Training Session Handouts

Stop RAC Auditors from Taking Back Your Medicare Money

Presented by:
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Stop RAC Auditors from Taking Back Your Medicare Money

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Agenda

1. Background on Healthcare Audits
2. RACs
3. Tips for Surviving a RAC Audit
4. Audit Readiness
5. Fraud
6. Common Ways to Become a Target

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Tips

Health Care Audits

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Why Are There Audits?

- To ensure that payments are made appropriately
- To recoup payments that were not made appropriately
- Pre-payment and post-payment

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JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE — Thursday, January 9, 2020

Justice Department Recovers over $3 Billion from False Claims Act Cases in Fiscal Year 2019

The Department of Justice obtained more than $3 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year ending Sept. 30, 2019, Assistant Attorney General Jody Hunt of the Department of Justice's Civil Division announced today. Recoveries since 1986, when Congress substantially strengthened the civil False Claims Act, now total more than $62 billion.

"The significant number of settlements and judgments obtained over the past year demonstrate the high priority this administration places on deterring fraud against the government and ensuring that citizens' tax dollars are well spent," said Assistant Attorney General Hunt. "The continued success of the department's False Claims Act enforcement efforts are a testament to the tireless efforts of the civil servants who investigate, litigate, and try these important cases as well as to the fortitude of whistleblowers who report fraud."

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Who Are The Auditors?

- Commercial payors
  - In-network and out-of-network
- Medicare
  - MAC (National Government Services, Inc.)
  - RAC (Performant Recovery, Inc.)
  - UPIC (replacing ZPIC) (SafeGuard Services LLC)
- Medicaid
  - The Connecticut Department of Social Services (DSS)

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Do You Have to Respond?

- Medicare, Medicaid, or in any commercial network participants
  - Required by law
  - Contractually bound through participation agreements
- Out-of-network providers are not necessarily contractually bound, but . . .
  - If you accept assignment, you are assumed to accept the conditions of payment
  - Patients' contract with insurers may require patients to allow records be audited in order for the patient to be reimbursed
- Refusal to cooperate may result in exclusion, offsets, or refusal to pay future claims

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Tips

Recovery Audit Contractors
(RACs)

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Medicare Fee for Service Recovery Audit Program

- The Medicare Fee for Service (FFS) Recovery Audit Program's mission is to **identify and correct Medicare improper payments** through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.

- There are also RACs for Parts C and D and each state has Medicaid RACs.

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Where did RACs originate?

- Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003: 3-year demonstration project in CA, FL & NY
- The Tax Relief and Health Care Act of 2006: Made the RAC program permanent and directed a nationwide expansion by January 1, 2010
- 2014- RAC Program Pause
- 2020- COVID Pause

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Alphabet Soup

- The RACs are responsible for identifying improper payments
- The MACs are responsible for the adjustments of these claims
- The RACs refer cases to UPICs when fraud is suspected
- All MACs and UPICs have a Joint Operating Agreement with each RAC in their jurisdiction

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How Are RACs Paid?

- RACs are paid a contingency fee for overpayments and underpayments
- RAC must have an accuracy rate of at least 95%, as calculated from the results of monthly accuracy audits performed by an independent validation contractor, or by CMS
- CMS expects that the RAC shall have an appeal affirmation rate of at least 90%, at the first level of appeal
- If a provider files an appeal disputing the overpayment determination and the appeal is adjudicated in the provider's favor at ***ANY*** level, the RAC shall repay Medicare any contingency fee payment that it received for that recovery

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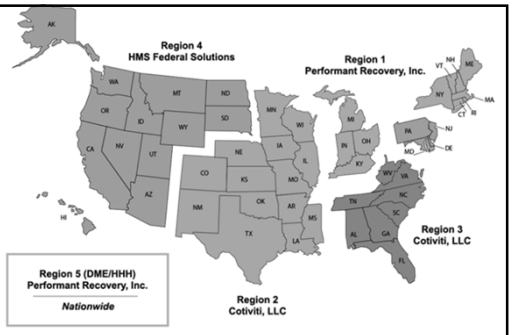

Who are the RACs?

- Competitive bidding process
- 4 RACs - one for each geographic region
- RACs in Regions 1-4 perform post payment review to identify and correct Medicare claims specific to Part A and Part B.
- Region 5 RAC is dedicated to review of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Home Health / Hospice

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Region	States	Websites	Email	Phone Number
Region 1 Performant Recovery, Inc.	CT, IN, KY, MA, ME, MI, NH, NY, OH, RI, and VT	https://performantrac.com/PROVIDERPORTAL.aspx	info@Performantrac.com	1-866-201-0580
Region 2 Cotiviti, LLC	AR, CO, IA, IL, KS, LA, MO, MN, MS, NE, NM, OK, TX, and WI	https://Cotiviti.com/RAC	RACInfo@Cotiviti.com	1-866-360-2507
Region 3 Cotiviti LLC	AL, FL, GA, NC, SC, TN, VA, WV, Puerto Rico and U.S. Virgin Islands	https://www.Cotiviti.com/RAC	RACInfo@Cotiviti.com	1-866-360-2507
Region 4 HMS Federal Solutions	AK, AZ, CA, DC, DE, HI, ID, MD, MT, ND, NJ, NV, OR, PA, SD, UT, WA, WY, Guam, American Samoa and Northern Marianas	https://racinfo.hms.com/home.aspx	racinfo@emailhms.com	**Part A:** 1-877-350-7992 **Part B:** 1-877-350-7993
Region 5 DME/HHE/ Performant Recovery, Inc.	Nationwide for DMEPOS/HHA/ Hospice	https://performantrac.com/PROVIDERPORTAL.aspx	info@Performantrac.com	1-866-201-0580

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Types of RAC Audits

- 3 year lookback (6 months for hospital patient status reviews)
- **Automated:** No medical record needed; data mining
- **Semi-Automated:** Claims review using data and potential human review of a medical record or other documentation
- **Complex:** Medical record required; the reviewer must be a qualified health care coder or clinician based on the type of review being undertaken
  - ADR (Additional Documentation Request) sent to provider
  - Provider has 45 days to respond
  - If no documentation is submitted by the provider, the full amount of the claim is sent to the MAC for adjustment

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ADR Limits

- Request an extension if needed!
- Different rules apply to physicians/non-physician practitioners, suppliers, and facilities
- One request every 45 days
- The limits are posted on the CMS website

ADR limits will be based on the number of individual rendering physicians/non-physician practitioners reported under each TIN/ZIP combination in the previous calendar year.

Group/Office Size	Maximum number of requests per 45 days
50 or more	50 records
25-49	40 records
6-24	25 records
Less than 5	10 records

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RAC Review

- The RAC must complete their complex reviews and notify the provider of the results within 30 days from receipt of the medical record documentation
- Unless granted an extension by the CMS, the RAC will not receive a contingency fee in cases where more than 30 days have elapsed between receipt of the medical record documentation and issuance of the review results letter

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RAC's Determination

- Full denial or partial denial
- RACs must only use policies and guidance in effect at the time of the claim submission; no retroactive application
- Discussion Period
  - Must be requested within 30 days of the Review Results letter
  - Before the claim is sent to the MAC for adjustment
  - Physician to physician dialogue

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Limitations

- The RAC should not attempt recoupment, or forward, any claim to the MAC, or applicable CMS Data Center, for adjustment, if the anticipated amount of the overpayment is less than $25.00
- The RAC shall not forward claims to the MAC for adjustment if the claim is incorrectly coded, but the coding error is not expected to equate to a difference in the payment amount. *For example, HCPCS code xxxxx requires a modifier for payment. Payment with the modifier is $25.50 per service; payment without the modifier is $25.50 per service. While the claim without the modifier is incorrect, there is no overpayment or underpayment and the claim shall not be forwarded for adjustment.*

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Extrapolation

- The RAC may use extrapolation:
  - when it has been determined that a sustained or high level of payment error exists (50% or higher) OR
  - after a documented educational intervention has failed to correct the payment error
- The RAC must receive authorization from CMS to go forward in recovering from the provider if the alleged overpayment exceeds $500,000 or is an amount that is greater than 25% of the provider's Medicare revenue received within the previous 12 months

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Settlement

- CMS has the authority to enter into administrative agreements including individual or group compromises or settlements with providers without requiring the RAC's approval or input
- If CMS determines that a compromise and/or settlement of a RAC identified overpayment is in the best interest of Medicare at any time, the payment to the RAC will be adjusted so that the contingency payment is based only on the portion of the overpayment that remains collected or recouped after the administrative agreement, settlement or compromise

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Audit Topics

- All subject to CMS approval
- Approved RAC Topics
- Proposed RAC Topics

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Medicare Fee for Service Recovery Audit Program

- Approved RAC Topics
- Proposed RAC Topics
- Resources

Approved RAC Topics

Do you have questions or concerns about the Recovery Audit Program? Please e-mail us at RAC@cms.hhs.gov. Please Do Not send Personal Health Information to this e-mail address.

Note: CMS often receives referrals of potential improper payments from the MACs, UPICs, and Federal investigative agencies (e.g., OIG, DOJ). At CMS discretion, CMS may require the RAC to review claims, based on these referrals. These CMS-Required RAC reviews are conducted outside of the established ADR limits.

Show entries: 5 per page | Filter On | Apply

Showing 1-10 of 177 entries

Issue Name	Review Type	Provider Type	MAC Jurisdiction	Date Approved
0001 - Inpatient Hospital MS - DRG Coding Validation	Complex	Inpatient Hospital	All A/B MACs	2017-02-01
0002 - Cataract Removal: Medical Necessity and Documentation Requirements	Complex	Ambulatory Surgical Center (ASC); Outpatient Hospital	JE, JF, JH, JJ, JK, JL, JN, J6, J11, J15	2017-02-01
0003 - Sacral Neurostimulation: Medical Necessity and Documentation Requirements	Complex	Ambulatory Surgical Center (ASC); Inpatient Hospital; Outpatient Hospital; Professional Services	Urinary incontinence- All A/B MACs Fecal incontinence- JE, JF, JH, JL, JN, J15	2017-02-01

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0176-Annual Wellness Visit: Incorrect Coding

Issue Name	0176-Annual Wellness Visit: Incorrect Coding
Date	2020-02-01
Review Type	Complex
Provider Type	Professional Services
MAC Jurisdiction	All A/B MACs

Description

Claims for Initial Preventative Physical Examination (IPPE), billed more than once in a lifetime, or after the initial 12 months or 12 months after the effective date of the beneficiary's first part B coverage period will be denied. Claims for HCPCS code G0438- Annual Wellness Visit (AWV); Includes a personalized prevention plan (PPPS); initial, billed more than once in a lifetime will be denied. Claims for HCPCS code G0439- Annual Wellness Visit (AWV); Includes a personalized prevention plan (PPPS); subsequent, billed more than once within 12 months of G0438 or G0439 will be denied.

Affected Code(s)

G0402, G0438, G0439

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0204-Vagus Nerve Stimulation: Medical Necessity and Documentation Requirements

Issue Name	0204-Vagus Nerve Stimulation: Medical Necessity and Documentation Requirements
Date	2021-02-02
Review Type	Complex
Provider Type	Ambulatory Surgical Center (ASC); Outpatient Hospital; Professional Services
MAC Jurisdiction	All A/B MACs

Description

Vagus Nerve Stimulation (VNS) is reasonable and necessary for patients with medically refractory partial onset seizures for whom surgery is not recommended or for whom surgery has failed. VNS is not reasonable and necessary for all other types of seizure disorders which are medically refractory and for whom surgery is not recommended or for whom surgery has failed. VNS is reasonable and necessary for treatment resistant depression through Coverage with Evidence Development. VNS for treatment of resistant depression is non-covered when furnished outside of a CMS-approved CED study. Medical documentation will be reviewed to determine that services were medically reasonable and necessary and a covered benefit.

Affected Code(s)

64568, 64569, 61885

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0075 - Home Health: Medical Necessity and Documentation Requirements

Issue Name	0075 - Home Health: Medical Necessity and Documentation Requirements
Date	2017-12-12
Review Type	Complex
Provider Type	Home Health Agency (HHA)
MAC Jurisdiction	All HHH MACs

Description

This review will determine whether the Home Health care is reasonable and necessary, based on documentation in the medical record. Claims that do not meet the indications for coverage and/or medical necessity will be denied.

Affected Code(s)

Revenue Codes: 027X, 042X, 043X, 044X, 023X, 055X, 056X, 057X

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0105-Physician Services during Hospice Period: Unbundling

Issue Name	0105-Physician Services during Hospice Period: Unbundling
Date	2018-08-07
Review Type	Automated
Provider Type	Professional Services

0122-Outpatient Service Related to Hospice Diagnosis: Unbundling

Issue Name	0122-Outpatient Service Related to Hospice Diagnosis: Unbundling
Date	2018-11-06
Review Type	Automated
Provider Type	Outpatient Hospital

0163-Ambulance Services Billed During Hospice: Unbundling

Issue Name	0163-Ambulance Services Billed during Hospice: Unbundling
Date	2019-07-02
Review Type	Automated
Provider Type	Laboratory/Ambulance

0114-Durable Medical Equipment Billed during Hospice Period: Unbundling

Issue Name	0114-Durable Medical Equipment Billed during Hospice Period: Unbundling
Date	2018-10-15
Review Type	Automated
Provider Type	DME Physician, DME Supplier

0201-Hospice Continuous Home Care: Medical Necessity and Documentation Requirements

Issue Name	0201-Hospice Continuous Home Care: Medical Necessity and Documentation Requirements
Date	2021-01-05
Review Type	Complex
Provider Type	Hospice
MAC Jurisdiction	All HHH MACs

Description

This review will determine if hospice Continuous Home Care services were reasonable and necessary to achieve palliation and management of the patient's acute medical symptoms to maintain the terminally ill patient at home, based on the documentation in the medical record. Claims that do not meet the indications of coverage and/or medical necessity will be denied.

Affected Code(s)

REV Code 0652

HCPCS codes G0299, G0300, G0156

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RESULTS

- RACs identified approximately $89 million in overpayments and recovered $73 million in FY 2018
- Since its inception, the RAC program has returned more than $10 billion in improper payments to the Medicare trust fund and more than $800 million in underpayments to providers.

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Medicare Fee-for-Service Recovery Audit Program

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Total Corrections* - by Fiscal Year (FY)**

	FY 2010 (in millions)	FY 2011 (in millions)	FY 2012 (in millions)	FY 2013 (in millions)	FY 2014 (in millions)	FY 2015 (in millions)	FY 2016 (in millions)	FY 2017 (in millions)	FY 2018 (in millions)	*Overall Total (in Billions)*
Overpayments Collected ***	$75.4	$797.4	$2,291.4	$3,650.9	$2,394.8	$359.73	$404.46	$24.33	$73.03	*$10.07*
Underpayments Returned	$16.9	$141.9	$109.4	$102.4	$173.1	$80.96	$69.46	$6.74	$7.67	*$0.71*
Total Corrections	$92.3	$939.3	$2,400.8	$3,753.3	$2,567.9	$440.69	$473.92	$31.07	$80.68	*$10.78*

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Appendix H: FY 2018 Corrections by Provider Type (Dollar Amount and Percentage of Total)

Provider Type	*Overpayments Collected*	*% of Total*	*Underpayments Restored*	*% of Total*	*Total Amount Corrected*	*% of Total*
Inpatient	$43,602,474.59	59.70%	$7,466,179.25	97.33%	$51068653.84	63.28%
SNF	$5,166,130.67	7.07%	$4,061.50	0.05%	$5170192.17	6.41%
Outpatient	$11,503,419.29	15.75%	$141,259.72	1.84%	$11644679.01	14.43%
Physician	$4,725,575.11	6.47%	$59,362.47	0.77%	$4784937.58	5.93%
DME	$8,032,338.88	11.00%	$0	0.00%	$8032338.88	9.95%
Total	$73,029,938.54	***100%***	$7,670,862.94	***100%***	$80700801.48	***100%***

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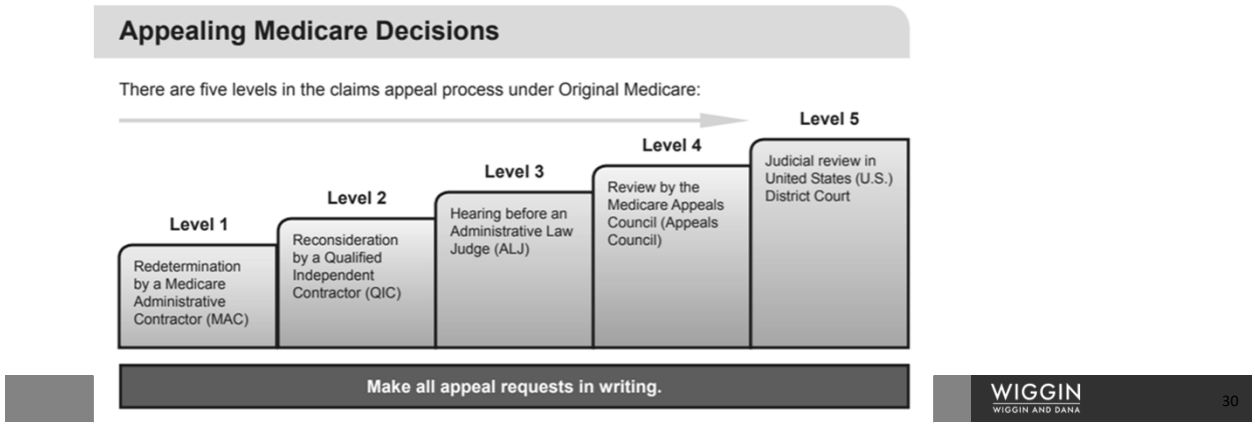
Appeal

- Once you get the MAC demand letter, you can appeal
- There is no recoupment during the first two levels of appeal



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Level	Summary of review process	Who performs the review?	When must you request an appeal?	When should you get a decision?	AIC
1st Level - Redetermination	Document review of initial claim determination	MAC	Up to 120 days after you receive initial determination	60 days	No
2nd Level - Reconsideration	Document review of redetermination (you should submit any evidence not previously presented at this level)	QIC	Up to 180 days after you receive MRN/RA	60 days	No
3rd Level - ALJ Hearing	May be an on-the-record review or an interactive hearing between parties	ALJ	Up to 60 days after you receive notice of QIC decision or after expiration of the applicable QIC reconsideration timeframe if you do not receive a decision	May be delayed due to volume	Yes*
4th Level - Medicare Appeals Council Review	Document review of ALJ's decision or dismissal (but you may request oral arguments)	Appeals Council	Up to 60 days after you receive notice of ALJ's decision or after expiration of the applicable ALJ hearing timeframe if you do not receive a decision	90 days if appealing an ALJ decision or 180 days if ALJ review time expired without an ALJ decision	No
5th Level - Judicial Review	Judicial review	U.S. District Court	Up to 60 days after you receive notice of Appeals Council decision or after expiration of the applicable Appeals Council review timeframe if you do not receive a decision	No statutory time limit	Yes*

* The AIC threshold is updated annually. For the current amount, refer to the Related Links section for Third Level of Appeal or Fifth Level of Appeal webpages.

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Appendix M: FY 2018 RAC Appeal Dispositions - Level 1 (MAC) Redetermination – by MAC and Type of Claim (Number of Dispositions by Disposition Type)

Claims Decided	Favorable to Appellant	Partially Favorable to Appellant	Unfavorable to Appellant	Claims Dismissed
7,670	3,239	344	3,688	399

- 46.7% MAC appeal success rate, with 42.2% of appeals being completely favorable to the appellant!

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Appendix N: FY 2018 RAC Appeal Dispositions - Level 2 (QIC) Reconsideration by RAC Region (Number of Dispositions by Disposition Type)

RAC	Claims Decided	Favorable to Appellant	Partially Favorable to Appellant	Unfavorable to Appellant	Claims Dismissed
1-Performant	233	64	4	133	32
2-Cotiviti	175	40	2	132	1
3-Cotiviti	76	22	2	51	1
4-HMS/HDI	197	61	4	125	7
5-Performant	110	29	0	81	0
Total	***791***	***216***	***12***	***522***	***41***

- At the second level of appeal, the success rate drops to 28.8%

Appendix O: FY 2018 RAC Appeal Dispositions - Level 3 (ALJ)* by RAC Region and Type of Claim (Number of Dispositions by Disposition Type)

RAC	Type of Claim	Claims Decided	Claims Found Fully or Partially Favorable to the Appellant	Unfavorable to Appellant	Claims Remanded	Claims Dismissed
3-Cotiviti	Part A	1	0	1	0	0
Total		***1***	***0***	***1***	***0***	***0***

Appendix P: FY 2018 RAC Appeal Dispositions - Level 4 (DAB) by RAC Region and Type of Claim (Number of Dispositions by Disposition Type)

RAC	Type of Claim	Appeals Decided	Favorable to Appellant	Partially Favorable to Appellant	Unfavorable to Appellant	Appeals Dismissed/ Withdrawn	Appeals Remanded
Total	***0***	***0***	***0***	***0***	***0***	***0***	***0***

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Appeal Backlog

- RAC appeals have contributed to a massive appeal backlog
- November 2018: 426,594 appeals
- AHA Lawsuit: HHS ordered to eliminate the backlog by the end of FY 2022
- CMS: The average processing time for appeals was 1,361 days in FY 2019 and 1,430.1 in FY 2020.

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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	1,108.7
FY18	1,193.9
FY19	1,372.0
FY20	1,430.1

https://www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html

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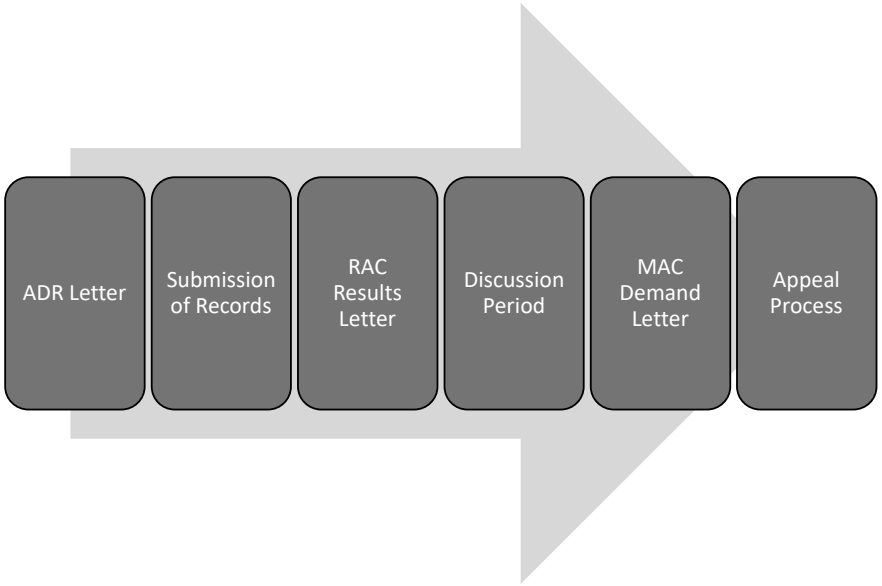

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Tips

Tips for Surviving the RAC Audit

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Tips

- **STAY CALM**
- Read the audit notification letter carefully
- Be mindful of deadlines
- Ask for more time if needed
- Follow the instructions for submission
  - Electronic versus paper
  - What to include and how to organize the records

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Tips Cont.

- Make copies of everything you provide to the auditor
- Carefully evaluate whether to submit anything other than the requested records
  - Additional parts of the medical record
  - Records from other providers
  - Summaries of the case

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Tips Cont.

- Internally review the records to assess risk
- May want to engage a consultant under attorney client privilege
- **If you find a problem:**
  - **STOP THE BLEEDING!**
  - Consider self-disclosure

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Tips Cont.

- Challenge RAC findings
  - Address factual errors
  - Address legal errors
  - Review and challenge cited authority
  - Argue that the disallowance should only be the difference between what was billed erroneously and what should have been billed
  - Challenge extrapolation (consider engaging a statistician under attorney client privilege)

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Tips Cont.

- Be organized and professional in your presentation
  - Type your response
  - Include documentation as exhibits
  - Make it easy to follow
    - Separate documentation by sample/finding
    - Put documents in chronological order
    - Highlight pertinent areas of the record
  - Be respectful and professional, but firm in your presentation

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Tips Cont.

- Be honest and cooperative
  - **The cover up is always worse than the crime**
  - Do not change documentation on samples that are requested for audit
  - Resist the urge to “fix” or “clarify”
- If you obtain oral guidance, document it!

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Audit Readiness

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Tips for Mitigating Risk

- Monitor the RAC Topics
- Self-Audit
- Compliance Program
- Culture of Compliance
- Hiring/Contracting
- Structuring Compensation
- Maintaining documentation integrity during audit
- Submitting self-disclosures, as needed
- Errors and Omissions (E&O) coverage

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A Word About Fraud

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False Claims Act

- It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent
- Federal and Connecticut, civil and criminal
- Per claim penalty PLUS treble damages
- Whistleblower provisions
- No specific intent required under the civil FCA
- "Knowing" =
  - Actual knowledge
  - Deliberate ignorance
  - Reckless disregard

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Anti-Kickback Statute

- Criminal law
- Prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs

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Other Laws

- Anti-Fraud Laws
- Exclusion Statute
- CMP Law

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Common Ways to Become A Target

- Whistleblowers
- Data analytics
- Medicaid/Medicare audits
- Hotline tips
- Patient complaints
- Competitor information
- Press reports

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High Risk Areas

- Impossible day
- Poor/no/fraudulent documentation
- Poor quality care
- Non-compliance with the billing rules
- Misapplication of CPT coding
- Reckless Disregard
  - Outsourcing billing function
  - Associate practitioners

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This presentation is a summary of legal principles.
Nothing in this presentation constitutes legal advice, which can only be obtained as a result of a personal consultation with an attorney.
The information published here is believed accurate at the time of publication, but is subject to change and does not purport to be a complete statement of all relevant issues.

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Questions?

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