Compliance

“What Every Coder Needs to Know...”

Presented to: AAPC Springfield Regional Conference
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October 8, 2010
Objectives

- History and Consumer Demand for Compliance
- Medicare Trust Fund
- Medicare Fraud
- OIG Work Plan
- Medicare Contracting Reform
- Medicare Integrity Program
- PSC’s, RAC’s, and ZPIC’s
- Risk Areas for Coding Compliance
- Compliance as it Relates to Coders
- Levels of Claims Appeal
What’s a coder to do?

- MACs
- ZPICs
- RACs
- MICs
- PSCs
- OIG
- CERT
- MIP
- MIP
Acronyms

• AC – Affiliated Contractor
• ARRA – American Recovery and Reinvestment Act
• BBA – Balanced Budget Act
• BBRA – Balanced Budget Relief Act
• BI – Benefit Integrity
• BPR – Budget Performance Requirement
• CERT – Comprehensive Error Rate Testing
• CIA – Corporate Integrity Agreement
• CMN – Certificate of Medical Necessity
• CMS – Centers for Medicare and Medicaid Service
Acronyms

• DHHS – Department of Health and Human Services
• DRA – Deficit Reduction Act
• ERRP – Error Rate Reduction Plan
• FCA – False Claims Act
• FERA – Fraud Enforcement Recovery Act
• FFS – Fee For Service
• FI – Fiscal Intermediaries
• HIPAA – Health Insurance Portability and Accountability Act
Acronyms

- **HITECH** – Health Information Technology for Economic and Clinical Health Act
- **HPMP** – Hospital Payment Monitoring Program
- **IPIA** – Improper Payments Act
- **MMA** – Medicare Prescription Drug, Improvement, and Modernization Act
- **MAC** – Medicare Administrative Contractor
- **MFCU** – Medicaid Fraud Control Unit
- **MIC** – Medicaid Integrity Contractor
- **MIG** – Medicaid Inspectors General
Acronyms

- MIP – Medicare Integrity Program
- MMA – Medicare Prescription Drug Improvement and Modernization Act
- OAS – Office of Audit Services
- OBRA – Omnibus Budget Reconciliation Act
- OCIG – Office of Counsel to the Inspector General
- OIE – Office of Evaluation and Inspections
- OI – Office of Investigations
- OIG – Office of the Inspector General
Acronyms

- ORT – Operation Restore Trust
- PI – Program Integrity
- PIM – Program Integrity Manual
- PPACA – Patient Protection and Affordable Care Act (Also called ACA)
- PSC – Program Safeguard Contractor
- QIC – Qualified Independent Contractor
- RAC – Recovery Audit Contractor
- TRHCA – Tax Relief and Health Care Act
- ZPIC – Zone Program Integrity Contractor
Compliance - History

- 1860 – False Claims Act
- 1978 – Inspector General Act (Public Law 95-452)
- 1992 – Presidential Campaign
- 1993 – Omnibus Budget Reconciliation Act
- 1996 – OIG Audits began
- 1996 – HIPAA
- 1996 – Health Care Fraud and Abuse Control Panel
- 1998 – Operation Restore Trust
- 1998 – Balanced Budget Act
- 1999 – Balanced Budget Relief Act
Compliance - History

- 2002 – Improper Payments Act
- 2003 – Medicare Prescription Drug, Improvement, and Modernization Act
- 2003 – Comprehensive Error Rate Testing Program
- 2005 – Deficit Reduction Act
- 2006 – Tax Relief and Health Care Act
- 2006 – Program Safeguard Contractors
- 2008 – Medicare/Medicaid Integrity Program
- 2010 – Affordable Care Act (Also called Patient Protection and Affordable Care Act)
Medicare Trust Fund
Expenditures (2008)

- Medicare Trust Fund
  - 45 Million Beneficiaries
  - $460.9 Billion in Expenditures
- Medicaid (Federal and State)
  - 48.2 Million Beneficiaries
  - $352 Billion in Expenditures
- Children’s Health Insurance Program (CHIP)
  - 7.4 Million Beneficiaries
  - $10 Billion in Expenditures
## Ten Year Enrollment Outlook

<table>
<thead>
<tr>
<th>(In millions)</th>
<th>2009</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>45.9</td>
<td>60.5</td>
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<tr>
<td>Medicaid/CHIP</td>
<td>51.8</td>
<td>82.2</td>
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<tr>
<td>Other Public</td>
<td>11.8</td>
<td>15.1</td>
</tr>
<tr>
<td>Employer</td>
<td>166.6</td>
<td>165.1</td>
</tr>
<tr>
<td>Private Insurer</td>
<td>26.6</td>
<td>11.4</td>
</tr>
<tr>
<td>Uninsured</td>
<td>44.3</td>
<td>24.4</td>
</tr>
<tr>
<td>Insured share of Population</td>
<td>85.6</td>
<td>92.7</td>
</tr>
</tbody>
</table>


## Ten Year Expenditure Outlook

<table>
<thead>
<tr>
<th>(In Billions)</th>
<th>2009</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Funds</td>
<td>$1,269.9</td>
<td>$2,231.6</td>
</tr>
<tr>
<td>Medicare</td>
<td>$507.1</td>
<td>$891.4</td>
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<tr>
<td>Medicaid/CHIP</td>
<td>$390.0</td>
<td>$896.2</td>
</tr>
<tr>
<td>Health Share of GDP</td>
<td>17.3%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Year of Report</td>
<td>Years to Insolvency</td>
<td>Year of Insolvency</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>1980</td>
<td>14</td>
<td>1994</td>
</tr>
<tr>
<td>1997</td>
<td>4</td>
<td>2001</td>
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<td>1999</td>
<td>16</td>
<td>2015</td>
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<td>2002</td>
<td>28</td>
<td>2030</td>
</tr>
<tr>
<td>2005</td>
<td>15</td>
<td>2020</td>
</tr>
<tr>
<td>2010</td>
<td>19</td>
<td>2029</td>
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</tbody>
</table>

Projections of Medicare Trust Fund

The TRAPP Group
## Distribution of Medicare Trust Fund

CMS maintains the following program:

- Carriers' MACs: Physicians 27%
- FIs/ MACs: Non-PPS Inpatient Hospitals 32%
- FIs / MACs* PPS Short Term Acute Care Inpatient Hospitals 37%
- DME MACs: DME Suppliers 4%

The Trapp Group

Medicare workload

Medicare receives over 1.2 billion claims per year. This equates to:

- 4.5 million claims per work day
- 574,000 claims per hour
- 9,579 claims per minute.
Why the crackdown?

- Public demand for better healthcare
- Increased cost to deliver healthcare
- Evidence of deliberate acts of fraud and abuse
- Public awareness beginning with the 1992 Presidential Campaign
- Concern of projected Medicare Insolvency
Medicare Fraud
Fraud and Abuse

• Fraud – deliberate act intended to obtain improper payments

• Abuse – repeated act that may not be deliberate but results in improper payment
Examples of Fraud or Abuse

- Incorrect use of diagnoses or procedures to increase payments.
- Unbundling or “exploding” charges
- Billing for services/supplies not furnished
- Billing for appointments the patient did not keep
- Deliberate Duplicate Billing
- Billing Medicare and the beneficiary for the same service
- Billing Medicare and another insurer to get paid twice
Examples of Fraud or Abuse

- Altering claim forms, electronic claim records, medical documentation to obtain a higher payment amount
- Billing group visits (e.g. 20 nursing home visits) without furnishing service to individual patients
- Misrepresentation of dates and descriptions
- Billing non-covered services as covered items
- Violating the participation agreement, assignment agreement, and the limitation amount
Examples of Fraud or Abuse

- Using another person's Medicare card to obtain medical care
- Giving false information about ownership in a clinical laboratory
- Using the payment process to generate fraudulent payments
- Kickbacks, bribes, or rebates
- Completing Certificates of Medical Necessity (CMNs) for patients not known by the provider
Examples of Fraud or Abuse

- Participating in schemes that involve collusion between a provider and a beneficiary
- Participating in schemes that involve collusion between a provider and an AC or MAC employee where the claim is assigned
- Filing False Cost Reports
- Billing for discharge in lieu of transfer
- Failure to refund credit balances
- Failure to provide services to patient’s of an HMO
Risk Areas for Fraud or Abuse

- Improper coding and billing
- Teaching physician guidelines
- Financial arrangements between hospitals and physicians
- Joint ventures
- Stark physician self-referral law
- Patient dumping
Examples of Fraud

$600,000
July 2006 – July 2007

Store Front Schemes
Examples of Fraud

$300,000

July 2006 – July 2007

$300,000


Store Front Schemes
**Health Care Fraud and Abuse Control Panel**

- Established by Congress in 1996
  - Included
    - OIG – Office of Inspector General
    - HHS – Department of Health and Human Services
    - DOJ – Department of Justice
    - FBI – Federal Bureau of Investigation
- 3.7% Medicare Dollars paid incorrectly
- $10.2 Billion returned to Medicare Annually

Affordable Care Act

• March 23, 2010 – Became Law
• Provides for preventive services at zero cost
• Pre-existing condition insurance plan
• Rebate checks to seniors for drug coverage
• $8 Billion saved and through 2019 expected $418 Billion will be saved with new law
• Adults to age 26 covered under parents plan
The TRAPP Compliance Enforcement GROUP

- Office of Inspector General (OIG)
- Centers for Medicare & Medicaid Services (CMS)
- Department of Justice (DOJ)
- U. S. Attorney’s Office
- Federal Bureau of Investigation (FBI)
- State Medicaid Fraud Control Units
- Office for Civil Rights (OCR)
- Health Care Fraud Prevention & Enforcement Action Team (HEAT)
Types of Enforcement

- Corporate Integrity Agreement (CIA)
- Exclusion from Federal Programs
- Civil Actions
  - Under Civil Monetary Penalties Law
- Convictions
  - Under Federal Sentencing Guidelines
Fraud and Abuse Efforts

- Office of Inspector General (OIG) Audits
- Medicare Integrity Program (MIP)
  - Medical Record Reviews (MR)
  - National Correct Coding Initiative (NCCI)
  - Medically Unlikely Edits (MUE)
  - Comprehensive Error Rate Testing (CERT)
  - Recovery Audit Contractor (RAC)
To protect program integrity and the well-being of program beneficiaries by detecting and preventing waste, fraud, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal laws.
Office of the Inspector General (OIG)

Office of Inspector General

• Includes:
  – Office of Audit Services (OAS)
  – Office of Evaluation and Inspections (OEI)
  – Office of Investigations (OI)
  – Office of Counsel to the Inspector General (OCIG)
Office of Inspector General

- Issued Program Guidance
- Issues annual OIG Work Plan
- Investigates healthcare fraud and abuse
- Recommends further investigations by Department of Justice
Seven Elements of OIG Program Guidance

1. Standards and Procedures
2. Compliance Officer
3. Training and Education
4. Communication
5. Response to detected problems
6. Internal auditing and monitoring
7. Enforcement of disciplinary standards
2010 OIG Work Plan

• Medicare A, B, C, and D
  – Hospitals and Physician Services
  – Home Health Services
  – Nursing Homes
  – Hospice Services
  – Durable Medical Equipment and Supplies
  – Medicare Part B for Prescription Drugs
  – Medicare Part A and Part B Contractor Operations
  – Medicare C Program (Medicare Advantage)
  – Medicare D Program (Prescription Drug Program)
2010 OIG Work Plan

- Medicaid Services
  - Medicaid Hospitals
  - Medicaid Home, Community, and Nursing Home
  - Medicaid Prescription Drugs
  - Medicaid Administration
  - Medicare and Medicaid Information Systems and Data Security
  - Children’s Health Insurance Program
  - Investigative and Legal Activities
2010 OIG Work Plan

• Public Health and Human Service Programs
  – Public Health Programs
  – Centers for Disease Control and Prevention
  – Food and Drug Administration
  – Health Resources and Services Administration
  – Indian Health Service
  – National Institutes of Health
  – Substance Abuse and Mental Health Services Administration
  – Cross-Cutting Public Health Activities
  – Public Health Investigations and Legal Activities
2010 OIG Work Plan

- Human Service Programs
  - Administration on Aging
  - Administration for Children and Families
2010 OIG Work Plan

• Department Wide Audits
  – Financial Statement Audits
  – Other financial Accounting Reviews
  – Automated Information Systems
  – Other Departmental Issues
• Recovery Act Work Plan
  – CMS Medicare Part A and Part B
  – Medicaid Program
  – Public Health Programs
  – Human Service Programs
  – Departmental Programs
2010 OIG Focus on Physician Services

- Physician Billing for Hospice and Utilization
- Incentive Payments for E-Prescribing
- Place of Service Errors
- Ambulatory Surgical Center Payment Systems
- E/M during global periods
- Part B Imaging Services
- Clinical Social Worker Services
- Physical Therapy Services
2010 OIG Focus on Physician Services

- Polysomnography
- Laboratory Test Unbundling
- Modifier GY
- Independent Diagnostic Testing Facilities
- Physician Reassignment of Benefits
- Compliance with assignment rules
- Services ordered or referred by Excluded Providers
2010 OIG Focus on Physician Services

- Ambulance Services for ESRD Beneficiaries
- Transforaminal Epidural Injections
- 2008 CERT Transportation Claims
- 2008 Part A and Part B CERT Error Rates
- Dates of Service after Beneficiaries Dates of Death
### OIG Recoveries since 2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Fraud Recoveries</th>
<th>Savings and Fraud Recoveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 (6 months)</td>
<td>$3.2 Billion</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>$4.5 Billion</td>
<td>$21 Billion</td>
</tr>
<tr>
<td>2008</td>
<td>$3.7 Billion</td>
<td>$20 Billion</td>
</tr>
<tr>
<td>2007 (6 months)</td>
<td>$2.9 Billion</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>$2.4 Billion</td>
<td>$38 Billion</td>
</tr>
<tr>
<td>2005</td>
<td>$2.8 Billion</td>
<td>$35 Billion</td>
</tr>
<tr>
<td>2004</td>
<td>$2.7 Billion</td>
<td>$30 Billion</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$22.2 Billion</strong></td>
<td><strong>$144 Billion</strong></td>
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## OIG Actions since 2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Exclusions</th>
<th>Criminal Actions</th>
<th>Civil Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 (6 months)</td>
<td>1,935</td>
<td>293</td>
<td>164</td>
</tr>
<tr>
<td>2009</td>
<td>2,556</td>
<td>671</td>
<td>394</td>
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<tr>
<td>2008</td>
<td>3,129</td>
<td>775</td>
<td>342</td>
</tr>
<tr>
<td>2007 (6 months)</td>
<td>1,278</td>
<td>209</td>
<td>123</td>
</tr>
<tr>
<td>2006</td>
<td>3,425</td>
<td>472</td>
<td>272</td>
</tr>
<tr>
<td>2005</td>
<td>3,806</td>
<td>537</td>
<td>262</td>
</tr>
<tr>
<td>2004</td>
<td>3,293</td>
<td>533</td>
<td>268</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,422</strong></td>
<td><strong>3,490</strong></td>
<td><strong>1,825</strong></td>
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</tbody>
</table>
FILE - In this Wednesday, July 29, 2009 file photo, federal agents raid a medical supply store in Houston. Lured by easier money and shorter prison sentences, Mafia figures and other violent criminals are increasingly moving into Medicare fraud and spilling blood over what once a white-collar crime. (AP Photo/Pat Sullivan, file)

*http://www.huffingtonpost.com/2010/05/13/medicare-fraud-enforcement_n_574553.html
2010 Recoveries

Office of Inspector General News

For Immediate Release
June 14, 2010
Phone: 202/619-1343

OIG Reports More Than $3 Billion in Expected Recoveries from Fighting Fraud, Waste, and Abuse for the First Half of FY 2010

OIG Reports $20.97 Billion in Savings and Recoveries in FY 2009

OIG Reports More Than $38 Billion in Savings and Recoveries for FY 2006

OIG Reports $35.4 Billion in Savings and Recoveries

Recoveries

06-22-2010
• After it self-disclosed conduct to the OIG, XXX Corporation, Massachusetts agreed to pay $200,962 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that XXX Corporation employed an individual that it knew or should have known was excluded from participation in Federal health care programs.

06-11-2010
• After it self-disclosed conduct to the OIG, XXX Corporation, Massachusetts agreed to pay $254,820 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that XXX Corporation employed an individual that it knew or should have known was excluded from participation in Federal health care programs.

05-26-2010
• After it self-disclosed conduct to the OIG, XXX Corporation, Massachusetts agreed to pay $99,787 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that XXX Corporation employed an individual that it knew or should have known was excluded from participation in Federal health care programs.

http://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp
Recoveries

04-01-2010
• XXX Associates, Massachusetts, agreed to pay $122,474 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that XXX Associates improperly billed Medicare for physical therapy services that were not properly supervised by a licensed physical therapist.

06-17-2009
• XXX Services, Massachusetts, agreed to pay $18,532 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that the Respondents improperly billed Medicare under certain CPT codes for physical therapy services when lower reimbursed codes and/or fewer units of these codes should have been billed.

04-03-2008
• After it self-disclosed conduct to the OIG, XXX Corporation, Massachusetts, agreed to pay $250,060 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that XXX Corporation employed an individual that it knew or should have known was excluded from participation in Federal health care programs.

http://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp
### Recoveries

<table>
<thead>
<tr>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>09-20-2007</td>
<td>XXX Therapy, Massachusetts, agreed to pay $398,357.49 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that XXX Therapy (1) submitted false or fraudulent claims for physical therapy services when no licensed physical therapist working for XXX Therapy during an approximately two month period in 2003, and (2) submitted upcoded claims for individual physical therapy services when those claims should have been submitted under a specific group therapy CPT code. Instead, those claims should have been submitted under a specific group therapy CPT code.</td>
</tr>
</tbody>
</table>

| 01-05-2006| An owner of a DME company located in Massachusetts agreed to pay $13,700 to resolve her liability under the CMP provisions applicable to false and fraudulent claims. The OIG alleged that between April 1998 through January 2002, the owner submitted false claims to Medicare for power wheelchairs provided to beneficiaries; failed to refund money to Medicare after beneficiaries returned the item(s); billed Medicare for electric wheelchairs, but provided beneficiaries with less expensive equipment; and billed Medicare for electric wheelchairs on particular dates of service, when in fact, the wheelchairs were not provided until months after the dates of service. In addition the owner and the DME company agreed to be permanently excluded from participation in Federal healthcare programs. |

http://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp
07-08-2005
• After it self-disclosed conduct to the OIG, XXX Corporation, New Hampshire agreed to pay $29,342.61 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that XXX Corporation employed a nurse that it should have known was excluded from participating in Federal health care programs.

03-03-2003
• XXX Hospital, Maine agreed to pay $25,000 to resolve its liability under the CMP provisions applicable to false or fraudulent claims and patient dumping violations. The OIG alleged that the hospital submitted a false document as an exhibit in support of a cost report appeal. The OIG also alleged that the hospital failed to ensure a safe and appropriate transfer of a woman with post-partum active bleeding and failed to perform an appropriate medical screening examination on a 19 year-old pregnant woman to determine if the patient had an emergency medical condition.

http://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp
CMS Initiatives Since 1996
To ensure health care security for beneficiaries.
To ensure the successful administration of Medicare services through the new Medicare Administrative Contractor (MAC).
To establish a premier health plan that allows for comprehensive, quality care and world-class beneficiary and provider service.

Medicare Contracting Reform
Medicare Fee-For-Service Program

Administrative Functional Environment

- Recovery Audit Contractors (RACs)
- Zone Program Integrity Contractors (ZPICs)
- Medicare Administrative Contractors (MACs)
- Qualified Independent Contractors (QIOs)
- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Beneficiary Contact Center (BCC)
- Healthcare Integrated General Ledger Accounting System (HIGLAS)
- Quality Improvement Organization (QIO)
- Administrative Qualified Independent Contractors (Ad QICs)

*See MAC Fact Sheet, July 2010
### MAC Award Status

The table below gives the current status of all MAC jurisdictions.

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Contractor</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>National Heritage Insurance Corp.</td>
<td>Fully Implemented</td>
</tr>
<tr>
<td>B</td>
<td>National Government Services</td>
<td>Round 2 - Contract Award</td>
</tr>
<tr>
<td>C</td>
<td>CIGNA Government Services</td>
<td>Fully Implemented</td>
</tr>
<tr>
<td>D</td>
<td>Noridian Administrative Services</td>
<td>Fully Implemented</td>
</tr>
<tr>
<td>1</td>
<td>Palmetto Government Benefits Administrators</td>
<td>Fully Implemented</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Solicitation Cancelled</td>
</tr>
<tr>
<td>3</td>
<td>Noridian Administrative Services</td>
<td>Fully Implemented</td>
</tr>
<tr>
<td>4</td>
<td>TrailBlazer Health Enterprises</td>
<td>Fully Implemented</td>
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<tr>
<td>5</td>
<td>Wisconsin Physicians Services</td>
<td>Fully Implemented</td>
</tr>
<tr>
<td>6</td>
<td>PROTEST OF CONTRACT AWARD</td>
<td>Bid Corrective Action</td>
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<tr>
<td>7</td>
<td>PROTEST OF CONTRACT AWARD</td>
<td>Bid Corrective Action</td>
</tr>
<tr>
<td>8</td>
<td>PROTEST OF CONTRACT AWARD</td>
<td>Bid Corrective Action</td>
</tr>
<tr>
<td>9</td>
<td>First Coast Service Options, Inc</td>
<td>Fully Implemented</td>
</tr>
<tr>
<td>10</td>
<td>Cahaba Government Benefit Administrators</td>
<td>Fully Implemented</td>
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<tr>
<td>11</td>
<td>Palmetto Government Benefits Administrators</td>
<td>Award Protest</td>
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<tr>
<td>12</td>
<td>Highmark Medicare Services</td>
<td>Fully Implemented</td>
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<tr>
<td>13</td>
<td>National Government Services</td>
<td>Fully Implemented</td>
</tr>
<tr>
<td>14</td>
<td>National Heritage Insurance Corp.</td>
<td>Fully Implemented</td>
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<tr>
<td>15</td>
<td>CIGNA Government Services</td>
<td>Award Protest</td>
</tr>
</tbody>
</table>
Current Status of A/B MAC Jurisdictions

[Map showing the status of A/B MAC Jurisdictions across the United States.]

Home Health/Hospice Medicare Administrative Contractor Jurisdictions (HH MAC)
Medicare Integrity Program (MIP)
To preserve and protect the integrity of the CMS programs by proactively developing strategies to identify, deter, and prevent fraud, waste, and abuse through effective partnerships with public and private entities.

Medicare Integrity Program

• Congress originally allocated $100 Million to begin crackdown on Medicare fraud

• Further funded by:
  – Proceeds from fraud and abuse investigations
  – Annual allocations from Congress

• Pay it Right Campaign
# CMS Initiatives since 1996

<table>
<thead>
<tr>
<th>Pre Payment Claim Review Programs</th>
<th>Post Payment Claim Review Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Correct Coding Initiatives (NCCI) Edits</td>
<td>Comprehensive Error Rate Testing (CERT) Program</td>
</tr>
<tr>
<td>Medically Unlikely Edits (MUE)</td>
<td>Recovery Audit Contractor (RAC)</td>
</tr>
<tr>
<td>Carrier/FI/MAC Medical Review (MR)</td>
<td>Carrier/FI/MAC Medical Review (MR)</td>
</tr>
</tbody>
</table>
Prepayment Review

• Providers with identified billing issues are placed on Prepayment Review for % of claims
• Once issues are resolved, removed from Prepayment Review

Postpayment Review

• Statistically Valid Sampling
• Estimated under or over payments
Carrier/FI/MAC Medical Review (MR)

- Potential issues identified through:
  - Analysis of Claims Data
  - Complaints

- Issues flagged as Minor, Moderate, or Significant

- Corrective actions imposed by Contractor
Pre Payment Claim Review

- National Correct Coding Initiatives (NCCI) Edits
  - Prepayment Claim Edit to reduce error rate
  - Updated Quarterly
  - Based on AMA CPT® and HCPCS®, LCDs and NCDs
  - Appropriate Modifiers should be used
  - Applies to Carriers and Fiscal Intermediaries
  - Denied edits may not be billed to Beneficiaries
### NCCI Edits

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>* = In existence prior to 1996</th>
<th>Effective Date</th>
<th>Deletion Date * = no data</th>
<th>Modifier</th>
</tr>
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<tbody>
<tr>
<td>10021</td>
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Pre Payment Claim Review

• Medically Unlikely Edits (MUE)
  – Unit of Service Edit (UOS)
  – Prepayment Claim Edit to reduce error rate
  – Updated Quarterly
  – Based on AMA CPT® and HCPCS®, LCDs and NCDs
  – Appropriate Modifiers should be used
  – Applies to Carriers and Fiscal Intermediaries
  – Denied edits may not be billed to Beneficiaries
  – Not on all codes (2,800 in 2007)
### MUE Edits

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Post Payment Claim Review

- Comprehensive Error Rate Testing Program
- Recovery Audit Contractor

CERT

RACs
Comprehensive Error Rate Testing Program (CERT)

Hospital Payment Monitoring Program (HPMP) (ended 2008)

Comprehensive Error Rate Testing Program (CERT)

• Began in 2003 as required by IPA 2002
• “Paying it right!”
• Random Sample of Claims by Provider
• Request for MR from Provider via letter
  – 30 days to respond
  – 3 attempts via letter and phone call request
  – If no MR sent after 75 claim considered as error
• Providers may appeal
Comprehensive Error Rate Testing Program (CERT)

Error Categories

• No Documentation
• Insufficient Documentation
• Medically Unnecessary Service
• Incorrect Coding
• Other
## CERT Findings Since 1996

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<td>1.2%</td>
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<td>0.5%</td>
<td>5.4%</td>
<td>3.1%</td>
<td>0.7%</td>
<td>0.6%</td>
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<td>2.7%</td>
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<td>1.1%</td>
<td>1.6%</td>
<td>1.6%</td>
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<td>1.3%</td>
<td>1.4%</td>
<td>4.0%</td>
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<td>Incorrect Coding Errors</td>
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<td>1.7%</td>
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<td>1.0%</td>
<td>1.1%</td>
<td>0.9%</td>
<td>0.7%</td>
<td>1.2%</td>
<td>1.5%</td>
<td>1.6%</td>
<td>1.5%</td>
<td>1.3%</td>
<td>1.6%</td>
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<td>Other Errors</td>
<td>1.1%</td>
<td>0.5%</td>
<td>0.7%</td>
<td>0.9%</td>
<td>0.4%</td>
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<td>0.0%</td>
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<td>0.1%</td>
<td>0.1%</td>
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<tr>
<td><strong>Improper Payments</strong></td>
<td>13.8%</td>
<td>11.4%</td>
<td>7.1%</td>
<td>8.0%</td>
<td>6.8%</td>
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<td><strong>Correct Payments</strong></td>
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# Table 3a: National Error Rates by Year

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<th>Year</th>
<th>Total Dollars Paid</th>
<th>Overpayments</th>
<th>Underpayments</th>
<th>Overpayments + Underpayments</th>
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<td>$168.1 B</td>
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<td>1998</td>
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<td>7.8%</td>
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<td>1999</td>
<td>$168.9 B</td>
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<td>8.3%</td>
<td>$0.5 B</td>
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<td>2000</td>
<td>$174.6 B</td>
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<td>8.1%</td>
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<td>2001</td>
<td>$191.3 B</td>
<td>$14.4 B</td>
<td>7.5%</td>
<td>$2.4 B</td>
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<td>2002</td>
<td>$212.8 B</td>
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<td>2003</td>
<td>$199.1 B</td>
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<td>2004</td>
<td>$213.5 B</td>
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<td>9.7%</td>
<td>$0.9 B</td>
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<td>2005</td>
<td>$234.1 B</td>
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<td>2006</td>
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<td>2007</td>
<td>$276.2 B</td>
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<td>3.6%</td>
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<td>2008</td>
<td>$288.2 B</td>
<td>$9.5 B</td>
<td>3.3%</td>
<td>$0.9 B</td>
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<td>2009</td>
<td>$308.4 B</td>
<td>$23.0 B</td>
<td>7.5%</td>
<td>$1.1 B</td>
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• Clinical review judgment could not override statutory, regulatory, ruling, national coverage decision or local coverage decision
• All documentation and policy requirements must be met before clinical review judgment applies
• CMS guidance for medical necessity and policy requirements and medical necessity requirements for DME accessories, repairs, and maintenance must be followed
• Claim must be denied if the signature on the medical record is absent or illegible.

Result – Increased Error Rates
Impact of CERT Changes

• CERT will only review documentation submitted
• CERT will no longer review physician orders, supplier documentation, and billing history
• CERT will no longer allow clinical review judgment
• CERT will now require signed orders for evidence of intent to order – will no longer consider MD signature on results
• CERT will disallow missing or illegible signatures
Top Errors Found

- Insufficient Documentation
- Majority of errors were in Evaluation and Management Coding
- Incorrect Coding
- Level of Service not substantiated in Documentation
Program Safeguard Contractors (PSC)
Recovery Audit Contractor Program (RAC)
RAC Program Evaluation Report

• Three Year Demonstration Project
• California, Florida, and New York – 2005
• Massachusetts, South Carolina, Arizona – 2007
• Purpose:
  – Detect and correct past improper payments
  – Prevent future improper payments
  – Lower the Medicare FFS claims payment error rate
• Not Random – Based on Error Data
RAC Program Evaluation Report

• Results:
  – $1.03 Billion in Improper Payments
  – Only .3% of all Medicare claims billed ($317 Billion) were impacted by RAC
  – Only 4.6% were overturned on appeal
  – 96% Over payments – 4% Under payments
  – 85% Over payments – Hospitals
  – 6% Over payments – Inpatient Rehab Facilities
  – 4% Over payments – Outpatient Hospital Providers
RAC Program Evaluation Report

Figure 2. Overpayments Vs. Underpayments

Overpayments Collected 96%

Underpayments Repaid 4%

Source: For Claim RACs, RAC invoice files and RAC Data Warehouse. For MSP RACs, Treasury deposit slips.
Table E1. Overpayments Collected by Error and Provider Type (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only (Percent of Total)

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<th>Error Type</th>
<th>Inpatient Hospital</th>
<th>Inpatient Rehabilitation Facility</th>
<th>Skilled Nursing Facility</th>
<th>Outpatient Hospital</th>
<th>Physician</th>
<th>Ambulance/Lab/Other</th>
<th>Durable Medical Equipment</th>
<th>Total Overpayments Collected</th>
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<tr>
<td>Medically Unnecessary</td>
<td>34.50</td>
<td>5.63</td>
<td>0.26</td>
<td>0.47</td>
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<td>0.00</td>
<td>0.00</td>
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<td>Incorrectly Coded</td>
<td>30.48</td>
<td>0.00</td>
<td>0.62</td>
<td>2.44</td>
<td>1.05</td>
<td>0.06</td>
<td>0.00</td>
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<tr>
<td>No/Insufficient Documentation</td>
<td>6.63</td>
<td>0.44</td>
<td>0.48</td>
<td>0.11</td>
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<td>Other</td>
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<td>0.41</td>
<td>1.22</td>
<td>1.44</td>
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<td>16.72</td>
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<td>Total</td>
<td>84.19</td>
<td>6.07</td>
<td>1.76</td>
<td>4.25</td>
<td>2.50</td>
<td>0.51</td>
<td>0.72</td>
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Note: These percentages are net of appeals and thus vary slightly from the data shown in other sections of the report.
Source: Self-reported by the Claim RACs.
Figure 6. Overpayments Collected by Error Type (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only

- $391.3 Million Medically Unnecessary (40%)
- $160.2 Million Other (17%)
- $74.3 Million No/Insufficient Documentation (8%)
- $331.8 Million Incorrectly Coded (35%)

Source: Self-reported by the Claim RACs.
RAC Demonstration only cost .20 for each dollar collected.

What you should know

- Region A – Connolly Consulting
- RAC audits are not Random – Based on Error
- RAC gets fee for reviewing
- RAC must review based on CMS Policy
- RAC will not review claims previously reviewed by another agency
- RAC will request refund and pay back overpayments to the provider if clear payment error – called **automated review**
What you should know

- RAC will request MR for review if likely payment error – called **complex review**
- Provider has 45 days to respond
- RAC has 60 days to provide results back
- You have 120 days to appeal
- Does not include Medicare Advantage or Medicare Prescription Drug Program
- Can only review up to 3 years prior
- Only 22.5% providers actually appeal claims
Questions Answered

• Possible to gradually expand RAC
• RACs can find improper payments
• Providers do not appeal every RAC overturned
• Cost to run RAC is significantly less than money returned to the Trust Fund
• RACs would provide outreach
• RACs did not disrupt CMS anti-fraud efforts
• RACs will work on contingency basis
Requests For Future Program

- New issues RACs wish to pursue would be reviewed first by CMS
- New RACs will hire a physician medical director
- RACs will pay back contingency fee if improper payment is overturned on any level of appeal
- Look-back would change from 4 to 3 years
- Maximum look back date to October 1, 2007
- Add web-based application for providers to review status of MR reviews
RAC Lessons Learned

1. Medicare processing systems were overwhelmed by high volume of improper payments recovered
2. Not all RAC audits were validated prior to wide spread review
3. Providers felt there was no measure of RAC accuracy
4. Hospitals could not resubmit claims when services were provided in the wrong setting
RAC Lessons Learned

5. Four year look back period is too long
6. Medical Record Requests is burdensome on providers
7. RACs paid back contingency fee only at the first level of appeal
8. Providers felt that lack of physicians at the RAC meant claims were erroneously denied
RAC Lessons Learned

9. No electronic platform to track status
10. Confusion about contractors involved in correcting and detecting improper payments
11. Inconsistent in documenting “good cause”
12. MSP collected few improper payments
13. Nondisclosure of RAC fees increased apprehension among providers
RAC Improvements

1. Medical Director now mandatory
2. Coding experts now mandatory
3. Reviewer credentials provided now mandatory if requested
4. Discussion with CMD regarding denial now mandatory if requested
5. Minimum claim amount is $10.00
6. External validation process now mandatory
RAC Improvements

7. RAC pay back fee if claim is overturned
8. Vulnerability reporting now mandatory
9. Notification of overpayment letters standardized
10. Look-back period now 3 years
11. Look back date now Oct 1, 2007
12. Now allowed to review claims in current FY
13. Limits now on number of MR requested
14. 45 day payment on photocopy mandatory
15. Medicare Secondary Payer now included
16. QA/Internal control now mandatory
17. Remote call monitoring mandatory
18. Reason for review now mandatory on overpayment letters
19. RAC claim status on WEB – January, 2010
20. Public disclosure of RAC fees now mandatory
Appendix Q
RAC Expansion Schedule

Summer 2008
Fall 2008
January 2009 or Later

[Map showing states grouped into three categories based on expansion schedule (Summer 2008, Fall 2008, January 2009 or Later)]
What Can Practices do?

- Educate Providers
- Perform internal audits
- Watch for improperly coded services
- Watch for medical necessity
- Respond to RAC Requests
- Assign contact person and notify RAC
- Track RAC requests and MRs sent
- Track Results
Zone Program Integrity Contractors (ZPICS)
Mission

To investigate allegations of fraud made by beneficiaries, providers, suppliers, CMS, OIG and other sources including proactive data analysis and pre and post pay medical review for benefit integrity.
What are ZPICS?

• Seven zones based on MAC jurisdictions
• Five “hot spot” zones
  – California, Florida, Michigan, New York and Texas
  – “Hot spots” align with Program Integrity field offices
  – Focus on quick response to fraud and administrative actions
  – Reduce emphasis on fraud referrals as law enforcement does not have the resources to accept them
• Two other zones
  – 24 states with limited incidence of fraud
  – Continue using proven PSC processes
• Contracting strategy integrates Medicare FFS and Medi-Medi program integrity functions
Responsibilities

• To explore all sources of fraud leads
• To refer investigations to the OIG or OI
• To support law enforcement in requests for information
• To recommend administrative actions to CMS
• To identify program vulnerabilities to CMS
• To work cooperatively with law enforcement, CMS, FIs, and MACs
• To initiate and maintain networking, education and outreach activities
ZPICs Do Not Address

- Medicare coverage issues
- Status of claims
- Appeals process issues
- Supplier issues
- Policy or program issues

*CMS
Complaint Examples:

- Allegations of services not received
- Allegations that services received are inconsistent with the services billed
- Allegations that a supplier has billed both beneficiary and Medicare for the same service
- Allegations regarding the waiver of coinsurance or deductibles
Complaint Examples

• Allegations that a supplier has an affiliation with a department of state, local or federal government whether expressed or implied

• Beneficiary inquiries concerning payment for a service which in his opinion, may exceed a reasonable payment
What coders need to know
Levels of Medicare Appeals

- Redetermination
- Reconsideration
- Administrative Law Judge Hearing
- Medicare Appeals Council
- Judicial Review in US District Court
Risk areas for Coding Compliance

- Global surgery rules
- Place of service errors
- Medical Necessity Services
- Teaching physician guidelines
- High Utilization Diagnostic Testing
- High Utilization Chiropractic Services
- Incident To services
- Evaluation and Management documentation
Coding for Compliance

• Follow CPT/AMA coding guidelines
• Follow all CCI Guidelines
• Follow LCD’s, (LMRP’s) and NCD’s
• Follow Official ICD-9-CM guidelines
• Follow Medical Necessity Rules
• Follow all CMS and Payer Billing Guidelines
• Educate physicians on rules
• Be aware of OIG Work Plan
• Review documentation and billing patterns
Education / Internal Audits

- Perform random internal audits
  - Two reviews of 20 visits per MD per year
  - Review results with MD and provide feedback and education
- Review risk areas
- Review documentation
- Review claim from schedule to payment
- Provide ongoing education to MD’s
Coding Documentation Audits

- Review CPT, ICD-9, HCPCS
- Review modifiers
- Review place of service
- Review billing guidelines
- Review E/M levels
- Review codes for unbundling
- Review documentation requirements
- Legibility
- Time documented when appropriate
Sample Audit Report to MD

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<td>2. Time not documented if required</td>
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<td>4. Medical Necessity</td>
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<td>Physician:</td>
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<td>7. E/M Service under documented</td>
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<td>Coder:</td>
<td>8. E/M Services billed under wrong category</td>
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<td>Date:</td>
<td>9. No documentation for service provided</td>
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<td>10. Surgery bundled contrary to CPT guidelines</td>
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<td>11. Insufficient documentation for TP participation</td>
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<td>12. Omitted procedure</td>
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Education is Key

Don’t Compromise Quality

*CMS
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Sources

- http://www.cms.gov/
- https://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp#TopOfPage
- http://www.racaudits.com/
- The Compliance Officer’s Handbook, © 2006 HCPro, Inc.
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