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Medicare Audits and Appeals

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The content of this presentation is not intended to serve as legal advice
Richelle Marting
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Richelle Marting is an attorney, registered health information administrator, and certified coder who focuses on healthcare coding, billing, and reimbursement issues. She has practical, in-the-trenches experience with coding and billing issues. She has served as an outpatient multi-specialty surgery coder, hospital-based outpatient coder and a compliance coordinator for a large multi-specialty medical group.

As an attorney she advises clients proactively on complex reimbursement questions and has guided multiple clients through extensive Medicare and OIG audits and investigations.
Overview

Types of Audits

The Five Levels of Appeal

Beginning of an Audit
Types of Audits
Medicare Audit Contractors

- Medicare Administrative Contractors (MAC)
  - Medical Review
  - CERT
  - Target, Probe, and Educate
- Recovery Audit Contractors (RAC)
- Zone Program Integrity Contractors (ZPIC)/UPICs
- Benefits Coordination and Recovery Center (BCRC), Commercial Repayment Center (CRC)
- Qualified Independent Contractors (QIC)
- Quality Improvement Organizations (QIO)
- Medicare Advantage Organizations (MAO), Independent Review Entities (IRE)
Beginning of an Audit
Before the Audit:
Request for Medical Records

- Save Medicare guidance (i.e. MAC website guidance), email communications, that you rely upon
- Comparative Billing Reports
  - Provider specific report with aberrant billing patterns
  - Could come before a probe audit or part of audit
- Medical Records Request (Additional Documentation Request)
  - Understand what services/codes are at issue
  - Research MAC and other coding, documentation, billing requirements
  - Look for “statistically valid sample”
  - Always evaluate the lookback period
  - RAC: consider record request limits
Before the Audit: What to Submit

- Identifies the records being requested, but consider what is needed to support services under review
- Any previous guidance you’ve relied upon?
- Any previous favorable Medicare reviews of these services?
- ABN forms
- Telehealth: consents, supervision
- **Review the records before submission**
- Consider a “mini appeal” when submitting records
- Signature logs
- [Signature attestations](#)
- Log all services under review
Before the Audit:
Record Submission

- **Submission of Records**
  - 45 days to respond – but beware of letters that give 30
  - Bates stamp
  - Call to confirm submission/receipt with reviewer
  - **Know deadline to respond; varies by type of audit**
    - 30-60 days
Audit Decisions

- Decision Letter v. Demand Letter
- Demand Letter Triggers Appeal Deadlines
- Reconcile decision letter against your log of services under review
- Contact reviewer immediately with any discrepancies
- Secondary payors may be notified automatically
- RAC discussion period
Before the Appeal, Rebuttals

- The provider may submit a rebuttal statement to the demand letter within 15 calendar days from the date of the demand letter.
- The rebuttal will lay out why Medicare should not initiate recoupment
  - The reasons should be other than a disagreement over the overpayment assessment
- A rebuttal statement is not an appeal
The Five Levels of Appeal
Level I: Redetermination

• An “initial determination” or “reopening determination” must exist
• The contractor’s decision on a claim is the “initial determination”
• An initial determination that is revised in a reopening by the MAC (as typically happens in post-payment audits) becomes a “revised” or “reopened” determination
• Form v. Letter
• File within 120 days of receipt of the initial determination
  • presumed to be five days after date of notice
  • but for stay of recoupment, file within 30 days
• Appointment of representation; duration of validity
Level I: Redetermination

- 95% of redeterminations should be decided by the MAC within 60 days of the filing
  - Submitting additional evidence extends deadline fourteen (14) days for each such submission
- No right to escalate to next level if MAC does not issue decision within 60-day (or as extended) time frame
- Desk review must be conducted by a different individual(s) than the one(s) who made the initial or reopened determination
- Qualifications of reviewers
### 2017 Redetermination Categories

**Part A**

<table>
<thead>
<tr>
<th>Appeal Category</th>
<th>Decided Claims</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (Hospice, etc.)</td>
<td>96,292</td>
<td>27%</td>
</tr>
<tr>
<td>Lab</td>
<td>84,617</td>
<td>23%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80,717</td>
<td>22%</td>
</tr>
<tr>
<td>Home Health</td>
<td>69,453</td>
<td>19%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>14,476</td>
<td>4%</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>13,918</td>
<td>4%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>2,034</td>
<td>1%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>361,507</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Part B**

<table>
<thead>
<tr>
<th>Appeal Category</th>
<th>Decided Claims</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>1,401,383</td>
<td>51%</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>916,551</td>
<td>33%</td>
</tr>
<tr>
<td>Other (Preventative Services, Vision, etc.)</td>
<td>157,842</td>
<td>6%</td>
</tr>
<tr>
<td>Lab</td>
<td>152,485</td>
<td>6%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>121,064</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,749,325</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Level I: Redetermination

Redetermination Dispositions for 2017

Part A Redeterminations

- Unfavorable: 44%
- Partially Favorable: 6%
- Fully Favorable: 50%

Part B Redeterminations

- Unfavorable: 42%
- Partially Favorable: 5%
- Fully Favorable: 53%
Level II: Reconsideration

- Form v. Letter
- File within 180 days of receipt of the redetermination
  - but for stay of recoupment, file within 60 days of date of redetermination
- Submit all necessary evidence at this level
- New evidence cannot be considered at subsequent levels of appeal, unless “good cause” is shown
- Evidence may be presented to the QIC at any time before its decision
  - Each submission extends the QIC’s deadline fourteen (14) days
- Decision within 60 days (plus extensions)
- If QIC cannot complete within its deadline, then appellant can, upon request to the QIC, “escalate” to ALJ level
  - Not practical option at this time
Level II: Reconsideration

• Once the QIC issues its decision, stay of recoupment ends
• On questions of medical necessity, the QIC must use panels of physicians or other “appropriate health care professionals”
• QIC may obtain evidence on its own
• QICs are not bound by contractor Local Coverage Decisions or CMS program guidance “such as program memoranda or manual instructions, but [must] give substantial deference to these”
• No hearing at the QIC level (desk review)
• Consider request to reopen for clear error
Level II: Reconsideration

Reconsideration Dispositions for 2017

Part A Reconsiderations
- Favorable: 77%
- Partially Favorable: 21%
- Unfavorable: 1%

Part B Reconsiderations
- Favorable: 59%
- Unfavorable: 37%
- Partially Favorable: 5%
Level I: Redetermination

Redetermination Dispositions for 2017

Part A Redeterminations

- 44% Unfavorable
- 6% Partially Favorable
- 50% Fully Favorable

Part B Redeterminations

- 42% Unfavorable
- 5% Partially Favorable
- 53% Fully Favorable
Level III: ALJ Hearings

- Amount in controversy (AIC) minimum for 2021 is $180/claim
  - You may request aggregation to meet AIC
- Request for hearing must be filed within sixty (60) calendar days of receipt of the QIC reconsideration or dismissal
  - Form OMHA-100, available at www.hhs.gov/omha
  - Add Form OMHA-100A to list multiple beneficiaries
  - Add Form OMHA-103 to request extension if past 60 days
- Submit a separate request for each reconsideration or dismissal
- There is no stay of recoupment during ALJ appeals process or during higher levels of appeal
- Copy requirement
  - Send a copy of request to parties identified on QIC reconsideration or dismissal
- Backlog challenges
  - Beneficiary-Initiated Appeals v. All Other Appeals
Level III: ALJ Hearings

• Issues for requests for hearing:
  • The unfavorable issues from below
  • The favorable portion of a claim or appealed matter specified in the request for hearing IF notice is provided.
  • Challenges to sampling / extrapolation IF articulated in your request for hearing.
• A dismissal by a QIC may be appealed to an ALJ, but to no higher level.
  • The issue is whether the dismissal was correct
• CMS contractors may participate in ALJ hearings, either as a party or a non-party participant.
  I If ALJ does not decide the case within 90 days of when appeal request received, an appellant may escalate certain appeals to Medicare Appeals Council.
Level III: ALJ Hearings

• Four Types of Hearing
  • In-person hearings
  • Video-teleconference (VTC) hearings
  • Telephone hearings
  • On-the-Record reviews (no oral hearing)

• New evidence admitted only for good cause
  • Applies to providers/suppliers and beneficiaries represented by providers/suppliers in Part A and Part B appeals
  • Provide good cause statement (explain why it is just now being submitted)
  • Does not apply to oral testimony at the hearing
  • Does not apply to unrepresented beneficiary, beneficiary represented by someone other than provider/supplier, CMS or its contractors, Medicaid State agency, and applicable plan

• Discovery is available, if CMS enters as a party
• Examine, and if possible obtain a copy of, the ALJ’s copy of the Record
• Prehearing conference—to “facilitate the hearing”
  • An option, but not a right
Level III: ALJ Hearings

• Witnesses
  • ALJ can call witness(es), such as medical or statistical expert
  • Your own, including expert witnesses
  • Use of affidavits in lieu of live testimony
  • QIC or other contractors

• CMS/Contractors as Parties or Participants
  • CMS (or a RAC, ZPIC, MAC, or QIC) intervening as a “party” or participating as a “non-party participant”?
  • Two opportunities to elect: (1) within 30 calendar days after notification that a request for hearing was filed (non-party participant elections only); and (2) within 10 calendar days of receipt of notice of hearing
Forms available on our website at [www.hhs.gov/omha](http://www.hhs.gov/omha):

- Request for ALJ Hearing or Review of Dismissal (Form OMHA-100)
- Request for ALJ Hearing or Review of Dismissal – Multiple Claim Attachment (Form OMHA-100A)
- Request for Extension of Time to File a Request for ALJ Hearing or Review of Dismissal (Form OMHA-103)
- Waiver of Advance Written Notice of Hearing (Form OMHA-143)
- Withdrawal of Request for ALJ Hearing or Review of Dismissal (Form OMHA-119)
- Filing of New Evidence (Form OMHA-115)
- Appointment of Representative (Form CMS-1696)
- Notice of Intent to Participate in Proceedings on a Request for ALJ Hearing or to be a Party to an ALJ Hearing (Form OMHA-105)
- Request for Copy of the Records in the Case File (Form HHS-719)
- Request for Escalation to Medicare Appeals Council (Form OMHA-384)
## Level III: ALJ Hearings

<table>
<thead>
<tr>
<th>Appeals</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
<th>FY18</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Favorable</td>
<td>53.2%</td>
<td>44.3%</td>
<td>36.6%</td>
<td>33.6%</td>
<td>25.6%</td>
<td>17.2%</td>
<td>17.3%</td>
<td>17.7%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Partially Favorable</td>
<td>6.4%</td>
<td>5.2%</td>
<td>2.8%</td>
<td>3.1%</td>
<td>2.0%</td>
<td>1.0%</td>
<td>1.1%</td>
<td>1.9%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Unfavorable</td>
<td>27.9%</td>
<td>25.5%</td>
<td>30.1%</td>
<td>37.5%</td>
<td>44.5%</td>
<td>24.9%</td>
<td>20.9%</td>
<td>26.1%</td>
<td>31.0%</td>
</tr>
<tr>
<td>Dismissed</td>
<td>12.5%</td>
<td>25.0%</td>
<td>30.5%</td>
<td>25.8%</td>
<td>27.9%</td>
<td>56.9%</td>
<td>60.7%</td>
<td>54.3%</td>
<td>50.4%</td>
</tr>
</tbody>
</table>
Level III: ALJ Hearings

Special resolution initiatives
  Settlement conference facilitation
  Statistical sampling
Level IV: Medicare Appeals Council

- Within sixty (60) days of receipt of notice of ALJ decision
- Form v. Letter
- The Medicare Appeals Council may initiate a review of an ALJ decision on its own motion within sixty (60) days
- Medicare Appeals Council must implement its own motion review within the sixty (60) days
- Usually a review on the record
Level V: Federal District Court
Questions?

Available Through Heartland Telehealth Resource Center for Technical Assistance
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