ZPIC Audits: What you Need to Know

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Disclosures

- Not representing CMS
- No outside affiliations
AAPC Code of Ethics

- Maintain and enhance the dignity, status, integrity, competence, and standards of our profession.
- Respect the privacy of others and honor confidentiality.
- Strive to achieve the highest quality, effectiveness and dignity in both the process and products of professional work.
- Advance the profession through continued professional development and education by acquiring and maintaining professional competence.
- Know and respect existing federal, state and local laws, regulations, certifications and licensing requirements applicable to professional work.
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Agenda

- ZPIC, Authority and Scope
- Audit Selection Process
- Prepay Audits
- Post-pay Audits
- Administrative Actions, Legal Remedies
- Applicable Statutes
- Appeals Process
- Reporting Suspected Fraud
- Coder’s Role in Creating a Culture of Compliance
What is a ZPIC?

- Zone Program Integrity Contractor (ZPIC)
- Primary focus is to investigate potential fraud
- Ensure that Medicare Trust Fund monies are not inappropriately paid out
- Take action to ensure mistaken or improper payments are recouped

Authority and Scope

- Section 202 of HIPAA authorized CMS to contract with entities to fulfill Medicare integrity functions
- Section 911 of Medicare Modernization Act of 2003
  - Implemented in late 2008 as PSCs
- Each ZPIC is responsible for a particular geographic area
- Perform integrity functions for:
  - Medicare Parts A & B (FFS Medicare)
  - DME, Prosthetics, Orthotics, and Supplies (DMEPOS)
  - Home Health, Hospice
  - Dual Eligibility
- ZPICs do not review Medicare Parts C and D
Role of ZPICs

1) Identify cases of suspected fraud;
2) Develop them thoroughly and in a timely manner;
3) Take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out; and
4) Recoup any mistaken or improper payments.

ZPIC Staffing
- Investigators, statisticians, data analysts, nurses, certified coders, physicians
**Definition**

- **Fraud**: An *intentional* deception or misrepresentation that can result in unauthorized benefit or payment
- **Waste**: Is *overutilization* of services or other practices that, directly or indirectly result in unnecessary costs to the health care system
- **Abuse**: Involves payment for items or services when there is no legal entitlement to that payment and the health care provider *has not knowingly and/or intentionally misrepresented facts* to obtain payment

**Examples of Fraud**

- Billing for services not provided, not ordered
- Billing for DME supplies not delivered
- Providing services a person does not need based on their medical history
- Falsifying claims or medical records
- Misrepresenting dates, frequency, duration or description of services rendered
- A provider bills for a time period greater than the time actually spent with the client
Impact of Fraud Estimates

- Medicare Expenditures: $580 Billion (2012 estimate)
- Medicaid Expenditure: $417 Billion (2012 estimate)
- Medicare/Medicaid Improper payment estimates:
  - 2010: $65 Billion in improper payments (CMS)
  - 2011: $98 Billion in improper payments (RAND)

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**Audit Selection**

ZPIC audits are not random audits

ZPIC audits are based on data analysis of billing practices.

**Basis of ZPIC Audits**

- Fraud Prevention System (FPS)
  - Leads received from CMS

- Information received from third parties
  - Current and former provider employees
  - Beneficiaries
  - Medicare Administrative Contractors (MACs)

- Proactive Data Analysis by contractor
  - Outliers
  - Aberrant billing pattern

- Predictive modeling by contractor
Common Triggers for a ZPIC Investigation

- Potential criminal, civil, or administrative law violations
- Allegations involving multiple providers, multiple states or widespread schemes
- Allegations involving known patterns of fraud
- Patterns of fraud or abuse threatening the life or well being of beneficiaries
- Schemes with large financial risk to the Medicare program or beneficiaries

Audit Selection

- **Proactive Data Analysis** also known as “data mining” looks for suspicious claim patterns, such as billing a high frequency of certain codes as compared to local and national patterns.

- **Predictive Modeling** uses algorithms and analytical processes to capture the relationship between variables (providers, billing patterns, beneficiary utilization) to estimate the likelihood of fraud.
Audit Selection

- Information Received from Third Parties including beneficiaries, current or former employees of the provider and other providers.

Suspicious Claim Pattern: Hours per Day

- Claim characteristics
  - Diagnoses
  - Procedures
- Utilization patterns
  - High volume
  - High cost services
- Billing patterns
**% 99215 billed by Family Doc**

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Prepay Review

- Purpose is to determine the accuracy of a claim before it is paid
  - Stops the flow of money when evidence of a potential billing aberrancy is present
  - An edit is placed in the system to stop the claim from processing prior to medical review

Pre-Payment Review (not pre-auth)

- Audit may be full or partial
- Definite start date; no definite end date
- Claims are not paid until provider submits requested documentation and a determination is made
- ZPICs have 60 days to review documentation
- Each time the provider submits an additional claim for payment, the ZPIC sends the provider an additional ADR letter
  - The provider has 30 days to submit the requested documentation
  - If the documentation is not received within 45 days the claim is denied and the provider must appeal the claim to redetermination.
Medical Review

- The medical record is reviewed to help determine if:
  - The service submitted was actually provided
  - The service was medically necessary
  - If patterns or trends exist which may indicate potential fraud, waste or abuse
    - Nearly identical documentation
    - Evidence of alteration of medical record
  - ZPIC will down code or deny, in part or in whole, if medical records do not support services billed

Basis for Medical Review Decisions

- Social Security Act (SSA)
- Code of Federal Regulations (CFR)
- National Coverage Determinations (NCDs)
- CMS Manuals
- Local Coverage Determinations (LCDs)
**Is this Really a Level 5 Visit?**

- HX: 22 year old male, *established* patient with dry skin
  - HPI: Itchy, red, dry skin on legs for one week
  - ROS: 10+ areas reviewed
  - PFSH: 3 of 3 reviewed
- Exam:
  - 8+ organ systems reviewed
- Assessment/Plan (MDM):
  - Eczema. OTC cream to be applied nightly

**Full Prepay Audits**

- There are two types of prepay audits—full and partial. Under full prepay audit, a provider does not receive payment for *any* item or service until the supporting documentation has been reviewed by the ZPIC and the claim has been found to be medically necessary and properly payable.
Partial Prepay Audit

- Under partial prepay audit, a provider does not receive payment for particular items or services until the supporting documentation has been reviewed by the ZPIC and the claim has been found to be medically necessary and properly payable.

- The ZPIC sends a notification letter to the provider informing them that they are being placed on Prepay review. There are no specifics about the review in the letter.

Initial Determination

- The first phase of the prepay audit process is called “Initial Determination.”

- Additional Documentation Request (ADR) letters are sent to the provider.

- Until the provider is released from prepay audit, each time the provider submits an additional claim for payment, the provider will receive an additional ADR letter.
More about ADRs

- You will receive an ADR for each claim the ZPIC will review.
- Each claim may require several pages of supporting documentation.
- Example: If you submit 100 claims for which the ZPIC has a prepay edit, you will receive 100 ADRs.
- If each claim requires 10 pages of supporting documentation you will have 100 x 10 = 1,000 pages of documentation to provide.
- ZPICs do not reimburse for staff time or copying expenses (PIM 100-08, Chapter 3 §3.2.3.6).

Response to ADRs

- Within 30 days of the date on the ADR letter, the provider should respond to the ZPIC with all documentation (i.e., prescription, lab reports, radiology reports, physician progress notes, nurses notes, face-to-face examination, CMN, et cetera) necessary to substantiate the claim.
- If the provider does not submit the documentation within 45 days, the claim is automatically denied by the claims processing system.
- If the provider chooses to appeal, this must be done through the MAC (Medicare Administrative Contractor).
**Initial Determination**

- The provider receives a Remittance Advice for each claim within about 60 days indicating whether the claim was paid, reduced or denied.

**Release from Prepay Review**

- For a provider to be released from pre-payment audit, numerous factors must be taken into consideration including a substantial improvement in the error rate and a lack of concerning red flags.
Normal Claim Processing Flow

1. Provider Performs Service
2. Claim Submitted
3. MAC
4. Claim Processed
5. Provider Receives EOB and is Paid for Service

Flow of a Claim on Prepayment Review

1. Provider Performs Service
2. Claim Submitted
3. MAC
4. ZPIC Edit Triggers ADR
5. ADR Automatically Sent by Claims System to Provider
6. ZPIC Sends Determination To MAC
7. ZPIC Performs Medical Review
8. Provider Sends Records To ZPIC
9. MAC Process Claim
10. Remittance Advice Sent To Provider
11. Provider Decides Whether to Appeal
**Impact of Prepay on Practice Financials**

- Under normal circumstances, if a provider submits $100,000 in claims to Medicare, the Medicare Administrative Contractor (MAC) will pay the $100,000 within two or three weeks.

- In the case of prepay audit, the MAC will pay the provider much more slowly (60 days or more) and the amount will depend on the outcome of the audit.

- Meanwhile, the provider continues to pay for all business-related costs (i.e., rent, wages, et cetera).

**Impact of Prepay Review**

- Long-Term interruption in revenue
  - Audit may last for several months
    - 3-6 months is not uncommon
  - During the audit the provider is reimbursed only for items approved by ZPIC
  - If 70% denial rate, provider reimbursed $0.30 for every dollar they would normally receive from Medicare
  - The revenue disruption can make it difficult to maintain or grow the business
  - During this period, the provider continues to have usual business expenses such as rent, payroll and insurance
** Reasons for Payment Denial **

- Lack of Medical Necessity
  - Lack of documentation
- Services not Reasonable and Necessary
- Inappropriate/Illegible Signatures
- Illegible Documentation
  - If auditor cannot read documentation, the claim will be denied
- Failure to meet requirements of LCDs
What to Expect with a Prepay Audit

- Respond to the ADR within 30 days of the date on the ADR
- Send all documentation to support the service provided along with the ADR
- Call the ZPIC if you have questions
  - ZPIC will not provide details on aberrancies
- Results of initial determination communicated in the Remittance Advice

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**Post-pay Review**

- Determines accuracy of the claim after payment
- Determines if an overpayment is due to the Medicare Trust Fund,
- Reopening of a post-pay claim can only be requested up to four years following initial determination (claims paid date)
  - Law Enforcement can go back longer
- A sample of claims is pulled from the provider’s claims history
  - Samples may be for specific provider, beneficiary or code
  - Statistically Valid Random Sample (SVRS)
  - Results can be extrapolated
- The result are communicated in an overpayment letter to the provider

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**Flow of a Claim on Post-pay Review**

1. **Provider Performs Service**
2. **Claim Submitted to MAC**
3. **MAC Processes Claim and Provider Paid**
4. **Record Request Letter Sent To Provider**
5. **MAC Sends Demand Letter with over-payment amount**
6. **ZPIC sends Overpayment letter & summary of MR finding**
7. **ZPIC performs Medical review on sample in universe**
8. **Provider Sends Records To ZPIC**
9. **Provider Decides Whether to pay overpayment or Appeal**
**Post-pay Record Request Letter**

- One Record Request Letter will be sent with the list of beneficiaries and a range of dates of service and documentation requested.

- Example #1: Record Request Letter with 30 benes listed. If 10 pages of supporting documentation each = 300 pages. This is common with an office visit.

- Example #2: Record Request Letter with 20 benes listed. If 1,000 pages of supporting documentation each = 20,000 pages. This is common with SNF, IRF, HH.

**Post-pay Review**

- ZPICs do not reimburse for copying records (PIM 100-08, Chapter 3 §3.2.3.6).

- Post-pay reviews are completed within 12 months.
  - Statisticians obtain statistically valid random samples.
  - Review findings may be extrapolated.
Potential Elements of a Post-pay Audit

- Review of medical records
  - Based on sample of claims previously submitted
  - Request for medical documentation to support the claim (Record Request Letter)
- Review of provider’s past audits, investigations or violations
- Telephone interviews with beneficiaries
- Unannounced site visit at the provider’s business location

Site Visit

- The ZPIC team will likely include an investigator(s) and a nurse
- Staff interviews
- Facility tour
- Medical records will be copied
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**Potential Adverse Outcomes & Consequences**

- Denial of payments
- Overpayment recovery
- Referral to CMS, OIG and/or Law Enforcement leading to:
  - Civil Monetary Penalties
  - Criminal Sanctions
  - Exclusion from Medicare
  - Payment Suspension
  - Corporate Integrity Agreements
Suspension and Revocation

- Suspension of payment:
  - If there is a credible allegation of fraud, the ZPIC can suspend provider payments
  - Suspensions must be approved by CMS
  - Providers can appeal by submitting a rebuttal to the ZPIC
  - CMS makes the final decision regarding the suspension
  - Payments suspended for at least 180 days

- Revocation
  - Method by which Medicare revokes assignment due to fraud
  - Provider is automatically revoked from Medicaid (if applicable) if revoked from Medicare

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**False Claims Act (FCA)**

- Civil Statute (31, U.S.C. §3729)
- Provider submits or causes to be submitted a false or fraudulent claim to a government program
- Knew or should have known the claim was false or fraudulent
  - Deliberate ignorance or reckless disregard for truth
- Treble damages and up to $11,000 per claim
- Allows a private party to sue on behalf of the government (qui tam)

**False Claims Act (FCA)**

- Criminal Statute (18 U.S.C. §287)
  - Prohibits the knowing submission of a false, fictitious or fraudulent claim against the United States or any department or agency thereof
  - Violations are felonies
  - Punishable by up to 5 years imprisonment and/or $25,000 in fines.
- Felony convictions result in exclusion from Medicare for a minimum of five years
Examples of False Claims

- Claims where the service is:
  - Not rendered
  - Already covered under another claim
  - Up-coded
  - Not supported by the patient’s medical record

Penalties for noncompliance with FCA

- Up to three times the Government’s loss and
- Between $5,500 and $11,000 per claim
- Up to 5 years in jail and/or $25,000 additional in fines.
**Example of FCA Penalty**

- Dr. Smith has been found to have filed false claims for services. Out of 50 charts audited, 40 claims were denied and found to represent false claims. Combined, these services represent an overpayment to the provider of $40,000. Dr. Smith must remit payment to Medicare for $560,000.

\[
40 \text{ claims} \times \$11,000 \text{ penalty per claim} = \$440,000 \\
\text{Overpayment} \times 3 = \$120,000 \\
\text{Total due Medicare} = \$560,000
\]

Plus 5 years in jail and/or $25,000 additional fine.

**Whistleblower Incentive (FCA)**

- Up to 30% of FCA recovery
- Who are whistleblowers?
  - Former business partners
  - Current and former employees
  - Competitors
  - Patients
According to 31 U.S.C. § 3279, the provider must return the money no more than 60 days from the date on which the overpayment was identified or the date any corresponding cost report is due, if applicable. Retention of any overpayment beyond this deadline results in liability under the False Claims Act.
Federal Anti-kickback Statute
42 U.S.C. §1320a-7b

- Prohibits inducing or rewarding referrals for Federal healthcare program business
- What is often a COMMON PRACTICE in other industries can be a CRIME when dealing with Federal healthcare programs

The statute prohibits:
- The knowing and willful
- Payment or receipt of any form of remuneration
- To induce someone to recommend, purchase or order any service that may be paid for under a federal healthcare program
Federal Anti-kickback Statute
42, U.S.C., §1320a-7b

- Example: Ophthalmologist pays family doc for referrals for cataract referrals
- Example: A device manufacturer gives a vacation, gift, or sham consulting fee to reward orthopedist for using their device in surgery
- Both the manufacturer and physician may be prosecuted
- Bribe, rebate, in cash or in-kind

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**Appeals Process**

- Appeal clock runs from receipt of Demand Letter
- Redetermination—120 days to request; 60 days to respond
- Reconsideration—180 days to request; 60 days to respond
- Administrative law Judge—60 days to request; 90 days to respond
- Medicare Appeals Council—60 days to request; 90 days to respond
- Judicial Review, U.S. District Court—60 days to request

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**Actions to Take if You Suspect Fraud or Abuse**

- Start with chain of command
- If non-responsive, report through OIG Hotline
  - Reporting can be anonymous
- Do not “hear no evil, see no evil, say no evil”

**How to report Fraud**

- OIG Hotline (may be anonymous)
  - **Phone:** 1-800-HHS-TIPS (1-800-447-8477)
  - **Fax:** 1-800-223-8164
  - **TTY:** 1-800-377-4950
  - **Mail:**
    US Department of Health and Human Services
    Office of Inspector General
    ATTN: OIG HOTLINE OPERATIONS
    PO Box 23489
    Washington, DC 20026

https://landerassociates.files.wordpress.com/2012/01/woman-on-phone.jpg
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Compliance

- Have an effective compliance program
- Routinely conduct internal audits to determine compliance with Medicare rules
- Determine corrective actions to avoid inappropriate billing
- Pay attention to your Comparative Billing Report (CBR)

Creating a Culture of Compliance

- Encourage staff to report concerns
- Be responsive to staff concerns
- Avoid language like:
  - “It’s all a game”
  - “Just use a different code and get it paid”
  - “This code pays more and it is almost the same”
How to Influence Provider Behavior

- Discuss Impact of prepay or post-pay audits:
  - Cash flow (70% denial rate means you’re getting 0.30 cents on the dollar)
  - No reimbursement for the time or cost of copying records to submit
  - FCA with:
    ▪ $11,000/claim
    ▪ Treble damages
    ▪ Up to five years in prison
  - Whistle blowers

Uses for CPT and ICD 9

- CPT/ICD9 codes not just used for reimbursement
- Used to code and classify mortality data from death certificates
- Used to monitor incidence and prevalence of diseases
  - Seasonal influenza
  - Chronic disease distribution, cancer, etc.
- Used for resource allocation
  - Communities with high rates of chronic diseases
- Used to classify association between injuries (E codes) and ICD 9 codes
  - Computer keyboarding (E011.0) and seizures
  - Trampoline (E005.3) and orthopedic injuries
- Used for outcomes studies MMWR surveillance reports
ICD 9

- Technology Outcomes:
Session Number 4D

Code: _______