



WHAT DO ZPICs DO?

- Use of “innovative data analysis methodologies” for early detection and prevention
- Proprietary software to analyze claims history data



- Complaints
- Referrals
- **Targets not randomly selected**



HOW ARE ZPICs DIFFERENT?

- Not looking for errors, looking for **fraud**
– *But their interpretation of fraud is different than yours*
- No specific look-back period
- No limits on document requests
- No physician review required
- No time limit on ZPIC review/decision
- No contingency fee (but do receive healthy contracts and performance bonuses)



INVESTIGATIONS

- Data Analysis
 - Data mining
 - Deviations in billing patterns, outliers, high utilization, high cost items or services
- Medical record requests (often 30 records)
- Business records requests
- EMR audit trail and PEPPER Reports
- Unannounced or onsite visits
- Interviews of staff and beneficiaries





**HOSPICE AUDIT AND APPEALS:
CONTEXT**

- **Hospice**
 - Terminal illness
 - Notice of Election
 - Relatedness
 - Signatures
 - Adherence to care plan
 - Staff credentials
 - Other primary payer

DENIAL REASONS (PALMETTO)

DENIAL CODE	DESCRIPTION	PERCENTAGE
SC36	Not Hospice Appropriate	27.1
SCF01	General Inpatient Services Not Reasonable and Necessary	19.5
SC900	Auto Deny - Requested Records not Submitted	12.4
SCFH6	Initial Certification Not Timely	10.5
SCFH9	Physician Narrative Statement Not Present or Not Valid	8.6
SCFNP	No Plan of Care Submitted	7.6
SCFH2	No Certification Present	4.3
SCFFF	Face to Face Encounter Requirements Not Met	2.9
SCFH3	No Certification for Dates Billed	2.4
SCFH7	Subsequent Certification Not Timely	1.9



POSSIBLE OUTCOMES

- **Referral to OIG/DOJ**
- Forward findings to MAC
 - Recoupment action
 - Provider education
- Prepayment review
- Discretionary payment suspensions
- Statistical extrapolation → enhanced recoupment





INITIAL RESPONSE TO ZPIC RECORD REQUEST



INITIAL RECORD RESPONSE

“You never get a second chance to make a good first impression.”



INITIAL RECORD RESPONSE

- If you receive a ZPIC record request, welcome to the big leagues. This is not a survey!
- Short time for producing records.
- Take the time, spend the money, and get things right the first time.
- Bring in a consultant.
- Don't be in denial or be overly confident.
- Good providers can have big ZPIC demands.
- This is probably most important phase in that you can prevent denials in the first place.



INITIAL RECORD RESPONSE

- Records should be so well organized that your elementary school librarian would be proud.
- Index as needed – spoon feed.
- They are looking for reasons to deny, so make it difficult for them to do so.
- **Do NOT** backdate records or alter – potential fraud, obstruction, jail, etc.
- Small things matter – signature legibility!
- Send in signature cards and signature lists.
- Prepare short summaries for each patient.



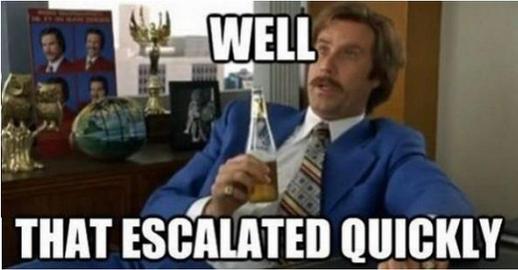
INITIAL RECORD RESPONSE

COMMON MISTAKES:

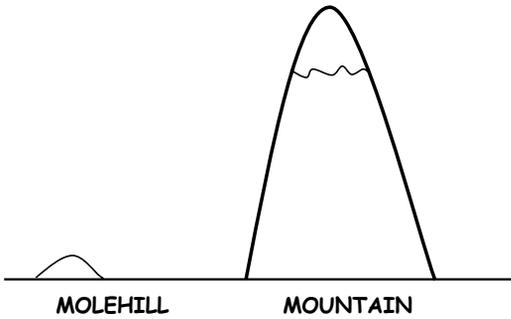
- Failure to provide records.
- Failure to have legible signatures or supported signatures are common grounds for denial.
- Physician's records do not provide detailed documentation to support certification.
- Proof of delivery is invalid or missing.



STATISTICAL EXTRAPOLATION: THE UGLY BEAST



EXTRAPOLATION





STATISTICAL EXTRAPOLATION

- Using statistical sampling to project an error rate across a universe of Medicare claims
- ZPICs and MACS are supposed to first make a determination of sustained or high error rates
- They are supposed to show that corrective action or efforts at education by the MAC to the provider has failed to correct the errors.
- Decision to extrapolate is not subject to appellate review.



STATISTICAL EXTRAPOLATION

- MACS will claim that they conducted a “statistically valid random sample”
- Recent hospice ZPIC extrapolation:
 - Reviewed 100 claims
 - Alleged \$127,539.17 in actual overpayments
 - Extrapolated to a demand of more than \$10.7 million
 - **84 times** multiplier



STATISTICAL EXTRAPOLATION

- The extrapolations are usually flawed:
 - Faulty probability sample or sample frame
 - Sample size that is way too small
 - Lack of homogeneity within the sample
 - Failure to stratify
 - High precision percent error
 - Non-replicable
 - Untested statistical methods, such as “penny sampling”
 - Straightforward errors, such as claims outside the audited range



STATISTICAL EXTRAPOLATION

- Because of the multiplier effect of extrapolation, much of the appeal process may focus on the statistics.
- If statics are tossed out, then the 85 times multiplier is gone.
- The mountain becomes a molehill again.





STATISTICAL EXTRAPOLATION

- Important to use experienced counsel for the statistical arguments.
- Retain one or more statisticians (Ph.D. level) to develop arguments and attack statistics.
- Background with common Medicare statistical flaws is important.
- But still important to challenge underlying claims.
- For each claim you knock out, there is a corresponding extrapolated victory.



STATISTICAL EXTRAPOLATION

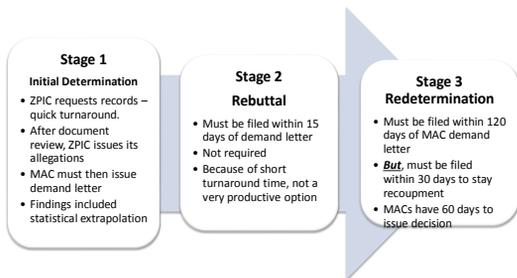




APPEALS PROCESS

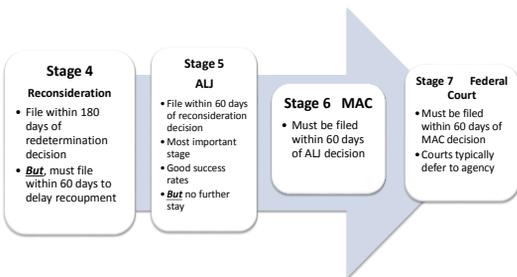


APPEAL STAGES





APPEAL STAGES



Stage 7 Federal Court

- Must be filed within 60 days of MAC decision
- Courts typically defer to agency



APPEALS

- **Initial Determination**
 - 15 days for rebuttal (not required)
 - 120 days to request **Redetermination**; **but** 30 days to stop recoupment (on 41st day)
 - Submit additional info → 14 day extension
- **Notice of Redetermination** (due 60 days)
 - 180 to request **Reconsideration** from QIC; **but** 60 days to stop recoupment on 76th day
 - Full and early submission of evidence requirement



APPEALS

- **Reconsideration Decision** (due in 60 days)
 - If denied, recoupment begins and interest owed
 - Must request ALJ hearing within 60 days
 - ALJ hearings (typically by phone)
 - Contractor may or may not actively participate
- **ALJ Decision** (due in 90 days)
 - Appeal to Medicare Appeals Council (“MAC”) within 60 days or review by MAC on its own
- **MAC Decision** (due in 90 days)
 - Appeal to federal court within 60 days



RECONSIDERATION STAGE



RECONSIDERATION STAGE

- Important because all evidence must be submitted at the reconsideration review phase.
- Absent good cause, cannot submit new evidence at subsequent stages of appeal.
- Reconsideration is before the Qualified Independent Contractor (QIC)
- Very important stage, but typically not resulting in high level of reversals.



LOWER LEVEL STAGES MOSTLY WEED OUT THE UNWARY



LOWER LEVEL PHASES—LITTLE BENEFIT

- “Administrative law is not for sissies -- so you should lean back, clutch the sides of your chairs, and steel yourselves”
Justice Antonin Scalia
- Administrative law, with its many levels and countless hard deadlines is designed in large part to weed out the unwary.
- The lower level ZPIC appeals are no different.
- They are long and laborious, with little resulting benefit.
- Success rates at these levels are so low as to raise due process questions, especially given high ALJ reversal rates.



ALJ APPEAL STAGE: RUBBER MEETS ROAD



ALJ STAGE

- Congress designed the ALJ process to be independent. The law states that:
 - “The Secretary shall assure the independence of administrative law judges.... In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from CMS.”

Medicare Prescription Drug, Improvement and Modernization Act of 2003, Section 931(b)(2)



ALJ STAGE

- The ALJ stage provides the first opportunity for a provider to obtain an independent review of its claim, where it can present evidence, respond to questions posed by the ALJ in real time, and explain the written materials in the record.
- The lower levels are no longer very fruitful. So little chance of prevailing that it’s practically a due process denial.
- Focus today and in the process is ALJ phase.
- Only real shot at debunking extrapolation.



ALJ HEARING

- **In-person hearing / Telephone / VTC**
 - all written evidence to be considered at the hearing must be submitted with the request for hearing or within 10 calendar days of receiving the notice of hearing.
 - Provider evidence not submitted prior to reconsideration must be accompanied by good cause statement
- All the issues brought out in the initial determination, redetermination, or reconsideration that were not decided entirely in a provider’s favor
- Substantial deference to applicable LCD’s
- Contractor Participation v. Contractor as a Party
- Discovery is permissible only when CMS or its contractor elects to participate in an ALJ hearing as a party.

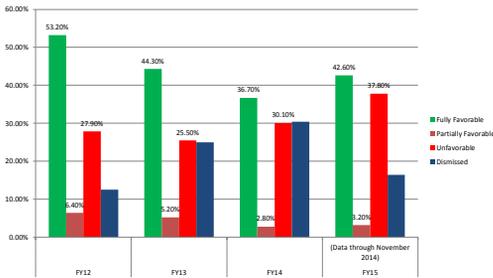


ALJ STAGE

- Option for provider to “escalate” its appeal and skip the ALJ level.
- CMS often touts this option when providers complain about the ALJ backlog.
- *But why would any provider skip the one and only stage where they actually have a shot at presenting evidence and winning?*
- Plus, you would only be getting out of one long line to go stand in another long line.



ALJ APPEALS





ALJ STAGE – HOSPICE PROVIDERS WIN

- A few years ago, hospice providers prevailed on approximately 70% of their appealed claims
 - 62 percent fully favorable
 - 6 to 8 percent partially favorable
- And that’s not like a flip of the coin win or lose on the entire appeal.
- If a provider has 100 claims under appeal, it may win fully on 62 of those claims.
- Win percentage is going down, however.



OMHA APPEAL BACKLOG



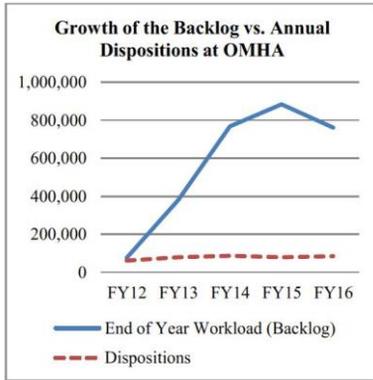
OMHA APPEAL BACKLOG

- **Multilayered administrative appeals**
- **ALJ level is the first stage for an independent review and presentation of arguments.**
- **Office of Medicare Hearings and Appeals administers ALJ hearings**
- **By statute, providers are entitled to a hearing and decision within 90 days.**
- **That deadline has gotten pushed back “a bit.”**



OMHA APPEAL BACKLOG

- **The current OMHA backlog is approaching one million appeals.**
- **It takes months to even have appeal docketed**
- ***Two year* moratorium on assignment of new appeals to an ALJ.**
- **Then years until a decision.**





Average Processing Time By Fiscal Year

Fiscal Year	Number of Days
FY09	94.9
FY10	109.6
FY11	121.3
FY12	134.5
FY13	220.6
FY14	414.9
FY15	661.8
FY16	877.2
FY17	
1st Qtr	1041.5
2nd Qtr	1057.2



OMHA ALJ APPEAL BACKLOG

BIG TAKEAWAY

- Because of the low success rate at the redetermination and reconsideration levels
- +
- Recoupment during years-long wait for justice at the ALJ level
- =
- Reason to avoid denials in the first place by investing heavily at the outset in response to document requests



STAYING RECOUPMENT AND INTEREST



INTEREST AND RECOUPMENT

- Two of the most important topics we are going to cover.
 1. Interest
 2. Recoupment
- Two of the most misunderstood areas
- Something that providers often don't think about or appreciate until late in the appeals process.
- But it is explained in MAC letters



INTEREST

- Interest begins to accrue on the 31st day following the MAC's demand letter.
- The current interest rate is around 10.00%
- That's 27 times the federal funds rate.
- About 6 times the average 10-year Treasury.
- Assessed in 30-day increments, so a payment on the 31st day results in an additional month's interest.
- Providers should almost never pay directly – only through recoupment



RECOUPMENT

- Recoupment is CMS's self-help measure: setting off overpayment demand against current Medicare payables.
- If CMS owes you \$200,000 for the month, it will withhold and apply it to overpayment.
- To stay recoupment, appeal initial demand by 30th day.
- To continue stay of recoupment, appeal redetermination decision by 60th day.
- Recoupment is not stayed at ALJ level.



INTEREST-MAC LETTER

Interest Assessment:

"If you do not refund in 30 days: In accordance with 42 CFR 405.378 simple interest at the rate of 10.75 percent will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment interest will continue to accrue on the remaining principal balance, at the rate of 10.75 percent."



RECOUPMENT- PER MAC LETTER

If you wish to appeal this decision:

"If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days from the date of this letter. However, if you wish to avoid recoupment from occurring, you need to file your request for redetermination within 30 days from the date of this letter as described above."



RECOUPMENT – PER MAC LETTER

How to Stop Recoupment:

“Even If the overpayment and any assessed interest has not been paid in full you can stop Medicare from recouping any payments. If you act quickly and decisively, Medicare will permit providers to stop recoupment at two points. The first occurs if we receive a valid and timely request for a redetermination within 30 days from the date of this letter. We will stop or delay recoupment pending the results of the appeal.

We will again stop recoupment if, following an unfavorable or partially favorable redetermination decision if you decide to act quickly and file a valid request for consideration with the Qualified Independent Contractor (QIC) The address and details on how to file a request for reconsideration will be included in the redetermination decisive letter.”

Horizontal lines for writing.



RECOUPMENT PER MAC LETTER

“Second Opportunity: If the redetermination decision is 1) unfavorable we can begin to recoup no earlier than the 60th day from the date of the Medicare redetermination notice (Medicare Appeal Decision Letter), or 2) if the decision is partially favorable we can begin to recoup no earlier than the 60th day from the date of the Medicare revised overpayment Notice/Revised Demand Letter. Therefore, it is important to act quickly and decisively to limit recoupment by requesting a valid and timely reconsideration within 60 days of the appropriate notice/letter. The address and details on how to file a request for reconsideration will be included in the redetermination decision letter.”

Horizontal lines for writing.



RECOUPMENT –PER MAC LETTER

“Following decision or dismissal by the QIC, if the debt has not been paid in full, we will begin or resume recoupment whether or not you appeal to the next level of Administrative Law Judge (ALJ).”

NOTE: Even when recoupment is stopped, interest continues to accrue.

Horizontal lines for writing.



Recoupment Summary

- Recoupment CANNOT be stayed at ALJ level, unless you enter an extended repayment schedule.
- Once you get to the ALJ level, CMS will begin recouping.
- Because of the backlog at the ALJ level, CMS may be able to recoup the entire alleged overpayment or will recoup until you are out of business – **BIG** potential problem.
- 100% of receivables at risk for recoupment.



APPEAL BACKLOG - RECOUPMENTS

- Up until the ALJ phase, providers are able to stay recoupment.
- Upon requesting an ALJ appeal, however, CMS can begin recouping against current Medicare payables.
- Wouldn't be too bad if 90 day decision deadline were enforced.
- Different when the decision is years off.
- Some recent successes obtaining injunctive relief.



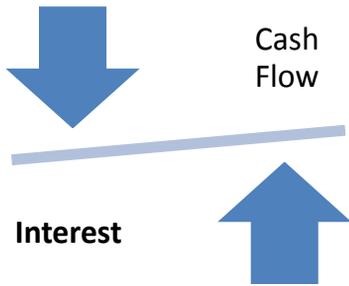
INTEREST



Interest shell game

- Interest begins to accrue on 31st day from initial MAC demand
- Because it is at such a high rate, some providers may be better off allowing early recoupment.
- Immediate hit to cash flow.
- If provider ultimately prevails on some or all claims, then the provider may recover a correspondingly high interest rate from CMS.

Recoupment Cost/Benefit





RECOUPMENT – CAUTION!!

- If a provider “voluntarily” repays money to the ZPIC rather than allowing recoupment, then the provider may not recover interest on those payments if it wins before the ALJ.
- I Repeat: If a provider actively repays money to the ZPIC rather than allowing recoupment, then the provider MAY NOT recover interest on those payments if it wins before the ALJ.



RECOUPMENT – CAUTION!!

- Providers typically do not have much success at the lower levels of appeal when they are able to stay recoupment.
- Provider must therefore do cost / benefit analysis to determine whether better to allow recoupment early.
- May be better to allow early recoupment so that less interest accrues against provider.
- Better chance of recovering more interest later.



PROVIDER RECOVERY OF INTEREST

- If the provider prevails in its appeal, CMS will refund the principal amount and the interest recouped.
- If a provider allows CMS to recoup the monies (as opposed to entering into an extended repayment plan), the provider will be entitled to receive interest on the principal amount recouped.
- CMS will not pay interest on interest.



INTEREST– ANOTHER CAUTION!!

- If the provider enters into an extended repayment schedule (a repayment plan), it will not be able to recover interest if it later wins.
- Repeat: If the provider enters into an extended repayment schedule (a repayment plan), it will not be able to recover interest if it later wins.
- Remember, usually better to allow recoupment than to pay.





EXTENDED REPAYMENT SCHEDULES



Extended Repayment Schedules (ERS)

- ERS is an agreement entered into with CMS
- Allows for payment schedule, like a loan
- Like a loan, the exorbitant interest continues to accrue.
- Limited time period – 3 years
- In cases where repayment will constitute an “extreme hardship,” CMS will go out to 5 years
- Provider must furnish financial information showing that they cannot pay.
- Lengthy application.
- Must make ERS payments per your proposed schedule while awaiting approval.



INTEREST– ANOTHER CAUTION!!

- If the provider enters into an extended repayment schedule (a repayment plan), it will not be able to recover interest if it later wins.
- If the provider enters into an extended repayment schedule (a repayment plan), it will not be able to recover interest if it later wins.
- Remember, usually better to allow recoupment than to pay.





INJUNCTIONS AGAINST RECOUPMENT



APPEAL BACKLOG - INJUNCTION

- What if the recoupments or even a five year extended repayment schedule would put a provider out of business?
- Provider's cash flow is frozen while it awaits its hearing – **over six years out?**
- What are the options?
- Typically, courts will not intervene in administrative appeals – statute against it.
- But what if the delay violates due process?



APPEAL BACKLOG - INJUNCTION

- Hospice Savannah case in Georgia.
- Faced with this very scenario.
- We obtained a TRO and then proceeded to hearing for a preliminary injunction.
- Appears to be first in country.
- CMS settled after the hearing, agreeing to postpone any recoupment until after the ALJ decisions and stay the accrual of interest.



APPEAL BACKLOG - INJUNCTION

- **The provider was not-for-profit.**
- **Operated only inpatient facility in Savannah.**
- **Longest running hospice in Georgia, going back to 1976.**
- **Hundreds of employees and patients.**
- **Shorter than average lengths of stay.**
- **Great PEPPER reports – top 25% nationally.**



APPEAL BACKLOG - INJUNCTION

- **Standard for injunction:**
 - Likelihood of success
 - Irreparable harm
 - No other remedy
 - Balance of equities
 - Interest of the public



APPEAL BACKLOG - INJUNCTION

- **This is not a silver bullet for every provider.**
- **Don't try this at home.**
- **Uphill battle requiring specific showings.**
- **Must be used only as last resort.**
- **American Hospital Association received favorable decision recently — Judge ordered that backlog be eliminated by December 31, 2020.**



APPEAL BACKLOG—AHA INJUNCTION

- American Hospital Association received favorable decision recently.
- Federal judge ordered that appeal backlog be eliminated by December 31, 2020.
- CMS has already told the court that it will not be able to meet this deadline.
- So we're on a collision course.
- Likely to see some mass resolutions – global settlements.



PREPAYMENT REVIEW



PREPAYMENT REVIEW

- Another very ugly tool at the ZPICs' disposal
- ZPIC, through the MAC, will not pay claims until a review is done
- May be partial or full prepayment review
- Serious impact on cash flow
- 3 months duration at a minimum
- Usually 6 to 18 months
- Flagged claims followed by ADR request
- Provider must work to submit perfect charts, using consultants and a SWAT team.



OTHER THINGS BREWING



OTHER THINGS BREWING

- The backlog is unsustainable, even with new funding.
- Hospitals received proposal from CMS for payment of 68 cents on dollar for every RAC claim on appeal. Many hospitals declined.
- Settlement conference facilitation project.
- Statistical sampling initiative.



UNIFIED PROGRAM INTEGRITY CONTRACTORS (UPICs)



UPICs—Coming Soon

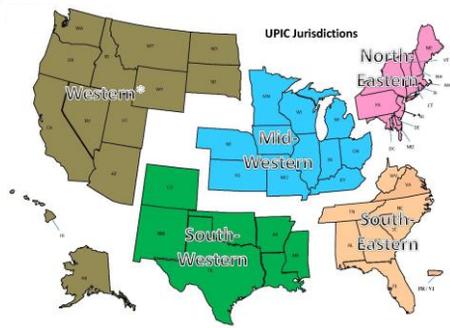
- Unified Program Integrity Contractors (UPICs)
- Consolidate Medicare and Medicaid program integrity audit and investigation work at the federal level into a single contractor.
- Contractor will serve defined multi-state area, which will complement state audit and investigation efforts.

79



UPICS – COMING SOON

- “[T]he scope of the UPICs will encompass functions that are currently performed by several contractors,” including: ZPICs, MICs and potentially MACs.
- See “*Comprehensive Medicaid Integrity Plan, Fiscal Years 2014 – 2018*,” available at:
- <http://www.cms.gov/Regulations-and-Guidance/Legislation/Deficit-Reduction-Act/Download/cmip2014.pdf>





QUESTIONS?

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