MEDICARE AND MEDICAID AUDITS

Anna Grizzle and Julia Tamulis

One of the greatest risks to a healthcare provider is a payment or claims audit. Claims audits can be performed by a spectrum of governmental and private audit contractors operating under different protocols. Recent attention on Medicare audits has focused on aggressive audits performed by recovery audit contractors (RACs), but other Medicare audit contractors also are actively auditing providers. On the Medicaid side, the introduction of new audit contractors in addition to traditional state Medicaid agency auditors shows that the Centers for Medicare and Medicaid Services (CMS) is also focused on Medicaid claims. This focus will only increase as new Medicaid enrollees are added to the Medicaid rolls through expanded Medicaid programs under the Patient Protection and Affordable Care Act (ACA).

At the same time, commercial payors have adopted some of these same government tactics to scrutinize commercial claims. These audits have left many providers making difficult choices about how to best use their resources to defend against these audits and fight claims denials. Providers can protect themselves by learning about the processes used by the Medicare and Medicaid audit contractors and commercial payor audits before undergoing an audit so that they can efficiently navigate the process and best protect themselves from a huge overpayment demand. This chapter first discusses the three major types of audits healthcare providers face: Medicare, Medicaid, and ERISA. It then offers suggestions on how to respond to these audits.

Medicare Audits

CMS works with a number of private contractors to conduct prepayment and post-payment audits of Medicare claims. Recently, industry scrutiny and provider complaints have focused largely on RAC audits, which drain providers’ resources when they choose to appeal aggressive overpayment decisions. However, other Medicare contractors, such as Medicare Administrative Contractors (MACs) and Zone Program Integrity Contractors (ZPICs), continue to audit claims in their specific target areas even as CMS has instituted a moratorium on certain RAC
audits. With the proposed introduction of a new comprehensive auditing contractor, the Unified Program Integrity Contractor (UPIC), CMS clearly intends to continue its heightened scrutiny of Medicare claims.

**Recovery Audit Contractors**

Medicare recovery auditors (formerly known as recovery audit contractors and widely referred to as RACs) hold the title for the most controversial Medicare contractor. The goal of the RAC program is to protect the Medicare trust fund through identification of improper payments, including overpayments and underpayments, which result from incorrect payment amounts, noncovered services, medically unnecessary services, incorrectly coded services, and duplicate services. In carrying out this mandate, RACs have inundated providers with audit requests and issued high numbers of denials, which are often overturned on appeal, but only after providers must incur the time and cost of appealing the adverse decisions.

The Medicare Modernization Act of 2003 (MMA) authorized the creation of the RAC program as a demonstration program to determine the cost-effectiveness of using private contractors paid on a contingency basis to audit claims. An RAC is paid a percentage of the improper payments it identifies. Initially operational in a handful of states with the highest Medicare expenditures, CMS hailed the program as a success, recouping nearly $1 billion in improper payments and returning almost $38 million in underpayments during the three-year demonstration period. In 2006, the RAC program became a permanent fixture of CMS’ recoupment efforts and the program expanded nationwide in 2010.

CMS assigns each RAC to a region (regions A through D) that encompasses approximately one-quarter of the country and matches the Durable Medical Equipment (DME) MAC jurisdictions. The states encompassing each region are as follows.

<table>
<thead>
<tr>
<th>Region</th>
<th>Contractor</th>
<th>Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>CGI Federal, Inc.</td>
<td>Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin</td>
</tr>
</tbody>
</table>

Medicare and Medicaid Audits

<table>
<thead>
<tr>
<th>Region</th>
<th>Contractor</th>
<th>Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Connolly, Inc.</td>
<td>Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Tennessee, Puerto Rico, South Carolina, Texas, U.S. Virgin Islands, Virginia, West Virginia</td>
</tr>
</tbody>
</table>

**RAC Reviews**

RACs may review claims for three years after the claim’s payment date. RACs conduct three types of review of Medicare Part A and B claims: (1) automated reviews with no medical records needed; (2) semi-automated reviews, which consist of an automated review followed by a demand letter requesting evidence supporting payment within 45 days; and (3) complex reviews of topics selected by CMS in which medical records are substantively reviewed. Most reviews are performed on an automated basis with providers given 30 days to dispute the findings of automated claims before the claims processing contractor will offset the overpayment.

RAC audits are unique in that providers are afforded an opportunity outside of the appeals process to supply additional information through a discussion period within the first 40 days after receipt of the demand letter or review results letter. If the provider does not appeal the overpayment determination, the MAC may recoup the funds by offsetting present or future Medicare payments against the overpayment or the provider may write a check.

**RAC Record Request Limitations**

RACs may request medical records as part of their review. CMS has set limits on audit requests, or additional document requests (ADRs), based on a provider’s Medicare claims volume from the prior year. RACs can select up to 75 percent of

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any single claim type for review, such as acute hospital inpatient (IPPS), hospital outpatient (OPPS), or skilled nursing facility (SNF) claims. The remaining 25 percent of the request limit may come from other types of claims. RACs can request up to 400 records and at minimum 20 records over a 45-day period, although providers with over $100 million in MS-DRG payments may be requested to provide up to 600 records in the same time frame. CMS may make exceptions in certain cases and allow RACs to exceed the ADR limits.

These limitations have proven to provide limited relief as providers struggle to meet the constant demands of ADRs received every 45 days. RACs’ focus on hospital inpatient short stays has been especially burdensome to hospitals that must satisfy constant ADRs. In February 2014, CMS suspended RACs’ ability to request documents pending the procurement process for new RAC contracts. CMS explained that the suspension would also allow it to review the ADR limits, time frames for review, and communications between RACs and providers.

**RAC Audit Targets**

CMS approves certain issues that may be reviewed by RACs prior to their review. The RACs post these issues to their websites. Recently approved issues include outpatient therapy claims above $3,700, SNF psychiatric conditions, high-cost implants, and incorrect billing of DME orthotics. If the RAC identifies an improper overpayment, it sends a demand letter, including the overpayment amount, rationale, and payment instructions, to the MAC, or claims processing contractor, to recover the payment. If an underpayment is discovered, the claims processing contractor will notify and pay the provider the underpaid amount.

**State of the RAC Program**

The RAC program remains controversial. Among other things, providers have raised concerns that RACs seek inappropriate and aggressive recoupment because they are motivated by the contingency compensation structure. In late 2014, CMS proposed changes to the program, including delaying payment to RACs until allegedly improper claims clear the second level of appeal. The proposed change has resulted in a moratorium on the RAC contract procurement process in several regions and the extension of current contracts through 2015.

On November 6, 2015, CMS issued Request for Proposals (RFPs) for the next round of RAC contracts. CMS allowed all RACs that signed a contract modification to resume recovery auditing activities, including issuing ADRs, effective November 13, 2015. By signing a contract modification, the four current RACs

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may continue recovery auditing activities through July 31, 2016. If a current RAC did not sign a modified contract, it was only permitted to send ADRs until October 16, 2015, and submit improper payment files to the MAC for adjustment until December 31, 2015.11

Despite CMS’ attempts to expand the program, widespread calls for program reform continue. Congressional leaders and the American Heart Association (AHA) have cited a 2012 Department of Health and Human Services (HHS) report stating that 72 percent of hospital-appealed RAC denials are overturned at the administrative law judge (ALJ) hearing level as evidence of improper overreaching by RACs to obtain commissions.12 CMS implemented an ongoing suspension of RAC reviews of inpatient claims by hospitals after establishment of the Two-Midnight Rule13 for inpatient billing until at least September 30, 2015.14 However, as discussed above, CMS permitted all RACs that signed a contract modification to resume recovery auditing activities, effective November 13, 2015. While the state of the RAC program remains in flux, the RACs’ controversial actions will likely remain a topic of heated debate as CMS attempts to curb program abuses.

Medicare Administrative Contractors

Development of the MAC program over time has led to increased claims auditing responsibility by MACs for Part A and Part B claims. MACs perform a number of services for the Medicare program as outlined in their statements of work, including provider enrollment, claims processing and provider education, medical review not for benefit integrity purposes, complaint screening, auditing provider cost reports, and appeals.15 Each business day, MACs process nearly 5 million claims

13. CMS’ controversial Two-Midnight Rule, effective on October 1, 2013, provides that inpatient hospital admission is assumed to have been appropriate if the patient’s stay spanned two midnights. Under the Two-Midnight Rule, if a patient’s hospital stay lasts less than two midnights, the patient’s care should be covered under observation status. CMS created the Two-Midnight Rule to address a perceived increase in hospital observation stays due to Medicare contractors challenging hospital inpatient admissions. However, hospital providers have largely responded negatively to the Two-Midnight Rule, which has led to CMS delaying its implementation.
and distribute approximately $365 billion in Medicare payments to providers per year.16

In exercising their claim oversight responsibilities, MACs may perform prepayment or post-payment audits. MACs also conduct probe audits, which cover certain services or specialties, to determine if additional audits should be conducted. Providers may be audited randomly or may be targeted based on information received by the MAC from patients, other agencies investigating fraud, or data mining that reveals anomalies or outliers in a providers’ claims statistics. Providers who meet specified criteria based on the MAC’s general industry claims focus also will have claims pulled prior to payment. MACs will then send an ADR to the providers and request records be returned within a specified time.

Probe sample requests usually cover between twenty and forty inpatient or outpatient records. If providers do not provide the requested documents by the deadline or the documentation does not substantiate the billed codes, the MAC will not pay the claims. Results of prepayment audits may lead to additional prepayment review by the MAC or referral to a ZPIC for further evaluation. When review of the documentation indicates fraud, the MAC will refer the claims to the appropriate agency for additional investigation.

**Zone Program Integrity Contractors**

Prior to the implementation of the ZPIC program, program safeguard contractors (PSCs) and Medicare drug integrity contractors (MEDICs) conducted benefit integrity activities for Medicare providers. However, the PSCs and MEDICs had no uniformity of jurisdiction, which resulted in one PSC being responsible for overseeing the integrity of Part A claims in one state while an entirely different PSC was responsible for overseeing the integrity of Part B claims in the same state.17

CMS attempted to correct this piecemeal approach by reducing the number of PSCs and MEDICs and creating seven ZPIC zones. CMS then tasked ZPICs with coordination of benefit integrity activities for Medicare Parts A and B; durable medical equipment, prosthetics, orthotics, and supplies; home health and hospice providers; as well as Medicare-Medicaid data matching.18 In 2008, ZPICs began assuming the duties of PSCs and MEDICs responsible for integrity efforts under Medicare Parts C and D.

ZPICs are “responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, provider and durable medical equipment claims), Part C (Medicare Advantage health plans), Part D (Medicare Part D prescription drug programs), and Part E (Medicare Part E prescription drug program for Medicare Advantage plans).”

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17. See Office of Inspector General, Department of Health and Human Services, Medicare’s Program Safeguard Contractor Activities to Detect and Deter Fraud and Abuse (July 2007), http://www.oig.hhs.gov/oei/reports/oei-03-06-00010.pdf. See also, Brian Petry, Centers for Medicare and Medicaid Services, Transition from Program Safety Contractors (PSCs) to Zone Program Integrity Contractors (ZPICs) 57 Health Care Fraud 46, 47–50, 53 (Jan. 2009).

18. Supra note 16.
Part D (prescription drug plans) and coordination of Medicare-Medicaid (Medi-Medi).” To accomplish the goal of promoting integrity in the Medicare and Medicaid programs, ZPICs have several objectives. First, ZPICs are charged with identifying, stopping, and preventing Medicare and Medicaid fraud, waste, and abuse and referring instances of such activity to appropriate law enforcement agencies. Other ZPIC objectives include

- decreasing the submission of abusive and fraudulent Medicare and Medicaid claims;
- recommending appropriate administrative action, to ensure appropriate and accurate payments for services are made; and
- coordinating identified potential fraud, waste, and abuse with the appropriate Medicare and Medicaid entities.

**ZPIC Audit Process**

CMS has assigned a ZPIC to each of the seven separate zones.

<table>
<thead>
<tr>
<th>Zone</th>
<th>Contractor</th>
<th>Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Safeguard Services</td>
<td>American Samoa, California, Guam, Hawaii, Mariana Islands, Nevada</td>
</tr>
<tr>
<td>3</td>
<td>Cahaba</td>
<td>Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin</td>
</tr>
<tr>
<td>4</td>
<td>Health Integrity</td>
<td>Colorado, New Mexico, Oklahoma, Texas</td>
</tr>
<tr>
<td>5</td>
<td>NCI AdvanceMed</td>
<td>Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia</td>
</tr>
<tr>
<td>7</td>
<td>Safeguard Services</td>
<td>Florida, Puerto Rico, U.S. Virgin Islands</td>
</tr>
</tbody>
</table>

21. Supra note 19.
22. See ZONE PROGRAM INTEGRITY CONTRACTOR (ZPIC), available at http://www.cgsmedicare.com/hhh/medreview/zpic.html (last accessed June 11, 2015). CMS originally awarded Zone 6 to Cahaba Safeguard Administrators, LLC. Several contractors are protesting that award. SafeGuard Services is covering this zone until the dispute is resolved.
ZPICs have taken an aggressive stance in examining provider payment fraud cases through their audits and processing of fraud complaints. If a provider receives a ZPIC audit request, the provider either is the subject of a fraud investigation, or the ZPIC is investigating to determine if a fraud investigation should be opened. ZPICs are authorized to conduct audits, interview beneficiaries and providers, initiate administrative sanctions (including suspending payments, determining overpayments, and referring providers for exclusion from Medicare), and refer providers and beneficiaries to law enforcement.

Several claims problems may trigger ZPIC audits, including improper or inaccurate billing that can be shown through high claim rejection or recoupment rates, aberrant utilization when compared to providers, claim mismatches with physician records, bundling fees, and lengths of stay outside the industry norms. Claims information obtained through use of data mining and information obtained from whistleblowers may also prompt ZPICs to conduct an audit.

ZPIC audits typically are unannounced or announced with very little notice and can consist of prepayment or post-payment review. Providers typically receive a written request for records from the ZPIC, but the ZPICs sometimes visit providers to conduct the audit on-site. The ZPICs may request a small number of records to review to determine if there is a fraud concern. Alternatively, the ZPIC might work with a statistician prior to contacting the provider to select a sample of claims for review, and may ultimately use statistical sampling to extrapolate the amount of any overpayment(s) made on claims based on the error rate within the sample claims. ZPICs also may request other information, such as contracts with other providers, to review relationships with referral sources.

In addition to requesting records, the ZPICs may conduct interviews with beneficiaries and the provider’s employees. For example, if the ZPIC is investigating whether a provider appropriately billed a Level 4 Evaluation and Management claim, it may ask beneficiaries such things as the amount of time that the provider spent with the beneficiaries during the visit in question.

Following a ZPIC audit, providers face one of three potential outcomes. The first and most serious potential outcome is referring the case to law enforcement for criminal, civil monetary penalty (CMP), or other sanction. If a referral occurs, the Office of Inspector General (OIG) of the Department of Health and Human Services or a U.S. attorney may contact the provider to investigate whether to bring a False Claims Act case against the provider.

Second, the ZPIC may refer the audit results, including the statistical calculation of an extrapolated overpayment, to the MAC for collection. In this circumstance, a provider can appeal the overpayment determination through the Medicare appeals process. Although time-consuming, most providers typically choose to appeal the audit results due to the large overpayment amounts being sought for extrapolated overpayment demands. If a provider is successful in

reversing the denial of even a few claims, the provider can undermine the basis for the ZPIC’s ability to extrapolate an overpayment amount based on a sample of claims and significantly reduce the provider’s damages.

Finally, the ZPIC may determine that provider education is the appropriate resolution. This result is the best outcome for a provider, as it means that the provider will not be assessed an overpayment demand or other potential sanction. In this instance, the ZPIC will inform the provider by letter of questionable or improper practices and the correct procedure to be followed. The ZPIC will also notify the provider that continuation of the improper practice may result in administrative sanctions.

**Unified Program Integrity Contractors**

Motivated by the prospect of consolidating its Medicare auditing program and preventing overlapping audits, CMS plans to establish a new type of auditing entity called a Unified Program Integrity Contractor (UPIC), which will assume the auditing duties of ZPICs, Medicaid Integrity Contractors (MICs), and PSCs in a national effort to streamline review of claims. CMS required interested contractors to submit their bids for UPIC contracts in response to its draft Statement of Work by June 9, 2014, with contracts expected to be awarded in the third quarter of fiscal year 2015. 24 On July 17, 2015, CMS issued a Request for Proposal for UPIC contracts and required submissions by August 25, 2015. 25 As of early 2016, the contract award process for UPICs is ongoing. After the UPIC contracts are awarded, there will be an additional delay due to a transition and implementation period.” CMS intends for this consolidation to result in increased data transparency to integrity contractors, improved contractor accountability through a nationwide strategy, and more data on healthcare providers’ claims and payments.

UPICs will perform complex data analysis, data matching, and prepayment and post-payment reviews on Medicare-only claims, Medicaid-only claims, and Medicare-Medicaid claims, plus other claims information, management care data, and private sector data. The UPICs will operate in five regional jurisdictions. Currently, it is expected that UPICs will limit their review to claims under Medicare Parts A and B for fraud, waste, and abuse. The new UPICs will completely replace MICs and likely ZPICs, although the other contractor types will continue to exist. When the UPICs become fully operational, the government will have access to more provider data and have a more comprehensive understanding of provider activity, enhancing its ability to target vulnerabilities in the system and problematic providers.


Medicaid Audits

In addition to the individual state auditing activities, CMS has created a system parallel to its Medicare audit programs to identify and correct payment errors and fraud, waste, and abuse in state Medicaid programs. Unlike Medicare auditors, Medicaid auditors operate within varying state laws governing the administration of audits and provider appeal rights. Recently, states have increasingly relied upon third-party contractors outside of state agencies to perform audits and assist with program integrity actions.

Medicaid reimbursement and appeals are distinct from the Medicare program. Given the variation in Medicaid requirements across states, multistate providers must meet the challenging task of navigating different Medicaid reimbursement requirements and appeal rights, as well as different Medicaid auditors responsible for varying regions. It is essential for Medicaid providers to understand the structure of Medicaid audit processes and appeal formats for their respective states.

Medicaid Integrity Contractors

Section 6034 of the Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program (MIP) within Section 1936 of the Social Security Act to address fraud and abuse in Medicaid programs administered by states.26 Under the MIP, CMS received more resources to combat Medicaid fraud, waste, and abuse, with $75 million in funding per fiscal year after 2009.27 The DRA required CMS to enter into contracts with Medicaid Integrity Contractors (MICs) that are tasked with auditing Medicaid claims for fraud and abuse, identifying overpayments, and educating providers regarding payment integrity and quality of care. Additionally, CMS must provide general support to states to combat Medicaid fraud while reporting to Congress annually on the effectiveness of MIP funds in their intended use.

The CMS Medicaid Integrity Group (MIG) is responsible for administering the MIP and is comprised of three divisions: (1) the Division of Medicaid Integrity Contracting, which oversees procurement and supervision of Medicaid Integrity contracts; (2) the Division of Field Operations, which conducts state Medicaid program integrity reviews and provides technical assistance; and (3) the Division of Fraud Research and Detection, which provides statistical and data support and detects fraud trends.28

The MIP utilizes three types of MICs: audit MICs, review MICs, and education MICs, each entrusted with a specific aspect of program integrity oversight.29

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These MICs are responsible for ensuring that paid claims were for properly provided and documented services, billed correctly with appropriate procedure codes, for covered services, and paid according to federal and state regulations in five jurisdictions, each containing two CMS regions. Audit MICs may receive financial bonuses depending on the effectiveness of their audits, as opposed to payment based on a contingency fee.

**MIC Audit Process**

CMS has awarded contracts to the following review and audit MICs for five jurisdictions across the country to streamline review.\(^\text{30}\)

<table>
<thead>
<tr>
<th>Audit MIC</th>
<th>Region</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thompson Reuters (Review)</td>
<td>(New York)</td>
<td></td>
</tr>
<tr>
<td>Health Integrity (Audit)</td>
<td>III/IV</td>
<td>Alabama, District of Columbia, Delaware, Florida, Georgia, Kentucky, Maryland, Mississippi, North Carolina, Pennsylvania, South Carolina, Tennessee, Virginia, West Virginia</td>
</tr>
<tr>
<td>Thompson Reuters (Review)</td>
<td>(Atlanta)</td>
<td></td>
</tr>
<tr>
<td>Health Integrity (Audit)</td>
<td>V/VII</td>
<td>Iowa, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin</td>
</tr>
<tr>
<td>AdvanceMed (Review)</td>
<td>(Chicago)</td>
<td></td>
</tr>
<tr>
<td>IntegriGuard (Audit)</td>
<td>VI/VIII</td>
<td>Arkansas, Colorado, Louisiana, Montana, North Dakota, New Mexico, Oklahoma, South Dakota, Texas, Utah, Wyoming</td>
</tr>
<tr>
<td>AdvanceMed (Review)</td>
<td>(Dallas)</td>
<td></td>
</tr>
<tr>
<td>IntegriGuard (Audit)</td>
<td>IX/X</td>
<td>Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Northern Mariana Islands, Nevada, Oregon, Washington</td>
</tr>
<tr>
<td>AdvanceMed (Review)</td>
<td>(San Francisco)</td>
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Any Medicaid provider may be audited by audit MICs looking for overpayments. Review MICs begin the process by reviewing post-payment claims and

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recommending providers for audit by an audit MIC. Audit MICs select providers based on data analysis or collaboration between state entities and CMS using standard state audit processes. CMS must establish that chosen providers are not already subject to investigations or audits by state or federal law enforcement, state Medicaid agencies, or Medicare contractors. Recent MIC targets include provider eligibility, billing for services not provided, reimbursements for unapproved drugs, duplicate billing, providing medically unnecessary services, and upcoding of services.

Audit MICs send a notification letter to a provider selected for audit, identifying the claims and records to be reviewed, and will schedule an entrance conference with the provider to discuss the audit’s scope and objectives. MICs are able to review claims up to the look-back period allowed by the specific state. Generally, providers have at least 30 business days to produce the requested documents to the audit MICs. Audit MICs may request records for an unlimited number of claims for production in as short a time frame as two weeks. Audit MICs will consider reasonable requests for extension of document production deadlines. Record review may occur at the audit MIC’s office or on-site when an audit MIC conducts a field visit.

The audit MIC will share its preliminary determinations with the provider at an exit conference after the audit’s completion, allowing the provider opportunity to comment. If the audit MIC finds potential overpayments, it will prepare a draft audit report to be shared first with CMS, followed by the state, and then with the provider. Upon receipt, the state and provider may draft comments for CMS’ consideration. After CMS incorporates revisions as appropriate, the state may make final additional comments. CMS will thereafter issue a final report to the state indicating any overpayment. The state will then seek collection of the overpayment according to its own procedures. However, CMS requires states to repay the federal share of overpayments within one year from the date of identification, with an additional 30 days permitted if recovering an overpayment arising from fraud.

**Medicaid Recovery Auditors**

Section 6411 of the Affordable Care Act required CMS to create a Medicaid RAC program comparable to the Medicare RAC program. As with the Medicare RAC program, Medicaid RACs may significantly impact Medicaid providers through their ability to audit a broad range of providers and claim types, utilize random sampling in states that have not used that method previously, and operate with fewer provider protections in certain states.

By statute, states must contract with Medicaid RACs on a contingency fee basis to recover overpayments and identify underpayments. Medicaid RAC contractors

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are required to coordinate with other state contractors and law enforcement agencies to avoid duplicating reviews and to report suspected fraud and abuse to the state.34

**Medicaid RAC Audit Process**

Based on responses to requests for proposals, states have awarded Medicaid RAC contracts to a patchwork of contractors, as shown in the following table.35

<table>
<thead>
<tr>
<th>Medicaid RAC</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myers and Stauffer, LC</td>
<td>Georgia, Hawaii, Louisiana, Wyoming</td>
</tr>
<tr>
<td>Cognosante, LLC</td>
<td>Missouri, North Dakota</td>
</tr>
<tr>
<td>HealthDataInsights</td>
<td>Kansas</td>
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<tr>
<td>OptumInsight</td>
<td>Iowa</td>
</tr>
<tr>
<td>Ingenix, Inc.</td>
<td>Kentucky</td>
</tr>
<tr>
<td>PRGX</td>
<td>District of Columbia, Mississippi, Rhode Island</td>
</tr>
<tr>
<td>Goold Health Systems</td>
<td>Alabama, New Hampshire</td>
</tr>
<tr>
<td>Public Consulting Group</td>
<td>North Carolina (shared with HMS)</td>
</tr>
<tr>
<td>Thompson Reuters</td>
<td>Indiana (HMS is subcontractor)</td>
</tr>
<tr>
<td>N/A</td>
<td>Arkansas (originally awarded to HMS, but state legislation opted not to pursue the contract), Florida (exemption to implement RAC approved by CMS), Maryland (in procurement process), Puerto Rico (seeking an exemption to the Medicaid RAC program), Tennessee (previously HMS, but the contractor did not renew the contract in 2014), South Dakota (exception to implement RAC approved by CMS), U.S. Virgin Islands (seeking an exemption to the Medicaid RAC program), Vermont (exemption to implement RAC approved by CMS), West Virginia (HMS opted not to renew the RAC contract)</td>
</tr>
</tbody>
</table>

34. 76 Fed. Reg. at 57, 811.
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With the exception of thirteen states that have obtained an exception, Medicaid RACs may audit claims 3 years from the date they are paid. The thirteen states may have a longer look-back period, such as New York’s 6-year look-back period. States must limit that number and the frequency of requested medical records, which generally equates to review of 1 percent of all claims submitted by a particular provider in the previous year. However, some states’ limitations vary, and CMS has granted exemptions to several states from requirements governing contingency fee caps, qualifications of the medical director, payment methodologies, and date of implementation. Additional distinctions amongst state requirements may develop as the delayed roll out of Medicaid RACs continues.

Unlike Medicare RACs, Medicaid RACs need not focus on particular target issues or types of claims. Medicaid RACs have great flexibility in choosing target areas for auditing and states have discretion to determine the types of required notice given to providers. Information on audit focus areas is available for a small number of states. For example, Colorado’s Medicaid RAC audits cover prepayment review of credit balance audits, incorrect billing and processing errors, and lack of medical necessity and post-payment data mining and medical records review. Some states appear to be auditing all types of providers, while others seem to audit only specific provider types. One popular Medicaid RAC audit target is credit balances. Other audit topics range from DRG coding to beneficiary office visit limits or dental claims. Overall, most states use automated reviews or data mining to identify claims requiring additional review, with some using random sampling or extrapolation. Record request limits and processes vary by state, reflecting the large flexibility in how states design and operate their programs. Certain state statutes and administrative codes establish rules for medical record requests and reimbursement for associated expenses.

As with Medicare audits, Medicaid RACs may perform various types of reviews to identify overpayments, including automated, semiautomated, and complex reviews. The Medicaid RAC will send the provider a Medical Record Request Letter covering claims at issue. In Illinois, providers have 21 days from the date of the request letter for a complex audit to submit the required documentation. HMS, the Medicaid RAC contractor servicing the most states, accepts records submitted electronically.

37. Supra note 34.
38. For further information on state-specific Medicaid RAC application, see CMS’ “Medicaid RACs at a Glance,” which contains the names of each state’s RAC contractor(s) and applicable exemptions, at http://w2.dehp.net/RACSS/Map.aspx.
41. Supra note 38.
Medicaid Audit Extrapolations

States may choose whether extrapolation for Medicaid audits is an allowed methodology for determining overpayments. For example, around twenty states use sampling and extrapolation to determine overpayments, while more than half of states do not use this method. Certain states, such as California and Connecticut, specifically regulate extrapolation to protect providers. Because of the significant variations on extrapolation among the states, providers should be aware of state law affecting use of extrapolated overpayments.

ERISA Audits

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum standards for retirement and health benefit plans in private industry. Although employers were not mandated to provide health insurance, those who chose to provide it were required to satisfy those minimum standards. ERISA does not cover health plans provided or maintained by federal or state governmental entities, churches, or plans only covering workers’ compensation, unemployment, or disability.

Under ERISA, qualified plans must provide procedural protections, including notice and a full and fair review, to beneficiaries and providers who accept assignment of their claims when adverse benefit determinations, or claims denials, are made. Agreements between providers and plans describe covered services for which the plan will reimburse the providers. However, covered services are defined by the ERISA plan, not the provider agreement. ERISA’s protections, when applicable, preempt state laws governing employee benefit plans. However, if the service is clearly not covered by the provider’s agreement with the plan, the claim was paid in error and state law may govern.

Practical Tips for Audit Preparation

In an environment of increased Medicare, Medicaid, and private payor audit activity, providers should prepare for audits before they happen. A provider's
compliance program, with a focus on appropriate billing standards, is the best defense against such audits. A robust compliance program allows a provider to identify potential issues and address them rather than allowing an auditor to find them and assess huge overpayment demands. In addition to establishing a robust compliance program, healthcare providers should consider the following steps.

**Establishment of an Audit Response Team**

Providers cannot prevent every audit, so they must be prepared to respond when receiving an audit request. The first step to prepare for a contractor audit is to designate a point person to coordinate any audit response. The point of contact should be the person who answers questions regarding where records are located, assists the auditor in setting up interviews with requested individuals, and sees that the auditor receives all requested records. After this point of contact is designated, personnel should be instructed to immediately direct all audit requests to this designated individual. The point of contact should also be familiar with the location of all relevant records so that audit responses are not delayed.

Because of the multiple types of audits with different time frames for response, it is important to have a tracking mechanism to ensure that the designated deadlines are met. For small organizations, this can be as simple as a spreadsheet. Larger organizations may want to consider investing in software designed to manage the intake and tracking of audit requests. Additionally, providers should make themselves aware of the applicable appeals process so that they can protect their rights throughout the audit process.

**Billing Policies and Procedures**

Providers should implement policies and procedures to ensure, insofar as possible, that claims are billed appropriately. When developing policies and procedures, providers should understand the billing and reimbursement standards for all contracted payors and know the terms of applicable contracts. Payors’ specific billing requirements should be incorporated in providers’ billing policies. Providers should also train their personnel on the billing policies and procedures so that everyone knows the standards that apply and understands the importance of compliance.

**Internal Monitoring and Corrective Actions to Address Billing Issues**

Because of the complexity of claims billing, it is impossible for providers to bill every claim perfectly. For that reason, providers should periodically audit their own claims to determine if there are any issues that should be addressed. Providers should base their internal audits on the risk areas or audit targets identified by payors. It may be helpful for providers to participate in provider outreach sessions offered by the audit contractors or payors for updates and tips. Staying up to date
with the latest audit trends can also help providers target areas of particular concern to auditors so they may perform self-audits to correct any systemic issues. Finally, if overpayments are identified, providers should refund the overpayments as required by applicable law or payor contract.

**Undergoing Audits**

Once an audit has been received, it should be routed to the designated point person responsible for responding to the request. The point person should review the request to determine whether the provider can fully respond using internal resources. Providers should ask for help from outside counsel when necessary. Outside counsel may be better able to monitor and document audits, defend providers’ rights, and appeal results depending on the provider’s resources. Response deadlines should be noted and docketed. Providers should not ignore deadlines, as a failure to respond may result in claims denials. If a provider determines it needs more time to respond, it should promptly ask for an extension from the contractor.

In responding to an audit, providers should offer complete documentation. Common audit errors leading to denied claims often include insufficient, missing, or illegible documentation. Providers should allow sufficient time to review documentation to be submitted to determine if additional records need to be gathered or an attestation provided to clarify illegible documentation. Providers should only sign statements attesting to the completeness of their records after reviewing the submission to make sure that all documents have been provided.

Before submitting requested records, providers should number the pages to ensure that all pages are received by the contractor. Providers should also copy the submitted records as proof of submission. Providers should send audit responses by a method that will allow the tracking of delivery, such as express or certified mail, and save proof of delivery of all submissions.

**Medicare Appeals**

When a provider receives Medicare claims audit results, it should carefully review the determination with knowledgeable staff or outside counsel to fully understand the denial reasons and appeal rights. If the results lack adequate information concerning the denial reasons or appeal rights and procedures, providers should immediately contact the audit contractor for additional information.

If a provider chooses to appeal the audit results, it should docket all appeal deadlines, which are typically strictly enforced. For Medicare appeals, these timelines vary at each level, so it is important to know the deadline at the outset of each appeal. Providers should consider developing an appeal tracking tool that keeps track of all appeal deadlines and the information submitted for appeals.

When appealing audit results, providers should submit a written position paper addressing both procedural and substantive arguments. For procedural arguments, providers should determine if the provider followed all of the applicable
rules when conducting the audit. Did the provider include claims in the audit that were time-barred from review? Did the provider apply the right standards? Billing requirements for Medicare, Medicaid, and commercial payors change periodically, so it is important for providers to know which standards govern the audit at issue.

For substantive arguments, providers should consider the denial reasons at each appeal level to determine available challenges. Audit contractors often deny claims for lack of meeting technical billing requirements. Providers should review all available records to see if technical billing requirements were actually met. If it appears that records are missing, providers should search their files to see if these records can be located to support the claims and submit these supplemental records as part of the appeal.

Providers must also address denials based upon lack of medical necessity, meaning that the audit contractor found that the patients did not actually need the services that were provided. As with the technical billing denials, providers should review the available records to determine if they can support the denied claims’ medical necessity. A medical expert who is knowledgeable of the services at issue can help to support medical necessity by preparing a written statement explaining why the services were actually necessary and appropriate. Providers also should consult with legal counsel to determine if additional legal arguments can be made.

If the audit results were determined using extrapolation, providers should assess the validity of the statistical sample, assess whether the contractor followed applicable guidelines, and employ applicable defenses against the extrapolation. For Medicare audits using extrapolation, providers may not invalidate the results by arguing that there were more precise methods available or the contractor failed to follow one or more Medicare Benefit Integrity Manual requirements. Rather, providers may challenge the validity of the sampling methodology by arguing that the use of the sample violates due process because the sample was not representative or statistically significant based on the actual statistical validity of the sample as drawn and conducted. This analysis will likely involve the engagement of a statistician. Providers should obtain all documentation related to the sampling calculations to allow a statistician the opportunity to conduct a full review and prepare a written report and oral testimony at a hearing.

**Challenging Medicare Audit Denials through the Medicare Appeals Process**

Providers who disagree with a Medicare contractor audit decision can appeal the results through a five-level appeals process. A provider may appoint a representative, such as a lawyer, to manage and argue its appeals, but must file the appropriate

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Appointment of Representative Form. Providers must strictly comply with the filing deadlines to avoid having an appeal dismissed for being untimely. Deadlines will only be extended if the provider can meet the high standards for good cause.

**Redetermination by a MAC**

Redetermination is the first level of appeal after the initial claim determination. A request for redetermination must be filed within 120 days of receipt of the remittance advice that details the payment determination. Providers should follow the advice in the remittance letter regarding appeal and may use the redetermination request form published by CMS. The MAC that reviewed the initial claim will also review the redetermination request, although the process will be conducted by a different internal reviewer. Providers should submit all available documentation to support payment of the claim at this level. The MAC will generally issue a redetermination decision within 60 days of receipt of the request for redetermination.

**Reconsideration by a Qualified Independent Contractor**

If a provider disagrees with a redetermination decision, it may file a request for reconsideration by a qualified independent contractor (QIC) within 180 days of receipt of the redetermination. Providers should again follow the advice in the remittance letter regarding appeal and may use the reconsideration request form published by CMS. The provider need not resubmit evidence already submitted at the redetermination level. However, to the extent the provider has new or additional evidence supporting claims payment, it must be submitted at the reconsideration level. If evidence is not submitted, it may be excluded in future appeal levels unless the provider can show good cause for why it was not submitted at an earlier level. Submission of additional evidence may extend the QIC’s decision deadline. Generally, the QIC will provide a decision within 60 days of receipt of the request. However, if the QIC cannot meet this deadline, the appeal may be escalated to an ALJ.

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50. Examples of good cause include serious illness, death in the provider’s immediate family, destruction of records by fire or natural disaster, the contractor’s failure to provide complete or correct information about how to request an appeal, the provider’s failure to receive the notice of the determination, or late receipt of the request by the contractor despite timely mailing. See 42 C.F.R. § 405.942(b)(3).
51. See 42 C.F.R. § 405.940 et seq.
53. See 42 C.F.R. § 405.960 et seq.
Administrative Law Judge Hearing

If a provider is dissatisfied with a reconsideration decision, it may file a request for a hearing before an ALJ within 60 days after receipt of the reconsideration. The provider should use the request for a Medicare hearing before the ALJ form published by the Office of Medicare Hearings and Appeals (OMHA). The claim must meet an amount in controversy requirement, which is updated annually. (The amount in controversy requirement for 2015 was $150.) The provider must request to aggregate claims, if applicable, in its request, explaining why the claims involve the same issues of law or fact. Hearings are conducted by phone, during which the provider will have an opportunity to present arguments in favor of payment of the claim. In some instances, CMS or its contractors will participate as parties at the hearing.

ALJs are required by regulation to provide a decision within 90 days of receipt of the request. However, extensive delays in the appeals process at the ALJ level have made this requirement functionally impossible to meet. Due to an exponential increase in Medicare appeals, partly fueled by the RAC program and inadequate resources within OMHA, requests for ALJ hearings submitted after April 1, 2013, are not being assigned for hearing to an ALJ until they can lessen the backlog of cases. OMHA anticipates assignment of appeals to ALJs will be delayed up to 28 months from the date of receipt of the requests for hearing. OMHA also predicts a delay of 20 to 24 weeks in entering or docketing new appeals into their case processing system. The average processing time for ALJ hearings during fiscal year 2015 was 547.1 days. Providers have the option of escalating their appeals to the Medicare Appeals Council (MAC) if the ALJ fails to issue a decision within the required time frame. However, many providers choose to wait for an ALJ hearing, where they can have a real-time discussion of the issues, which is often more favorable than the on-the-record reviews provided in the other levels of appeal.

Medicare Appeals Council Review

If a provider remains unsatisfied after the ALJ’s decision, it may appeal to the Medicare Appeals Council, the highest level of internal review of Medicare appeals within HHS, within 60 days of receipt of the ALJ’s decision. Providers should

55. See 42 C.F.R. § 405.1000 et seq.
58. 42 C.F.R. § 405.1016(a).
60. See 42 C.F.R. § 405.1100 et seq.
use the request for review of the ALJ Medicare decision or the dismissal form published by the Departmental Appeals Board. The Medicare Appeals Council normally issues decisions within 90 days of receipt of a request for review and 180 days if the case has been escalated from the ALJ level. If the Medicare Appeals Council does not complete its review within the applicable time frame, the appeal may be escalated to federal district court.

**Federal District Court**

If the provider desires to appeal its claims to the final level of review outside of the HHS administrative appeals process, it may file a request for judicial review in U.S. District Court as outlined in the MAC decision. There is a minimum amount in controversy requirement to file an appeal to federal district court, which is updated annually. The amount in controversy requirement for 2015 was $1,460.

**Recoupment of Overpayments and Assessment of Interest**

Medicare contractors are not allowed to recoup overpayments during the first two levels of appeal (redetermination and reconsideration) if the provider submits the appeals within the time period noted in the demand letter to avoid offset. This time limit is much shorter than the time for submitting the appeals. Interest will continue to accrue during these appeals until the overpayment is repaid. If a provider decides to continue appealing beyond the second level of appeal, CMS may begin collection of the overpayment. If the ALJ overturns the overpayment determination, CMS will refund the recouped principal and interest and pay interest on the principal amount CMS obtained from ongoing Medicare payment offsets.

**Statistical Sampling for Overpayment Extrapolations**

For many years, Medicare has used statistical sampling to calculate overpayment amounts for claims involving excessive amounts of records or a volume of claims too large for individual review. Courts have found statistical sampling to be

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62. 42 C.F.R. § 405.1136.
65. The legal basis for statistical sampling for overpayment extrapolation was first set forth by HCFA Ruling 86-1, which reads, “The use of statistical sampling to project an overpayment…does not deny a provider or supplier due process. Neither the statute nor regulations require that a case-by-case review
appropriate provided the extrapolation is formed from a representative sample of claims and is statistically significant.  

A contractor may only use extrapolation to determine overpayment amounts if there is a sustained or high level of payment error or if documented educational intervention has failed to correct the payment error. Determination of a high level of payment error may be ascertained through an MR unit or ZPIC, probe samples, data analysis, provider/supplier history, information garnered through an investigation, allegations of wrongdoing by current or former employees of the provider or supplier, or OIG audits or evaluations.

To perform an extrapolation, the period of claims must be selected and the universe, sampling unit, and sampling frame defined. Once the sampling plan has been designed, each sampling unit must be reviewed to determine whether there was an overpayment or underpayment. Finally, the overall overpayment or underpayment across all claims must be determined.

**Medicaid Appeals**

Medicaid RACs are required to notify providers of overpayment determinations within 60 calendar days of receipt of requested medical records. States must establish a sufficient appeals process under state law for review of adverse Medicaid RAC decisions and may rely on existing appeal structures.

**Challenging Medicaid Audit Denials through State Medicaid Appeals**

Providers who disagree with a Medicaid audit result may challenge the denial through an appeal. Unlike Medicare claims audits, there is no unified appeals process for Medicaid claims appeals. Each state has its own appeals process that must be followed to appeal adverse Medicaid claims decisions. Medicaid appeal processes are significantly different across states. Typically, the state will provide an opportunity for informal review of an issue, frequently by the Medicaid state agency, before a formal appeal or grievance level. The formal appeals process may involve several levels and be followed by judicial review. At the judicial review level, recoupment of the overpayment may no longer be stayed. The Medicaid appeals process must be followed to avoid waiving appeal rights.

**ERISA Appeals**

It is important for the purposes of an ERISA appeal to distinguish between a plan’s action that constitutes an adverse benefit determination and one that is simply the

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plan’s interpretation of the provider agreement. The former entitles the provider, through the beneficiary, to notice and appeal rights. Providers can appeal claims denials through the enforcement of the beneficiaries’ rights for payment. These appeals must be filed within 60 days of receipt of an adverse benefit determination. Many major ERISA plans are currently attempting to recoup money for ERISA claims from providers for alleged overpayments, citing various reasons, including waiver of copayments. The plans contend that their actions do not constitute adverse benefit determinations, but are billing disputes outside of ERISA protections. Although it has been long understood that claim denials trigger ERISA’s notice and appeal rights, recent case law extended those rights to recoupment decisions, requiring health plans to give providers appeal rights prior to recouping alleged overpayments. Significantly, in November 2012, the Department of Labor filed an amicus brief in a Third Circuit case and stated its position that retroactive overpayment demands are adverse benefit determinations under ERISA.

ERISA health plans’ aggressive recoupment tactics have led to multiple lawsuits across the country. Recently, the Supreme Court granted certiorari to hear a case on whether ERISA plans may recoup from a provider’s general assets if the money specific to the alleged overpayments has been spent. Circuit courts are currently split as to whether a plan may obtain an equitable lien on a provider’s assets under ERISA if the provider no longer possesses the actual overpaid funds.

Conclusion

Healthcare providers will continue to face an alphabet soup of audits from both public and private payors. Responding to audits and appealing adverse results are simply a cost of doing business in the healthcare space. However, providers can take steps to reduce the likelihood of an audit by ensuring that they are billing claims appropriately and have a plan in place to respond to any audit. In taking proactive steps, providers can increase the chance that they will not be targeted and best position themselves if an auditor does show up.

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68. 29 U.S.C. § 1132; see also, Tri3 Enterprises, LLC v. Aetna, Inc., 535 F. App’x 192, 196 (3d Cir. 2013); CardioNet, Inc. v. Cigna Health Corp., 751 F.3d 165, 177 (3d Cir. 2014) (finding that healthcare providers may obtain standing to assert ERISA claims on behalf of their patients by assignment from a plan participant). Group health plans have 180 days from receipt of an adverse benefit determination to appeal. 29 U.S.C. § 2560.503-1(h)(3).