Medicare Reviews

Why Does Medicare Conduct Reviews?

- To detect fraud.
- To detect abuse.
- To ensure that claims are filed properly.
- To determine overpayments.
- To determine error rates for providers.

Definitions

- **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 deliberately lying to Medicare to receive benefits and abuse is making an unintentional mistake.

Types of Reviews

- Automated Reviews – Automatically performed by the computer.
- Routine Reviews – Performed by the non-medical staff.
- Complex Reviews – Performed by licensed professionals. By federal law these must be at least a RN.
- The automated and routine reviews do not usually involve records requests. The complex reviews do involve records requests.

NOTE - If you are receiving requests for records from Medicare, you <u>are</u> under review.

Automated Reviews

- **National Correct Coding Initiative Edits**
- CCI Edits are codes that should not occur on the same day of service by the same provider. For Example: 98941(CMT 3-4 areas) and 98925 (Osteopathic Manipulative Treatment 1-2 areas)
- **Medically Unlikely Edits**
- MUEs are concerned with units of service and are used as a pre-payment review to help prevent inappropriate payments.

Who can conduct reviews?

- Office of Inspector General of Health and Human Services (OIG)
- Centers for Medicare and Medicaid Services (CMS)
- CMS works through various contractors and subcontractors.

OIG

- The OIG is strictly concerned with fraud and preventing it. They have their own inspectors and auditors and they can enter your office and inspect your files without a warrant. The also can go back to the first day of your practice if they want to.
- OIG also maintains the List of Excluded Individuals/Entities. If you are Hiring anyone to work in your office, you should search this list at http://exclusions.oig.hhs.gov/ and print the results and place the copy in the individuals employment record. This proves that you performed due diligence. Associates should also search this database for the doctor that they are considering working for.
- The OIG can also levy Civil Money Penalties (CMP) and refer cases to the Department of Justice (DOJ) for prosecution. Last year (2008) they collected $17 for every $1 they spent on audits and collected a total of over $3.6 billion.

What To Do When The OIG Knocks

- Having the OIG in your office is like inviting a bear to dinner, the chances are that you will be the main course.
- With the OIG reviewing every chiropractor in the country the likelihood of you having an in-office audit has greatly increased.Knowing what not to do is as important as know what to do.
- If the OIG comes to your office, you are under suspicion of fraud.
- Your first impulse will be to try to explain.
- DON'T
- When you are informed that the OIG is coming to your office your first step should be to call someone who is trained and experienced.
- That person should refer you to an attorney.
- You should hire the attorney who will then hire the consultant.
- This places the consultant under attorney-client privilege.The consultant will then work with you to determine who is best equipped to locate files and associated information.
- You should then call all patients scheduled for that day and reschedule them.
- You will close the office for the time of the audit and have only the consultant the designated person present.The OIG will often got to the homes of staff members to interview them.
- You CANNOT tell your staff that they cannot talk to the OIG representatives.
- You can, however, tell them that they have the right to refuse to talk to them, to designate the time and place to talk to them and to have a lawyer present.
- You can also offer to supply the lawyer.By insulating yourself and your staff from direct, uncontrolled exposure to the OIG auditors you will decrease the chances of an escalation in the scope of the audit.
- By following these procedures you will have time and expert advice to answer questions properly with well thought out answers

Provider Error Rate

Indications at this time are that carriers track the error rate of individual providers. If the error rate is above a certain percentage (8%) the provider is put on review.

CMS

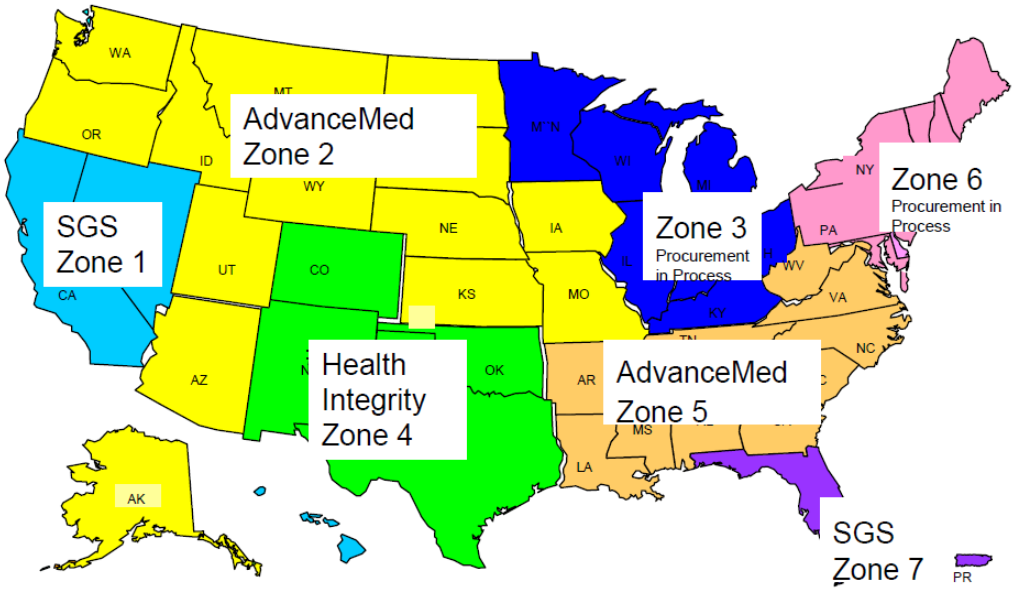
- CMS is concerned with abuse. If they find evidence of fraud, the ZPIC gathers evidence and develops a case then turns the case over to the OIG and the DOJ for further action. The MACs use various contractors and subcontractors to perform reviews. The contractors that are concerned with reviews are:
- Comprehensive Error Rate Testing (CERT)
- Zone Program Integrity Contractors (ZPIC)
- Recovery Audit Contractor (RAC)
- Qualified Independent Contractors (QIC)
- Quality Improvement Organization (QIO)

Comprehensive Error Rate Testing (CERT)

The purpose of the CERT Program is to determine the accuracy of Medicare Fee-For-Service payments. The CERT contractor randomly selects 120,000 submitted claims each year and requests records for the selected claims. The claims and medical records are reviewed for compliance with Medicare coverage, coding, and billing rules. Any detected abuse or fraud cases are turned over to the appropriate entity for further action.

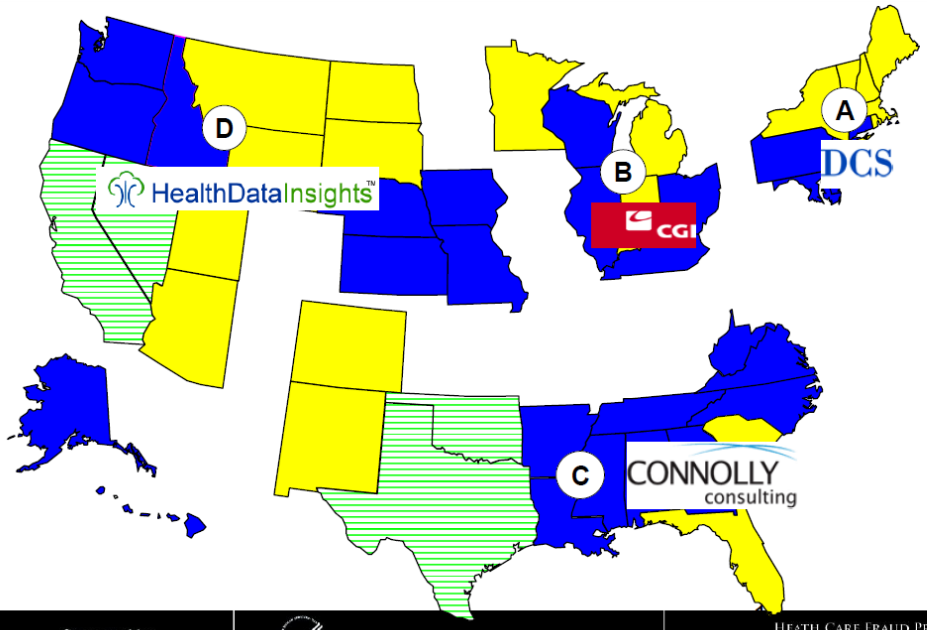
Zone Program Integrity Contractor (ZPIC)

The ZPIC (Zone Program Integrity Contractor) BI (Benefit Integrity) unit is responsible for preventing, detecting, and deterring Medicare fraud. The ZPIC BI units are required to use a variety of techniques, both proactive and reactive, to address any potentially fraudulent billing practices. If you receive a records request from a ZPIC there has been an allegation of fraud.



Recovery Audit Contractors (RAC)

- The purpose of the RACs is to detect and correct past improper payments. They review claims on a post-payment basis by using the same policies as the Medicare carriers: National Coverage Determinations, Local Coverage Determinations, and Medicare manuals.
- The RAC program was fully implemented in January 2010. They use two types of reviews: automated reviews and complex reviews. They can go back three years on your records and the appeals process is the same as for carriers.
- RACs have a limit to the number of medical records that they can request based on the number of locations and the number of doctors at each location
    - Location:
        - If you have more than one location within the same zip code they are counted as a single location.
        - If you have more than one location in more than one zip code then they are counted as multiple locations.
    - Group size:
        - If you have less than 5 doctors in the group then they can ask for 10 records every 45 days.
        - If you have 6-24 doctors in the group then they can ask for 25 records every 45 days.
        - If you have 25-49 doctors in the group then they can ask for 40 records every 45 days.
        - If you have 50 or more doctors in the group then they can ask for 50 records every 45 days.
    - RACs are paid on commission. The more they "recover", the more that they are paid. The published rates are about 12.5%. There are indications that incentives and bonuses may push these rates considerably higher.
    - As of June 2010:
        - 12.7% of the RAC determinations from the RAC demonstration project had been appealed.
        - Of those appealed 64.4% had been decided in the provider's favor.



Qualified Independent Contractor (QIC) Provide independent review of appealed claims.Review cases at the Reconsideration level (second level) of the appeals process.Currently First Coast (Florida MAC)

Quality Improvement Organization (QIO) Provides "peer review" of quality of care where specific questions arise.

- Conduct additional quality of care projects as directed by CMS.

Carrier or MAC

- When MR (Medical Review) staff is reviewing a medical record for MR purposes, their focus is on making a coverage and/or coding determination. Carriers/MACs can perform prepayment reviews and postpayment reviews. They can go back 2 years for records.

Progressive Corrective Action (PCA)

- 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.
- All Medicare reviewers use PCA to determine how to allocate resources. If they conduct a probe review and find errors, they will conduct more extensive reviews.

How to Respond to a Request for Records

- Just like testifying in court, not enough information is bad and too much information is bad.
- You need to prove that the services in question were medically necessary without causing Medicare to want to review further.
- When you receive a request for records, you need to consider the following:
    - Most Important: Don't ignore the request for records.
    - Note what they are requesting
    - Note the time frame
    - Note the deadline
    - Send all records necessary to cover the indicated time frame.
    - If you have handwritten records the reviewer may not be able to read 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.When you transcribe records you cannot add new information.
    - You can translate what information is there.
    - It is appropriate to transcribe hard to read hand written records before sending them in.

- You need to understand Medicare so that you have a system in place to prove that the care that you rendered was medically necessary

Clinical Review Judgment

- The CRJ was implemented 6-15-2010
- The CRJ involves two steps:
- the synthesis of all submitted medical record information (e.g., progress notes, diagnostic findings, medications, nursing notes) to create a longitudinal clinical picture of the patient, and
- the application of this clinical picture to the review criteria to make a reviewer determination on whether the clinical requirements in the relevant policy have been met.
- AC, MAC, CERT, RAC, PSC, and ZPIC clinical review staff shall use CRJ when making complex review determinations about a claim.
- The CRJ does not replace poor or inadequate medical records.
- CRJ by definition is not a process that ACs, MACs, CERT, RACs, PSCs and ZPICs can use to override, supersede or disregard a policy requirement. Why is this important?
- It gives us another tool to help the doctor survive a review.
- "the synthesis of all submitted medical record information (e.g., progress notes, diagnostic findings, medications, nursing notes) to create a longitudinal clinical picture of the patient"
- The doctor can now submit the additional documentation necessary to develop a complete picture of the patients condition and it **must** be considered.

Re-Submitting Claims

- If you have submitted a claim and received a denial you cannot resubmit a claim. This may be considered fraud. You must appeal.
- If the claim is returned as unprocessable you may resubmit it after making corrections.
- If the claim is unprocessable there will be three codes indicating that fact.

Unprocessable Claims

- Three codes associated with an unprocessable claim.
- CO16 – Claim is unprocessable.
- MA130 – No appeal rights exist.
- Third code – varies and describe why the claim is unprocessable.
- Code key is on bottom of Remittance Advice