New ZPIC Medicare Audits: Are You Ready? Preparing for Heightened CMS Enforcement Against Fraud and Abuse

A Live 90-Minute Teleconference/Webinar with Interactive Q&A

Today's panel features:
Sara Kay Wheeler, Partner, King & Spalding, Atlanta
Steve Lokensgard, Special Counsel, Faegre & Benson, Minneapolis

Thursday, July 29, 2010
The conference begins at:
1 pm Eastern
12 pm Central
11 am Mountain
10 am Pacific

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New ZPIC Audits: Are You Ready?:
Preparing for Heightened CMS Enforcement Against Fraud and Abuse

July 29, 2010

Sara Kay Wheeler, King & Spalding LLP
Steve Lokensgard, Faegre & Benson LLP
Goals of Session

• Understand ZPICS
  – ZPICs and PSCs
  – Authority
  – Audit Approach
  – Appeal Opportunities
  – Important 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!!
Oversight by Compliance and Legal as records are submitted
Background
• Providers should expect to encounter the scrutiny of Medicare and Medicaid affiliated contractors regardless of the strength of their compliance efforts

• Not all contractors are created equally

• Providers should critically evaluate the activities of each contractor category to develop best practices for confronting government contractor audits and appeals
ZPIC Background

• To understand jurisdiction of ZPICs, revisit role of Program Safeguard Contractors (PSCs)
  – Section 202 of HIPAA authorized CMS to contract with entities to fulfill Medicare integrity functions
  – PSC authority is delineated in Task Orders, Statement of Work, and CMS Medicare Program Integrity Manual
  – PSCs are compensated based on a fixed contractual rate
• Each PSC is responsible for overseeing a particular geographic area and a particular claim category (Medicare Part A, Part B, DME, etc.)

• CMS is presently transitioning these benefit integrity contracts from PSCs to ZPICs

• Transition to be completed in 2011
• Created in section 911 of the Medicare Prescription Drug, Improvement and Modernization act of 2003
  – 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
ZPICs (cont’d)

• Charged with same tasks as PSCs – but covering larger geographic areas and all types of claim categories
  – Combined oversight of Medicare Parts A, B, DME, Home Health and Hospice
  – Potentially will combine oversight of Medicare Parts C and D

• CMS will award 7 umbrella contracts with each containing 2 simultaneously awarded task orders:
  – Task Order 1 is Medicare Part A, B, DME Home Health and Hospice
  – Task Order 2 is Medicare Medicaid Data Matching Projects
  – Future task orders will be awarded at CMS’s discretion for activities related to fraud, waste and abuse
<table>
<thead>
<tr>
<th>Zone 1</th>
<th>California, Nevada, American Samoa, Guam, Hawaii and the Mariana Islands</th>
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<tbody>
<tr>
<td>Zone 2</td>
<td>Alaska, Washington, Oregon, Montana, Idaho, Wyoming, Utah, Arizona, North Dakota, South Dakota, Nebraska, Kansas, Iowa and Missouri</td>
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<tr>
<td>Zone 3</td>
<td>Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio and Kentucky</td>
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<tr>
<td>Zone 4</td>
<td>Colorado, New Mexico, Oklahoma and Texas</td>
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<tr>
<td>Zone 5</td>
<td>Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia and West Virginia</td>
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<td>Zone 6</td>
<td>Pennsylvania, Massachusetts, New Jersey, Connecticut, Rhode Island, New Hampshire, Delaware, District of Columbia, Maine, Maryland, New York and Vermont</td>
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<tr>
<td>Zone 7</td>
<td>Florida, Puerto Rico and Virgin Islands</td>
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</tbody>
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ZPIC Map

* Denotes Zone award involved in protest
ZPIC Statement of Work (SOW) Highlights

- Reactive and proactive identification of potential fraud, waste and abuse
  - Data analysis, evaluation of complaints, referrals from law enforcement and other contractors (RACs, MACs) fraud alerts

- Support for law enforcement during investigation and prosecution of healthcare fraud cases
  - Medical review, data analysis, overpayment determination, subject matter expert testimony

- Fraud, waste and abuse training for MAC and AC staff
ZPIC Oversight

- ZPIC Task Orders typically dictate contractual performance periods of 5 years
- ZPIC activity is monitored by CMS
  - The ZPIC Umbrella SOW requires timely reporting to the ZPIC’s assigned Government Task Leader (GTL) and Contracting Officer at CMS
  - Every ZPIC must develop a Project Management Plan
    - Work breakdown
    - Key staff
    - Timelines
ZPIC Reports and ZPIC Compensation

• Regular ZPIC reports are expected to address:
  – Costs
  – Self-assessments
  – Freedom of Information Act requests
  – Law enforcement requests

• ZPIC compensation
  – Compensated based on a fixed contractual rate
  – Bonuses available for high quality service and administrative actions
  – CMS may withhold payment if reports are not timely submitted
ZPIC Data Analysis

- PSCs and ZPICs are expected to engage in proactive data analysis
  - Identify actual payment errors
  - Identify potential payment errors

- CMS expects PSCs and ZPICs to use innovative analytical methods

- Review areas:
  - Claim characteristics
    - Diagnoses
    - Procedures
  - Utilization patterns
    - High volume
    - High cost services
  - Billing patterns

- Effort can result in identification of investigation targets
Data Analysis (cont’d)

• Data Sources:
  – National claims data from the Health Care Customer Information System
  – CMS Data Center’s Part B Analytics Systems
  – Local data compilations
ZPIC Statistical Sampling and Extrapolation

- ZPICs are authorized to engage in statistical sampling and extrapolation techniques
  - Any method should be carefully assessed
  - Determine whether there has been a finding that the provider sustained a high level of payment error
    - Prior audits?
    - Employee complaints?
    - Other forms of data analysis

- Consultants may enhance providers’ ability to effectively assess sampling and extrapolation techniques
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.
• Prepayment Review

• Interactions with MACs and Applicable Appeal Processes

• Referrals to Law Enforcement

• Practical Strategies
Potential Consequences of ZPIC Audit

- Allegations of fraudulent conduct...
- Payment denial
- Recoupment of alleged overpayments
- Referrals to law enforcement... which can lead to:
  - Subpoenas
  - Investigation expenses
  - Penalties and sanctions
Practical Strategies
Responding to the Record Request

- Stamp Date and Time Received
- Train staff on identity of contractors
- Ensure that staff are aware of deadlines to submit records
- Ensure contractor is sending to the correct person/ address
Responding to the 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 Record 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?
  – Shadow review of all records submitted
    • Resource intensive
    • Allows for early identification of issues
    • Establishes priority for appeals
Oversight by Compliance and Legal as records are submitted
Medicare Appeals

- Notification of the results of the audit
  - Process described in Ch. 3 of Program Integrity Manual
- PSC/ ZPIC will give you an opportunity to review and comment on report
- Following receipt of comments, PSC/ ZPIC will go final on report and refer any overpayment to FI or Carrier who will issue a Demand Letter
- 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 appeal 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 (10.875%)

• Allow recoupment on day 41 but file appeal within 120 days
  – If successful, receive value of claim plus interest

• File appeal within 30 days to avoid recoupment
  – Interest continues to accrue and must be paid if unsuccessful
• Issues to Consider
  – Appeal within 30 days to avoid recoupment
  – 120 days to request reconsideration
  – 10.875% interest accrues from date of determination
  – Cash flow – can extend repayment for 180 days through the appeals process
  – Six months of interest on a $6,000 claim = $326.25
The Appeal Process

First Level = Request for Redetermination

- Made to Fiscal Intermediary, Carrier, or to the Medicare Administrative Contractor
- 120 days to file appeal, 30 to avoid recoupment
- 42 CFR §§ 405.940-.958
- CMS Pub. 100-4, Ch. 29, § 310
- No minimum amount in controversy requirement
- Records review
The Appeal Process

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

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

Second Level = Request for Reconsideration

• Made to Qualified Independent Contractor (MAXIMUS)

• 180 days to file appeal, 60 to avoid recoupment

• 42 CFR §§ 405.960-.978

• CMS Pub. 100-4, Ch. 29, § 320

• 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 Appeal Process

- Contractor has 60 days to issue redetermination
- 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

  Qualified Independent Contractor
  MAXIMUS Federal Services
  P.O. Box 62410
  King of Prussia, PA 19406
The Appeal 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
Third Level = Administrative Law Judge (ALJ)

- 60 days to appeal
- 42 CFR §§ 405.1000-.1064
- CMS Pub. 100-4, Ch. 29, § 330
- Minimum amount in controversy: $120
- Hearing by video teleconference, teleconference, or in-person
- The level when most RAC appeals have been successful
The Appeal 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
The Appeal Process

Fourth Level = Request for Review by the Medicare Appeals Council

• 60 days to appeal

• 42 CFR §§ 405.1100-.1130

• CMS Pub. 100-4, Ch. 29, § 340

• 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 Appeal 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
The Appeal Process

Fifth Level = Federal District Court

- 60 days to appeal
- 42 CFR §§ 405.1136
- CMS Pub. 100-4, Ch. 29, § 345
- Minimum amount in controversy: $1,220
• 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
Medicare Appeals

• 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
Defenses

• 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
Special Appeal Issues

• Extrapolation Defenses
  – Methodology was flawed
  – 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
Compliance Program Improvements

- Many contractors are identifying issues with high error rates

- Effective Compliance Program
  - Prepare for issues identified by
    - Reviewing new issues posted on RAC website
    - Review any issues on Noridian website
    - Other Sources (CERT’s, PSC’s, OIG)
  - Assess compliance through an internal audit
  - Educate and communicate
  - Develop policies and procedures to get it right
Thank you!

Questions and Answers

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