Revenue Cycle Management Sessions
Day Two
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AUDITS AND APPEALS

Disclaimer
• The case studies presented here are real
• However, they are offered here as teaching examples only and it does not mean that your agency would experience a similar outcome
• Many examples involve the large-scale post-payment overpayment demands, but same guidelines apply to individual claim denials and appeals

The Goal...
Nuggets of information to help with your audits and appeals

Audits – In General

Enforcement is at an all time high

New Compliance Environment

THE NEW “ALPHABET SOUP” OF COMPLIANCE

RACs – Recovery Auditors
ZPICs – Zone Program Integrity Contractors
MIs – Medicaid Integrity Contractors
MFCUs – Medicaid Fraud Control Units
FERA – Fraud Enforcement Act of 2002
HEAT – Health care Fraud Prevention and Enforcement Action Team
1. You're Not Immune

- Any type of ambulance service can be (and has been) audited
  - Private, public
  - For profit, non-profit
  - Large, small
  - Fire based
  - Small volume or large

Examples

- Large Midwestern city subject to audit
  - 911 emergency services reviewed
  - Less than 200 total transports reviewed
  - $2.8 million overpayment demand (extrapolation)
  - Reduced to $25,000 on appeal

Examples

- East Coast Hospital-based service audited for ambulance services
  - Only represented 1% of gross revenue for hospital system
  - Emergency and interfacility transports audited
  - Appeal was pursued to prevent Medicare from expanding the audit to other hospital departments

Examples

- Large private Texas service subject to two large volume claim reviews (greater than 500 transports), and a pre-payment audit
  - $850,000 overpayment demand reduced to $100,000 after ALJ level
  - No extrapolation, just large volume of transports

Examples

- Small private Texas Ambulance service had a review of only 62 transports
  - $2.6 million overpayment demand reduced to $400,000
  - Extrapolation still used, but small number of trips deemed overpayments after ALJ level

Examples

- Small non-profit Midwest ambulance service faced 15 claim review of ALSE (A0427)
  - ZPIC “recoded” 12 ALS trips to BLS ($50 overpayment/claim; $550 total overpayment)
  - Low overall “error rate” (less than 8%) No extrapolation used; no further audit/investigation; no appeal
  - Compare with City of Dallas/ City of Clinton
Lessons Learned

• Audits cannot be avoided
• Not a matter of “if” – a matter of “when”
• Must be proactive and take steps to ensure results of the audit are positive
  • Self-audits
  • Self-correction
  • Minimize risks – better PCR documentation is critical!

2. Denials Happen

• RAC Auditors get a “commission” for detected overpayments – incentive to find errors.
  • BUT…
    • ZPIC and MAC audits are NOT commission-based
    • Most ambulance audits do not involve RACs, but are MAC and ZPIC-based, medical necessity reviews

Example

• One of the top 10 largest cities in the Country was audited for 911 Emergency trips
  • Initial $20 million overpayment demand (extrapolated), near 90% error rate detected by ZPIC
  • Medical necessity and signature issues
  • Demand reduced to $1.8 million in the appeal process
  • Appeal still ongoing

Lesson Learned

• No matter the type of business or quality of documentation, Medicare will find reasons for a denial (even if ridiculous or incorrect)
  • Medical necessity
  • Patient signature
  • Crew signatures
  • Excess mileage/nearest appropriate facility

3. You CAN Win An Appeal

• You think your documentation is good, but Medicare sees otherwise
• Frustrating process,
• ALJ is most favorable level for providers
  • But not a practical option at present

The “Appeal” Levels
**Fight Early**

- While first two levels can often be a “rubberstamp” of the initial determination, the fight now must be fought there.

**Example**

- A Texas entity had extrapolated $500,000 demand reduced to $3,000 at Redetermination level.
  - Sample dates (from TriCenturion audit) overlapped dates previously reviewed by TrailBlazer and previously recovered – resulted in double recovery if upheld.
  - Note client submitted letter directly (not on attorney letterhead) – possible strategy to consider?

**Lesson Learned**

- Don’t give up
- Be persistent
- Don’t be discouraged
- You can get a partial win in most cases
- Use the “kitchen sink” approach

**Quick Detour**

**Reopening vs. Redetermination**

**Example 1**

- After a document request, where a claim is denied for non-responsiveness, but documents are later provided as part of the Redetermination appeal, the MAC may treat the document submission as a “reopening” and not an appeal, and sends matter back to the ZPIC for processing.
- Restarts the appeal clock once a decision is rendered.

**Example 2**

- Claim is rejected (not denied) for invalid name, HIC, ICD Code or HCPCS Code.
- Biller realizes claim was billed improperly (i.e. wrong level of service).
- Proper course of action for administrative relief is “reopening” not a redetermination request.
Example 3

• Favorable Decision from QIC was reopened by the QIC, because the reason to reject use of extrapolation was not explained
• Reopened decision reopened again because some trips were not included in the decision

Example 3 (cont.)

• Letter from the QIC stated the second reopen was done in error and previous decision stood
  • Which decision? – It was unclear
• Third Reopened Decision was now final – QIC reported the letter to cancel the reopening was done in error – this final decision was now binding

4. An Audit Could Jeopardize Your Business

• Medicare has the upper hand
• Auditors often make unfavorable determinations
  • Vague application of “medical necessity” definition
  • You have the burden to show why the claim should be allowed
  • Appeals are the way to resolve
  • Generally, ZPICs and MACs will not entertain complaints or arguments in response to initial findings

Examples

• Pennsylvania ambulance service was forced to close down in wake of audit, because recoupment efforts restricted cash-flow
  • Predominately dialysis transports
  • Mostly Medicare transports
  • Without Medicare money, business floundered

Example

• Two Southern ambulance entities repaid the alleged overpayment amounts while awaiting ALJ Hearing
  • Chose to withdraw the ALJ appeal instead of continuing to wait
  • Desire to “move on”
  • Realized they had made errors

Examples

• California ambulance service chose to pay the alleged overpayment, shut down, and forego the appeals process in the wake of a post-payment audit with $500,000 demand
• Cited that “state and federal regulations are becoming too burdensome” to continue in the ambulance business
Lessons Learned

• Diversify business model
  • Don’t rely on one particular payer or type of transport
• Know when to throw in the towel on individual claims or the whole bunch – concessions aren’t always bad
• Use the audit as a learning experience

Lessons Learned

• Ensure compliance with Medicare billing requirements from the start – don’t learn Medicare rules because of an audit – by then it’s too late

5. You MUST Be Proactive

• Most audits start with a “document request” from ZPIC or MAC – must be responsive to the request
• Know the difference between the initial findings letter from ZPIC and overpayment demand letter from the MAC
• Pursue appeal where appropriate

Responding to an ADR – Palmetto Guidance

Question: Is it acceptable to highlight information in the medical records when responding to a Medical Review Additional Documentation Request (ADR)?

Answer: Medicare encourages providers to take the initiative and review medical records prior to submission. However, highlighting to draw attention to a specific part of the medical record may render the information unreadable. A better practice is to circle or mark the information with an asterisk.

Examples

• A Midwest ambulance service received an initial findings letter from the ZPIC, but no overpayment demand letter
  • Offset initiated
  • Letter was misdirected, because company was in the process of moving
  • Had to contact MAC to get duplicate copy of demand
Examples

• New York private service subject to probe and SVRS audit, both of which used extrapolation
• ZPIC consolidated entire overpayment calculation into one letter
• MAC separated components of the audit into multiple letters
• MAC caused confusion, ambulance service had to clarify the scope of the audit through multiple follow-up letters

Lessons Learned

• Cannot sit back and hope Medicare will figure everything out on its own or suddenly do the right thing
• Need to contact MAC, QIC, CMS Regional Office or Central CMS Office
• Find contacts at the MAC or QIC who can help you
• Make sure appeal is actually received – don’t assume it was

Pre-Payment Audits

• This allows Medicare to decrease reliance on the “pay and chase” postpayment audit model and prevent improper payments in the first place

History

• Popular several years ago (“Yellow Letters” used by a former MAC in Texas)
• Gaining popularity again as an audit tool – prevents improper payments on front end, instead of dealing with overpayments and recoupment efforts

History

• Novitas (in Texas, especially) and Noridian (in California, especially) is using the pre-payment tool again
• Noridian (MAC) and Health Integrity (ZPIC) are also performing on-site audits and pre-payment reviews to ensure compliance before payment is made

Post-Payment Audits

• Medicare pays first, then performs an audit (perhaps 4 years later) to find and recover overpayments
History

- Medicare post-payment audits are often triggered by
  - Complaints
  - Data mining
  - Whistleblowers

- Common tool, usually involves use of extrapolation
  - On-site visit, or document request by mail
  - Usually leads to recoupment efforts
    - Offset
    - Withhold
    - Takeback

Why it is Used

- Moneymaker!
- A way for Medicare to find fraud
- Used as “probe” sample, to trigger a second, larger audit
- Find the “bad apples”

How to Handle

- Be responsive to Document Requests (ADRs)
  - Failure to Respond can result in automatic denials
  - Appeal when you believe you are correct
  - Do NOT
    - Stop submitting claims completely
    - Hold certain types of claims

Resolution

- Cooperation is key – do your best to follow what the MAC expects
  - Applies to pre-payment review, as well as prior authorization process
  - Don’t argue with MACs and ZPICs
  - Save arguments for appeals

Medicare Appeals
Medicare Appeals

• After appeal is filed:
  • No warning a decision is coming
  • Usually decisions are not sent by a trackable method
  • Decision letters have been lost in the mail (or missed)
  • Important Medicare decisions have come like this…

The Current Theme with Medicare Appeals…

Delay at the ALJ Level

• At least 4 years from time appeal is filed until ALJ hearing
• Over 750,000 appeals in queue
• Approximately 75,000 appeals handled annually
• So, mathematically, this could mean a 10 year wait for an ALJ hearing

Good News

• Able to talk to a human – no paper-pushing back and forth between you and the Medicare Contractors
• Greatest degree of “victory” at the ALJ level (compared to MAC and QIC)

Example

• A NJ company with thousands of claims subject to review had a Video Conference Hearing
  • This is unusual
  • Usually hearings are done by telephone
  • In-person hearing is even more unusual

Case Studies
The Cases of The Missing Documentation

Facts – Case 1
- A private California company responded to document request via faxing option
  - ZPIC lost the documents
  - Trips were denied for failure to respond
  - Had to appeal and provide records as part of appeal

Facts – Case 2
- Small Midwestern service appealed to the Redetermination level, offset initiated
  - Contacted the MAC, and the service was advised the appeal was never received
  - USPS tracking records proved otherwise, but the appeal had to be resubmitted
  - Decision noted the appeal was received timely

The Case of the Partial Decision
- Small Midwestern ambulance service pursued appeal to QIC level challenging both individual overpayments and use of extrapolation
  - Reconsideration Decision only discussed the individual transports, no mention of the extrapolated overpayment
  - Contacted the QIC which agreed to reopen to address the extrapolation component

The Cases of the Inattentive MAC
Facts – Case 1
• Virginia ambulance services received a favorable QIC decision, abandoning use of extrapolation, greatly reducing total overpayment
  • MAC failed to follow plain language of QIC decision by issuing a revised overpayment demand which improperly included the use of extrapolation
  • Ambulance service had to follow-up with MAC to ensure QIC decision was followed
  • Total liability reduced to $8,400

Facts – Case 2
• NY ambulance services received a favorable QIC decision, abandoning use of extrapolation, greatly reducing total overpayment
  • MAC failed to follow plain language of QIC decision by improperly recouping over $400,000
  • Used pressure from Regional Office and Senator to ensure QIC decision was followed
  • Total liability less than $70,000, and previously recouped money was returned

Facts – Case 3
• A Southeastern ambulance service faced a large overpayment demand, using extrapolation
  • MAC statistician issued report noting use of extrapolation was invalidated
  • That report was not followed by MAC
  • Ambulance service had to highlight that report in appeals to get extrapolation invalidated
  • Still pending at ALJ level

The Case of the Improper Recoupment
(and another where Recoupment was proper)

History
• In a post-payment audit and overpayment demand:
  • Interest continues to accrue
  • Offset can occur
  • Offset can be avoided if file:
    • Redetermination Appeal within 30 days of initial determination, and
    • Reconsideration Decision within 60 days of Redetermination Decision

History
• Offset/recoupment can also be avoided if:
  • Repayment is made in full
  • Extended Repayment Plan is entered into
  • Declaring Bankruptcy may have an impact on CMS’s ability to recover the total amount, but will likely not stop recoupment/offset activity
Facts – Case 1

• A Southeastern ambulance service appealed promptly to avoid offset
• Medicare regulations preclude offset if Redetermination Appeal is filed within 30 days, and if Reconsideration Appeal filed within 60 days (of previous decision)
• MAC improperly initiated offset when appeal was filed and pending

The Citations

• 42 CFR § 405.379(d)
  • (d) General rules. (1) Medicare contractors can begin recoupment no earlier than 41 days from the date of the initial overpayment demand but shall cease recoupment of the overpayment in question, upon receipt of a timely and valid request for a redetermination of an overpayment, if the recoupment has not yet gone into effect; the contractor shall not initiate recoupment.
  • (2) If the redetermination decision is an affirmation in whole or in part of the overpayment determination, recoupment may be initiated or resumed in accordance with paragraph (a) of this section.
  • (3) Upon receipt of a timely and valid request for a reconsideration of an overpayment, the Medicare contractor shall cease recoupment of the overpayment in question. If the recoupment has not yet gone into effect, the contractor must not initiate recoupment.

The Citations

• 42 CFR 405.379(e)
  • (e) Initiating or resuming recoupment after redetermination decision. (1) Recoupment that has been deferred or stopped may be initiated or resumed if the debt (remaining unpaid principal balance and interest) has not been satisfied in full and the provider or supplier has been afforded the opportunity for rebuttal in accordance with the requirements of §§405.373 through 405.375. Recoupment may be resumed under any of the following circumstances:
    • (i) Immediately upon receipt by the Medicare contractor of the provider’s or supplier’s request for a withdrawal of a request for a redetermination in accordance with §405.952(a).
    • (ii) On the 60th calendar day after the date of the notice of redetermination issued under §405.956 if the redetermination decision is an affirmation in whole of the overpayment determination in question.
    • (iii) On the 60th calendar day after the date of the written notice to the provider or supplier of the revised overpayment amount, if the redetermination decision is an affirmation in part, which has the effect of reducing the amount of the overpayment.
  • (2) Notwithstanding paragraphs (e)(i), (ii) and (iii) of this section, recoupment must not be resumed, or if resumed, must cease upon receipt of a timely and valid request for a reconsideration by the QIC.

Contrast

• A Northeastern ambulance service received an overpayment demand, but offset initiated almost immediately
  • MAC was contacted, and MAC advised that an “automatic offset/recoupment” form had previously been filed
  • Form was valid until revoked

Lessons Learned

• Need to be familiar with the appeal rules
  • Cannot trust Medicare will act correctly
  • Advise contractors of mistakes – find helpful people
  • Raise errors and problems in the appeal process
  • Know what you sign, and what impact it can have on future events

The Cases of The Extended Repayment Schedule
History
- In large dollar amount demands, ERP can be used to prevent offset
- Still involves monthly payments
- Can be financially crippling

Facts – Case 1
- Three Mid-Atlantic ambulance services used ERP to avoid offset
  - Business suffered
  - Repayment plan was abandoned after some time in one case
  - Better option than offset, but still involves interest

Facts – Case 2
- An Ohio ambulance service was able to negotiate a settlement with CMS for ERP
  - Interest was not included in the settlement amount
  - Very rare
  - Medicare always wants the interest (who wouldn’t at 10%?!) 

The Citations
- 42 CFR 401.607(c)(2) and (3)
- Medicare Financial Management Manual, Chapter 4, Debt Collection

Lessons Learned
- ERP difficult to maintain over time
  - Must disclose financial records if requesting a repayment plan longer than 12 months
  - Medicare desires short repayment schedule (usually less than 27 months)
- High interest rate (around 10%)
- Use bank loan instead
- Consider bankruptcy

The Cases of the Extrapolated Overpayment Demand
History

• Legitimate tool Medicare is authorized to use

• But also limited by statute 42 USC 1395ddd(f)(3)

What It Means

• Applies to post-payment audits

• Causes exorbitant increase in the demand
  • Every “denied dollar” can equal tens of thousands of dollars in overpayment demand

• Must be performed correctly by MACs and ZPICs – sometimes it is not, and it’s use can be challenged

• History of successful appeals

Why it is Used

• Moneymaker!

• Medicare contractors have the ability to use it to recover lots of cash, and sometimes are overzealous in its application and use

Facts – Case 1

• Ohio service only had small number of claims audited and denied
  • Appealed to prove a point
  • Prevent the small audit from being a “probe” to warrant a second audit
  • Avoid setting precedent for similar trips

Facts – Case 2

• A Southern ambulance service was subject to a small audit (30)
  • 17 deemed overpayments
  • Extrapolation used
  • $275,000 demand
  • Each “denied trip” worth thousands of extrapolation dollars

Facts – Case 3

• Another Southern ambulance service saw a claim review, with a low error rate (less than 10%)
  • Extrapolation not used from the start because the error rate was so low
  • No clear line in the sand as to what a “low” enough rate may be to avoid extrapolation
  • Less than 15% seems to be safe, but that low a number is a rare audit finding
Facts – Case 4
• A Southern ambulance service saw the use of extrapolation invalidated at the ALJ level due to no valid probe review
  • Older case, before changes in the law
  • Issue involved proof that the sample upon which extrapolation was based was an “SVRS”

Facts – Case 5
• A West Virginia service had use of extrapolation invalidated due to errors in sampling $675,000 overpayment demand was reduced to $1,200
  • MAC failed to perform the calculations correctly or retain sufficient documentation of the process employed

Facts – Case 6
• A major US City saw the use of extrapolation invalidated because of a discrepancy in the claims and date range subject to the review
  • MAC statistician unable to replicate sample and methodology as used by ZPIC in the initial review
  • Extrapolation methodology flawed for lack of supporting documentation

Important Development
• In several recent cases, use of extrapolation was “abandoned” by the QIC due to lack of notice to beneficiaries whose claims were subject to extrapolation – unable to identify them
  • Midwestern service saw $450,000+ extrapolated overpayment demand reduced to $2,200 after Reconsideration Decision abandoned extrapolation

Lessons Learned
• Extrapolation can be challenged and in most cases, must be challenged
• Use statistical expert
• Challenge legal and mathematical components
• Medicare must use extrapolation correctly, and provide their work to support the calculations
• Low error rate ≠ no extrapolation

The Case of the Treasury Department Referral
Facts – Case 1
• Overpayment demand caused a Texas entity to close
  ▪ No current claims, so no offset
  ▪ Demand was referred to US Treasury Department, then a collection agency
  ▪ Ambulance service claimed inability to pay, settlement with HHS ongoing

How to Handle
• Some CMS Contractors are too quick to refer to Treasury – while an appeal is still pending
• Need to work with collection agency and advise of the appeal and cite to rule limiting recoupment
  ▪ 42 CFR 405.379 “Limitation on recoupment of provider and supplier overpayments”

The Case of the Remand

Facts – Case 1
• Ohio company saw the DAB/MAC remand to ALJ, then ALJ remanded to QIC
  ▪ Important question about use of extrapolation and lack of information provided to ambulance service
  ▪ Ultimately got back up to DAB/MAC again
  ▪ Awaiting final resolution

Lesson Learned
• Stick with it – be patient
• If you can afford to stay in business, keep fighting, use ERP, refund, or bank loan to avoid offset/recoupment
• If repay more than what is owed after future appeals Medicare owes money back to you – sometimes with interest at same prevailing rate (around 10%)
The Case of the Consolidation

Facts
- Pennsylvania Case involved consolidation of provider and patient appeals – fully favorable – quicker resolution
- Both ambulance and one (of 20) patient appealed the Reconsideration Decision
- Partially favorable decision (many claims allowed in an on-the-record decision)
- Strategy for the future?

The Cases of the Uneducated ALJ

Facts – Case 1
- ALJ in a Texas case gave great deference to PCS, despite medical necessity not being clearly documented on the PCR
- Found favorable decisions for numerous NE trips, based largely on the mere presence of a PCS

Facts – Case 2
- ALJ in a Northeast area case admitted that it was his first ambulance overpayment case, and that he was not familiar with the ambulance regulations
- Ambulance service educated the ALJ in the hearing, and the ultimate (largely favorable) decision mirrored the arguments the ambulance company made during the appeal

Facts – Case 3
- North Carolina ambulance service had large sample audited, many already paid on appeal
- 20 conceded as not payable, only 15 appealed to ALJ
- ALJ only considered the 15, and found them all payable, determining $0 overpayment, and therefore found extrapolation “null and void”
- ALJ failed to factor in the 20 conceded trips
Variation – The Clueless QIC

- Failed to render a decision for some of the trips
  - Instead of reporting “Favorable” or “Unfavorable,” the QIC could not decide
  - Reported “Maybe” as to whether the trip was payable or not

Lessons Learned

- Be confident
- Make all necessary arguments (within reason, of course!)
- You never know who will be deciding your case
- Sometimes you get lucky

The Cases of the Waiver of Liability

History

- Certain “limitation of liability” or “waiver of liability” concepts exist
- “Knew of should have known”
- Complex statutory concepts, usually don’t result in a “win” for ambulance services
- There are some nuances and arguments to use

Facts – Case 1

- Ohio appeal saw a Redetermination decision invalidate the ability for any recovery by Medicare
  - SSA1870 argument “waiver of liability”
  - Huge delay between time audit started and time demand was issued
  - Review appeared to be hung up in possible fraud investigation
  - No recovery if demand comes 5 years after review

Facts – Case 2

- MACs and the QIC sometimes determine that the beneficiary cannot be billed for medical necessity denials – this is WRONG
  - Usually includes a reference to not having an ABN
  - Need for ABN for “medical necessity” denials for ambulance is DIFFERENT than for other health care providers
The Citations

- SSA 1870
- SSA 1879
- “The Medicare Ambulance Benefit & Statutory Bases for Denials of Claims”
  - Located on CMS Ambulance web page (right side, about halfway down the page)

The Case of the Payment Suspension

Facts

- Pre-payment audit or certain subset of transports
- Approximate 20% “error rate” detected
- On appeal, many trips were paid (error rate <5%)
- Second pre-payment review initiated on larger universe
- Payment suspension initiated

Facts

- Rationale for suspension – threat of overpayments or risk of claims being paid improperly
- Post-payment audit initiated
- Used rebuttal process to challenge initiation of suspension
- Had call with CMS and ZPIC

Resolution

- Arguments were convincing, as CMS agreed to:
  - Cease all pending ADR (pre-payment reviews)
  - Cease post-payment review
  - Cease payment suspension

Citations

- 42 CFR 405.371 (a)(1) - allows for suspension when there is “reliable information that an overpayment exists or that the payments to be made may not be correct”
- 42 CFR 405.371 (b)(1)(iii) - allows a good cause exception to not use suspension “if other available remedies implemented by CMS or a Medicare contractor more effectively or quickly protect Medicare funds than would implementing a payment suspension.”
Parting Thoughts

Closing Strategies

- Prevention Before The Audit
  - Good solid clinical documentation essential – field crew training an absolute must
  - Educate the facilities on medical necessity, PCS completion
- Get all records early – including hospital and facility records and submit with original request for documents

Closing Strategies

- Get medical director input early – consider submitting “Medical Review Summaries” with the initial documents or at redetermination level
- Highlight key points on records that support payment of the claim – but not with a highlighter!
- Organization of all submissions is very important – make their job easier to see it your way