

# HEALTH LAW

## Update

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

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## Preparing For A Medicare Audit By A Program Safeguard Contractor

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### Introduction

The Health Insurance Portability and Accountability Act of 1996<sup>1</sup> authorized the Centers for Medicare & Medicaid Services ("CMS") to contract with entities known as Program Safeguard Contractors ("PSCs") to conduct Medicare program integrity activities.<sup>2</sup> In today's enforcement environment, as the federal government devotes more resources to enforcement initiatives, providers should expect an increase in the number of site visits from PSCs. For example, recent reports in the trade press indicate that the PSC assigned to audit Medicare Part B payments in Tennessee has been on an audit "blitz."<sup>3</sup> As the incidence of provider audits increases, it is imperative for providers to understand the PSC program, how the audit and appeals process works, and the steps to take to prepare for an audit.

### Program Safeguard Contractors

PSC activities include conducting post-payment audits of providers to ensure that claims have been appropriately billed, and, if errors are apparent, to determine the necessary overpayment amounts.<sup>4</sup> In 2002, AdvanceMed, a subsidiary of Computer Sciences Corporation that is headquartered in Maryland, was awarded the contract to serve as the PSC for the CIGNA Part B workload in Tennessee and North Carolina.<sup>5</sup> AdvanceMed continues to serve as the PSC for these areas. This Health Law Update will use AdvanceMed as an example to illustrate how the PSC audit process works.

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<sup>1</sup> PL 104-191, §202.

<sup>2</sup> The responsibilities of PSCs are set forth in the Medicare Program Integrity Manual, Chapter 3 "Verifying Potential Errors and Taking Corrective Actions" and Chapter 4 "Benefit Integrity."

<sup>3</sup> Tennessee Medical Association, *AdvanceMed on TN Blitz for Medicare*, (June 13, 2007) <<http://www.medwire.org/>>

<sup>4</sup> Medicare Program Integrity Manual, Chapter 3, Post Payment Review.

<sup>5</sup> CIGNA Government Services, *To Healthcare Practitioners and Managerial Members of the Provider Staff in Tennessee and North Carolina (CMS awards PSC to AdvanceMed)*, (August 2, 2002). <[http://www.cignamedicare.com/partb/pubs/news/2002/0702/PSC/tn\\_nc\\_letter.html](http://www.cignamedicare.com/partb/pubs/news/2002/0702/PSC/tn_nc_letter.html)>

## Audit Process

Audits conducted by AdvanceMed generally are unannounced, with AdvanceMed representatives appearing at a provider's office and presenting a staff member with a list of Medicare beneficiaries and dates of service.<sup>6</sup> The AdvanceMed representatives then request that the provider make available for copying all information in the requested patients' medical records that supports the services billed on the dates in question. AdvanceMed representatives may appear at either a corporate or billing office or any base or satellite clinic. AdvanceMed representatives may bring their own copiers and scanners or could request that the provider copy the requested documents.<sup>7</sup> The audits also may include interviews of physicians, clinical staff, and/or billing office staff.

It is unclear what criteria (size of practice, medical specialty, particular billing trends, or geographic or alphabetical order) AdvanceMed is using in determining practices or physicians to audit. The actual audits also appear to be a random sampling of claims and not necessarily focused on particular services or physicians within an audited practice. That being said, two common areas of focus are: (1) the use of procedure or revenue codes that describe more extensive services than those actually performed; and (2) misrepresenting noncovered services as medically necessary by using inappropriate procedure or diagnosis codes.

## Audit Findings and Demand for Payment

Within 60 days after the on-site audit, the PSC will notify the provider of the results of the audit.<sup>8</sup> CMS authorizes PSCs to use statistical sampling during the audit process to calculate and project (i.e. extrapolate) overpayment amounts to be recovered by recoupment.<sup>9</sup> Providers should be aware that statistical sampling and extrapolation used by PSCs often result in significantly high overpayment determinations. Even if the audit found an "actual" overpayment of only a few thousand dollars, the extrapolation could increase this amount to several hundreds of thousands or millions of dollars.<sup>10</sup>

"The PSC's findings also are sent to the Fiscal Intermediary or Carrier ("FI") assigned to the provider. Approximately two weeks after receipt of the letter from the PSC, the FI will issue a demand for the provider to repay the overpayment amount. If the full amount is not repaid within 30

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<sup>6</sup> While this list is technically not a subpoena or search warrant, providers must nonetheless comply with the PSC's request. Pursuant to 42 USC §1395u, PSCs are required to conduct reviews of providers to ensure that Medicare Part B claims have been appropriately billed. 42 USC § 1395l(e) and 42 CFR § 424.5(a)(6) place the burden upon the provider to furnish such information as may be necessary if payment is (or was) due. *Also see* Medicare Program Integrity Manual, Chapter 3, Section 3.6.2; *The Medicare Medical Review Program*, (June, 2007) <http://www.cms.hhs.gov/MLNProducts/downloads/MedReviewProgbroch07.pdf>

<sup>7</sup> There is no clear guidance on who bears the costs associated with such copies; however, informal indications are that such costs are often borne by the provider.

<sup>8</sup> Medicare Program Integrity Manual. §3.6.5, *Notification of Provider(s) or Supplier(s) and Beneficiaries of the Postpayment Review Results*. §3.6.5A requires that PSCs send the Notification of Postpayment Review Results to each provider within 60 days of the exit conference (for provider or supplier site reviews).

<sup>9</sup> Medicare Program Integrity Manual. §3.10.1.1. PSCs use statistical sampling (i.e., extrapolation) when it has been determined that a sustained or high level of payment error exists, or where documented educational intervention has failed to correct the payment error. Once a determination has been made that statistical sampling may be used, the PSC must comply with the six steps for conducting statistical sampling as set forth in the Medicare Program Integrity Manual.

<sup>10</sup> Providers may challenge the extrapolation process, which involves comparing the statistical methods used by the PSC with those set forth in *Supra* n. 9. Challenging the extrapolation process can be costly as it generally requires hiring expert witnesses, including statisticians.

days of demand, interest on overpayments will begin to accrue and will be charged on the balance of the overpayment at the end of each *full* thirty (30) day period the payment is delayed.<sup>11</sup> Interest will continue to accrue during periods of administrative and judicial appeal until final disposition of the claim.<sup>12</sup> If the overpayment determination is later reversed, the amount recouped plus the interest will be repaid to the provider.<sup>13</sup> The current interest rate applicable to overpayments is 12.625 percent.<sup>14</sup> Additionally, the FI may turn over collection of the debt to federal debt collection services.

## Appeal Rights

Under the appeals process, if a provider is audited by CMS and receives an initial overpayment determination, it has the right to appeal the decision. CMS has established a five-level appeals process: (1) redetermination from the FI; (2) reconsideration from a Qualified Independent Contractor; (3) appeal to an administrative law judge ("ALJ"); (4) appeal to the Medicare Department Appeals Board; and (5) appeal to a federal district court. Although expensive, most providers have no choice but to appeal due to the large extrapolated overpayment amounts sought by the FI. Furthermore, if the provider is successful in reversing the denial of even a few claims, the provider can undermine the basis for the PSC's ability to extrapolate an overpayment amount, which would drastically lower the provider's damages.

This first level of appeal is the redetermination stage.<sup>15</sup> At this stage, a provider must submit a redetermination request in writing to the FI within 120 calendar days from the receipt of notice of the initial determination.<sup>16</sup>

If the redetermination by the FI is unfavorable to the provider, the next level of appeal is the reconsideration stage.<sup>17</sup> The provider must submit its request for reconsideration in writing within 180 calendar days from notice of the redetermination.<sup>18</sup> Reconsideration "consists of an independent, on-the-record review of an initial determination, including the redetermination and all issues related to payment of the claim"<sup>19</sup> and is adjudicated by Qualified Independent Contractors ("QIC").<sup>20</sup> This stage of the appeals process is a significant departure for Part B providers from the prior appeals process where providers were afforded an in-person "Carrier Hearing." Part B providers in large post-payment audit cases will be especially impacted by this change. Previously these providers were able to benefit from the in-person hearing through expert testimony from physicians, statisticians, and other experts.<sup>21</sup> Under the current procedure, providers must rely on alternative means to support their appeal, such as written affidavits by experts.<sup>22</sup>

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<sup>11</sup> 42 C.F.R. §405.378(b), (b)(2). Note that any period of less than thirty days will not be treated as a full thirty day period. 66 Fed. Reg. 45605 (July 30, 2004.)

<sup>12</sup> *Id.* at § 405.378(e).

<sup>13</sup> 42 U.S.C. § 1395ddd(f)(2)(B).

<sup>14</sup> Pub-100-06, Transmittal 129, *Notice of New Interest Rate for Medicare Overpayments and Underpayments – 4<sup>th</sup> Qtr. FY 2007*, July 13, 2007. New rate effective July 20, 2007.

<sup>15</sup> 42 C.F.R. §§ 405.940 to 405.958.

<sup>16</sup> *Id.* § 405.942(a).

<sup>17</sup> *Id.* at §§ 405.960 to 405.978.

<sup>18</sup> *Id.* at § 405.962(a).

<sup>19</sup> *Id.* at § 405.968(a)(1).

<sup>20</sup> *Id.*

<sup>21</sup> Andrew B. Wachler & Abby Pendleton, *The New Medicare Part A and Part B Appeals Process*, Wachler & Pendleton, HEALTH LAW HANDBOOK, page 10 (2006).

<sup>22</sup> *Id.*, at 9, 24.

Another significant requirement at the reconsideration stage is the requirement of complete and early presentation of evidence.<sup>23</sup> Failure to submit evidence at the reconsideration stage, including documentation requested in the notice of redetermination, could preclude subsequent consideration of that evidence.<sup>24</sup> Providers must be aware that they could be prevented in later stages of appeal from introducing additional evidence to support their claim, absent a showing of good cause, if not introduced at the reconsideration stage.<sup>25</sup>

Should the provider be dissatisfied with the outcome of the reconsideration, it may file a written request within 60 days of the reconsideration to appeal to an administrative law judge ("ALJ") hearing.<sup>26</sup> Depending on the available technology, the hearing may be conducted by video-conference or by telephone. The provider may request an in-person ALJ hearing, but these requests are granted only upon finding of good cause, generally when there are complex or challenging issues presented.<sup>27</sup> A party may submit new evidence not presented during the early stages of appeal only on a showing of good cause, which determination is committed to the discretion of the ALJ.<sup>28</sup>

The fourth level of appeal is the Medicare Department Appeals Board ("DAB").<sup>29</sup> A request for a DAB review must be written and filed within 60 days after the ALJ decision.<sup>30</sup> While there is not a hearing at this level of appeal, the parties will be given an opportunity to file briefs or other written statements.<sup>31</sup> The provider may only request a DAB review, and the decision of the DAB to dismiss or deny a request for review is binding upon the provider and not subject to judicial review.<sup>32</sup>

If still unsatisfied with the outcome of the DAB review, the final stage of the new Appeals process is judicial review.<sup>33</sup> The provider must request review with the federal district court within 60 days of receipt of the DAB's notice of decision.<sup>34</sup>

## Recoupment

During the appeals process, providers also face the recoupment of the overpayment amount sought by the FI. If the full amount demanded by the FI is not repaid within 30 days of the original demand, the FI will begin recoupment of this amount from the provider. At the redetermination and reconsideration levels, recoupment is stayed only while the provider's appeal is pending and not during the period before the provider has actually submitted an appeal.<sup>35</sup> For example, although the provider has 180 days to seek reconsideration, once recoupment recommences following the redetermination decision, recoupment does not stop until the request for reconsideration is

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<sup>23</sup> 42 C.F.R. § 405.966

<sup>24</sup> 42 C.F.R. § 405.966(a)(2)

<sup>25</sup> *Id.*

<sup>26</sup> *Id.* at §§ 405.1000 to 1054.

<sup>27</sup> *Id.* at §§ 405.1000, § 405.1020.

<sup>28</sup> *Id.* at § 405.1028.

<sup>29</sup> *Id.* at §§ 405.1100 to 1134.

<sup>30</sup> *Id.* at § 405.1102.

<sup>31</sup> *Id.* at § 405.1120 to 1122.

<sup>32</sup> *Id.* at § 405.1100; § 1116.

<sup>33</sup> *Id.* at §§ 405.1134 to 1140.

<sup>34</sup> *Id.* at § 405.1136.

<sup>35</sup> 42 U.S.C. § 1395ddd(f)(2)(A); *see* 71 Fed. Reg. at 55407, "based on the statutory language, we could recoup during the period in which the provider is actively pursuing an appeal at this first level..."

submitted.<sup>36</sup> This aspect of the process forces providers into the difficult choice of taking sufficient time to draft a thorough appeal or rushing the appeal in order to stop recoupment.<sup>37</sup> After the reconsideration decision is rendered, recoupment is not stayed under any circumstances, even if additional levels of appeal are pursued.<sup>38</sup>

### Steps to Prepare for Audit

Providers should take steps to be prepared for these unannounced PSC audits. Providers should designate the Compliance Officer or another administrator as the employee responsible for the audit. A provider should inform all employees to notify this designated employee if anyone is contacted by a PSC or if a PSC appears at any office. This designated employee should then serve as a point of contact with AdvanceMed or another PSC to coordinate the audit, answer questions regarding where records are located, and assist the PSC in setting up interviews with requested individuals. If the provider has more than one office, providers should suggest that the PSC stage its audit out of the provider's corporate or business office.

The designated employee should contact the provider's legal counsel if a PSC arrives to conduct an audit. Legal counsel then can assist in interfacing with the PSC and can monitor and document the audit process, including being present during interviews and assisting in document collection.

Providers must ensure that complete documentation is provided to the PSC to support the services billed for the patients under review. A provider should not permit the PSC to rush the process but must proceed deliberately to collect all relevant documentation. The document collection cannot be left solely to clinical personnel who may not be aware of documentation necessary to support claims from a billing perspective. For this reason, providers should involve billing personnel in the production of documents.

It also is important to ensure that providers have adequate time to collect the requested documents. A PSC may request records, such as hospital or surgery center records, that a provider may not have on-site. A provider also may have multiple sites. If a provider has multiple sites or does not have access to all of the documentation requested by the PSC, the provider should request additional time to submit documentation not collected by the PSC during the on-site audit and should document the PSC's agreement to additional time.

Under no circumstances should a provider sign any statement certifying the completeness of the medical records it is providing unless the provider's designated employee responsible for the audit (and perhaps legal counsel as well) has confirmed that all documents have been provided. Staff members should be trained that any requests by a PSC for the staff member to sign off on any matter should be referred to the provider's designated employee.

Providers should retain a copy of all documents provided to the PSC. After the collection is complete, it is recommended that the provider or legal counsel send a letter to the PSC memorializing

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<sup>36</sup> 42 U.S.C. § 1395ddd(f)(2)(A).

<sup>37</sup> Note that CMS has proposed a rule which would require recoupment to cease when a valid first level appeal is received. If the provider loses at the first level, CMS would then proceed to recoup 30 days after giving notice to the provider unless the provider appeals to the QIC in the interim. Therefore, a provider who acts in a timely fashion can preclude any recoupment until the QIC decision is rendered. *See* 71 Fed. Reg. at 55407.

<sup>38</sup> 42 U.S.C. § 1395ddd(f)(2)(A).

the documents collected and persons interviewed during the audit if any issue ever arises regarding how the audit was conducted.

## Conclusion

PSC audits and the appeals of the results of PSC audits are time-consuming and expensive. Therefore, providers must protect their rights during the audit and appeals process. If you have any questions regarding PSC audits or the Medicare appeals process, please contact any of the attorneys in the Healthcare Practice Area listed at the end of this Update.

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