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RAC and Other Audits

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Stacy Harper, JD, MHSA, CPC
sharper@forbeslawgroup.com
913-341-8619

Overview

- Landscape of Current Auditing Activity
- Categories of Overpayment Requests
- Impact of Physician Documentation
- Importance of Physician Involvement
- Recommendations for Survival

Medicare Program Integrity

"Addressing improper payments in the Medicare fee-for-service program is a top priority for CMS."

Goal is to always pay the right amount to a legitimate provider, for covered, correctly coded and correctly billed services, provided to an eligible beneficiary.

Improper Payments result from:

- Fraud
- Abuse
- Provider Errors
- Errors in Payor Processing

Current Auditors

- Comprehensive Error Rate Testing (CERT) contractors and Hospital Payment Monitoring Program (HPMP)
- Carriers, fiscal intermediaries (ACs), and Medicare Administrative Contractors (MACs)
- Recovery Audit Contractors (RACs)
- Zone Program Integrity Contractors (ZPIC)
- Medicaid Integrity Contractors (MIC)
- Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Private Payor Audits

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CERT and HPMP Contractors

- Reviews statistically selected claims
- Requests Medical Records from Providers
- Determines Accuracy of Payment
- Requests Refund if Overpayment is Discovered
- Measure’s contractor’s payment error rate
- NOT intended to identify fraud
- Most recent CERT Error Rate Report available at http://www.wpsmedicare.com/part_b/business/1109_cert_errors.pdf

CERT Audit Findings

- Insufficient Documentation
  - No Response to Request
  - CBC w/ Diff, UA w/ Microscopy
  - 99211
  - Injections: Site, route, dosage
- Physician Certifications and Re-certifications
- Inpatient vs. Outpatient Observation
- Coding
- Level of E/M service provided
  - Medical Necessity
    - Missing Orders
    - Covered Diagnoses Billed Not Supported by Documentation
  - Unbundling
  - E/M Services Within the Global Period of Procedures
  - Valid Signatures

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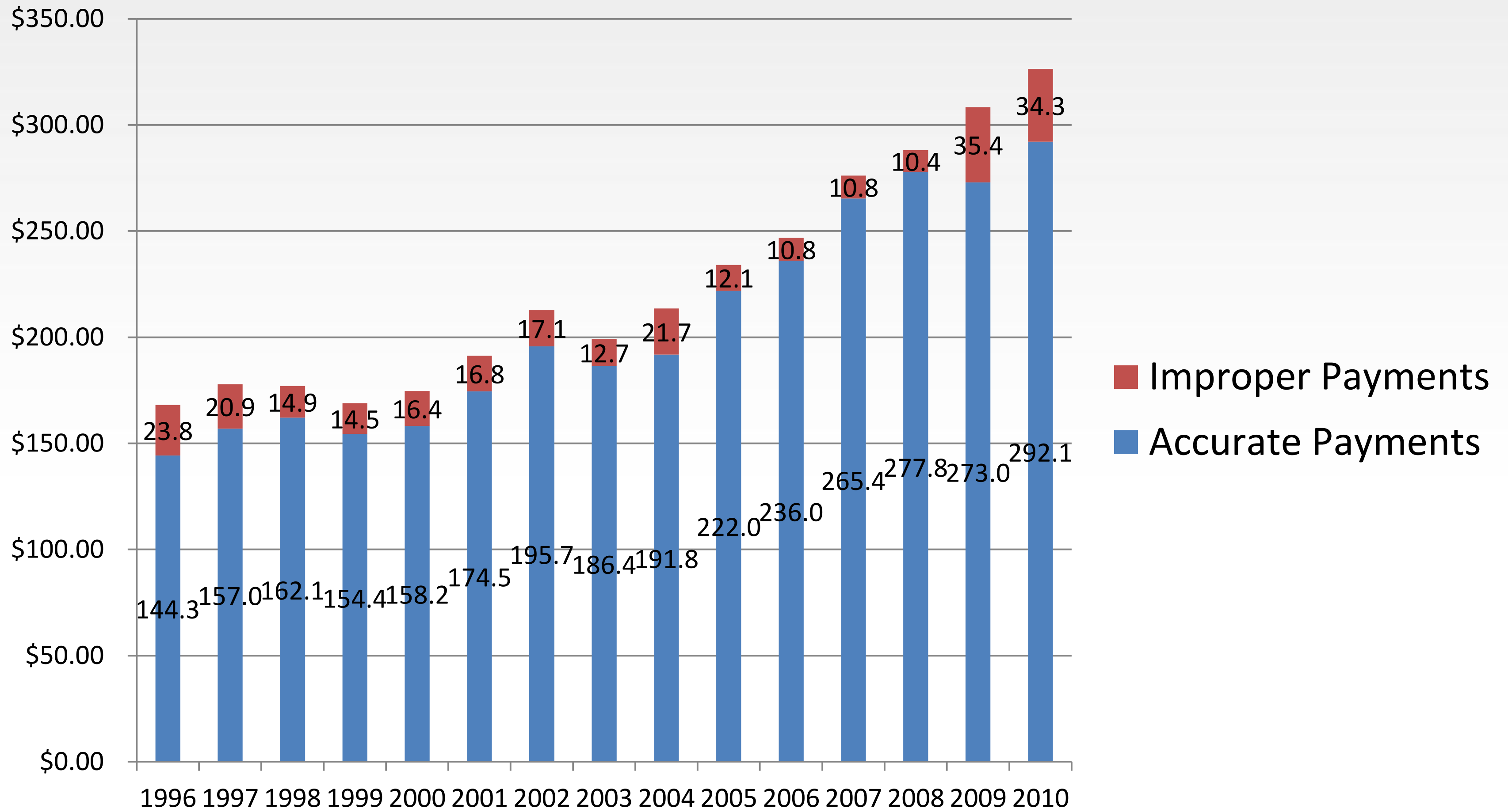
CERT Audits



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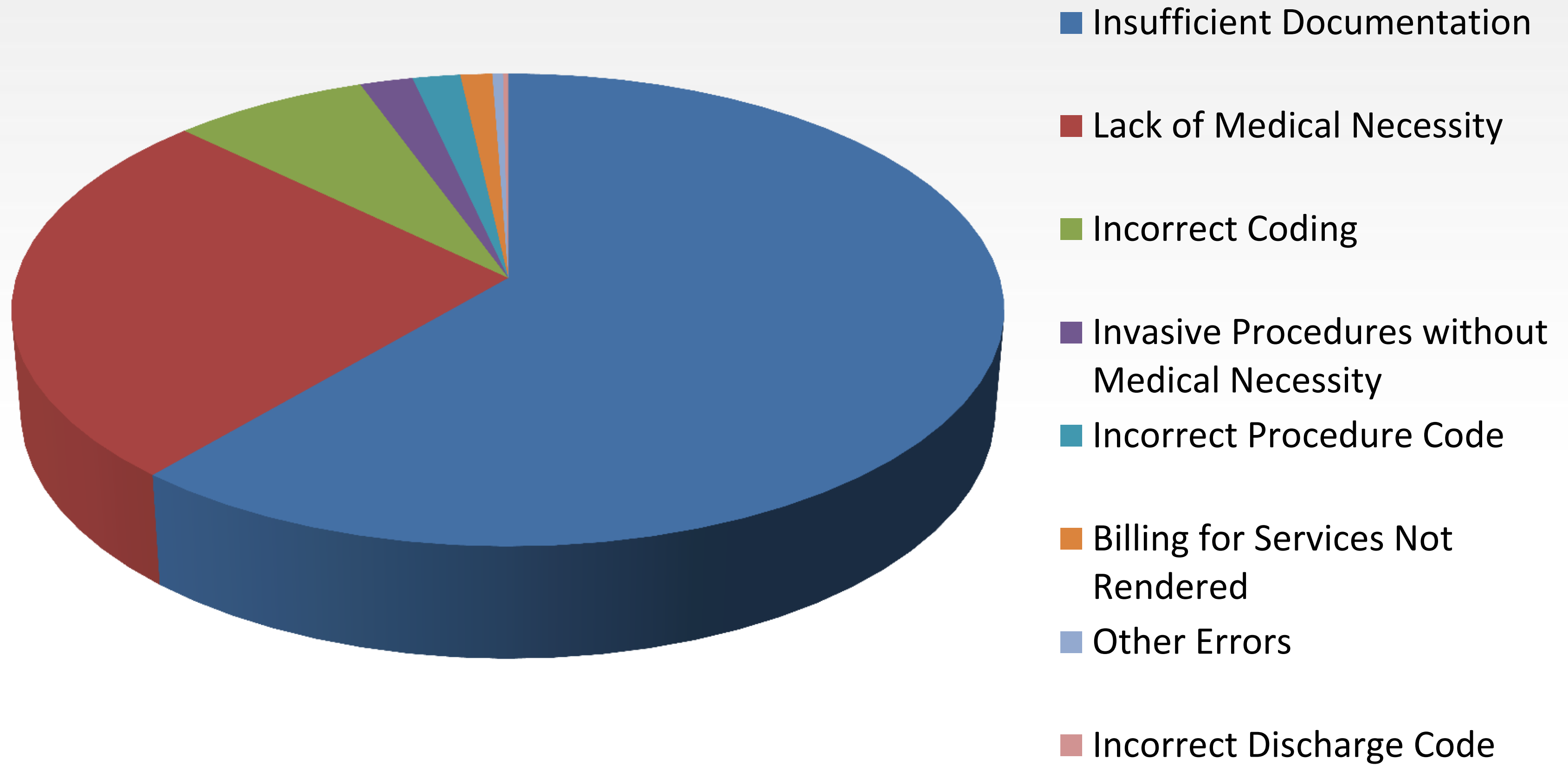
CERT Audit Findings



ACs and MACs

- Utilize Vulnerabilities Identified by CERT and RAC
- Analyze Internal Data
- Identify Errors for Failure to Follow Medicare Coverage, Coding, or Billing Rules
- Primary Initiatives:
  - Targeted provider education in areas of highest improper payments
  - Prepayment and postpayment review of services with highest improper payments
  - New/revised LCDs, articles, or coding instructions to assist providers in determining what is reasonable and necessary

RACs

- Identifies Improper Payments in Order to Implement Processes to Prevent Errors in Future Payments
- CMS-Approved Issues; Automated, Semi-Automated or Complex Reviews
- 3 Year Look Back Period; Limit 300 Records/45 Days
- Audit Findings and Focus Areas
  - Outpatient Surgery Billed as Inpatient
  - Erroneous or Overpayment of Non-Covered Services
  - Coding, DRG Assignment
  - Duplicate Payments
  - Utilization Limits (Frequency, Units)
  - Medically Unlikely/NCCI Edits
  - New Patient v. Established Patient
  - Global Periods
  - Admissions w/o Admit Order
  - Add-On Codes w/o Base Code

RACs

ZPIC

- Perform a wide range of medical review, data analysis and Medicare evidence-based policy auditing activities
- Follow patterns of other CMS auditors
- Strongly tied to identification of Fraud and Abuse
- Have a pattern of faster escalation to Fraud and Abuse investigations

MIC

- Ensure Claims Are Paid Only for Covered Services Provided, Properly Documented, Correctly Coded, and in Accordance with Applicable Laws, Regulations, Policies
- Review, Audit, and Education MICs
- 5 Year Look Back Period
- Focus Areas
  - Provider Eligibility
  - Billing for Services Not Provided/Documented
  - Payment of Services Not Medically Necessary
  - Upcoding

HEAT

- Fraud fighting task force made up of representatives from Department of Justice (DOJ), Health and Human Services (HHS), Office of the Inspector General (OIG), and Center for Medicare and Medicaid Services (CMS)
- Currently located in Baton Rouge, Brooklyn, Detroit, Houston, Los Angeles, Miami-Dade and Tampa Bay

Private Payor Audits

- Similar structure to Government Audits
- Payor-provider contract will provide limitations to the audit process
- Correct coding depends on the payor’s policy and contract requirements
- Appeals rights are often more limited and may include arbitration
- Any dispute is governed by contract law

Common Audit Triggers

- Part B Claim on Same Date of Service as RHC Visit
- Coding Distribution Outside the Bell Curve
- Routine Procedures or Standing Orders
- Modifiers 59 and 25
- Incident to Services
- RAC Audit Services
- OIG Workplan

RAC Topics

- Once in a Lifetime Codes
- Excessive Units Billed
- DME Bundling- urological, wheelchair, knee orthotic
- Global vs. TC/PC billing
- Facility vs. Non-facility Reimbursement
- SNF Consolidated Billing
- Lower limb prosthetics
- Medically unlikely edits
- Incorrect Patient Discharge Status
- NCCI Edits
- DRG Validation
- Hospice Patients
- Multiple Surgery and Global Days
- Medical Necessity for Inpatient Visits
- Annual wellness visits within 12 months
- Duplicate Services

OIG Hot Topics for 2012

- Compliance with Assignment Rules
  - Calculation of co-pay when encounter involves preventative visit
- Place of Service Errors
- Incident To Services
- Trends in E&M Coding
  - Specific focus on EMR documentation
  - Focus on identical documentation
- E&M Within Global Period and use of Modifiers
- Error Prone Providers

The Auditing Process

- Medical Records Request (unless automated RAC audit)
- Overpayment Request
- Appeals Process
  - Redetermination Request
  - Qualified Independent Contractor Consideration
  - ALJ Hearing
  - Medicare Appeals Counsel Review
  - Judicial Review in Federal Court
- Follow Up Audits

Connections to Fraud and Abuse

- High error rates are more likely to receive follow up audits or escalation to FBI/DOJ
- Contractors are using extrapolation of data to request larger overpayment amounts
- Private payors are beginning to terminate provider agreements based on high error rates

Categories of Overpayment Requests

- True Error by the Provider
- Error by the Auditing Contractor
- Billing Error Easily Corrected
- Complete Documentation Not Sent
- Documentation Does Not Reflect Services Performed

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Common Documentation Deficiencies

- Insufficient History or Examination
- Failure to Meet all Three Components for New Patients and Admissions
- Incomplete Time Documentation
- Failure to Provide Reasons for Medical Decisions
- Insufficient Support of Medical Necessity
- Failure to Reference/Incorporate Other Documents
- Incomplete/non-specific diagnoses
- Missing Physician Order
- Illegible/Missing Signature
- National/Local Coverage Policy Not Met

Inpatient Admission

CPT Code	History	Exam	Medical Decision Making	Time
99221	**Detailed** Chief Complaint HPI (4+) Ext. ROS (2-9) Pert PFSH (1)	**Detailed** Extended exam of affected area and other systems (2-7)	**Low** Diagnosis (2) Data Reviewed (2) Low Risk	30 minutes
99222	**Comprehensive** Chief Complaint HPI (4+) Complete ROS (10) Complete PFSH (3)	**Comprehensive** Comprehensive single system or multi-system (8+)	**Moderate** Diagnosis (3) Data Reviewed (3) Moderate Risk	50 minutes
99223	**Comprehensive** Chief Complaint HPI (4+) Complete ROS (10) Complete PFSH (3)	**Comprehensive** Comprehensive single system or multi-system (8+)	**High** Diagnosis (4+) Data Reviewed (4+) High Risk	70 minutes

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Subsequent Hospital Visit

CPT Code	History	Exam	Medical Decision Making	Time
99231	**Problem Focused** Chief Complaint HPI (1-3)	**Problem Focused** 1 Body area/system	**Straightforward** Diagnosis (1) Data Reviewed (0-1) Minimal Risk	15 min
99232	**Exp. Prob. Focused** Chief Complaint HPI (1-3) ROS (1)	**Exp. Prob. Focused** Limited exam of affected area and other systems (2-7)	**Moderate** Diagnosis (3) Data Reviewed (3) Moderate Risk	25 min
99233	**Detailed** Chief Complaint HPI (4+) Ext. ROS (2-9) Pert PFSH (1)	**Detailed** Extended exam of affected area and other systems (2-7)	**High** Diagnosis (4+) Data Reviewed (4+) High Risk	35 min

New Patient Office Visit

CPT Code	History	Exam	Medical Decision Making	Time
99201	Problem Focused	Problem Focused	Straightforward	10 min
99202	Exp. Prob. Focused	Exp. Prob. Focused	Straightforward	20 min
99203	Detailed	Detailed	Low	30 min
99204	Comprehensive	Comprehensive	Moderate	45 min
99205	Comprehensive	Comprehensive	High	60 min

Subsequent Office Visit

CPT Code	History	Exam	Medical Decision Making	Time
99211	Nurse visit			5 min
99212	Problem Focused	Problem Focused	Straightforward	10 min
99213	Exp. Prob. Focused	Exp. Prob. Focused	Low	15 min
99214	Detailed	Detailed	Moderate	25 min
99215	Comprehensive	Comprehensive	High	40 min

Failure to Provide Reasons for Medical Decisions

- Tie the diagnosis to the plan
- Example:
  - 1. Ulcer to the left foot
    - Clean wound
    - Apply Profore wrap
    - Follow up for dressing change in one week
  - 2. Diabetes
    - Check HgbA1C
    - Glucophage 500mg twice daily
  - 3. Hypertension
- In the hospital, correlate the progress note to the physician orders

Insufficient Support of Medical Necessity

- New focus of audits is medical necessity
- Now having board certified physicians review medical records to determine medical necessity for tests ordered and level of service provided
- Increased importance on documentation of complicating factors and medical reasoning
- Document reasons for tests similar to how it is explained to the patient
- In the hospital, if patient is receiving higher level of care than expected, explain why

Failure to Reference/Incorporate Other Documents

- Documents other than the progress note can be used toward the documentation requirements
- In order to use these documents, they must be referenced in the progress note
- Other documents commonly incorporated:
  - Physician order sheets
  - Patient history sheet or other forms completed by patient or staff
  - Nursing notes
  - Laboratory, radiology, and other diagnostic test reports

Incomplete/Non-Specific Diagnoses

- Documentation often includes a simple reference to the diagnosis, rather than full detail regarding the diagnosis. Eg. DM rather than Type II DM uncontrolled without other complication
- If documented in the medical record, often not communicated to the biller/coder
- Better specificity on diagnosis codes can support medical necessity

Missing Physician Order

- Order Completely Missing
  - Nurse Checks
  - Incomplete or unwritten protocols
- Order-Test Mismatch
  - CXR
  - CBC
  - UA

Missing or Incomplete Signature

- Signature Stamps are No Longer Accepted
- Send signature page with records
- If EMR, have electronic signature policy

National and Local Coverage Determinations

- Recent focus by fiscal intermediaries
- If coverage policy not met, then per se no medical necessity
- Coverage policies available on payer websites

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Recommendations for Survival

- Ensure staff understands when a Part B claim is proper
- Develop templates, etc to assist the physician in completing appropriate documentation
- Put systems in place to improve communication to billers/coders so that claims are accurate
- Review records before responding to a request and discuss discrepancies with the physician
- Add addendums or cover letters to records where needed
- It is more cost effective to be proactive
- Use ICD-10 preparation to improve your documentation now

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Questions????

Stacy Harper, JD, MHSA, CPC
Forbes Law Group, LLC
10740 Nall Avenue, Suite 330
Overland Park, KS 66211
(913) 341 – 8619
sharper@forbeslawgroup.com