

HEALTH LAW UPDATE

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

Providers Can Look Forward to *MooreCare* in Audits

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A pair of recent opinions from the Federal District Court for the Middle District of Tennessee offers a victory for ambulance providers and potentially positive implications for other healthcare providers and suppliers that are subject to a claims audit by a Medicare contractor. In the recent opinion of *MooreCare Ambulance Service, LLC v. The Department of Health and Human Services* (“HHS”)¹, the Court overturned a decision by the Medicare Appeals Council (“MAC”), which had denied several claims for reimbursement of ambulance transports, on the ground that the MAC applied the wrong standard for nonemergency, scheduled repetitive transports. In so holding, the Court ruled that a physician’s written order certifying the medical necessity of the transport was by itself sufficient to support the claim and that the MAC’s review of additional medical records was inappropriate.

MooreCare Audit and Administrative Appeal

In 2007, AdvanceMed Corporation, (“AdvanceMed”), a Program Safeguard Contractor (“PSC”) that contracts with the Centers for Medicare and Medicaid Services (“CMS”) to “safeguard” Medicare from abuse,² subjected MooreCare Ambulance Service, LLC, (“MooreCare”), an ambulance service provider, to an audit. AdvanceMed audited medical records and supporting documentation for 60 ambulance transport services claims submitted by MooreCare to Medicare over a year-and-a-half period. After reviewing the records, AdvanceMed found that MooreCare had improperly billed 89.32 percent of the reviewed claims for a total overpayment of \$19,131.59. AdvanceMed characterized this error rate as a “high level of payment error,” and extrapolated the finding over all claims submitted to Medicare during the audit period for an extrapolated overpayment amount of \$2,114,613.³

¹ *Moorecare Ambulance Serv., LLC v. Dep’t of Health & Human Services*, Civ. No. 1:09-0078, 2011 WL 2682987 (M.D. Tenn. July 11, 2011) and *Moorecare Ambulance Serv., LLC v. Dep’t of Health & Human Services*, Civ. No. 1:09-0078, 2011 WL 839502 (M.D. Tenn. March 4, 2011).

² CMS has replaced the PSCs with Zone Program Integrity Contractors (“ZPICs”). AdvanceMed is the ZPIC assigned to Zones 5 (encompassing the states of Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia and West Virginia) and 2 (encompassing the states of Alaska, Arizona, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming). ZPICs’ specific responsibilities include identifying vulnerabilities in the Medicare program, identifying and investigating potential cases of fraud, and referring cases to law enforcement for possible prosecution.

³ The Court reserved ruling on whether this extrapolation was justified.

MooreCare appealed this determination through Medicare's five-step administrative appeals process.⁴ Eventually MooreCare reached the MAC, which upheld most of AdvanceMed's findings. Although MooreCare provided written physician certification statements attesting to the medical necessity of ambulance transportation for the vast majority of its repetitive ambulance transport claims at issue, the MAC unequivocally found that a written physician order certifying the service's medical necessity is not, by itself, sufficient to support medical necessity for the purpose of reimbursement.

***MooreCare* in the Middle District of Tennessee**

In a review of the MAC's opinion upholding the denial of MooreCare's claims for reimbursement of nonemergency, scheduled and repetitive services, the Court expressed "serious concerns" about the MAC's unsupported rationale on medical necessity and concern for "hindsight bias" in the MAC's review of claims. The critical ruling from *MooreCare* is this: A valid written order by a physician certifying the medical necessity of a nonemergency, scheduled, repetitive ambulance transport service is conclusive of medical necessity, and any further review of additional medical records or documentation is unnecessary.

The Court explained that under the basic rule for ambulance reimbursement, ambulance services are covered by Medicare where other forms of transportation are contraindicated by the patient's condition.⁵ The regulations provide a general and a special rule for ambulance service. Under the general rule, ambulance transport is reimbursable if medically necessary – demonstrated by bed confinement and documentation that other forms of transportation are contraindicated or demonstrated by the patient's medical condition, regardless of bed confinement.⁶ Where the ambulance service is nonemergency, scheduled and repetitive – such as transport for dialysis – the "special rule" applies. Under the "special rule," ambulance services are reimbursable where a physician's order certifies the medical necessity of the transport. The Court found that this order is conclusive of medical necessity and rejected HHS' arguments that the Medicare Benefit Policy Manual provisions or other CMS guidance imposed additional requirements that ambulance providers must also meet.

Impact of *MooreCare*

The *MooreCare* decision may have positive implications for other Medicare providers. It is common in Medicare audits for the contractors conducting the audits to request records in addition to the physician orders to support the medical necessity of ancillary services, such as ambulance transports, laboratory or other diagnostic tests, or durable medical equipment. Healthcare providers facing an unfavorable Medicare audit result should review the applicable statutes and regulations to determine if the contractors have denied claims based upon requirements that are in addition to or inconsistent with those found in the applicable statutes and regulations. In these situations, the *MooreCare* decision may provide a defense to the audit result.

⁴ A Medicare provider subject to an audit has the right to appeal an unfavorable audit result through a five-step process: (1) redetermination from the Medicare Administrative Contractor, (2) reconsideration from a Qualified Independent Contractor, (3) hearing before an Administrative Law Judge, (4) review by the Medicare Appeals Council, and (5) appeal to a federal district court.

⁵ 42 U.S.C. § 1395(x)(s)(7)

⁶ 42 C.F.R. § 410.40(d)(1)

Bass, Berry & Sims Healthcare Fraud and Abuse Attorneys

Sarah K. Bogni
(615) 742-7813
sbogni@bassberry.com

J. Taylor Chenery
(615) 742-7924
tchenery@bassberry.com

Matthew M. Curley
(615) 742-7790
mcurley@bassberry.com

Michael L. Dagley
(615) 742-7729
mdagley@bassberry.com

Wallace W. Dietz
(615) 742-6276
wdietz@bassberry.com

Mary Beth Fortugno
(615) 742-7739
mfortugno@bassberry.com

Lauren Gaffney
(615) 742-7824
lgaffney@bassberry.com

Anna M. Grizzle
(615) 742-7732
agrizzle@bassberry.com

Britt K. Latham
(615) 742-7762
blatham@bassberry.com

J. Brook Lathram
(901) 543-5905
blathram@bassberry.com

Taylor J. Phillips
(615) 742-7802
tphillips@bassberry.com

W. Brantley Phillips, Jr.
(615) 742-7723
bphillips@bassberry.com

Eli J. Richardson
(615) 742-7
erichardson@bassberry.com

Brian D. Roark
(615) 742-7753
broark@bassberry.com

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