The Most Common Questions and Misconceptions About Audits and Reviews

Health Law Webinar

February 12, 2025

We Found Several Notes From A Physician Where The Documentation Does Not Support The Code Billed. Must We Do A Random Sample Of Records?

- Does the payor require documentation?
- If not, do you think that the service was performed?
- If documentation is required, or the service was miscoded, I'd dig deeper.

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Making a Production About Production

- It is easy to focus on coding anomalies.
- I don’t expect everyone to be the same.
- When someone claims to be doing more than most others, that is a place to focus compliance resources. While half of your workforce works harder than average, way more than half of your issues will arise in that half.

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We’ve Looked At Five Records. One Was Billed Improperly. Must We Do a Bigger Sample?

- Hard question. One error is 20%. And one error.
- Old OIG guidance authored by Janet Rehnquist sets a 5% threshold for organizations on a Corporate Integrity Agreement.
- Worth asking, “does it feel like the tip of an iceberg?”
- The 60-day statute/regulation is interesting.

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The Old Days: SSA 1128B. [42 U.S.C. 1320a–7b]

- Whoever has knowledge of…any event affecting his initial or continued right to any [benefit or payment under any federal health care program]…and conceals or fails to disclose such event with an intent to fraudulently secure [the] benefit or payment…shall be guilty of a felony, and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both.”

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The 60 Day Provision: SSA §1128J

- GENERAL.—If a person has received an overpayment, the person shall—
  - *(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and*
  - *(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.*

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The 60 Day Provision: SSA §1128J

- An overpayment must be reported and returned under paragraph (1) by the later of—
  - *(A) the date which is 60 days after the date on which the overpayment was identified; or*
  - *(B) the date any corresponding cost report is due, if applicable.*

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What is "Identified?" 42 CFR §401.305(a)(2)

- "A person has identified an overpayment when the person has, <u>or should have through the exercise of reasonable diligence</u>, determined that the person has received an overpayment and quantified the amount of the overpayment. A person should have determined that the person received an overpayment and quantified the amount of the overpayment <u>if the person fails to exercise reasonable diligence and the person in fact received an overpayment</u>."

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Is That About to Change?

- A proposed rule would dramatically modify the definition.
- The proposal deletes all references to “quantification.”
- Many a proposed rule has died on the vine.

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The Proposal: 87 F.R. 79452

- (2) A person has identified an overpayment when the person knowingly receives or retains an overpayment. The term “knowingly” has the meaning set forth in 31 U.S.C. 3729(b)(1)(A).

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We Found Things We Failed To Bill. Can We Offset Them?

- "*Overpayment* means any funds that a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title."

- 42 CFR §401.303

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Applicable Reconciliation: Can You Offset Underpayments?

- “The applicable reconciliation occurs when a cost report is filed; and …”

  - – 42 CFR 401.305(c)

  - *Page 7668 includes a convoluted assertion that reconciliation is cost-report specific. The discussion refers to Parts A and B. Part B doesn’t feature cost reports.*
  - *Offsetting underpayments seems entirely consistent with the statute, and CMS’s interpretation seems baseless.*
  - *A theme: don’t voluntarily unreasonably penalize yourself.*

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The Possible Overpayment Is Small. How Much Work Should We Do?

- Small issues can create interesting traps.
- Intellectual consistency is vital.
- It is possible to "over-refund" without hurting yourself. But it is also possible to do significant damage.
- Candor is a powerful tool.

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We Are Engaging In Outside Consultants. Should We Do It Under Privilege?

- It can’t hurt.
- The main benefit is a chance to edit their report. That can be very important.
- The duty to refund greatly limits the benefit of privilege.
- Consultants can make things infinitely better, or worse.

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We Are Ready To Send Money. Do We Do a Letter Or Use a Form?

- Some MACs have been rejecting letters. We still like them.
- Brevity is the sole of wit.
- Don’t overpromise.

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Will Refunding Get Us In Trouble?

- Any follow up is extremely rare.
- I’ve seen one absurd reaction in hundreds of refunds.
- Always balance risks. Not refunding is far worse.

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Who Should The Refund Go To?

- Governmental payors: Do you want a False Claims Act release? To get one, you're going to pay a penalty.
  - Self-disclosure protocols for U.S. Attorney's Office will cost more than a straight refund.
  - The MAC is almost always the right choice.
- Private payors: Send them a check, but don't be shocked if it is never cashed.

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How Far Back Do You Go?

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How Far Back Do You Go?

- Medicare: four years absent “fraud or similar fault.” Wonder why? Ask for our memo! And see 42 C.F.R. §405.980.
- Medicaid: up to the state.
- Private payers:
  - Have a contract? Look at it. It may just be one year!! Silent? Contract statute of limitations.
  - No contract? Tort statute of limitations.
  - Don’t forget state law.

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Words To Live By/Avoid.

- “As part of our ongoing compliance process”
- “More appropriate” / “possible issues”
- “The level we are confident defending . . .”
- Reserve the right to recant.
- Don’t say “our attorney said . . .”
- Use “refund” not “overpayment.”
- “Steps to improve”

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Hurt So Good?

- Internal communications about reviews high risk/high reward.
- Risk starts with “audit.”
- Wording that gets attention without creating exposure is rare.
- Emphasize what the other side may argue/claim, NOT what “is.”
- Quantification routinely comes back to bite you.

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The Insurer Is Rejecting Our Refund Telling Us We Must Rebill. Are They Right?

- Not unless the contract says so.
- Rebilling is a pain for everyone. It does correct data irregularities.
- As long as they waive timely filing, rebilling is an option. But some insurers try to use timely filing to steal from you.

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One Reason To Rebill….. And a Problem With Sampling.

- If you have sampled, no particular claim has been “refunded.”
- This will be something to watch.
- Note this is an issue even if the audit is on a different problem.
- In any overpayment situation, always look at prior refunds/audits on the same issue. And different issues!

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External Audits

- When you get one….

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External Audits

- Immediately consider insurance!
  - General liability
  - Errors and Omissions
  - Director's and Officers.
  - Medical Malpractice.
- Work Product Privilege applies.
- Sometimes political solutions are worthwhile. Sometimes they are nearly impossible to use effectively.
- For gross abuse consider the Regional Office or politicians (Medicare) or insurance regulators (private insurance.)

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Even Before the Letter Arrives…

- Educate your staff about directing letters from the government or private payors to the correct person in your organization. **Current mail issues/work from home make this more difficult and absolutely vital.**
- Update Pecos!
- Staff should understand that appeals are time sensitive.
- Date stamping.
- Calendar deadlines. **Don't assume you can get an extension!**
- Envelopes. (Be a packrat!!)

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Do We Need To File Anything Under Seal?

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A Private Insurer Wants Records. Why Don’t I Just Say No?

- Look at your contract.
- Even if not required, the optics of saying “no” are terrible.
- That said, absent a contractual requirement, you probably have the right to decline.

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Telephone Calls

- They used to be rare. They aren’t anymore.

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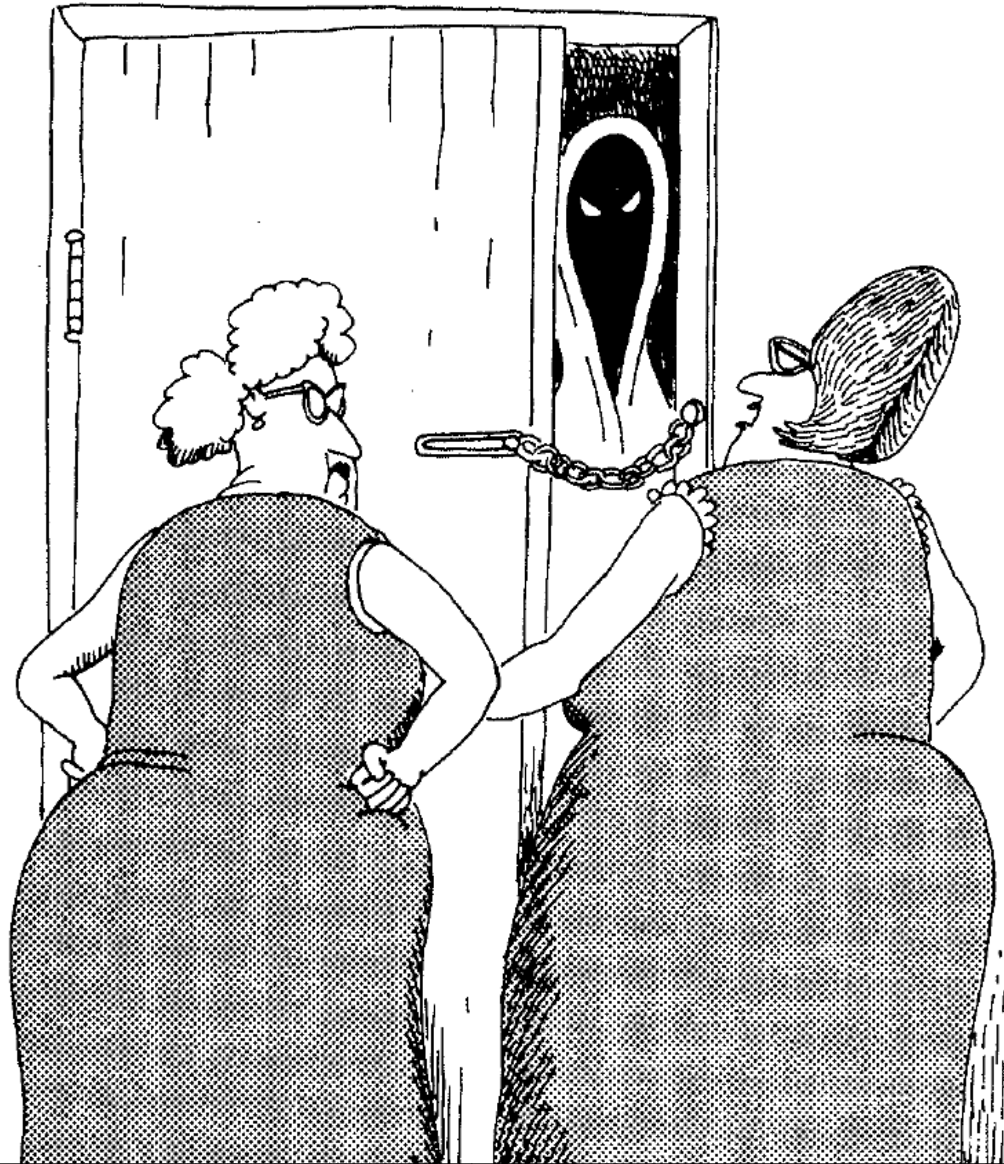

"Now wait just a minute here ...
How are we supposed to know you're the REAL Angel of Death?"

Telephone Calls

- Assume it is a scam until proven otherwise!
- Be super polite, but direct about this. Get the caller's name.
- Find out what they are calling about but share NOTHING except possibly your counsel.
- You, or better yet counsel, call the person back at a number that was googled. This will allow you to verify the caller's identity, and gather your thoughts.

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Medicare Initial Determination

- The letter notifying you of an overpayment decision is an “initial determination” that you may appeal.
- Appeal levels:
  - Level 1: Redetermination.
  - Level 2: Reconsideration.
  - Level 3: Administrative Law Judge.
  - Level 4: Medicare Appeals Council.
  - Level 5: District Court.

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Medicare Level 1: Redetermination

- You have 120 days from receipt of the initial determination to submit a request for “redetermination.”
  - BUT, to stop recoupment, you must submit the appeal within 30 days after receipt. Do you want to stop recoupment?
  - Appealing within 30 days and asking them hold on a decision has historically worked, BUT, is that changing?
- “Receipt” is presumed to be 5 days after the letter date.
- If you don’t pay, interest accrues at a ridiculous rate.

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I Can’t Send Outside Records, Right?

- Wrong. Everything in your possession is <u>your</u> record.

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I Should Never Send More Than They Asked For, Right?

- Wrong again. Use your judgment as to what will help you.
- Make sure you keep an exact copy of what you send.
- Pagination can be helpful. Consider how you cite to the record.

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Tips From The Judges

- Don’t resend everything. (That worries me a bit.)
- Don’t bates number/paginate. (Also counterintuitive to me!)
- Ask for a copy of the record if it is a big case. (Please do this judiciously, they ask.)
- For truly large cases an in-person hearing may be possible.
- “New evidence” and “new arguments” are different.

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What Are The Most Common Mistakes In Appeals?

- Missing deadlines.
- Wordy letters.
- Letting the auditors frame the argument.
- Not properly considering the audience. Is the decision maker a lawyer or medical professional?
- Sending the appeal to the wrong place.
- For Medicare:
  - Failing to copy the beneficiary.
  - Skipping the Appointment of Representative form.

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Do I Need To Refund During An Appeal?

- "If the provider appeals the contractor identified overpayment, the provider may reasonably assess that it is premature to initiate a reasonably diligent investigation into the nearly identical conduct in an additional time period until such time as the contractor identified overpayment has worked its way through the administrative appeals process."

- 81 FR 7654, 7667 (Feb. 12, 2016)

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Handling Common Problems

- What if your documentation is hard to follow?
- What if your documentation is missing?
- How long should you expect to wait to hear something?
- What do you do if you hear nothing?

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Handling Common Problems

- What if the insurer uses a sample?
- What if they don't?
- Interviewing your staff?
- Do you do a review while the insurer is doing theirs? If so, who do you use?

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State of Stats

- Sampling cases present a dilemma.
- For Medicare, winning on sampling may make a gov. appeal more likely/more successful.
- Good statisticians are hard to find/expensive.
- MACs statistical “effort” is often laughable.

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Sampling Issues

- Sampling unit (claim/patient/line item). (Are “paid claims” a fair unit?)
- Size.
- Simple versus stratified.
  - Variability.
  - Footballs and fish.
- Precision (.1 vs. .25 vs. .6).
- Confidence intervals.

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What Is The State Of The Treating Physician Rule?

- The rule originated in Social Security Disability cases. Changes in rules have eliminated its applicability there.

Austin contends that this case is analogous to *Walker v. Commissioner, Social Security Administration*, 911 F.3d 550 (8th Cir. 2018), where we reversed a denial of disability benefits because the ALJ credited a non-treating physician's opinion over a treating physician's opinion without sufficient explanation. Id. at 553-54. Austin maintains that the ALJ made the same error here by crediting Dr. Vowell's opinion over Dr. Addison-Brown's without sufficient explanation. But *Walker* is unhelpful . . . , *Walker* involved **the now-defunct treating physician rule,** which required that the opinion of the claimant's treating physician receive "controlling weight" unless the ALJ provides "good reasons" for giving it less weight. See id. at 553. **Under the revised regulations, this rule no longer applies**. See Bowers, 40 F.4th at 875. Therefore, Walker is both factually and legally inapposite.

Austin v. Kijakazi, 52 F.4th 723, 730 (8th Cir. 2022) (emphasis added).

- What does that mean for Medicare?

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