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Proactive Coding Compliance: The Best Way to Avoid the CMS Administrative Appeal Process

Related Professionals

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As an attorney specializing in healthcare reimbursement, I have focused my practice on helping healthcare providers navigate the Center for Medicare and Medicaid ("CMS") administrative appeal process. I usually get a call once the provider receives a notice from their Medicare Administrative Contractor ("MAC") advising that billing and/or documentation errors have been found and demanding that the provider repay CMS for overpayments. The provider is usually shocked because they have been paid for years for the services at issue without any indication they were doing something wrong. Many times they feel outrage because mistakes were made by their billing company or staff. After a tough conversation to explain that CMS can lookback at claims for six years and that the provider is ultimately responsible for errors made by his/her agents, the gravity of the situation sets in. Then, the long, arduous process begins in trying to find the balance between fighting the good fight on appealable claims while trying to keep the provider financially afloat. Without fail, the provider regrets not identifying the issues before the CMS audit began.

Overview of Appeal Process

There are five levels of appeal in the CMS appeal process.

- ***Redetermination:*** The first level is a written appeal straight to the MAC who found the overpayment. Almost uniformly, the MAC will rubberstamp its original decision.
- ***Reconsideration:*** At the second level, also only a review of the written appeal record, the reviewer is independent from the MAC, and providers can have some success in appealing.
- ***Administrative Law Hearing:*** While the provider will lose its appeal rights if a filing deadline is missed, CMS currently has a backlog of around six years before the third level hearing before an

Administrative Law Judge ("ALJ") is scheduled! Many of my clients have been waiting for over six years, and are still waiting, for a chance to tell their side of the story to a judge. The Covid-19 pandemic has only increased delays as most of the ALJs are now conducting telephone hearings remotely.

→ ***Medicare Appeals Council:*** Because of the long delays, a provider can choose to escalate their appeal to the Medicare Appeals Council, the fourth level of appeal, but wait times are now exceeding 800 days for a decision that Medicare regulations state should be completed in 180 days. I have a client who has been waiting almost two years for a decision on their escalated appeal.

→ ***Federal District Court:*** If a provider can survive through the first four levels and still has not had success, the final level of appeal available is through a federal district court.

Costly Process

→ ***Legal fees, interest and recoupment****:* Most providers realize they need legal counsel to navigate the CMS appeals process if the alleged overpayment amount is significant. Interest and recoupment on alleged overpayments hit quickly. Interest will start to accrue 30 days after the demand letter is issued regardless of whether the provider appeals to the next level. After the second level of appeal, any claims denial overpayments that are not overturned will be subject to recoupment thirty days after the decision is rendered regardless of whether the provider appeals to the next level. The bottom line at this point in the process is that a provider must be able to withstand no Medicare revenue coming in due to recoupment until the overpayment is satisfied. Some of my clients who had alleged extrapolated overpayments that totaled over five million dollars. They had to shut down their practices as Medicare was their primary payor and they could not remain financially viable with no reimbursement.

→ ***Pros and Cons to Appealing****:* Providers have a good chance of winning at the ALJ level and can potential recover all the interest and recouped money if CMS decides not to appeal to the next level. However, over five years will pass before achieving this potential victory. It is an option to obtain a loan or enter into a repayment plan with CMS to pay the overpayment and avoid this recoupment, but in my experience, CMS will continue to audit providers who do not appeal, especially when medical necessity issues are involved. If subsequent investigations occur, the allegations are often raised to the fraud level if the provider continues to make the same alleged documentation and billing errors. When a provider receives notice of an overpayment, the decisions regarding whether to appeal or not usually come down to economics. The legal costs and lost revenue due to engaging in the CMS appeal process, as well as not engaging in the process, can be disastrous.

Key Takeaways

After years of assisting providers with these tough decisions, I have realized two things:

(1) Most of these providers are good providers. They are not intentionally billing the wrong codes and/or are not intentionally documenting their services improperly. They are focused on what they were trained to do: patient care. Oftentimes, unbeknownst to them, they hire incompetent billers and office staff or they employ mid-level providers who cut corners. They genuinely believe they are running compliant practices; and

(2) If the provider had taken expended resources on proactive compliance, they could have avoided the CMS scrutiny or at least, reduced their exposure.

Proactive Coding Compliance is The Way to Go

All medical providers and entities need an effective compliance plan and program and a compliance officer or compliance staff, depending on the size of the provider. A key component of the compliance program should include effective auditing and monitoring of ongoing billing and coding.

As a starting point, if ongoing audits of patient charts and associated claim forms is not already being performed, I recommend immediately hiring a certified coding and documentation expert to conduct an initial baseline audit of patient charts and corresponding claim forms so errors made by in-house billers, billing companies or clinical providers can be identified and mitigated. Depending on the size of the provider and other safeguards, this audit function should continue on a scheduled basis, so that ongoing coding compliance can be assured. Additional audits should also be conducted as the need is identified through various risk factors, new regulatory developments, establishment of new service lines or services, or concerns raised by individuals related to coding compliance.

Regular training and education sessions on proper documentation should also be coordinated so all clinical providers understand how to document medical necessity for all procedure codes being billed.

Due to the current public health emergency, CMS rules have been changing daily and providers will be expected to keep up. More audits are coming and reviewing your CMS compliance plan is more crucial than ever. Proactive coding compliance takes time and costs money, but ask any provider entangled in a Medicare audit or forced to shut down due to a Medicare audit, and they will say they wish they had made the investment.