Winning the Audit Appeal Game

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Experts offer tips on what providers need to implement to create a winning audit appeal strategy.

By Joseph Duffy

Fighting audits is a lot like playing a board game with a constantly shifting rulebook. Worse yet, the game of overturning recoupments is won providers must play to win, because their businesses — and patients — depend on those victories.

Audits continue to strangle many HME providers, tying up human resources and draining already dwindling revenue. Wayne van Halem, AHFI, CFE, President of The van Halem Group, ranks audits as the No. 2 industry challenge, only behind reimbursement cuts. Here's why:

"The audits are intrusive and require a significant amount of work," he said. "Couple that with lower reimbursement, it is even more challenging. Audits are difficult because they rely on the referring physician to document certain things that they may not be aware of because Medicare does not do a good job in educating the physicians on DMEPOS coverage policies. And they have no skin in the game.

"So, ultimately it is up to suppliers to educate their referral sources, which they are not usually receptive to," van Halem continues. "Suppliers have little control over what the physician documents but ultimately they are held liable. With the volume and intensity of the

audits, the liability factor has increased dramatically over the last several years."

Compounding the overall problem is a lack of good audit data, which industry experts say is integral in seeking relief through Congress (see Audit Key sidebar).

So with the number of audits not diminishing anytime soon, HME providers need to understand and strategize behind their important right to appeal audit findings.

Appeal Basics

Denise M. Leard, Healthcare Regulatory Attorney at Brown & Fortunato, P.C., offered a quick breakdown of the audit appeal process:

- A supplier has 120 days from the date of the demand letter to file its redetermination request.
- Once the redetermination appeal is received, the carrier has 60 days to issue a decision.
- Once that decision is received, the supplier has 180 days to file its reconsideration decision.
- Although the ALJ is required by statute to issue a decision within 90 days, it will be several years before the case is assigned to an ALJ and a decision is issued.
- If unsatisfied with the ALJ decision, a provider may appeal to the Medicare Appeals Council (MAC). The appeal must be filed within 60 days of receiving the ALJ decision.
- If unsatisfied with the MAC decision, a supplier can file in federal district court. The demand letter will set forth the supplier's rights regarding appeal.

The supplier needs to have a process in place that puts appeal deadlines on the calendar. If a deadline is missed, further appeal rights are forever lost.

Leard suggested that all suppliers visit the website for the Medicare Office of Hearings and Appeals at www.hhs.gov/omha/process/index.html. You will find detailed appeals process information, including how to submit an appeal and what elements are required.

"The first two levels of appeal have historically been harder to obtain a reversal," she said. "The third level of appeal or the ALJ Hearing is the most successful."

To Appeal or Not to Appeal

Although any audit finding can be appealed, experts have different tactics on approaching an appeal decision. Moreover, the tactics are regular shifting given the massive backlog of hundreds of thousands of appeals at the administrative law judge level, the zenith of the appeals process. Now standing at three-plus years, the backlog forced the Office of Medicare Hearings and Appeals to stop assigning ALJs to appeals until it could reduce the glut.

"Suppliers have to make a business decision regarding how appeals are handled," said Kim Brummett, vice president of Regulatory Affairs for the American Association for Homecare. "The first step is for the supplier to know if the patient qualifies according to all of the requirements Medicare requires. If the patient does not meet the criteria, then a supplier might decide it is not worth the cost to appeal. If a patient does qualify then a supplier should definitely file at least the first and potentially second level of appeal.

"However, as the backlog at the ALJ level grows, the decision to pursue the third and the fourth level of appeal needs to be thoroughly

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may deny the claim, another one may pay it, she said.

Esther Apter, CEO, Medforce Technologies, said that in general, she recommends appealing because the subsequent claims will be docked if you don't take any action. But, like any business decision, you need to weigh the cost of the effort with the potential value. Time is money and there is effort associated with an appeal.

"We coach our clients to sort appeals by strategic priority — usually by dollar value, but it can also be by deadline or complexity," she said. "That is when a business process management tool is especially helpful in helping to organize and prioritize appeals. If you are following traditional paper methods, appeals are often handled by the order they come in, or alphabetically, or just randomly.

"Plus, the piles of paper that need to be sorted can be especially time consuming," she adds. "When you use technology, you can first tackle the appeals that will reap the most reward. Also, you can gain access to all the needed documentation and can track the status of compiling the appeals package and make sure to stay on track and on time."

Leard said that auditors are taking a hard line, which means you need to have excellent documentation, or you will fail, resulting in the issuing of an overpayment demand.

"This often results in claims where, by looking at the documentation, a patient clearly needs the equipment in question but the claim is denied because of a technical defect," she said. "When an overpayment is issued, typically the notice letter will be accompanied by a spread-

Under Siege? Home Audit Key Needs Your Info

The American Association for Homecare (AAHomecare) is trying to quantify audit data through its Audit Key (www.hmeauditkey.org) program. The goal is to collect provider data that will completely and accurately track the impact of Medicare audits on HME suppliers and then present this data to policymakers.

HME providers can register securely, provide their data and remain anonymous. AAHomecare will begin collecting data in January 2016 for audits received starting October 1, 2015, on a quarterly basis.

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sheet that sets forth, in detail, the reason that the claim was denied. All items stated as reasons for denial should be addressed. For example, in a recent audit I was working on, there was an issue with the proof of delivery. The supplier had not included the information that tied the tracking documents to the patient and what was in the box in accordance with the supplier manual's requirements. In that case, it would be important to address the proof of delivery deficiencies."

Leard encourages anyone filing an appeal to submit all documentation that supports compliance with the local coverage determination (LCD) and all supplier manual documentation requirements that are relevant to the item being dispensed. Specifically, in regard to the LCD, the supplier should review the medical records being submitted and be able to identify in the medical records the criteria set for the LCD. Physician medical records that lack documentation of the need for the equipment are the biggest reason for an overpayment determination.

According to Apter, 86 percent of audits are based on inaccurate or incomplete documentation, such as date not stamped or the detailed written order is missing, and 22 percent is for missing documentation completely, such as delivery tickets and proof of a Face-to-Face with a physician.

"The top criteria for building a case to appeal are all about documentation," she said. "Do you have the right documentation to meet requirements? DWO, signature, date stamp? Do the medical records meet requirements? Do you need to prove medical necessity? And if so, did the physician hand-sign the CMN?"

Leard said the most successful suppliers are the ones that obtain physician records prior to dispensing medical equipment.

"These suppliers will also review the medical documentation, and if it does not address the criteria set forth in the LCD, they will go back to the physician before dispensing the equipment," she said. "At that time, the physician can either do an addendum to the medical records or the physician can have the patient make another visit. The other thing that will make a supplier successful in defending an appeal is to have a valid corporate compliance program that includes a good self-audit component. Self-audits will allow a supplier to identify areas of deficiency and to take corrective action prior to an audit request. This can greatly reduce any negative findings."

According to Stephanie Greene with ACU-Serve Corp., suppliers need to evaluate the ALJ level of appeal because of the amount of time it takes from appeal request to actually appearing for your hearing. ALJ appeals used to take nine months to a year, and now can take two-and-a-half years or longer. Greene said that when you waited no longer than a year for ALJ appeal, the timeliness of a resolution made it more inviting to enter the process. But when you have to wait three or four years, she said more suppliers are reevaluating the strengths of their arguments and appropriateness of their documentation at the reconsideration level more than they have before.

Best Practices for the Appeal Process

Although a successful appeals process is a collection of practices and processes that should start well before you even see a patient, our experts offer some solid tips that aim to make your appeals process successful:

"Most audits are a result of data analysis," said van Halem. "They will review claim denials and identify high error rates. Then they will deter-

The Best Offense for Appeals: A Good Defense

One of the best strategies against an audit and possible appeal is prevention — making sure your processes are created and maintained to produce a claim that is virtually audit-proof. Wayne van Halem, President of The van Halem Group, recently held an HME Business University webinar titled, Top 10 Audit Tips. He suggested:

Have a compliance program that meets all of Medicare's requirements. The elements you need to have in place to consider your program is valid include:

- Policies and procedures
- Compliance Officer/Committee
- Internal audits
- Targeted education and training
- Publicized and utilized disciplinary guidelines
- Timely response to issues/offenses

Look at your data — 95% of audits are direct results of data analysis. Medicare will focus on:

- Spikes in billing
- NPI concentrations
- Maximum allowed amounts
- Diagnosis codes
- Accessories
- Risk assessments

Develop an internal quality assurance/prescreen process. Look at it from a reimbursement standpoint, especially at the high-risk codes. Make sure to:

- Use checklists
- Implement a prior approval process
- Track errors and issues
- Perform education and training
- Implement corrective actions or disciplinary standards

To listen to the webinar, get important details and hear all his top tips, click here.

mine which suppliers bill the most or have the highest error rates and target them. They look for spikes in billing for particular providers or particular codes and then focus on those. They could be billing apparently in comparison to their peers and that will often spark an audit. Lastly, complaints received from physicians or beneficiaries will often result in an audit."

Greene offered the following tips for the first two levels of appeal:

- Redetermination level — Make sure your records are organized and legible and include all coverage requirements and audit requests. Organization lets auditors easily find your provided information. When the reviewer can easily navigate through your documentation and see you have met the guidelines, your appeal can go a lot smoother. Also, don't impact your cash flow — submit your appeal as soon as possible.
- Reconsideration level — Focus on why you disagree with the redetermination decision. Why do you think your records support the claims and why do you think the redetermination decision is wrong? Build on answering these questions while keeping in mind the continued importance of organization.

Brummett suggested that suppliers follow the requirements for each level of appeal as published by Medicare.

"The first step when an audit is denied is to evaluate the patient information to assess if all aspects truly meet all Medicare requirements," she said. "The best way to improve the odds of winning is to set up a process at intake to ensure all requirements are met. A good internal compliance program that assesses all aspects prior to delivering goods and services to a patient is the best way to ensure a winning audit resolution and appeals process."

Leard said every provider must:

- Get your documentation up front, prior to dispensing the equipment.
- Be intimately familiar with the LCD for the items you are dispensing and ensure that all the medical necessity elements are met.
- Constantly train. On a regular routine basis, engage your staff and make sure they understand and can apply the relevant LCD. There are multiple resources available, including DME MAC education offerings.
- Organize your appeal documentation. More is not always better. The reviewers have large workloads and may only spend a few minutes on the claim at hand. Therefore, the supplier should provide a patient summary outlining where in the physician progress notes the LCD criteria is found. By making sure the important information is easy to find, the supplier will increase its chances of being successful.
- Always be on the defense. Constantly assess your billing processes and look for ways to improve.

And Apter suggested:

- The first step is having a strong internal process for handling an appeal. This includes establishing procedures and protocol, assigning responsibilities and having appropriate training.
- Once you are faced with a denial that you'd like to appeal, refer to the guidelines and checklists that Medicare provides. They are created by type of equipment (oxygen, power device, etc.) and can be incredibly helpful in ensuring you can defend that you provided the service or product in a way that justifies reimbursement.
- Now that you know the lay of the land and what the auditors will be looking for, start by gathering all of the information and organizing all of your documentation into one place.
- Review all of your documents to make sure they are clear and legible. If the auditors can't tell what it is or read the document, they won't give you the benefit of the doubt.
- A clear and concise cover letter is a must. Indicate what was denied on what date, what you are sending, what is attached, and why it meets the guidelines. Clearly state what your request is at the end. Don't leave anything up to guessing on the auditors' part because they will not give you the benefit of the doubt. End with a direct state-

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ment, such as "Please reconsider…"

Finally, Apter recommended leveraging technology to help win an appeal:

- At a minimum, a robust document management tool will enable you to gather all of the needed documentation with a few clicks, especially when you can leverage full-text-search in the case that something has been misfiled.
- Business Process Management (BPM) tools are incredibly powerful when it comes to planning appeals. The BPM technology sets out a workflow that determines who needs to take what action, with which documentation at what time. The who, what and when are laid out to guide you, and the timeline and use of alerts and escalations keeps everything on track.
- If a provider is not able to purchase a full BPM system, look for something that is geared specifically toward appeals. We have an Appeals Management App that is focused specifically on workflows that manage incoming ERNs, gathering pertinent documentation and creating professional cover letters. Not only does technology help keep things from falling through the cracks, but it dramatically reduces the effort associated with planning and tracking an appeal, which improves your effort-to-value ratio.
- esMD is another technology that can help with the transmission of these requested documents to auditors. When you send by email or fax, it can feel like your submission went into a black hole. That is why we had Medforce certified as a one of the first HIH providers, so we can assist our clients in electronic submission of medical documentation (esMD). ■

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