Medicare Reviews 2014

Medicare Reviews

- Why?
  - To detect 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."
  - To detect abuse.
    - "Billing Medicare for services that are not covered or are not correctly coded."
  - To ensure that claims are filed properly.
  - To determine overpayments.
  - To determine error rates for providers.
- Types of reviews
  - Automated reviews
    - Computer
    - 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.
    - Other Automated Reviews
      - Medicare has a computer and they know how to use it.
      - They can program specialized reviews as needed.
      - Example: number of spinal regions billed (98940, 98941, or 98942) vs. number of spinal regions listed in the diagnosis section.
  - 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 works through various contractors and subcontractors

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OIG

- 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.
- Can go back to the first day of your practice if they want to.
- Maintains the Excluded Individuals list
- Can levy Civil Money Penalties (CMP)
- Can refer cases to the Department of Justice (DOJ) for prosecution
- In 2008 they collected $17 for every $1 they spent on audits
- In 2010 they fined Phizer $2.3 Billion for advertising a drug for off-label usage.

What to Do When the OIG Knocks

- With the OIG reviewing chiropractors across the country the likelihood of you having an in-office audit has greatly increased.
- Having the OIG in your office is like inviting a bear to dinner, the chances are that you will be the main course.
- Knowing what not to do is as important as knowing 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

- At this time indications are that each provider has their error rate tracked by the carrier.
- If the error rate is above a certain percentage, then the provider is reviewed.
- A denial counts as an error

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- A denial reversed on appeal is not counted as an error.

CMS

- Concerned with abuse.
- If they find evidence of fraud, they refer the case to the ZPIC who gathers evidence and develops a case then turns it over to the OIG.
- The MACs and various contractors and subcontractors can perform reviews.
    - Comprehensive Error Rate Testing (CERT)
    - Zone Program Integrity Contractors (ZPIC)
    - Recovery Audit Contractor (RAC)
    - Qualified Independent Contractor (QIC)
    - Quality Improvement Organization (QIO)

Comprehensive Error Rate Testing

- Program to determine the accuracy of Medicare Fee-For-Service payments
- Randomly select 120,000 submitted claims
- Request records for selected claims
- 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
- 2010 errors for chiropractors in WPS:
    - 8 instances of "insufficient documentation".
    - 26 instances of "medically unnecessary service or treatment".
    - 2 instances of "service incorrectly coded".

Zone Program Integrity Contractors

- 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.
- 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 been an allegation of fraud.

Recovery Audit Contractor

- Purpose: to detect and correct past improper payments
- Review claims on a post-payment basis
- Use that same policies as the Medicare carriers: NCDs, LCDs, and Medicare manuals.
- "If the physician bills Medicare Fee-for-Service their claim will eventually end up reviewed by the RAC."
- Were fully implemented January 2010
- Two types of reviews
    - Automated reviews

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    - Complex reviews
- Can go back three years on records.
- Appeals process same as for carriers
- 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.
- Appeal all adverse determinations!
- RACs are paid on commission. The more they "recover", the more that they are paid.
- In June of this year the RAC program was suspended because of a two year backlog of appeals at the ALJ level.
- In late August, they resumed operation on a limited basis.
- There are four RACs in the United States

Qualified Independent Contractors

- 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 Organizations

- 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.
- Prepayment Reviews
- Postpayment Reviews
- Can go back 4 years

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.

How to Respond to a Request for Records

- 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.

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- 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.
- 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.
- You can add addenda if you date it and sign it.
- 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.

Clinical Review Judgment

- The CRJ was implemented 6-15-2010
- The CRJ involves two steps:
- (1) 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
- (2) 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 patient's 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.
- The following is from the Noridian website:
- "If a claim is suspended by Medical Review, Medical Review has 60 days from the receipt of documentation from the provider to review and make their claim payment determination. Because of this timeframe, the provider may not receive a remittance advice (RA) for 8-10 weeks.
- Providers shall not:
    - Resubmit claims while an identical claim is pending
    - Add or delete diagnosis codes and/or modifiers on a claim for the purpose of payment
    - Split claims for resubmission

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- Only those claims denied/rejected as unable to be processed (MA130) may be resubmitted. Refer to your RA to determine if the claim can be resubmitted.
- Claims denied for any other reason must be appealed. Appeal requests for claims that were denied for Medical Review reasons must be submitted in writing.
- Resubmission of claims, while another is pending, may delay the claims determination."

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

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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