



Sixth National Medicare RAC Summit

**Lessons for Providers from the First Year of  
ZPIC Audits**

November 8, 2011

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# Agenda

- Understand ZPICS
  - ZPICS and PSCs
  - Authority
  - Audit Approach
  - Appeal Opportunities
  - Recent Developments
- Discuss issues that may be high priority for ZPICS
- Explore steps to be pursued by providers and counsel to prepare and respond to ZPIC reviews
- Questions and answers



# Agenda

- ZPIC/ PSC Background
- ZPIC Audits
- Recent Developments
- Lessons Learned



Special Thanks to  
Sara Kay Wheeler

For her contributions  
to this presentation!

King and Spaulding,  
Atlanta, Georgia





# ZPIC / PSC Background



# Background

- Historically – benefit integrity work ( i.e. fraud and abuse detection and deterrence) was conducted by the FI or Carrier
- 1996 – Congress authorized CMS to contract with external entities to conduct fraud and abuse work
- 1999 – CMS awarded the first contract to a Program Safeguard Contractor (“PSC”)
- 2003 – CMS transferred all fraud and abuse work from Fiscal Intermediaries and Carriers to PSCs
- The **primary function** of PSCs was to ferret out and investigate fraud and abuse by healthcare providers, and make referrals to law enforcement.



# Background

- PSC contracts were awarded by line of business:
  - Medicare Part A (e.g., inpatient care in hospitals, and skilled nursing facilities)
  - Medicare Part B (e.g., physician services, outpatient care, ambulance services)
  - Durable Medical Equipment (DME)
  - Home health and hospice (HHH)



# Background

- 2003 – Congress
  - Authorized CMS to contract with MACs to replace fiscal intermediaries and carriers.
  - Authorized CMS to transform benefit integrity contractor jurisdictions to coincide with administrative contractor jurisdictions.
- Goal was to transition from fragmented PSC system to consolidate benefit integrity activities in only a handful of contractors across seven zones.



# Background

- CMS evaluates PSCs on 9 specific activities:
  1. Fraud Case Development
  2. National/Regional Data Analysis
  3. Law Enforcement Support
  4. Medical Review to Support Fraud and Abuse Cases
  5. Civil Monetary Penalties and Other Administrative Actions
  6. Submit Proposed Fraud Alerts
  7. Fraud Prevention/Detection Education
  8. Fraud Complaint Processing
  9. Incentive Reward Program



# Background

- PSC referrals to Law Enforcement
  - 2006            384
  - 2007            444
  - 2008            574
  - 2009            560 in first 10 months

Source: March 11, 2011 Report Issued by the Senate Finance Committee



# Background

- In 2009, CMS began to transition responsibility for benefit integrity activities to ZPICs.
- CMS' goal was to combine oversight of Medicare Parts A, B, DME and HHH by consolidating benefit integrity activities into only a handful of contractors across seven geographic zones, corresponding with the jurisdictions of the existing MAC which processes claims.
  - Unlike PSCs, ZPICs have access to Medicaid records.
- To date, CMS has awarded umbrella contracts to ZPICs for benefit integrity activities in 4 of 7 zones.
- CMS is presently transitioning these benefit integrity contracts from PSCs to ZPICs, to be completed in 2011.

# Background

<b>Zone 1</b>	California, Nevada, American Samoa, Guam, Hawaii and the Mariana Islands
<b>Zone 2</b>	Alaska, Washington, Oregon, Montana, Idaho, Wyoming, Utah, Arizona, North Dakota, South Dakota, Nebraska, Kansas, Iowa and Missouri
<b>Zone 3</b>	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio and Kentucky
<b>Zone 4</b>	Colorado, New Mexico, Oklahoma and Texas
<b>Zone 5</b>	Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia and West Virginia
<b>Zone 6</b>	Pennsylvania, Massachusetts, New Jersey, Connecticut, Rhode Island, New Hampshire, Delaware, District of Columbia, Maine, Maryland, New York and Vermont
<b>Zone 7</b>	Florida, Puerto Rico and Virgin Islands





# Background

- ZPICs activities, include, among other things:
  - Reactive and proactive identification of potential fraud, waste and abuse and referrals to appropriate law enforcement agencies;
  - Recommend appropriate administrative actions against providers (including imposition of overpayment, exclusion from participation, or revocation of a provider's billing privileges);
  - Coordinate their own efforts with numerous federal and state agencies responsible for investigating fraudulent activities so that efforts are maximized and not duplicated;
  - Develop list of entities that may have shown potentially fraudulent or abusive behavior tendencies that may require future monitoring; and
  - Support law enforcement during investigation and prosecution of healthcare fraud cases (with medical review, data analysis, overpayment determination and subject matter expert testimony).



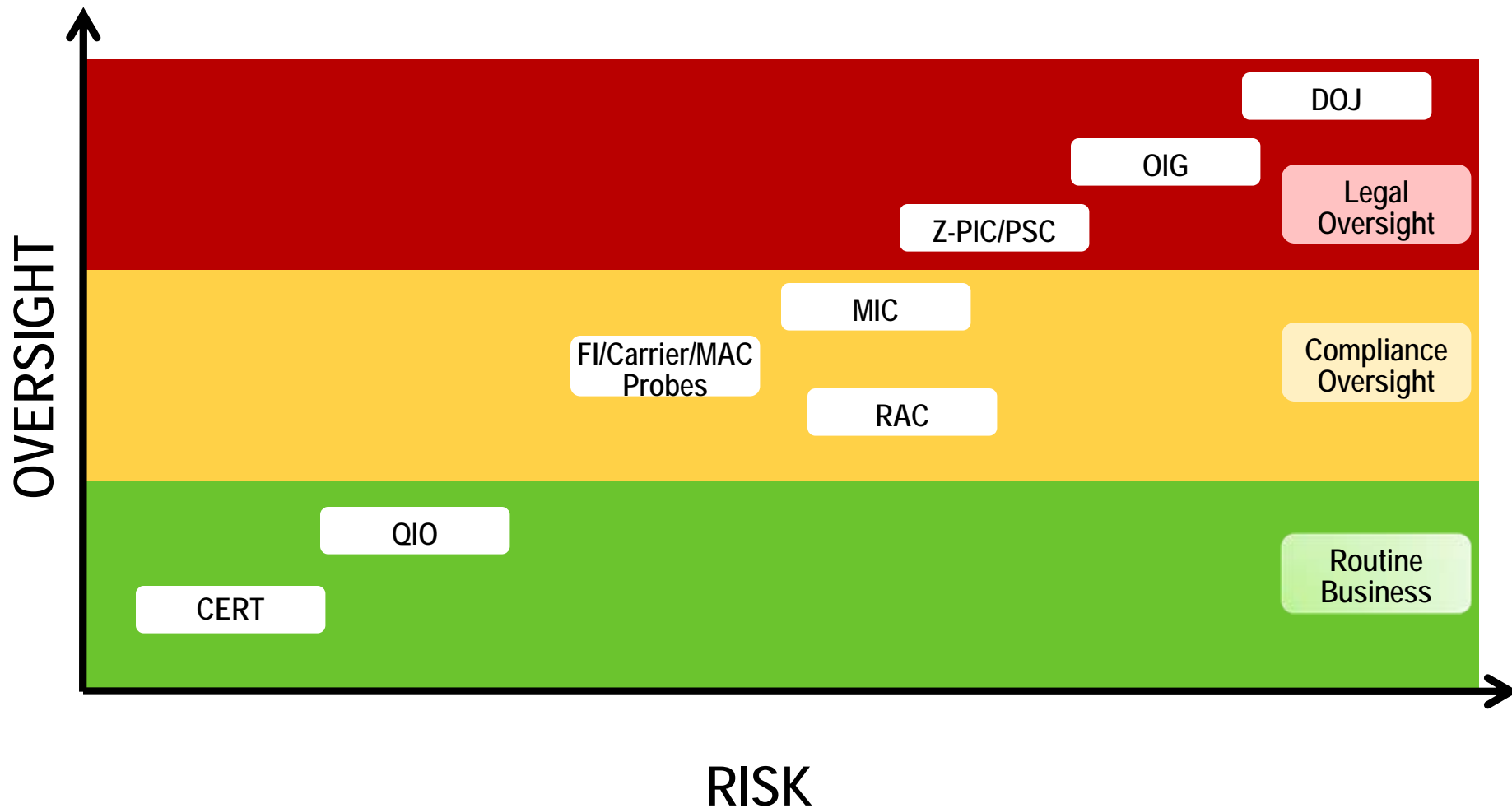
# ZPIC AUDITS



# ZPIC Benefit Integrity Reviews

- If a provider is the target of ZPIC medical review, it should be assumed that it has been specifically targeted and the audit is not random.
- This posture influences the manner in which a ZPIC request for records should be received and evaluated by the provider.
  - Include legal
  - Include compliance
  - Others?
- Review may include investigative techniques in addition to data analytics and claims review.

# Oversight by Compliance and Legal as records are submitted





# ZPIC Audits

- ZPICs perform two types of audits: (1) proactive audits; and (2) reactive audits.
- **Proactive Audits:**
  - Detect medically unnecessary services, ZPICs use specially trained data analysts who work closely with audit and investigative staff members to detect outliers, whether by service, geographic area or provider.
  - CMS is pushing for most audits to be initiated as a result of this intense data analysis.
  - ZPICs are expected to engage in proactive data analysis to identify investigation targets, and to use innovative analytical methods
  - Data analysis samples identify areas of potential errors, claim review strategies that efficiently prevent or address potential errors, high volume or high costs services that are being widely over-utilized and program areas and/or specific providers for possible fraud investigation.
  - ZPICs gather national claims data from the Health Care Customer Information System, CMS Data Center's Part B Analytics Systems and internal compilations.



# ZPIC Audits

- Reactive Audits:
  - Reacting to a pattern of complaints from a contractor (e.g. a MAC) that a provider was providing unnecessary services or billing for supplies not used.
  - In addition to claims review and data analytics, investigative techniques will be used (e.g., patient or family member interviews to inquire about the services received, or requests for documentation from referring physicians to support inpatient admission and Resource Utilization Group codes (RUG – measures of staffing intensity used to categorize residents for Medicare reimbursement).
  - May also consider other data sources in a “reactive” mode (e.g., beneficiary complaints, fraud alerts, referrals from other contractors and agencies, etc.).

# ZPIC Statistical Sampling and Extrapolation

- ZPICs are authorized to engage in statistical sampling and extrapolation techniques if a provider has a “sustained or high level of payment error”
  - Medicare Program Integrity Manual, Chapter 8
- Sampling methodology must be approved by a statistician.
- Error rates found by the ZPIC on a small number of claims can be extrapolated to a much larger universe of claims to determine an overpayment – this could represent a significant dollar amount depending on type of error and time period extrapolated.
- Consultants may enhance providers’ ability to effectively assess sampling and extrapolation techniques.



# Defenses Against Extrapolation

- May challenge the statistical methodology.
  - Some providers have found it worthwhile, because invalidation limits overpayments to the sample overpayment.
- May argue that statutory limitation on extrapolation applies.
  - Note: a determination by the Secretary of sustained or high levels of payment errors is not reviewable (by the district court), but could be considered at lower levels.
  - Another statistically valid sample from the same universe of claims yields a different result.



# Potential Consequences of ZPIC Audit

- A ZPIC audit may lead to:
  - Determination of no overpayment and closure of the case;
  - Provision of education to the provider;
  - Payment denial;
  - Pre-payment review;
  - Recoupment of alleged overpayments (if there was a statistically valid sample then the overpayments could be extrapolated);
  - Recommendation of provider's exclusion from federal healthcare programs; and/or
  - Referral to a law enforcement agency (primarily OIG).



# RECENT DEVELOPMENTS

# Congressional Research Service (CRS) Report

## Health Care Fraud and Abuse Control and Medicare Integrity Program Discretionary Spending

<u>FY</u>	<u>Total Spending</u>
• 2009	\$198 million
• 2010	\$311 million
• 2011 (est.)	\$561 million
• 2012 (est.)	\$580 million

## Estimated Medicare FFS Error Rates and Improper Payment Amounts

<u>FY</u>	<u>Rate</u>	<u>Payment</u>
• 2002	8.0%	\$17.1 billion
• 2004	10.1%	\$21.7 billion
• 2006	4.4%	\$10.8 billion
• 2008	3.6%	\$10.4 billion
• 2009	12.4%	\$35.4 billion
• 2010	10.5%	\$34.3 billion

Source: Congressional Research Service Report, "Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse," July 29, 2011.



# ZPIC Pre-Payment Review

- Providers can be placed on up to 100% prepayment review by a ZPIC.
- CMS is moving away from a “pay and chase” model to proactive fraud identification.
  - The use of prepayment review appears to be increasing.
- Prepayment review can be a significant administrative burden.



# Levinson Testimony

- Testimony of Daniel Levinson, HHS Inspector General before House Committee on Oversight and Government Reform (July 28, 2011)
  - \$47.9 billion in Medicare improper payments in 2010.
    - Not all improper payments represent fraud, however, which is the primary focus of ZPICs.
  - Recommends that CMS enhance pre-payment review of claims, including the use of specific adjustments to address identified payment errors.
    - CMS seems to be moving away from the “pay and chase” system and is looking for more ways to identify improper payments before claims are paid using fraud detection technology and an increased use of pre-payment review.
  - OIG has identified 27 “high risk” hospital billing practices and by using data mining will focus on these problem areas in “selected hospitals,” utilizing site visits to perform reviews of billing and medical record documentation.



# Morris Testimony

- Testimony of Lewis Morris, HHS OIG General Counsel before Senate Committee on Homeland Security & Governmental Affairs (July 12, 2011)
  - Provides overview of OIG’s use of information technology in support of audits and fraud investigations, especially data mining.
  - Comments that OIG has experienced “persistent” problems with the performance of CMS program integrity contractors (PSCs, MEDICs, RACs) over the past 10 years.
  - OIG’s performance evaluations show extreme variability in contractor performance (in number of investigations and law enforcement referrals), lack of proactive data analysis, and lack of CMS oversight over the contractors.
  - Over the next year, OIG will issue reports on vulnerabilities related to ZPICs and MEDICs.



# Predictive Modeling

- On July 1, 2011, CMS began using “predictive modeling technology” to fight Medicare fraud.
- According to a June 17, 2011 CMS press release, the predictive modeling initiative builds on new anti-fraud tools and resources provided by PPACA.
- Medicare claims will be analyzed using risk scoring technology that applies effective predictive models to “real-time” claims data to help CMS identify suspicious claims.
- At this point, it is unclear whether (or to what extent) contractors such as ZPICs will be tasked with investigating potential issues identified through the use of CMS’ new predictive modeling technology.



# Lessons Learned



# Lessons Learned

- Ensure that all relevant medical records are timely submitted
- Engage in early and proactive communication with the ZPIC
  - Ensure that the ZPIC has all the necessary information
  - Express willingness to cooperate fully with the ZPIC
- Confirm whether the ZPIC/PSC has jurisdiction to request records
- If a provider has received multiple ZPIC audits, consider whether there is a connection between the requests
  - Is the same person requesting records from several different sites?
  - Do the records have anything in common that may suggest the focus of the ZPIC's review?



# Lessons Learned

- Make sure all ZPIC correspondence is immediately elevated to the appropriate team within the organization
- Review the ZPIC Statement of Work to help determine whether the ZPIC has possibly exceeded its authority by requesting information such as confidential documents, for example
- Review the ZPIC's look-back period to determine if the ZPIC has potentially exceeded its authority
  - Medicare reopening rules (42 C.F.R. § 405.980(b))
- Review the sample size to determine whether the alleged overpayment is likely to be extrapolated (e.g. were 15 or 80 records requested?)
- Review other contractor audit activity because other contractors may refer providers to ZPICs
  - e.g. is the facility also on MAC prepayment review?



# Thank you!

## Questions and Answers

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# Supplemental Materials



# Current Contractor Landscape

# Overview of Current Contractor Landscape

- Historically, the Centers for Medicare and Medicaid Services (CMS) utilized contractors (fiscal intermediaries (FIs), carriers, and durable medical equipment regional carriers (DMERCs)) to process claims for reimbursement.
- In the last several years, however, CMS has begun to employ contractors who focus on ensuring the integrity of federal healthcare programs, primarily Medicare and Medicaid, by identifying and investigating, erroneous, improper payments to providers and potential fraud.
- Accordingly, the contractor landscape has significantly intensified:
  - Medicare Parts A and B Recovery Audit Contractors (RACs)
  - Medicaid RACs
  - Medicare Parts C and D RACs
  - Medicare Administrative Contractors (MACs)
  - Comprehensive Error Rate Testing Contractors (CERTs)
  - Medicaid Integrity Contractors (MICs)
  - Program Safeguard Contractors (PSCs)
  - Zone Program Integrity Contractors (ZPICs)

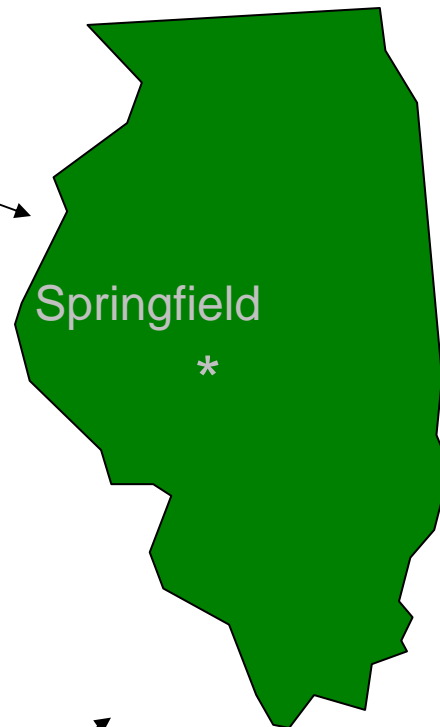
# Significant Contractor Developments

- 1965 – Establishment of Medicare and Medicaid
- 1976 – US Department of Health and Human Resources - Office of Inspector General (OIG)
- 1977 – Health Care Financing Administration (HCFA) – Fiscal Intermediaries (FI)
- 1996 – Medicare Integrity Program (MIP)
- 1996 – Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- 1999 – PSC Program
- 1999 – Quality Improvement Organization (QIO)
- 2001 - HCFA changes to CMS
- 2003 - CERT Program
- 2005 – 2007 – RAC Demonstration Project
- 2006 – MIC Program
- 2008 - Permanent RAC Program
- 2008 – 2011 – Transition from PSCs to ZPICs
- 2009 - Health Information Technology for Economic and Clinical Health Act (HITECH)
- 2010 - Patient Protection and Affordable Care Act (PPACA)
- 2010 - RAC Program expanded to Medicaid and Medicare Parts C and D.

# What does this mean for Illinois Providers? Consider...

## Medicaid

- AdvanceMed (acquired by NCI in April 2011): Review of Provider MIC
- Health Integrity: Audit MIC
- Strategic Health Solutions: Education MIC
- Illinois Medicaid Fraud Control Unit (MFCU)
- Medicaid RAC(s): TBD



## Potential Fraud

- ZPIC: TBD
- TrustSolutions: PSC

## Medicare

- A/B MAC: Bid Corrective Action (to be consolidated with Jurisdiction 5)
- National Government Services: FI
- Wisconsin Physicians Service: Carrier
- National Government Services: DME MAC
- Palmetto GBA: Home Health and Hospice MAC
- CGI: A/B RAC



# Big Picture

- Federal and state governments outsourcing oversight responsibilities.
- Providers should expect to encounter the scrutiny of Medicare and Medicaid affiliated contractors regardless of the strength of their compliance efforts.
- Greater number of private companies authorized to request and analyze information from provider community.
- Contractors are not created equally.
  - ZPICs have a very different charge -- identifying fraud and abuse and making referrals to law enforcement.
  - There is increased pressure on contractors to continuously demonstrate results.
- Understanding different roles and authority of each contractor category will enhance providers' ability to succeed in new contractor world.



# Practical Strategies

# Compliance Programs and Contractor Preparedness

- PPACA § 6401 mandates compliance programs for Medicare and Medicaid providers.
- Create an effective Compliance Program:
  - Prepare for issues identified by:
    - Reviewing new issues posted on RAC website
    - Review any issues on Noridian website
    - Other Sources (CERTs, PSCs, ZPICs, OIG)
  - Assess compliance through an internal audit.
  - Educate and communicate.
  - Develop policies and procedures to get it right.

# Responding to a ZPIC Record Request

- Stamp Date and Time Received.
- Train staff on identity of contractors.
  - ZPIC requests should be treated differently.
- Ensure that staff are aware of deadlines to submit records.
- Ensure contractor is sending to the correct person / address.



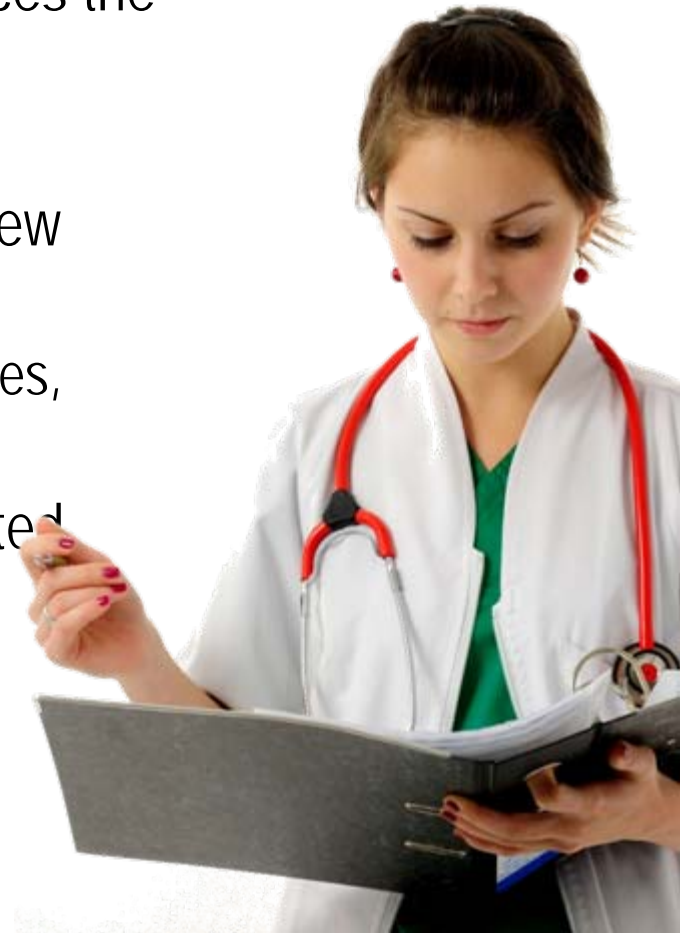
# Responding to a ZPIC Record Request

- Document Management
  - Stamp number (Bates Stamp) on bottom of each page produced
  - Scan everything produced to contractor
  - Include cover letter itemizing contents of box of documents or CD
  - Send certified mail or, if regular mail, complete affidavit of service by mail



# Responding to the Records Request

- Process Options
  - Treat as normal ROI request and HIM produces the records.
    - Cost effective
  - Normal ROI Process with some Clinical Review
    - Ensure entire record is copied
    - Include copies of NCD, LCD, coding guidelines, CMS guidance?
  - Perform shadow review of all records submitted
    - Resource intensive
    - Allows for early identification of issues
    - Establishes priority for appeals





# Medicare Appeals Process



# Medicare Appeals

- Notification of the results of the audit:
  - Process described in Ch. 3 of Medicare Program Integrity Manual
- ZPIC / PSC will issue findings.
- MAC will issue a Demand Letter for recoupment of the overpayment.
- Appeal clock runs from receipt of Demand Letter.



# Medicare Appeals

- Stamp the date received
  - Appeal period begins when you receive the determination (“Demand Letter”), which is presumed to be five days after the date of the letter absent evidence to the contrary.
  - You have 120 days to appeal (i.e. request a redetermination).
  - File request for redetermination within 30 days to avoid recoupment on day 41.



# Medicare Appeals

- Evaluate the Denial – Gatekeeper / Traffic Cop:
  - Lack of documentation (records not submitted timely)
  - Coding issues
  - Charging issues
  - Medical necessity denials
- Gatekeeper / Traffic Cop ensures database used to track claims is updated.
- Generate dashboard for senior management.

# Medicare Appeals

- Medical Necessity Denials
  - Case management / utilization management nurse
  - Physician options
    - Attending physician
    - Medical Director
    - Handful of internal experts
    - Outside physician advisors
  - Document Conclusions
  - Contracts
    - Stark
    - Anti-Kickback



# Medicare Appeals

- Essential Resources
  - Case Management / Utilization Management
  - Physicians / physician advisors
  - Coders / accounting firms
  - Chargemaster
  - Compliance
  - Law Department / outside counsel





# Medicare Appeals

- Pay by check within 30 days.
- Allow recoupment on day 41.
  - Recoupment will include a month's worth of interest at a rate specified in the Demand Letter, for example, 11.5%.
- Allow recoupment on day 41 but file request for redetermination within 120 days.
  - If successful, receive value of claim plus interest.
- File request for redetermination within 30 days to avoid recoupment.
  - Interest continues to accrue and must be paid if unsuccessful.



# Appeals Strategy

- **Issues to Consider**
  - Appeal within 30 days to avoid recoupment
  - 120 days to request redetermination
  - Cash flow – can extend repayment for 180 days through the appeals process
  - 11.5% interest accrues from date of determination, for example
  - Six months of interest on a \$6,000 claim = \$345.00



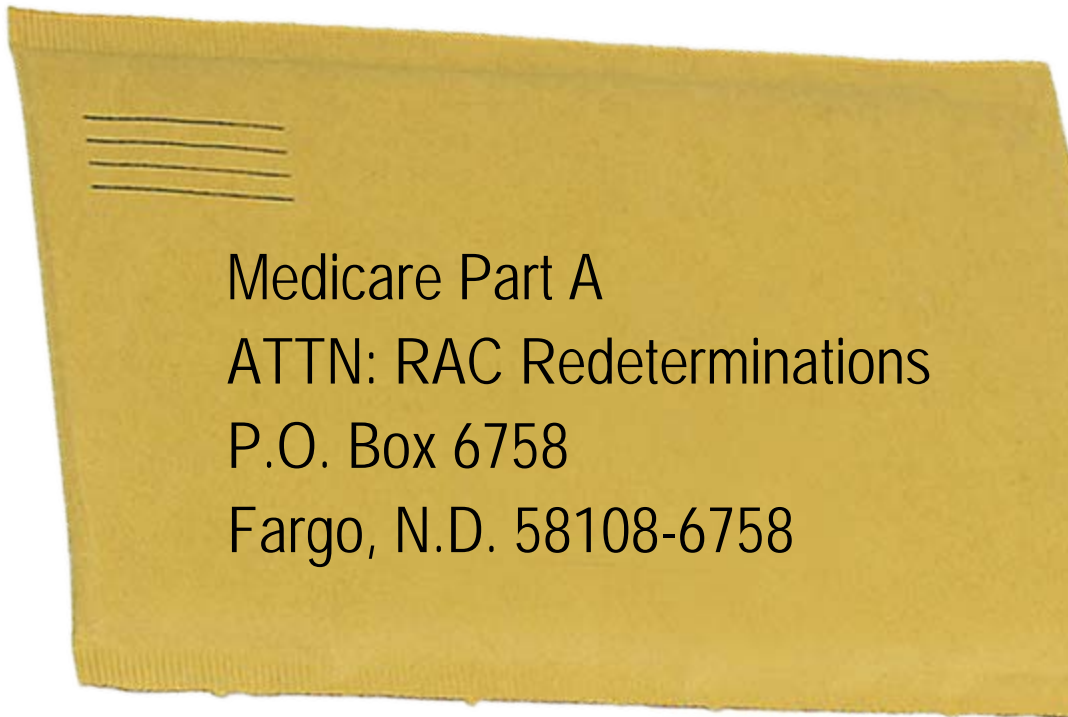
# The Appeals Process

## First Level = Request for Redetermination

- Made to Fiscal Intermediary, Carrier, or to the Medicare Administrative Contractor (MAC)
- 120 days to file appeal, 30 days to avoid recoupment
- No minimum amount in controversy requirement
- Records review

# The Appeals Process

- Contractor has 60 days to issue redetermination decision.
- Use Form CMS 20027 (or your own form with same information).
- Send RAC appeals to (MN for example):



Medicare Part A  
ATTN: RAC Redeterminations  
P.O. Box 6758  
Fargo, N.D. 58108-6758

A Medicare Redetermination Request Form (CMS 20027) with numbered fields for beneficiary information, description of service, and requester details. The form is titled "MEDICARE REDETERMINATION REQUEST FORM" and includes fields for: 1. Beneficiary's Name, 2. Medicare Number, 3. Description of Item or Service in Question, 4. Date the Service or Item was Received, 5. I do not agree with the determination of my claim. MY REASONS ARE: (with lines for text), 6. Date of the initial determination notice (with a note about 120-day rule), 7. Additional Information Medicare Should Consider: (with lines for text), 8. Requester's Name, 9. Requester's Relationship to the Beneficiary, 10. Requester's Address, 11. Requester's Telephone Number, 12. Requester's Signature, 13. Date Signed, 14. I have evidence to submit. (Attach such evidence to this form.) I do not have evidence to submit. (with checkboxes). A NOTICE section at the bottom states: "NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law." The form number "Form CMS-20027 (04/02) 17-00000" is printed at the bottom left.



# The Appeals Process

## Second Level = Request for Reconsideration

- Made to Qualified Independent Contractor (MAXIMUS)
- 180 days to file appeal, 60 days to avoid recoupment
- No minimum amount in controversy requirement
- Records review
- Traditional success rate (pre-RAC):
  - 20% for Part A; 36% for Part B; 28% for DME

# The Appeals Process

- Contractor has 60 days to issue reconsideration decision
- Use Form CMS 20033 (or your own form with same information)
- Send to:

Qualified Independent Contractor  
MAXIMUS Federal Services  
P.O. Box 62410  
King of Prussia, PA 19406

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

**MEDICARE RECONSIDERATION REQUEST FORM**

1. Beneficiary's Name: \_\_\_\_\_

2. Medicare Number: \_\_\_\_\_

3. Description of Item or Service in Question: \_\_\_\_\_

4. Date the Service or Item was Received: \_\_\_\_\_

5. I do not agree with the determination of my claim. MY REASONS ARE:  
\_\_\_\_\_  
\_\_\_\_\_

6. Date of the redetermination notice:  
(If you received your redetermination more than 30 days ago, include your month for not meeting this request earlier.)  
\_\_\_\_\_  
\_\_\_\_\_

7. Additional Information Medicare Should Consider: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Requester's Name: \_\_\_\_\_

9. Requester's Relationship to the Beneficiary: \_\_\_\_\_

10. Requester's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Requester's Telephone Number: \_\_\_\_\_

12. Requester's Signature: \_\_\_\_\_

13. Date Signed: \_\_\_\_\_

14.  I have evidence to submit. (Attach such evidence to this form.)  
 I do not have evidence to submit.

15. Name of the Medicare Contractor that Made the Redetermination: \_\_\_\_\_

**NOTICE:** Anyone who misrepresents or fabricates essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

Form CMS-20033-0101 07-06-09



# The Appeals Process

- Legal Review at Second Level?
  - Last opportunity to submit contemporaneous documents
  - If an appeal to the third level is required, must show “good cause” to submit additional documents
- If unsuccessful after Second Level, overpayment will be recouped.



# The Appeals Process

## Third Level = Administrative Law Judge (ALJ)

- 60 days to appeal
- Minimum amount in controversy: \$120
- Hearing by video teleconference, teleconference, or in-person
- The level at which most RAC appeals have been successful

# The Appeals Process

- ALJ has 90 days from the request for hearing to issue decision.
- Use Form CMS 20034 A/B (or your own form with same information).
- Send to:

Office of Medicare Hearing & Appeals  
 Midwestern Field Office  
 200 Public Square, Suite 1300  
 Cleveland, OH 44114-2316

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 OFFICE OF MEDICARE HEARINGS AND APPEALS

**REQUEST FOR MEDICARE HEARING BY AN ADMINISTRATIVE LAW JUDGE**  Part A  
 Part B

Effective July 1, 2006. For use by party to a reconsideration determination issued by a Qualified Independent Contractor (QIC) (unless a otherwise noted be QIC or name).

Send copies of this completed form to:  
**Appellant** - Office of Medicare Hearings and Appeals Field Office specified in the QIC Reconsideration Notice  
**Appellant** - Appellant -  Appellant -  Appellant - All other parties.  
 Failure to send a copy of this completed request to the other parties to the appeal will delay the start date of your appeal.  
 Did you send all required copies?  Yes  No

**Appellant** (The party opposing the reconsideration determination)

Beneficiary if over 65 years of age or spouse:		Provider or Supplier (see item 6 above in the appeal):	
Address		Address	
City	State	Zip Code	City
State	State	Zip Code	State
Area Code/Telephone Number	E-mail Address	Area Code/Telephone Number	E-mail Address
Health Insurance (Medicare) Claim Number	Document control number assigned by the QIC		
QIC that made the reconsideration determination		Date of Service	
		From <input type="checkbox"/> To <input type="checkbox"/>	

**I DISAGREE WITH THE DETERMINATION MADE ON MY APPEAL BECAUSE:**

You have a right to be represented at the hearing. If you are not represented but would like to be, your Office of Medicare Hearings and Appeals Field Office will give you a list of legal referral and service organizations. If you are represented please do not check any of the boxes below.

Check <input type="checkbox"/> <b>Only One</b> <input type="checkbox"/> <b>Multiple</b> to have a hearing	Check <input type="checkbox"/> <b>Only One</b> <input type="checkbox"/> <b>Multiple</b> additional evidence to submit
Statement <input type="checkbox"/> <b>Only One</b> <input type="checkbox"/> <b>Multiple</b> to have a hearing and I request that a section be made on the basis of the evidence in my case. (Complete box only QIC) (Issue of Rights on the reverse.)	Statement <input type="checkbox"/> <b>Only One</b> <input type="checkbox"/> <b>Multiple</b> additional evidence to submit

If you have additional evidence to submit, please attach the evidence or attach a statement explaining what you intend to submit and when you intend to submit it. If you are a provider, supplier, or transferee represented by a provider or supplier, the evidence must be accompanied by a good cause statement explaining why the evidence is being submitted for the first time at the hearing.  Yes  No

The appellant should complete box 1 and the representative, if any, should complete box 2. If a representative is not present to sign, print his or her name in box 2. Where applicable, check to indicate if appellant will accompany the representative at the hearing.  Yes  No

1. Appellant's Signature:	Date	2. Representative's Signature/Name:	Date
Address	Address	Address	Address
City	State	City	State
State	State	State	State
Area Code/Telephone Number	E-mail Address	Area Code/Telephone Number	E-mail Address

Answer the following questions that apply:

A) Does claim involve multiple claims? (If yes, a list of all the claims must be attached)  Yes  No  
 B) Does claim involve multiple beneficiaries? (If yes, a list of beneficiaries, their HCFA and the dates of service)  Yes  No  
 C) Did the beneficiary assign his or her appeal rights to you as the provider/supplier? (If yes, you must complete and attach form CMS 20031. Failure to do so will prevent approval of the assignment)  Yes  No

Must be completed by the provider/supplier if representing the beneficiary.

I waive my rights to charge and collect a fee for representing \_\_\_\_\_ beneficiary name \_\_\_\_\_ before the Office of Medicare Hearings and Appeals.

Signature of provider/supplier representing beneficiary \_\_\_\_\_ Date \_\_\_\_\_

CMS-20034-A-B (01-2006) OF 06/0606 ATTACH A COPY OF THE RECONSIDERATION DETERMINATION IF AVAILABLE TO THIS COPY



# The Appeals Process

## Fourth Level = Request for Review by the Medicare Appeals Council

- 60 days to appeal
- No minimum amount in controversy
- De novo review
- Record review, but may request oral argument
- MAC will remand to ALJ if additional facts are necessary.

# The Appeals Process

- Medicare Appeals Council has 90 days to act
- Use Form DAB-101 to request review
- Send to:

Department of Health & Human Services  
 Departmental Appeals Board  
 Medicare Appeals Council, MS 6127  
 Cohen Building Room G-644  
 330 Independence Ave., S.W.  
 Washington, D.C. 20201

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) / DEPARTMENTAL APPEALS BOARD Form DAB-101 (6/05)

**REQUEST FOR REVIEW OF ADMINISTRATIVE LAW JUDGE (ALJ) MEDICARE DECISION / DISMISSAL**

1. APPELLANT (the party requesting review)	2. ALJ APPEAL NUMBER (on the decision or dismissal)
3. BENEFICIARY*	4. HEALTH INSURANCE CLAIM NUMBER (HICN)*

\*If the request involves multiple claims or multiple beneficiaries, attach a list of beneficiaries, HICNs, or other information to identify all claims being appealed.

5. PROVIDER, PRACTITIONER, OR SUPPLIER	6. SPECIFIC ITEM(S) OR SERVICE(S)
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7. Does this request involve authorization for an item or service that has not yet been furnished?  
 Yes  No  
If Yes, skip to Block 8. Dates of Service: \_\_\_\_\_

8. Medicare claim type:  Part A  Part B  Part C - Medicare Advantage  
 Part D - Medicare Prescription Drug Plan  Entitlement/Involvement by Part A or Part B

I request that the Medicare Appeals Council review the ALJ's  decision or  dismissal order (check one) dated \_\_\_\_\_ I disagree with the ALJ's action because (specify the parts of the ALJ's decision or dismissal you disagree with and why you think the ALJ was wrong):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional sheets if you need more space.)

**PLEASE ATTACH A COPY OF THE ALJ DECISION OR DISMISSAL ORDER YOU ARE APPEALING.**

DATE	DATE				
APPELLANT'S SIGNATURE (the party requesting review)	REPRESENTATIVE'S SIGNATURE (include signed appointment if not already submitted)				
PRINT NAME	PRINT NAME				
ADDRESS	ADDRESS				
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE				
TELEPHONE NUMBER	FAX NUMBER	E-MAIL	TELEPHONE NUMBER	FAX NUMBER	E-MAIL

(SEE FURTHER INSTRUCTIONS ON PAGE 2)



# The Appeals Process

## Fifth Level = Federal District Court

- 60 days to appeal
- Minimum amount in controversy: \$1,220



# Additional Considerations

- Denial of Inpatient Admission
  - Cannot re-bill for outpatient service
    - Must have flipped to outpatient before patient was discharged
    - CMS says statute would have to be changed
  - Can re-bill for allowable Part B services
    - List of Part B services found in the Medicare Benefit Policy Manual, CMS Pub 100-2, Ch. 6, Section 10
      - Examples: diagnostic tests, radioactive isotope therapy, prosthetic devices, artificial legs, arms and eyes, outpatient physical therapy, outpatient speech-language pathology services, and outpatient occupational therapy, Epoetin Alfa (EPO)
  - *But see In re O'Connor Hospital*, Medicare Appeals Council, February 1, 2010.

# O'Connor Medicare Appeals Council Decision

- O'Connor Hospital (San Jose, California) was audited during the A/B RAC Demonstration Project.
- The A/B RAC denied certain claims for failing to meet medical necessity standards for inpatient admission.
- The hospital successfully appealed three of the four claims at the ALJ level by demonstrating that the inpatient admission had been medically necessary. The Medicare Appeals Council decision involves one claim for which the hospital was not able to establish the appropriateness of inpatient admission at a lower appeal level.
- At the third level of the RAC appeal process, the ALJ determined that inpatient admission was not medically necessary, but found that *"the observation and underlying care were warranted."*
- The ALJ ordered that the amount of *any overpayment for the inpatient admission should be offset by the appropriate Part B payment for an observation case.*

# O'Connor Medicare Appeals Council Decision

- CMS appealed, arguing that observation and underlying care are not separately billable under Part A and, therefore, the ALJ erred as a matter of law when it ruled that the hospital was entitled to the offset.
- The Medicare Appeals Council disagreed with CMS, reasoning that CMS's position that it was not required to offset or otherwise reimburse the hospital under Part B for the observation services is inconsistent with the guidance set forth in CMS Manuals, and in particular, the Medicare Benefit Policy Manual, Chapter 6, § 10.
- The Medicare Appeals Council found that "CMS has expressly stated that Part B payment may be made if Part A payment is denied."

The background of the slide features a composite image. On the left, a microscope is visible, with its lens and body partially shown. On the right, there are several US dollar bills, including a \$100 bill and a \$20 bill, with the text 'THE UNITED STATES OF AMERICA' and 'FEDERAL RESERVE NOTE' visible. The overall color scheme is a mix of green and brown tones, typical of currency and scientific equipment.

# Defenses Against Recoupment

- 1-year limit on reopening claims
- Limitation of Liability (Section 1879 of the Social Security Act)
- No Fault (Section 1870 of the Social Security Act)
- Treating Physician Rule
- Qualifications of Staff
- NCD or LCD is unlawful
- Should at least get paid an APC rate or some amount to reflect the outpatient services provided



# Defenses Against Recoupment

- Reviewer Used the Wrong Standards
  - Coding clinic, LCD, NCD, other CMS guidance
  - Note: QIC and ALJ are bound by laws and regulations, NCD's, and Medicare rulings, but not by other CMS guidance (such as Medicare Claims Processing Manual or Transmittals)
- Reviewer Applied the Standards Incorrectly
  - Review Medicare Ruling 95-1 on medical necessity standards
  - Support argument with affidavit/ testimony of physician
  - Include any evidence of community standard
  - Include any scientific articles that support your position