Responding to Audits and Investigations

January 30, 2024

Fredrikson

Where Law and Business Meet®

Agenda

- Preparing for external audits and investigations
- Looking under the hood.
- Preparing your people.
- Understanding what Medicare, Medicaid and Private Insurers can get and do.
- Strategies for responding to requests and inquires.


DUAL
V

Carry An Umbrella

- Review Documentation*.
- Read your contracts.
- Examine code distribution patterns.
  - Variation from the norm.
  - Changes.
- Know professionals' total production.
- Get a quarterly certification!
- Review OIG Workplan.
- Calm nervous employees.

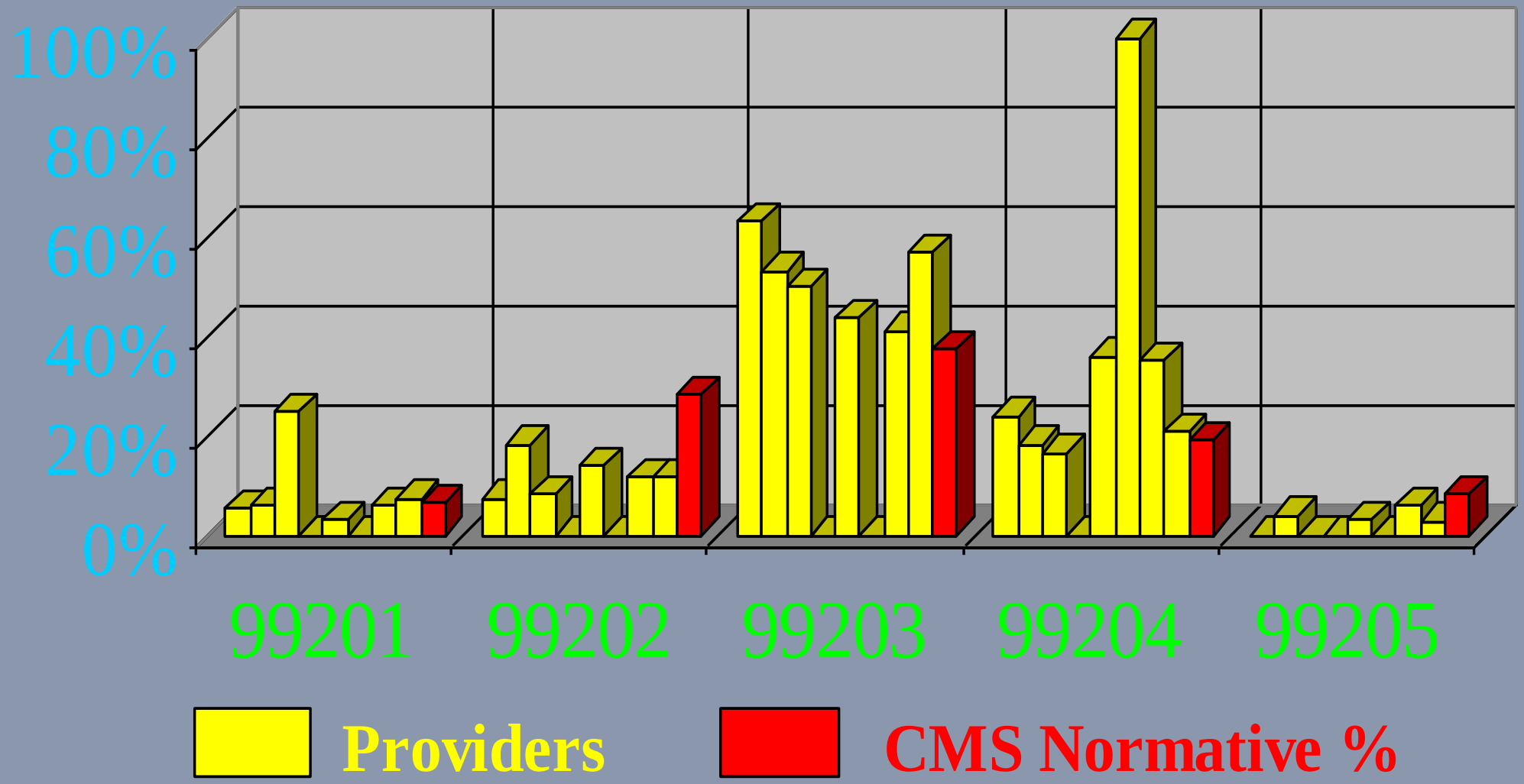
Is It Bad To Be Atypical?

- Standouts may draw more attention.
- What data matters?
- Data is rarely dispositive.
- Is variation always good?

ABC COMPANY

Comparison to CMS Norms - New Patient Office Visits

Variance by Specialty - Family Practice

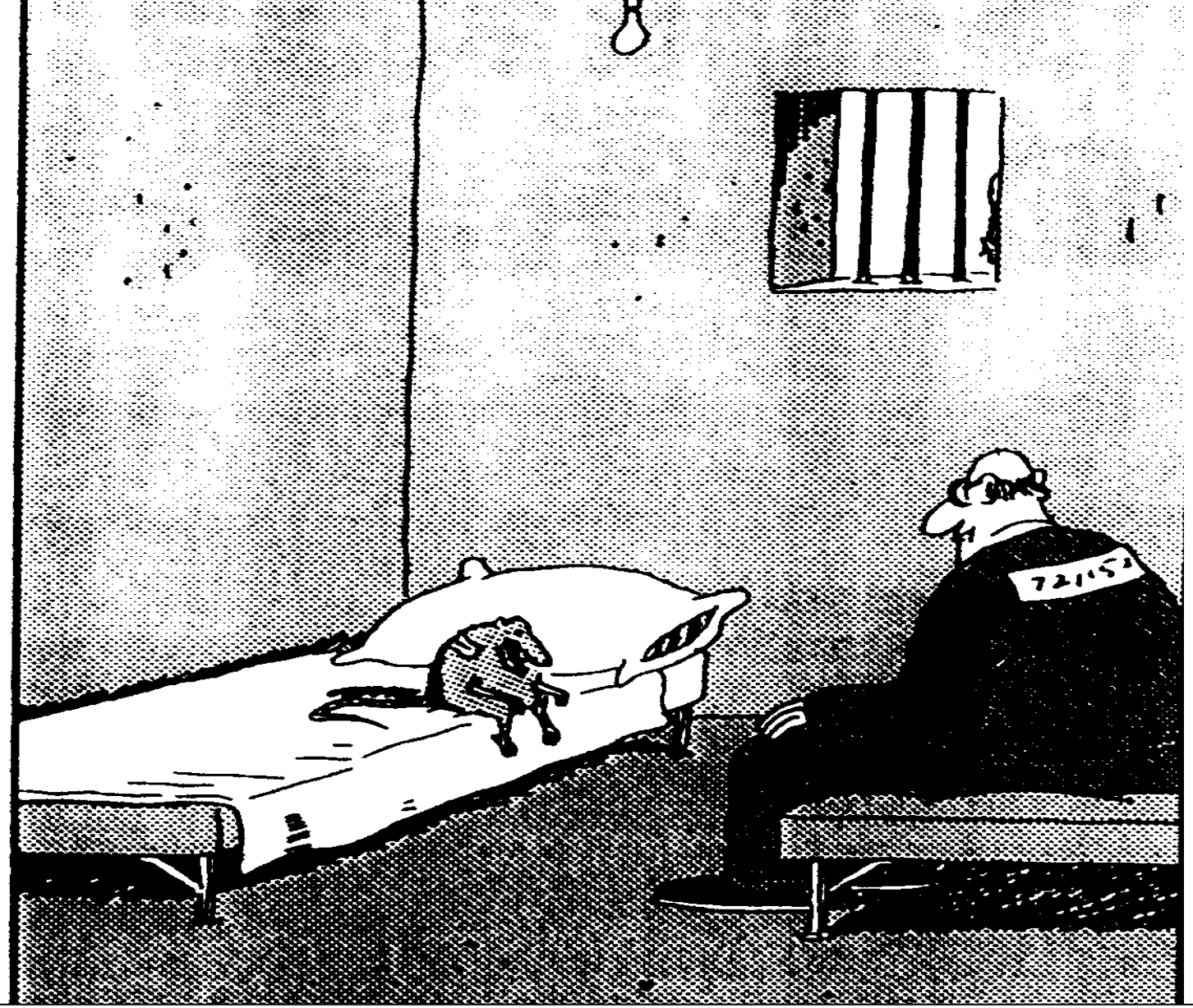


Speaking Of Umbrellas…

- What insurance do you already have?
  - Med Mal rider?
  - General liability?
  - E/O or D/O?
- What insurance do you want?

Even Before the Letter Arrives…

- Educate your staff about directing letters from the government or private payors to the correct person in your organization. **Current mail issues/work from home make this more difficult and absolutely vital.**
- Update Pecos!
- Staff should understand that appeals are time sensitive.
- Date stamping.
- Calendar deadlines. **Don’t assume you can get an extension!**
- Envelopes. (Be a packrat!!)



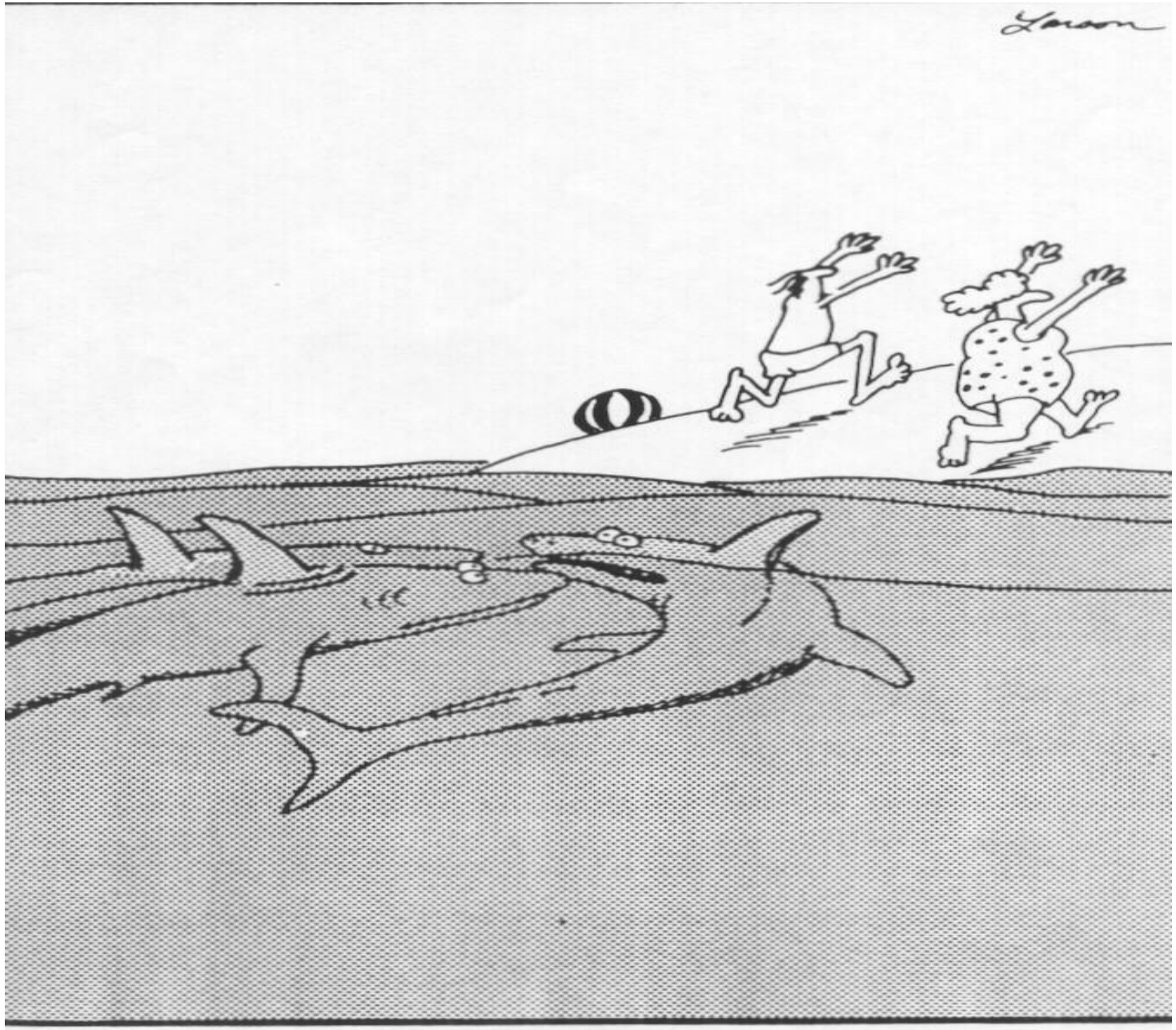
“I would have gotten away scot free if I had just gotten rid of the evidence. … But, shoot - I’m a packrat.”

You Have Mail

- Request for records:
  - MAC
  - PSC, ZPIC, BISC, UPIC
  - RAC
  - Medicaid
  - Private insurance
  - CERT
  - Subpoena
- Revalidation.
- On-site surveyors (especially DME).

Communication With Payors

- What you do now may affect appeals 5 years from now.
- Disclose all relevant facts.
- Get it (or, better yet, give it) in writing. (Send it certified.)
- Don’t incriminate yourself.



"Well, somehow they knew we were—whoa! Our dorsal fins are sticking out! I wonder how many times *that's* screwed things up?"

Communication With Payors

- What you do now may affect appeals 5 years from now.
- Disclose all relevant facts.
- Get it (or, better yet, give it) in writing. (Send it certified.)
- Don’t incriminate yourself.
- Keep it!! Save website pages as PDFs! It’s a pain, but really useful to future you.

Insurer Asserts Your Inpatient Care Should Be Outpatient

- How will they contact you?
- How should you respond?
- Should you contact counsel?
- Do you have insurance for this?

Private Insurers: First Contact

- Can you discern anything from the initial contact?
- Is it a “routine audit?”
- Does the title of the person matter?
- Can you tell if the cops are involved?
- Should you record calls? Keep notes?
- Can you give them records? Who pays for the copies? Should you give them only the records they ask for?

The Letter

- Who sent it?
- Requests for multiple records are much more troubling.
- Make sure you keep a copy of everything you send.
- Use tracked delivery.
- Number your pages!
- Be thorough.
- Talk with counsel.

Telephone Calls

- They used to be rare. They aren’t anymore.

“Now wait just a minute here …
How are we supposed to know you’re the REAL Angel of Death?”

Telephone Calls

- Assume it is a scam until proven otherwise!
- Be super polite, but direct about this. Get the caller's name.
- Find out what they are calling about but share NOTHING except possibly your counsel.
- You, or better yet counsel, call the person back at a number that was googled. This will allow you to verify the caller's identity, and gather your thoughts.

Interacting With Auditors

- Be friendly but firm.
- Keep them in a room where you know what they have.
- Keep track of what is reviewed.
- Make sure they don’t get, or alter, any originals.
- Keep them in a low trafficked area.
- Take advantage of any exit conference. Involve your counsel if possible.

Using Counsel

- Start early. Strategy matters.
- Use someone who knows the ropes.
- Using counsel doesn’t mean you can’t do much of the leg work.
- Create an assembly line. Use a team.
- Remember insurance!
- Understand how privilege works.

What Is Privileged?

- Attorney-client privilege:
  - Oral and written communications.
  - Communications from the client as well as advice from the attorney and retained agents.
  - Key issue: whether the communication was in furtherance of obtaining legal advice?
- Work product privilege:
  - Materials prepared or assembled at the direction of counsel.
  - Must be in anticipation of potential litigation.
  - Be wary of over labelling. If you call something “work product” you may have a duty to preserve documents.

Hiring Consultants

- Consider using privilege.
- Discuss the consultant's role; is s/he an advocate or a cop?
- Get references. There are some horror stories.

Before You Appeal, Call 911?

- Talk to your trade groups. Can you band together?
- Medicare: Congress people will often prefer to let the system play out, BUT if there is an existential threat, they may be willing to help.
- Private Pay:
  - Know who regulates insurance.
    - *Commerce/insurance depts.*
- Is there an employer ally?

Medicare Initial Determination

- The letter notifying you of an overpayment decision is an “initial determination” that you may appeal.
- Appeal levels:
  - ✓ Level 1: Redetermination.
  - ✓ Level 2: Reconsideration.
  - ✓ Level 3: Administrative Law Judge.
  - ✓ Level 4: Medicare Appeals Council.
  - ✓ Level 5: District Court.

Medicare Level 1: Redetermination

- You have 120 days from receipt of the initial determination to submit a request for "redetermination."
  - BUT, to stop recoupment, you must submit the appeal within 30 days after receipt. Do you want to stop recoupment?
- "Receipt" is presumed to be 5 days after the letter date.

Who Is Responsible for the Appeal?

- Identify your appeals team.
- Involve a physician early.
  - Treating physician versus reviewing physician?
  - Think ahead to who will testify at any hearing.

Gathering the Record

- Inside versus outside records.
- Defining the relevant time frame.
- The importance of pagination.
- Make an exact copy. Really.
- Thorough review by the physician.

Presentation Of Your Arguments

- What is the best format to present your case?
  - ✓ Always include a cover letter.
  - ✓ Consider the use of tables or spreadsheets for claim-by-claim arguments.
  - ✓ Exhibit books.
    - *Medicare currently takes out all tabs!!!*
    - *That will change with the electronic appeals system.*
  - ✓ Bottom line: make it easy for the reviewer to see your arguments and evidence.

Tips From The Judges

- Don’t resend everything. (That worries me a bit.)
- Don’t bates number/paginate. (Also counterintuitive to me!)
- Ask for a copy of the record if it is a big case. (Please do this judiciously, they ask.)
- For truly large cases an in-person hearing may be possible.
- “New evidence” and “new arguments” are different.

Writing The Appeal Letter

- A good strategy: write one good appeal letter to use at all levels:
  - ✓ Redetermination.
  - ✓ Reconsideration.
  - ✓ Administrative law judge.
- The lesser alternative: quick and dirty on the first level.

Writing The Appeal Letter

- Make it terse.
- Frame the argument using authority (statute, regulation, manual). Don’t let the auditor control this!
- Use plain language.
- Include only facts relevant for the standard.

Example 1

- Payor denies a hospitalization for an infant who had a fever for week. They explain that “there was no ‘official’ documentation of a fever.”

Example 1: Do you:

1. Resubmit the medical records highlighting mentions of a fever from the history?
2. Point out the “official” records?
3. Reframe the argument, and challenge the idea that there are “official” and “unofficial records?”

Example 1: What Was Done?

- “We learned that the primary care clinic did not take the patient’s temperature prior to presentation at our ED, so there is no official documentation as to fever.”
- “Official documentation of fever for 7+ days is not a requirement for medical necessity.”
- “As an analogy, a patient presenting to the ED with self-reports of chest pain for a day or more would not have to present official documentation of such pain for medical necessity to justify a heart attack.”

Example 1: What I'd Do?

- The parent's report of fever constitutes evidence of the fever. Patient history is part of the documentation. There is no such thing as "official documentation."
- Your position seems to be that there must be a *clinically measured* fever. No such requirement exists.
- The MI point.

Example 2

- Medicare denies an inpatient stay for a patient undergoing a right carotid artery to right subclavian artery bypass.

Example 2: Do you:

1. Write a letter citing InterQual?
2. Write a letter citing MCG?
3. Write a letter detailing the patient's hospital stay?
4. 1 or 2, and 3?
5. Write a letter describing the physician's expectation for the length of the hospital stay?

Example 2: What Was Done?

- Preface: This memorandum is to appeal the denial of certification and to request a reconsideration. It is also our response to the unfavorable decision issued by _____. We trust that this memorandum will outline the medical necessity for this admission. In view of the reasonable and necessary care provided during this inpatient admission, we request the reversal of the denial of this admission.
- Case Review.

Example 2: What Was Done?

- Medical necessity of the hospital admission: “This inpatient admission was appropriate and consistent with regional and national standards of medical practice. The patient was a diabetic patient with severe peripheral arterial disease who presented to undergo a right carotid artery to right subclavian artery bypass. His ASA class was IV and it required several hours to complete. Postoperatively he had an arterial line and he had difficulty voiding.”

Example 2: What Was Done?

- “Patients with scores of at least three on the outpatient admission index (OSAI) are at higher risk of immediate hospital admission, according to evidence-based research.”
- “For the holdout half of the data set, scores of four or higher had an odds ratio of 34.62 (95% confidence interval, to 8.55-41.97).
- CONCLUSION: The proposed outpatient surgery admission index provides an evidence-based guide to assist clinicians and the health care systems in which they work and identifying patients at risk of immediate hospital admission.”

Example 2: What Was Done?

- “Based on the duration of surgery, this patient required an inpatient admission due to the risk of post-operative pulmonary complications and need for intensive monitoring and management.”

Example 2: What I'd Do

- Cut the chatter.
- Skip that study.
- Cite the Two-Midnight Rule.
- Explain the physician's expectation.
- Keep the pulmonary complication discussion.

Example 2: But Private Pay

- If contracted, must work with the contract.
  - The Two-Midnight rule is close to meaningless. (Unless its Medicare Advantage!)
  - Need to use their criteria.
- If not contracted, industry norms control.
  - Where does that leave the Two-Midnight rule?
  - InterQual or MCG?

Example 3

- A 53-year-old woman presents in the emergency department with right side abdominal pain and nausea that started approximately 1 year prior to this admission. The pain progressed over the preceding two months and was accompanied by nausea, weakness and a 35-pound weight loss. At the time of admission, she also complained of chest pain. Her past medical history was significant for hypertension, GERD, Polycythemia, vertigo and former tobacco use. Her past surgical history included an appendectomy, a tonsillectomy, a tubal ligation, a hysterectomy and decompression of the endolymphatic sac for vertigo.

Example 3: What Was Done?

- A long section under the heading, “Patients with poor nutritional status may be high risk for surgery and require inpatient hospitalization.”
- “This patient who met SIRS criteria clearly had sepsis and required inpatient hospitalization.”
- “In this case, the patient had two signs of SIRS including leukocytosis and tachycardia. Since two signs of SIRS were present, this patient was clearly septic and required prompt inpatient hospitalization.”

Example 3: What I'd Do?

- Articulate the Two-Midnight Rule.
- Discuss the physician's expectation.
- Lead with the sepsis.

Example 4

- Medicare downcodes a 99215 to a 99213 asserting the documentation is insufficient.

Example 4: Do You:

1. Carefully point out how the service in fact qualified for qualified for a 99215?
2. Explain why documentation isn’t the proper measure of the service?
3. Both 1 and 2?

Example 4: What Was Done?

- “We believe that the documentation of this chart can be interpreted as meeting a 99214.”

Example 4: What I'd Do?

- "The documentation meets the guidelines for a 99214." There is no tax deduction for being self-deprecating.
- Explain why we believe a 99215 was properly billable. Cite factors including RVUs, appointment times and other as appropriate.

Required Contents of Medicare Appeal

- The request MUST include:
  - ✓ Beneficiary name.
  - ✓ Beneficiary Medicare health insurance claim number.
  - ✓ Item(s)/service(s) underlying appeal.
  - ✓ Date(s) of service.
  - ✓ Name and signature of party or representative.
- Appointment of Representative form.

Sending the Letter

- Use the address provided in the initial determination.
- Copy the right parties. (Medicare: Beneficiary!!?)
- Use tracking.
- Call to confirm receipt?

Other Process Issues

- Requesting time extensions.
  - Not a Medicare option.
  - Can work on private pay.
- Can they recoup while you fight?
- What do you do with new claims on the same issue?
- Do you need to refund other claims under the 60-day rule? NO! Not if you are appealing.

81 FR 7654, 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.”

Handling Common Problems

- What if your documentation is hard to follow?
- What if your documentation is missing?
- How long should you expect to wait to hear something?
- What do you do if you hear nothing?

Handling Common Problems

- What if the insurer uses a sample?
- What if they don’t?
- Interviewing your staff?
- Do you do a review while the insurer is doing theirs? If so, who do you use?

State of Stats

- Sampling cases present a dilemma.
- For Medicare, winning on sampling may make a gov. appeal more likely/more successful.
- Good statisticians are hard to find/expensive.
- MACs statistical “effort” is often laughable.

Sampling Issues

- Sampling unit (claim/patient/line item). (Are “paid claims” a fair unit?)
- Size.
- Simple versus stratified.
  - Variability.
  - Footballs and fish.
- Precision (.1 vs. .25 vs. .6).
- Confidence intervals.

Private Pay Questions

- What rules apply?
  - ✓ Do you have a contract?
  - ✓ Do Medicare Rules matter?
  - ✓ What if it is a Medicare Advantage Patient?
  - ✓ Are you bound by the Insurer’s Manuals?
  - ✓ How do industry norms factor in?
- Do you have a legal duty to return overpayments?

MAC/District Court

- MAC: usually on the record; often remands.
- District court: can be expensive, but offers settlement options.

Overpayment

"*Overpayment* means any funds that a person has received or retained under title XVIII of the Act to which the person, *after applicable reconciliation*, *is not entitled under such title.**"

-42 CFR 401.303

*This is important, but we will come back to it.

Can You Offset Underpayments: Applicable Reconciliation

"The applicable reconciliation occurs when a cost report is filed; and …"

- 42 CFR 401.305(c)

- Page 7668 includes a convoluted assertion that reconciliation is cost-report specific. The discussion refers to Parts A and B. Part B doesn't feature cost reports.

- Offsetting underpayments seems entirely consistent with the statute, and CMS' interpretation seems baseless.

Challenging Documentation Denials

- “If it isn’t written, it wasn’t done,” isn’t the law.
- Medicare payment is determined by the content of the service, not the content of the medical record.
- The documentation guidelines are just that: guidelines (although the Medicare contractor won’t believe that).

Medical Necessity Denials

- Use the “treating physician rule.”
- The theory is that the patient’s physician is objective. Therefore, the physician’s opinion receives deference.
- Medicare’s legislative history supports this argument.

Manuals/Guidance Can’t Limit Coverage

- 42 USC § 1395hh(a)(1) says nothing other than an NCD may change benefits unless promulgated as a regulation.
- The Brand memo articulates a longstanding principle that only statutes and regulations determine Medicare payment.

How Far Back Can Medicare Go?

- Two statutory provisions limit recovery of overpayments, 1870 and 1879 don’t use the word “reopening.”
- 1870 focuses on “without fault” and includes a time frame, 1879 uses “did not and should not” have known, no timeframe.
- Regulations limit reopening, are silent on recovery.
- Manuals both limit reopening and recovery.

How Does § 1870 Work?

- Focus only on the YEAR payment is made.
- Payment made 1/4/13. Can recover 5 years after 2013, so count: 2014, 15, 16, 17, 18. Recovery possible through 12/31/18.
- Payment made 12/31/12. If new provision applies, 2013, 14, 15, 16, 17. Recovery until 12/31/17.
- Note that references to “five years” are very misleading. Simplicity trumps accuracy.

42 C.F.R. § 405.980

- (b) A contractor may reopen an initial determination or redetermination on its own motion—
- (1) Within 1 year from the date of the initial determination or redetermination for any reason.
- (2) **Within 4 years from the date of the initial determination or redetermination for good cause as defined in § 405.986.**
- **(3) At any time if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault as defined in § 405.902.**

42 C.F.R. § 405.902

"Similar fault" means "to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled. This includes, but is not limited to, a failure to demonstrate that he or she filed a proper claim…"

42 CFR § 411.21 defines a "proper claim" as a "claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or Insurer."

Can You Appeal Following Your Refund?

"*Comment*: Several commenters requested that CMS confirm that refunds based on statistical sampling will maintain appeal rights. Because individual claim adjustments may not be made when sampling is utilized to estimate an overpayment amount, CMS should confirm that providers and supplier may still appeal such findings if necessary."

Can You Appeal Following Your Refund?

"*Response*: To the extent that the return of any self-identified overpayment results in a revised initial determination of any specific claim or claims, a person would be afforded the appeal rights that currently exist. As is currently the case under the existing voluntary refund process, there are no appeal rights associated with the self-identified overpayments that do not involve identification of individual overpaid claims and individual claim adjustments." – 81 FR 7668

How Far Back Can Private Payors Go?

- Is there a contract? What does it say?
- State law:
  - Tort?
  - Contract?
- Is there something else that limits liability? Change in policy?

How Do Refunds Affect RACs?

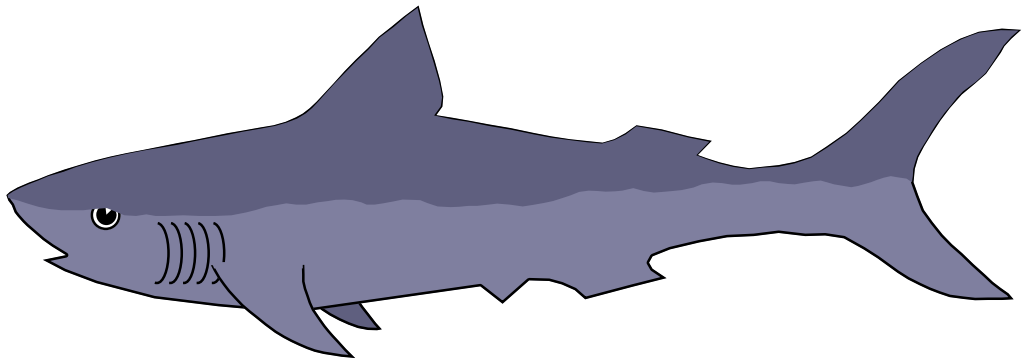
- If you have sampled, no one claim has been “refunded.”
- This will be something to watch.
- Note this is an issue even if the audit is on a different problem.
- In any overpayment situation, always look at prior refunds/audits on the same issue.
- (Note tie-in to rebill/refund issue!)

What About Private Payors?

- Contract (and manual??) control.
- Refund requirement is gov. only, but “health fraud” is a federal crime.
- State statute of limitations apply.
- State insurance law.
- Is Medicare Advantage a private payor?

Here Comes Trouble

- CMS
- OIG
- FBI
- MFCU
- Postal Inspector
- IG Railroad Retirement Board
- DCIS
- Licensing boards
- NRC
- FDA
- DEA



Prep Work Is Key

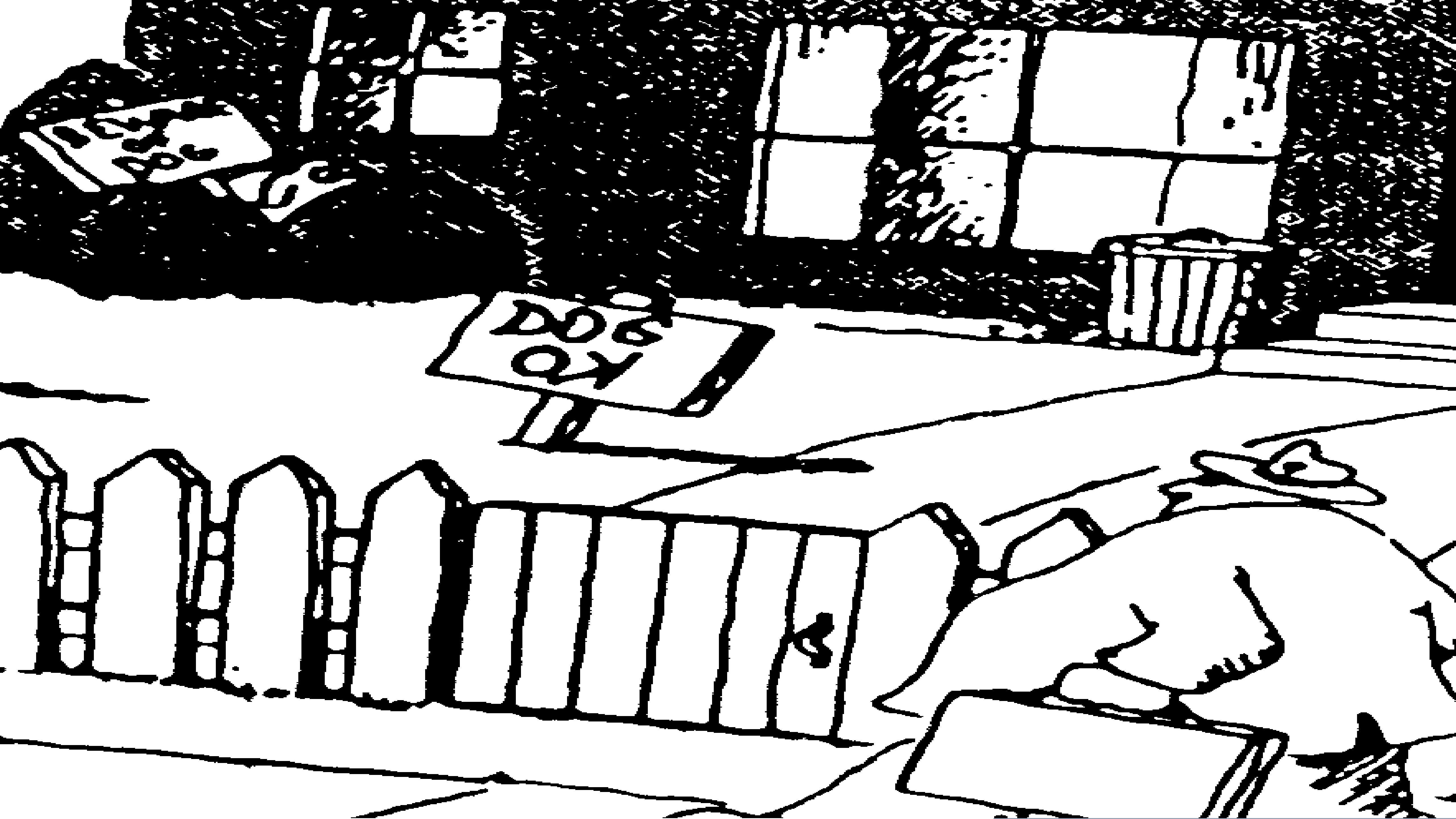
- Know what to do/who to call.
- Try to remember these tips; it is easy to forget, and hard not to panic. (Get our laminated card.)
- An emergency plan must include how to contact people at odd hours.

The Subpoena

A grand jury subpoena from Atlanta says, "The United States Attorney requests that you do not disclose the existence of this subpoena. Any such disclosure would impede the investigation being conducted and thereby interfere with the enforcement of the law."

Armed Agents At The Door

- If they have a warrant, let them in.
- Do not talk to them.
- Get I.D. and call a lawyer.



The Courageous Nurse Alex Wubbels

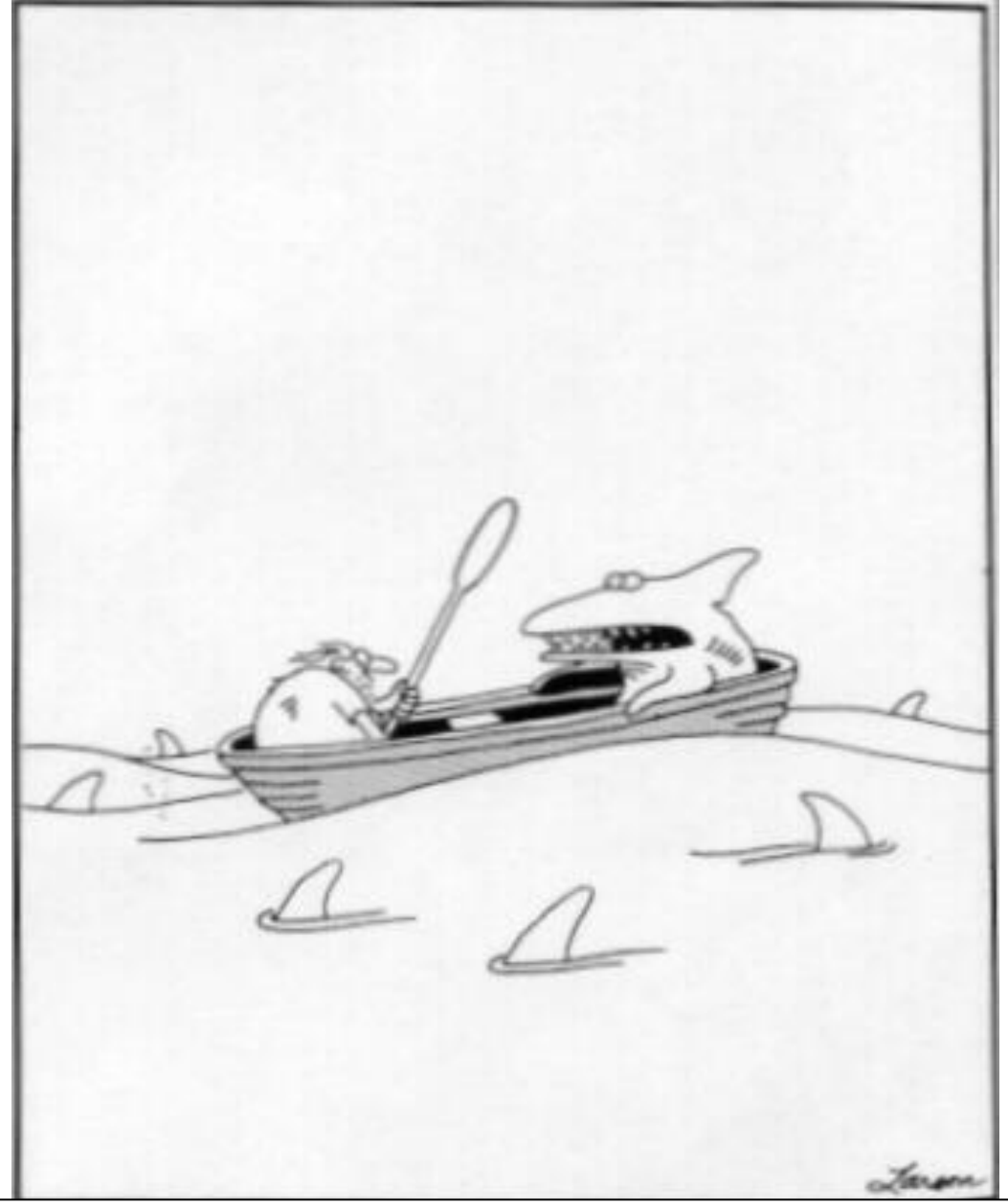
- She stood her ground.
- She stayed calm.
- Good policies in place. She knew where to find them!
- She realized you can’t unring the bell. An important question: What permanent harm is done waiting for an answer?

What Else Could Have Been Done?

- Video the encounter. (That is often resisted by officers, BUT IT IS ABSOLUTELY 100% LEGAL.)
- Contact general counsel.
- As it escalates, bystanders can intervene/contact others.

Dealing With Investigations

- Agents want you to talk. They will use your:
  - ✓ Fear;
  - ✓ Confidence.
- Your biggest weapon:
  - ✓ Silence.
- Be especially wary of saying “my lawyer told me it was ok.” You will have waived the attorney-client privilege.



“OK. I’ll go back and tell my people that you’re staying in the boat, but I warn you they’re not going to like it.”

The Agents Are NOT Your Friends

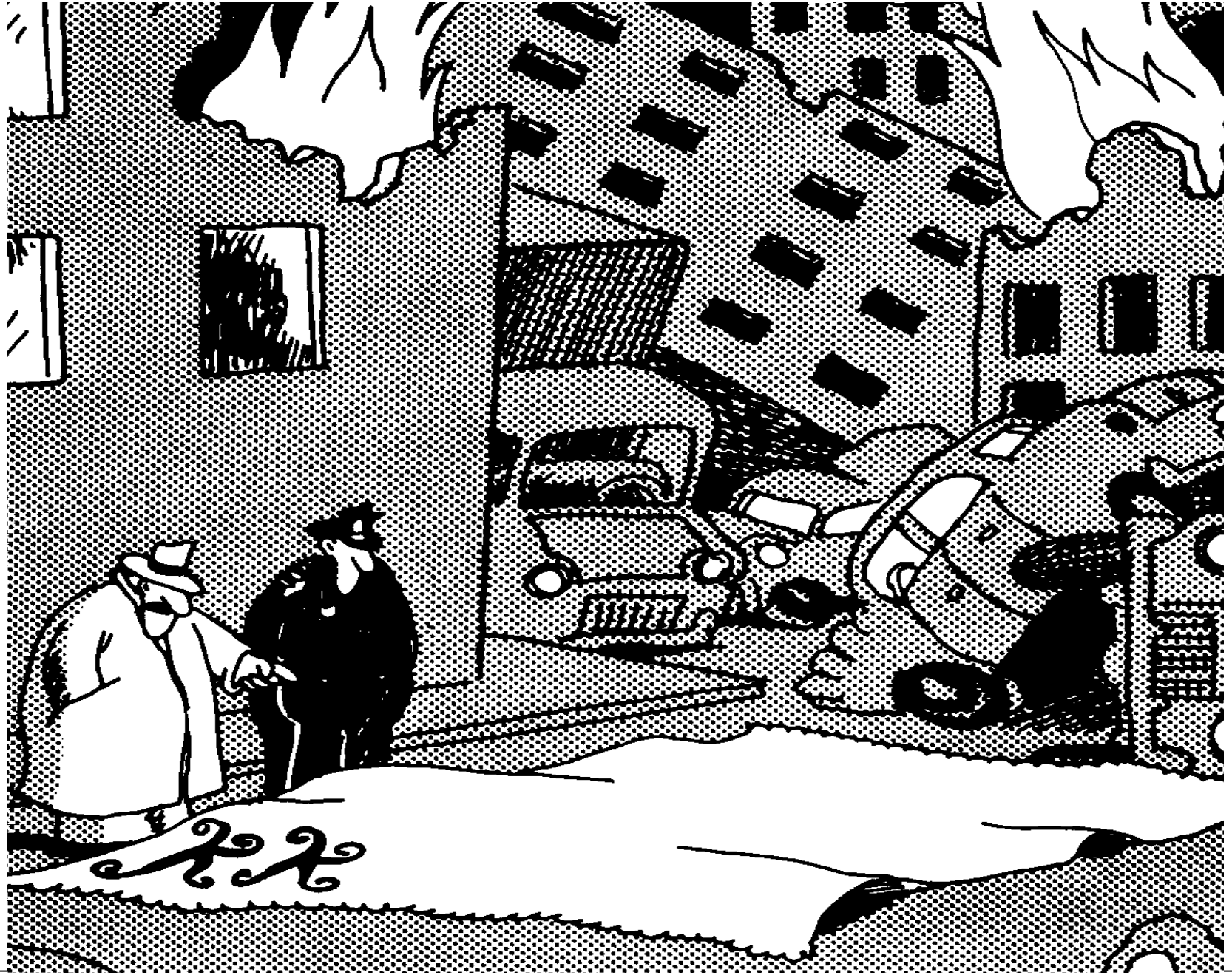
- Don’t try to convince the agent “It is all a misunderstanding.”
- Remember two key points:
  - ✓ Medicare rules are complicated. You may have violated one without knowing it;
  - ✓ To many investigators - there is no such thing as an “innocent mistake.”

Know Your Rights

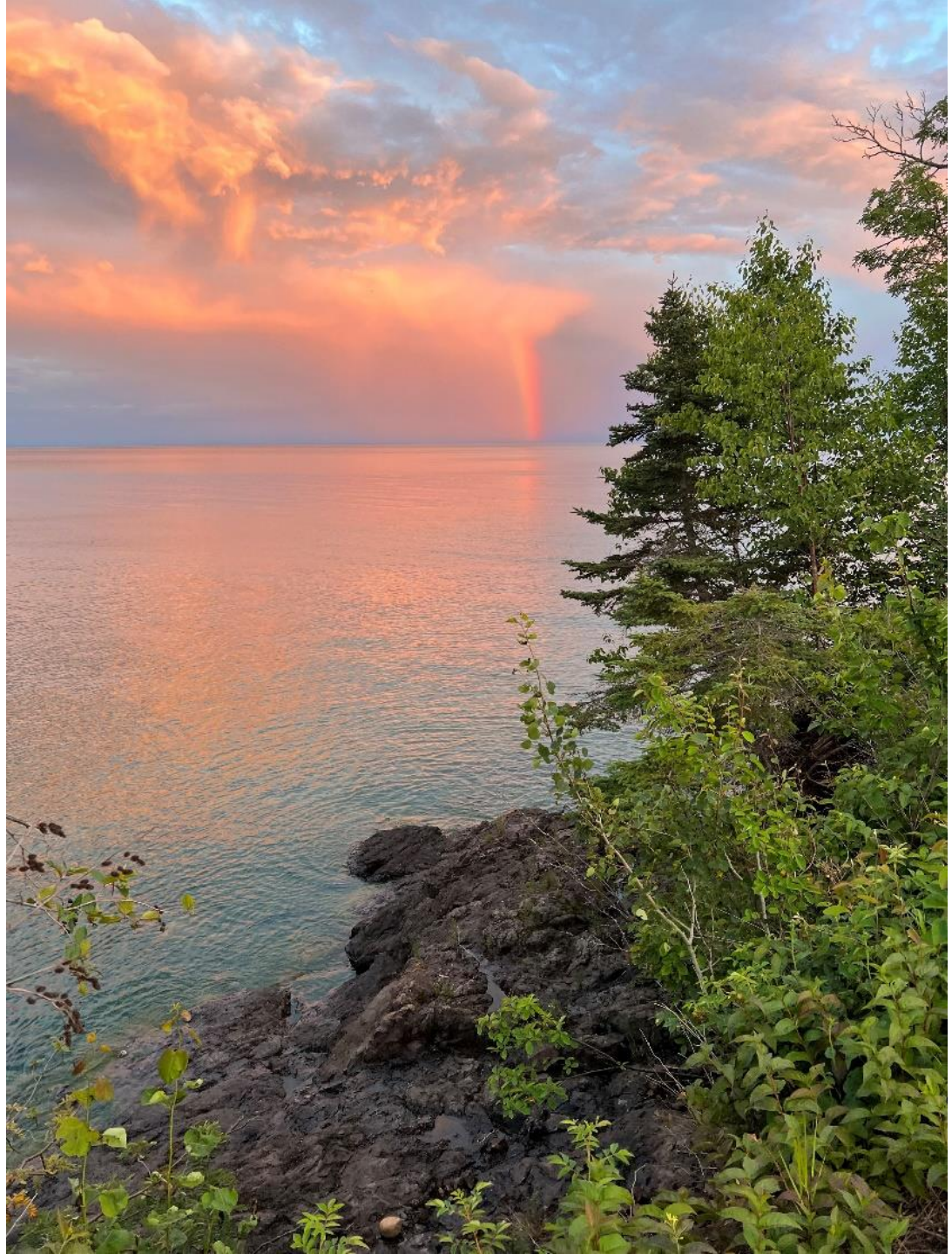
- Agent:
  - ✓ Can’t require anyone to attend interview.
  - ✓ Can’t obtain documents without a warrant or subpoena.
  - ✓ Can’t obtain privileged information.
  - ✓ Can’t prevent you from talking about the interaction.

Know Your Obligations

- Cannot prevent employees from talking.
- If you talk, you must tell the truth.
- Never destroy/hide documents.



“Which monster did this - Godzilla? Gargantua? Who?”



Presenter

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