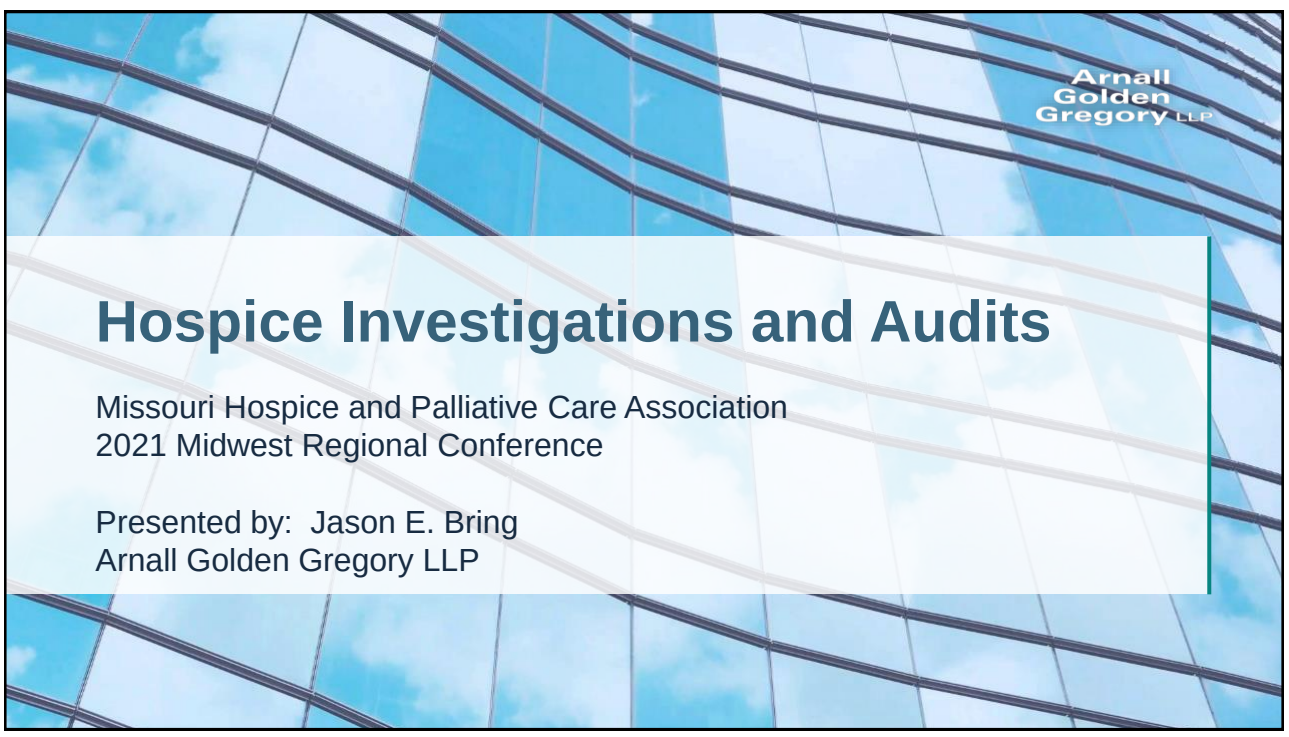

Hospice Investigations and Audits

Missouri Hospice and Palliative Care Association
2021 Midwest Regional Conference

Presented by: Jason E. Bring
Arnall Golden Gregory LLP

1

What are We Going to Cover?

- Investigation and audit preparedness
- Types of auditors
- Focus areas for hospice
  - OIG Work Plan
  - OIG Report
- OIG / DOJ investigations – soup to nuts
- Corporate Integrity Agreements
- UPICs f/k/a ZPICs

2

"We have excellent surveys!"

Just because you are getting good survey results does not mean that you are submitting clean claims for reimbursement.

Reimbursement is greatest area of risk

Surveys

Reimbursement Risk

Types of Audits

- For hospices, the main audits we see are:
  - MIC: Medicaid Integrity Contractors
  - ADR: Additional Development Requests
  - SMRC: Supplemental Medical Review Contractor
  - TPE: Targeted Probe and Educate
  - UPIC: Unified Program Integrity Contractors
  - MFCU: Medicaid Fraud Control Units
  - OIG / DOJ: Office of Inspector General and Department of Justice

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ADRs

- Conducted by intermediary or MAC
- ADRs relate to a particular probe or edit, which may be service-specific (e.g. non-cancer length of stay, general inpatient care, etc.), provider-specific, beneficiary-specific or diagnosis driven.
- If claim payment is denied after its ADR review (initial review determination), the hospice may choose to appeal that denial through the Medicare appeals process.

6

MFCUs

- Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud as well as patient abuse or neglect in health care facilities and board and care facilities.
- MFCUs operate in 49 States and DC
- Usually part of State Attorney General's office
- Employ teams of investigators, attorneys, and auditors
- Are constituted as single, identifiable entities
- Must be separate and distinct from the State Medicaid agency.

Medicaid Integrity Contractors (MICs)

- Established under Medicaid Integrity Program (MIP) – 2005 Deficit Reduction Act
- Hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues
- Provide support and assistance to States in their efforts to combat Medicaid provider fraud and abuse

9

Areas of Focus – Hospice

- Overuse of GIP
- Hospice eligibility
  - Long average lengths-of-stay
  - High live discharge rates
- Aggressive marketing and bonuses (especially for ***clinical*** staff)
- Lack of physician certifications
- Improper physician incentives / medical director relationships

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Areas of Focus – Hospice

- Inappropriate uses of inpatient respite care for nursing home patients
- Failure to discharge
- In a study, OIG alleged that 82% of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements

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OIG Work Plan

- The OIG Work Plan sets forth various projects including OIG audits and evaluations that are underway or planned to be addressed during the fiscal year.
- Previously, OIG updated its public-facing Work Plan to reflect those adjustments once or twice each year.
- OIG now updates its Work Plan website monthly.

Announced or Revised	Agency	Title	Component	Report Number(s)
October 2019	Centers for Medicare & Medicaid Services	Review of Hospice Inpatient and Aggregate Cap Calculations	Office of Audit Services	W-00-19-35826
Completed	Centers for Medicare & Medicaid Services	Protecting Medicare Hospice Beneficiaries From Harm	Office of Evaluation and Inspections	OEI-02-17-00021
June 2018	Centers for Medicare & Medicaid Services	Medicare Payments Made Outside of the Hospice Benefit	Office of Audit Services	W-00-17-35797, W-00-18-35797
Completed	Centers for Medicare & Medicaid Services	Duplicate Drug Claims for Hospice Beneficiaries	Office of Audit Services	A-06-17-08004; W-00-17-35802;
Completed	Centers for Medicare & Medicaid Services	Trends in Hospice Deficiencies and Complaints	Office of Evaluation and Inspections	OEI-02-17-00020

Review of Hospice Inpatient and Aggregate Cap Calculations

Hospice care can provide great comfort to beneficiaries, families, and caregivers at the end of a beneficiary's life. To ensure that hospice care does not exceed the cost of conventional medical care at the end of life, Medicare imposes two annual limits to payments made to hospice providers: the inpatient cap and the aggregate cap. The inpatient cap limits the number of days of inpatient care for which Medicare will pay to 20 percent of a hospice's total Medicare patient care days, and a hospice must refund to Medicare any payment amounts in excess of the inpatient cap. The aggregate cap limits the total aggregate payments that any individual hospice can receive in a cap year to an allowable amount based on an annual per-beneficiary cap amount and the number of beneficiaries served. Any amount paid to a hospice for its claims in excess of the aggregate cap is considered an overpayment and must be repaid to Medicare. Medicare administrative contractors (MACs) oversee the cap process and hospices must file their self-determined aggregate cap determination notice with their MAC no later than 5 months after the end of the cap year and remit any overpayment due at that time.

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OIG Work Plan

November 2016	Centers for Medicare & Medicaid Services	Hospice Home Care - Frequency of Nurse On-Site Visits to Assess Quality of Care and Services	Office of Audit Services	W-00-16-35777
November 2016	Centers for Medicare & Medicaid Services	Review of Hospices' Compliance with Medicare Requirements	Office of Audit Services	W-00-16-35783; various reviews
November 2016	Centers for Medicare & Medicaid Services	Medicare Payments for Chronic Care Management	Office of Audit Services	W-00-17-35785
Completed	Centers for Medicare & Medicaid Services	Medicare Hospice Benefit Vulnerabilities and Recommendations for Improvement: A Portfolio	Office of Evaluation and Inspections	OEI-02-16-00570

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OIG July 2018 Report On Vulnerabilities In Hospice

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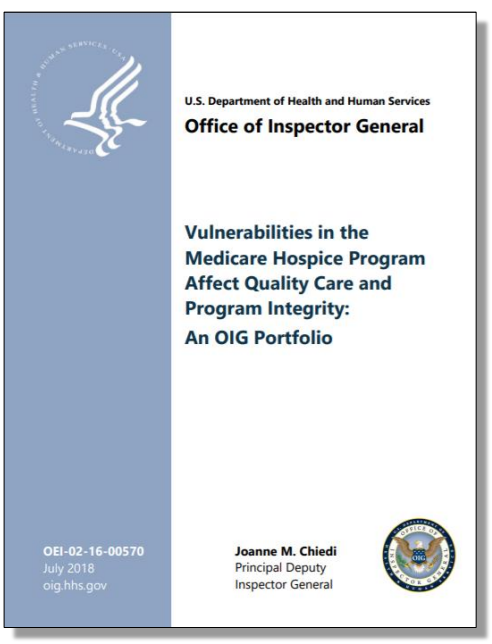

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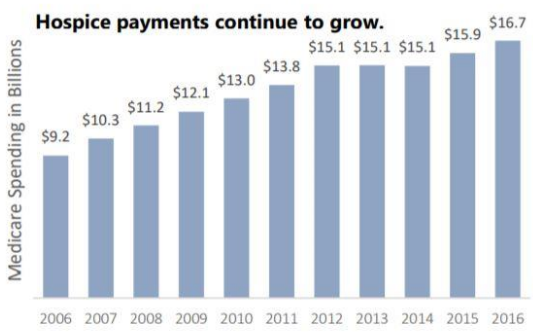
Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity

What OIG Found

Hospice care can provide great comfort to beneficiaries, families, and caregivers at the end of a beneficiary's life. Use of hospice care has grown steadily over the past decade, with Medicare paying $16.7 billion for this care in 2016. It is an increasingly important benefit for the Medicare population; 1.4 million beneficiaries received hospice care in 2016.



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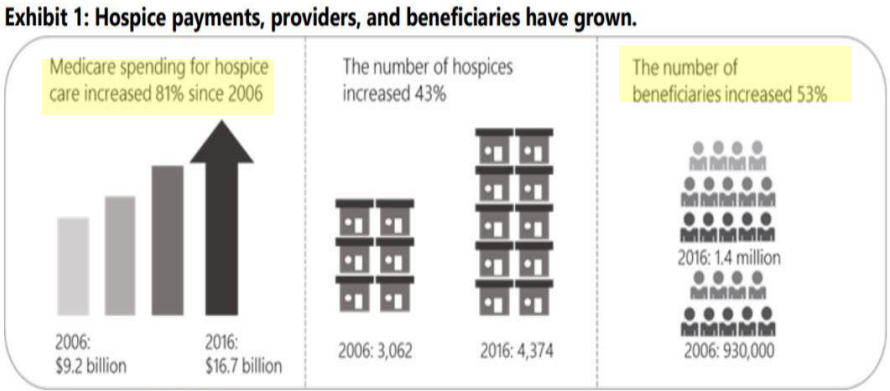
2018 OIG REPORT

Exhibit 1: Hospice payments, providers, and beneficiaries have grown.



Source: OIG analysis of CMS data, 2017.

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OIG "Findings" In Report

- "Hospices often do a poor job care planning"
- "Hundreds of hospices provide only one level of care"
- "Most beneficiaries do not see a hospice physician"
- "Common fraud schemes involve inappropriately enrolling beneficiaries"
- "Beneficiaries and their families and caregivers do not receive crucial information to make informed decisions about hospice care"
- "Hospices often provide beneficiaries incomplete or inaccurate information about the benefit"

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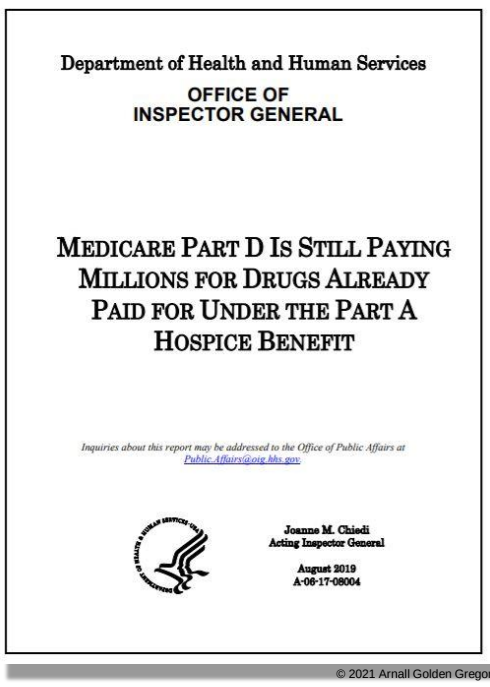
OIG "Findings" In Report

- "Hospices frequently bill Medicare for a higher level of care than the beneficiary needs"
- "Medicare sometimes pays twice for the same service"
  - Part D drug billing
- "Hospice physicians are not always meeting requirements when certifying beneficiaries for hospice care"
- "Hospice fraud schemes are growing and include kickbacks and false billing"
- "Hospices seldom provide services on weekends"

OIG Report
August of 2019



Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICARE PART D IS STILL PAYING MILLIONS FOR DRUGS ALREADY PAID FOR UNDER THE PART A HOSPICE BENEFIT

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov

Joanne M. Chiedi
Acting Inspector General

August 2019
A-06-17-08004

Arnall Golden Gregory LLP

OIG Oversight Recommendations

- Increase oversight of general inpatient care claims and focus particularly on general inpatient care provided in SNFs.
- Ensure that hospices are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D.
- Address lengthy general inpatient care stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled.

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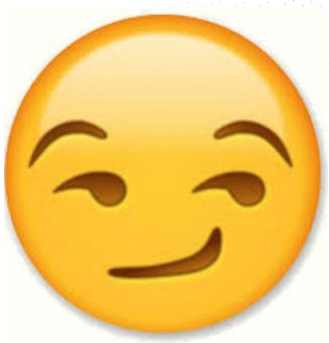
SMRC

"smile in an irritatingly smug, conceited, or silly way."



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SMRC: Supplemental Medical Review Contractor

- The SMRC conducts medical reviews of Medicare Part A and B claims.
- The SMRC evaluates medical records to determine whether claims were billed in compliance with coverage, coding, payment, and billing requirements.
- The focus of the medical reviews may include vulnerabilities identified by CMS internal data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations and Federal oversight agencies.
- The SMRC is Noridian Healthcare Solutions.

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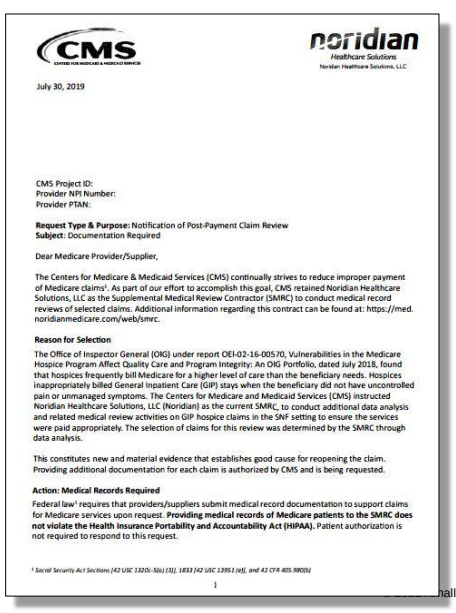
Noridian SMRC Letter



CMS

noridian
Healthcare Solutions
Noridian Healthcare Solutions, LLC

July 30, 2019

CMS Project ID:
Provider NPI Number:
Provider PTAN:

Request Type & Purpose: Notification of Post-Payment Claim Review
Subject: Documentation Required

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce improper payment of Medicare claims[1]. As part of our effort to accomplish this goal, CMS retained Noridian Healthcare Solutions, LLC as the Supplemental Medical Review Contractor (SMRC) to conduct medical record reviews of selected claims. Additional information regarding this contract can be found at: https://med.noridianmedicare.com/web/smrc.

Reason for Selection

The Office of Inspector General (OIG) under report OEI-02-16-00570, Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio, dated July 2018, found that hospices frequently bill Medicare for a higher level of care than the beneficiary needs. Hospices inappropriately billed General Inpatient Care (GIP) stays when the beneficiary did not have uncontrolled pain or unmanaged symptoms. The Centers for Medicare and Medicaid Services (CMS) instructed Noridian Healthcare Solutions, LLC (Noridian) as the current SMRC, to conduct additional data analysis and related medical review activities on GIP hospice claims in the SNF setting to ensure the services were paid appropriately. The selection of claims for this review was determined by the SMRC through data analysis.

This constitutes new and material evidence that establishes good cause for reopening the claim. Providing additional documentation for each claim is authorized by CMS and is being requested.

Action: Medical Records Required

Federal law[1] requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. **Providing medical records of Medicare patients to the SMRC does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request.

[1] *Social Security Act Sections [42 USC 1320c-5(a) (3)], 1833 [42 USC 1395 l (e)], and 42 CFR 405.980(b)*

1

Noridian SMRC Letter – focus on GIP

Reason for Selection

The Office of Inspector General (OIG) under report OEI-02-16-00570, Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio, dated July 2018, found that hospices frequently bill Medicare for a higher level of care than the beneficiary needs. Hospices inappropriately billed General Inpatient Care (GIP) stays when the beneficiary did not have uncontrolled pain or unmanaged symptoms. The Centers for Medicare and Medicaid Services (CMS) instructed Noridian Healthcare Solutions, LLC (Noridian) as the current SMRC, to conduct additional data analysis and related medical review activities on GIP hospice claims in the SNF setting to ensure the services were paid appropriately. The selection of claims for this review was determined by the SMRC through data analysis.

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Why are claims so risky?

- Three times damages
- Penalties of $10,957 to $21,916 per claim
- Example: 6 months on service = 6 claims
- 180 days times $200 per day = $36,000
- $36,000 x 3 = $108,000
- + $10,957 per claim x 6 = $65,742
- Grand total for one resident = $173,742

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THEN EXTRAPOLATION

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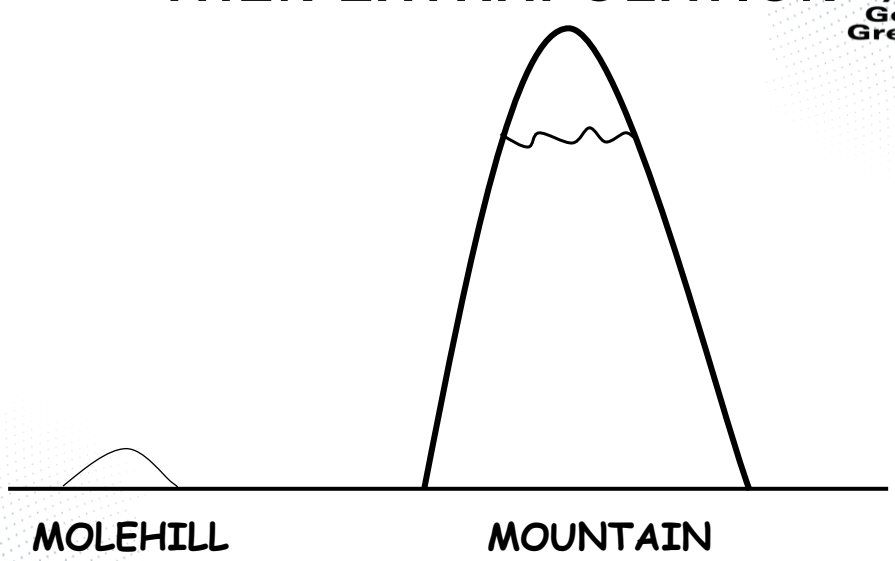

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The Government's Standard Formula

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Hospice paid its marketers incentives

↓

Hospice only documented patient declines

↓

Hospice had some long lengths of stay

↓

Government's post-hoc review by hired expert concludes handful of patients were not appropriate

↓

Government extrapolates

↓

Demands Refund / Settlement

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Investigations and Ultramarathons

100 miles; 66,000 feet elevation change; average time – 41 hours

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How it Begins: Stages of an OIG/DOJ Investigation

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Investigation Stages– DOJ / OIG

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- Snooping Phase (*may trigger legal hold*)
- Formal Document Demand and Production (*triggers legal hold*)
- Formal Interviews / Depositions
- Competing Presentations
- Litigation or Resolution

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Initiating An Investigation

- **Investigations are initiated based on:**
  - ✓ **Qui Tam (Whistleblower) Lawsuits**
  - ✓ **Calls to the OIG Hotline**
  - ✓ **Information developed during audits, claims reviews, etc.**
  - ✓ **Media reports by investigative journalists**
  - ✓ **Activity and communications on the internet**
  - ✓ **Complaints**
  - ✓ **Data Mining!**

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Possible Steps Government May Have Already Taken Before You Are Contacted

- Reviewed corporate filings
- Interviewed former employees
- Obtained financial records
- Conducted physical surveillance of employees and – to the extent it is open and public – of the company premises
- Conducted electronic surveillance.

How Do Companies Typically Learn About An Investigation?

- Government agents contact current or former employees of the company for interviews, who in turn advise the company.
- Service of an OIG subpoena, DOJ civil investigative demand (CID) or similar request.
- Government search warrant or raid.

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Legal Holds

- Required once litigation is reasonably anticipated.
- Must take steps necessary to preserve and prevent destruction of any documents and/or data related in any way to the subject matter of the dispute.
- Must preserve all hard-copy and electronically-stored information, regardless of the form in which the information is generated and maintained.
- Destruction, loss, or alteration of potentially relevant evidence may result in sanctions against the company and/or counsel.

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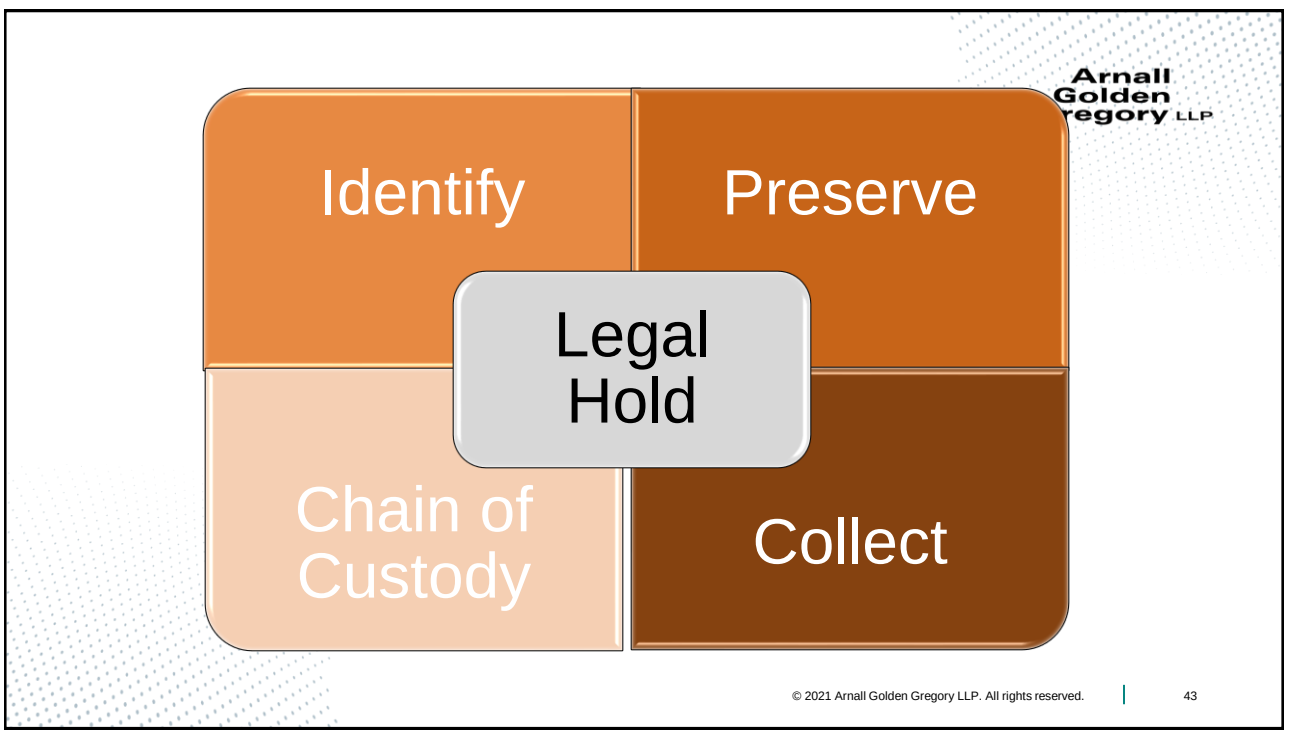

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Legal Hold – Identification. Phase 1

- Identify Custodians
- Identify Their Data
- Issue Them Hold Notices

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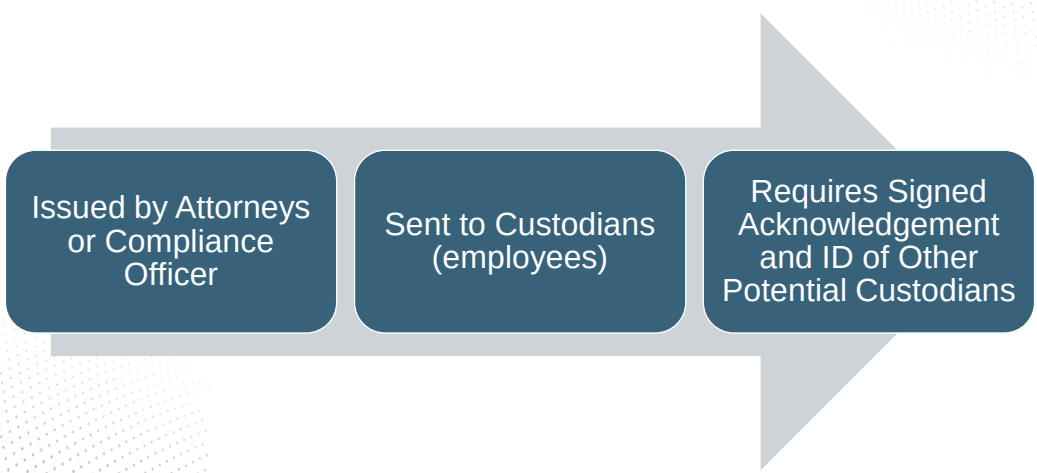
Legal Hold Notice – Preserve. Phase II



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Legal Hold Tracking

We use sophisticated software to issue and track litigation hold responses and to issue updates:

Jane Doe, CFO	John Doe, COO
☑ Issued Notice	☑ Issued Notice
☑ Acknowledged Notice	☑ Acknowledged Notice
☑ Identified other custodians	☐ Identified other custodians
☑ Issued routine reminders	☑ Issued routine reminders

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Preservation

Preserve in Place	Suspend Destruction	Implement IT Freezes
• Leave files untouched • Leave email in its place • Do not access or move electronic info	• Suspend automatic purging • Suspend scheduled file destruction • May include suspending shred boxes	• Custodian accounts archived or mirrored by IT • Auto-delete functions suspended • Delete functions suspended

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Collection – Phase III

Documents
- Physical files
- Board minutes
- Employee files
- Patient charts
- Billing info
- Financials

ESI
- Word documents
- Memos
- PowerPoints
- Spreadsheets
- OneNote
- EHR
- Usually collected natively
- Laptops
- Personal devices

Email
- Collect entire custodian account from server
- Personal email accounts if used for work
- Laptops
- Everything is collected and then filtered later

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Actual DOJ Hospice Request

c. All "electronically stored information" such as:

i. Electronic correspondence (e.g., e-mail messages, voice mail messages, text messages and instant message dialogues);

ii. Electronically created and stored writings or records (e.g., word processing documents, spreadsheets, data compilations, presentation documents and personal and shared calendars);

iii. Computer data bases (e.g., financial and human resource databases);

iv. System information (e.g., logs or "metadata" created by a computer system detailing and tracking events on the system including changes to documents); and

v. All of the above in whatever media it may be stored including:

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1. Online storage media (e.g., computer hard drives, network storage devices, PDAs, "Blackberries," and cell phone media chips, fax machine and photocopier memory chips, and related residual data or replicate files);

2. Near-line storage media (e.g., disk and tape libraries that access individual disks or tapes);

3. Off-line storage devices (e.g., floppy disks, CD ROMs, DVD ROMs, and flash drives); and

4. Back-up tapes.

d. All drafts or non-identical copies of every document where such draft or copy is not identical to the original because of any addition, deletion, alteration, or notation; and

e. All attachments, enclosures, or other matter affixed to or incorporated by reference within documents responsive to this subpoena.

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3. All training materials including, but not limited to, dates of training, attendee lists, materials distributed, agendas, and curricula, and other documents that govern, describe, or otherwise relate to admissions, treatment, discharges, and billing.

4. All documents that relate to any internal or external audits or reviews related to any procedures, services, or treatments provided by [redacted].

5. All documents and correspondence between [redacted] and any Federal health care program including, but not be limited to, audits and record reviews.

6. All documents and correspondence between [redacted] and any Federal health care program including, but not limited to, enrollment, billing and/or electronic data interchange (EDI) agreements, and participating provider agreements.

7. All contracts between [redacted] and any physician.

8. All documents that relate to any complaints, concerns, or questions from any source, including, but not limited to, [redacted] employees or contractors, patient or patient family members.

9. A [redacted] employee listing of all current and former employees (including leased employees or independent contractors) with the following information: name, title, job description, address and telephone number, Social Security number, and dates of tenure.

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16. All documents that relate to any amount charged by or amount reimbursed to [redacted] for any procedure, service, or treatment provided by [redacted] to Federal health care program beneficiaries listed in **ATTACHMENT C,** including, but not limited to, superbills, claims, remittance notices, explanation of benefits, and other documents that relate to the description of the procedure, service or treatment, and to any codes or units of service billed.

17. All software billing and communication notes and/or comments for the Federal health care program beneficiaries listed in **ATTACHMENT C.**

18. Complete medical records from **January 1, 2011 to December 31, 2012** relating to any procedure, service or treatment provided by [redacted] to Federal health care program beneficiaries listed in **ATTACHMENT C**, including, but not limited to:
    - Patient/census rosters
    - Patient profile/information sheets
    - Orders and treatment plans
    - Facility, clinical and/or hospital records
    - Subjective, Objective, Assessment Plans
    - Interdisciplinary team notes or documents
    - Counseling, nursing, therapy, Chaplin, and/or physician progress notes or reports
    - Revocation forms and documents
    - Discharge notes

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19. For any procedure, service, or treatment provided by [redacted] to Federal health care program beneficiaries, all documents that constitute or relate to any billing, coding, or claims submission policies and procedures utilized by [redacted] in documenting, preparing, and submitting claims to Federal health care programs, including, but not limited to, instructions to employed staff (including leased employees and independent contractors) or contracted billing agents, billing manuals, policy statements, training materials created for or used by individuals responsible for billing, internal memoranda, bulletins, letters, instructions, handbooks, billing agent contracts, notes or minutes of meetings, or notes of telephone calls.

20. All [redacted] financial statements.

21. A listing of all [redacted]'s owners, officers, directors.

22. All documents related to Board or executive meetings including but not limited to meeting minutes.

23. [redacted]'s past and current organizational charts.

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Data Processing and Production

- The civil investigative demand will usually state that documents must be produced within 30 days
- That is impossible.
- Typically attorneys agree to a rolling production:
  - Documents produced in phases
  - Government typically places emphasis on early production of e-mails
- Production for one CID may take 4 to 8 months
- Potential for additional document requests

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Data Processing and Production

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Processing
- Documents scanned and indexed
- Loaded into secure data base
- Chain of custody
- Metadata preserved

Filtering
- Date range filters
- Custodian filters
- De-duping
- Attorney-client filters
- Search term algorithms

Reviewing
- Review for attorney-client privilege
- Non-responsive data
- Identify good/ bad info for later use

Production
- Data produced to gov't.
- Bates stamping
- Encrypted CDs
- Indexing
- Clawback agreement

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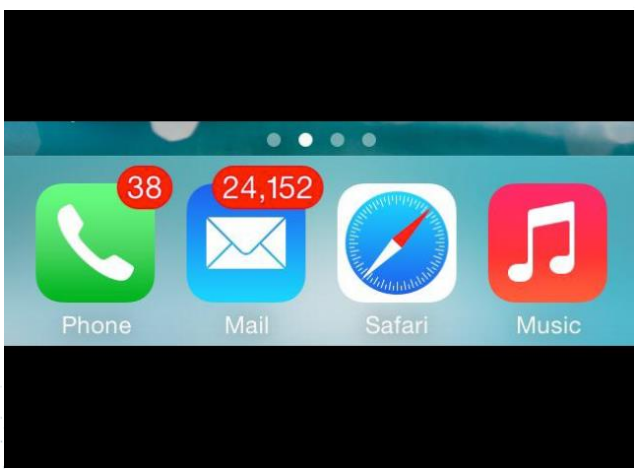
Email is Taking Over



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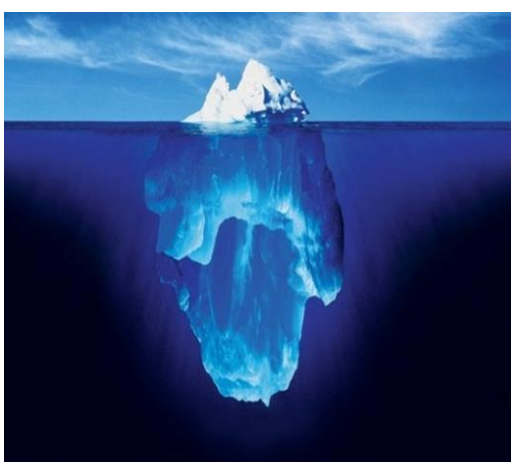
“Your first experience with ediscovery will be your most expensive.”



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eDiscovery's Biggest Challenge: Asymmetrical Data

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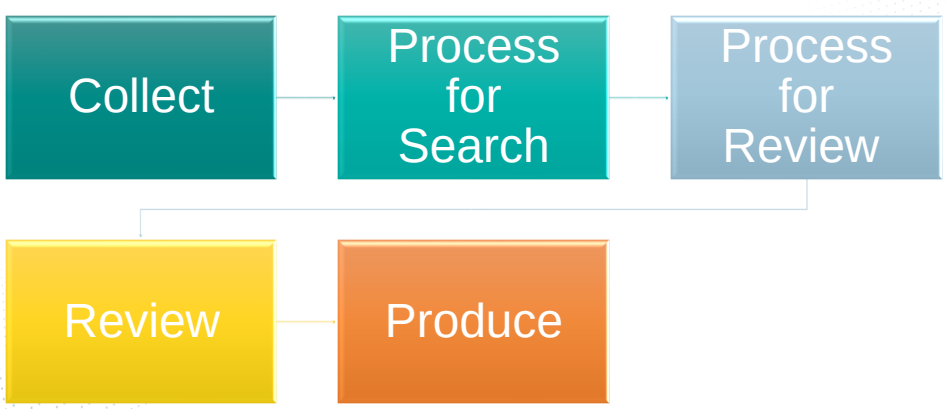
Dealing with Email in Discovery



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E-Discovery Costs Are High

- The RAND Institute for Civil Justice has estimated that each gigabyte of data reviewed costs a company approximately $18,000.
- Average of $1.8 million dollars per case just for e-mail review.

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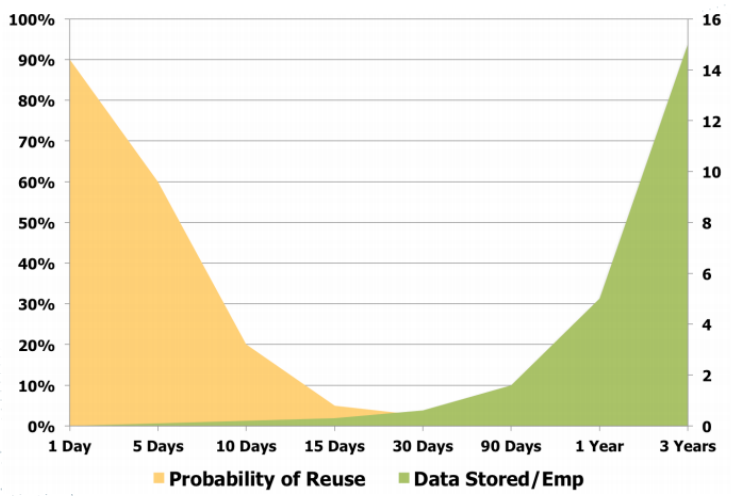
But . . . we *need* our emails.



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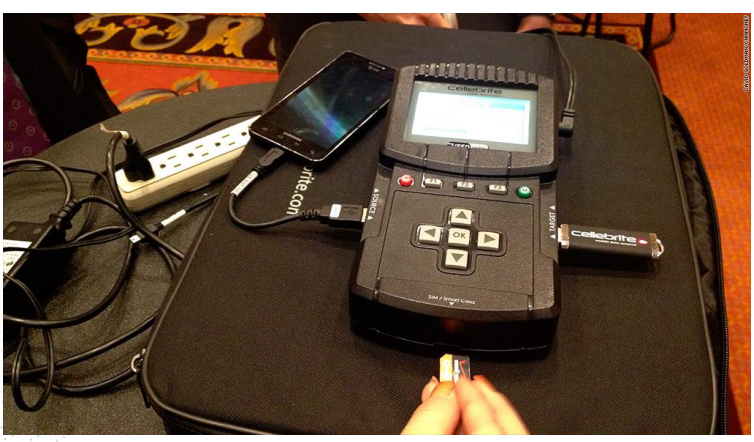
Cell Phone Discovery is Possible, Expensive, and Absurdly Intrusive



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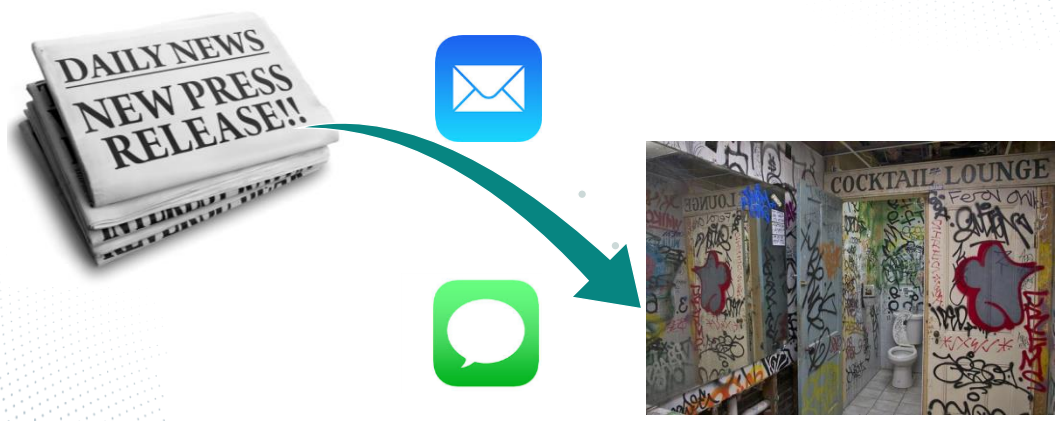
Spectrum of Professionalism in Communications



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Government's Theory in Many Big Hospice Cases

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Pressure from management for census (usually established via e-mails)

+

Borderline Admissions

=

Fraudulent Claims

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Formal CID Interviews of Employees

- Agreed upon time
- Topics to be given in advance
- Agents and government attorneys often try to dictate location
- Company's attorney may attend
- If there is a relator, relator's counsel may attend
- If employee has personal attorney, they may attend
- Objections are limited
- Court reporter transcribes
- Sometimes we see other agents attend – FBI, etc.

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Formal CID Interviews of Employees

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- Employee must be thoroughly prepared
- Opportunity to review and correct transcript, but government is becoming more obtuse
- For former employees, typically no need for the government to provide notice. Ability of the company's counsel to attend may be limited.

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Presentations / Resolution

- Upon conclusion of presentation, government typically presents its concerns or alleged findings
- Typically done at Department of Justice Office
- Sometimes loaded with accusations and accompanied with intimidation
- May or may not provide copy of presentation
- Company then will often prepare rebuttal presentation
- Company is at somewhat of a disadvantage as far as time for preparing response

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Presentations / Resolution

- Possible resolutions:
  - Government drops the investigation
  - Government declines to intervene in whistleblower suit
  - Government makes demand and parties reach settlement
  - Settlement often includes payment and corporate integrity agreement, as well as payment of relator's attorney fees
  - If no settlement, then parties proceed to litigation in federal court

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Corporate Integrity Agreements

- OIG negotiates CIAs with health care providers following settlement of Federal health care program investigations (usually FCA cases)

- Providers agree to CIA, and in exchange, OIG agrees not to seek their exclusion from participation in Medicare and Medicaid

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CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
[redacted] HOSPICE, LLC AND [redacted]

I. PREAMBLE

[redacted] Hospice, LLC and [redacted] (collectively, "[redacted] Hospice") hereby enter into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). This CIA applies to [redacted] Hospice, any entity in which [redacted] Hospice has an ownership or control interest at any time during the term of the CIA, as defined in 42 U.S.C. § 1320a-3(a)(3), and any other Covered Persons as defined in Section II.C. Contemporaneously with this CIA, [redacted] Hospice is entering into a Settlement Agreement with the United States.

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Corporate Integrity Agreements

- CIAs have many common elements, but each one addresses the specific facts at issue and may attempt to accommodate and recognize many of the elements of preexisting voluntary compliance programs.
- A comprehensive CIA typically lasts 5 years

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Corporate Integrity Agreements

Standard Requirements:

- Hire a compliance officer/appoint a compliance committee
- Develop written standards and policies
- Implement a comprehensive employee training program
- Retain an independent review organization to conduct annual reviews

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Corporate Integrity Agreements

Standard Requirements (*continued*):

- Establish a confidential disclosure program
- Restrict employment of ineligible persons report overpayments, reportable events, and ongoing investigations/legal proceedings
- Provide an implementation report and annual reports to OIG on the status of the entity's compliance activities

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Corporate Integrity Agreements

- CIAs include breach and default provisions that allow OIG to impose certain monetary penalties (referred to as Stipulated Penalties) for the failure to comply with certain obligations set forth in the CIA.
- In addition, a material breach of the CIA constitutes an independent basis for the provider's exclusion from participation in the Federal health care programs.

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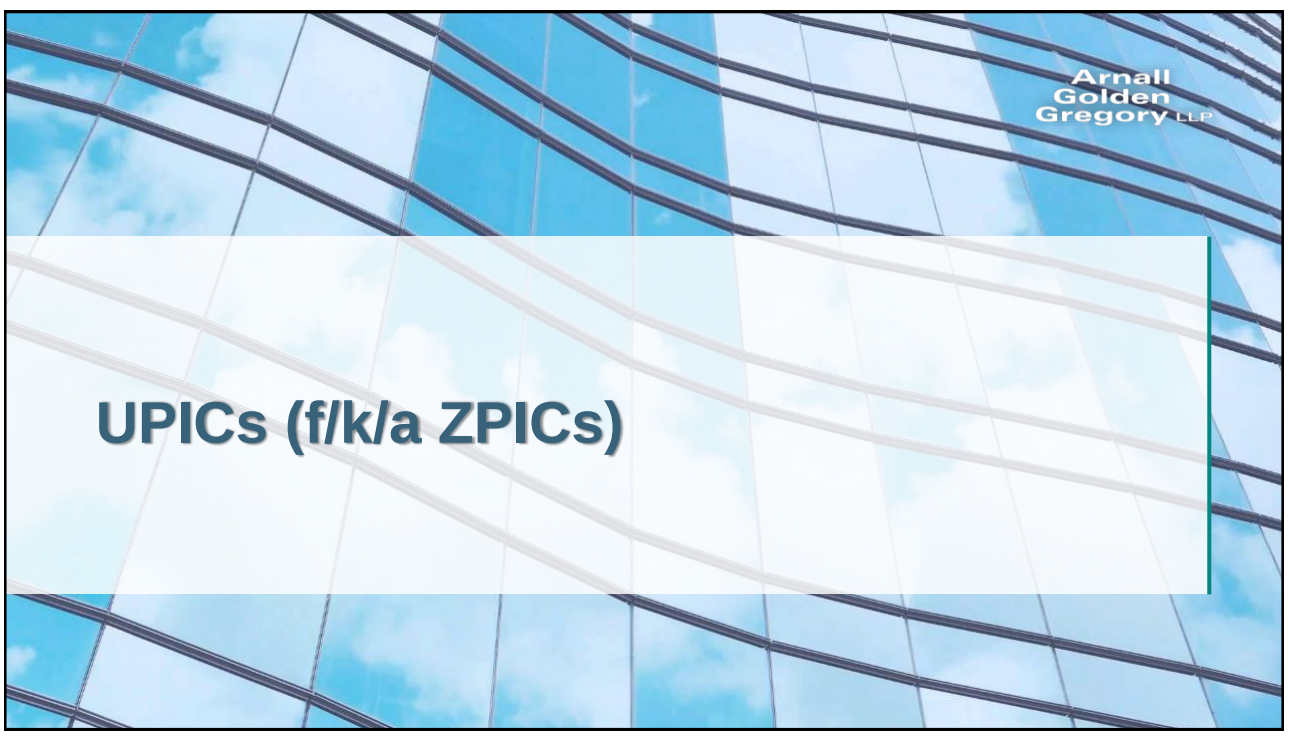

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What Do UPICs Do?

- Use of “innovative data analysis methodologies” for early detection and prevention
- Proprietary software to analyze claims history data

- Complaints
- Referrals
- ***Targets not randomly selected***

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How Are UPICS Different?

- Not looking for errors, looking for ***fraud***
  - *But their interpretation of fraud is different than yours*
- No specific look-back period
- No limits on document requests
- No physician review required
- No time limit on UPIC review/decision
- No contingency fee (but healthy contracts)

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UPIC Investigations

- Data Analysis
  - Data mining
  - Deviations in billing patterns, outliers, high utilization, high cost items or services
- Medical record requests (often 30 records)
- Business records requests
- EMR audit trail and PEPPER Reports
- Unannounced or onsite visits
- Interviews of staff and beneficiaries

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UPIC Denial Reasons

- **Hospice**
  - Terminal illness
  - Notice of Election
  - Relatedness
  - Signatures
  - Adherence to care plan
  - Staff credentials
  - Other primary payer

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Possible Outcomes

- **Referral to OIG/DOJ**
- Forward findings to MAC
  - Recoupment action
  - Provider education
- Prepayment review
- Discretionary payment suspensions
- Statistical extrapolation → enhanced recoupment

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"You never get a second chance to make a good first impression."

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Initial Record Response

- If you receive a UPIC record request, welcome to the big leagues. This is *not* a survey!
- Short time for producing records.
- Take time, spend the money, and get things right the first time.
- Bring in a consultant.
- Don't be in denial or be overly confident.
- Good providers can have big UPIC demands.
- This is probably most important phase in that you can prevent denials in the first place.

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Initial Record Response

- Records should be so well organized that your elementary school librarian would be proud.
- Index as needed – spoon feed.
- They are looking for reasons to deny, so make it difficult for them to do so.
- **Do NOT** backdate/alter records—potential fraud, obstruction, jail, etc.
- Small things matter – signature legibility!
- Send in signature cards and signature lists.
- Prepare short summaries for each patient.

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Initial Record Response

COMMON MISTAKES:

- Failure to provide records.
- Failure to have legible signatures or supported signatures are common grounds for denial.
- Physician's records do not provide detailed documentation to support certification.
- Proof of delivery is invalid or missing.

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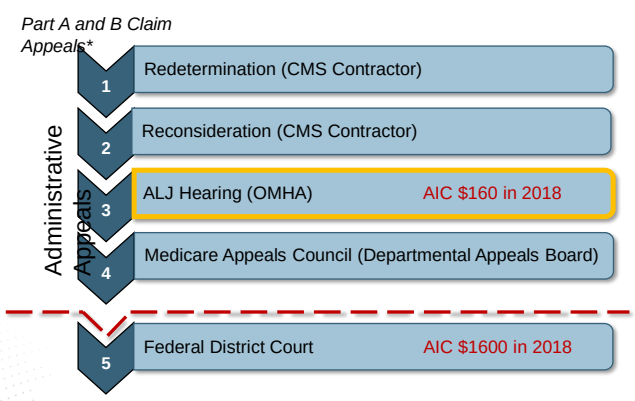
UPIC Appeal Stages



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Appeal Stages

Stage 1

Initial Determination

- UPIC requests records – quick turnaround.
- After document review, UPIC issues its allegations
- MAC must then issue demand letter
- Findings included statistical extrapolation

Stage 2

Rebuttal

- Must be filed within 15 days of demand letter
- Not required
- Because of short turnaround time, not a very productive option

Stage 3

Redetermination

- Must be filed within 120 days of MAC demand letter
- ***But***, must be filed within 30 days to stay recoupment
- MACs have 60 days to issue decision

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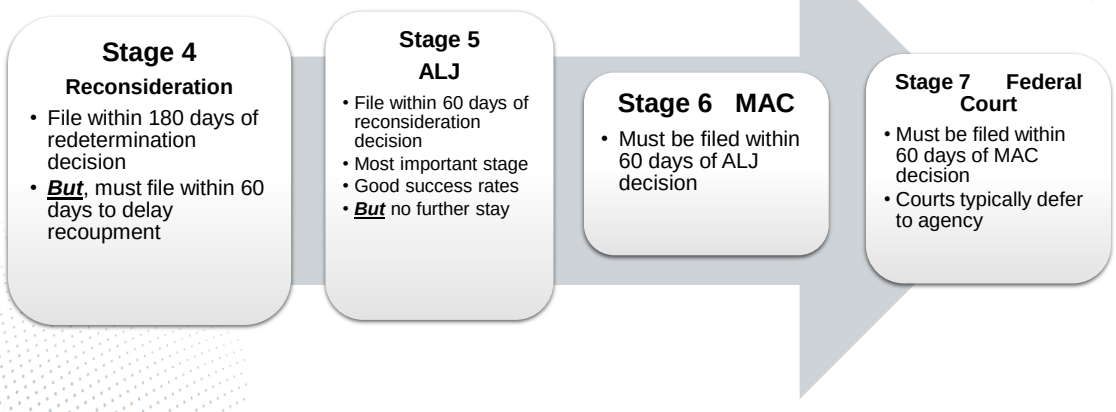
Appeal Stages



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Appeals

- **Initial Determination**
  - 15 days for rebuttal (not required)
  - 120 days to request **Redetermination**; *but* 30 days to stop recoupment (on 41st day)
  - Submit additional info → 14 day extension
- **Notice of Redetermination** (due 60 days)
  - 180 to request **Reconsideration** from QIC; *but* 60 days to stop recoupment on 76th day
  - Full and early submission of evidence requirement

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Appeals

- **Reconsideration Decision** (due in 60 days)
  - If denied, recoupment begins and interest owed
  - Must request ALJ hearing within 60 days
  - ALJ hearings (typically by phone)
  - Contractor may or may not actively participate
- **ALJ Decision** (due in 90 days)
  - Appeal to Medicare Appeals Council ("MAC") within 60 days or review by MAC on its own
- **MAC Decision** (due in 90 days)
  - Appeal to federal court within 60 days

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ALJ Stage

- The ALJ stage provides the first opportunity for a provider to obtain an independent review of its claim, where it can present evidence, respond to questions posed by the ALJ in real time, and explain the written materials in the record.
- The lower levels are no longer very fruitful. So little chance of prevailing that it's practically a due process denial.
- Focus today and in the process is ALJ phase.
- Only real shot at debunking extrapolation.

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ALJ Hearing

- In-person hearing / Telephone / VTC
- All the issues brought out in the initial determination, redetermination, or reconsideration that were not decided entirely in a provider's favor
- Substantial deference to applicable LCDs
- Discovery is permissible only when CMS or its contractor elects to participate in an ALJ hearing as a party.

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ALJ Stage

- Option for provider to “escalate” its appeal and skip the ALJ level.
- CMS often touts this option when providers complain about the ALJ backlog.
- *But why would any provider skip the one and only stage where they actually have a shot at presenting evidence and winning?*
- Plus, you would only be getting out of one long line to go stand in another long line.
- *. . . a second line in which the chances of losing are much greater.*

ALJ Stage – Hospice Providers Can Win

- A few years ago, hospice providers prevailed on approximately 70% of their appealed claims
  - 62 percent fully favorable
  - 6 to 8 percent partially favorable
- And that’s not like a flip of the coin win or lose on the entire appeal.
- If a provider has 100 claims under appeal, it may win fully on 62 of those claims.
- Win percentage is going down, however.

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OMHA Appeal Backlog

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- Multilayered administrative appeals
- ALJ level is the first stage for an independent review and presentation of arguments.
- Office of Medicare Hearings and Appeals administers ALJ hearings
- By statute, providers are entitled to a hearing and decision within 90 days.
- But it now takes years.

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Big Takeaway

- Because of the low success rate at the redetermination and reconsideration levels

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- Recoupment during years-long wait for justice at the ALJ level

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- Reason to avoid denials in the first place by investing heavily at the outset and in response to document requests

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Interest And Recoupment

- Two of the most misunderstood areas
- Something that providers often don't think about or appreciate until late in the appeals process.
- But it is explained in MAC letters

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Interest

- Interest begins to accrue on the 31st day following MAC's demand letter.
- The current interest rate is around 11.00%
- That's many times the federal funds rate.
- Assessed in 30-day increments, so a payment on the 31st day results in an additional month's interest.
- Providers should almost never pay directly – only through recoupment

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Recoupment

- Recoupment is CMS's self-help measure: setting off overpayment demand against current Medicare payables.
- If CMS owes you $200,000 for the month, it will withhold and apply it to overpayment.
- To stay recoupment, appeal initial demand by 30th day.
- To continue stay of recoupment, appeal redetermination decision by 60th day.
- Recoupment is not stayed at ALJ level.

Questions?

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Thank you

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