Medicare Reviews 2018

By

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Medicare Reviews

- Why are reviews performed?
  - To detect fraud.
  - To detect abuse.
  - To ensure that claims are filed properly.
  - To determine overpayments.
  - To determine error rates for providers and provider types.
- Fraud and Abuse
  - Fraud
    - "The intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person."
  - Abuse
    - "Billing Medicare for services that are not covered or are not correctly coded."
  - In other words:
    - Fraud is a deliberate act on your part.
    - Abuse is an ooops.
- Types of reviews
  - Automated reviews
    - Computer
  - Routine reviews
    - Staff (non-medical)
  - Complex reviews
    - Licensed Professional (RN minimum)
- Who can conduct reviews
  - Office of Inspector General of Health and Human Services (OIG)
  - Centers for Medicare and Medicaid Services (CMS)
  - CMS contractors and subcontractors
    - Medicare Administrative Contractors
    - Recovery Audit Contractors
    - Zone Program Integrity Contractors
    - Comprehensive Error Rate Testing Contractors
    - Specialized contractors as needed
- Common terms related to reviews:
  - ADR – Additional Documentation Request – Medicare asking for more documentation relating to the claim.

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  - Extrapolation – Medicare taking your error rate from the review of about 34 (more or less) claims and applying it to all of your Medicare claims for the time frame of the review.
  - PCA – Progressive Corrective Action - PCA is an operational principle upon which all medical review activity is based. It serves as an approach to performing medical review and assists contractors in deciding how to deploy medical review resources and tools appropriately. It involves data analysis, error detection, validation of errors, provider education, determination of review type, sampling claims and payment recovery.
- Different reviews will have a different impact on the doctor and the practice.
- Some reviews are simply the luck of the draw and have little or no impact on the practice.
- Some reviews indicate that there is a problem with a particular claim.
- Some reviews are the start of a series that could be problematic.
- Some reviews are an immediate danger to both the doctor and the practice.
- Knowing how to spot the difference between these types of reviews can be very helpful by indicating when the doctor should get some help and informing doctor when to worry.
- Some of these reviews are indicated by who is conducting the review and some by what is being asked for in the documentation request.
- I will cover these from the least dangerous to the most dangerous.

Automated Reviews

- National Correct Coding Initiative Edits
- Codes that should not occur on the same day of service by the same provider
- Example: 97140 (Manual Therapy Techniques) and any CMT code (98940-98942)
- Medicare is watching usage of –59 modifier as they consider its' abuse as a method of getting around NCCI Edits.

Comprehensive Error Rate Testing

- One of the least harmful reviews is the Comprehensive Error Rate Testing program or CERT.
- Being selected for this review is quite literally the luck of the draw.
- 50,000 claims are randomly selected from all of the claims submitted in a given year.
- This program is ongoing and claims are selected and reviewed every year.
- This is the lowest risk review that you can have.
- The purpose of this program is to determine the accuracy of Medicare Fee-For-Service payments
- The CERT contractor will request records for a selected claim or claims
- They will review the claims and medical records for compliance with Medicare coverage, coding, and billing rules
- If they find an overpayment they turn the case over to the MAC for collections
- What do you do if chosen for CERT review?
  - Send in the requested records.

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  - If they determine that you were overpaid then you will get a request for the payment to be returned.
  - If you get a denial you should appeal it.
  - This should not be a problem for the doctor or the office.

Carrier or MAC

- The Medicare Administrative Contractors (MACs) will from time to time conduct reviews of claims.
- Sometimes it is because of a problem with a specific claim.
- Sometimes it is because of problems with the billing pattern of the doctor.
- "When MR (Medical Review) staff is reviewing a medical record for MR purposes, their focus is on making a coverage and/or coding determination."
- The MACs can conduct two types of reviews
  - Prepayment Reviews – reviews conducted prior to them releasing payment
  - Postpayment Reviews – reviews conducted after the payment has been made.
- If errors are found on a postpayment review then you will be required to refund the overpayment.
- They can go back 4 years
- The cornerstone of the MACs' efforts to prevent improper payments is each contractor's Error Rate Reduction Plan (ERRP), which includes initiatives to help providers comply with the rules.
- These initiatives usually fall into one of three categories:
  - Targeted provider education to items or services with the highest improper payments,
  - Prepayment and postpayment claim review targeted to those services with the highest improper payments.
  - New or revised local coverage determinations, articles or coding instructions to assist providers in understanding how to correctly submit claims and under what circumstances the services will be considered reasonable and necessary
- What do you do if chosen for a review by a MAC?
  - First, send in the requested records.
  - If the claim is denied then make every effort to find out what the problem is and fix it.
  - If you believe your claim was denied wrongly then appeal the denial.
  - You may need a consultant to assist you with the appeal.

Targeted Probe and Educate

- The Targeted Probe and Educate (TPE) program is new to Medicare.
- From the TPE website:
  - "CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help."
  - "The goal: to help you quickly improve. Medicare Administrative Contractors (MACs) work with you, in person, to identify errors and help you correct them."
- They list for examples of common claim errors:

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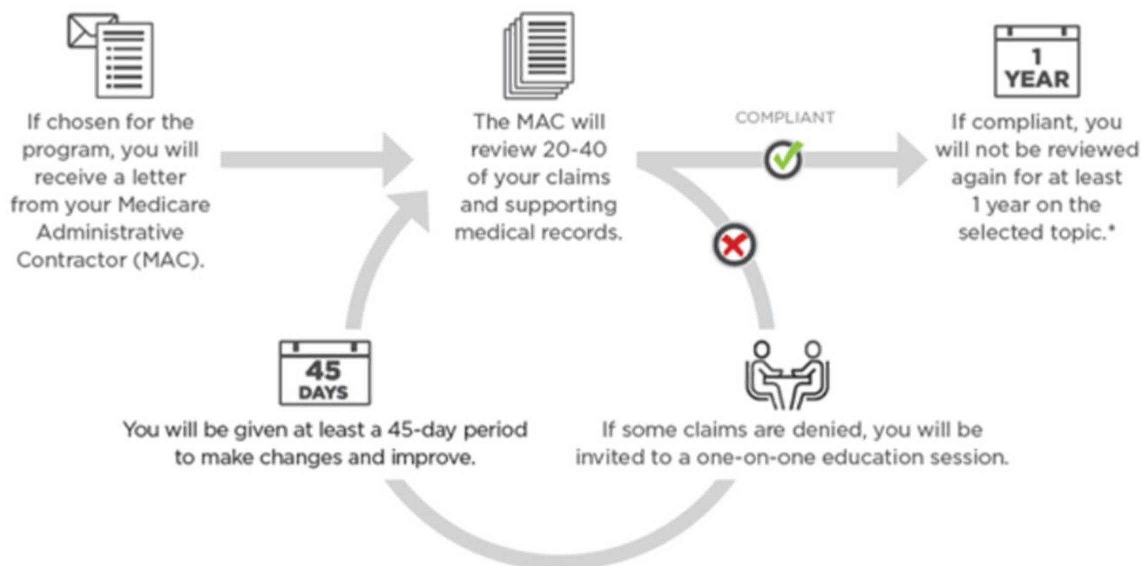
- The signature of the certifying physician was not included.
- Encounter notes do not support all elements of eligibility.
- Documentation does not meet medical necessity.
- Missing or incomplete initial certifications or recertification.

- Chiropractors are likely to run afoul of the first and third examples.



- This is an honest effort on the part of Medicare to help the provider correct their errors.
- You will get three rounds to improve your documentation.
- “However, any problems that fail to improve after 3 rounds of education sessions will be referred to CMS for next steps.”
- “These may include 100 percent prepay review, extrapolation, referral to a Recovery Auditor, or other action.”
- What do you do if chosen for a TPE?
  - Send in the records and cooperate with them.
  - If there are errors then take the time to talk to the reviewers and ask very direct questions.
  - Implement the suggested changes to the best of your ability.
  - If you fail the second round of reviews then get a consultant to assist you with your records and sit in with you and the reviewer.
  - Extrapolation is one of the options for failing for the third time so you definitely want to avoid that third failure.
- Your consultant may need to explain to reviewers how your records comply with the Medicare regulations.

Supplemental Medical Review Contractors

- The Supplemental Medical Review Contractor's (SMRC) main tasks are to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid programs.
- Having a centralized medical review resource that can perform large volume medical reviews nationally allows for a timely and consistent execution of medical review, activities and decisions.
- These are review contractors that take on additional review tasks as needed.
- A recent example of this is the targeted reviews conducted by Strategic Health Solutions on a select population of chiropractors identified in an OIG report.
- They also have the ability to look at doctors that have received Comparative Billing reports.
- What do you do if chosen for review by a SMRC?
  - Respond to the request for records.
  - Review the results of the review.
  - If there are denials get the assistance of a consultant and challenge the denials.

Zone Program Integrity Contractors

- The ZPIC investigates fraud leads and builds fraud cases
- They work with Medicare Administrative Contractors and Law Enforcement.
- If you receive a records request from a ZPIC there has, in all probability, been an allegation of fraud.
- What do you do if chosen for review by a ZPIC?
  - This is a situation where you request help immediately.
  - Start by contacting your malpractice carrier. Most now provide coverage to assist with this type of review.
  - Next hire a lawyer that specializes in this area of law and hire a consultant.
  - After you have consulted with the lawyer and consultant, respond to the request.
  - If there are denials then challenge the review and appeal the results.
  - These types of reviews can be a threat to both the doctor and the practice.
  - Follow the advice of you lawyer and your consultant.

OIG

- The OIG is strictly concerned with fraud and preventing it.
- They have their own inspectors and auditors.
- They can enter your office and inspect your files without a warrant however if they are concerned that files may be destroyed they will use a warrant or a subpoena.
- They can go back to the first day of your practice if they have reason to believe that fraud has been committed.
- If the OIG is looking at your records you have a problem.
- There is a good probability that they are investigating an accusation of fraud.

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- It could be as simple as something appearing improper or it could be an anonymous tip they are following up on.
- Whatever the circumstances, if you are contacted by the OIG understand that this is a very serious situation.
- What do you do if the OIG comes calling?
    - Step 1: CALL YOUR LAWYER…NOW!!
    - Step 2: SHUT UP UNTIL YOUR LAWYER GETS THERE!!
    - It is a very common urge to explain the situation and any "extenuating circumstances".
    - You can easily explain yourself into a great deal more trouble than you start out in.
    - You have the right to remain silent. USE IT.
    - After that, do what your lawyer tells you to.
- The OIG may come to your office or they may just send a request for records.
- If the come to your office they may call first and schedule a time (usually no more than a week in advance) or they may just show up.
- Either way you need to follow my first two steps.
- Realize that the OIG may talk to your staff and/or your patients.
- You cannot tell your staff to not talk to them.
- However you can advise them that they have the right to not talk to them, they have the right to choose the time and place where they talk to them, and they have the right to have a lawyer present.
- You would be wise to provide the lawyer.
- If the OIG just shows up at your office you should immediately do a couple of things after you call your lawyer;
- Cancel all patients for the rest of the day, and
- Send all non-essential employees home.
- If the OIG takes some copies of records you should have a consultant do a shadow audit on those records.
- The consultant should review the records that the OIG took to determine your maximum, worst-case exposure.
- This gives you a good idea of what to expect from the OIG.

Responding to Records Requests

- For routine reviews (those that are not initiated by the OIG or the ZPIC) you will want to follow these steps.
- First: respond to the request and send in the records.
- Failure to respond and send in the records will result in a denial, you paying back the money, and no chance to appeal the denial.
- If your records are handwritten and hard to read (ask your CA) then you will want to transcribe them.
- If the reviewer cannot understand you records either because they cannot read your writing or because they cannot understand your shorthand and abbreviations, they will reject the claim.

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- It is appropriate to transcribe your records when you hand write them or when you use shorthand and/or abbreviations.
- When you transcribe records you cannot add new information.
- You can translate what information is there.
- What do you do if there is information missing from the record.
- It is appropriate to insert addenda is some circumstances.
- The addenda needs to be an addition to the record and it needs to be signed by the doctor and dated as to when it was inserted.
- When the results of the review come back to you, go over them immediately.
- If several of your records were denied you will want to appeal those denials.
- Do not assume that the reviewers know more than you do.
- It may be advisable to contact a consultant at this point.
- In all probability, if your claim is denied it is for lack of medical necessity.
- You want to submit sufficient documentation to prove that the care you provided was medically necessary.
- This usually includes the records for the date of service in question, the exams before and after the date of service in question including outcomes assessments, and the treatment records between those two exams.
- The Medicare term for a records request is an ADR – Additional Documentation Request.
- The ADRs are generally sent in writing and may contain a notice that a probe review has been initiated.
- The doctor has 45 days to submit the requested documentation (Medicare Program Integrity Manual, Chapter 3, Section 3.2.3.2)

Routine Reviews

- Comprehensive Error Rate Testing Program
- Medicare Administrative Contractor
- Targeted Review and Educate (first round)
- Recovery Audit Contractors
- Supplemental Medical Review Contractors (sometimes)
- These contractors usually perform routine reviews.
- Appeal all denials from these contractors

Non-Routine Reviews

- Zone Program Integrity Contractor
- Office of Inspector General for Health and Human Services
- Reviews, audits, and/or investigations from these entities are a threat to the doctor and the practice.
- Get legal and expert consulting help immediately!!

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Summary

- There is considerable fraud, waste, and abuse in the Medicare program.
- These various reviews are designed to identify and correct fraud, waste, and abuse.
- Unfortunately, simple errors due to ignorance can result in fines and penalties that would usually result from fraud, waste, and abuse.
- You need to know what Medicare is looking for, who is looking, and where your responsibility lies.
- Understanding the Medicare review process will help in this understanding.

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