CAH Billing Requirements and Compliance 2015 (and important appeals tips too!)

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Topic

- Audit/appeal tips.
- 60 day refund requirement.
- 96 Hour CAH Condition of Payment?
- Two midnight rule.
- Manuals don't limit coverage.
- Tips for medical necessity issues.
- Time limits on recovery.

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What Can You do to Prevent an Audit?

- A trick question.
- Get an “Anomalies Happen” bumper sticker.
- Goal: Know that you can defend yourself if you are audited.
- Means: Investigate like an auditor.

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What Do You Look for Before an Audit?

- Documentation.
- Code distribution patterns.
  - Variation from the norm.
  - Changes.
- Total Production.
- Bundling.
- Nervous employees.
- Credit Balances.

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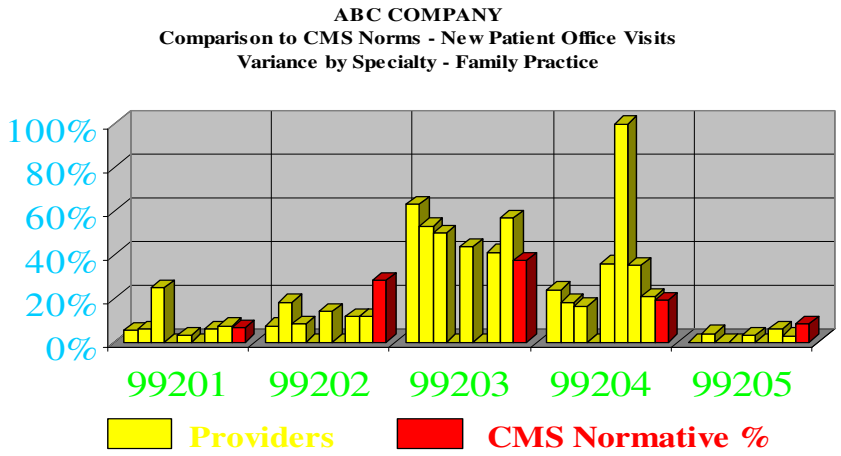
ABC Company

Comparison to CMS Norms – New Patient Visits

Variance by Specialty – Family Practice



5

Even before the letter arrives . . .

- Educate your staff about directing letters from the government to the correct person in your organization.
- Staff should understand that appeals are time sensitive.
- Date stamping.
- Envelopes. (Be a packrat!!)
- Calendar deadlines.

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Initial determination

- The letter notifying you of an overpayment decision is an "initial determination" that you may appeal.
- Appeal levels
  - Level 1: Redetermination
  - Level 2: Reconsideration
  - Level 3: Administrative Law Judge
  - Level 4: Medicare Appeals Council
  - Level 5: District Court

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Level 1: Redetermination

- You have 120 days from receipt of the initial determination to submit a request for "redetermination."
  - BUT, to stop recoupment, you must submit the appeal within 30 days after receipt.
- "Receipt" is presumed to be 5 days after the letter date.

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Who is responsible for the appeal?

- Identify your appeals team.
- Involve a physician early.
  - Treating physician versus reviewing physician?
  - Think ahead to who will testify at the ALJ hearing.

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Gathering the record

- Inside versus outside records.
- Defining the relevant time frame.
- The importance of pagination.
- Make an exact copy.
- Thorough review by the physician.

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Presentation of your arguments

- What is the best format to present your case?
  - Always include a cover letter.
  - Consider the use of tables or spreadsheets for claim-by-claim arguments.
  - Exhibit books.
  - Bottom line: make it easy for the reviewer to see your arguments and evidence.

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Writing the appeal letter

- The goal: write <u>one</u> good appeal letter to use at <u>all</u> levels:
  - Redetermination.
  - Reconsideration.
  - Administrative law judge.

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Writing the appeal letter

- Make it terse.
- Frame the argument using authority (regulation, manual). Don't let the auditor control this!
- Use plain language.
- Include only facts relevant for the standard.

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Required contents of appeal

- The request MUST include:
  - Beneficiary name.
  - Beneficiary Medicare health insurance claim number.
  - Item(s)/service(s) underlying appeal.
  - Date(s) of service.
  - Name and signature of party or representative.
- Appointment of Representative form.

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Sending the letter

- Use the address provided in the initial determination.
- Copy the right parties. (Beneficiary!!?)
- Use tracking.
- Call to confirm receipt?

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Other process issues

- RAC Rebuttal Process.
- Requesting time extensions.
  - Only rare circumstances.
  - Do NOT rely on this.
- Pay outstanding amount? Issues associated with interest.

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Level 2: Reconsideration

- You have 180 days from receipt of the redetermination to submit a request for "reconsideration."
  - BUT, to stop recoupment, you must submit the request within 60 days after receipt.

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Level 2: Reconsideration

- This is the last stage to submit new evidence, unless you can show "good cause" to the ALJ.
  - Don't count on winning a "good cause" argument.
  - What is "new" evidence? Statistics? Testimony?
- The requirements for redetermination request apply to reconsideration.

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Shakespearian Statistics

- Sampling cases present a dilemma.
- Winning on sampling may make an appeal more likely.
- Good statisticians are hard to find/expensive.
- MACs statistical “effort” is often laughable.

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Sampling Issues

- Sampling unit (claim/patient/line item).
- Size.
- Simple versus stratified.
  - Variability.
  - Footballs and fish.
- Precision (.1 vs. .25 vs. .6).
- Confidence intervals.

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Level 3: Administrative Law Judge

- 60 days after receipt of the reconsideration to request an ALJ hearing.
- CMS may resume recoupment.
- Amount in controversy requirements.
- 2 year moratorium/litigation.

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Level 3: Administrative Law Judge

- What type of review are you requesting?
  - On the record?
  - Telephone, video or in-person?
- Will you call witnesses?

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Preparing for the hearing

- Prepping witnesses
  - Legal standard.
  - Effusive or terse?
  - Cross examination.
- Exhibits.

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MAC/District Court

- Better if you don't go there.
- MAC: usually on the record; often remands.
- District court: expensive.

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Challenging Documentation Denials

- "If it isn't written, it wasn't done," isn't the law.
- Medicare payment is determined by the content of the service, not the content of the medical record.
- The documentation guidelines are just that: guidelines (although the Medicare contractor won't believe that).

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Role of Documentation: The Law

"No payment shall be made to any provider of services or other person under this part **unless there has been furnished such information** as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period."

Social Security Act §1833(e)

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Role of Documentation: Guidance from CPT and CMS

The CPT Assistant explains: “it is important to note that these are *Guidelines,* not a law or rule. Physicians need not modify their record keeping practices at all.”

CPT Assistant Vol. 5, Issue 1, Winter 1995

Then HCFA, now CMS publicly stated that physicians are not required to use the Documentation Guidelines.

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Role of Documentation: Guidance from CMS/HCFA

“Documentation Guidelines for Evaluation and Management Services Questions and Answers

These questions and answers have been jointly developed by the Health Care Financing Administration (CMS/HCFA) and the American Medical Association (AMA) March 1995.

1.

No.

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Guidance from CMS/HCFA

However, it is important to note that all physicians are potentially subject to post payment review. In the event of a review, Medicare carriers will be using these guidelines in helping them to determine/verify that the reported services were actually rendered. Physicians may find the format of the new guidelines convenient to follow and consistent with their current medical record keeping. Their usage will help facilitate communication with the carrier about the services provided, if that becomes necessary. Varying formats of documentation (e.g. SOAP notes) will be accepted by the Medicare carrier, as long as the basic information is discernible."

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Guidance from CMS/HCFA

"6. How will the guidelines be utilized if I am reviewed by the carrier?

If an evaluation and management review is indicated, Carriers will request medical records for specific patients and encounters. The documentation guidelines will be used as a template for that review. If the documentation is not sufficient to support the level of service provided, the Carrier will contact the physician for additional information."

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How Do We Demonstrate A Service Was Performed?

- Ask.
  - The physicians.
  - Others (nurses, receptionists).
  - Secret shopper/shadowing.
- Schedules/time based billing.
- Production data.

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The "60 Day Rule"

- ACA REQUIRES reporting and returning any Medicare/Medicaid overpayment within 60 days of "identification" of the overpayment.
- What is an overpayment?
- What is identification?

New Provision

- GENERAL.—If a person has received an overpayment, the person shall—

  (A) **report and return** the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

  (B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

Overpayment

"Any funds that a person receives or retains under title [Medicare or Medicaid] to which the person, after applicable reconciliation, is not entitled under such title."

- Many things are NOT overpayments.
  - Poor documentation.
  - Violations of COP.
  - Reassignment problems.

Identification

- Not defined.
- House bill required reporting when you "know of an overpayment."
- "Identification" seems to require quantification. Otherwise, how could you return the payment?

Short Stays: Pre 10/1/13 Guidance

Medicare Benefit Policy Manual
(CMS Pub. 100-02)
§10 - Covered Inpatient Hospital Services Covered Under Part A

An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. **Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight** and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

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Pre 10/1/13 Guidance

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. **Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors**,

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Pre 10/1/13 Guidance

including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;

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Pre 10/1/13 Guidance

- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

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Pre 10/1/13 Guidance

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

Minor Surgery or Other Treatment - When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered **outpatients** for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

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Things to note

- Consistency is the hobgoblin??
- Expectation-based.
- The idea of intensity of service/severity of illness is absent.
- No reference to InterQual/Milliman or others.
- WHAT HAPPENS DURING THE STAY DOESN'T REALLY MATTER!

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New Inpatient Admission Rule

§ 412.3 Admissions

(a) For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§ 482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital. This physician order must be present in the medical record **and** be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A. In addition to these physician orders, inpatient rehabilitation facilities also must adhere to the admission requirements specified in § 412.622 of this chapter.

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§ 412.3 Admissions cont.

(b) The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. The practitioner may not delegate the decision (order) to another individual who is not authorized by the State to admit patients, or has not been granted admitting privileges applicable to that patient by the hospital's medical staff.

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§ 412.3 Admissions cont.

(b) The physician order also constitutes a required component of physician certification of the medical necessity of hospital inpatient services under subpart B of Part 424 of this chapter.

(c) The physician order must be furnished at or before the time of the inpatient admission.

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§ 412.3 Admissions cont.

(e)(1) Except as specified in paragraph (e)(2) of this section, when a patient enters a hospital for a surgical procedure not specified by Medicare as inpatient only under § 419.22(n) of this chapter, a diagnostic test, or any other treatment, and the physician **expects** to keep the patient in the hospital for only a limited period of time that does **not** cross 2 midnights, the services are generally inappropriate for inpatient admission and inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the patient used a bed.

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§ 412.3 Admissions cont.

Surgical procedures, diagnostic tests, and other treatment are generally appropriate for inpatient admission and inpatient hospital payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least 2 midnights. The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.

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§ 412.3 Admissions cont.

(2) **If an unforeseen circumstance**, such as a beneficiary's death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and hospital inpatient payment may be made under Medicare Part A.

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§ 412.46 Medical Review Requirements

(a) Physician acknowledgement.

(1) Basis. Because payment under the prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record, physicians must complete an acknowledgement statement to this effect.

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§ 412.46 Medical Review Requirements

(2) Content of physician acknowledgement statement. When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice: Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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§ 412.46 Medical Review Requirements cont.

(3) Completion of Acknowledgement.

The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

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Speaking of Admissions…..

"We expect these guidelines to reduce the volume of Part A claim denials and subsequent appeals because these guidelines provide additional clarification regarding the circumstances under which a beneficiary should be admitted as an inpatient and of the criteria that will be used during the medical review process."

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Speaking of Admissions…..

"Although we believe our previous guidelines were clear, we believe the revised guidelines will promote greater shared or mutual understanding between hospitals, physicians and Medicare's review contractors."

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Timing is Everything

"Our previous guidance also provided for a 24-hour benchmark, instructing physicians that, in general, beneficiaries who need to stay at the hospital less than 24 hours may usually be treat as inpatients. Our proposed 2-midnight benchmark, which we now finalize, simply modifies our previous guidance to specify that the relevant 24 hours are those encompassed by 2 midnights. . . .

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Timing is Everything

. . . Contrary to the commenters' suggestion, we do not refer to "level of care" in guidance regarding hospital inpatient admission decisions. Rather, we have consistently provided physicians with the aforementioned time-based admission framework to effectuate appropriate inpatient hospital admission decisions. . . .

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Timing is Everything

. . . This is supported by recent findings in the Office of Inspector General (OIG) Hospitals Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries, OEI-02-12-0040."

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Appeals

- You can still appeal (and should) denials of short stays with admission dates prior to 10/1/13.
- In fact, the new rule supports appeals of pre-10/1/13 admissions where the physician expected the patient to stay overnight or 24 hours.

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The 96 Hour "Rule"

- Really two statutes. Condition of payment/COP (COP is condition of participation.)

COP: A CAH "provides not more than 25 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient"

SSA 1820(c)(2)(B)(iii)

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The 96 Hour "Rule"

The reg reads: "*Standard: Length of stay.* The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.

42 CFR§ 485.620(b)

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96 Hour Rule: **42 U.S. Code § 1395f**

(a) **Requirement of requests and certifications**
Except as provided in subsections (d) and (g) of this section and in section 1395mm of this title, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc of this title and only if—

(8)in the case of inpatient critical access hospital services, a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the critical access hospital.

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96 Hour Rule: 42 CFR §424.15

Requirements for inpatient CAH services.(a)*Content of certification.* Medicare Part A pays for inpatient CAH services only if a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

(b)*Timing of certification.* Certification is required no later than 1 day before the date on which the claim for payment for the inpatient CAH services is submitted.

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CMS Guidance

e. CAHs: For inpatient CAH services, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

Hospital Inpatient Admission Order and Certification Sept.5, 2013

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CMS Guidance

5. Default Methodology for Initial Certification: In the absence of specific certification forms or certification statements, CMS and its contractors will look for the following medical record elements in order to meet the initial inpatient certification requirements….

e. The CAH 96 hour expectation requirement will be met **either** by physician notes **or by actual discharge within 96 hours**.

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January 30, 2014 Guidance

e. For inpatient CAH services only, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. Time as an outpatient at the CAH does not count towards the 96 hours requirement. The clock for the 96 hours only begins once the individual is admitted to the CAH as an inpatient. Time in a CAH swing-bed also does not count towards the 96 hour inpatient limit.

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January 30, 2014 Guidance

If a physician certifies in good faith that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH and something unforeseen occurs that causes the individual to stay longer at the CAH, there would not be a problem with regards to the CAH designation as long as that individual's stay does not cause the CAH to exceed its 96-hour annual average condition of participation requirement.

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January 30, 2014 Guidance

However, if a physician cannot in good faith certify that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH, the CAH will not receive Medicare reimbursement for any portion of that individual's inpatient stay.

Hospital Inpatient Admission Order and Certification Guidance, January 30, 2014.

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Medical Necessity Denials

- Use the "treating physician rule."
- The theory is that the patient's physician is objective. Therefore, the physician's opinion receives deference.
- Medicare's legislative history supports this argument.

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The "Treating Physician Rule."

"It is a well-settled rule in Social Security Disability cases that the expert medical opinion of a patient's treating physician is to be accorded deference by the secretary and is binding unless contradicted by substantial evidence… This rule may well apply with even greater force in the context of Medicare reimbursement. The legislative history of the Medicare Statute makes clear the essential role of the attending physician in the statutory scheme; 'the physician is to be the key figure in determining utilization of health services.'" Gartmann v. Secretary of the U.S. Department of HHS, 633 F.Supp. 671, 680-681(E.D. N.Y. 1986).

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The "Treating Physician Rule."

A carrier is expected to place "significant reliance on the informed opinion of the treating physician" and to give "extra weight" to the treating physician's opinion. Baxter v. Sullivan, 923 F.2d 1391, 1396 (9th Cir. 1991).

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The "Treating Physician Rule."

- CPM Ch. 30, § 100.2 forbids carriers from recouping an overpayment on the basis of a lack of medical necessity if a situation is ambiguous enough that the carrier requests its own physician consultant to review whether the services are covered.
- This should place the burden of proof on a carrier during an appeal.
- It provides a firm ground for challenging the carrier's arguments that office visits can be denied as not medically necessary.

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Manuals/Guidance Can't Limit Coverage

- 42 USC §1395hh(a)(1) says nothing other than an NCD may change benefits unless promulgated as a regulation.

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Manuals/Guidance Can't Limit Coverage

"Thus, if government manuals go counter to governing statutes and regulations of the highest or higher dignity, a person 'relies on them at his peril.' Government Brief in Saint Mary's Hospital v. Leavitt.

"[The Manual] embodies a policy that itself is not even binding in agency adjudications…. Manual provisions concerning investigational devices also 'do not have the force and effect of law and are not accorded that weight in the adjudicatory process.' " Gov't brief in Cedars-Sinai Medical Center v. Shalala.

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Time Limits On Recovery

- Statutory limits:
  - 1870 (note recent change).
  - 1879.
- Regulations.
  - Any reason w/in 1 year of determination.
  - Good cause w/in 4 years of determination.
  - Anytime for fraud/similar fault.
- Manuals.

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Time Limit on RACs

- A whole different ballgame. Governed by a different statute and a statement of work.
- Statute is four FISCAL years (10/1) after the year of payment.
- Statement of work is three years. (Three years from the date of payment.)
- Statement of work should carry the day.

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Compliance Points

- How is your training?
- Do you seek certifications?
- How do you handle exit interviews?
- Are your staff prepared for unexpected guests?

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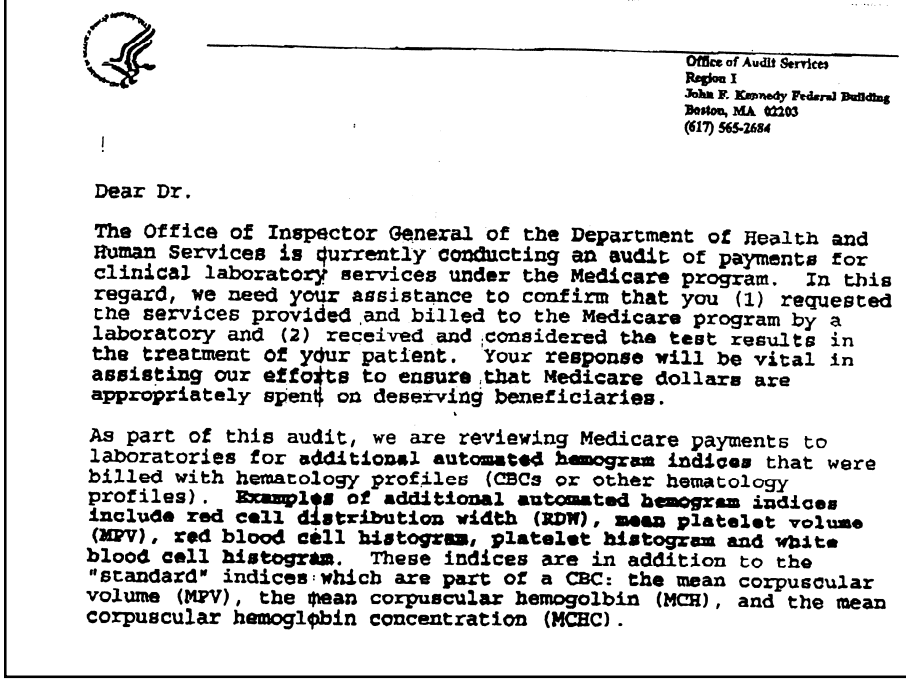
Beware of:

- Personalized correspondence.
- Medicare bulletins.
- Overpayment letters.
- Frequent denials.
- "Routine audit"/survey.



Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

Dear Dr.

The Office of Inspector General of the Department of Health and Human Services is currently conducting an audit of payments for clinical laboratory services under the Medicare program. In this regard, we need your assistance to confirm that you (1) requested the services provided and billed to the Medicare program by a laboratory and (2) received and considered the test results in the treatment of your patient. Your response will be vital in assisting our efforts to ensure that Medicare dollars are appropriately spent on deserving beneficiaries.

As part of this audit, we are reviewing Medicare payments to laboratories for additional automated hemogram indices that were billed with hematology profiles (CBCs or other hematology profiles). Examples of additional automated hemogram indices include red cell distribution width (RDW), mean platelet volume (MPV), red blood cell histogram, platelet histogram and white blood cell histogram. These indices are in addition to the "standard" indices which are part of a CBC: the mean corpuscular volume (MPV), the mean corpuscular hemogolbin (MCH), and the mean corpuscular hemoglobin concentration (MCHC).

1. **Did you order a complete blood count (sometimes referred to as a "CBC") or other hematology profiles for this patient on this date?**

   _____Yes _____No

2. **Did you specifically request any of the additional automated hemogram indices referenced above for this patient on this date?**

   _____Yes _____No

4. **If you answered "No" to question 2, please answer questions 4a through 4e below.**

   4a. Did you receive the additional automated hemogram indices as part of the test result provided from the laboratory?

   ____Yes _____No

   4b. Were the additional automated hemogram indices routinely provided as part of your request for the hematology profiles?

   _____Yes _____No _____Not Applicable

4c. Did the laboratory notify you that these additional automated hemogram indices were automatically included as part of hematology profiles?

_____Yes _____No _____Not Applicable

4d. Were you aware that these additional automated hemogram indices or other indices were billed separately under the Medicare program?

_____Yes _____No _____Not Applicable

4e. If you received the additional automated hemogram indices as part of the laboratory results, were the indices useful to you in the treatment of the Medicare patient?

_____Yes _____No _____Not Applicable

NOTE: If available, please provide an example copy of the laboratory requisition form.

Beware of:

- Contact from the carrier or OIG.
- Sudden delays in reimbursement.
- Complaints from patients.
- Complaints from colleagues.

You're Under the Microscope If:

- Medicare requests multiple medical records. (Don't worry about individual prepayment reviews.)
- You receive an overpayment letter.
- The carrier or Office of Inspector General contacts you with specific questions or seeks a meeting.
- Armed agents pop up at your home (or maybe office).

Here Comes Trouble

- CMS
- OIG
- FBI
- MFCU
- Postal Inspector
- IG Railroad Retirement Board
- DCIS
- Licensing boards
- NRC
- FDA
- DEA
- Patients

Prep Work is Key

- Know what to do/who to call.
- Try to remember these tips; it is easy to forget, and hard not to panic. (Get our laminated card.)
- An emergency plan must include how to contact people at odd hours.

The Letter

- Who sent it?
- Requests for multiple records are much more troubling.
- Make sure you keep a copy of everything you send.
- Be thorough.
- Talk with counsel.

Telephone Calls

- Get the caller's name.
- Find out what they are talking about.
- Call the person back. This will allow you to verify the caller's identity, and gather your thoughts.

The Subpoena

- A grand jury subpoena from Atlanta says, "The United States Attorney requests that you do not disclose the existence of this subpoena. Any such disclosure would impede the investigation being conducted and thereby interfere with the enforcement of the law."

Armed Agents At the Door

- If they have a warrant, let them in.
- Do not talk to them.
- Get I.D. and call a lawyer.

Dealing with Investigations

- Agents want you to talk. They will use your:
  - Fear;
  - Confidence.
- Your biggest weapon:
  - Silence.
- Be especially wary of saying “my lawyer told me it was ok.” You will have waived the attorney-client privilege.

The Agents are Not Your Friends:

- Don't try to convince the agent "It is all a misunderstanding."

Remember two key points:

- Medicare rules are complicated. You may have violated one without knowing it;
- To many investigators - there is no such thing as an "innocent mistake."

Know Your Rights

Agent:

- Can't require anyone to attend interview.
- Can't obtain documents without a warrant or subpoena.
- Can't obtain privileged information.
- Can't prevent you from talking about the interaction.

Know Your Obligations:

- Cannot prevent employees from talking.
- If you talk, you must tell the truth.
- Never destroy/hide documents.

Questions?

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