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On the topic:

The Medicare Audit Survival Kit

Lisa Maciejewski-West, CMC, CMOM, MCS-P
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The Medicare Audit Survival Kit

Presented by:
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Disclaimer

This presentation contains SAMPLE documentation forms throughout to assist you in understanding common documentation procedures. These documents are not exclusive and may not be all of the documentation you need to substantiate the need for medical necessity of a patient encounter, and/or subsequent insurance claim. You, the doctor, should inquire with the applicable insurance carriers, billing agencies, your state licensing board and your malpractice carrier to determine if additional documentation is necessary. These forms are not provided as a substitute for legal or clinical advice.

Please use these documents as illustrative of the components of documentation and not as a replacement for your clinical expertise or decision making. These forms are not intended to replace or direct your clinical expertise or decision making as you provide care to your patients.

DEFINITIONS OF FRAUD AND ABUSE

Source: ICN 006827 August 2014
What is Medicare Abuse?

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and priced fairly.

Examples of Medicare abuse include:
- Billing for services that were not medically necessary;
- Charging excessively for services or supplies; and
- Misusing codes on a claim, such as upcoding or unbundling codes.

Medicare abuse can also expose providers to criminal and civil liability.

Figure 1 shows examples along the spectrum of causes of improper payments.

Figure 1. Types of Improper Payments

Program Integrity encompasses a range of activities to target the various causes of improper payments:

1. Mistake
2. Inefficiencies
3. Bending the Rules
4. Intentional Deception

Examples:
- Error: Incorrect coding
- Waste: Medically unnecessary service
- Abuse: Improper billing practices (such as upcoding)
- Fraud: Billing for services or supplies that were not provided

What is Medicare Fraud?

Medicare fraud is typically characterized by:
- Knowingly submitting false statements or making misrepresentations of fact to obtain a federal health care payment for which no entitlement would otherwise exist;
-Knowingly soliciting, paying, and/or accepting remuneration to induce or reward referrals for items or services reimbursed by Federal health care programs; or
- Making prohibited referrals for certain designated health services.

Anyone can commit health care fraud. Fraud schemes range from solo ventures to broad-based operations by an institution or group. Even organized crime has infiltrated the Medicare Program and masqueraded as Medicare providers and suppliers. Examples of Medicare fraud include:
- Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items or billing Medicare for appointments that the patient failed to keep; and
- Knowingly billing for services at a level of complexity higher than the service actually provided or documented in the file.

Case Studies

To learn about real-life cases of Medicare fraud and abuse and the consequences for perpetrators, visit http://www.stopmedicarefraud.gov/newsroom/on the Internet.

Defrauding the Federal government and its programs is illegal. Committing Medicare fraud exposes individuals or entities to potential criminal and civil remedies, including imprisonment, fines, and penalties. Criminal and civil penalties for Medicare fraud reflect the serious harms associated with health care fraud and the need for aggressive and appropriate intervention. Providers and health care organizations that commit health care fraud risk exclusion from participation in Federal health care programs and the loss of their professional licenses.
CMS 1500 FORM – BOX 31, FALSE CLAIMS ACT

- Box 31 = Signature of Physician or supplier
- HAVE YOU EVER READ THE BACK of the CMS 1500 FORM? (the fine print)

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA, BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations and program instructions which are available from the medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision…….

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal Funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal Laws.

MEDICARE AUDITS: TYPES OF AUDITS

- Audits are COMMON and VARIED
  - Automated – within the claims processing system
    - Clearinghouse audits (are not reported to Medicare, but will delay processing and payments)
    - Non-complex – random automated review of claims at carrier (MAC) site
    - Most Common are NCCI Edits/MUE Edits
  - ZPIC’S/PSC’S – Contractors who specifically investigate medicare fraud
  - CERT – Comprehensive Error Rate Testing Audit
  - SMRC Audits – Look for issues within medical specialties nationwide
  - Medicare FFS Recovery Auditors, aka, RAC Audits

SOURCE: CMS MLN Booklet, Medicare Claim Review Programs
Background
The Federal Government estimates that about 12.7 percent of all Medicare Fee-For-Service (FFS) claim payments are improper. The Centers for Medicare & Medicaid Services (CMS) implemented several initiatives to prevent or identify and recover improper payments before CMS processes a claim, and to identify and recover improper payments after processing a claim. The overall goal is to reduce improper payments by identifying and addressing coverage and coding billing errors for all provider types. This booklet is designed to provide education on the different CMS claim review programs and assist providers in reducing payment errors – in particular, coverage and coding errors.

Claim Review Contractors
Under the authority of the Social Security Act, CMS employs a variety of contractors to process and review claims according to Medicare rules and regulations. Table 1 describes the contractors discussed in this booklet.

Key Terms
- Prepayment Review: Review of claims prior to payment. Prepayment reviews result in an initial determination.
- Postpayment Review: Review of claims after payment. Postpayment reviews may result in either no change to the initial determination or a revised determination, indicating an underpayment or overpayment.
- Underpayment: A payment a provider receives under the amount due for services furnished under Medicare statute and regulations.
- Overpayment: A payment a provider receives over the amount due for services furnished under Medicare statute and regulations. Common reasons for overpayment are:
  - Duplicate submission and subsequent payment of the same service or claim;
  - Payment to an incorrect payee;
  - Payment for excluded or medically unnecessary services;
  - Payment for services that were furnished in a setting that was not appropriate to the patient's medical needs and condition; or
  - Billing for excessive or non-covered services.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).
Table 1. Medicare Contractors and Responsibilities

<table>
<thead>
<tr>
<th>Type of Contractor</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td>Medicare Administrative Contractors (MACs)</td>
<td>Process claims submitted by physicians, hospitals, and other health care professionals, and submit payment to those providers according to Medicare rules and regulations (includes identifying and correcting underpayments and overpayments)</td>
</tr>
<tr>
<td>Zone Program Integrity Contractors (ZPICs)/Program Safeguard Contractors (PSCs)*</td>
<td>Perform investigations that are unique and tailored to the specific circumstances and occur only in situations where there is potential fraud and take appropriate corrective actions</td>
</tr>
<tr>
<td>Supplemental Medical Review Contractor (SMRC)</td>
<td>Conduct nationwide medical review as directed by CMS (includes identifying underpayments and overpayments)</td>
</tr>
<tr>
<td>Comprehensive Error Rate Testing (CERT) Contractors</td>
<td>Collect documentation and perform reviews on a statistically valid random sample of Medicare FFS claims to produce an annual improper payment rate</td>
</tr>
<tr>
<td>Medicare FFS Recovery Auditors</td>
<td>Review claims to identify potential underpayments and overpayments in Medicare FFS, as part of the Recovery Audit Program</td>
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* All PSCs transitioned to ZPICs with the exception of Zone 6. For more information, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLNMattersArticles/Downloads/SE1204.pdf on the CMS website.

For contact information for these contractors, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the CMS website.

While all contractors have a specific area of focus, each contractor conducting a claims review must apply all Medicare policies to the claims under review. Additionally, once a claim is reviewed, a different contractor should not reopen it. Therefore, it is important when conducting claims review, contractors review each claim in its entirety.

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Claim Review Programs

This booklet describes the five claim review programs and their role in the life cycle of Medicare claims processing. Each claim review program has at least one of the following levels of review:

- **Non-complex review:** Does not require a clinical review of medical documentation; or
- **Complex review:** Requires licensed professionals who review additional requested documentation associated with a claim.

The columns in Table 2 divide the Medicare claim review programs based on performance of prepayment or postpayment reviews. See Table 1 for a summary of the five claim review programs and how they prospectively identify potential coverage and coding errors.

Table 2. Medicare Prepayment and Postpayment Claim Review Programs

<table>
<thead>
<tr>
<th>Prepayment Claim Review Programs</th>
<th>Postpayment Claim Review Programs</th>
</tr>
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<tbody>
<tr>
<td>National Correct Coding Initiative (NCCI) Edits</td>
<td>Comprehensive Error Rate Testing (CERT) Program</td>
</tr>
<tr>
<td>Medically Unlikely Edits (MUEs)</td>
<td>Recovery Audit Program</td>
</tr>
<tr>
<td>Medical Review (MR)</td>
<td>Medical Review (MR)</td>
</tr>
</tbody>
</table>

* In 2012, CMS introduced the Recovery Audit Prepayment Review Demonstration, which allows Recovery Auditors to conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments. The demonstration focuses on 11 States: California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, and Texas.
How do I “armor” my practice against audits?

► Don’t stick your head in the sand. Having an “it won’t happen to me” attitude is dangerous.
► Be prepared to submit to an audit. If you were audited TODAY, what do you think would happen?
► If you are worried about TODAY, do a gap/risk analysis of the areas of your practice administration that could cause negative results on audit.

AUDIT RISK – Coding

► Are the CPT/HCPCS codes you are submitting to the insurance carrier reflective of the information in your documentation? Your documentation and coding must be a MIRROR of each other.
► Do you/your coders routinely spot check your codes against the supporting documentation? Audit yourself!
► Are your ICD10 codes reflective of the condition/diagnosis that the patient presents with?
► Are your ICD10 codes submitted at the highest level of specificity?
Audit Risk – Coding outside the NCD/LCD

- CMS Provides NCD’s (National Coverage Determinations) to help explain and guide HCP’s through correct coding, billing and documentation processes of certain procedures.
- Medicare Administrative Contractors may expand an NCD and create an LCD that further clarifies and interprets the NCD.
- Much of the verbiage contained in LCD’s will be similar to NCD’s.
- MAC’s do have latitude on giving more specificity to dx coding, documentation and utilization guidelines in their LCDs.
- Do you code, document and bill your Medicare services according to your specialty’s LCD guidelines?

Search for your LCD at your local carrier site.
Audit Risk - Documentation

How would you “grade” your notes?

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   - reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   - assessment, clinical impression or diagnosis;
   - plan for care;
   - date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient’s progress, response to and changes in treatment, as well as revision of diagnosis should be documented.
7. The CPT® and ICD-10 codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
Audit Risk - Documentation

▶ Other risk factors relating to Documentation
  ▶ Hand written notes
    ▶ Legibility
    ▶ Use of unrecognized “non standard” medical abbreviations
    ▶ Failure to provide a legend or translation
  ▶ Templates
    ▶ Relying entirely on the template to create the note.
    ▶ Not “customizing” each visit, each note looks exactly the same
  ▶ SALT – “Same as last time”
  ▶ Notes not being signed in a timely fashion – 48 hrs.

Audit Risk – Billing Errors

▶ Excessive billing errors are a high risk factor in triggering an audit.
  ▶ Garbage in – Garbage out. Are your demographics accurate?
  ▶ Are you scouring your claims for coding errors prior to transmission? Incorrect codes, missing modifiers, ICD10 codes that are not coded to the highest level of specificity, etc.
  ▶ Are too many of your claims coming back with CO-16/MA130 and OA18 denials/rejections?
  ▶ What percentage of your claims are denied/rejected? Over 10% puts you at audit risk.
COMMON BILLING ERRORS THAT CAN TRIGGER AUDITS

► CO-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
► MA-130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
► OA-18 Exact duplicate claim/service
► CO-29 The time limit for filing has expired.
► CO-11 The diagnosis is inconsistent with the procedure.

OTHER AREAS OF AUDIT RISK

► Failure to follow patient collection rules
  ► Discounting copays/coinsurance/deductible
  ► Dual fee schedules
  ► Writing off balances before attempting to collect
► Failure to follow rules of the Managed Care contracts
  ► Are you allowed to collect deductibles up front? Some contracts prohibit
  ► Do you let patients “self pay” if they have a high deductible? Most managed care agreements require you to bill, unless patient has signed a waiver (commercial plans)
► Failure to have Medicare patients sign ABN
► Failure to document non-compliant patient (missed appointments, patients releasing themselves AMA)
WHAT TO DO IF YOU ARE AUDITED

- **TAKE IT SERIOUSLY.** When receiving a notice of a Medicare audit, time is of the essence.

- **HANDLE IT PERSONALLY.** Avoid the temptation to delegate this as a routine matter to an administrative employee.

- Provide all the information requested in the letter.

- Include a copy of the complete record and not just those from the dates of service requested.

- Make sure all the medical records are legible and legibly copied. If illegible, transcribe the original record.

- If transcribing a record, make sure than any such transcriptions are clearly marked as a transcription with the current date it was actually transcribed.

- If your practice involves taking or interpreting x-rays or other diagnostic studies, include these studies.

- **Never alter the medical records after a notice of an audit.**

WHAT TO DO IF YOU ARE AUDITED

- Make color copies of medical records when the original record includes different colored ink of significance.

- Include a brief summary of the care provided to the patient with each record.

- Include an explanatory note and any supporting medical literature, clinical practice guidelines, local coverage determinations (LCDs), medical journal articles, or other documents to support any unusual procedures or billings.

- Any telephone communication with the auditor should be followed up with a letter confirming the telephone conference.

- Send all communications to the auditor by certified mail.

- Properly label each copy of each medical record you provide and page number everything you provide the auditors, by hand, if necessary.

- Keep complete, legible copies of all correspondence and every document you provide.