Medicare and Medicaid Audits and Fraud Investigations (Part 2)

Steven J. Meyerson, M.D.
Vice President
Regulations and Education Group
Accretive Physician Advisory Service
Medicare receives over 1.2 Billion claims per year (1,200,000,000) from over 1 million providers.

This equates to:

- 4.6 million claims per work day, or
- 575,000 claims per hour
- 9,580 claims per minute
- 160 claims per second

- Each year, Medicare pays over $430 billion for more than 45 million beneficiaries.
## Error Rates and Improper Payments

### Health Care Fraud and Abuse Control and Medicare Integrity Program Discretionary Spending

<table>
<thead>
<tr>
<th>FY</th>
<th>Total Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$198 million</td>
</tr>
<tr>
<td>2010</td>
<td>$311 million</td>
</tr>
<tr>
<td>2011 (est.)</td>
<td>$561 million</td>
</tr>
<tr>
<td>2012 (est.)</td>
<td>$580 million</td>
</tr>
</tbody>
</table>

### Estimated Medicare FFS Error Rates and Improper Payment Amounts

<table>
<thead>
<tr>
<th>FY</th>
<th>Rate</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>8.0%</td>
<td>$17.1 billion</td>
</tr>
<tr>
<td>2004</td>
<td>10.1%</td>
<td>$21.7 billion</td>
</tr>
<tr>
<td>2006</td>
<td>4.4%</td>
<td>$10.8 billion</td>
</tr>
<tr>
<td>2008</td>
<td>3.6%</td>
<td>$10.4 billion</td>
</tr>
<tr>
<td>2009</td>
<td>12.4%</td>
<td>$35.4 billion</td>
</tr>
<tr>
<td>2010</td>
<td>10.5%</td>
<td>$34.3 billion</td>
</tr>
</tbody>
</table>

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Congressional Research Service Report
“Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse,” July 29, 2011.
Improper payments for health care are estimated to range between 3% and 10% of total healthcare expenditures nationally.

The Affordable Care Act (ACA) provided tools for enhanced fraud prevention and prosecution.
  – Enhanced screenings and enrollment requirements for medicare providers
  – Increased data sharing among auditors and government agencies
  – Expanded overpayment recovery efforts
  – Greater oversight of private insurance abuses

Improper Payment Elimination and Recovery Act (IPERA)
  – Signed by President Obama on 7/20/2010
“Reducing Improper Payments and Eliminating Waste in Federal Programs” signed by Pres Obama 11/20/2009
Added new requirements for all federal agencies
- Identification and measurement of high risk areas
- Reporting comprehensive improper payment measurements and reduction activities
- Posting reports on Internet
Methods to include: debarment, suspension, financial penalties, and identification through a public Internet.
Goals set by President Obama: Reduce the Medicare FFS improper payment rate from 12.4% (2009) to 8.5% by Nov 2011 and 6.2% by Nov 2012.

- Identify past improper payments through data analysis
- Correct past improper payments through post pay review.
- Prevent future improper payments through provider education.
What are “Improper Payments”? 

- Includes over and underpayments.
- Is it fraud? (Intentional falsification or deceit to obtain payment)
- Is it abuse or a “pattern of disregard” for regulations? 
  OR
- Is it hospitals providing appropriate care to their patients but unable to comply with a myriad of confusing, vague technical Medicare documentation and billing rules despite their good intentions?
  - How does CMS tell the difference? The importance of documentation!
  - How do providers protect themselves?
<table>
<thead>
<tr>
<th>#1 Defibrillator Implant (DRG514/515)</th>
<th>$64.7 M</th>
</tr>
</thead>
<tbody>
<tr>
<td>#2 CHF and shock (DRG 127)</td>
<td>$34.1 M</td>
</tr>
<tr>
<td>#3 Pacemaker implant (DRG 116)</td>
<td>$21.9 M</td>
</tr>
<tr>
<td>#4 Chest pain (DRG 143)</td>
<td>$19.1 M</td>
</tr>
<tr>
<td>#5 Misc GI (DRG 182)</td>
<td>$14.4 M</td>
</tr>
</tbody>
</table>
## Top 10 “Improper Payments” ($ prior to appeal)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Diagnosis</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>#6</td>
<td>Vascular procedures (DRG 143)</td>
<td>$13.9 M</td>
</tr>
<tr>
<td>#7</td>
<td>COPD (DRG 88)</td>
<td>$10.4 M</td>
</tr>
<tr>
<td>#8</td>
<td>Medical back (DRG 243)</td>
<td>$10.0 M</td>
</tr>
<tr>
<td>#9</td>
<td>Renal failure (DRG 316)</td>
<td>$8.5 M</td>
</tr>
<tr>
<td>#10</td>
<td>Nutr/ Metabolic (DRG 296)</td>
<td>$7.4 M</td>
</tr>
<tr>
<td>#</td>
<td>Next 10 “Improper Payments” (by $$)</td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>TIA (DRG 524)</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Syncope (DGR 141)</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Other circ system disorders (DRG 144)</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Kidney and UTI (DRG 320)</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Arrhythmia w CC (DRG 138)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>RBC Disorder (DRG 395)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Degenerative CNS disorders (DRG 012)</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Atherosclerosis w CC (DRG 132)</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Other GI (DRG 188)</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Cardiac PCI (DRG 517)</td>
<td></td>
</tr>
</tbody>
</table>
Permanent RAC: Nationwide since January 1, 2010
● Contingency fee: 9 to 12.5%
● Fee must be returned if denial overturned at any level
● Payment based on Part A overpayment minus Part B paid on re bill
RACs: Recovery Audit Contractors

Now called Recovery Auditors (RAs)
Medicare Providers Subject to RAC Audit

- Acute care hospitals (including critical access hospitals)
- Physicians (and other Part B providers)
- Long term acute care hospitals
- Inpatient rehab facilities
- Skilled nursing facilities
- Laboratories
- Ambulatory surgical centers
- DME providers
- Hospice plans
- Ambulance services
- Home health agencies
- Medicare Part D pharmacy providers
- Medicare Advantage (Part C) plans
- Any provider that bills Medicare
RAC Targets for Recovery

- Incorrect level of care: Inpatient vs. Outpatient (Observation)
- Incorrect setting (outpatient surgery: office vs. outpt hospital)
- Lack of legible documentation to support billing
  - Documentation doesn’t support medical necessity
  - Lack of physician orders
  - Illegible or missing signatures
  - No records sent to auditor
- Services that are not “reasonable and necessary”
  - Local or national coverage policies: LCDs, NCDs limit coverage
- Incorrect coding / wrong DRG
- Incorrect payments
- Ineligible beneficiaries
- Non-covered or duplicate services paid
Three Year Look Back

- The Recovery Auditor shall not attempt to identify any overpayment or underpayment more than 3 years past the date of the initial determination made on the claim.
- The initial determination date is defined as the claim paid date. Any overpayment or underpayment inadvertently identified by the Recovery Auditor after this timeframe shall be set aside.
- The Recovery Auditor shall take no further action on these claims except to indicate the appropriate status code on the RAC Data Warehouse.

2012 Statement of Work for the Recovery Audit Program, Paragraph IV. Specific Tasks, Task 2
Proposed regulations would extend the look back period for overpayments to ten years “if a person identifies the overpayment within 10 years of the date the overpayment was received.”

A definite time frame after which providers could “close their books.”

Bring it in line with the statute of limitations in the False Claims Act.

The Federal Register (Vol. 77, No. 32, P. 9184) 2/16/12
3 Types of RAC Reviews

- **Automated review**: Done by computer. Obvious billing or coding errors. Automatic recovery.
- **Complex review**: Selection based on CMS approved issues. Hospital sends medical record for RAC review.
  - Up to 2% of # of prior year’s Medicare claims
  - Up to 400 records per 45 days
  - Up to 600 records for hospitals that exceed $100 million in Medicare payments annually. (Min 35/45 days).
  - Paid for copying: $.12/pg; max $25/record. Auto payment.
- **Hybrid (semi-automated) review** (new in FY 2012): Computer selects records for review. Hospital sends medical record.
  - Any issue “probe audits” - not on published list
  - No numerical limit
  - No reimbursement for copying records
Physician ADR Limits

- Solo Practitioner - 10 medical records
- Group of 2 to 5 individuals - 20 medical records
- Group of 6 to 15 individuals - 30 medical records
- Large Group (16+ individuals) - 50 medical records
● For coverage and medical necessity determinations: clinicians, such as registered nurses or therapists
● For coding determinations: certified coders
● One medical director per RAC region
● “Auditors are not authorized to go outside of their scope of practice. Some reviews may require the skills of both a clinician and a coder.”

Medicare Quarterly Provider Compliance Newsletter
Volume 2, Issue 2 - January 2012
2172 hospitals have participated in RACTrac since data collection began in January of 2010.

Nearly two-thirds of medical records reviewed by RACs did not contain an improper payment.

$444 million in denied claims reported since Q1 2010.

The majority of complex denials are short-stay medical necessity denials.

The majority of medical necessity denials reported were for 1-day stays where the care was found to have been provided in the wrong setting, not because the care was not medically necessary.
● 2172 hospitals reporting their RAC activity to AHA RACTrac (www.aharactrac.com)

● “Medically unnecessary admission” is major reason for denial.

● The majority of medical necessity denials reported were for one-day stays where care was provided in the wrong setting, not because the care provided was not medically necessary.
• Nearly three-quarters of participating hospitals with RAC activity reported receiving at least one underpayment determination.

• Hospitals reported appealing nearly one-third of all RAC denials, with a 74% success rate in the appeals process.
  – $1/3 \times 3/4 = 25\%$ “error rate” based on completed appeals

American Hospital Association, RACTrac, Executive Summary
# RAC Denials by Reason

## RAC Denials by Reason, 1st Quarter 2012 by $$ impacted

<table>
<thead>
<tr>
<th>Region</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Unnecessary Short Stay Admission</td>
<td>53%</td>
<td>57%</td>
<td>75%</td>
<td>81%</td>
</tr>
<tr>
<td>Incorrect DRG or other coding error</td>
<td>18%</td>
<td>28%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Other med unnec</td>
<td>25%</td>
<td>10%</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>No or insufficient documentation</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Incorrect APC or OP billing code</td>
<td></td>
<td></td>
<td></td>
<td>2%</td>
</tr>
</tbody>
</table>

AHA RACTrac: Q1 2012
<table>
<thead>
<tr>
<th>% of Complex Denials for Lack of Medical Necessity for Admission – 1st Quarter 2012 - by $$ Impacted</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Syncope and collapse (MS-DRG 312)</td>
<td>25%</td>
</tr>
<tr>
<td>Percutaneous Cardiovascular Procedure (PCI) w drug-eluting stent w/o MCC (MS-DRG 247)</td>
<td>24%</td>
</tr>
<tr>
<td>Chest pain (MS-DRG 313)</td>
<td>9%</td>
</tr>
<tr>
<td>T.I.A. (MS-DRG 69)</td>
<td>6%</td>
</tr>
<tr>
<td>ESOPHAGITIS, GASTROENT &amp; MISC DIGEST DISORDERS W/O MCC (MS-DRG 392)</td>
<td>4%</td>
</tr>
</tbody>
</table>

AHA RACTrac: Q1 2012
### “All other” Complex Denials

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYNCOPE AND COLLAPSE (MS-DRG 312)</td>
<td>10%</td>
</tr>
<tr>
<td>OTHER RESP SYSTEM O.R. PROCEDURES W MCC (MS-DRG 166)</td>
<td>6%</td>
</tr>
<tr>
<td>OTHER RESP SYSTEM O.R. PROCEDURES W MCC (MS-DRG 166)</td>
<td>5%</td>
</tr>
<tr>
<td>EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC (MS-DRG 981)</td>
<td>4%</td>
</tr>
<tr>
<td>CHEST PAIN (MS-DRG 313)</td>
<td>4%</td>
</tr>
</tbody>
</table>

AHA RACTrac: Q1 2012
<table>
<thead>
<tr>
<th>Region</th>
<th>Major Medical Necessity Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A</td>
<td>Cardiovascular procedures</td>
</tr>
<tr>
<td>Region B</td>
<td>Cardiovascular procedures</td>
</tr>
<tr>
<td>Region C</td>
<td>Cardiovascular procedures</td>
</tr>
<tr>
<td>Region D</td>
<td>Minor Surgery and Other Treatment Billed as an Inpatient Stay</td>
</tr>
</tbody>
</table>

FY 2012 Q2 (Jan – March 2012)

Major Medical Necessity Issues by Region

Medicare Fee-for-Service Recovery Audit Program Report, May 2012
## Average Dollar Amount of Automated and Complex Denials (97% are complex denials)

<table>
<thead>
<tr>
<th>RAC Region</th>
<th>Automated</th>
<th>Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A</td>
<td>$435</td>
<td>$5,815</td>
</tr>
<tr>
<td>Region B</td>
<td>$454</td>
<td>$5,515</td>
</tr>
<tr>
<td>Region C</td>
<td>$515</td>
<td>$5,426</td>
</tr>
<tr>
<td>Region D</td>
<td>$654</td>
<td>$6,522</td>
</tr>
<tr>
<td>National</td>
<td>$435</td>
<td>$5,839</td>
</tr>
</tbody>
</table>

AHA RACTrac: Q1 2012
### % of Appeals Pending

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A</td>
<td>68%</td>
</tr>
<tr>
<td>Region B</td>
<td>61%</td>
</tr>
<tr>
<td>Region C</td>
<td>75%</td>
</tr>
<tr>
<td>Region D</td>
<td>80%</td>
</tr>
<tr>
<td>National</td>
<td>71%</td>
</tr>
</tbody>
</table>
## RAC Appeals

<table>
<thead>
<tr>
<th>Region</th>
<th># Denials Appealed</th>
<th>% of denials appealed</th>
<th>Appeals pending</th>
<th>Appeals withdrawn</th>
<th>Appeal success</th>
<th>% of denials overturned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A</td>
<td>12,296</td>
<td>41%</td>
<td>8,939</td>
<td>741</td>
<td>1,741</td>
<td>70%</td>
</tr>
<tr>
<td>Region B</td>
<td>15,306</td>
<td>40%</td>
<td>9,338</td>
<td>868</td>
<td>4,692</td>
<td>84%</td>
</tr>
<tr>
<td>Region C</td>
<td>16,795</td>
<td>27%</td>
<td>12,854</td>
<td>690</td>
<td>2,654</td>
<td>79%</td>
</tr>
<tr>
<td>Region D</td>
<td>17,332</td>
<td>43%</td>
<td>13,800</td>
<td>1,282</td>
<td>1,578</td>
<td>55%</td>
</tr>
<tr>
<td>National</td>
<td>61,729</td>
<td>36%</td>
<td>44,931</td>
<td>3,581</td>
<td>10.665</td>
<td>75%</td>
</tr>
</tbody>
</table>

AHA RACTrac: Q1 2012
## Major RAC Issues by Region

<table>
<thead>
<tr>
<th>Major Medical Necessity Issues by Region</th>
<th>Region A</th>
<th>Region B</th>
<th>Region C</th>
<th>Region D</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2012 Q2 (Jan – March 2012)</td>
<td>Cardiovascular procedures</td>
<td>Cardiovascular procedures</td>
<td>Cardiovascular procedures</td>
<td>Minor Surgery and Other Treatment Billed as an Inpatient Stay</td>
</tr>
</tbody>
</table>

Medicare Fee-for-Service Recovery Audit Program Report, May 2012
Will allow Medicare RACs to review claims before they are paid.


Program delayed to consider comments and develop logistics

The RACs will focus on the types of claims that historically result in high rates of improper payments.

Eleven states: Seven states with high numbers of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, IL) and four states with high volumes of claims for short inpatient hospital stays (PA, OH, NC, MO).
Prepayment issues to be phased in:

- **Month 1:** MS-DRG 312 Syncope
- **TBD:** MS-DRG 069 TIA
  
  MS-DRG 377 G.I. Hemorrhage w MCC
- **TBD:** MS-DRG 378 G.I. Hemorrhage w CC
  
  MS-DRG 379 G.I. Hemorrhage w/o CC/MCC
- **TBD:** MS-DRG 637 Diabetes w MCC
  
  MS-DRG 638 Diabetes w CC
  
  MS-DRG 639 Diabetes w/o CC/MCC
• Additional Documentation Requests will come from the MAC
• Providers will have 30 days to send documentation
• If deadline missed, claim denied. Appeal to MAC (usual process)
• RAC will review records and communicate payment determination to the MAC
• Providers will receive determination on their remittance advice within 45 days
• RACs will also send detailed review results letter
● Limits on # of prepayment reviews within current post-payment ADR limits
● Providers may appeal denial same as current RAC denial.
● Medical records sent to MAC will be sent to the RAC for review
● Claims will not be subject to future post-payment reviews
● CMS will give notice of implementation date and additional issues.
Delay in payments while documentation is reviewed? Slower cash flow. (But prompt payment by Medicare is statutorily required.)

Improved documentation
- New forms, checklists
- Pre submission review

Enhanced physician motivation for compliance

More physician education required

Improved physician office communication

Fewer LOC errors - Pre-submission review

Future reduction in retrospective repayment demands
“…nondiagnostic services that are subject to the payment window to include any nondiagnostic service that is clinically related to the reason for a patient’s inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same.”

June 25, 2010, Public Law 111–192

“A hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary’s inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services provided during the payment window.”

Medicare Claims Processing Manual, Pub 100-04, Transmittal 2234
“Hospitals may attest to specific non-diagnostic services as being unrelated to the inpatient stay (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary’s admission) by adding **condition code 51**...to the separately billed outpatient non-diagnostic services claim.”

Medicare Claims Processing Manual, Pub 100-04, Transmittal 2234
• Previously, when the RAC denied an admission, a hospital could only bill for limited Part B services.
• Hospital lost ability to bill for many preadmission services, including surgery and procedures which had been included on the inpatient bill.

Example: Patient had AICD implant as outpatient and was admitted after the procedure. If admission denied, hospital would be unable to bill for AICD.
Revised three day payment window: “When an admission is disallowed or is determined to be unbillable, the hospital may unbundle the preadmission outpatient services that had been rolled into the Part A bill and bill them “as the outpatient services that they were.”

MLN Matters (MM7672) December 29, 2011

Example: Patient had AICD implant as outpatient and was admitted after the procedure. If admission denied, now hospital can bill for AICD implant.
Administrative Law Judge (ALJ) at the third level of appeal gave a "partially favorable decision" to a hospital regarding a RAC denial of a Part A claim for inpatient hospitalization services for one beneficiary. ALJ denied Part A coverage because inpatient hospitalization services weren't reasonable and necessary, but found that "the observation and underlying care are warranted."

CMS referred the case to the Medicare Appeals Council, asserting that "the ALJ erred as a matter of law by ordering Medicare payment for ‘the observation and underlying care' provided to the beneficiary because those services are not separately billable under Part A…"
However, the Medicare Appeals Council "does not agree that the case contains an error of law." The Council cited references …to point out the inconsistencies in CMS' position. Section 10 in Chapter 6, "Hospital Services Covered Under Part B," of the Medicare Benefit Policy Manual "clearly indicates that payment may be made for covered hospital services under Part B, if a Part A claim is denied for any one of several reasons," says the Council.

FierceHealthFinance, 3/24/2010
(http://www.fiercehealthfinance.com)
CMS Memorandum

- CMS instructed contractors to pay hospitals for Part B and/or for observation when ALJ orders payment.
- Incentive to appeal “unappealable” inpatient denials.
- Appeals should request Part B and observation if Part A denied

CMS Memorandum TDL-12309, Dated July 13, 2012
• Sophisticated data analysis to identify claims suspect for error prior to payment
• Mandated by Section 4241 of the Small Business Jobs Act of 2010 (SBJA)
• CMS $77 million contract with Northrop Grumman and IBM to develop predictive modeling systems to identify high-risk claims. $27 million has been spent.
• All Medicare claims screened since June 30, 2011

MLN Matters, Number SE1133
Predictive Modeling

- Uses algorithms and analytical processes to assign risk score to claim.
- “CMS’s predictive modeling technology also enables automated cross-checks of provider, beneficiary, and claim information against historical trends and external databases.”
- Requires manual review of medical record
- “Prompt payment of claims is a statutory requirement…only in exceptional and urgent circumstances will CMS leverage its authority to waive prompt payment to conduct further investigation or review.”

MLN Matters, Number SE1133
Outcomes of claim review:

- Claim paid
- Payment withheld (MAC notified)
- Targeted audits
- Referral for suspected fraud (ZPIC)
- “and in cases of egregious fraud, revoke Medicare billing privileges.”

MLN Matters, Number SE1133
Since the predictive modeling system was activated, CMS has stopped, prevented, or identified $20 M in payments that should not have been made (through 11/2011)

- 2,500 leads for further investigation
- 600 preliminary law enforcement cases for review
- 400 direct interviews with providers who would not have otherwise been contacted.

“Predictive modeling won’t reach its full potential overnight, but it’s already making an incredible difference and will do even more in the weeks, months and years ahead.”

CMS Blog (Feb 24, 2012), http://blog.medicare.gov/2012/02/
The Medicare Data Warehouse

● Repository of all Medicare claims
  – All Medicare auditors have access to claims data
  – Data mining at will
  – Concordance of claims: Parts A, B, C, D
  – Auditors input results of reviews
  – Red flag suspicious activities to alert other auditors

● Public disclosure required by ACA
It’s not just the RAC!

- PERM  Payment Error Rate Measurement Program
- CERT  Comprehensive Error Rate Testing
- QIO   Quality Improvement Organization
- MAC   Medicare Administrative Contractor
- ZPIC  Zone Program Integrity Contractor
- HHS OIG Office of the Inspector General
- MIC   Medicaid Integrity Contractor
- MIG   Medicaid Integrity Group
- QIC   Qualified Independent Contractor
- HEAT  Healthcare Fraud Prevention and Action Team
- Medicaid RAC
It’s not just the RAC

Cross referrals: Auditors talk to each other through Data Warehouse.

Auditors required to refer suspicious activities for fraud investigations
# Payment Review (Audit) Entities

## Roles of Various Medicare Improper Payment Review Entities

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>How selected</th>
<th>Volume of Claims</th>
<th>Type of Review</th>
<th>Purpose of Review</th>
<th>Other Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIO</td>
<td>Inpatient Hospital claims only</td>
<td>Very small</td>
<td>• Prepay &amp; Concurrent (Patient still in hospital) • Complex Only</td>
<td>To prevent improper payments through DRG upcoding</td>
<td>Quality Reviews</td>
</tr>
<tr>
<td>CERT*</td>
<td>All Medical Claims Randomly</td>
<td>Small</td>
<td>• Postpay only • Complex only</td>
<td>To measure improper payments</td>
<td>None</td>
</tr>
<tr>
<td>PERM*</td>
<td>All Medical Claims Randomly</td>
<td>Small</td>
<td>• Postpay only • Automated &amp; Complex</td>
<td>To measure improper payments</td>
<td>None</td>
</tr>
<tr>
<td>Medical Review Units* at MACs</td>
<td>All Medicare FFS Claims Targeted</td>
<td>Depends on number of claims with possible improper payments for this provider</td>
<td>• Prepay &amp; Postpay • Automated, &amp; Complex</td>
<td>To prevent future improper payments</td>
<td>• Education • Appeals</td>
</tr>
<tr>
<td>Medicare Recovery Auditors*</td>
<td>All Medicare FFS Claims Targeted</td>
<td>Depends on number of claims with possible improper payments for this provider</td>
<td>• Postpay • Automated and Complex</td>
<td>To detect and correct past improper payments</td>
<td>None</td>
</tr>
<tr>
<td>PSC/ZPICS</td>
<td>All Medicare FFS Claims Targeted</td>
<td>Depends on number of potentially fraudulent claims submitted by provider</td>
<td>• Prepay and Postpay • Automated and Complex</td>
<td>To identify potential fraud</td>
<td>——</td>
</tr>
<tr>
<td>OIG</td>
<td>All Claims Targeted</td>
<td>Depends on number of potentially fraudulent claims submitted by provider</td>
<td>• Postpay • Complex</td>
<td>To identify fraud</td>
<td>——</td>
</tr>
</tbody>
</table>

* Overseen by OFM/PCG
● Required by the Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA)
● Measures improper payments in Medicaid and Children's Health Insurance Program (CHIP)
● Produces error rates for each program
● First year data reported: 2008
● PERM Contractor requests medical records via paper letter.
● Claims are selected randomly
- If a provider fails to submit a requested record, it counts as an improper payment and the payment is recouped.
- Reviews are conducted by clinicians and certified coders.
- All reviews are post payment
- Overpayments are recovered from the states.
- Providers file appeals at State Medicaid Error Rate Findings website.
PERM findings: Error rates

**Three-Year Rolling Medicaid Error Rates***

<table>
<thead>
<tr>
<th>Year</th>
<th>PERM Cycles Included</th>
<th>Overall</th>
<th>FFS</th>
<th>Managed Care</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Cycle 2 – FY 2007</td>
<td>9.4%</td>
<td>4.4%</td>
<td>1.0%</td>
<td>5.9%</td>
</tr>
<tr>
<td></td>
<td>Cycle 3 – FY 2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cycle 1 – FY 2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>Cycle 3 – FY 2008</td>
<td>8.1%</td>
<td>2.7%</td>
<td>0.3%</td>
<td>6.1%</td>
</tr>
<tr>
<td></td>
<td>Cycle 1 – FY 2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cycle 2 – FY 2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Considered the official rates reported by CMS
HHS Agency Financial Report: Target 3-yr rolling average error rate:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rolling rate</td>
<td>9.4%</td>
<td>8.4%</td>
<td>7.4%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>
Medicaid RACs

- Required by Affordable Care Act, Section 6411
  - CMS Final Rule: Sept 14, 2011
- Operational in every state: Jan. 1, 2012
  - Approx. 20 states have contracts.
- States contract with a RAC
  - May be regional (multistate contractors)
  - State set scope of review: Hospital, DME, SNF, physician, etc.
  - Contingency fee established by state
- Notify provider of overpayments within 60 days
- Appeal processes vary by state (with CMS approval)
Medicaid RACs

- Must coordinate with other audit agencies and federal and state law enforcement (e.g., fraud referrals)
- Must have at least one M.D. or D.O. Medical Director
- States allowed to exclude Medicaid MCOs
- States set limits on number and frequency of records requests
- Must hire certified coders…unless the State determines that certified coders are not required
- State to develop an education and outreach program including notification of audit policies and protocols.
- Acceptance of medical records on CD, DVD or via FAX
Medicaid RACs

- Must identify and return underpayments
  - States must incentivize RAC to detect underpayments
  - Expected to be 18% of corrections based on Medicare RACs
- Mandatory RAC customer service measures, including:
  - Toll-free customer service telephone number
  - Compiling and maintaining provider-approved addresses and points of contact for RAC communications
- According to the Department of Health and Human Services, the Medicaid RAC program will save an estimated $2.1 billion over the next five years, $900 million of which will be returned to states.
  
  http://medicaid-rac.com/medicaid-rac-activity
Medicaid RACs

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- Go to http://medicaid-rac.com/medicaid-rac-activity
Medicaid RACs

- Early risk area: Protocols require physician order (e.g. high risk OB)
- DRG assignment errors
- CMS is developing performance metrics to determine accuracy of RAC reviews.
- According to the Department of Health and Human Services, the Medicaid RAC program will save an estimated $2.1 billion over the next five years, $900 million of which will be returned to states.
- Authorized by Affordable Care Act. ACA under review by US Supreme Court → could be abolished if ACA found unconstitutional.
Medicaid RACs: Projected Savings

CMS - Potential Financial Impact of Medicaid RACs:

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Estimated Savings (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>80</td>
</tr>
<tr>
<td>2012</td>
<td>170</td>
</tr>
<tr>
<td>2013</td>
<td>250</td>
</tr>
<tr>
<td>2014</td>
<td>310</td>
</tr>
<tr>
<td>2015</td>
<td>330</td>
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</table>

© 2011 eduTrax® 12281020
<table>
<thead>
<tr>
<th><strong>STATE:</strong></th>
<th>Tennessee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SPA Status:</strong></td>
<td>SPA Approved</td>
</tr>
<tr>
<td><strong>Date SPA Received:</strong></td>
<td>11/7/2011</td>
</tr>
<tr>
<td><strong>Date SPA Approved:</strong></td>
<td>2/3/2012</td>
</tr>
<tr>
<td><strong>Exception Requested:</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>RAC Fee Structure:</strong></td>
<td>Contingency Fee</td>
</tr>
</tbody>
</table>

**Note:**
Tennessee had previously submitted a RAC SPA on 12/28/2010, which was approved on 3/23/2011. (The information shown on the lines above reflects a new RAC SPA that Tennessee submitted on 11/7/2011.)

http://www.cms.gov/medicaidracs/
Medicaid RAC in Tennessee

- HMS contracted
- 5 year look back
- Institutional and private providers included
- May audit all claims from provider if suspicious
- Electronic record submission allowed
- Data portal: https://ecenter.hmsy.com
- HMS Provider Services: 855-809-3984.

http://www.tn.gov/tenncare/forms/RACFAQ.pdf
Medicaid RAC in Tennessee

- ADR limit: 1% of previous year’s TennCare claims
- I/8 every 45 days
- Max 300 records; Min 35 / 45 days
- Multiple locations = One facility for ADR limit if same Tax ID and first 3 of ZIP
- 30 (automated) / 45 (complex) days to send records.
- 3-step appeal process

http://www.tn.gov/tenncare/forms/RACFAQ.pdf
Medicaid RAC in Tennessee

- No payment if
  - No service
  - Not medically necessary
- Partial payment if
  - Should have been billed at a lower level of service
  - Upcoded
  - Incorrect code
- Extrapolation from sample allowed

http://www.tn.gov/tenncare/forms/RACFAQ.pdf
<table>
<thead>
<tr>
<th><strong>STATE:</strong></th>
<th>Kentucky</th>
</tr>
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<tbody>
<tr>
<td><strong>SPA Status:</strong></td>
<td>SPA Approved</td>
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<tr>
<td><strong>Date SPA Received:</strong></td>
<td>3/29/2012</td>
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<tr>
<td><strong>Date SPA Approved:</strong></td>
<td>5/24/2012</td>
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<tr>
<td><strong>Exception Requested:</strong></td>
<td>Yes</td>
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<tr>
<td><strong>RAC Fee Structure:</strong></td>
<td>Contingency Fee</td>
</tr>
</tbody>
</table>

**Note:** Kentucky had previously submitted RAC SPAs on 12/2/2010 and 11/15/2011, which were approved on 2/28/2011 and 2/6/2012, respectively. (The information shown on the lines above reflects a new RAC SPA that Kentucky submitted on 3/29/2012.)

http://www.cms.gov/medicaidracs/
Kentucky Medicaid conducts retrospective audits under the Surveillance and Utilization Review System (SURS).

Audits include analysis of paid claims and appropriateness of billing, as well as medical record reviews.

Medicaid recently announced a new SURS contractor, Ingenix, a subsidiary of UnitedHealth Group. It is possible that Ingenix will also administer the Medicaid RAC program in Kentucky, but no formal announcement has yet been made.

https://www.kyma.org 8/27/2012
There are 5 Medicaid Integrity Contractor jurisdictions each covering 2 CMS regions

3 types of MICs
- Review MICs
- Audit MICs
  - Desk Audits
  - Field Audits
- Education MICs

Payment: Cost Plus, not contingency

Overpayments collected by state

Look back period – 5 yrs
Quality Improvement Organization

- CMS contracts with QIO in every state
- QIO performs quality reviews
  - “All medically unnecessary procedures represent quality of care problems as well as utilization problems and shall be referred to the QIO for quality review after claim adjustment is made.”
    - Medicare Program Integrity Manual, Chapter 6
- Readmissions: Evaluates quality of care of first admission, stability of patient at discharge, discharge planning, etc. and can require hospital to bundle admissions.
- Settles disputes between patient and hospital: Determines medical necessity for admission or continued stay
December 8, 2003, the Medicare Modernization Act (MMA) Section 911 replaced FIs with MACs

- Pays all Medicare providers except DME
- Allows claims matching (Part A vs. Part B)
- Adjusts payments after RAC review
  - Sends N432 remittance notice to hospital: Notice of impending Demand Letter repayment
  - Applies recoupments
  - Corrects underpayments
- Performs first level RAC appeal
- Supplies information to Data Warehouse
Medicare Administrative Contractor (MAC)

- **Post payment review**
  - Overpayment is recouped.
  - Underpayment is paid back.
- **Pre pay review**: Claims found to be improper are denied and no payment issued.
- Performs provider education re regulatory compliance
  - May provide one on one provider education
  - Audits to evaluate effectiveness of education
- Provides customer service on recoupment and appeals
- Performs first level of RAC appeal
- Refers suspected fraud for investigation
Requests medical records for review via paper letter.

Reviews conducted by clinicians (nurses, physical therapists, etc) and certified coders

Reviews claims most likely to contain an improper payment based on:

- Claims history files
- Comprehensive Error Rate Testing (CERT) findings
- Office of the Inspector General (OIG) reports
- CMS requests
- Recovery Auditor activity
CERT evaluates MAC’s payment error rate

- Claims are randomly selected
  - Post payment only
  - CERT contractor reviews medical records
  - Reviews conducted by at least one nurse

- Claims paid incorrectly are scored as “errors”
  - No documentation error: Failure to submit record
  - Insufficient documentation
  - Lack of medical necessity
  - Incorrect coding
  - Other errors (duplicate payments / no benefit category / other billing errors)
CERT: Comprehensive Error Rate Testing

- Computes and reports error rates:
  - Nationally
  - By Contractor
  - By Service
  - By Provider Type
- CMS and contractors analyze MAC error rate data and develop Error Rate Reduction Plans to reduce improper payments
- Payments can be adjusted by CERT – referred to MAC
- Appeals go to MAC
- Provides “targets” for future RAC and MAC issues
Zone Program Integrity Contractor (ZPIC)

RAC Monitor. RAC University Webinar Oct 6, 2011
Zone Program Integrity Contractor (ZPIC)

- Consolidation of Medicare fraud investigations into one agency
- Formerly Program Safeguard Contractors (PSC)
- “The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse.” (MLN Matters, Number: SE1204)
- Not paid on contingency basis
Zone Program Integrity Contractor (ZPIC) Focus Areas

- Medicare Part A and B claims
- DMEPOS (Durable Medical Equipment, Prosthetics/Orthotics & Supplies)
- Home health
- Hospice
- Dually eligible individuals
- CORFs (Comprehensive Outpatient Rehabilitation Facility)-Zone 7
Zone Program Integrity Contractor (ZPIC) Techniques

- **Targeted audit**: Selected area of concern (not random)
  - Probes sample of claims.
  - Unannounced on site audit
  - Statistical sample: Can use extrapolation

- **Proactive audit**: Based on data mining
  - Target high volume or high cost services that are often overutilized

- **Reactive audit**: Reacting to a pattern of complaints from a contractor (e.g., a MAC or CERT)

- Uses law enforcement investigative techniques to build fraud case. May refer for criminal investigation.
Zone Program Integrity Contractor (ZPIC) Audit Outcomes

- Determination of no overpayment and closure of case
- Provision of education to the provider
- Recoupment of overpayments.
  - Extrapolation a threat
  - Recoupments can be appealed
- Place provider on pre-payment review
  - CMS moving away from a “pay and chase” model to proactive fraud identification.
  - Up to 100% prepayment review.
  - No mandatory time frame for ZPIC investigation (vs. MAC - 60 day response required)
Zone Program Integrity Contractor (ZPIC) Audit Outcomes

- 6 month suspension of Medicare payments.
  - Must be approved and can be extended by CMS
  - No other oversight. No access to courts.
  - “Payment purgatory” waiting for decision
- Recommendation to HHS to exclude provider from federal healthcare programs
- Referral to a law enforcement agency (primarily OIG)
● OIG accesses data base of overpayments as determined by all audit agencies and performs fraud investigations
● Refers to law enforcement agencies for suspected fraud
● How hospitals chosen for OIG review
  – $$ at risk
  – Prior work at hospitals
  – OIG audits and investigations
  – DOJ cases
  – Voluntary and involuntary refunds to MAC
  – Information from Medicare contractors including QIO
Medicare inpatient and outpatient payments to acute care hospitals to determine compliance with selected billing requirements, the results of which will be used to recommend recovery of overpayments and to identify providers that routinely submit improper claims. Compare compliance programs of high vs. low risk hospitals.
• **Judgmental Sample**
  – Sample 200-300 records depending on number of “risk areas” under investigation
  – Additional records added as needed

• **Statistical sample**
  – Used when a trend is noticed or large number of errors in sample.
  – May use extrapolation
Office of Inspector General (OIG) Audits

- Contact letter goes to Compliance Officer
  - Investigators interact through Compliance

- Multiple auditors on site for up to 2 months or more
  - Look for cause of errors in sample
  - Interviews of hospital staff; Review of hospital operations

- Hospital must respond with Corrective Action Plan.

- If agreement on overpayments, immediate refund of overpayments to MAC

- Completed reviews reported on OIG website

- ROI: $6.80 to $1 spent
HEAT (Health Care Fraud Prevention & Enforcement Action Team)

- Created in 2009 – Now in nine cities
  - Investigators and prosecutors from the Justice Department, the FBI, and the HHS Office of Inspector General
- FY 2011: Federal government recovered more than $4.1B as a result of health care fraud prevention and enforcement – a record amount.
- Charged a record number of 1,430 defendants
- Convicted 743 defendants; sentenced 175 to prison.
- Average prison sentence in strike force cases in FY 2011 was more than 47 months.
- Recovered $2.4 B under False Claims Act in 2011

Health Care Fraud and Abuse Control Program (HCFAC) Annual Report, Feb 14, 2012
HEAT (Health Care Fraud Prevention and Enforcement Action Team) cities

- Baton Rouge
- Brooklyn
- Chicago
- Dallas
- Detroit
- Houston
- Los Angeles
- Miami
- Tampa Bay
Total government anti-fraud activity has resulted in:

- $4.1 billion in prevention and recovery in fiscal year 2011 (compared to $2.14 in FY 2008) according to the joint HHS and DOJ Annual Report.
- The number of individuals charged with fraud increased from 821 in fiscal year 2008 to 1,430 in fiscal year 2011 – nearly a 75 percent increase.”

CMS Blog (Feb 24, 2012)
The Spectrum of Medicare Auditors

- OVERSIGHT
  - FI/Carrier/MAC Probes
  - MIC
  - Z-PIC/PSC
  - OIG
  - DOJ
  - Legal Oversight
  - Compliance Oversight
  - Routine Business

- RISK
  - QIO
  - CERT

Sixth National Medicare RAC Summit, November 8, 2011
Lessons for Providers from the First Year of ZPIC Audits
Steve Lokensgard, Faegre & Benson LLP
CMS has awarded $9 million to 52 organizations “…to educate older adults receiving Medicare and Medicaid benefits to prevent, detect, and report health care fraud.”

- Recruit volunteers in the effort to empower older adults to protect themselves from fraud,
- Funded by the U.S. Administration on Aging.

stopmedicarefraud.gov
Senior Medicare Patrol

http://stopmedicarefraud.gov

Confidential and proprietary. Any use or disclosure to non-clients is not authorized.
March 2010, H.R. 3590, the Patient Protection and Affordable Care Act (PPACA)

- A Medicare provider aware of an overpayment must self-report and return funds to CMS by the later of 60 days after the overpayment was identified or the date the corresponding cost report is due and
- Notify the Secretary, the State, an intermediary, a carrier or a contractor in writing of the reason for the overpayment.
- Failure to comply: Subject to False Claims Act
- Triple damages and other penalties
- Impacts self-audits
“One of the most powerful tools in that effort is the False Claims Act, which the Justice Department has used to recover more than $6.7 billion since January 2009 in cases involving fraud against federal health care programs. The Justice Department's total recoveries in False Claims Act cases since January 2009 are over $9 billion.”

Depart of Justice Press Release, 4/20/2012
I wonder how much I’ll have to shell out this time.
To test or not to test, that is the question.
Whether ‘tis nobler in the mind to suffer the slings and arrows of the outrageous RAC or to take arms against a sea of auditors and by opposing end them.
To appeal; to deny; no more.

Ronald Hirsch, MD, FACP, ACMA LearningLink, 5/4/2012
Accretive Health Physician Advisory Services
AccretivePAS®

Contact Information:
Steven J. Meyerson, M.D., VP of Regulations and Education group
231 S LaSalle St, 16th FL
Chicago, IL 60614
Cell: 305-342-7936
smeyerson@accreteivehealth.com
Q&A
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