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INTRODUCTION

- Hawley Troxell's Health Law practice group
  - Boise Office – Tom Mortell, Chair, John Ashby, Mark Peterson, Mindy Muller, Chelsea Porter
  - Idaho Falls Office – Marvin M. Smith, Marvin K. Smith, Austin Strobel
  - Pocatello Office – Howard Burnett, Julian Gabiola
- Firm represents hospitals and physicians all across Idaho and western Wyoming

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INTRODUCTION

- Firm provides legal services for Idaho's hospitals for health care law, medical malpractice defense, employment, business transactions, tax, and intellectual property
- We are active politically on issues hospital industry cares about
  - Medicaid expansion in Idaho
  - Affordable Care Act
  - Health care reform

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DISCLAIMER

- This seminar and our discussion today does not establish and attorney-client relationship
- We are not providing legal advice that may relate to a specific problem or issue that you are facing
- If you have legal issues, obtain legal advice from your attorney or call us off-line

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WHAT WE WILL COVER

- Medicare appeals
- Medicaid appeals
- Audits
- Repayments
- Not covering fraud and abuse enforcement, investigations and repayments

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QUICK REVIEW OF OTHER AREAS OF THIRD PARTY CLAIMS TO CONSIDER

- Estate Claims – (1)must timely file claims against the estate; (2) Follow-up on claim in probate process
- Bankruptcy – (1) Critical to File Proof of Claim – should be filed every time; (2) Follow-up differently depending upon what chapter and circumstances
- Medical Indigency – Can be a large source of reimbursement for providers. Complicated process that requires expertise to navigate
- Involuntary Treatment- Applies to any kind of health care at the commencement of the involuntary hold. Judges tend to default to fixing costs on patients and have to challenge decisions where appropriate

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MEDICARE AND MEDICAID APPEALS

- Medical providers can appeal both Medicare and Medicaid claim denials
- Unsurprisingly, the appeals process for Medicare and Medicaid is governed by a relatively complicated web of regulations and rules
- Thus, many times providers often do not pursue appeals of these decisions.
  - However, in a report published in 2018 by the U.S. Department of Health, the department found that from 2014-2016, roughly 75% of denials that were appealed were overturned.
- The appeals process under these two programs is different. This presentation is designed to provide a general overview of the appeals process under both the Medicare and Medicaid programs

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MEDICARE APPEALS OVERVIEW

- Medicare Appeals are governed by Title 42, Chapter IV, Subchapter B, Part 405
- Heath care providers may appeal processed claims after an initial determination has been made
- There is a procedure to address clerical errors apart from the appeal process
- If the issue is not a clerical error, then a provider may appeal a denial. There are five levels of appeals

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CLERICAL ERROR REOPENING (CER) 45 CFR § 405.980

- Not technically an appeal. Used to reopen a claim after a denial when a clerical error is the cause of a denial
- Clerical errors are things like:
  - Transposed procedure or diagnostic codes
  - Inaccurate data entry
  - Mathematical or computational mistakes
- CER's may be requested
  - Within 1 year from the date of initial determination for any reason;
  - Or 4 years for good cause as defined under 405.986 (new and material evidence that was not available or known at time of initial determination that may result in different outcome)

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CLERICAL ERROR REOPENING (CER) 45 CFR § 405.980

- Things that **can** be addressed with a CER:
  - Number of units billed
  - Adding a diagnosis code
  - Changing a CPT code
  - Changing a date of service
  - Adding modifiers
  - Changing billed amounts

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CLERICAL ERROR REOPENING (CER) 45 CFR § 405.980

- Things that **cannot** be addressed with a CER and require an appeal:
  - Any part of a denied line item on a partially paid claim
  - Any part of a denied line item by Medical Review
  - Ambulance services
  - Medicare Secondary Payer (MSP) issues
  - Issues where a Recovery Auditor (RAC) demand is involved

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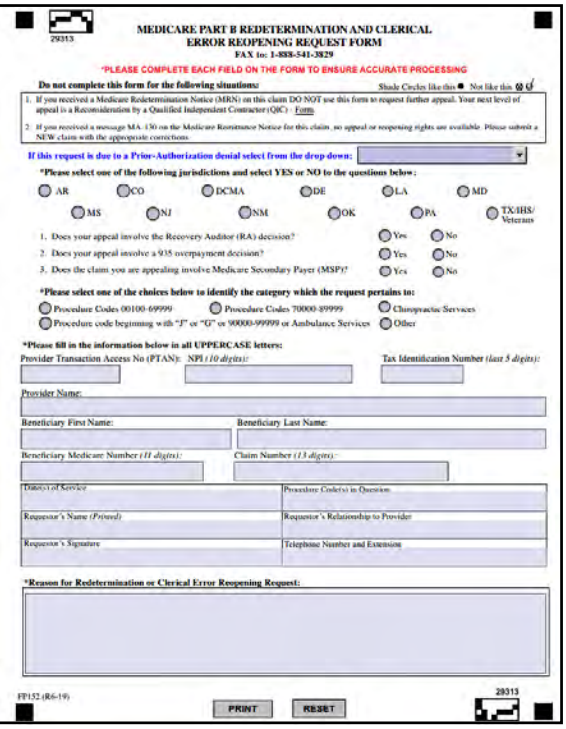
FORM FOR CER

https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00008291



MEDICARE PART B REDETERMINATION AND CLERICAL ERROR REOPENING REQUEST FORM

FAX to: 1-888-541-3829

*PLEASE COMPLETE EACH FIELD ON THE FORM TO ENSURE ACCURATE PROCESSING

Do not complete this form for the following situations:

1. If you received a Medicare Redetermination Notice (MRN) on this claim DO NOT use this form to request further appeal. Your next level of appeal is a Reconsideration by a Qualified Independent Contractor (QIC) - Form
2. If you received a message MA 130 on the Medicare Remittance Notice for this claim, no appeal or reopening rights are available. Please submit a NEW claim with the appropriate corrections

If this request is due to a Prior-Authorization denial select from the drop down:

*Please select one of the following jurisdictions and select YES or NO to the questions below:

AR CO DCMA DE LA MD MS NJ NM OK PA TX/HHS/Veterans

1. Does your appeal involve the Recovery Auditor (RA) decision? Yes No
2. Does your appeal involve a 935 overpayment decision? Yes No
3. Does the claim you are appealing involve Medicare Secondary Payer (MSP)? Yes No

*Please select one of the choices below to identify the category which the request pertains to:

Procedure Codes 00100-69999 Procedure Codes 70000-89999 Chiropractic Services
Procedure code beginning with "J" or "G" or 90000-99999 or Ambulance Services Other

*Please fill in the information below in all UPPERCASE letters:

Provider Transaction Access No (PTAN): NPI (10 digits): Tax Identification Number (last 5 digits):

Provider Name:

Beneficiary First Name: Beneficiary Last Name:

Beneficiary Medicare Number (11 digits): Claim Number (13 digits):

Date(s) of Service | Procedure Code(s) in Question

Requestor's Name (Printed) | Requestor's Relationship to Provider

Requestor's Signature | Telephone Number and Extension

*Reason for Redetermination or Clerical Error Reopening Request:

CMS-29313 (R6-19) PRINT RESET 29313

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APPEALS FOR MEDICARE PARTS A & B

- Beneficiaries, providers, and suppliers are considered "parties" and may appeal an initial claim determination
- There are five levels of appeal
  - Redetermination
  - Reconsideration
  - Administrative Law Judge (ALJ) Hearing
  - Medicare Appeals Council Review
  - Judicial Review in Federal Court

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FIRST LEVEL OF APPEAL:
REDETERMINATION BY MEDICARE ADMINISTRATIVE CONTRACTOR (MAC)

Question	Answer
When must I file a request?	You must request a redetermination within 120 days from the date of receipt of the Electronic Remittance Advice (ERA) or Standard Paper Remittance Advice (SPR) that lists the initial determination
How do I file a request?	File your request in writing by following instructions in the ERA or SPR. Use the Medicare Redetermination Request (Form CMS-20027), or any written document
	REMEMBER • You or your representative must include your name and signature • Attach any supporting documentation • Keep a copy of all appeals documentation you send to Medicare
Who makes the decision?	Medicare Administrative Contractor (MAC) staff uninvolved with the initial claim determination perform the redetermination. Current MAC contractor in Idaho is Noridian Healthcare Solutions

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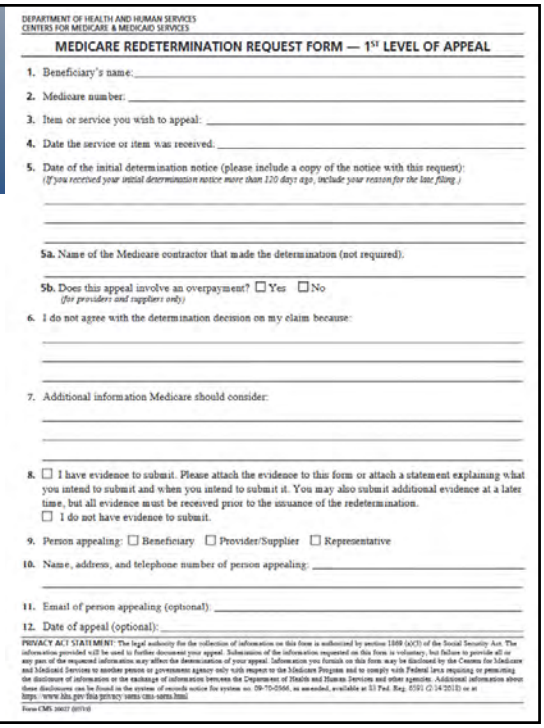
FORM FOR REDETERMINATION

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20027.pdf



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM — 1ST LEVEL OF APPEAL

1. Beneficiary's name: _____
2. Medicare number: _____
3. Item or service you wish to appeal: _____
4. Date the service or item was received: _____
5. Date of the initial determination notice (please include a copy of the notice with this request):
(If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)

5a. Name of the Medicare contractor that made the determination (not required).

5b. Does this appeal involve an overpayment? ☐ Yes ☐ No
(for providers and suppliers only)

6. I do not agree with the determination decision on my claim because:

7. Additional information Medicare should consider:

8. ☐ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.
☐ I do not have evidence to submit.

9. Person appealing: ☐ Beneficiary ☐ Provider/Supplier ☐ Representative

10. Name, address, and telephone number of person appealing: _____

11. Email of person appealing (optional): _____

12. Date of appeal (optional): _____

PRIVACY ACT STATEMENT: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 83 Fed. Reg. 6591 (2/14/2018) or at https://www.hhs.gov/foia/privacy/sorns/cms-sorns.html

Form CMS-20027 (07/18)

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SECOND LEVEL OF APPEAL: RECONSIDERATION BY AN QUALIFIED INDEPENDENT CONTRACTOR

Question	Answer
When must I file a request?	You must file a request for reconsideration within 180 days of receipt of decision from the first appeal

How do I file a request?	File your request in writing by following instructions provided on the decision from the first level of appeal. Use the Medicare Reconsideration Request (Form CMS-20033), or any written document that contains the required elements listed in the first decision
	REMEMBER
	• Clearly explain why you disagree with the redetermination decision and submit:
	  • A copy of the original denial and the first level appeal denial
	  • The beneficiary name and Medicare number
	  • Any missing evidence noted in the redetermination
	  • Any other relevant appeal evidence or documentation
	  • The name of the MAC that made the redetermination
	NOTE: Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you demonstrate good cause for submitting the evidence late

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SECOND LEVEL OF APPEAL: RECONSIDERATION BY AN QUALIFIED INDEPENDENT CONTRACTOR (CONTINUED)

Question	Answer
How long does it take to make a decision?	Generally, a decision is sent by the independent contractor to all parties within 60 days of receipt of the request for reconsideration. If the independent contractor cannot complete its decision in the applicable timeframe, it informs you of your rights and the procedures to escalate the case to Office of Medicare Hearings and Appeals (OMHA) **NOTE: If you do not receive a decision on the reconsideration within 60 days, consider allowing an additional 5 to 10 days for mail delays before escalating your appeal to OMHA**

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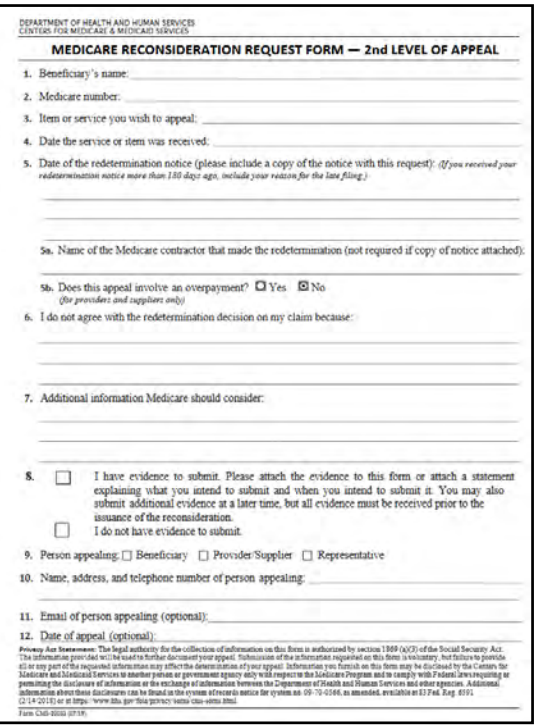
RECONSIDERATION REQUEST FORM



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE RECONSIDERATION REQUEST FORM — 2nd LEVEL OF APPEAL

1. Beneficiary's name:
2. Medicare number:
3. Item or service you wish to appeal:
4. Date the service or item was received:
5. Date of the redetermination notice (please include a copy of the notice with this request): *(If you received your redetermination notice more than 180 days ago, include your reason for the late filing.)*

5a. Name of the Medicare contractor that made the redetermination (not required if copy of notice attached):

5b. Does this appeal involve an overpayment? ☐ Yes ☒ No
(for providers and suppliers only)

6. I do not agree with the redetermination decision on my claim because:

7. Additional information Medicare should consider:

8. ☐ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the reconsideration.
☐ I do not have evidence to submit.

9. Person appealing: ☐ Beneficiary ☐ Provider/Supplier ☐ Representative

10. Name, address, and telephone number of person appealing:

11. Email of person appealing (optional):

12. Date of appeal (optional):

Privacy Act Statement. The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 83 Fed. Reg. 6591 (2/14/2018) or at https://www.hhs.gov/foia/privacy/sorns/cms-sorns.html.

Form CMS-20033 (07/19)

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20033.pdf

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THIRD LEVEL OF APPEAL:
DECISION BY AN ADMINISTRATIVE LAW JUDGE (ALJ) WITH THE OFFICE OF MEDICARE HEARINGS AND APPEALS (OMHA)

Question	Answer
When must I file a request?	You must file a request for an Administrative Law Judge (ALJ) hearing within 60 days of receipt of the reconsideration decision letter
How do I file a request?	File your request in writing by following the reconsideration letter instructions. You may also request an ALJ hearing by completing the Request for ALJ Hearing or Review of Dismissal (Form OMHA-100) REMEMBER • **To have an attorney represent you at the hearing you must complete an Appointment of Representative form** • You must send a copy of the ALJ hearing request to all other parties. • The ALJ sets hearing preparation procedures.
Who makes the decision?	The ALJ or attorney adjudicator makes the decision. If the OMHA cannot complete a decision in the applicable timeframe, it informs you of your rights and procedures to escalate the case to the Council If no referral is made to the Council, and the ALJ or attorney adjudicator decision overturns a previous denial (in whole or in part), the AdQIC notifies the MAC it must pay the claim, according to the OMHA decision, within 30–60 days

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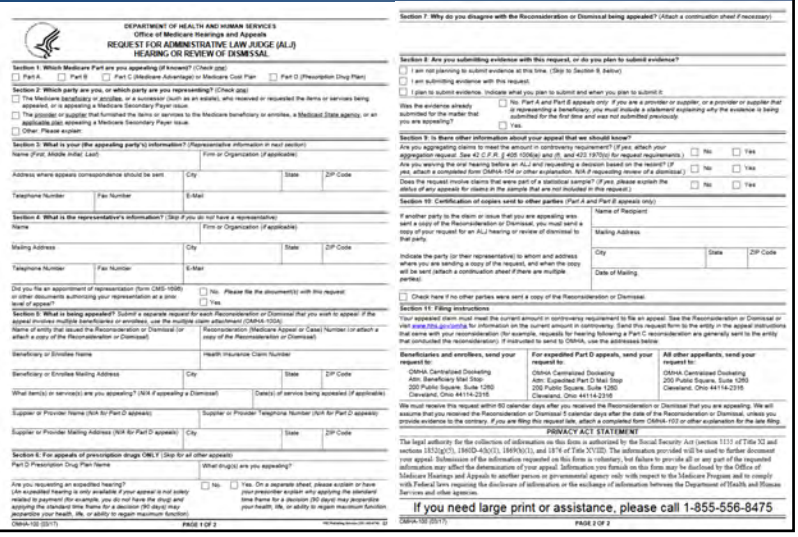
ALJ REQUEST FORM

https://www.hhs.gov/sites/default/files/OMHA-100.pdf



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals
REQUEST FOR ADMINISTRATIVE LAW JUDGE (ALJ) HEARING OR REVIEW OF DISMISSAL

If you need large print or assistance, please call 1-855-556-8475

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FOURTH LEVEL OF APPEAL: REVIEW BY THE MEDICARE APPEALS COUNCIL (COUNCIL)

Question	Answer
When must I file a request?	You must file your request for Council review within 60 days of receipt of the ALJ's decision or after the OMHA decision timeframe expires
How do I file a request?	File your request in writing by following OMHA instructions. You may also request a Council review by completing the Request for Review of ALJ Medicare Decision/Dismissal (Form DAB-101) or the electronic version accessible through the DAB E-File webpage REMEMBER • Explain which part of the OMHA decision you disagree with and your reasons • You must send a copy of the Council review request to all the parties included in OMHA's decision
Who makes the decision?	The Council makes the decision. The Council may deny review, or remand the case to the ALJ or attorney adjudicator. If the Council cannot complete its decision in the applicable timeframe, it informs you of your rights and procedures to escalate the case to U.S. District Court The Council forwards the decision and case file to the AdQIC, the central manager for all Council FFS Medicare claim case files If the Council decision overturns a previous denial (in whole or in part), the AdQIC notifies the MAC it must pay the claim according to the Council's decision within 30–60 days

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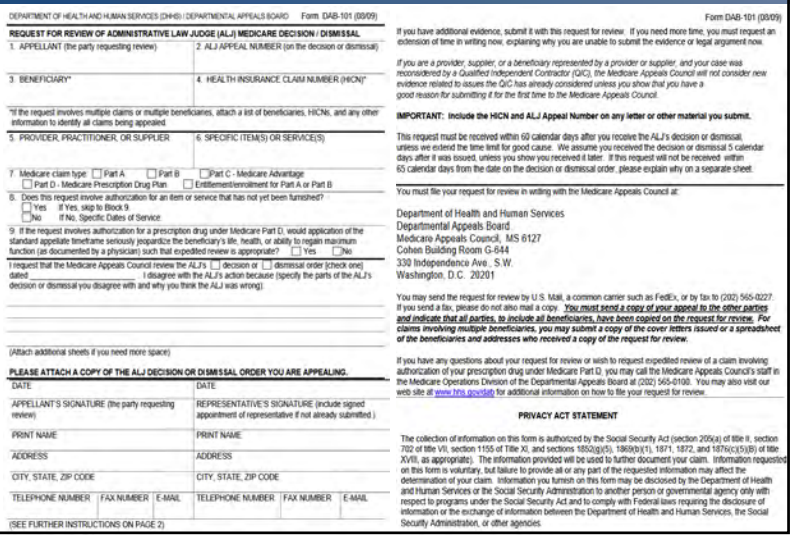
FORM TO REQUEST REVIEW BY THE COUNCIL



DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) / DEPARTMENTAL APPEALS BOARD Form DAB-101 (08/09)

REQUEST FOR REVIEW OF ADMINISTRATIVE LAW JUDGE (ALJ) MEDICARE DECISION / DISMISSAL

1. APPELLANT (the party requesting review) | 2. ALJ APPEAL NUMBER (on the decision or dismissal)

3. BENEFICIARY* | 4. HEALTH INSURANCE CLAIM NUMBER (HICN)*

*If the request involves multiple claims or multiple beneficiaries, attach a list of beneficiaries, HICNs, and any other information to identify all claims being appealed.

5. PROVIDER, PRACTITIONER, OR SUPPLIER | 6. SPECIFIC ITEM(S) OR SERVICE(S)

7. Medicare claim type: ☐ Part A ☐ Part B ☐ Part C - Medicare Advantage ☐ Part D - Medicare Prescription Drug Plan ☐ Entitlement/enrollment for Part A or Part B

8. Does this request involve authorization for an item or service that has not yet been furnished?
☐ Yes If Yes, skip to Block 9.
☐ No If No, Specific Dates of Service:

9. If the request involves authorization for a prescription drug under Medicare Part D, would application of the standard appellate timeframe seriously jeopardize the beneficiary's life, health, or ability to regain maximum function (as documented by a physician) such that expedited review is appropriate? ☐ Yes ☐ No

I request that the Medicare Appeals Council review the ALJ's ☐ decision or ☐ dismissal order [check one] dated _____. I disagree with the ALJ's action because (specify the parts of the ALJ's decision or dismissal you disagree with and why you think the ALJ was wrong):

(Attach additional sheets if you need more space)

PLEASE ATTACH A COPY OF THE ALJ DECISION OR DISMISSAL ORDER YOU ARE APPEALING.

DATE	DATE
APPELLANT'S SIGNATURE (the party requesting review)	REPRESENTATIVE'S SIGNATURE (include signed appointment of representative if not already submitted.)
PRINT NAME	PRINT NAME
ADDRESS	ADDRESS
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE
TELEPHONE NUMBER / FAX NUMBER / E-MAIL	TELEPHONE NUMBER / FAX NUMBER / E-MAIL

(SEE FURTHER INSTRUCTIONS ON PAGE 2)

Form DAB-101 (08/09)

If you have additional evidence, submit it with this request for review. If you need more time, you must request an extension of time in writing now, explaining why you are unable to submit the evidence or legal argument now.

If you are a provider, supplier, or a beneficiary represented by a provider or supplier, and your case was reconsidered by a Qualified Independent Contractor (QIC), the Medicare Appeals Council will not consider new evidence related to issues the QIC has already considered unless you show that you have a good reason for submitting it for the first time to the Medicare Appeals Council.

IMPORTANT: Include the HICN and ALJ Appeal Number on any letter or other material you submit.

This request must be received within 60 calendar days after you receive the ALJ's decision or dismissal, unless we extend the time limit for good cause. We assume you received the decision or dismissal 5 calendar days after it was issued, unless you show you received it later. If this request will not be received within 65 calendar days from the date on the decision or dismissal order, please explain why on a separate sheet.

You must file your request for review in writing with the Medicare Appeals Council at:

Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6127
Cohen Building Room G-644
330 Independence Ave., S.W.
Washington, D.C. 20201

You may send the request for review by U.S. Mail, a common carrier such as FedEx, or by fax to (202) 565-0227. If you send a fax, please do not also mail a copy. ***You must send a copy of your appeal to the other parties and indicate that all parties, to include all beneficiaries, have been copied on the request for review. For claims involving multiple beneficiaries, you may submit a copy of the cover letters issued or a spreadsheet of the beneficiaries and addresses who received a copy of the request for review.***

If you have any questions about your request for review or wish to request expedited review of a claim involving authorization of your prescription drug under Medicare Part D, you may call the Medicare Appeals Council's staff in the Medicare Operations Division of the Departmental Appeals Board at (202) 565-0100. You may also visit our web site at www.hhs.gov/dab for additional information on how to file your request for review.

PRIVACY ACT STATEMENT

The collection of information on this form is authorized by the Social Security Act (section 205(a) of title II, section 702 of title VII, section 1155 of Title XI, and sections 1852(g)(5), 1869(b)(1), 1871, 1872, and 1876(c)(5)(B) of title XVIII, as appropriate). The information provided will be used to further document your claim. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed by the Department of Health and Human Services or the Social Security Administration to another person or governmental agency only with respect to programs under the Social Security Act and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services, the Social Security Administration, or other agencies.

https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/DABform.pdf

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FIFTH LEVEL OF APPEAL:
JUDICIAL REVIEW IN FEDERAL DISTRICT COURT

Question	Answer
When must I file a request?	You must file a request for judicial review within 60 days of receipt of the Council's decision or after the Council decision timeframe expires
How do I file a request?	The Council's decision (or notice of right to escalation) informs you how to file a claim in U.S. District Court. But, generally involves filing a complaint/petition for judicial review in the U.S. District Court in which the party appealing the decision resides or has its principal place of business

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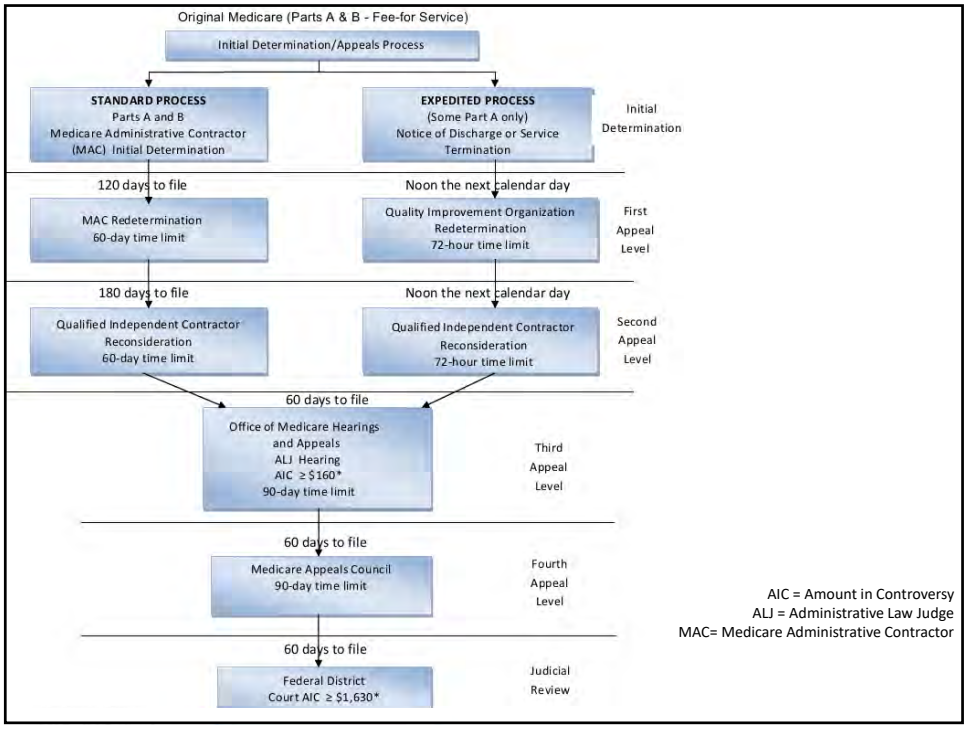

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TIPS

Some things to remember when filing an Appeal:

- **Make all appeal requests in writing and use the appropriate forms when applicable**
- Starting at Level 1, consolidate all similar claims into one appeal
- File timely requests with the appropriate entity
- Include a copy of the decision letter(s) or claim information issued at the previous level(s)
- Include a copy of the demand letter(s) if appealing an overpayment determination
- Include all relevant supporting documentation with your first appeal request
- **Include a copy of the Appointment of Representative form (generally a lawyer)** if the requestor is not a party and is representing the appellant
- Respond promptly to requests for documentation

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MEDICAID APPEALS

- There are two categories of Medicaid Appeals:
  - Appeals from original claim denials
  - Appeals from retrospective denials (denials after the claim has already been paid but Medicaid conducts a retrospective review)
- The appeals process for these two categories is different and we'll briefly cover both

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MEDICAID (NON RETROSPECTIVE) APPEALS

- These appeals are for providers. They are not for cases where the participant is denied coverage in the first instance. Rather, they apply after coverage has been granted but a specific claim is denied or reduced
- Claim Review Request
- Medicaid Review of Claim Determination
- Formal Appeal

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CLAIM REVIEW REQUEST

- Involves an individual with DXC Technology Medicaid, (Idaho's contracted Medicaid provider) physically reviewing the claim
- Filed using the form provided at www.idmedicaid.com which can be supplemented with a written letter
- Deadline to file is 28 days from receiving a notice of determination
- Attach any documents you feel will help support your request, including EOB with remark codes, medical records, chart notes, reports, etc.

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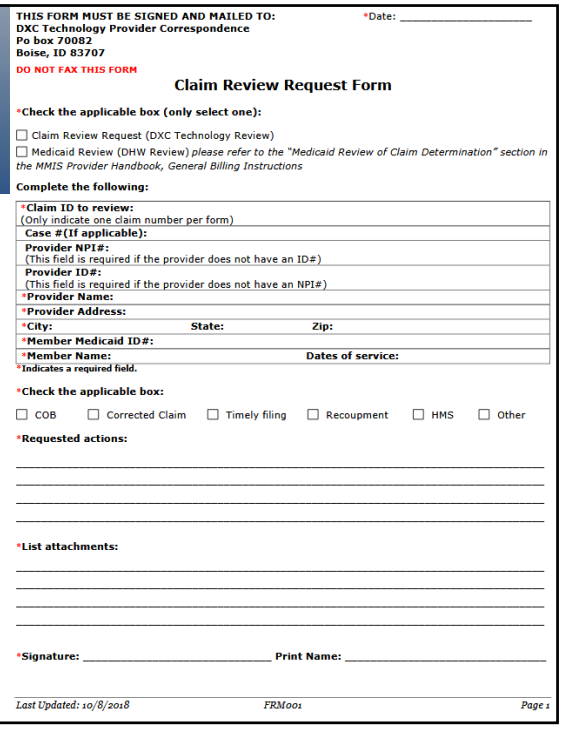
CLAIM REVIEW REQUEST FORM

- The same form is used for the 1st and 2nd levels of appeal. Be sure to check the right box depending on the level of appeal you are requesting

https://www.idmedicaid.com/Forms/Claims%20Review%20Request%20Form.pdf



THIS FORM MUST BE SIGNED AND MAILED TO:
DXC Technology Provider Correspondence
Po box 70002
Boise, ID 83707

*Date: _____

DO NOT FAX THIS FORM

Claim Review Request Form

*Check the applicable box (only select one):

☐ Claim Review Request (DXC Technology Review)
☐ Medicaid Review (DHW Review) *please refer to the "Medicaid Review of Claim Determination" section in the MMIS Provider Handbook, General Billing Instructions*

Complete the following:

*Claim ID to review:
(Only indicate one claim number per form)
Case #(If applicable):
Provider NPI#:
(This field is required if the provider does not have an ID#)
Provider ID#:
(This field is required if the provider does not have an NPI#)
*Provider Name:
*Provider Address:
*City: State: Zip:
*Member Medicaid ID#:
*Member Name: Dates of service:

*Indicates a required field.

*Check the applicable box:

☐ COB ☐ Corrected Claim ☐ Timely filing ☐ Recoupment ☐ HMS ☐ Other

*Requested actions:

_____
_____
_____
_____

*List attachments:

_____
_____
_____
_____

*Signature: _____ Print Name: _____

Last Updated: 10/8/2018 *FRM001* *Page 1*

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MEDICAID REVIEW OF CLAIM DETERMINATION

- Review conducted by an individual at the Medicaid Central Office
- Filed using the form provided at www.idmedicaid.com
- Deadline to file is 28 days from receiving the claim review determination letter
- Must include a copy of the DXC Technology claim Review Determination Letter
- Can include additional documentation related to timely filing, medical necessity, notes, or reports

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FORMAL APPEAL

- Available after you receive a Medicaid Review of Claim Determination letter
- Conducted by the Idaho Department of Health & Welfare (IDHW), typically by an attorney from the Attorney General's office
- Must submit appeal within 28 days of receiving denial of Medicaid Review of Claim Determination
- Must include a copy of the Medicaid Review of claim Determination letter and a copy of the DXC Technology review letter as well as other documents
- Sent directly to IDHW, who may set a hearing, and issue a final determination in writing, typically within 60 days

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JUDICIAL REVIEW

- Only available after going through the prior three appeal levels
- Initiated by filing a petition for judicial review with the state district court in which the party requesting review resides or where such individual, institution, or agency has it principal place of business
- Must file within 28 days of receiving final determination from IDHW

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MEDICAID RETROSPECTIVE REVIEW RECONSIDERATION AND APPEALS

- A retrospective review is when Medicaid conducts a review and issues a determination of coverage after a claim has been submitted, and often even after payment has been made
- If claim is found to have been inappropriate, payment may be recouped
- A provider may seek reconsideration of a retrospective review that denies a claim or recoups all or part of a prior payment
- There are three levels of review:
  - Request for Reconsideration
  - Request for Appeal
  - Judicial Review

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REQUEST FOR RECONSIDERATION OF RETROSPECTIVE REVIEW

- The deadline for filing a request for reconsideration is 28 days from the *mailing* date of the first Notice of Decision
- There is no form to request a reconsideration
  - Simply prepare a written request (typically in letter form) and accompanying brief
    - Set out why you think the decision was wrong, may include medical records and citations to applicable law and regulations
- The request is submitted to the agent that conducted the Retrospective Review
- Medicaid will conduct a reconsideration review and issue a second Notice of Decision either granting or denying the reconsideration request.
  - If the request is denied you can seek a request for appeal

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REQUEST FOR APPEAL

- The deadline for filing a request for appeal is 28 days from the *mailing* date of the Second Notice of Decision
- Again, no set form, submitted by preparing a written request and accompanying brief
  - Set out why you think the second notice of decision was wrong, may include medical records and citations to applicable law and regulations
    - Must include a copy of the First Notice of Decision
    - Must include a copy of the Request for Reconsideration
    - Must include a copy of the Second Notice of Decision
- The request is mailed to the Hearings Coordinator at IDHW
- The IDHW will then set a hearing after which the hearing officer will issue a preliminary order. The hearing officer is an attorney from the Attorney General's office
- You have 14 days from the issuance of a preliminary order to appeal the order to the Board of IDHW
- IDHW will issue a written final decision, which may also be appealed to the state district court

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JUDICIAL REVIEW

- Only available after going through the prior appeal levels
- Initiated by filing a petition for judicial review with the state district court in which the party requesting review resides or where such individual, institution, or agency has it principal place of business
- Must file within 28 days of receiving final determination from IDHW

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TIPS

Some things to remember when filing an Appeal:

- **Determine whether this is an Appeal for an originally denied claim or for a denial after a retrospective review and make sure you are following the correct process for your claim**
- Make all appeal requests in writing and use the appropriate forms when applicable
- File timely requests with the appropriate entity
- Include a copy of the decision letter(s) or claim information issued at the previous level(s)
- Include all relevant supporting documentation with your first appeal request
- If you want an attorney to represent you, you must include a copy of the Authorized Representative form
- Respond promptly to requests for documentation
- Make sure to sign your request for appeal

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A CASE STUDY

- Medicare Patient was treated at a Long Term Care Hospital (LTCH) for a variety of issues. The Patient experienced multiple medical issues and would have required admittance to an emergency room at an acute care hospital, if she had been at a lower-level of care.
- The LTCH submitted a claim to the Medicare contractor for payment. Medicare contractor denied payment.
  - They noted the number of treatment modalities and determined the care at the LTCH was not medically necessary and could have been provided by a Skilled Nursing Facility (SNF).
- LTCH requested a redetermination and provided all relevant medical records and a narrative statement about why the stay at the LTCH was medically necessary.
- The Medicare contractor reviewed and affirmed its prior decision.
  - They stated, "the services provided were determined as not medically reasonable and necessary for an inpatient level of care to an LTCH facility." and
  - The LTCH knew or should have known the services would not be covered, therefore the LTCH was responsible for the charges and they could not charge the Patient.

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A CASE STUDY

- LTCH requested reconsideration from an independent Medicare contractor who affirmed on the same basis.
- The LTCH appealed to OMHA for an administrative law judge hearing.
- LTCH retained an attorney. The attorney setting strategy for and attending the hearing was able to elicit testimony from an expert retained by the attorney and LTCH (many times can be an employed physician).
- The testimony stated that the level of care received at the LTCH was not only necessary but created value for the Patient and prevented another trip to the ER if she had been transferred to a SNF. Her condition improved to the point she could be safely discharged home. The expert addressed modalities of therapy at the LTCH and that care needed was not available at the SNF level.
- Relying on the expert testimony, the administrative law judge agreed with the LTCH and overturned the prior two decisions and ordered payment to the LTCH.

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A CASE STUDY

- **The morale of the story**: If you feel confident in your position perseverance pays. Don't give up just because the first two levels of appeal do not result in a favorable decision. You may need to reach the level of appeal that involves a hearing before you will see a favorable result because that is when you can more effectively present your evidence and narrative.

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CONCLUSION

- Medicare and Medicaid appeals can be complicated and burdensome. However, if handled properly, the chances of success rise dramatically
- Always include as much evidence as you can with the first level of appeal
- The early levels of appeals can often be handled by in-house staff but once you reach the level of appeal that requires a hearing, it is typically best practice to engage an attorney to represent you at the hearing
- Perseverance Pays

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WHY HAVE A COMPLIANCE PLAN?

- Facilitates compliance if effective
- May mitigate punishment under Sentencing Guidelines, False Claims Act, and exclusion law and regs.
- May improve bottom line performance
  - Capture revenue that facility might otherwise miss
  - Avoids reimbursements, penalties, and related expenses
- May help identify and prevent patient care problems
- Boosts morale and strengthens culture of integrity
- Provides formal vehicle for compliance education
- Right thing to do

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FRAUD AND INVESTIGATIONS

- I love talking about fraud and government investigations.
- But, not today.
- Maybe some other time.

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OIG COMPLIANCE PROGRAM GUIDE: ELEMENTS

1. Written standards, policies and procedures
2. Compliance officer and committee
3. Effective education and training
4. Open lines of communication, e.g., hotline
5. System to respond to and enforce compliance issues
6. Audits or evaluations to monitor compliance
7. Investigation and remediation of compliance issues

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OIG 2005 SUPPLEMENTAL COMPLIANCE PROGRAM FOR HOSPITALS

OIG – single biggest risk area – preparation and submission of claims:

- All claims and all supporting documentation –
  - must be complete and accurate
  - must reflect reasonable and necessary services
  - ordered by licensed medical professional who is participating in health care program
  - Hospitals must disclose and return any overpayments that result from mistaken or erroneous claims

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AN EFFECTIVE AUDIT PROGRAM

Develop annual audit plans designed to minimize the risks associated with improper claims and billing practices. Some factors to possibly include the following:

- Annual re-evaluations. Does audit address the proper areas of concern. Past history, risk areas identified from annual risk assessment, and high volume services?
- Does the audit plan include an assessment of billing systems in an effort to identify the root cause of billing errors?

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AN EFFECTIVE AUDIT PROCESS

- Role of the auditors clearly established?
- Coding and audit personnel independent and qualified, with the requisite certifications?
- Audit department available to conduct unscheduled reviews?
- Is compliance department able to request additional audits or monitoring should the need arise?

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AN EFFECTIVE AUDIT PROCESS

- Evaluation of error rates identified in the annual audits?
- If the error rates are not decreasing, further investigation to determine hidden weaknesses and deficiencies?
- Does the audit include a review of all billing documentation, including clinical documentation, in support of the claim?

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IF YOU THINK YOU HAVE A PROBLEM…

- Don't ignore it
- Don't submit claims until you have resolved it
- Promptly investigate and document results
- Make necessary changes
- Report and repay as necessary

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OVERPAYMENTS: AFFORDABLE CARE ACT

- "Overpayment" = Medicare or Medicaid funds a person receives or retains to which the person is not entitled
- Note: Overpayment
  - Includes innocent mistakes
  - Does not require an intent to defraud the government

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OVERPAYMENTS: AFFORDABLE CARE ACT CHANGE

- What do you do with an overpayment?
  - Providers and suppliers must report and return overpayments to HHS or Idaho Medicaid

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OVERPAYMENTS: AFFORDABLE CARE ACT CHANGE

- What happens if you don't report and return the overpayment on time?
  - Retaining any overpayment after the deadline for reporting and returning the overpayment is an "obligation" under False Claims Act

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OVERPAYMENTS: AFFORDABLE CARE ACT CHANGE

- What happens if you don't report and return the overpayment on time?
- Intent to defraud not required
  - The "knowing" failure to repay such an "obligation"—regardless of whether it was the result of an innocent mistake or an intentional act—is legally the same as if the money had been obtained by fraud
  - Gov't does not need to prove a specific intent to defraud

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OVERPAYMENTS – FINAL REGULATIONS (FINALLY)

- CMS proposed regulations on Feb. 16, 2012. Final Regulations issued in February, 2016
- Overpayment is "identified," when:
  - the provider has, or should have through the exercise of reasonable diligence, determined that it has received an overpayment and quantified the amount of the overpayment

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OVERPAYMENTS – FINAL REGULATIONS (FINALLY)

  - the provider "should have" determined that it received an overpayment and quantified the amount of the overpayment if it "fails to exercise reasonable diligence" and in fact received an overpayment
  - when "a person has actual knowledge of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment."

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OVERPAYMENTS – FINAL REGULATIONS (FINALLY)

- failure to make a "reasonable inquiry" with "all deliberate speed" could lead to a provider "knowingly retaining an overpayment because it acted in "reckless disregard" or "deliberate ignorance" of whether it received an overpayment

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OVERPAYMENTS – FINAL REGULATIONS (FINALLY)

- "reasonable diligence" includes both:
  - proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments and
  - investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment

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OVERPAYMENTS – FINAL REGULATIONS (FINALLY)

- For purposes of the 60-day repayment obligation, an overpayment has not been "identified" until the amount has been "quantified"
- Allows for a more thorough and accurate review, but not open-ended
- CMS's commentary makes it clear that any audit should be completed within six months, giving the provider a total of eight months to identify and quantify the overpayment and to make the repayment

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OVERPAYMENTS: POTENTIAL PENALTIES

- "Knowing" failure to report and refund overpayments by the date due may result in penalties under:
  - False Claims Act
    - $5,500 to $11,000 penalty per claim
    - 3x damages
    - Qui tam lawsuit
    - Exclusion from Medicare or Medicaid
  - Civil Monetary Penalties Law
    - $10,000 penalty

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IDAHO MEDICAID – DUTY TO REPAY

- Provider must repay overpayments or claims previously found to have been obtained contrary to statute, IDAPA rule or other regulation.
- Provider agreement also requires providers to immediately repay overpayments
- To resolve overpayment, may enter repayment agreement, with interest, which is typically no longer than 12 months

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IDAHO MEDICAID – DUTY TO REPAY

- Penalty for not repaying, $1,000 for each item or service or 10% of total claims
- Penalty is to cover Medicaid's costs of investigation.
- Medicaid may seek repayment and suspend payments or terminate provider agreement
- Referral to Medicaid fraud unit
- Usually no penalties if you self-report

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REPAYMENT AND/OR DISCLOSURE

- Bottom line:
  - If you learn of overpayment, you should repay and/or disclose facts relating to overpayment
  - Carefully consider whether to what extent, to whom, and when disclosure should be made
  - Get legal help

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QUESTIONS?

THANK YOU!

THOMAS J. MORTELL
208.388.4929
tmortell@hawleytroxell.com

MARK PETERSON
208.388.4958
mpeterson@hawleytroxell.com

HAWLEY TROXELL
ATTORNEYS AND COUNSELORS

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