

An Alphabet Soup of Government Audits: RACs, MICs and ZPICs

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Overview

- ▶ Introduction to RACs, ZPICs, and MICs and the scope of their activities
- ▶ Review of audit processes
- ▶ Possible outcomes after an audit
- ▶ Challenging adverse determinations through the Medicare Appeals process

RACs, ZPICs, and MICs

- ▶ Contractors are selected by CMS after a bidding process
- ▶ Recovery Audit Contractor (RAC)
 - 4 regions across USA
 - Performant Recovery in NJ
- ▶ Zone Program Integrity Contractor (ZPIC)
 - 7 “integrity zones” across USA
 - NJ is in Zone 6
 - Currently under protest
 - Protesters challenge the contract with Cahaba Safeguard Administrators
 - Dispute must be resolved before ZPIC contract is awarded
- ▶ Medicaid Integrity Contractor (MIC)
 - IPRO is Audit MIC for Region I, which encompasses NJ

General Duties of Contractors

- ▶ Act as representatives for CMS
- ▶ Focused on reviewing possible overutilization of supplies, double-billing, upcoding, kickbacks, implementation of medically unnecessary procedures, and rendering of substandard care
- ▶ Contractors may require providers to supply them with owner names, business practices, licenses, claims, and billing and medical records

RACs: Purpose and Scope of Work

- ▶ Purpose: to identify and correct Medicare overpayments and underpayments with the goal of preventing future improper payments
- ▶ Recoup overpayments
- ▶ Conduct pre- and post-payment audits
- ▶ Must give notice of audit
- ▶ Confined to a three year look back period from the date the claim was paid

RACs: Purpose and Scope of Work

- ▶ RAC staff must include a physician contractor medical director (CMD), nurses, therapists, and certified coders
 - CMD must be an MD or DO with relevant experience
- ▶ CMS must approve RAC audits, and MACs send overpayment demands after final RAC decision
- ▶ Paid on a contingency fee, but the fee must be returned if overturned on appeal
- ▶ RACs conduct targeted audits by focusing on providers whose billing trends are higher than the majority of their counterparts in the relevant community

Three Types of RAC Audit Processes

- ▶ **Automated:** appropriate when a service is not covered or incorrectly coded in *clear violation* of a written Medicare policy
 - No human intervention
- ▶ **Semi-Automated:** appropriate when there is a *high level of suspicion* of improper billing
 - Provider will have 45 days to dispute the findings after receiving a notification letter
 - If the provider disputes the findings, a person will become involved
- ▶ **Complex:** appropriate when it is *likely* that a service is not covered or incorrectly coded or there is no written Medicare policy on the issue
 - A human auditor will request and review the relevant medical record
 - Coverage issue: medical record evaluated by RN or therapist for indication of medical necessity
 - Coding issue: evaluated by certified coder
 - Individual claim issue: physician works with team to determine if claim is supported by relevant medical literature in lieu of formal policy

Update on the RAC Program

- ▶ CMS has announced a plan to transition down current RAC contracts
- ▶ RACs must complete all outstanding claim reviews by the end date of existing contracts
- ▶ RACs may continue to conduct automated reviews through **June 1, 2014**
- ▶ RACs may not accept new Discussion Period requests on or after **July 1, 2014**
 - RAC Discussion Period: provider has an opportunity to discuss the improper payment determination with the RAC before formal Medicare Appeals Process begins
- ▶ The Medicare Appeals process will continue

ZPICs: Purpose and Scope of Work

- ▶ Purpose: to investigate suspected fraud, waste, and abuse
- ▶ Refer fraud cases to the OIG and other law enforcement officials
- ▶ Conduct pre- and post-payment audits
- ▶ May request medical records and other documentation, conduct interviews with beneficiaries, make onsite visits, and suspend payments
- ▶ Not paid on contingency like RACs, but may receive bonuses for detecting overpayment

ZPIC Audit Process

- ▶ Why might a ZPIC initiate an audit?
 - Statistical indicators of fraud
 - Whistleblowers
 - Referrals from RACs or MACs
 - Hotline complaints or tips
 - Fraud alerts
 - Billing errors
- ▶ ZPIC will send an Additional Document Request (ADR) Letter to provider, which alerts provider that it is subject to an audit
- ▶ Provider must respond to ADR letter within 30 days of receipt
 - Provider must provide evidence in support of medical necessity
- ▶ ZPIC will use statistical sampling to extrapolate the amount of overpayments

ZPIC Audit Process

- ▶ During an audit, ZPICs may make unannounced site visits
- ▶ Medicare providers are obligated to cooperate with ZPICs during the site visits
- ▶ During a site visit, providers should note the actions of the ZPIC and keep track of any collected documents

MICs: Purpose and Scope of Work

- ▶ Purpose: to prevent, identify, and recover Medicaid overpayments, and to help states prevent Medicaid fraud and abuse
- ▶ Conduct post-payment audits, as well as conduct review and educational tasks
 - Review MICs: analyze claims for irregularities and help identify audit targets for Audit MICs
 - Audit MICs: conduct post-payment audits to identify overpayments
 - Education MICs: educate providers and others about Medicaid integrity efforts
- ▶ Paid according to fee for service model, earning bonuses for efficiency

MIC Audit Process

- ▶ Before initiating an audit, claims will be reviewed for irregularities
- ▶ State and law enforcement officials may question providers who were identified for audit
- ▶ MIC will conduct the audit and prepare a draft report, which it shares with the state
- ▶ After the state reviews the report, it will be sent to the provider
- ▶ CMS will finalize the report and issue it to the state, identifying the overpayment amount

What happens after there is an adverse determination?

- ▶ Options: (1) return the allegedly overpaid amount or (2) appeal the determination
 - Repayment plans may be available
- ▶ The Medicare Appeals Process is very labor intensive
- ▶ Rebuttal Opportunity: within 15 days of initial determination from a contractor, provider may submit a statement as to why recoupment is improper, accompanied by supporting evidence
 - Supply missing documentation to the contractor and request more specific information
 - Rebuttal could change if or how there is recoupment

The Medicare Appeals Process

- ▶ If a provider receives an adverse initial determination from a contractor, it may appeal.
- ▶ Five levels in claims appeal process:
 1. Redetermination by CMS contractor
 2. Reconsideration by a Qualified Independent Contractor (QIC)
 3. Hearing before an ALJ
 4. Review by Appeals Council in DHHS
 5. Hearing in Federal District Court

The Medicare Appeals Process Timeline

- ▶ Timeliness is especially crucial at Redetermination and Reconsideration stages
- ▶ **Redetermination**
 - Must file request within 120 days from receipt of initial determination
 - *BUT* if you file within **30 days**, recoupment will be stayed
 - Interest accrues even when recoupment is stayed
 - Contractor will issue a decision within 60 days of receipt of redetermination request
- ▶ **Reconsideration**
 - Must file request within 180 days of receipt of redetermination
 - *BUT* if you file within **60 days**, recoupment will be stayed
 - QIC will issue a decision within 60 days of receipt of reconsideration request
 - Stay of recoupment ends after this level of appeal

The Medicare Appeals Process Timeline

▶ ALJ Hearing

- May request a hearing within 60 days of receipt of reconsideration decision if at least \$140 is in controversy
- ALJ will typically issue a decision within 90 days of receipt of hearing request, but may take longer under certain circumstances
- ALJs are overloaded, so appeals could be delayed

▶ Appeals Council Review

- Must submit request for review within 60 days of receipt of ALJ decision
- Typically, the Appeals Council will issue a decision within 90 days of receipt of the request, but may take longer under certain circumstances

▶ Judicial Review in Federal District Court

- Amount in controversy must be at least \$1,430
 - Must file request for judicial review within 60 days of receipt of Appeals Council decision
- ▶ Required amounts in controversy are adjusted annually

Practice Tips

- ▶ Maintain thorough documentation practices regardless of whether an audit has been initiated
- ▶ Stay organized during the audit and designate a point person at the facility to communicate with the contractor
- ▶ Maintain documentation of correspondence with the contractor so that counsel can review for procedural compliance
- ▶ Successful appeals depend largely on available documentation
 - Be prepared to produce patient medical records and explain how services were medically necessary
- ▶ Timely responses are the key to staying recoupment

Practice Tips

- ▶ After receiving a Demand Letter or ADR Letter, gather and summarize patient records as they relate to the claim in question. Include all supporting evidence from:
 - Hospital records
 - Physician certification
 - Facility plan of care
 - Diagnoses
 - Patient notes
 - Progress notes
- ▶ Bolster a Request for Redetermination with summarized information from patient files

Practice Tips

- ▶ When submitting a Request for Reconsideration, include all correspondence related to the audit to date, such as:
 - Demand letter
 - Redetermination notice
 - Reconsideration request form
 - Redetermination request form and supporting exhibits
- ▶ Also include a clearly defined Statement of Reasons for Appeal
 - Relevant claims
 - Applicable laws, regulations, and guidelines
 - Supporting medical records
 - Other useful background information

Practice Tips

- ▶ When the focus is medical necessity, consider how the patient's file can support the treatment decision
 - Are the reasons clearly stated?
 - Look at the big picture—has the patient's condition been treated consistently throughout various stages of care?
- ▶ When the audit determination is based on extrapolation, the appeal should include an examination of statistical methods
 - What are some of the provider's unique practices that may have mistakenly been identified as outliers?
 - Consider consulting a statistics expert
- ▶ As the appeals process progresses, decision-makers will begin to focus more on the applicable legal standards than on medical or professional justifications
 - Typically this shift will occur at the ALJ, Appeals Council, and District Court stages

Conclusion and Q&A

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