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FAST BREAK: MEDICARE AUDITS

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Topics for Today

- How are audits triggered?
- The Medicare audit process
- The Big "E" – Extrapolation
- Overpayment demand: now what?
- Tips for risk mitigation and audit avoidance

An Audit is Born

- CMS delegates most audit functions to contractors such as MACs, ZPICs, UPICs, and RACs
  - These contractors operate with a lot of discretion
  - Incentive payments
  - Strong data mining and analytics platforms

- Contractors look for outliers, aberrant data, and other hints of improper payments
  - Also rely on complaints and referrals from other sources (CMS, OIG, other contractors)
  - Restrictions and processes set out in Medicare Program Integrity Manual

An Audit is Born

- Initial audits can take several different forms
  - Probes
  - ADR/TMR
  - TPE
  - CERT
  - OIG

Any request for records from a Medicare/Medicaid contractor should be given a consistently high level of attention

The Medicare Audit Process

- Depending on type of audit, contractor may ask for documentation related to just one or a few claims or a much larger sample
  - If just a few, this is likely a probe audit designed to identify and confirm presence of high risk billing errors
    - Will likely lead to larger audit in the future
  - Other times, contractor may move straight to larger audit in order to create a statistically valid random sample (SVRS)
    - Results of audit will be used in projecting an extrapolated overpayment demand

The Medicare Audit Process

- Audit requests come either through a provider's electronic system (FISS, etc.) or through a "records request" letter sent by a contractor
  - "Records request" letters typically contain more detail, potentially including a basis for the request (complaint, data analysis, etc.) and often are made for multiple records
- Providers typically have 15-30 days to submit the requested records
  - This period is often extended through negotiation with the contractor
    - Generally an extra 2-4 weeks is approved
- A variety of ways to transmit the materials
  - CD, thumb drives, paper, website portals
- Other materials may be requested as well (copies of contracts, employee lists, etc.)

The Medicare Audit Process FAQs

- What if you don't respond?
  - If a provider doesn't respond timely to a records request, the contractor will deny those claims for lack of documentation
  - Depending on the facts of the matter, contractors also may refer a provider to CMS for further administrative action, including billing revocation

- Should you include a summary or other supporting materials with a response?
  - Often may be helpful to submit summaries of why coverage of claims is appropriate
  - Other supporting information also useful – at least for developing a record
  - Reviewers cannot rely on extraneous material but may help guide them to relevant documentation

The Big "E" - Extrapolation

- Extrapolation, also known as statistical sampling, involves projecting the findings of a small sample onto a larger universe
  - Even if a contractor reviews only 30 claims, it may be able to project those findings on to all of a provider's claims for a certain time period
  - Post-pay reviews typically cover a 1-3 year period

- Extrapolation is limited by statutes but often easy for contractors to meet their threshold requirements
  - Must determine that a "sustained" or "high" level of payment error exists
  - That determination cannot be subject to challenge by a provider in the appeals process or in court

The Big "E" - Extrapolation

- Contractors must also conduct statistical sampling in accordance with CMS rules and guidance
  - Samples must be representative and able to be replicated
  - Generally, the "lower bound" of the point estimate is used to give providers the benefit of the doubt
  - Extrapolation is often challenged throughout the appeals process and statistical experts are used (on both sides) to weigh in on the validity of an extrapolation

Extrapolation can quickly turn a $100,000 audit into a $5 million audit

The Results Are In

- ADRs and single/few claim audits generally determined in 30-45 days
- Longer for probe samples and extrapolated samples – 4-10 months
- Unless MAC is conducting audit, an overpayment determination letter will be issued first
  - This letter will identify:
    - Claims/claim period under review
    - The determination for each claim line (covered/not covered)
    - The explanation for each denied claim line (or a legend explaining the rationale)
    - The total overpayment amount determined
  - Not an official demand – no repayment obligation, no interest accrual, no appeal rights
  - May include CD that contains spreadsheets, extrapolation materials, etc.

The Results Are In

- Only MAC has authority to issue an overpayment demand
  - This letter is issued after overpayment determination (generally a week but highly variable)
  - Identifies the overpayment amount demanded
  - Describes important information about interest, appeal rights, and payback options
  - Generally references back to the overpayment determination letter to support the basis for the demand

- This letter starts the clock on appeal, rebuttal, recoupment and interest accrual timeframes

Risk Mitigation and Audit Avoidance

- Several important ways to reduce risk of audit and contain exposure
  - Understand your metrics
    - Contractors are comparing you to your peers; do the same
    - Number of resources available
  - Conduct internal auditing to understand if you are an outlier in a high risk area
    - Learn which areas are current audit priorities
    - Focus on internal assessments of those areas

Risk Mitigation and Audit Avoidance

- Treat all requests for records as serious
  - A single ADR can lead to a vicious cycle of further auditing
  - Ensure someone in the organization is in charge of reviewing each submission for complete and adequate documentation
  - Learn from previous denials; change processes as necessary to ensure prior issues are not repeated

- Appeal almost everything
  - Many findings are overturned on appeal
  - Contractors keep track of providers' cumulative error rates, so overturning as many denials as possible helps to keep your error rate low

Thanks!

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Jake Harper represents a variety of health care providers in government audits and investigations and provides regulatory and compliance counseling on reimbursement and fraud and abuse matters. In addition to defending providers in DOJ and OIG investigations on Stark, AKS, exclusion, and false billing matters, Jake maintains an active appeals practice, including representing health care providers before the PRRB and ALJs at the Office of Medicare Hearings and Appeals.

Join us next month!

Please join us for next month's Fast Break continuing our discussion of Medicare appeals:

"*Fast Break:* Medicare Appeals"

With Jake Harper

- Wednesday, December 20, 3:00 PM (EST)