DEFENDING MEDICARE AUDITS AND OVERPAYMENT IN THE UNITED STATES

C. WILLIAM HINNANT, JR. MD JD FCLM
HINNANT MEDICAL & LAW OFFICES, LLC
ANDERSON, SC USA
netdoc37@aol.com
001-864-226-6132

MEDICARE, MEDICAID AND TRICARE

- Established in 1965 by Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq*.
- Reimbursement is governed by statute and by regulations issued by HHS
- Covers the elderly (>65 yrs), the disabled, renal failure and ALS patients
- Administered by private contractors in the states
- Medicaid covers the poor, many children (Title XIX)
- Administered by the Center for Medicare and Medicaid Services.
- TriCare covers the uniformed services and retirees

EXECUTION – MAJOR STEPS

- 1) Selecting the provider or supplier (MAC, RA, ZPIC ;
- 2) Selecting the period to be reviewed;
- 3) Defining the universe, the sampling unit and the sampling frame;
- 4) Designing the sampling plan and selecting the sample;
- 5) Reviewing each of the sampling units and determining if there was an overpayment (the actual overpayment);
- 6) Estimating the overpayment for the defined universe and determining the demand amount.
- 7) Demand with statistical extrapolation made
- 8) Either payment by provider or appellate process
- 9) If payment not made, offset initiated on all claims paid

NOTICE OF OVERPAYMENT

- PIM states that overpayment demand letter should include information about the review and statistical sampling that was followed:

  Information about sampling methodology:
  – Description of universe, frame, sample design;
  – Definition of sampling unit;
  – Sample selection procedures, numbers and definitions of strata and size of sample;
  – Time period under review;
  – Sample results, including overpayment estimation methodology and calculated sampling error as estimated from sample results;
  – The amount of the actual overpayment from each of the claims reviewed.

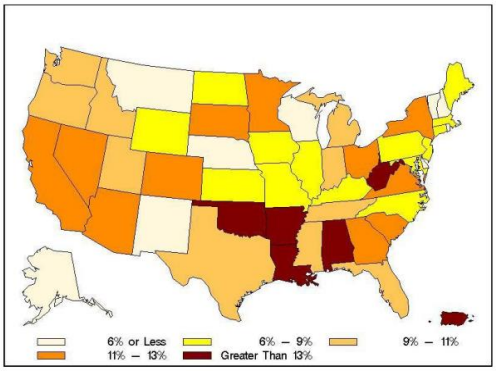
THE ALPHABET SOUP OF PLAYERS

Contractor	Claim Types	Claim Selection	Claim Volume	Purpose of Review
CERT	All Claim Types Medicare	Random	Small	Measure improper payment rates
PERM	All Claim types for Medicaid	Random	Small	Measure improper payment rates
MAC (medical review department)	All claim types with Medicare fee for service	Targeted	Depends on this issue and amount of improper payments	Prevent improper payments Provider Education
RA (formerly RAC)	All claim types with Medicare fee for service (Will begin reviewing Medicaid claims)	Targeted	Size depends of the magnitude of improper payments	Detect past improper payment find program vulnerabilities
ZPIC	All claim types with Medicare fee for service Medi- Medi in some states	Targeted based on potential fraud, waste, and abuse	Size depends of the magnitude of potential fraud and abuse	Identify fraud, waste, and abuse

Table G1: Improper Payment Rates by Provider Type and Type of Error: Part B

Provider Types Billed to Part B	Improper Payment Rate	Number of Claims in Sample	Type of Error				
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other
Chiropractic	51.4%	484	0.5%	93.8%	4.6%	0.3%	0.8%
Occupational Therapist in Private Practice	32.2%	39	0.0%	97.4%	0.0%	2.6%	0.0%
Vascular Surgery	29.4%	72	85.5%	5.5%	6.9%	2.1%	0.0%
Clinical Laboratory (Billing Independently)	24.4%	1,037	0.5%	95.3%	3.8%	0.5%	0.0%
Psychiatry	22.1%	257	0.0%	69.9%	0.0%	30.1%	0.0%
Clinical Social Worker	21.6%	90	0.0%	100.0%	0.0%	0.0%	0.0%
Physical Therapist in Private Practice	18.7%	491	0.8%	91.0%	0.6%	5.4%	2.2%
Pulmonary Disease	18.1%	288	0.4%	61.3%	0.0%	38.3%	0.0%
Clinical Psychologist	17.8%	116	3.9%	93.1%	0.0%	1.7%	1.2%
General Practice	15.8%	81	12.5%	52.0%	0.0%	35.5%	0.0%

Figure 4: 2012 Improper Payment Rates by State[52]



STATUTES OF LIMITATIONS

- **Prior to 2013, for Medicare overpayments, the federal government and its carriers and intermediaries had 3 calendar years from the date of issuance of payment to recoup overpayment. This has been changed to 5 years based on provision in Taxpayer Relief Act of 2012.**
- **The Statute of Limitations does not apply to recovering overpayments made as result of false pretenses or fraud.**

STATISTICAL EXTRAPOLIATION

- *Chaves County Health Svcs. v. Sullivan*, 931 F.2d 914 (D.C. Cir.1991)

The Court finds that absent an explicit provision in the statute that requires individualized claim adjudications for overpayment assessments against providers, the private interest at stake is easily outweighed by the government interest in **minimizing administrative burdens.**

PREREQUISITES TO USING STATISTICAL EXTRAPOLATION

- **42 U.S.C. § 1395ddd(f)(3) (Section 1893(f)(3))**
  A Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset or otherwise unless the Secretary determines that -

1) **There is a sustained or high level of payment error; or**
2) **Documented educational intervention has failed to correct the payment error.**

MECHANISMS TO ATTACK ALLEGED OVERPAYMENT

(1) CLAIM VALIDATION:

- CHALLENGE THE MEDICINE
- CHALLENGE THE ADEQUACY OF THE MEDICAL RECORD DOCUMENTATION

(2) EXTRAPOLATION CHALLENGE:

- CHALLENGE THE EVOCATION OF STATISTICAL EXTRAPOLATION
- CHALLENGE THE STATISTICAL METHODOLOGY

(3) COMBINATION OF THE TWO

WHAT A PROVIDER SHOULD DO

- GET AN EXPERIENCED HEALTH LAWYER!!!!!!
- Administrative Appeals Process:
- 42 C.F.R. Part 405 Subpart I:
- **Initial Determinations: Medicare overpayment determination and determination of liability**
- **STEP 1** - Redetermination: 42 C.F.R. § § 405.940, 948:
  – Contractor independent review of the initial determination.
- **STEP 2** - Reconsideration by a Qualified Independent Contractor ("QIC"): 42 C.F.R. § 405.904.

ADMINISTRATIVE APPEAL – STEP 3

- ALJ Hearing. 42 C.F.R. § 405.1000.
- In 2005, CMS amended its regulations to explicitly permit CMS or its contractor to participate or be a party to such proceeding where "input from CMS or a contractor will help resolve an issue in a case." 70 Fed. Reg. 11420, 11459 (Interim Final Rule) (Mar. 8, 2005).
- 42 C.F.R. § § 405.1010, 405.1012: participation/party status.
- The ALJ may not draw any adverse inferences if CMS or a contractor declines to participate or invoke party status. 42 C.F.R. § § 405.1010(f), 405.1012(d).

ADMINISTRATIVE APPEAL – STEP 4

- Departmental Appeals Board (Medicare Appeals Council)
- A **party to the ALJ hearing may submit a request** for review of the ALJ's decision by the DAB. 42 C.F.R. § § 405.1100, 405.1102.
- The **DAB may on its own motion review the** decision of the ALJ if the decision contains an error of law material to the outcome of the claim and is not supported by the preponderance of the evidence in the record pursuant to 42 C.F.R. § 405.1110.

STEP 4 (CONT.)

- CMS or its contractor may request that the DAB take on own motion review of a case if CMS or its contractor **participated in the appeal at the ALJ level and in the CMS's view, the ALJ's decision or dismissal is not supported** by the preponderance of evidence in the record or the ALJ abused his or her discretion. 42 C.F.R. § 405.1110(b).
- CMS or any of its contractors may refer a case to the MAC if, in their view, the decision or dismissal contains an **error of law material to the outcome of the claim or** presents a **broad policy or procedural issue that may** affect the public interest. Id.

JUDICIAL REVIEW

- Judicial Review
- A party has 60 days to request judicial review
- 42 C.F.R. § 405.1006(c)
- 42 U.S.C. § 405(g)
  – Secretary's findings of fact, if supported by substantial evidence, are conclusive.

AUDIT APPEAL PROCESS

120 days **60 days** **MAC, RA, ZPIC**
Initial---------->Request for---------->Redetermination Decision
Determination Redetermination
(MSN or RA)

180 days **60 days** **QIC**
Unfavorable---------->Receipt of Reconsideration---------->Reconsideration
Redetermination Request by QIC Decision

60 d to file **90 d** **No timeframe** **ALJ**
Reconsideration-------->Receipt of ALJ----->OMHA-ALJ----->Case forwarded
Decision Request Decision to AdQIC

POST ALJ REVIEW

AdQIC Initiated

Accepts Referral---------> DAB Hearing
10 d Sent to DAB--<
Ad QIC------< Denies Referral---->Effectuation to MAC
Decision no **30 d to effectuate**
review needed ----------> **60 d to complete**

Party Initiated

60 d to file 90 d timeframe
ALJ Decision--------->Receipt of DAB--------->DAB Decision-----|

APPELLANT HAS 60 DAYS TO APPEAL TO FED DISTRICT COURT

WAIVERS

§ 1870(b) – rebuttable presumption that providers not liable for overpayments more than 3 (now 5) years after initial determination

§ 1870(c) – waiver of recoupment of overpayments where no fault on behalf of provider, where would defeat purposes of Titles II and XVIII, and/or would be against equity and good conscience

§ 1135 – waiver of enforcement in event of national emergency

CLAIM VALIDATION DEFENSES

- Medical Record documents alleged deficiency earlier in time
- Level of billing is justified based on earlier documentation
- That MAC or PSC incorrectly portion of the medical record allegedly deficient
- That documentation deficiency is de minimus

SAMPLING BURDEN OF PROOF

- "CMS Rulings are published under the authority of the CMS Administrator. Consistent with § 401.108 of this chapter, rulings are binding on all CMS components, on all HHS components that adjudicate matters under the jurisdiction of CMS …" 42 C.F.R. § 405.1063(b).
- CMS Ruling 86-1: the use of statistical sampling creates a presumption of validity as to the amount of an overpayment which may be used as a basis for recoupment. The burden then shifts to the provider.

THIS IS A PRESUMPTION UNDER U.S. LAW

ATTACKING EXTRAPOLATION

- Challenge Burden of Proof (*statistical validity*)
- Challenge Constitutional Due Process (*no property interest in retained overpayments, notice includes solely opportunity to correct payer error*)
- Lack of Threshold Determination (*no notice requirement as to sustained or high level of payment error*)
- Challenge Sample Size (*no statistical sample size floor*)
- Challenge Precision (*no specific level of sampling precision required*)
- Challenge Representativeness of Sample (*sample does not have to correlate to whole population*)

ATTACKING EXTRAPOLATION

- Challenge Lack of Documentation (*no minimum documentation requirement must be produced*)
- Challenge Stratification (*proportionately stratified design more accurate than random sampling of same size*)
- Challenge Procedural Issues (*no right to cross examine non-party, carrier need not appear*)
- Challenge Waiver of Liability (*Hurricane Katrina*)
- Challenge Failure to Follow PIM (*PIM is not a set of mandatory regulations*)

RECOMMENDATIONS

- Adhere to all appeal deadlines;
- Review the medical record in depth
- Make sure you have **all documentation needed to recreate sampling methodology;**
- Keep in mind the burden of proof - **conclusory allegations are insufficient.**
- Make sure your expert demonstrates how the lack of precision, representativeness, etc. prejudices the provider

HIRE AN ATTORNEY WHO'S EXPERIENCED