FOCUS ON REVENUE CYCLE & APPEALS

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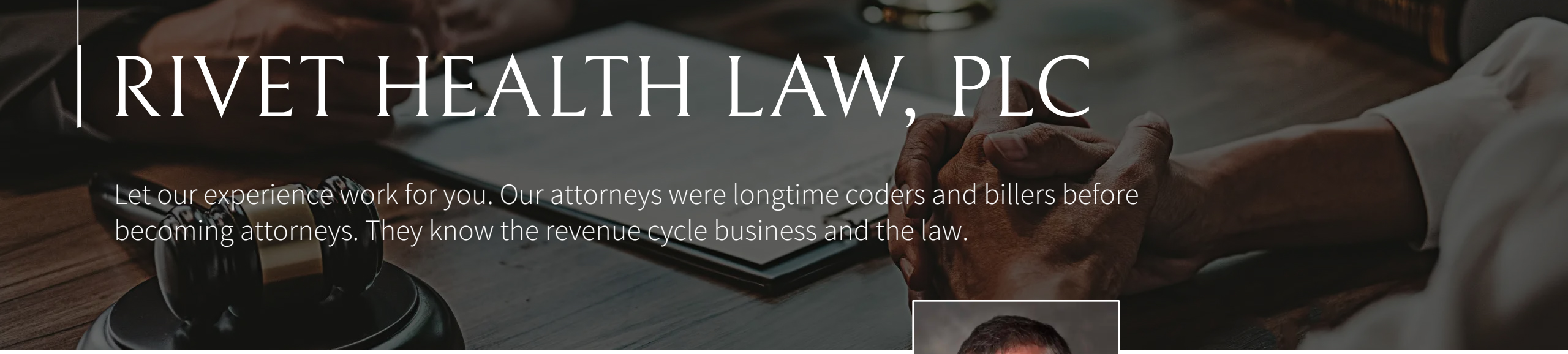
RIVET HEALTH LAW, PLC



Let our experience work for you. Our attorneys were longtime coders and billers before becoming attorneys. They know the revenue cycle business and the law.

Rivet Health Law addresses the full spectrum of healthcare and reimbursement matters involving government and commercial payors audits and appeals. Our practice areas includes:

- Payor Audits & Appeals
- Reimbursement
- Coding & Billing
- Revenue Cycle
- Compliance
- Regulatory Guidance

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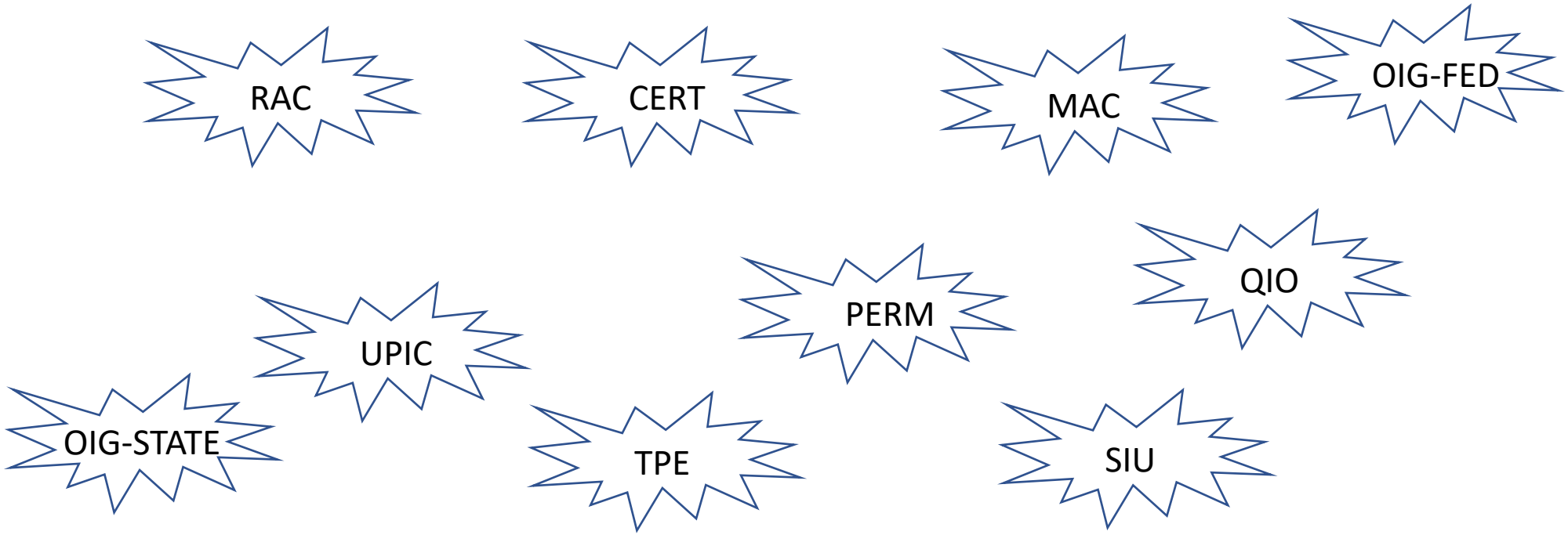
UNDERSTAND THE TYPE OF AUDIT

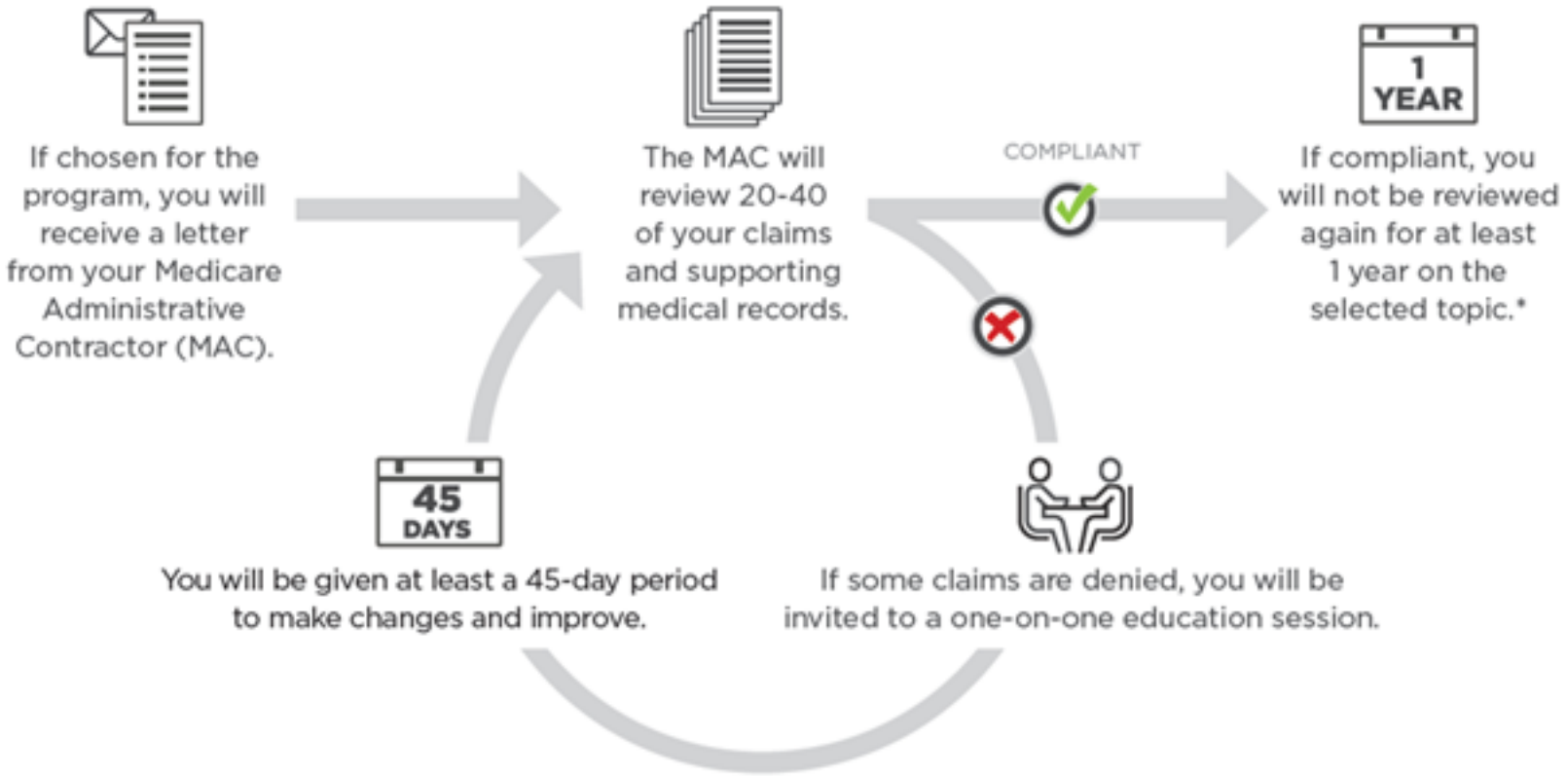
- Know the audit arm or agency auditing
- Each audit type can have it's own timeline, process, and formality



GENERAL AUDIT FRAMEWORK

- Medical Record Request
- Audit Finding
- Period to Respond – Appeal or repay (offset claims)
- Appeal
- Response
- ALJ or Legal Suit (mediation if required by contract)

TPE AUDIT EXAMPLE



UNDERSTAND THE AUDIT LETTER

- Dates are key
  - Date Received
  - Date to respond (e.g., 30 days from the date of the letter)
- Findings
- What did the auditor rely on (Read and understand the authority)
  - Policies
  - LCD/NCD
  - Statutes
- What is next (refund, offset, appeal)

THE AUDIT / OVERPAYMENT LETTER

- What can you find just in the letter:
  - Inconsistent information
  - Date range outside the contract terms (if commercial)
  - Application of the incorrect rule
  - Application of the correct rule but applied incorrectly
  - Conflicting audit findings
    - Itemized list of claims – may see comments of ”no findings” yet overpayment letter identifies findings
- Why is this important?
  - You have started to build an audit response
  - The credibility of the audit is called into question

OVERPAYMENT LETTER EXAMPLES

[redacted] proud of the partnership we continue to build as we promote better health care. In working with you, we strive to make every process truly efficient. However, errors sometimes do occur. During a recent audit of anesthesia claims for [redacted] (CPT code 01967) for dates of services of 2017 and 2018, [redacted] identified **$23,190.63** in potential overpayments to your organization.

...

Because [redacted] does not have the actual Anesthesia Start and Stop time, the Anesthesia Total Time was used to determine how long the analgesia was provided.

OVERPAYMENT LETTER EXAMPLES

[redacted] BY: [redacted] D.O.B. [redacted] Acct #: [redacted] Member ID: [redacted] 6500

Claim #	D.O.S.	CPT	Units	Hours Paid	Billed	Allowed	Mbr's OOP	Paid	Correct ABU	Correct Payment	MBR's OOP Refund Due	Financial Error
[redacted]	12/1/2017	01967	115	8	$1,500.00	$492.44	$0.00	$492.44	7	$265.16	$0.00	$227.28
Total:					$1,500.00	$492.44	$0.00	$492.44		$265.16	$0.00	$227.28

[redacted] [redacted] D.O.B. [redacted] Acct #: [redacted] Member ID: [redacted] 6500

Claim #	D.O.S.	CPT	Units	Hours Paid	Billed	Allowed	Mbr's OOP	Paid	Correct ABU	Correct Payment	MBR's OOP Refund Due	Financial Error
[redacted]	4/15/2017	01967	242	16	$1,500.00	$795.48	$0.00	$795.48	9	$340.92	$0.00	$454.56
Total:					$1,500.00	$795.48	$0.00	$795.48		$340.92	$0.00	$454.56

[redacted] [redacted] D.O.B. [redacted] Acct #: [redacted] Member ID: [redacted] 1 1000

Claim #	D.O.S.	CPT	Units	Hours Paid	Billed	Allowed	Mbr's OOP	Paid	Correct ABU	Correct Payment	MBR's OOP Refund Due	Financial Error
[redacted]	12/15/2017	01967	98	7	$1,500.00	$454.56	$0.00	$454.56	7	$265.16	$0.00	$189.40
Total:					$1,500.00	$454.56	$0.00	$454.56		$265.16	$0.00	$189.40

Tuesady June 7, 2016 Auditor: [redacted] Page 1

OVERPAYMENT LETTER EXAMPLES

[redacted] is an authorized contractor for [redacted] A post payment review relating to selected Medicaid claims for dates of service 10/15/2013 to 12/31/2017 was recently completed and records indicate that your agency submitted claims which billed for a basic life support (BLS) and advance life support (ALS) transportation trip, round trip, and/or mileage without evidence that the ambulance transported to an approved destination or from approved discharge location. No3424 claims found outside of transportation the day previous, the same day, or the day after. This is an indication that transport services were not rendered, medically unnecessary, or not covered by Medicaid. As an ambulatory provider you have improperly billed Medicaid.

Findings

NCAC Title 10A - Health and Human Services Section .0200- AMBULANCE SERVICES 10 A NCAC 25W .0201 AMBULANCE SERVICES; NC Ambulance Service Manual 1999 Chapter 4 DEFINITIONS; Provider Agreements; NC Division of Medical Assistance Medicaid and Health Choice Ambulance Services Clinical Coverage Policy No: 15 Effective Date: February 1, 2016 Section Attachment A pp 17-19.

Source

[redacted] has tentatively identified an overpayment amount of $13,250.56 as a result of these error findings.

RE-AUDIT

- Review and re-audit the records
- Note discrepancies between your findings and the auditor
- Have this done by two auditors independent, then compare and discuss
- Those with solid findings are ripe for appeal

PROVIDER CONTRACT

- Don’t overlook this step
- Generally, contracts have key audit provisions including:
  - Audit notices
  - Look-back period
    - Example: 18 months from date of service vs. 18 months from paid date
  - Material changes clauses (e.g., billing edits, payment policies)
  - Appeal process
  - Which line of business may be included or excluded
    - Double check with beneficiaries audited

PAYOR COMMUNICATIONS

- Medical Policies
- Service specific policies (e.g. MOHS, DME, Anesthesia, etc.)
- LCD
- Provider Manual
- Information available on the payor website / provider portal
- Payor published bulletins

LOOK AT THE DETAILS

- Effective dates of policies
- Review revision history
- Definitions of terms (e.g., ”medically treated”)
  - Terms can be key, particularly with medical necessity denials
- Review the policy for payor lines of business (there can be exclusions)
- Beneficiaries evidence of coverage

AUDIT FINDINGS – BUT DIFFERENT APPEAL APPROACH

- Not Medically Necessary Denials
- Experimental
- Setting of Care (policy may say otherwise, claim configuration)
  - IP vs. OP
  - OP vs. ASC
  - Check state law
- Billed services not met/denied/reduced
  - Refer to coding/billing policies
  - Medicaid – look to the Medicaid Manual
  - Coding guidelines

DRAFTING THE APPEAL LETTER

- General items:
  - Payor required forms
  - Address of whom letter goes to (Proper spelling of name)
  - Date of letter
  - Re: (case number or other reference to specific audit)
  - Patient demographics (if appropriate)
  - Tone of the letter

BASIC CONSTRUCT OF LETTER

- Introduction
- Restate the audit issue/finding(s)
- Provide a summary of the relevant rule and/or law
- Politely make your analysis of the authoritative source to the scope of records
- If multiple findings – categories them
- Conclusion and ask of the auditor
- Enclosures (policies, LCD, guidelines, etc.)

NOT RECOMMENDED

- Do not:
  - Demand
  - Be negative
  - Threaten
  - Be condescending
  - Impose deadlines to the payor/auditor

LIVE HEARINGS

- Commonly by phone with payors and ALJs
- Understand the purpose and desired outcome
  - ALJs hearings do not have rules of evidence
- Review everything prior to the hearing (not an hour before)
- Have available and clearly marked:
  - All correspondence (emails and letters)
  - Applicable policies and/or statutes
  - Applicable payor manuals or relevant sources
  - Applicable medical records in question

DOCUMENT THE CALL

- Date of call
- Purpose of call
- Case number
- Attendees from payor or agency (proper spelling, title, contact info)
- Detailed notes of the call
- Document any citations of law, rule, regulation, or other authorative source during the call
- Attached all document including meeting requests
- Scan all documents into appropriate internal file
- If additional information is requested clearly note:
  - What is requested
  - Due date
  - Contact of whom to send it to and what method of delivery
- Next steps
  - Document when decision is to be determined
  - What method determination will be sent
  - Verify contact information of whom and where request will be sent

COMMON QUESTIONS

- Should I or can I call the auditor on the letter?
- Can I clarify with the auditor?
- Can I clarify with the auditor or ALJ?
- I received the letter last minute and have not time to respond. What can I do?
- Should I send what I think the auditor really needs?
- They did not ask for a signature log, should I provide one?