Specific Case Studies of Successful Discussion Period and Appeal Strategies

Andrew B. Wachler
Wachler & Associates, P.C.
210 E. Third St., Suite 204
Royal Oak, MI 48067
248-544-0888
awachler@wachler.com

Denise Wilson
Intersect Healthcare, Inc.
1729 York Road, Suite 201
Lutherville, MD 21093
410-252-4343 ext 16
dwilson@intersecthealthcare.com

THE CURRENT AUDIT LANDSCAPE

- CMS contractors in the current audit landscape
  - –Medicare Administrative Contactors (MACs)
  - –Zone Program Integrity Contractors (ZPICs)
  - –Recovery Audit Contractors (RACs)
    - Medicare RACs & Medicaid RACs
  - –Medicaid Integrity Contractors (MICs)

Medicare Administrative Contractors (MACs)

- MACs are assuming all functions of the current intermediaries and carriers
- Provider services will be simplified by having a single MAC process both its Part A and Part B claims

Zone Program Integrity Contractors (ZPICs): What do they do?

- ZPICs are responsible for preventing, detecting and deterring Medicare fraud
  - Different from the Medicare Review program which is primarily concerned with preventing and identifying errors
  - ZPICs request medical records and conduct medical review to evaluate for potential fraud
  - ZPICs may also refer to the OIG and DOJ for further investigation

Zone Program Integrity Contractors (ZPICs): What do they do?

- In performing their functions, ZPICs may, as appropriate:
  - Request medical records and documentation;
  - Conduct an interview
  - Conduct an onsite visit
  - Identify the need for prepayment or auto-denial edit and refer these edits to the MAC for installation;
  - Withhold payments; and
  - Refer cases to law enforcement

Policies for Government/Third Party Payor Investigations

- Cooperation and coordination with government investigations.
- If an employee receives any inquiry, subpoena or other legal document relating to the employer's business:
  - Notify the Compliance Officer immediately.
    - The Compliance Officer will contact legal counsel.
  - Do not provide false or inaccurate information to a government investigator.

Policies for Government/Third Party Payor Investigations

- Initial contact with a government investigator:
  - Obtain information specified in compliance program
- On-Site Inquiries
  - Obtain “initial contact” information
  - Contact Compliance Officer
  - Draft memorandum regarding information obtained from the investigator and provide to Compliance Officer

Policies for Government/Third Party Payor Investigations

- Search Warrants
  - Contact Compliance Officer immediately
  - Compliance Officer will immediately contact legal counsel
- Employees speaking with government investigators:
  - Cannot be prohibited from speaking with government investigators
  - May politely decline to speak with investigators
  - May request legal counsel to be present during an interview

Recovery Audit Contractors

Who are the RACs?

- **Region A: Diversified Collection Services, Inc.**
  - Working in CT, DE, D.C., MA, MD, MA, NH, NJ, NY, PA, RI and VT
  - www.dcsrac.com
- **Region B: CGI Technologies and Solutions, Inc.**
  - Working in KY, IL, IN, MI, MN, OH and WI
  - http://racb.cgi.com
- **Region C: Connolly Consulting, Inc.**
  - Working in AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, SC, TN, TX, VA and WV
  - www.connollyhealthcare.com/RAC
- **Region D: HealthDataInsights, Inc.**
  - Working in AK, AZ, CA, IA, KS, MO, MT, ND, NE, **NV**, OR, SD, UT, WA, WY, Guam, American Samoa and Northern Marianas
  - http://racinfo.healthdatainsights.com/home.aspx

Medicaid RACs

- **September 16, 2011:** CMS publishes Final Rule for the Medicaid RACs
- **January 1, 2012**: States required to have implemented their Medicaid RAC programs
- **The Final Rule**:
  - States have the discretion to perform medical necessity reviews within the scope of state laws and regulations
  - The Final Rule does not require states to obtain advanced approval of medical necessity reviews

Medicaid Integrity Contractors

- **Section 6034(e)(3) of the Deficit Reduction Act of 2005 mandated the creation of the Medicaid Integrity Program (MIP)**
  - CMS hires contractors to review Medicaid providers' activities, audit claims, identify overpayments, and educate providers on Medicaid program integrity issues

- **Different Types of MICs**:
  - **Review MICs**: review and select providers for audits
  - **Audit MICs**: request and review documentation to determine if an overpayment exists

- **MIC Fraud Referrals**: Audit MICs must report potential Medicare or Medicaid fraud to the Medicaid Integrity Group or the OIG

The Medicaid Appeals Process

- Provider appeals of MIC audits will be handled through the state appeals process, pursuant to state law.

- The appeal processes for the various states may differ, but they are likely governed by the state's administrative procedures act.

The Medicaid Appeals Process

Defenses in State Courts

- No Waiver of Liability, Provider Without Fault defenses
  - Equitable Estoppel
  - Laches
- Statutory Limitations

- Emerging Issues:
  - Limitations on withhold
  - Discovery, Freedom of Information Act requests
  - Pro hac vice admission
  - Settlement authority – are settlements still available?
  - State law and constitutional issues

SUCCESSFUL APPEAL STRATEGIES
State Medicaid Managed Care Plans

Statistical Sampling in Medicaid Managed Audits

- **Defenses**
  - Contract
  - Federal law
  - State law

Consumer Appeals Process

- Interim Final Rules issued July 23, 2010
  - 45 CFR §147.136
- New regulations give consumers the right to:
  - Appeal decisions through the health plan's internal review process and
  - Appeal decisions made by the health plan to an outside decision-maker, regardless of the state they live in or type of health coverage they have.
- State will establish or update their external appeals process to meet new standards
  - If state laws do not meet the new standards, consumers in those states will be protected by a comparable Federal external appeals process

CMS Demonstration Programs

- Part A to Part B Rebilling Demonstration Program

- Recovery Audit Pre-Payment Review Demonstration Program (Implementation Delayed on December 30, 2011. Anticipated start date is on or after June 1, 2012.)

The Part A to Part B Rebilling Demonstration Program: The Basics

- Voluntary program
- 380 hospitals: 80 large hospitals (300+ beds), 120 moderate hospitals (100-299 beds), and 180 small hospitals (99 or less beds)
- January 1, 2012 to December 31, 2014
- Enrollment opened on December 12, 2011 at 2pm ET

The Part A to Part B Rebilling Demonstration Program: The Attestation

- Volunteer participants must sign an attestation at the beginning of the program agreeing to:
  - Not file an appeal for claims eligible for rebilling under the program
  - Hold beneficiaries harmless
  - Not bill for observation services
  - Not reveal the demonstration code for billing the Part A claims

The Part A to Part B Rebilling Demonstration Program: Rebilling Part A Claims

- Participants can only rebill short-stay inpatient claims denied during a Medicare Administrative Contractor, Zone Program Integrity Contractor, Recovery Auditor or Comprehensive Error Rate Testing audit
- All claims must have been denied during an audit which occurred after January 1, 2012 and denied because the services were provided in the incorrect setting
- Hospitals will receive 90% of the total Part B payment, not including observation services

The Part A to Part B Rebilling Demonstration Program: The High Price for Participation

- Participants are required to waive their right to appeal all inpatient short-stay claims denied for lack of medical necessity because the services were provided in the incorrect setting
- An “all or nothing” program
- CMS’ reasoning for the waiver requirement: concern that providers will “double-bill”
- No evidence of double-billing during the RAC demonstration program during which providers could rebill a claim at any stage of the appeals process

The Part A to Part B Rebilling Demonstration Program: The High Price for Participation

- Will RACs target participants because the RACs' denials will be essentially immune from review?
  - CMS assured that contractors will not be aware of the hospitals participating in the program
  - RACs may be able to decipher which hospitals are participating:
    - Demonstration Code
    - Denials not followed by appeals
    - RACs will receive a lower contingency fee
- CMS encourages providers to report a RAC's egregious behavior

Recovery Auditor Pre-Payment Review Demonstration Program: The Basics

- Program's implementation was delayed on December 30 until ***on or after*** **June 1, 2012**
- Mandatory program for providers in 11 states:
  - FL, CA, MI, TX, NY, LA, IL, PA, OH, NC and MO
- Program allows Recovery Auditors (RACs) to conduct pre-payment reviews on providers' Medicare claims in those states
- Prior to the program and in states outside of the program, RACs may only conduct post-payment reviews

Recovery Auditor Pre-Payment Review Demonstration Program: The Basics

- Hospitals that participate in both the AB Rebilling Demonstration Program and the Pre-Payment Review Demonstration Program will not be allowed to appeal denied inpatient short-stay claims

Recovery Auditor Pre-Payment Review Demonstration Program: Rolling Out the Reviews

- CMS will phase-in more DRGs as the program progresses
- CMS will continue to introduce new claims subject to review and noted that claims reviewed may extend beyond inpatient short-stay claims

Recovery Auditor Pre-Payment Review Demonstration Program: Rolling Out the Reviews

- **<u>MS-DRGs for Review under the initial program (may change)</u>:**
  - MS-DRG 312 Syncope & Collapse
  - MS-DRG 069 Transient Ischemia and MS-DRG 377 G.I. Hemorrhage W MCC
  - MS-DRG 378 G.I. Hemorrhage W CC and MS-DRG 379 G.I. Hemorrhage W/O CC/MCC
  - MS-DRG 637 Diabetes W MCC, MS-DRG 638 Diabetes W CC and MS-DRG 639 Diabetes W/O CC/MCC

Recovery Auditor Pre-Payment Review Demonstration Program: Operational Aspects

- Demonstration program is *in addition to* and not a replacement of the current RAC program

- According to CMS, less than 100% of the claims subject to review will be reviewed, but it would not provide a specific percentage

Recovery Auditor Pre-Payment Review Demonstration Program: Operational Aspects

- Facilities will submit a claim, the claim will be suspended and then the facility will receive notification to submit additional documentation
- Facilities will have 30 days to submit the documentation and will receive an automatic denial if documentation is not sent within 45 days
- The request for additional documentation will inform the facility whether to send the documentation to the MAC or the RAC
- Facilities should learn within 45 days of submitting the documentation whether the claim is denied

Other Pre-Payment Reviews on the Horizon

- First Coast Services Options, MAC for Florida, announced 100% prepayment medical review of certain Florida inpatient hospital claims beginning on January 1, 2012

- CMS has expressed that a MAC's decision to conduct pre-payment review of claims and the Demonstration Program are separate and distinct programs

- Possibility that hospitals in Florida will receive pre-payment review from the Demonstration Program, once it begins, and First Coast?

Recovery Auditor Pre-Payment Review Demonstration Program: Effects of Pre-Payment Review

- Pre-Payment Review severely affects providers' cash flow
- It is very important that hospitals seek Part B reimbursement for Part A claims denied during a pre-payment review
- Will hospitals' billing shift to favor Part B Outpatient?

Recovery Auditor Pre-Payment Review Demonstration Program: Effects of Pre-Payment Review

Reimbursement Timeline under Pre-Payment Review

- Demand Letter issued
- Redetermination: Provider appeals within 30 days
- Redetermination Decision: Contractor issues decision within 60 days
- Reconsideration: Provider appeals redetermination decision within 60 days
- Reconsideration Decision: QIC issues decision within 60 days
- ALJ: Provider appeals the reconsideration decision within 60 days
- ALJ Decision: ALJ issues decision within 90 days

Total: 360 days (at least)

Medicare Appeals Processes

- Medicare Appeals Processes
- Preparation/Strategies
- Special Issue: Appealing Part A Claim Denials and Seeking Part B Reimbursement

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

OVERVIEW

- *Rebuttal*
- *Discussion period*
- Redetermination
- Reconsideration
- Administrative Law Judge Hearing
- Medicare Appeals Council (MAC)
- Federal District Court

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Redetermination

- After an initial determination, a provider has **120 days** to file a request for redetermination
  - Request for redetermination must be filed **within 30 days** after the date of the first demand letter to avoid recoupment of the overpayment.
  - Recoupment begins on the **41st day** after the date of the demand letter.
- The contractor has **60 days** from the date of the redetermination request to issue a decision
  - Providers may submit additional evidence after the request is submitted, and the contractor may extend the 60 day decision-making time period by 14 days for each submission.

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Reconsideration

- Once the contractor issues a reconsideration decision, a provider has **180 days** to file a request for reconsideration
  - Request for reconsideration must be filed **within 60 days** after the redetermination decision in order to avoid recoupment of the overpayment. Recoupment begins on the 76th day after the redetermination decision.

- **Key Considerations**:
  - Full and early presentation of evidence requirement
  - Submission of additional evidence, 14 day extension of time period for decision
  - Reviewer credentials

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Early Presentation of Evidence Requirement

- Medical Records
- Affidavits
- Testimony
- Submit alternative request for Part B reimbursement at reconsideration
- Self Data Mining
- Learned Treatises

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Administrative Law Judge (ALJ) Hearing

- A provider must file a request for an ALJ hearing **within 60 days** of the QIC's reconsideration decision.
- Amount in controversy requirement must be met
- ALJ hearing may be conducted in person, by video-teleconference (VTC), or by phone
- CMS will recoup the alleged overpayment during this and following stages of appeal

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Contractor Participation in ALJ Hearing

- The nature of the contractor's involvement in the hearing often is impacted by how they choose to participate.
  - **Two Options for Participation:**
    - Party
    - Non-Party Participant (more common)
  - **As non-party participants contractors may not:**
    - Call witnesses
    - Cross-examine a provider's witnesses
    - Be called by the provider as a witness
  - **As non-party participants contractors may:**
    - File position papers
    - Provide testimony to clarify factual or policy issues of the case
- **Notice Requirements for Contractors**: 10 days after receiving the notice of hearing (42 CFR § 405.1010(b))

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Medicare Appeals Council (MAC)

- A provider dissatisfied with the ALJ decision has **60 days** to file an appeal to the Medicare Appeals Council (MAC)
  - Use of past Medicare Appeals Council cases
    - http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/mac_decisions.html
    - http://www.hhs.gov/dab/macdecision/

Federal District Court

- A provider must submit an appeal to the federal district court within **60 days** of the date of the MAC decision
  - Amount in controversy requirements must be met

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Preparation and Presentation of the Case

- Legal/Regulatory/Policy
- Clinical
  - Expert Testimony
  - Learned Treatises
- Communication with the ALJ Office
- Reviewing Redetermination and Reconsideration findings

SUCCESSFUL APPEAL STRATEGIES
Arguing the Merits

- **Merit-based arguments include**:
  - Medical necessity of the services provided
  - Appropriateness of the codes billed
  - Frequency of services

- **To effectively argue the merits of a claim**:
  - Draft a position paper laying out the proper coverage criteria
  - Summarize submitted medical records and documentation
  - If relying on medical records in an ALJ hearing:
    - Organize using tabs, exhibit labels and color coding
    - Use graphs and medical summaries to assist in the presentation of evidence

SUCCESSFUL APPEAL STRATEGIES
Use of Experts

- Experts such as physicians, registered nurses, coding experts, and inpatient rehabilitation specialists may be helpful in appealing a contractor determination

- **Experts can**:
  - Assess strength of a case early on and help develop a strategic plan
  - Assist with the interpretation and organization of medical records
  - Provide testimony regarding appropriateness and/or necessity of services
    - Affidavit at redetermination and reconsideration levels
    - Live testimony at ALJ hearing

SUCCESSFUL APPEALS STRATEGIES
Audit Defenses

- Provider Without Fault
- Waiver of Liability
- Treating Physician's Rule
- Challenges to Statistics
- Reopening Regulations
- Regulatory & Constitutional Challenges

Special Issue: Appealing Part A denials and Seeking Part B Reimbursement

- **Standards for Appealing Part A Denials**
  - **Medicare Benefit Policy Manual (CMS Pub. 100-02), Chapter 1, § 10**
    - RAC's inappropriate use of InterQual criteria as a basis for denial
    - Hindsight prohibited for denial rationale
  - **The Medicare Program Integrity Manual (CMS Pub. 100-08), Ch. 6, § 6.5.2**
    - Address the manual's language in its appropriate context

Appealing Part A denials and Seeking Part B Reimbursement

Medicare Benefit Policy Manual (CMS Pub. 100-02), Chapter 1, § 10

- ***Inpatient hospital services -***
  - An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. *Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.*

Appealing Part A denials and Seeking Part B Reimbursement

Medicare Benefit Policy Manual (CMS Pub. 100-02), Chapter 1, § 10

- ***Inpatient hospital services—cont'd:***
  - The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. ***Physicians should use a 24-hour period as a benchmark***, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. ***However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors***, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, ***the hospital's by-laws and admissions policies***, and the relative appropriateness of treatment in each setting.

Appealing Part A denials and Seeking Part B Reimbursement

Medicare Benefit Policy Manual (CMS Pub. 100-02), Chapter 1, § 10

- **Factors to be considered when making the decision to admit include such things as**:
  - The severity of the signs and symptoms exhibited by the patient;
  - The medical predictability of something adverse happening to the patient;
  - The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours of more) to assist in assessing whether the patient should be admitted; and
  - The availability of diagnostic procedures at the time when and at the location where the patient presents.
- ***Admissions of particular patients are not covered or non-covered solely on the basis of the length of time the patient actually spends in the hospital…***

Appealing Part A denials and Seeking Part B Reimbursement

- **The Medicare Program Integrity Manual (CMS Pub. 100-08), Ch. 6, § 6.5.2** *reminds reviewing contractors that*:
  - Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting.
  - Is this a heightened standard?

Appealing Part A denials and Seeking Part B Reimbursement

- The language in Section 6.5.2(A), of the Medicare Program Integrity Manual should be viewed in conjunction with the Medicare Benefit Policy Manual.
  - The Medicare Benefit Policy Manual discusses factors to be considered by the attending physician when making the decision to admit while the Medicare Program Integrity Manual discusses factors to be considered when contractors review the medical necessity of an inpatient admission.
  - In both instances, the factors to be considered relate to the severity of the illness and intensity of the service and whether the patient's health or safety would suffer if the care was provided in a less intensive setting.

Appealing Part A denials and Seeking Part B Reimbursement

- This language should also be viewed in its proper context within the *Medicare Program Integrity Manual*.
  - It is found directly between the following instructions:
    - Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission.
    - Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay.
  - Instead of a heightened standard, this language should more properly be viewed as an instruction to reviewing contractors to focus on the medical reasons for inpatient admission as opposed to reasons of convenience.

Appealing Part A denials and Seeking Part B Reimbursement

Hospital Condition of Participation: Utilization Review

If the UR committee maintains the responsibility to fulfill the required UR functions:

- A UR committee consisting of two or more practitioners carry out the UR function. At least two members of a hospital's UR committee must be doctors of medicine or osteopathy, and the other members may be any of the other types of practitioners specified in the regulation.

- The determination that an admission or continued stay is not medically necessary must be made either by (i) one member of the UR committee if the practitioner(s) responsible for the care of the patient either concurs with the determination or fails to present their views when afforded the opportunity, or (ii) two members of the UR committee in all other cases.

- The UR committee must consult with the practitioner(s) responsible for the care of the patient and allow them to present their views before making a determination.

- If the UR committee determines that an admission is not medically necessary, the committee must give written notification, no later than 2 days after the determination, to the hospital, the patient, and the practitioner responsible for the care of the patient.

- A review of an inpatient admission may be performed before, at or after an admission

Appealing Part A denials and Seeking Part B Reimbursement

- **<u>Support for Part B Reimbursement (cont)</u>**
  - Medicare Benefit Policy Manual, CMS Pub. 100-02
  - Medicare Claims Processing Manual, CMS Pub. 100-04

MAC Cases: Important Guideposts for Part B Reimbursement

O'Connor Hospital v. National Government Services, Medicare Appeals Council (February 1, 2010)

- Hospital appealed claim and the Administrative Law Judge (ALJ) found that this claim was "partially favorable."
  - Denied Part A claim – inpatient hospitalization services were not reasonable and necessary
  - Approved Part B claim – covered because the "observation and underlying care are warranted."
- The Medicare Appeals Council concluded that it would not review the ALJ's decision

MAC Cases: Important Guideposts for Part B Reimbursement

UMDNJ, Medicare Appeals Council *(*March 14, 2005*)*

- At the lower levels, the reviewers found that the inpatient admissions were not medically necessary and reasonable. The hospital's appeal sought payment for outpatient services.
- The Medicare Appeals Council agreed that the Manual support Part B reimbursement.
- Council concluded that it would not review the ALJ's decision

Sequoia, *Medicare Appeals Council (Oct. 6, 2010)*

- The Medicare Appeals Council affirmed the denial of inpatient services, but found the hospital responsible for only the overpayment arising "from the difference between the covered and non-covered services."

MAC Cases: Important Guideposts for Part B Reimbursement

Montefiore Medical Center, Medicare Appeals Council (May 10, 2011)

- Hospital appealed inpatient services denied for lack of medical necessity.
- The Medicare Appeals Council affirmed the denial of the services, but ordered Part B reimbursement.
- "Consistent with the CMS manual provisions discussed above, the contractor **shall work** with the provider to take whatever actions are necessary to arrange for billing under Part B, and to offset any Part A overpayment. The contractor **shall issue** a new initial determination up effectuation. 42 C.F.R. § 405.1046(c)." (emphasis added)

Appealing Part A denials and Seeking Part B Reimbursement

Enforcement of an ALJ Order: Medicare Claims Processing Manual (CMS Pub. 100-04, Ch. 29, §§ 330.4 and 330.5)

Function of an Administrative QIC (AdQIC)

- AdQIC serves as a clearinghouse: receives case file and the ALJ decision for a favorable case, then forwards effectuation notice to the contractor
- Contractor issues a payment or changes liability based upon effectuation notice.
  - No agency referral to the MAC: Contractor has 30 days to effectuate.
  - No agency referral to the MAC and the contractor must compute amount: Contractor has 30 days to effectuate after it computes the amount, but it must compute it as soon as possible.
  - Clarification from AdQIC necessary: Contractor considers the final determination date for purposes of effectuation.

Appealing Part A denials and Seeking Part B Reimbursement

- Rebilling to achieve Part B Reimbursement

- Enforcing an ALJ order in Federal Court

Specific Case Studies of Successful Discussion Period and Appeal Strategies

Denise R. Wilson MS, RN, RRT

Learning Objectives

- Understand the Discussion Period and Process
- Understand the when to use the Discussion Period
- Understand the how RAC denials are being overturned in the Discussion Period

CMS Appeals Process

CMS Recovery Audit Program

- http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/index.html

Provider Options Chart

- http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/ProviderOptionsChart.pdf

CMS Appeals Process

Provider Options - RAC Overpayment Determination

	Discussion Period	Rebuttal	Redetermination
Which option should I use?	The discussion period offers the opportunity for the provider to provide additional information to the RAC to indicate why recoupment should not be initiated. It also offers the opportunity for the RAC to explain the rationale for the overpayment decision. After reviewing the additional documentation submitted the RAC could decide to reverse their decision. A letter will go to the provider detailing the outcome of the discussion period.	The rebuttal process allows the provider the opportunity to provide a statement and accompanying evidence indicating why the overpayment action will cause a financial hardship and should not take place. A rebuttal is not intended to review supporting medical documentation nor disagreement with the overpayment decision. A rebuttal should not duplicate the redetermination process. (See 42 CFR 405.374-375)	A redetermination is the first level of appeal. A provider may request a redetermination when they are dissatisfied with the overpayment decision. A redetermination must be submitted within 30 days to prevent offset on day 41.
Who do I contact?	Recovery Audit Contractor (RAC)	Claim Processing Contractor	Claim Processing Contractor
Timeframe	Day 1 - 40	Day 1-15	Day 1-120 Must be submitted within 120 days of receipt of demand letter. To prevent offset on day 41 the Redetermination must be filed within 30 days.
Timeframe Begins	Automated Review: Upon receipt of Demand Letter Complex Review: Upon receipt of Review Results Letter	Date of Demand Letter	Upon receipt of Demand Letter
Timeframe Ends	Day 40 (offset begins on day 41)	Day 15	Day 120

Confusing! Day 1 for Complex Review is Date of Review Results Letter!

935 Limitation on Recoupment

CMS Internet Only Manuals (IOMs)

Pub 100-06 Chapter 3 Limitation on Recoupment (935)

Medicare Financial Management Manual

- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019018.html

Recoupment: When does it Begin?

200.1.3 - Adjustment of the Part A Claim

- *If the adjustment results in a refund due the providers, physicians and suppliers, Medicare contractors shall follow existing underpayment policies. This will also trigger recoupment to begin on the 41st day after the date of the demand letter.*

Recoupment: When does it End?

200.2 - Additional Requirements for Demand Letters

5. *Medicare contractors shall insert in the demand letter, language that clearly explains that recoupment will begin on the 41st day from the date of the first demand letter if 1) payment is not received in full, 2) an acceptable request for an extended repayment schedule, or 3) a valid request for a contractor redetermination is not date stamped in the mailroom by day 30 from the date of the demand letter.*

CMS Appeals Process

200.2.2 - Recoupment After the First Demand: When Does it Begin?
(Rev. 141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

Timeframe	*Medicare Contractor*	*Provider*
Day 1	*Date of Demand Letter (Date demand letter mailed)*	*Provider receives notification by first class mail of overpayment determination*
Day 1-15	*for Rebuttal upment*	*Provider must submit a statement within 15 days from the date of demand letter.*
Day 1-40	*occurs*	*Provider can appeal and potentially limit recoupment from occurring*
Day 41	*Recoupment begins*	*Provider can appeal and potentially stop recoupment*

Only if these two dates match!!

CMS FAQs Re: Discussion Period

https://questions.cms.gov/

> Topic: Medicare Demonstration Projects & Eval Reports Subtopic: Recovery Audit Contractors (28 FAQs)

What is the length of the Recovery Audit Contractor (RAC) discussion period?) The discussion period begins with the time of notification (demand letter for automated reviews and the review results letter for complex reviews) through the time recoupment occurs. The discussion period normally requires written notification to the RAC. The discussion period does not extend the provider's appeal timeframes.

Discussion Period Findings

- Midwest hospital participating in the RAC A/B Rebilling Demonstration
- Only option to 'appeal' is to participate in the Discussion Period
- Of 25 cases submitted for discussion, 7 have been overturned
- RAC = HDI
- MAC = Wisconsin Physician Services

Case Study #1
Overturn at Discussion

RAC Finding:

72 year old female presented for an anterior vaginal vault reconstruction for prolapsed bladder and was billed as an acute inpatient. Past medical history and the pre-existing conditions were stable. The medical record did not document pre-existing medical conditions or extenuating circumstances, such as post operative complications, that made the acute inpatient admission medically reasonable and necessary. The medical record documents services that could have been provided as outpatient services in the hospital. The necessity for the inpatient admission is not documented in the medical record.

Case Study #1
Overturn at Discussion

Discussion:

Pt. admitted for post procedure complications

The patient was initially admitted as an outpatient, but on post op day 1:

- spiked a temperature, low grade at 99.7
- hemoglobin had dropped down to 10
- and she was on 2 liters of oxygen to maintain her oxygen saturation

She was converted to an inpatient to work on ambulation and wean off her 02.

Case Study #1
Overturn at Discussion

Requirement	Source	Present or Supported in Medical Record	Comments
The severity of the signs and symptoms exhibited by the patient warrant possible need for inpatient admission.	CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.	Yes Progress Notes; p. 50 of medical record. Lab Results; pp. 15 and 51 of medical record. Orders; p. 41 of medical record. Patient Care System Discharge Summary; pp. 96-97 of medical record.	7/28/11 Day 1 post op. 1. Temperature 99.7 this A.M. 2. Hbg 11.9 to 10. 3. Needing 2L oxygen to maintain SATS 4. BP good and output adequate Plan- convert to Inpatient-ambulate 7/28/11 Convert to Inpatient status- A.M. temp 99.7, required 2L of O2 to maintain sats. 7/28/11 00:03 Temperature-98.8, Pulse-66, Respiratory rate-16, BP 114/65, Oxygen-93% on nasal cannula. 7/28/11 04:15 Vitals signs; Temperature-98.1, Pulse-68, BP 119/73, Oxygen-93% on nasal cannula.

Case Study #2
Overturn at Discussion

RAC Finding:

74 year old female with chest pain, diagnostic testing unremarkable for acute cardiac findings or cardiac source with the final diagnosis of left arm and neck pain and was billed as an acute inpatient. Past medical history and the pre-existing conditions were stable. The medical record did not document pre-existing medical conditions or extenuating circumstances that made the acute inpatient admission medically reasonable and necessary. The medical record documents services that could have been provided as outpatient services in the hospital. The necessity for the inpatient admission is not documented in the medical record.

Case Study #2
Overturn at Discussion

Discussion:

Pt. was complaining of arm and shoulder pain that radiated to her neck. Additionally, an EKG performed in the emergency room revealed abnormal results, specifically ST & T wave abnormality-possible anterior ischemia, and an elevated D-Dimer. This 74 year old female patient reported that the pain woke her from sleep one hour prior to presentation.

Initially, she was admitted as an Outpatient (5/13/10), but the treating physician ordered a change in her status on 5/14/10, to Inpatient status.

Case Study #2
Overturn at Discussion

Requirement	Source	Present or Supported in Medical Record	Comments
The beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting.	CMS Medicare Program Integrity Manual; Chapter 6; Section 6.5.2 - Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claims	Yes Lab Report; p. 92 of medical record EKG; p 95 of medical record Consultation; pp. 18-20 of medical record. Physician Orders; p. 50 of medical record	D-Dimer- 237 NG/ML (0-224) *(>224 NG/ML = Additional Evaluation for PE Or DVT Recommended) ST & T Wave Abnormality, Possible Anterior Ischemia; Abnormal ECG ASSESSMENT 1. Left arm and shoulder pain. Consider angina. 2. Hypokalemia. 3. Elevated D-dimer. Rule out pulmonary embolus. PLAN/RECOMMENDATIONS Heart catheterization. We will schedule that for the morning. We will also order a CTA of the chest given the elevated D-dimer. KCL for treatment of hypokalemia “Upgrade to full admit”.

Case Study #3
Overturn at Discussion

RAC Finding:

88 year old female with urinary sepsis, treated with intravenous fluids and antibiotic with the final diagnosis of urinary tract infection and was billed as an acute inpatient. Past medical history and the pre-existing conditions were stable. The medical record did not document pre-existing medical conditions or extenuating circumstances that made the acute inpatient admission medically reasonable and necessary. The medical record documents services that could have been provided as outpatient services in the hospital. The necessity for the inpatient admission is not documented in the medical record.

Case Study #3
Overturn at Discussion

Discussion:

Pt. presented via EMS and was complaining of suprapubic distention and inability to void status post pelvic ramus fracture on 4/5/10 (2 days PTA).

After multiple failed attempts to place a urinary catheter by three different RNs at nursing home, increasing discomfort and moderate distention suprapubically, patient was transported to hospital for placement of catheter and further evaluation. In the emergency room, she was found to have pain from her pelvic fracture, but also found to have a UTI. The patient was admitted to the medical floor with IV antibiotics to treat UTI and also pain medication to control her pelvic pain.

Case Study #3
Overturn at Discussion

Requirement	Source	Present or Supported in Medical Record	Comments
There are pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary.	CMS Medicare Program Integrity Manual; Chapter 6; Section 6.5.2 - Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claims	Yes History and Physical; pp. 17-19 of medical record ER Physician Documentation; p. 65 of medical record. Physician Orders p. 62 of medical record	Patient is of advanced age, 88, status post Pelvic ramus fracture on 4/5/10. Per report, "Brought tonight by ambulance for abdominal distension, pain; exam limited by dementia related to Parkinson's. Is not able to give history and is unintelligible tonight". Patient on chronic Coumadin therapy, Type 2 diabetes requiring insulin Differential Diagnoses: Considering Constipation, UTI, Other (dementia, drug delirium, abdominal gas) Admitting orders: Admit Inpatient-medical Admitting diagnoses- Urinary sepsis, pelvic ramus fracture, Parkinson's disease.

Case Study #4
Overturn at Discussion

RAC Finding:

65 year old male with left sixth nerve palsy, negative neurological and cardiac workups with the final diagnosis of cranial nerve ocular palsy, migraine headache and was billed as an acute inpatient. Past medical history and the pre-existing conditions were stable. The medical record did not document pre-existing medical conditions or extenuating circumstances that made the acute inpatient admission medically reasonable and necessary. The medical record documents services that could have been provided as outpatient services in the hospital. The necessity for the inpatient admission is not documented in the medical record.

Case Study #4
Overturn at Discussion

Discussion:

Pt. presented via EMS and was complaining of the inability to move left eye medially, headache and sudden onset of double vision, dizziness and vertigo.

Patient did report that he had a history of migraine headaches for many years, however had no previous complication with his migraines and no history of stroke-like event in his life.

Case Study #4
Overturn at Discussion

Requirement	Source	Present or Supported in Medical Record	Comments
The medical predictability of something adverse happening to the patient warrants possible need for inpatient admission.	CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.	Yes History and Physical; pp. 14-15 of medical record. EDM patient summary; pp 21-30 of medical record.	Per The American Stroke Association, *Definition and Evaluation of Transient Ischemic Attack: A Scientific Statement for Healthcare Professionals, June 2009*, "It is reasonable to hospitalize patients with TIA if they present within 72 hours of the event and any of the following criteria are present: a. ABCD2 score of >3 (Class IIa, Level of Evidence C)." This patient had an ABCD2 score of 5: Age > 60 = 1 Clinical symptoms of focal weakness with the spell = 2 Duration > 60 minutes = 2

Case Study #4
Overturn at Discussion

Requirement	Source	Present or Supported in Medical Record	Comments
The beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting.	CMS Medicare Program Integrity Manual; Chapter 6; Section 6.5.2 - Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claim	Yes History and Physical; pp. 14-15 of medical record. EDM patient summary; pp 21-30 of medical record. Consultation; p. 17 of medical record.	"In combined validation cohorts, the 2-day risk of stroke was 0% for scores of 0 or 1, 1.3% for 2 or 3, 4.1% for 4 or 5, and 8.1% for 6 or 7." "Close observation during hospitalization has the potential to allow more rapid and frequent administration of tissue plasminogen activator should a stroke occur." DIAGNOSIS AND IMPRESSION 1. Acute ischemic stroke, probably small vessel disease. 2. Complicated migraine, especially basilar migraine.

Top Five Appeal Tips

1. Never miss a timeframe for appeal.
2. Incorporate CMS Guidelines and documentation of the Standard of Practice in the Local Medical Community (Evidence Based Guidelines/Practice Guidelines) in your appeal.
3. Use the guidelines in place at the time the service was rendered!

Top Five Appeal Tips

4. Provide a “Road Map to the ALJ”. Point your reviewer to the exact location of the documentation in the chart.
5. Build a library of appeal templates.

Never give up!

QUESTIONS?

Andrew B. Wachler
Wachler & Associates, P.C.
210 E. Third St., Suite 204
Royal Oak, MI 48067
248-544-0888
awachler@wachler.com
www.wachlerblog.com

Denise Wilson
Intersect Healthcare
dwilson@intersecthealthcare.com
410-252-4343 ext 16
http://www.intersecthealthcare.com/index.php/category/blog/compliance-corner/