Anticipating Medicare's Alphabet Soup of Audit Contractors, Ranging from ZPICs and RACs to CERTs and MACs

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Objective

• 1) Obtain valuable information concerning CMS audit contractors to allow your laboratory to track and monitor their activities.

• 2) Understand the focus of each contractor and how they interact in their pursuit of detecting and preventing errors or fraud committed by healthcare providers including clinical laboratories.

• 3) Get practical strategies that your laboratory can apply immediately to allow you to anticipate and survive a CMS audit of your laboratory.
At the End of the Session….

• You should be able to focus your resources in an efficient and effective manner in preventing activities that could lead to a CMS audit, or,

• Respond appropriately should your lab find itself under scrutiny or dealing with a demand letter for a refund from a CMS audit contractor
MACs Are The Center

Consolidating the old system of individual Part A and Part B contractors formally known as Fiscal Intermediaries and Carriers began in 2003.

The current 15 A/B MAC jurisdictions will be consolidated to 10.

There are also “specialty MAC jurisdictions” for Durable Medical Equipment and Home Health and Hospice providers.

To find out anything or everything you ever wanted to know about this go to this webpage:
http://www.cms.gov/Medicare/Medicare-Contracting/MedicareContractingReform/index.html
Current and Future MACs
The Program Integrity Audit Contractors

- Program Integrity Contractors
  - Fee For Services (FFS) Recovery Auditors (RAs) formally known as Recovery Audit Contractors or RACs
  - State Medicaid Recovery Auditors
  - Program Safeguard Contractors (PSCs) now called Zone Program Integrity Contractors (ZPICs)
  - Comprehensive Error Rate Testing Contractors (CERTs)
  - Payment Error Rate Measurement Contractors (PERMs)
  - Medicaid Integrity Contractors (MICs)
All You Ever Wanted To Know

• CMS has created a document titled “Contractor Entities at a Glance”
• This tool will give you a view of every kind of contractor entity CMS has contracted with for everything from Program Integrity to Appeals
• The website URL did not fit on a slide but you can “Google” using the following terms without the quotation: “medicare contracting entities at a glance”
• On the next slide I will show you an example of what you find there for Recovery Auditors
<table>
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<th>Definitions and Responsibilities</th>
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<td><strong>A. Program Integrity Contractors:</strong></td>
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<td>1. Fee-For-Service (FFS) Recovery Auditors (Visit <a href="http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html">http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html</a> for more information.)</td>
<td>FFS Recovery Auditors are entities that contract with CMS to identify Medicare Fee-For-Service (FFS) improper payments (underpayments and overpayments) and correct the improper payment(s). There are four FFS Recovery Auditors. The Tax Relief and Health Care Act of 2006 (TRHCA) authorizes the FFS Recovery Audit program to perform claims reviews to identify and correct improper payments for Part A and Part B FFS claims. Recovery Auditor responsibilities include working with providers to detect and correct past Medicare improper payments and prevent future improper payments. Recovery Auditors conduct reviews of claims: • Automated (no medical records are needed); • Semi-Automated (medical records are supplied at the discretion of the provider to support a claim identified by data analysis as an improper payment); • Complex (medical record is required).</td>
<td>FFS Recovery Auditors contact providers to request additional documentation to determine if improper payments were made. If an improper payment is determined, the FFS Recovery Auditor will send a review results letter, providing the decision and the accompanying reviewer rationale. The Demand letter is issued to you by the Medicare Administrative Contractor (MAC), once the claim is adjusted. The MAC is responsible for fielding administrative concerns such as timeframes for payment recovery and the appeals process. Contact the Recovery Auditor for audit specific questions, like their rationale for identifying the potential improper payment. (Visit <a href="http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLNMattersArticles/downloads/MM7436.pdf">http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLNMattersArticles/downloads/MM7436.pdf</a> for more information.) The FFS Recovery Auditor will offer you an opportunity to discuss the improper payment determination (this is outside the normal appeal process).</td>
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Demands, Appeals and Voluntary Refunds

• Becomes important as auditing activity increases on both sides
• There are risks associated with each demand for a refund
  – Paying the refund without challenge could be seen as an admission of inaccurate billing
  – The 60 day refund time frame does not leave a lot of room for review and internal audit
• Your own audits may result in your laboratory making “voluntary refunds”
  – Risks associated with voluntary refunds include exposure to wider audits by contractors
  – Challenges of your auditing result especially when the refund is based on a sampling and not a 100% population review
  – Could expose your lab to prepayment reviews or even payment suspensions if seen as egregious
Errors vs Fraud

- Simply, errors are unintentional violations of Government or Medicare billing and/or coding rules and regulations.
- Fraud is intentional violations of Government or Medicare billing and coding rules and regulations.
- Both “errors” and “fraud” can result in improper payments.
- Improper payments was defined in the “Improper Payments Information Act of 2002” as:
  - (A) means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; and
  - (B) includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payments for services not received, and any payment that does not account for credit for applicable discounts.
Errors vs Fraud

• Prevention of making improper payments is the duty of the payer
  – Usually accomplished by using computer edits to identify and deny improper claims
  – Educating providers and suppliers about billing errors and claims submittal problems
• Prevention of submitting claims that result in improper payments is the duty of the provider or supplier
  – Usually accomplished by using computer edits to prevent improper claims from being sent to the payer
  – Educating employees and clients about billing errors and claims submittal problems
• Improper payments can result in the appearance of fraud when there is no fraud
Denial Versus Return

• If a claim is not processable because there is missing information or the information provided is not valid, the claim is returned to the provider and the provider is afforded an opportunity to correct the claim and resubmit it.

• These claims effectively do not enter the Medicare system and are not adjudicated for medical necessity or any other problem; they are rejected before they ever get into the system:
  – These claims have not been “adjudicated” or “denied” so they are not subject to an appeal.
  – Once the corrected information is provided and the claim is resubmitted, it could be “denied” for some other reason.
Causes of Improper Payments

• Medically Unnecessary Services
  – Claims are placed into the medically unnecessary category when claim review staff identifies enough documentation to make an informed decision that the services billed were not medically necessary based on Medicare coverage policies or other medical necessity criteria.

• Insufficient documentation errors
  – An insufficient documentation error occurs when the provider does not submit sufficient documentation to determine whether the claim should have been paid.
Claims Review Programs

• The overall goal of CMS’ claims review programs is to reduce payment errors by:
  – “identifying and addressing billing errors concerning coverage and coding made by providers” and suppliers
• Prevent improper payments to avoid the old “pay and chase” system
• CMS newest tool is called “predictive modeling” and is designed to detect a provider who has a pattern of claims submittal that suggests it is submitting improper claims or committing fraud
  – See MML SE1133 or Google; cms medicare predictive modeling
AC/MAC Medical Review

- Tracks and monitors error rates produced by the CERT program, the Recovery Audit (RA), analysis of claims data and other information and sources
- Identifies suspected billing problem
- Targets Medical Review (MR) activities at the identified problem and reviews a sample of claims
- Verifies an error exists and classifies the error for severity as minor, moderate or significant
- Imposes corrective action appropriate for the severity of the problem
Corrective Actions

• Informs the provider of proper billing procedures
• Imposes a prepayment review process that may include MR of a sample of claims, or all claims, depending on severity which requires review BEFORE claims are paid
  – Results in delays in payment for the claims under MR
• Imposes postpayment review which involves an MR of a sample of claims without requesting all records from the provider
  – Sometimes none are requested
Review of Records

- Either prepayment or postpayment reviews may require providers or suppliers to provide medical records or other documentation in support of the claim.
- Providers should supply all documentation requested or provide a reason for not providing a document.
- Providers should supply the information within the time frame required or the claims will be denied.
Recovery Auditor Program (RA)

- In my experience, working with laboratories who are dealing with RA audits, the supporting documents for the audits and the interpretations made by the auditors often contain inaccuracies and inconsistencies in terms of the overpayment determination.
- Laboratories need to make a decision concerning RA audits and the information provided in those audits of whether they will appeal or not.
- In many cases, laboratories do not appeal because the cost of the appeal process often is financially not beneficial, in other words, it’s cheaper to write them off than to appeal them, in the minds of the laboratory’s administrators.
- There may be unintended consequences of taking this course of action and the laboratory should carefully consider how they respond to demands for overpayments by RAC contractors and other fraud subcontractors.
• Zone Program Integrity Contractors (ZPIC) focus on performing integrity activities to prevent fraud, waste and abuse in Medicare
  – Very aggressive and specifically focus on fraud and abuse to report to the OIG
• Already have experienced some problems with effectiveness of their audits and with conflicts of interest
• Labs and hospitals have reported potentially abusive and irregular behavior by ZPICs
• OIG has conducted two separate reviews of ZPICs since November of 2011
ZPICs

• ZPICs are referred to as “the policeman of the Medicare contractor world”
• Authorized to conduct investigations, support law enforcement and conduct audits of Medicare Advantage plans
• Laboratories should take any contact from a ZPIC very seriously as they often lead to referral to the OIG for potential criminal investigations
• Contact by a ZPIC should set off bells and should invoke careful self reviews or audits of the activities cited by the ZPIC
• Some anecdotal reports by hospitals and laboratories indicating that ZPICs may overstep their authority
• CMS needs more effective oversight of ZPIC
Potential Consequences

- Audits are conducted on a sample of claims representing a specific time frame.
- Auditors may extrapolate overpayment amounts based on the sample resulting in larger refund determinations than may actually exist.
- If the laboratory agrees that the overpayments are justified and repays them, it must consider how to deal with similar cases that are outside of the timeframe used by the auditors.
  – In other words, the laboratory may find itself deciding on self-reporting additional refunds it suspects exist based on the findings of this particular audit.
- The results of these audits are reported to the Office of the Inspector General (OIG) and eventually could lead to other investigations.
- Prepayment review and medical review scrutiny is increasing.
Auditing And Being Audited

• One of the best defenses for coding and billing risks is an effective auditing plan focused on high risk areas
  – Routine auditing to catch problems
  – Defensive audits when demands for refunds are received

• Government auditors have not been very good so far and a fairly high percentage of refund demands are overturned if challenged with an appeal
  – Problem is many providers do not appeal
    • Cost of appeal outweighs refund amount
    • Fear of contractor retaliation
    • Unsure or coding and billing regulations
What Documentation Should You Submit?

• The best case for the laboratory is to win your appeal as early in the process as possible
• The best way to accomplish this is to provide complete information and documentation in the early parts of the appeal process
• Carefully review the documents associated with the denial or refund demand and make sure you provide all of the requested documents
  – Also make sure you understand why the claim was denied or the refund is required
• In any case where the documents requested are not available, explain why they are missing
Documentation

• If you know, or have an idea, that the documentation you are submitting may create a problem or misunderstanding by the auditor, explain the documentation
  – For instance, if the “order” includes a panel or profile that is customized and the explanation of the panel’s contents are included elsewhere, explain that and provide the necessary documentation to support the order which may be the signed physician acknowledgement
  – If there are inconsistencies in the documentation you send, explain that
Review of the Documentation

• Make sure that all of the documents you send are copied
• Make sure the submission is thoroughly reviewed by staff sufficiently knowledgeable about the claims submittal process in your lab
• Make sure the review includes the compliance officer
• Look for wrong documents, wrong dates of service, other inconsistencies with the request by the auditor as well as the issues involved in why the claims may be wrong
• Don’t get caught in simple problems like administrative errors which may irritate the requestor and give them a bad impression about your lab
• Use the same personnel throughout the appeal process to ensure efficient and effective responses
Follow-up and Tracking

• Keep a log or record of each refund request or audit conducted by government auditors
  – One reason is to make sure your lab isn’t subject to the same audit by some other government contractor
• Keep a library of the resources and laws and regulations involved in each audit
  – Try to determine any trends that may lead to an internal undiscovered trend or systemic problem
• Consider these audits and appeals as serious matters worth the commitment of appropriate resources to resolve them
• Use them as training tools and improvement tools for your laboratory systems and processes
Know What You Are Doing and/or Get Expert Help

- Develop auditing skills through education, conferences and self study
- Practice your skills by conducting mock audits or real audits of your own billing and coding
- Make sure you thoroughly understand the rules and regulations and the appeals process or hire an expert that does
- Read all government documentation that accompanies a demand for a refund carefully and critically, looking for errors and misquotes etc.
- Make certain you supply the appropriate documents requested and make note or comment on anything that is missing or cannot be provided
- Conduct your own review of the requested records and documents
Questions and Discussion

• We can discuss the information I provided during the presentation today or any other laboratory related questions you may have.

• If you would like to add comment or share your experience, don’t be shy, networking among attendees is one of the real benefits of the War College.

• Thank you for inviting me.