TN Division of TennCare

March 7, 2018

[redacted]

RE: Notice of Hearing, [redacted]

Dear Mr. [redacted]:

Pursuant to the Court's pre-hearing order in this matter, please find enclosed the notice of the hearing scheduled in the above-referenced matter. The appeal will be set on a date to be determined by the Administrative Procedures Division. The attached notice sets forth the issues in this case in more detail.

HOW TO PARTICIPATE IN YOUR HEARING:

- **Location:** Division of TennCare
  310 Great Circle Road, Conference Room TBD
  Nashville, TN 37243

- **Date/Time:** **To be determined by the Administrative Procedures Division**

Please contact me should you have any questions or need additional information. You may reach me at 615-507-6858.

Sincerely,

Katie E. Moss

Katie Evans Moss
Senior Associate General Counsel

BEFORE THE COMMISSIONER OF THE
TENNESSEE DEPARTMENT OF FINANCE & ADMINISTRATION

IN THE MATTER OF: [redacted]	)	**TENNCARE PROVIDER APPEAL** [redacted]

NOTICE OF HEARING

I. PARTIES AND JURISDICTION

1. Pursuant to Executive Order No. 23 issued on October 19, 1999, the Department of Finance and Administration is the designated agency to administer all functions related to the TennCare Program.

2. [redacted] ("Provider") is a Tennessee limited liability corporation with a principle office located at [redacted].

3. Jurisdiction for this matter is provided under TENN. COMP. R. & REGS. 1200-13-18-.01, 42 U.S.C. § 1396u-6, and 42 C.F.R. § 455.200 *et seq.*

4. Pursuant to Tenn. Code Ann. § 71-5-113 and TENN. COMP. R. & REGS. 1200-13-18-.01, this contested hearing shall be held in accordance with the Uniform Administrative Procedures Act, Tenn. Code Ann. §§ 4-5-301, et seq. and TENN. COMP. R. & REGS. 1360-04-01-.01.

II. ISSUE

Whether TennCare correctly determined that [redacted] was overpaid for services that were not medically necessary, not covered, not properly coded, or not adequately documented.

III. FACTS

1. On [redacted], Centers for Medicare and Medicaid Services ("CMS") assigned the audit of [redacted] ("Provider") to [redacted], a private contractor that performed the audit of Provider on behalf of TennCare. **Attachment, page 1.**

2. The focused field audit was for the period of [redacted] as outlined in the updated Audit Test Plan. **Attachment, pp. 2-8.**

3. Provider was notified of the audit when the audit team arrived onsite on [redacted]. **Attachment, pp. 9-14.**

4. The BlueCare and United HealthCare Draft Audit Reports ("DAR")[1] were sent to Provider on [redacted]. **Attachment, pp. 15-32.**

5. Provider submitted a response to the BlueCare and United HealthCare DARs dated [redacted] **Attachment, pp. 33-35.**

6. The BlueCare and United HealthCare Revised Draft Audit Reports ("RDAR") were issued on [redacted]. **Attachment, pp. 36-59.**

[1] The Exhibits to the DARs, RDARs, and FARs and will be filed at a later date under seal after entry of a Protective Order because they contain HIPAA-protected information. Note the exhibits to the DARs and RDARs are encompassed in the FAR exhibits and therefore, only the exhibits to the FAR will be filed.

[2] Protected Health Information was contained in Provider's response which included a complete patient file as Exhibit A. Additionally, the complete Provider response (approximately 200 pages) is included as an exhibit to the FAR. Therefore, the attachments to the Provider's response are not attached to this Notice and will later be filed as a supplement under seal.

7. The BlueCare and United Healthcare Final Audit Reports ("FAR") were issued on [redacted]. **Attachment, pp. 60-84.**

8. The FARs identified an overpayment to Provider in the amount of [redacted]0 for the period of [redacted]. This total included [redacted]0 for claims paid by BlueCare Tennessee and [redacted] for claims paid by United Healthcare for services that were not medically necessary, not covered, not properly coded, or not adequately documented. Based on the FARs, an Overpayment Demand letter was sent to provider on [redacted] along with copies of the FARs. **Attachment, pp. 85-86.**

9. Provider filed an appeal on [redacted]. **Attachment, p. 87.**

IV. APPLICABLE LAW

1. **TENN. COMP. R. & REGS. 1200-13-18-.01(5):** Provider appeals shall be conducted as contested case hearings by the Tennessee Department of State, Administrative Procedures Division, pursuant to the Tennessee Uniform Administrative Procedures Act (APA).

2. **TENN. COMP. R. & REGS. 1200-13-18-.01(1)(b):** An approved provider of TennCare services may appeal the following administrative actions:… An action proposed or taken by the Bureau of TennCare or its audit contractor to recover, recoup or withhold payment from a provider, as a result of any audit performed by or on behalf of the Centers for Medicare and Medicaid Services or the Bureau pursuant to state or federal law.

3. **TENN. COMP. R. & REGS. 1200-13-18-.02(29):** Standard of Proof. A preponderance of the evidence.

4. **TENN. COMP. R. & REGS. 1360-04-01-.02(3):** Petitioner - The "petitioner" in a contested case proceeding is the "moving" party, i.e., the party who has initiated the proceedings. The petitioner usually bears the ultimate burden of proof and will therefore present his or her proof first at the hearing. In some cases, however, the party who initiated the proceedings will

not be the party with the burden of proof on all issues. In such cases, the administrative judge will determine the order of proceedings, taking into account the interests of fairness, simplicity, and the speedy and inexpensive determination of the matter at hand. The "petitioner" is usually a state agency or department.

5. **TENN. COMP. R. & REGS. 1360-04-01-.02(7):** Burden of Proof - The 'burden of proof' discussed in the definition of "petitioner" above refers to the duty of a party to present evidence on and to show, by a preponderance of the evidence, that an allegation is true or that an issue should be resolved in favor of that party. A "preponderance of the evidence" means the greater weight of the evidence or that, according to the evidence, the conclusion sought by the party with the burden of proof is the more probable conclusion. The burden of proof is generally assigned to the party who seeks to change the present state of affairs with regard to any issue. The administrative judge makes all decisions regarding which party has the burden of proof on any issue.

6. **TENN. COMP. R. & REGS. 1200-13-18-.04(1):** The Bureau is required by state and federal law to protect the integrity of the Medicaid program. This is accomplished in part by causing audits of provider claims to be conducted. Audit findings are reported to the Bureau for the purpose of recovering incorrect payments, by recoupment or withhold.

7. **TENN. COMP. R. & REGS. 1200-13-18-.04(2):** The Bureau shall notify a provider of its intent to recoup or withhold based upon audit findings by issuing a notice of action.

8. **TENN. COMP. R. & REGS. 1200-13-18-.02(4):** Audit. The systematic process of objectively obtaining and evaluating evidence regarding assertions about economic actions and events to ascertain the degree of correspondence between those assertions and established criteria and communicating the results to interested parties. Audits are conducted in accordance with AICPA (American Institute of Certified Public Accountants) auditing or attestation engagement

standards. For purposes of this chapter, audits are conducted of health care provider records, financial information, and statistical data according to principles of cost reimbursement to determine the reasonableness and allowance of costs reimbursable under the Program. Statistically valid random sampling is used to determine actual damages.

9. **TENN. COMP. R. & REGS. 1200-13-18-.02(4):** Claim. Any request or demand for money, property, or services made to any employee, officer, or agent of the state, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded was issued from, or was provided by, the State.

10. **TENN. COMP. R. & REGS. 1200-13-18-.02(28):** RAT-STATS. A widely accepted statistical software tool designed to assist the user in conducting statistically valid random sampling and evaluating audit results.

11. **TENN. COMP. R. & REGS. 1200-13-18-.02(30):** Statistically Valid Random Sampling. A method for determining error rates in healthcare billings using extrapolation. Typically used for large numbers of suspect claims or patients, a random sample of claims from a chosen population is selected using RAT-STATS or a similar program. That sample is then analyzed for errors. If the sample is the result of statistically valid random sampling, the error rate in the sample can be extrapolated to the entire population of claims.

12. **TENN. COMP. R. & REGS. 1200-13-18-.02(15):** Error Rate. The percentage of claims in a sample population that was not billed properly and is actionable. Error rates can be applied to entire populations if the sample was the result of statically valid random sampling. The use of the term 'error' does not indicate the intent of the person or entity submitting the claim.

13. **42 U.S.C.A. § 1396u-6(a)**: There is hereby established the Medicaid Integrity Program (in this section referred to as the "Program") under which the Secretary shall promote

the integrity of the program under this subchapter by entering into contracts in accordance with this section with eligible entities, or otherwise, to carry out the activities described in subsection (b) of this section.

14. **42 U.S.C.A. § 1396u-6(b)**: Activities described in this subsection are as follows:

(1) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State plan approved under this subchapter (or under any waiver of such plan approved under section 1315 of this title) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds under this subchapter in a manner which is not intended under the provisions of this subchapter.

(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this subchapter, including--(A) cost reports; (B) consulting contracts; and (C) risk contracts under section 1396b(m) of this title.

(3) Identification of overpayments to individuals or entities receiving Federal funds under this subchapter.

(4) Education or training, including at such national, State, or regional conferences as the Secretary may establish, of State or local officers, employees, or independent contractors responsible for the administration or the supervision of the administration of the State plan under this subchapter, providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

15. **42 C.F.R. § 455.232**: The contract between CMS and a Medicaid integrity audit program contractor specifies the functions the contractor will perform. The contract may include any or all of the following functions:

(a) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State Plan approved under title XIX of the Act (or under any waiver of such plan approved under section 1115 of the Act) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have the potential for resulting in an expenditure of funds under title XIX in a manner which is not intended under the provisions of title XIX.

(b) Auditing of claims for payment for items or services furnished, or administrative services rendered, under a State Plan under title XIX to ensure proper payments were made. This includes: cost reports, consulting contracts, and risk contracts under section 1903(m) of the Act.

(c) Identifying if overpayments have been made to individuals or entities receiving Federal funds under title XIX.

(d) Educating providers of service, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

16. **CMS Medicaid Program Integrity Manual, Chapter 10,[3] Section 10000**: Audit Medicaid Integrity Contractors (Audit MICs) are private companies that conduct audit-related activities under contract with the CMS MIG. Audit MICs conduct post payment audits of all types of Medicaid providers and, where appropriate, identify overpayments.

17. **CMS Medicaid Program Integrity Manual, Chapter 10, Section 10005**: the CMS's [Audit MICs] can audit claims for payment for items or services furnished under a State

[3] Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mpi115c10.pdf and attached as Exhibit 1.

plan and can identify overpayments made to individuals or entities receiving federal funds under Medicaid. The CMS' Audit MICs perform these functions.

18. **CMS Medicaid Program Integrity Manual, Chapter 10, Section 10010**: The objectives of the MIC audits are to audit provider claims and identify overpayments by ensuring that claims are paid for items and services provided and properly documented; that items and services are billed using appropriate procedure codes; and the covered items and services are paid in accordance with Federal and State laws, regulations and policies.

19. **CMS Medicaid Program Integrity Manual, Chapter 10, Section 10025**: All audits are being conducted according to Generally Accepted Government Auditing Standards (Yellow Book). If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report, which is shared with the State and the provider for comment…Based on these comments, the audit report may be revised. The MIG makes the final decision on any revisions or changes. When the audit report with any associated overpayment is finalized, the MIG sends the final audit report to the State. The State pursues collection of the overpayment from the provider in accordance with the State's laws, regulations, and procedures.

20. **CMS Medicaid Program Integrity Manual, Chapter 10, Section 10030**: Effective October 1, 2010 the look back period when requesting records must be for 5 years from the start of the audit (date the engagement letter is sent to the provider). For example, if an audit begins in October 2010, the look back period for reviewing claims and request for records would go back to October 2005.

21. **CMS Medicaid Program Integrity Manual, Chapter 10, Section 10040**: All audit findings must be supported by adequate documentation. Adequate documentation consists of documents obtained by the auditor during the course of the audit and should be part of the

audit working paper file. The working paper file contains evidence accumulated throughout the audit to support the work performed, the results of the audit, including adjustments made and the judgment of the auditor. Examples of documents are: 1. Copies of Federal and/or State policies and regulations; 2. Copies of medical/financial records to support the finding; 3. Copies of State generated Remittance Advices which support the claim payment or credit adjustment; 4. Correspondence, such as Provider Notification Letters and Record Request Letters/Lists; 5. Auditor's notes regarding the audit; and 6. Miscellaneous memoranda that pertain to the audit.

22. **CMS Medicaid Program Integrity Manual, Chapter 10, Section 10045:** Under CMS' regulations, the discovery date for overpayments begins on the date of the final written notice of the State's overpayment determination to the provider. (42 CFR § 433.316).

V. NOTICE OF SCHEDULING AND HEARING RIGHTS

TennCare gives notice to Petitioner and representative as follows:

1. A hearing in this matter will be conducted in person on a date to be determined by the Administrative Procedures Division.

2. At this hearing, Petitioner bears the ultimate burden of proof and has a duty to present evidence on and to show, by a preponderance of the evidence, that TennCare improperly determined to recoup or withhold payments to Petitioner based upon audit findings.

3. The hearing shall be conducted before an administrative law judge from the Office of the Secretary of State pursuant to the Uniform Administrative Procedures Act, Tenn. Code Ann. §§ 4-5-301, et. seq.

4. Petitioner has the right to be represented by counsel at Petitioner's expense.

Respectfully submitted,

Katie E. Moss

Katie Evans Moss (#026291)
J. Michael Kendrick (#035019)
Tennessee Department of Finance and Administration
Division of TennCare
Office of General Counsel
310 Great Circle Road, 3 West
Nashville, Tennessee 37243
(615)507-6858
(615)507-6846

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of this document has been sent by placing a true and correct copy of same by Fed Ex delivery, postage prepaid and via electronic mail to the following on this [redacted]:

[redacted]

Katie E. Moss

Katie E. Moss