not binding law, but shows CMS intent and they are given deference (*see* Cleary Memo discussion later)
    - Consider clarity of regulations and statutes
  - Is the issue “material” to the payor’s decision to pay

Scope of Review: Issue Areas

- Clearly define scope prior to pulling data, reviewing claims, etc.
- Limit scope to key issue areas, using the ‘credible information’ as a guidepost
  - If credible information involved only a specific procedure, limit review to that procedure
  - Errors outside the original scope may be found requiring additional investigation

Scope of Review: How Far Back?

- Factual limit: “When did the problem start?”
  - Changes in personnel, changes in software or billing system, etc.
- Legal limits
  - Medicare A & B requires a six-year lookback
  - State Medicaid programs vary
  - Contractual limits (for Medicare Advantage or Medicaid managed care)
  - False Claims Act requires six years (generally)

Scope of Review: What Payers?

- Government Payers
  - Medicare & Medicare Advantage
  - Medicaid (including Medicaid managed plans)
  - VA, Tricare, FEHBP
- Commercial
- Considerations:
  - Determine whether investigation should apply to one or all payers (depends on the factual scenario)
  - Don’t assume Medicare rules apply to all payers
  - Commercial plans should be considered, but risk dependent on contractual obligations, state law

Identifying the Internal Review Team

- Depends on the factual scenario
- Balance between ensuring key stakeholders involved and protecting confidentiality/privilege
- Consider including:
  - Legal (internal and/or external)
  - Compliance
  - Individuals with knowledge of issue (*e.g.*, IT, Billing, HR)
  - Leadership

When to Consider Outside Counsel

- Factors favoring use of outside counsel:
  - Protecting privilege
  - Need for objectivity and independence (or a ‘bad guy’)
  - Subject matter expertise (reimbursement, efficiency in scoping risk)
  - Advocacy and leverage with CMS
  - Systemic or wide-ranging issues
- Factors favoring internal counsel only:
  - Cost
  - Internal institutional knowledge
  - Routine billing/coding issues

When to Conduct a Review Under Privilege

- Factors that favor use of privilege:
  - Potential FCA or criminal issues
  - Whistleblowers
  - Potentially significant exposure
  - Complex reimbursement issues
- Factors that disfavor use of privilege:
  - Simple billing/coding issues
  - Finite period and issues
  - Lack of concern about improper intent

What Should the Process Look Like?

- In most cases, start with a probe audit to confirm there is a systemic issue worthy of full review
  - Consider number of cases or claims
- Based on probe findings, determine feasibility of reviewing all claims or a statistically valid sample
- Based on findings of broader review, consider whether extrapolation is necessary
- Overall Reasonable Diligence Period: Six months

Identification of Overpayments

- An overpayment is “identified” only following reasonable diligence inquiry **and** quantification
- No materiality or *de minimus* threshold
- For probe samples, an overpayment is not “quantified” until the entire claim universe is analyzed

Reporting & Refunding

- For Medicare Parts A & B, report and return within **60 days** of identification (for claims-based repayments)
- Acceptable reporting methods:
  - MAC voluntary refund process
  - Requesting a claim adjustment or offset
- Clock is tolled for providers/suppliers who
  - Request an Extended Repayment Schedule, or
  - Use another approved disclosure method (*e.g.*, OIG Protocol)

Reporting & Refunding

- Primary goal: make the refund in a manner that achieves finality, but minimizes risk of additional governmental review
- Re-process claims if possible and practical
- Refund letter
  - Cover letter as needed to describe process
  - Include supporting details, including claim by claim information
  - Take care to ensure that all statements are accurate
  - Avoid unnecessary admissions

Reporting & Refunding

- Failure to report and return overpayments in accordance with the statute gives rise to FCA liability
  - *Kane v. Healthfirst* ($2.95M settlement based on ~$800K for original Medicaid overpayment)
  - First Coast Cardiovascular Institute ($448K settlement for original overpayment of $175K)

Underpayments & Improper Denials

Payments Do Not Always Match What Providers Expect WHY??

- Lots of reasons – it's important to understand the cause
- Provider-side:
  - Is correct and complete information on the claim?
  - Does the documentation support what is on the claim?
  - Did you calculate what was "expected" correctly?
  - Do the services meet regulatory requirements (e.g., clinical criteria for POS, supervision, clinical/dx requirements, etc.)?
  - Duplicate claims? MSP errors?
- Payor-side:
  - Are they performing a pre-payment audit?
  - Do they have the correct information loaded in their system (e.g., provider-type)?
  - Are they interpreting a regulation or payment provision differently?

Understand the Denial/Short-Pay

- Is the Issue Technical vs. Substantive?
  - Lack of Medical Necessity – Substantive
  - Clerical error – Technical
  - Documentation – may be technical or substantive
- Understanding the denial reason will shape the right response

Considerations

- Even the most proactive providers get denials and short pays
- Train billing/denial management team on denial response
  - Be careful about accepting payor assessment
  - Do not miss appeal deadlines; consider what 1st level appeal should say
  - ***Seek*** information from the payor, but consider when its appropriate to ***give*** more information
    - "Yes, the diagnosis code was inadvertently misidentified on the claim. We will correct and resubmit the claim"
    - "You are correct, none of these patients meet the LCD criteria for the service."
- Consider when to bring in legal team
  - Legal can't be involved in every denial
  - ***BUT,*** legal can help recover amounts due when issue is more widespread
  - Some legal arguments for recovery of denial or short-paid claims are not intuitive and require a good understanding of relevant authorities and
- Balance cost of appeal vs scope of issue
- Can you "settle" with a payor to resolve overpayments and underpayments at the same time?

Understand the Relevant Authority

- Statutes
- Code of Federal Regulations
- Medicaid State Plans
- Sub-Regulatory Guidance:
  - Medicare/Medicaid Policies & Guidance
  - Medicare/Medicaid Manuals
  - National or Local Coverage Determinations
- Waivers
- Case Law (*e.g.*, Escobar, Wit)

These Do Not All Apply in the Same Way

Understand the Relevant Authority

- Not all authorities apply in the same way
- May use some of the same arguments you would use to defend why something is not
- Examples:
  - Issue identified not a condition of payment
  - Cannot enforce sub-regulatory guidance (Cleary memo)
  - Case law (e.g., Escobar, Wit, WI Sup. Ct.)
  - Technical error should not equate to no payment for medically necessary services
  - Applying incorrect clinical standard
  - Used wrong standard or calculation on cost-report

Cleary Memo

- Issued in October 2019, the Cleary Memo by CMS counsel, it analyzes the impact on overpayment and enforcement actions based on audits.
- States that HHS and CMS cannot take enforcement actions based on sub-regulatory standards or manuals unless such guidance is closely tied to statutory or regulatory requirements.

External Overpayment Investigations

Outside Audits

- Overview of framework
  - Types of external audits
  - Appeal framework/process
- Managing external audits in order to limit the provider's exposure
  - Strategies for handling external audits and appeals
  - Tools to challenge audit scope and findings, including a review of recent (and helpful) guidance and case law (e.g. Cleary Memo)

CMS Claim Review Programs

- Federal government estimates 12.1 percent of all Medicare FFS claim payments are improper
- CMS utilizes two types of claim review programs:
  - Pre-payment review to reduce improper payments
  - Post-payment review to recover improper payments
- Programs are categorized as either:
  - “Complex” – requires licensed professionals to review additional documentation associated with a claim; or
  - “Non-Complex” – does not require a clinical review of medical documentation

CMS Claim Review Contractors

- What is Appealable?
  - *Initial determinations* on claims for benefits under Part A or Part B based on reviews conducted by Medicare contractors
- Medicare Administrative Contractors (MACs)
  - Process claims from physicians, hospitals, and other health care professionals, and submit payment to those providers according to Medicare rules and regulations
  - includes identifying and correcting underpayments and overpayments
- Zone Program Integrity Contractors (ZPICs)/Program Safeguard Contractors (PSCs)
  - All PSCs transitioned to ZPICs, save for Zone 6
  - Perform investigations that are unique and tailored to specific circumstances and occur only in situations where there is potential fraud, and take appropriate corrective actions

CMS Claim Review Contractors

- Supplemental Medical Review Contractor (SMRC)
  - Conduct nationwide medical reviews
  - Includes identifying underpayments and overpayments
- Comprehensive Error Rate Testing (CERT) Contractors
  - Collect documentation and perform reviews on a statistically-valid random sample of Medicare FFS claims
  - Produce an annual improper payment rate
- Medicare FFS Recovery Auditors (formerly Recovery Audit Contractors)
  - Review claims to identify potential underpayments and overpayments in Medicare FFS, as part of the Recovery Audit Program

CMS Claim Review Programs

- Pre-payment Claim Review Programs
  - National Correct Coding Initiative (NCCI) Edits – non-complex review
    - Denials based on improper coding, not medical necessity
    - Conducted by MACs, ZPICs, CERT, and RAs
  - Medically Unlikely Edits (MUEs) – Non-Complex
    - An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report, under most circumstances, for a single beneficiary on a single date of service.
    - The MAC's systems analyze the procedures on the submitted claim to determine if they comply with the MUE policy
  - Medical Review (MR) – Complex (also used for post-pay reviews)
    - Conducted by MACs, ZPICs/PSCs, and SMRC
    - identify suspected improper billing through error rates produced by the CERT Program, vulnerabilities identified through the Recovery Audit Program, claim data analysis, and evaluation of other information (e.g., complaints)
    - May result in Provider Education, Prepayment review, or Post-Payment Review

CMS Claim Review Programs

- Post-payment Claim Review Programs
  - CERT – Complex
    - Randomly selected statistically valid sample of processed Medicare FFS claims
    - Reviewed claims subject to potential postpayment denials, payment adjustments, or other actions
    - CMS calculates overall national improper payment rate, and improper payment rates by service type
    - Used to evaluate MAC performance and causes of errors
    - CMS publishes results annually
  - Recovery Audit Program – Complex
    - Recovery Auditors review past Medicare FFS claim data for potential overpayments or underpayments
    - Review medical records when necessary to make determinations
    - In general, Recovery Auditors do not review a claim previously reviewed by another entity
    - Analyze claim data using proprietary software to identify claims that clearly or likely contain improper payments

TPE Audits

TPE Audits:

- CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.
- The goal: to help you quickly improve. Medicare Administrative Contractors (MACs) work with you, in person, to identify errors and help you correct them. Completed in rounds, with education after each round.
- Recent tactics: Add additional items mid-round, continue auditing multiple codes even if denials limited to single issue, lack of contact/education

TPE Audits

TPE Audits:

- Inpatient and outpatient rehabilitation on contractor medical review lists.
- After years of dormancy, seeing significant uptick in volumes of requests.
- *Outpatient rehabilitation: significant focus on document completeness, timing of sessions, etc.*
- Inpatient: big focus on medical necessity.

Unified Program Integrity Contractors

- Implementation of the UPIC initiative to begin in 2016
  - Combines the audit and investigation work currently conducted by the ZPICs (and their responsibilities) with the Audit Medicaid Integrity Contractors (Audit MICs) to form the UPIC
- Contracts with ZPICs/PSCs and MICs will end as the UPIC is implemented in specific geographic regions
- Implementation of the UPICs will be over a multi-year period in order to allow current contractors to transition out
- Umbrella contracts awarded in May 2016
- Potential 10 year, $2.5 billion contract vehicle

Audit Response Strategies

- Timeliness matters.
- Education of entire revenue cycle staff is key.
- Train your medical teams.
- Keep good records, especially when you upload.
- Send everything right on the first appeal.
- Strong audit leadership. Be aggressive.

Audit Response Strategies

- State law and contracts are your friend. Some states (TX) have insurance codes that prohibit payors from auditing submitted charges prior to making payment at 100% of the contracted amount.
- Analyze your document production strategy for both pre and post payment requests. Know what you're obligated to give and when it's required. Have a quality (invested) gate-keeper vs. a vendor making decisions regarding whether to produce or not to produce.
- ERISA Plans- is there any limit to their audit "authority"?

Audit Response Strategies

- Compliance Officer letters - initiate a compliance complaint
- Congressional assistance – request congressional investigation
- Medicare Advantage Plans – CMS on-line complaint
- Department of Labor – Employee Benefits Security Administration
- Social media assistance – TV interviews and newspaper articles
- Don’t forget the patient – they are the best advocate (with assistance)!

Before the Demand

- Encourage stakeholders to notify you of any unusual audit activity ASAP
  - Most providers deal with fairly routine MR audits / ADR requests
  - Speak with client about developing policy to deal with any non-standard audit request
    - Identify exactly what department and job title will have responsibility
- Discuss when it makes sense to involve legal counsel
  - Team sophistication
  - Size of audit/potential liability
  - Complexity of services and potential for regulatory interpretation
- Use subject matter experts from the beginning!

After the Demand

- Attack statistical extrapolations on the front end
- Develop both procedural and substantive arguments with a focus on medical necessity
- Preserve the record for later levels of appeal
  - Demand documentation and proof from contractor for anything that is not supported
  - Don’t be afraid to argue for remand

Medicare Claim Appeals

- Covers pre-payment and post-payment claim disputes for:
  - Part A providers
  - Part B suppliers
    - including Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers
  - Medicare Beneficiaries, and
  - Medicaid State Agencies
- HHS components involved in Medicare claim appeals:
  - CMS
  - Office of Medicare Hearings and Appeals (OMHA)
  - Departmental Appeals Board (DAB)
- Part A providers have a separate appeals process for disputes arising from cost reports through the Provider Reimbursement Review Board (PRRB) at CMS

Claim Appeals Process

- Administrative appeals process has 5 levels:
  1. Redetermination
  2. Reconsideration
  3. Administrative Law Judge Hearing Decision
  4. Medicare Appeals Council Review
  5. Judicial Review by U.S. District Court

See 42 C.F.R. §§ 405.900 *et seq.*.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Questions?

Don’t Forget to Register…

Part 2 of Health Care Reimbursement Conundrums:

Priorities and Strategies for Commercial Payor Reimbursement in the COVID – 19 Environment

Wednesday, September 16th

12:00 PM – 1:00 PM CDT

Contact events@polsinelli.com if you are not already registered!

Polsinelli's Reimbursement Institute

Check out more information on Polsinelli's **Reimbursement Institute** here….

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