Training Session Handouts

Reduce Medicaid Audit Triggers and Overpayment Demands

Presented by:
Knicole Emanuel, JD

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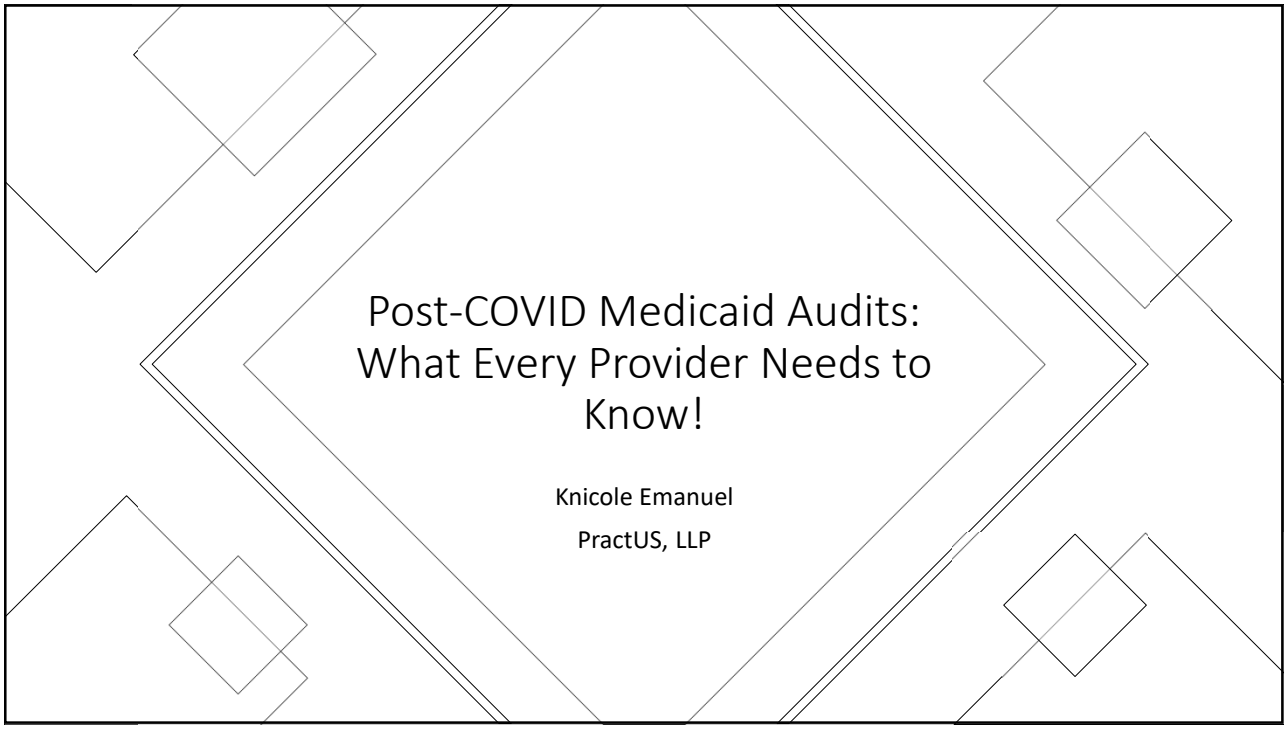
1


Post-COVID Medicaid Audits: What Every Provider Needs to Know!
Knicole Emanuel
PractUS, LLP

2

18

KNICOLE C. EMANUEL

Partner

For more than 20 years, Knicole has maintained a healthcare litigation practice, concentrating on Medicare and Medicaid litigation, healthcare regulatory compliance, administrative law and regulatory law. She understands the intricate Medicare and Medicaid payment system, the unique business of healthcare providers, the overlay of federal and state Medicare and Medicaid rules and regulations, and actions of state agencies that affect the way healthcare entities operate. Knicole has tried over 2,000 administrative cases in over 30 states and has appeared before multiple states' medical boards. Knicole has successfully obtained federal injunctions in numerous states, which allowed healthcare providers to remain in business despite the state or federal laws allegations of healthcare fraud, abhorrent billings, and data mining. Across the country, Knicole frequently lectures on healthcare law, the impact of the Affordable Care Act and regulatory compliance for providers. She is a weekly panelist on RACMonitor, as a national expert on Medicare and Medicaid audits. Prior to joining Practus, Knicole was a Partner with Potomac Law Group, Co-Managing Partner with Gordon & Rees, and served as North Carolina Assistant Attorney General in the Health and Public Assistance Section where she gained a thorough understanding of the Medicaid system that informs her practice today.

EDUCATION

- University of Missouri-Kansas City School of Law, J.D., *magna cum laude*
- North Carolina State University, B.A., *magna cum laude*

AREAS OF EXPERTISE

Medicare & Medicaid Regulatory Compliance • Healthcare Litigation • Administrative Law • Medicare & Medicaid Audits • False Claims Act Litigation • White Collar Healthcare Fraud

3

Medicare v. Medicaid Audits

Federal	• State
National Government Services	• Medicaid Integrity Program (MIP)
RAC, CERT, ZPIC, UPIC Audits	• Medicaid Fraud Control Unit
5-level, appeal process	• RAC Audits
OIG, FBI, CMS	• TPE Audits
Managed Care Audits	• The Department/Divisions
	• Managed Care Audits

4

Medicaid Integrity Contractors (MICs)

- Five jurisdictions:
  - New York (CMS Regions I & II)
  - Atlanta (CMS Regions III & IV)
  - Chicago (CMS Regions V & VII)
  - Dallas (CMS Regions VI & VIII)
  - San Francisco (CMS Regions IX & X)

5

Types of Medicaid Audits

- Post-payment
- Prepayment
- TPE/educational

6

Post-Payment v. Prepayment

- Lookback period
- Best alternative
- No recoupments until litigation is complete

- Payments are immediately suspended
- Preliminary Injunction

7

Steps of a Medicaid Audit

- Documentation request
  - Usually 50 – or so claims
- Documentation compilation
  - Make copies! Keep accurate accounting.
- Wait period
  - Generally, 60 days
- Notice of tentative overpayment
  - Extrapolated
- Reconsideration review

8

How are you targeted?

- Data Mining
- High volume per service code
- Any abnormal spike in billings
- Anonymous complaint to the Medicaid Fraud Division

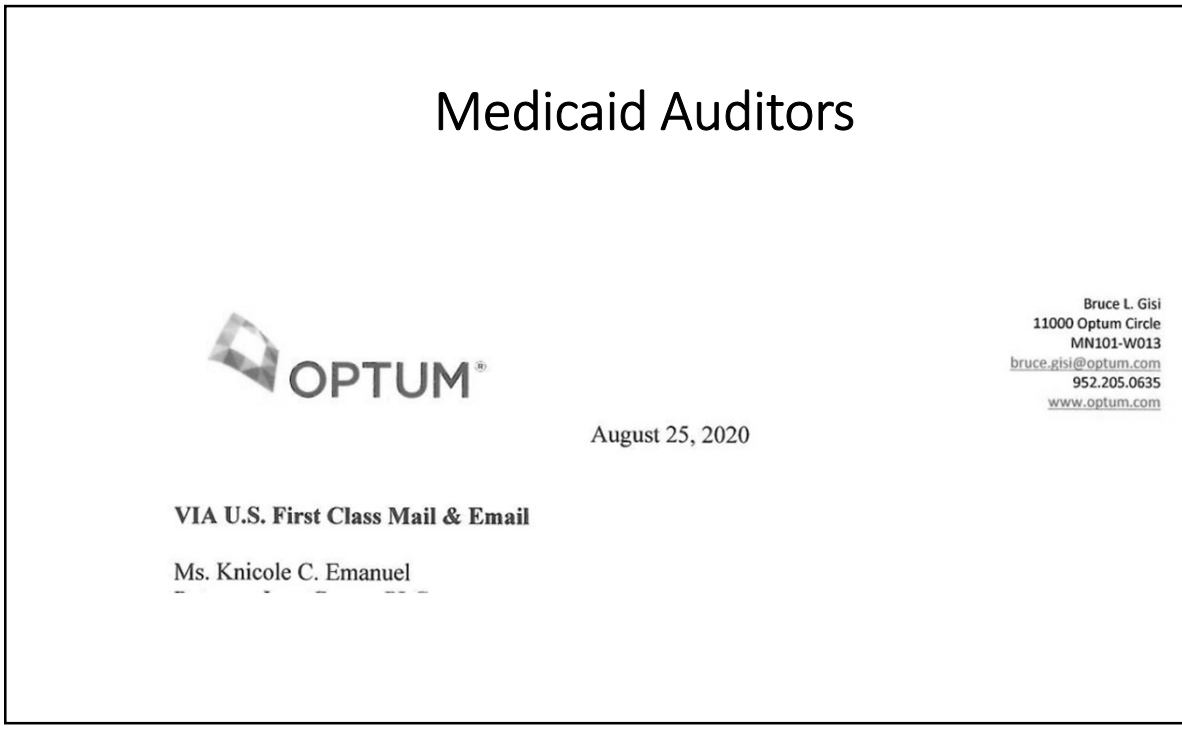
9

The Regulations Germane to Medicaid Audits

42 CFR Part 455	Subpart A	Subpart B	Subpart C
Subpart D	Subpart E	Subpart F	

10

Medicaid Auditors



OPTUM®

Bruce L. Gisi
11000 Optum Circle
MN101-W013
bruce.gisi@optum.com
952.205.0635
www.optum.com

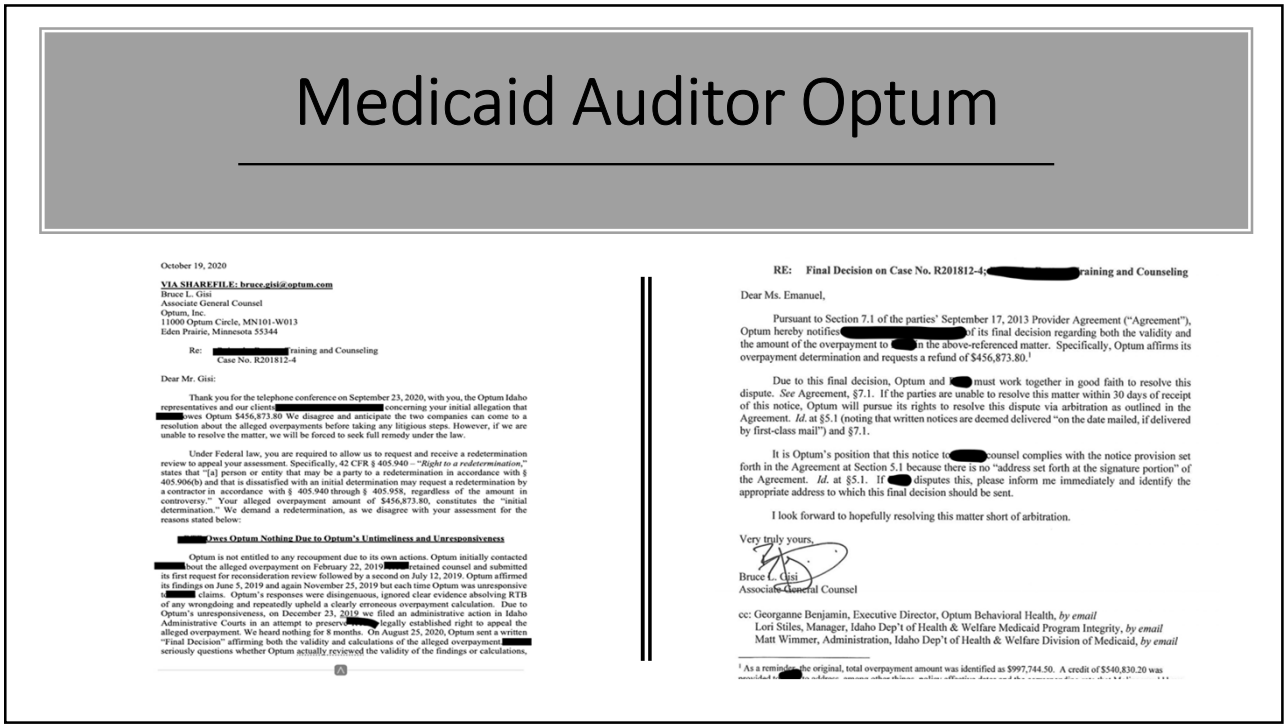
August 25, 2020

VIA U.S. First Class Mail & Email

Ms. Knicole C. Emanuel

11

Medicaid Auditor Optum



October 19, 2020

VIA SHAREFILE: bruce.gisi@optum.com
Bruce L. Gisi
Associate General Counsel
Optum, Inc.
11000 Optum Circle, MN101-W013
Eden Prairie, Minnesota 55344

Re: [redacted] raining and Counseling
Case No. R201812-4

Dear Mr. Gisi:

Thank you for the telephone conference on September 23, 2020, with you, the Optum Idaho representatives and our clients[redacted] concerning your initial allegation that [redacted]owes Optum $456,873.80 We disagree and anticipate the two companies can come to a resolution about the alleged overpayments before taking any litigious steps. However, if we are unable to resolve the matter, we will be forced to seek full remedy under the law.

Under Federal law, you are required to allow us to request and receive a redetermination review to appeal your assessment. Specifically, 42 CFR § 405.940 – "*Right to a redetermination*," states that "[a] person or entity that may be a party to a redetermination in accordance with § 405.906(b) and that is dissatisfied with an initial determination may request a redetermination by a contractor in accordance with § 405.940 through § 405.958, regardless of the amount in controversy." Your alleged overpayment amount of $456,873.80, constitutes the "initial determination." We demand a redetermination, as we disagree with your assessment for the reasons stated below:

[redacted]Owes Optum Nothing Due to Optum's Untimeliness and Unresponsiveness

Optum is not entitled to any recoupment due to its own actions. Optum initially contacted [redacted]bout the alleged overpayment on February 22, 2019[redacted]retained counsel and submitted its first request for reconsideration review followed by a second on July 12, 2019. Optum affirmed its findings on June 5, 2019 and again November 25, 2019 but each time Optum was unresponsive t[redacted] claims. Optum's responses were disingenuous, ignored clear evidence absolving RTB of any wrongdoing and repeatedly upheld a clearly erroneous overpayment calculation. Due to Optum's unresponsiveness, on December 23, 2019 we filed an administrative action in Idaho Administrative Courts in an attempt to preserve [redacted] legally established right to appeal the alleged overpayment. We heard nothing for 8 months. On August 25, 2020, Optum sent a written "Final Decision" affirming both the validity and calculations of the alleged overpayment [redacted] seriously questions whether Optum actually reviewed the validity of the findings or calculations,

RE: **Final Decision on Case No. R201812-4;[redacted]raining and Counseling**

Dear Ms. Emanuel,

Pursuant to Section 7.1 of the parties' September 17, 2013 Provider Agreement ("Agreement"), Optum hereby notifies [redacted] of its final decision regarding both the validity and the amount of the overpayment to [redacted]n the above-referenced matter. Specifically, Optum affirms its overpayment determination and requests a refund of $456,873.80.[1]

Due to this final decision, Optum and [redacted] must work together in good faith to resolve this dispute. *See* Agreement, §7.1. If the parties are unable to resolve this matter within 30 days of receipt of this notice, Optum will pursue its rights to resolve this dispute via arbitration as outlined in the Agreement. *Id.* at §5.1 (noting that written notices are deemed delivered "on the date mailed, if delivered by first-class mail") and §7.1.

It is Optum's position that this notice to [redacted]ounsel complies with the notice provision set forth in the Agreement at Section 5.1 because there is no "address set forth at the signature portion" of the Agreement. *Id.* at §5.1. If [redacted] disputes this, please inform me immediately and identify the appropriate address to which this final decision should be sent.

I look forward to hopefully resolving this matter short of arbitration.

Very truly yours,

Bruce L. Gisi
Associate General Counsel

cc: Georganne Benjamin, Executive Director, Optum Behavioral Health, *by email*
Lori Stiles, Manager, Idaho Dep't of Health & Welfare Medicaid Program Integrity, *by email*
Matt Wimmer, Administration, Idaho Dep't of Health & Welfare Division of Medicaid, *by email*

[1] As a reminder, the original, total overpayment amount was identified as $997,744.50. A credit of $540,830.20 was [redacted]

12

Pro-Provider Case Law

- *Bader, M.D. v. Wernert*, M.D. (2016)
- *The Counseling Center, Inc. v. New Mexico Human Services Department* (2018)
- *K.C. v. Shipman* (2013)
- *N.C. Dept. of Health and Human Services v. Parker Home Care* (2013)
- *U.S. v. Asercare, Inc., et al* (2019)

13

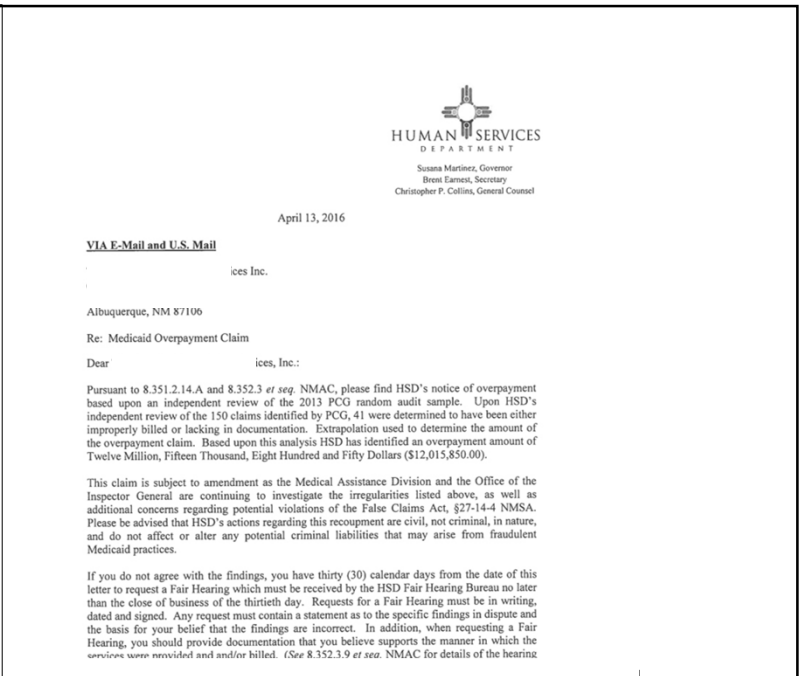
Discrediting Auditors

- Education
- Experience
- Which policy used/relied upon
- False negatives (illegible signatures)
- Ghost criteria (not in rules or regulations)
- Oversight

14

Extrapolation Example

Over $12 million
Appealed to Administrative Law Judge
$896.94
Department overturned



HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Christopher P. Collins, General Counsel

April 13, 2016

VIA E-Mail and U.S. Mail

ices Inc.

Albuquerque, NM 87106

Re: Medicaid Overpayment Claim

Dear ices, Inc.:

Pursuant to 8.351.2.14.A and 8.352.3 *et seq.* NMAC, please find HSD's notice of overpayment based upon an independent review of the 2013 PCG random audit sample. Upon HSD's independent review of the 150 claims identified by PCG, 41 were determined to have been either improperly billed or lacking in documentation. Extrapolation used to determine the amount of the overpayment claim. Based upon this analysis HSD has identified an overpayment amount of Twelve Million, Fifteen Thousand, Eight Hundred and Fifty Dollars ($12,015,850.00).

This claim is subject to amendment as the Medical Assistance Division and the Office of the Inspector General are continuing to investigate the irregularities listed above, as well as additional concerns regarding potential violations of the False Claims Act, §27-14-4 NMSA. Please be advised that HSD's actions regarding this recoupment are civil, not criminal, in nature, and do not affect or alter any potential criminal liabilities that may arise from fraudulent Medicaid practices.

If you do not agree with the findings, you have thirty (30) calendar days from the date of this letter to request a Fair Hearing which must be received by the HSD Fair Hearing Bureau no later than the close of business of the thirtieth day. Requests for a Fair Hearing must be in writing, dated and signed. Any request must contain a statement as to the specific findings in dispute and the basis for your belief that the findings are incorrect. In addition, when requesting a Fair Hearing, you should provide documentation that you believe supports the manner in which the services were provided and and/or billed. (*See* 8.352.3.9 *et seq.* NMAC for details of the hearing

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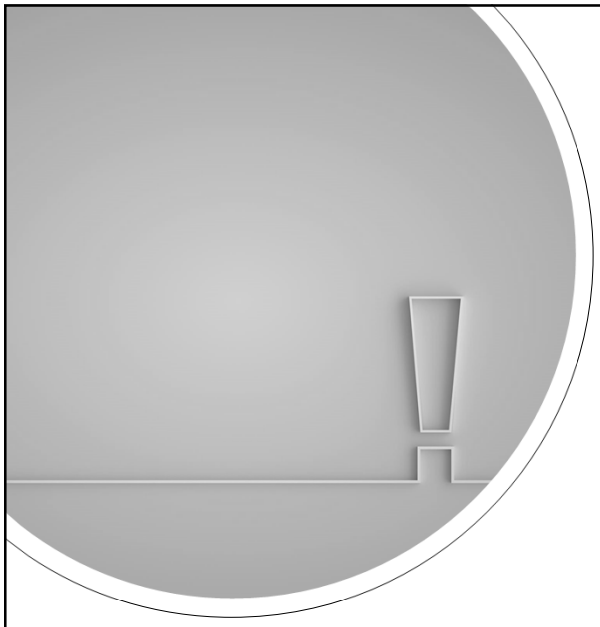


Changes to Extrapolation Rules

- Change Request 10067
- Extrapolation shall be used when a sustained or high level of payment error exists.
- Extrapolation may be used after documented educational intervention (such as in the Targeted Probe-and-Educate (TPE) program).
- It follows that extrapolation should not be used if there is not a sustained or high level of payment error or evidence that documented educational intervention has failed.

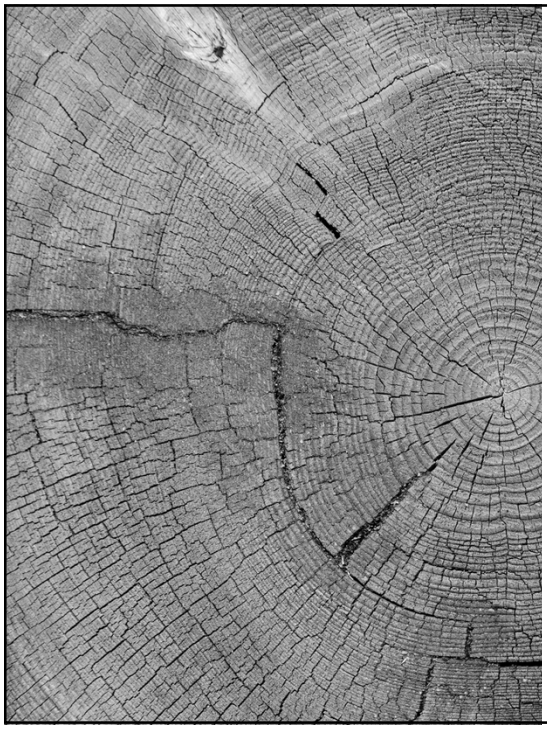
16

16

Personal Care Products v. Smith

- Personal Care Products did not agree to repay the overpayments and refused to pledge a security interest to show good faith,
- HHSC imposed a partial hold on payments due to Personal Care Products
- Personal Care Products challenged the payment hold in federal court under 42 U.S.C. § 1983, resulting in a stay of the administrative appeal until the federal suit was resolved
- By the time the administrative appeal again became active, the HHSC reviewer who initially reviewed the files had retired and was not available to testify at the hearing. HHSC therefore requested another reviewer, Steven Morgan, to review the files. Morgan found errors that resulted in a higher overpayment amount than the $ 1,152,918 that HHSC had noticed in 2007. HHSC amended its notice in August 2013, seeking repayment of $ 2,357,115 in overpayments in its First Amended Notice of Hearing and Complaint (First Amended Notice).
- Court upheld the overpayment
- Pers. Care Prod., Inc. v. Smith, 578 S.W.3d 262, 265 (Tex. App. 2019)

17



The Past Matters

- The contractor may review the provider's past noncompliance for the same or similar billing issues or a historical pattern of noncompliant billing practice.

18

Authorization from CMS

- RAC auditor now 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 percent of the provider's Medicare revenue received within the previous 12 months.

19

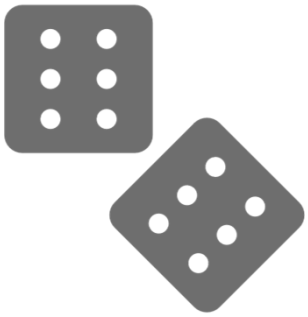
19

Challenges to the Extrapolation

- Sample size too small
- Lack of homogeneity within sample strata may be extrapolated to unrelated claims
- Poor precision and confidence intervals
- Not representative of the universe
- Auditor's credentials (or lack thereof)

20

ID of the Claims Universe



- CMS admitted in the change request that, on occasion, "the universe may include items that are not utilized in the construction of the sample frame. This can happen for a number of reasons, including, but not limited to: a) some claims/claim lines are discovered to have been subject to a prior review; b) the definitions of the sample unit necessitate eliminating some claims/claim lines; or c) some claims/claim lines are attributed to sample units for which there was no payment."

21

Medicaid Extrapolations

Administrative appeals will be reviewed and a decision will be given within 90 calendar days of the appeal request. Send provider administrative appeals to:

Provider Appeals Department
ConnectiCare
175 Scott Swamp Road
Farmington, CT 06032-3124

22

Property Rights

- The right to use the good (thing that is owned),
- The right to earn an income from it,
- The right to transfer it to others, and
- The right to enforce property rights.

23

23

What Are Property Rights?

- Right to Own
- Security
- Right to Prosper
- Right to life, liberty, and the pursuit of happiness

24

24

TERMINATIONS

25

25

Personal Care Products v. Smith

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- HHSC imposed a partial hold on payments due to Personal Care Products
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- Court upheld the overpayment
- Pers. Care Prod., Inc. v. Smith, 578 S.W.3d 262, 265 (Tex. App. 2019)

26

Medicare Audit Appeals

- Initial determination
- Redetermination (MAC or UPIC)
- Reconsideration (QIC)
- ALJ Hearing
- Medicare Appeals Council Review
- Judicial Review

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27

Medicaid Audit Appeals

- Initial determination
- Reconsideration review
- Exhaust administrative remedies
- Office of Administrative Hearings
- Judicial Review

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28

Common Mistakes

- FAXED PAGES STICK TOGETHER
- ILLEGIBLE SIGNATURES
- LOST PAGES
- PROVIDERS NOT MAINTAINING COPIES

29

COVID EXCEPTIONS

- COVID has created a scenario in which the exceptions to the rule becomes the general rule. SNFs face hundreds of COVID regulatory exceptions that will be eliminated upon the expiration of the PHE. Audits will follow.

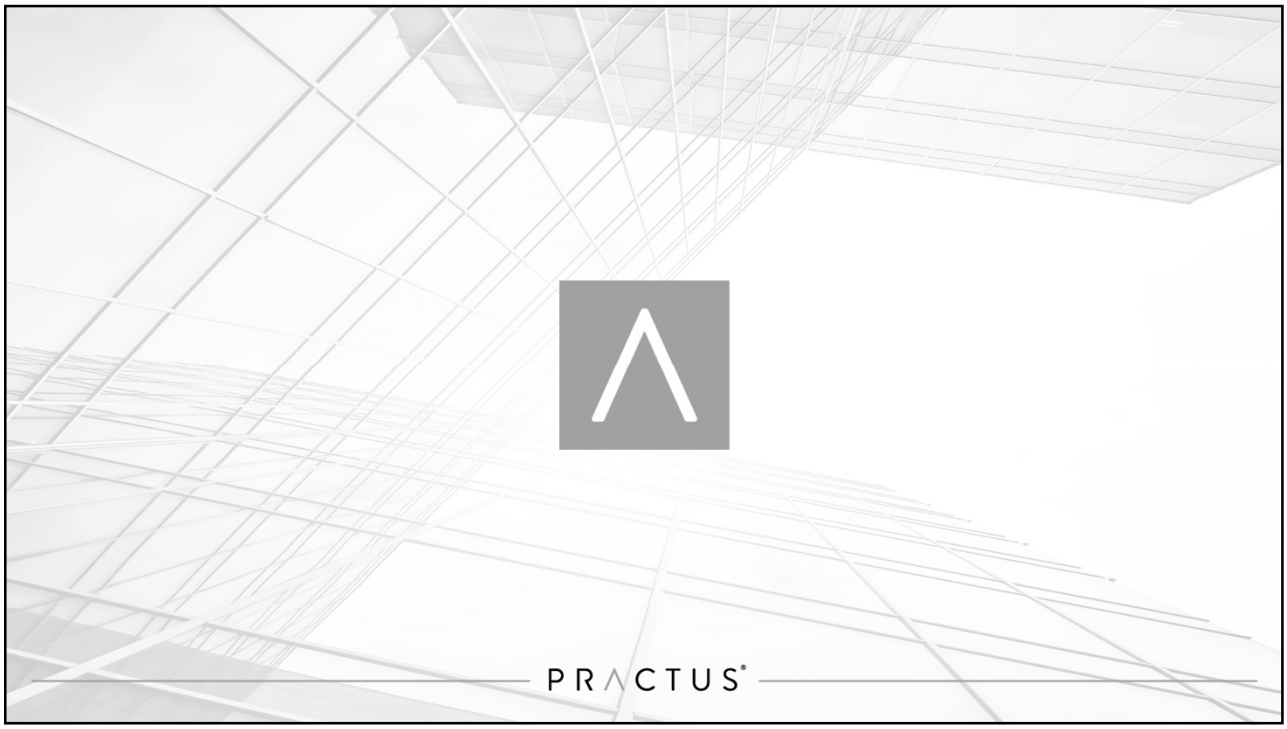
30

PUBLIC HEALTH EPIDEMIC (PHE)

- Executive Orders signed by President
- March 13, 2020, effective March 1st
- Every 90 Days
- Scheduled to expire October 23, 2020
- January 21, 2021

31

32



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