

THE MEDICARE APPEALS PROCESS: STRATEGIES FOR
DEFENDING MEDICARE AUDITS

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I. The Medicare Audit

Medicare audits are generally designed to determine whether a provider has been reimbursed by the Medicare program for services which are properly reimbursable by the federal government. Medicare selects physicians and other practitioners (commonly referred to as “suppliers”) for Medicare Part-B audits based on (1) random reviews (2) prior problems or atypical billing patterns or (3) a particular kind of billing problem that the carrier is focusing on. Primarily, medical review, processes focus on identification of irregularities or patterns of inappropriate billing, educating providers on Medicare coverage and coding requirements, and performing medical review of claims and the supporting documentation. Most Medicare review audits fall into one of two broad categories: (1) “prepayment manual review” -- a review of claims before Medicare pays the physician and (2) “post-payment medical review” -- an analysis of claims after payment. Early intervention by an attorney is recommended to assist in determining how to respond to a Medicare audit.

Who is the Audit Letter From?

One of the first issues to consider is a determination of the nature of the party who is trying to audit you. Routine audits are usually conducted by the Medicare carrier or intermediary (e.g., National Heritage Insurance Company). Audits by a Medicare safeguard contractor (e.g., EDS), Department of Justice or other third party are considered non-routine comprehensive audits (usually the result of beneficiary complaints or whistleblowers) and are generally more serious in nature than a routine audit. For example, a letter signed by a “Special Investigator—Medicare Program Integrity Unit” indicates a non-routine request based on a prior identification of problems.

What Type of Audit is Being Conducted?

When initiating provider specific prepay or any kind of post-pay review, Medicare carriers must notify physicians that the provider has been selected for review and provide the specific reason for such selection. The carrier must advise the provider whether the review will occur on a prepayment or post-payment basis. If it is on a post-payment basis, the carrier must provide the list of patients for which the provider must submit medical records. Prepayment audits, the most common type, are random sweeps in which carriers typically want to look at only one or two claims from each physician. The primary function of the pre-payment medical review team is to ensure that services flagged for review are both reasonable and necessary. The prepayment staff also initiates claims review for specific claims and services either at random or selected samples, and conducts claims review for providers or groups with identified billing problems that require monitoring prior to reimbursement.

Post-payment medical reviews consists of validation of potential billing errors or clarification of payment errors. Primarily, the carrier is just trying to educate a provider about a problem with their coding. Still, the carrier may sometimes ask a provider to refund an overpayment. In some cases, the provider may be required to submit documentation with every future claim. In a comprehensive post-payment medical review, the carrier goes over a small sample of claims and uses the results to calculate a projected overpayment for a period of months or years.

How to Respond to a Carrier's Request

If you receive a letter from your Medicare carrier requesting a number of charts, contact your health care law attorney immediately and fax him or her the letter. Your attorney may hire a coding expert to review the charts, preferably before you submit them to the carrier. If the expert can't complete the review before the carrier's deadline, either ask for an extension or simply have the expert conduct his review at the same time as the carrier. Your attorney should have the review done under the attorney “work-product privilege” so that the results will be

confidential. Review all charts before you submit them to the carrier. Be certain to include everything that could support your claim.

Notification of Provider Audit Results

After the audit has been completed the provider is presented with the carrier's findings and requested to repay alleged overpayments and implement a corrective action plan, if applicable. This is the point when a provider must consider whether or not to appeal the audit finding. A carrier must notify each provider in writing of the results of a post-payment review. The notification must be provided within sixty (60) days of the receipt of medical records. The carrier notification must include:

- the reason for conducting the review
- a narrative description of the overpayment or underpayment situation
- the findings for each claim in the sample
- an explanation of the provider's right to submit a rebuttal statement prior to recoupment
- the provider's appeal rights, and
- an explanation of the process for recovery of overpayments.

Responding to the Initial Notification of Provider Audit Results

After completing the audit, the carrier will usually give the physician three choices:

- pay the assessment
- waive all appeal rights and submit evidence to prove the assessment is wrong
- have the carrier examine a larger sample of charts while leaving the physician the right of appeal.

We generally recommend the last option, however, before making a decision, carefully review the letter to determine if it:

- gives the provider an opportunity to submit additional documentation
- provides an opportunity for a meeting to discuss the findings
- indicates that the physician will be audited again
- requires the provider to attend an educational seminar, and
- includes the actual and potential overpayment amount.

The carrier's assessments are often wrong, and there's no reason to give up your right of appeal. Industry sources indicate that only 10% of claim denials or audits are appealed, but that 90% of appeals are successful. One indication of the scope of the audit is the number of medical records requested. You needn't be too concerned about a request for one chart. A request for five or more, on the other hand, suggests that the carrier is seeking a pattern of miscoding. If it finds such a pattern, overpayments can run into hundreds of thousands of dollars; in rare cases, they may result in criminal or civil penalties. That's why providers need to be prepared and represented by legal counsel during Medicare audits.

II. The Medicare Appeals Process

CMS implemented changes to Medicare appeal procedures in 2005. Providers and suppliers undergoing Medicare audits are well advised to understand the new appeals process, as many of the changes in the final rule impact not only the appeals procedure, but also the substantive rights of providers and suppliers during the appeals process. Providers should understand that there may be many effective strategies that can be successfully employed in the appeals process. The regulations governing the uniform Medicare Part A and Part B appeals process are contained in 42 C.F.R. Part 405 subpart I. The first level in the appeals process is the re-determination. A provider must submit re-determination requests in writing within 120 calendar days of receiving notice of initial determination. There is no amount in controversy requirement. A carrier or intermediary is not permitted to recoup any monies it has determined that have been paid in error once a request for re-determination has been filed, until there is a

decision rendered at the second stage of appeal, the reconsideration stage. Providers in the appeals process should be aware that many carriers and intermediaries are initiating withholds in the days following an initial determination, well before the 120-day timeframe in which the provider must file its request for re-determination has elapsed. In essence, if the provider wishes to avoid the withhold, this forces the provider to file its request for re-determination before the 120-day timeframe has expired. In addition, some carriers and intermediaries are also taking the position to re-initiate a withhold after an unfavorable decision has been issued on re-determination and before a request for reconsideration has been filed.

A provider dissatisfied with a carrier's re-determination decision may file a request for reconsideration to be conducted by a Qualified Independent Carrier ("QIC"). This second level of appeal must be filed within 180 calendar days of receiving notice of the re-determination decision. There is no amount in controversy requirement. The QIC hearing is an "on-the-record" review. In conducting its review, the QIC considers evidence and findings upon which the initial determination and re-determination were based plus any additional evidence submitted by the parties or that the QIC obtains on its own. If an initial determination involved a decision regarding the medical necessity of an item or service, the QIC's reconsideration must involve consideration by a panel of physicians or appropriate health care professionals, and must be based on clinical experience, the patient's medical records, and medical, technical, and scientific evidence on record. Where the claim involves physician services, the reviewing professional must be a physician, however, the physician reviewer need not be in the same specialty as the physician whose claims have been denied.

Physicians must submit a full presentation of evidence in the reconsideration stage. When filing a reconsideration request, a provider must present evidence and allegations related to the dispute and explain the reasons for the disagreement with the initial determination and re-determination. Absent good cause, failure of a provider to submit evidence prior to the issuance of the notice of reconsideration precludes subsequent consideration on the evidence. Accordingly, providers may not be permitted to introduce evidence in later stages of the appeals process if such evidence was not presented at the reconsideration stage.

The third level of appeal is the Administrative Law Judge (ALJ) hearing. A provider dissatisfied with a reconsideration decision or who has exercised the escalation provision at the reconsideration stage may request an ALJ hearing. The request must be filed within 60 days following receipt of the QIC's decision and must meet the amount in controversy requirement. ALJ hearings may be conducted by video-teleconference ("VTC"), however if VTC is unavailable or in other extraordinary circumstances the ALJ may hold an in-person hearing. Alternatively, the ALJ may offer a telephone hearing.

The fourth level of appeal is the Medicare Appeals Counsel ("MAC") Review. The MAC is within the Departmental Appeals Board of the U.S. Department of Health & Human Services. A MAC Review request must be filed within 60 days following receipt of the ALJ's decisions. Among other requirements, a request for MAC Review must identify and explain the part of the ALJ action with which the party disagrees. Unless the request is from an unrepresented beneficiary, the MAC will limit its review to the issues raised in the written request for review. Upon request, the MAC will grant the parties a reasonable opportunity to file briefs or written statements. Additionally, a party may request an opportunity to present an oral argument. The MAC will grant this request if the case raises an important question of law, policy, or fact that can't be readily decided based upon the written submissions. If the MAC fails to issue a decision or remand the case within the mandatory timeframe, the provider may request the appeal to be escalated to the federal district court. The final step in the appeals process is judicial review in federal district court. A request for review in district court must be filed within 60 days of receipt of the MAC's decision. In a federal district court action, the findings of fact by the Secretary of the Department of Health and Human Services are deemed conclusive if supported by substantial evidence.

III. Legal and Other Strategies for Defending Payor Audits

Many strategies exist that can be successfully employed in the appeals process to get meaningful results. These strategies involve effectively advocating the merits of the underlying services as well as employing legal defenses. When advocating the merits of a claim in the audit process, it is beneficial to engage the services of a qualified expert, particularly when the audit involves medical necessity denials. Other strategies that can prove successful include the use of medical summaries and other similar types of color-coded charts that are user-friendly for the

decision maker. The summaries should focus on the services that were denied and the medical explanation of why the services were medically necessary and appropriately billed.

In addition to advocating the merits of a claim, certain legal defenses are available. The Medicare statutes contains two important defenses for physicians: The “Waiver of Liability Defense” and the “Provider Without Fault Defense.” The referenced defenses are available if the physician is “without fault,” that is, if he or she (a) made full disclosure of all material facts and (b) had a reasonable basis to believe that on the basis of all information available to him or her, that the payment was proper. If so, there may be no liability for a claimed overpayment.

IV. Conclusion

Our firm has assisted numerous providers in responding to Medicare Audits and preparing Medicare Appeals. If you have any questions about Medicare Audits or Medicare Appeals, please contact Michael Dowell at (310) 788-3533 (mdowell@tocounsel.com) or the lawyer in the firm who advises you on health care issues.

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