COMMERCIAL PAYOR AUDITS

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Agenda

- Background
- Initiation of the Audit
- Overpayment Notice
- Collect the Relevant Information
- Formulating a Response
- HCAPPA
- Other Relevant New Jersey Law
- Preventative Measures

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Background

- Payors usually hire third-party vendors to mine claims data and perform overpayment audits.
- Vendors focus on providers whose billing or treatment profiles differ significantly from their peers in the same geographic area.

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Background

- Do not assume that the payor will go easy on you because of a long standing relationship.
- Vendors usually work on a contingency fee so they are motivated to recoup from providers.
- Recoupments save the payors money and, in some cases, can generate money.

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Initiation of the Audit

- Provider audits start with a notice from the payor or the payor's vendor requesting medical records.
- Identify a point person in your office to gather the medical records.
- Do your own investigation by reviewing the medical records to identify commonalities.

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Initiation of the Audit

- Engage your billing company to identify commonalities on how the claims were billed.

- If you are in-network, review the provider agreement to determine your rights in connection with audits.

- Do not take these audits lightly because many audits will lead to fraud allegations.

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Overpayment Notice

Overpayment allegations are usually based on one of the following:

(1) miscoding, including the use of incorrect modifiers;

(2) unbundling;

(3) service was not covered;

(4) service was not medically necessary;

(5) the service is investigational or experimental; and

(6) medical records do not support the services you billed.

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Overpayment Notice

- Review the overpayment notice carefully to make sure it explains the basis of the overpayment because that will dictate your response.
- Under New Jersey law, payors are required to explain the basis of the overpayment.
- Method of recoupment: (1) recoupment from current and future payments or (2) immediate payment.

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- The notice should include information on the appeal process.

- You must timely appeal or potentially waive your right to appeal.

- Bahman Vojdani, D.M.D., Comprehensive Dental of Lincoln Park LLC, et al. v. Aetna Life Ins. Co., Docket No. A-5000-17T2 (failing to timely object to an overpayment request may result in a waiver of your rights to appeal the overpayment).

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- Set up a conference with the payor to discuss the audit.
- Review the provider agreement.
- Review the payor’s website.
- Demand that the payor provide you with all of the documents that the payor used when determining the overpayment, including internal guidelines.
- Review state law.
- Request the benefit plans covering the patients at issue.

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- **Coding issues:** Recruit your billing company to find literature that the modifiers and billing codes are correct.
- **Service is investigational or experimental:** Locate journal articles to support your position and find out what other payors are doing, especially CMS.
- **Uncovered services:** Review the benefits plan to determine if it is covered and review state law.

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Formulating a Response

- **Not medically necessary:** Must properly document the reasons for the service. Your medical judgment does receive some deference based on the patient-physician relationship.

- **Medical records do not support the services you billed:** New Jersey law dictates what has to be in a medical record, and the payor should not require you to do more.

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HCAPPA: Background

- Payor must remit payment to a provider within 30 days of receiving an electronic claim or, if not submitted by electronic means, 40 days, as long as the claim qualifies for payment. See N.J.S.A. 17B:27-44.2(d)(1).

- If the payor fails to pay within that time, the payment is considered overdue entitling the provider to interest. See N.J.S.A. 17B:27-44.2(d)(7).

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- If the payor does not remit payment within these time frames, it must provide you with a "statement" within 30 days of submitting an electronic claim:

  1) If it is a documentation issue, what documentation is required?
  2) If it is an information issue, what information must be corrected?
  3) If the payor disputes the claim "in whole or part," it must inform you of the "basis" of that dispute.

<u>See</u> N.J.S.A. 17B:27-44.2(d)(2)(i), (ii), (iii).

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HCAPPA: Information Requirement

- If the payor cannot adjudicate all or a portion of the claim because the diagnosis code, procedure coding, or any other data is missing, the payor has to inform you within seven days of making that determination and request the information from you. N.J.S.A. 17B:27-44.2(d)(3).
- If payment is withheld, and the payor does not inform the provider of the reason for withholding payment, then the payment is considered overdue. N.J.S.A. 17B:27-44.2(d)(7).

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HCAPPA: Fraud

- Within 30 days of submitting a claim, the payor must inform the provider if the payor finds "strong evidence of fraud and has initiated an investigation." N.J.S.A. 17B:27-44.2(d)(2)(iv).
- Payors cannot seek overpayments after 18 months except for "claims that were submitted fraudulently" or that "have a pattern of inappropriate billing." N.J.S.A. 17B:27-44.2(d)(10).
- A payor cannot extrapolate an overpayment through sampling, unless there is "clear evidence of fraud." N.J.S.A. 17B:27-44.2(d)(10)(d).

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- A payor cannot collect the overpayment until after the provider has timely exhausted the appeal rights, unless the payor has determined that the overpayment was the result of fraud. N.J.S.A. 17B:27-44.2(d)(10).
- Payors will allege fraud to avoid the 18-month time limitation, extrapolate claims, and immediately collect the overpayment.
- “Fraud” under HCAPPA is not common law fraud, which requires intent to deceive. Instead, the type of fraud is insurance fraud, which does not require an intent to deceive.

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HCAPPA: Fraud

- "Proof of fraud under the Insurance Fraud Prevention Act, as opposed to common law fraud, does not require proof of reliance on the false statement" or "proof of an intent to deceive." Open MRI of Morris & Essex, L.P. v. Frieri, 405 N.J. Super. 576, 583 (App. Div. 2009).
- Payor must demonstrate that: (1) the defendant "presented" a "written or oral statement"; (2) the defendant knew that the statement contained "false or misleading information"; (3) the information was "material" to "a claim for payment or other benefit pursuant to an insurance policy or the Unsatisfied Claim and Judgment Fund Law"; and (4) that the payor was damaged as a result of the violation of the IFPA. See N.J.S.A. 17:33A-4(a)(1); N.J.S.A. 17:33A-7(a).

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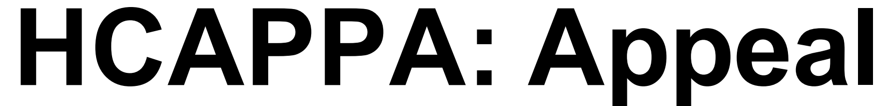

HCAPPA: Appeal

- A provider must appeal within 90 days of receiving the payor's overpayment determination, and the payor has 30 days to respond to the provider's objections. If the payor does not respond within 30 days, the provider may pursue other avenues. N.J.S.A. 17B:27-44.2(e)(1).
- One avenue is arbitration, which is final and binding. N.J.S.A. 17B:27-44.2(e)(2).

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Other Relevant New Jersey Law

- **Independent Health Care Appeals Program**
  - A program strictly for medical necessity appeals operated by the Department of Health. N.J.S.A. 26:2S-11.
  - Must appeal within 60 days after the payor's final decision.
  - A provider must exhaust the payor's internal appeal process.

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Other Relevant New Jersey Law

- **Assignment Law**
  - If a patient assigns, through an assignment of benefits, his or her right to receive reimbursement to an out of network provider, the payor "shall" remit payment directly to the provider or to the health care provider and patient as joint payees. N.J.S.A. 26:2S-6.1.
- **Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act**
  - It has a separate arbitration procedure for claims that fall under this Act.

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CMS AUDITS

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- Background
- Contracting Entities
- Five Stage Appeal Process
- Recoupment Time Table
- Formulating a Response
- 60 Day Rule

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Background

CMS started the concept of hiring third party vendors to conduct audits, including the following:

1) Medicare Administrative Contractors (MACs)
2) Medicare Recovery Auditors (RACs)
3) Comprehensive Error Rate Testing (CERT) contractors
4) Zone Program Integrity Contracts (ZPICs)

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- MACs serve as a provider's primary contact for enrollment, training on Medicare coverage and billing requirements, and issuing local coverage determinations.
- Main goal of a MAC audit is to educate providers.

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RACs

- RACs are paid on contingency fees. They focus on overpayments.
- Must have “good cause” to review claims that are a year old, and CMS generally limits their audits to a three year look back.
- Can extrapolate claims based on sampling.

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- Responsible for determining the amount of overpayments that CMS is paying under the Medicare Program.

- Randomly select providers to review medical records.

- CMS uses the CERT program to determine the underlying reasons for claim errors, to adjust its action plans, and to improve compliance in payment, documentation, and provider billing practices.

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- Serve as a de facto fraud unit.
- Providers are usually referred from other Medicare auditors who suspect fraud based on their audit.
- Known for aggressively extrapolating claims.

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Five Stage Appeal Process

1) Redetermination
2) Reconsideration
3) Administrative Law Judge (“ALJ”) Hearing
4) Medicare Appeals Council (“Council”) Review
5) Federal Courts

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Stage 1: Redetermination

- Must make a Redetermination Request within 120 days of receipt of an overpayment notice.
- For all appeal stages, CMS assumes that the provider received the notice letter five days after the date of the notice.
- The contractor cannot raise new issues during a redetermination.
- The contractor must make a decision within 60 days.

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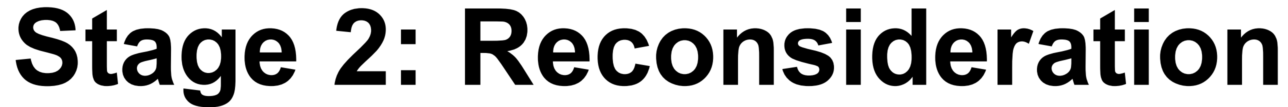

Stage 2: Reconsideration

- Must make a request for reconsideration within 180 days of receipt of a redetermination decision.
- A provider must submit all evidence at this stage, and cannot submit new evidence after this stage absent a showing of good cause.

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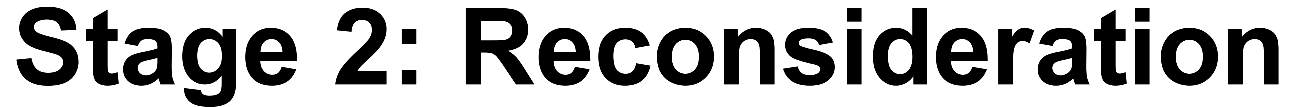

Stage 2: Reconsideration

- The contractor is bound by national coverage decisions, but not local coverage decisions, local medical review policies, or CMS program guidance. However, must give substantial deference.
- A decision must be rendered within 60 days of receipt of a request for reconsideration.

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Stage 3: ALJ Hearing

- Request must be made within 60 days of receiving your reconsideration determination.
- A decision must be rendered within 90 days of receipt of a request for an ALJ hearing.

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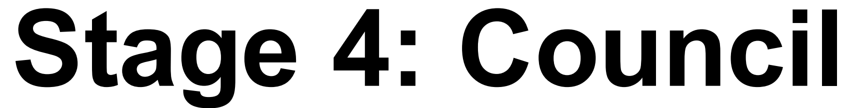

Stage 4: Council

- Request must be made within 60 days of receiving the ALJ decision.
- Council must render a decision within 90 days or you can escalate the issues to the Federal Courts.

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Stage 5: Federal Courts

- Request must be made within 60 days of receiving the Council’s decision

- If the Council’s decision is supported by “substantial evidence,” then the decision will stand.

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- Medicare cannot begin recouping until after the reconsideration stage concludes.
- A contractor can demand that you file your redetermination request sooner than 120 days.
  - If you do not file within 30 days, Medicare will begin recouping. Medicare will cease recouping once it receives your redetermination request.
- A contractor can demand that you file your reconsideration request sooner than 180 days.
  - If you do not file a reconsideration request within 60 days, Medicare will begin recouping until you file the request.

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Formulating a Response

- Waiver of Liability: If CMS denies based on medical necessity, but the provider could not reasonably know that CMS considered the service as not medically necessary, then CMS has to pay the provider. CMS focuses on many factors to determine your knowledge.

- Treating Physician Rule: Applies to medical necessity determinations. A treating physician's determination that a service is medically necessary is binding unless there is substantial evidence to the contrary. However, recent decisions have scaled back on this doctrine.

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Formulating a Response

Provider without Fault: CMS cannot recover overpayments if the provider was without fault in providing the challenged services.

1) A provider is “without fault” if he or she complied with all relevant regulations, made full disclosure of the material facts, and on the basis of information available, including all Medicare publications, had a reasonable basis for assuming that the payment was correct.
2) A provider is presumed to be “without fault” if the overpayment is discovered after the fifth calendar year after the year of payment.
3) This doctrine applies in situations where the provider received a local coverage determination.

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Formulating a Response

Challenge Statistical Sampling:

1) Obtain the documents that the contractor used to extrapolate. If a statistician cannot replicate the results, you can challenge the results as being inconclusive.

2) Review the sample results (i.e., patient records).

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60-Day Rule

- If a provider identifies an overpayment on his or her own, the provider must return the overpayment to CMS within 60 days. Otherwise, the provider potentially face penalties and fraud charges. See 31 U.S.C. § 3729(a)(1)(G).

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