LACMA Physician
September 19, 1994

Wrangling With Recoupment

How to Hold On to Your Reimbursement in A Medicare Post-Payment Review

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If the number of complaints is any indication, among to the more frustrating experiences with which physicians must deal are denials of payment from Medicare or, worse yet, being asked to repay money to the Medicare program. Let's face it, your reimbursements from Medicare have gone consistently down while your expenses for billing the program have gone up as a result of the detailed billing requirements. And now, Medicare wants to take back some of that money after already having paid you. It seems patently unfair, and physicians want to know why and what they can do about this request for repayment.

In other words, what should you do when confronted with a denial of payment for services rendered or a request for reimbursement of payment for services already rendered? Before answering this question, you need to know how these requests are generated.

Post-payment Review

All Medicare intermediaries arc required by contract with the Health Care Financing Administration (HCFA) to perform post-payment review. The goal of this review is to monitor medical necessity of services provided to Medicare beneficiaries and to detect "fraud and abuse" in the Medicare program.

Fraud by physicians is increasingly becoming an all too convenient explanation for the deficiencies in our healthcare delivery system in this country. Thus, the reality of a small number of dishonest physicians who engage in fraudulent practices has been exaggerated into a widespread enforcement effort, having as its target the average physician engaged in the day-to-day practice of his or her profession.

What this means, as a practical matter, is that physicians must be ever more vigilant in the business aspects of the practice of medicine. In the Medicare or Medi-Cal arena, there can be a fine dividing line between billing for services with questionable justification for reimbursement and fraudulent billing for services. Many times it comes down to a question of the intent of the billing physician.

There are measures that physicians can take to protect themselves from charges of fraudulent practices and potential criminal and civil penalties.

It is often an excellent strategy to pursue one's remedy (usually in the form of an appeal) under the Medicare system for two basic reasons: first, to obtain reimbursement for a medically necessary procedure that was rendered to the patient; second, to establish through the hearing procedure a legitimate and lawful basis of payment for the procedures rendered, therefore, negating any plausible claims in the future that the billed charges were fraudulent.

Regardless of the outcome of the fair hearing procedure, the physician obtains a measure of protection against claims of fraudulent intent. Even if the appeals procedure is ultimately lost, it is apparent that it has been pursued in good faith and it would be difficult in either a criminal or civil proceeding to credibly pursue the claim that the physician in question acted with fraudulent intent when tenable grounds have been presented at the administrative hearing level in support of the physician's claim for payment.

Recoupment Requests

Every physician who bills Medicare has probably experienced a denial of payment for services rendered. The reasons for these denials vary considerably, but usually the explanation given will guide the physician in his or her response. What is often not so clear are the reasons why Medicare wants to recoup payments it has already made. The reasons for these recoupment requests may also vary, but the more common requests are the result of post-payment reviews.

There are three potential "red flags" that can generate post-payment reviews:

- **Patient Complaint** - In a case where a patient has made a complaint to the Medicare carrier, the carrier will review the records in question. These reviews will usually only involve the records of the patient who made the complaint.
- **Utilization Patterns** – In cases where the carrier has identified a physician with utilization patterns that exceed those of other physicians of the same specialty in the same area, usually 15 to 30 charts will be reviewed. You may be able to identify particular codes that are common to all of the charts reviewed.
- **Random Audits** – The Medicare program is required to audit a set percentage of its total cases. Usually 15 to 30 charts will be reviewed, but these are chosen at random.

Most often, a physician's first indication that she or he is being audited is a request for medical records. After submission of copies to the intermediary (sometimes hundreds of pages of copy), a period of anywhere from two to 10 months may elapse. Then the physician will receive a detailed list of denied items along with a request for a refund of money. This is called a *Letter of Denial and Request for Repayment.* The reason for denial is usually given as "not medically necessary," but there are also items denied based upon what the reviewer feels is "in adequate documentation."

The *Letter of Denial and Request for Repayment* also specifies a time frame by which the money is to be refunded, and then states that a request for a "fair" hearing can be made any time up to six months after the date the letter was prepared for the provider. There is a basic inequity here, and it is one that we have been unable to resolve You may request a hearing, which typically takes at least three to four months to schedule. Meanwhile, Transamerica Occidental (Southern California's Part B Medicare carrier) demands repayment within 30 days or it begins to take those payments, with interest, from current reimbursements. The final paragraph in the *Letter of Denial* suggests that since "this educational information" has been provided to the provider, further continuance of the "inappropriate behavior" 'wilt be subject to sanctions which may include, but are not limited to, monetary fines and refusal to be allowed to participate in the Medicare program. Many questions have been raised regarding the lack of input in this review process of those with medical knowledge and the policies leading to denials. LAGMA continues to push for a Medical Policy Committee at Transamerica made up of physicians to help address these issues. There are indications that this process will be formalized in the near future.

Medicare Appeals Procedure

So, what can you do? The Medicare appeal procedures available to physicians are as follows:

- **The Fair Hearing**

At the first level, if a physician is dissatisfied with the carrier's initial determination denying or reducing the amount of payment, the physician may, within six months of the date of initial determination, request review by the carrier of the initial determination. The carrier is obligated to issue a written decision if the physician is dissatisfied with the decision. Further, there is a right, upon request, to a fair hearing with respect to all claims where the amount in controversy is or exceeds 5100. Typically, when a hearing is requested by a physician, Transamerica Occidental will arrange for a telephone hearing unless there is a specific request for an in-person hearing. At this fair hearing, the physician is entitled to a hearing officer who is competent, knowledgeable, and impartial. Hence, the hearing officer should not have been involved in the initial review determination in any way. The requirement of impartiality does not mean that the hearing officer cannot be employed by the carrier and, indeed, the hearing officers are typically insurance carrier employees. At the Medicare fair hearing, a physician has the right to be represented by an attorney of his or her choice, the right to present. oral arguments and/or written statements, the right to bring witnesses to testify the right to bring and present evidence, the right to question witnesses, and the right to examine the evidence and to register objections to the inclusion of any document in the record. Typically, at the Medicare fair hearing, no actual witnesses are presented by the carrier and the carrier's review determination is supported only by documentation. The Medicare hearing is thus an excellent opportunity for the physician to win the case and obtain a reversal of the initial decision.

Following the Medicare fair hearing, a written decision should be issued containing a statement of the issues, a statement of the applicable law and regulations, a discussion of the law and the evidence, a statement of the specific facts determined by the hearing officer, and the decision of the hearing officer.

If the hearing officer's decision is clearly in error, or if it does not contain a complete statement of reasons for the decision, or if the legal precedents relevant to the decision have changed, a written request may be made to reopen the decision.

- **Administrative Review**

If there is dissatisfaction with the decision of the hearing officer, a hearing may be requested before an administrative law judge of the Office of Hearings and Appeals of the Social Security Administration. Such a request must be filed no later than 60 days after receipt of the decision if the amount in question exceeds $500.

The request for hearing should be in writing and should include a statement of any additional evidence to be submitted, the date that it will be submitted, and the reasons that the appellant disagrees with the previous decision. Thereafter, the appealing physician should submit the evidence (or a summary of the evidence) to be considered at the hearing. The administrative law judge will then send a notice of the time and place of the hearing and the issues to be decided.

In presenting the case before the administrative law judge, the physician should present a written summary of the case. He or she should also present whatever evidence he or she is relying upon. This evidence may be admitted even though it may be inadmissible in court.

In a hearing before an administrative law judge, the administrative law judge may issue subpoenas upon request when it is "reasonably necessary for the full presentation of the case." Similarly, documents can be subpoenaed if they are material to any issue at the hearing itself, witnesses may appear who may be questioned by the administrative law judge. The administrative law judge is required to look fully into the issues, question the appealing physician and other witnesses, and accept as evidence any material documents.

Following the hearing before the administrative law judge, a written decision is prepared, giving findings of fact and the reasons for the decision. The decision of the administrative law judge is binding unless there is a basis to make a further appeal to the Appeals Council.

- **Appeals to the Appeals Council**

An appeal may be made from an administrative law judge decision to the appeals council when the physician is dissatisfied with the decision of the administrative law judge. The appeal to the appeals council must be in writing and must be filed within 60 days after receipt of the administrative law judge's decision. The appeal should include a statement of the specific documents (or other evidence that the physician seeks to have

the appeals council consider) and a statement of the specific issues or findings of facts and conclusions of law with which a physician disagrees.

The appeals council is not required to review all cases. It will, however, review a case where there appears to be an abuse of discretion by the administrative law judge; where there is an error of law; where the actions, findings, or conclusions of the administrative law judge are not supported by substantial evidence; or where there is a broad policy or procedural issue that may affect the general public interest. In an appeals council review, a physician or his or her attorney may file briefs and/or may appear before the appeals council to present evidence and make oral arguments.

The appeals council may modify, affirm, or reverse the decision of the administrative law judge. It may also remand the case to the administrative law judge for additional proceedings. The decision of the appeals council must be based upon the evidence in the hearing record and any additional evidence received by it.

That decision is final and binding unless judicial review is sought.

- **Judicial Review**

In cases where $1,000 or more is in controversy after administrative review, a lawsuit may be filed in federal district court to challenge the decision. Regardless of considerations of fraud and abuse, all physicians should be aware of the quasi-judicial procedures available to them to challenge erroneous or unfair Medicare decisions. Physicians who make such challenges have an excellent opportunity to overturn the initial determinations against them.

When one considers fair hearings, alone, reversal rates of 50% and greater are not uncommon.

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