How to Respond to a Payor Audit

- Who Are They?
- What Do They Want?
- What Should I Do?

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Goals

- Understand who is performing the audit
- Understand what they want
- Understand how to proceed
- Minimize your exposure

- Don’t Panic: there is an appeal process
- Learn how to avoid future audits
Agenda

• Which Organizations are conducting Audits?
• The difference between Medicaid & Medicare RAC’s
• The difference between Private Payor & RAC audits
• Why did they chose me?
• How did they choose the claims? Which tools?
• Automated vs. Comprehensive Reviews?
• What do I do if I receive an audit notice?
• How do I appeal an adverse finding?
• How do I prevent new audits?
Which Organizations Conduct Audits?

- CERT: Comprehensive Error Rate Testing
- HEAT: Healthcare Fraud Prevention & Enforcement Action Team
- MIC: Medicaid Integrity Contractor
- Medicaid RAC: Medicaid Recovery Audit Contractor
- RAC: Medicare Recovery Contractor
- ZPIC: Zone Program Integrity Contractors
Which Organizations Conduct Audits?

- Private Payors: United, Aetna, Anthem, Humana, Cigna
- MAC/CMS FI: Medicaid Administrative Contractor
- OIG: Office of the Inspector General
- State Audits: Many different programs
- CMS ERRP: Early Retiree Reinsurance Program
- CMS RADV Audits: Risk Adjusted Data Validation Audit
Why are Organizations Auditing?

• Improper Payments
• Budget Gaps
• Affordable Care Act: Pay for future programs
• Finding Money: 10% of all dollars
  – Medicare: 10.5% ($34.3 Billion)
  – Medicaid: 9.4% ($22.5 Billion)
  – Medicare Advantage: 14.1% ($13.6 Billion)
Medicare Recovery Audit Contractor: RAC

- Contracted by CMS: 4 Regional Vendors
- Reduce Improper Medicare Payments
- Overpayments, Underpayments, Future Payments
- Goal: reduce CMS error rates
- Not responsible for detecting **fraud and abuse**
  - Zone Program Integrity Contractors/ZPICs: fraud and abuse
Medicare RAC Scope of Work

- Post Payment (after October 2007)
- Incorrect payment amounts
- Non-covered services
- Incorrectly coded services: DRG miscoding
- Medical Necessity
- Duplicate services
- Follow CMS Rules and Guidelines
- Medicare Fee For Service: Not Medicare HMO’s
- Within last 3 years
- Focused Selection: Data Mining
Other Audit Organizations

Medicaid Recovery Audit Contractors
• Follow State Rules
• Each State Program is Different
• Medicaid FFS (sometimes Medicaid HMO’s)

CMS Medicaid Program Integrity Contractors
• Chosen by CMS
• Audit State Medicaid Programs
• Work with CMS and State Medicaid Agency
• Look back period of 5 years (vs. 3 for RAC’s)
Zone Program Integrity Contractor: ZPIC

Focus on Fraud and Abuse

• Often overlap with CMS MIC
• Focus: Physicians, Home Health, DME, Chiropractors
• Support Law enforcement: investigations/prosecution
• Provide fraud and abuse training
• Focus: Eliminate Fraud (RAC’s $\rightarrow$ Improper payments)
• Fixed Rate Payments vs. Contingency Fees
• Target Specific Providers vs. Specific Services
• Formerly Program Safeguard Contractors (PSC’s)
Other Audit Organizations

CMS ERRP Audit Contractor
- New: Early Retiree Reinsurance Plan
- Audit Health Plans

CMS RADV Auditors
- Focus on Risk Adjusted Rating
- Audit Health Plans

State Audit Programs
- Can be any program for Medicaid

CMS MAC/Fiscal Intermediaries
- Obligation to manage Fraud, Waste & Abuse
Other Audit Organizations

HEAT

- Directed by DOJ → High Fraud Areas
- FY 2010: 140 indictments against 284 defendants
  - $590 million in fraudulent billings
  - 146 defendants → average 40 months in jail
  - 9/7 sting: 91 people in 8 cities ($295 million in fraud)

CERT (Established 2003)

- Focus on determining payment error (improper $$$)
- Does not label claims as fraud
- As of 2009, includes Hospital Program
- Ex: 99214, 99232, 99233 and 99211 are problem areas
# Medicare vs. Medicaid RAC

## Medicare
- Follow CMS Rules
- Many limitations
- No Prepay Audits
- Pay for Medical Records
- Limit on # of records
- Minor Errors: no recovery
- Exclude records under audit
- Accept records on CD/DVD
- Fraud reported to CMS
- Quality reported to QIO

## Medicaid
- CMS and State Rules
- More flexibility
- Prepay possible
- Does not pay for records
- No set limit on # records
- Minor errors: may recover
- Look back 5 yrs (vs. 3 yrs)
- No set rule on accepting records
- Fraud reported to AIG (state)
- Quality reporting varies
### Private Payor vs. Medicare RAC

#### Medicare RAC
- Follow CMS Rules
- Many limitations
- No Prepay Audits
- Pay for Medical Records
- Limit on # of records
- Minor Errors: no recovery
- Exclude records under audit
- Accept records on CD/DVD
- Fraud reported to CMS
- Quality reported to QIO

#### Private Payor
- CMS, State & Other Rules
- Very flexible
- Prepay Common
- Contractual
- No limit on # records
- Minor errors: may recover
- Look back 5 yrs if fraud/abuse
- No set rule on accepting records
- Fraud reported to SIU
- Quality reporting varies
QUESTIONS?
Private Payors

Can have multiple audit programs

• Prepay vs. Postpay
• Automated vs. Comprehensive (Medical Record)
• Hospital Service vs. Professional Service
• Fraud and Abuse (SIU) vs. Claim Recovery
• Claim Focused vs. Provider Focused
Private Payors

• Often use multiple vendors
• Can process fraud and abuse
• Recover overpayments & prevent future errors
• Specific Appeal Rights
• Wider scope but more flexible
• Claim Focus and Provider Focus
Private Payors: Audits are not by Accident

Are you an outlier?

- Make sure
  - Check your profile
  - Check your distribution
- Can you explain?

Do you use problem/abused codes?

- Is there a reason?
- How often do you use them?
- Your specialty vs. Others: OM with level 5 E&M
Private Payors: Audits are not by Accident

Does your practice bill high $$$?

- How many providers?
- How many physician extenders?
- How many patients?

Is one particular doc high?

- Are all claims going under his ID?

Do you have unique circumstances?

Do you have multiple offices under one provider/Tax ID?
Private Payors: Insight

• Which department is auditing you?
  • SIU vs. Claim Recovery

• What kind of an audit?
  – Education vs. Recovery
  – Coding vs. Medical Necessity
  – Automated vs. Medical Record Review

• How did they choose you?
• How many claims are involved?
Private Payors: Insight

- How many claims are involved?
  - 20 or less versus 100 or more?
- Is the sample statistically valid?
  - Are you sure?
  - This is critical: Extrapolation and self reporting
  - Remember tiers and stratification
- Is extrapolation involved?
  - Not without a statistically valid sample
- Are they asking for records?
Why Did They Choose You?

- Outlier with respect to Peers
- Aberrancy in Billing Patterns
- High use of Abused Codes
  - 99233 → 97.24% denial rate for Cardiology (MAC Probes)
  - 99214 → 48% denial rate for Family Practice (MAC Probes)
  - Place of Service → Office and ASC Same Day (OIG)
  - E&M → especially in global period (OIG)
- High use of Problem Areas
- OIG focus
- High dollar amount categories
Why Did They Choose You?

- Add on Codes without Parent Procedure
- Duplicate Claims
- Unit Discrepancies
- E&M Focus
  - 99232 and 99233
  - Consults
  - Modifier 25 or 59
- Critical Care
- Prolonged Service Codes
- EMR’s → cloned documentation
How Do They Choose the Claims?

Known Issues

- Problems known to OIG or RAC’s: IVCD, Mod 25
- Use of abused codes/medical necessity
- Announced areas of Focus: OIG Work Plan

Data Mining

- Outlier with respect to peers: Focus on codes or service
- Medically Unlikely
- ICD-9 and CPT do not Match: Let’s discuss
- Aberrancy
- Medical Necessity
Tools Used to Choose Physicians/Claims

Data Mining Tools
- McKesson
- Ingenix
- IBM (FAMS)
- STARS

Statistical Tools: Aberrancy
- SAS
- Fair Isaacs (FICO)

New Tool: Predictive Modeling
- Prepayment: Alerts and Risk Scores (Credit Card)
Automated vs. Complex Reviews

Automated Review: Review claim without review (human) of a medical record

- Performed for non-covered services or inappropriate coding of a service and there is a CMS policy regarding the service
- Performed when there is a duplicate or incorrect payment made
- Violates a very clear edit or rule
- Hard and Fast Rule: Usually
Automated vs. Complex Reviews

Complex Review: Review claim by reviewing the medical record (human review)

• Often when claim is suspicious
  – When Payor is unsure about a circumstance
• When medical necessity is a potential issue
  – When edit or rule is not sufficient or applicable
  – When critical information is in MR but not in the claim
Automated Review

Denied based on claim only: Use of edits

- Billing a service that is not allowed
- Unbundled services: NCCI Edits
- Date of Service is outside the range of eligibility
- Once in a lifetime: Service billed more than once
- Place of service: Facility vs. Non-Facility
- No supporting service: Facet injection without fluoroscopy
- Excessive Units: Billed for Box instead of Vial
- Medically unlikely edits: Same procedure with two different approaches
Automated Review

Denied based on claim: Use of edits

- Global Periods: Another procedure without modifier
- Pre-op and Post-op E&M
- Multiple surgeries on same patient without Modifier 51
- E&M Service with pre-op/post-op procedure
- Global vs. TC/PC Billing: Cannot double bill
- Co-surgeries: one physician forgets the Modifier 62
- Duplicate E&M Claims by 2 physicians in same group
- E&M Service during global days: Modifier 24
Semi-Automated Review

Hybrid between Automated and Comprehensive

- May see with RAC’s and Private Payors
- Claim identified as part of automated review
- Automated review is inconclusive
- Auditor requests medical record: May cite reason
- No record request limits (RAC)
- No reimbursement for records (RAC)

An automated review leads to a comprehensive review
Complex/Comprehensive Review

Denied based on review of Medical Record

- Certified Auditor/Nurse reviews medical record
- Applies Standard Rules: CMS/CPT/CCI/NCD/LCD
- Was the service performed?
- Did it meet the criteria: indications or contraindications?
- Was a different service performed, i.e. was another code more appropriate?
- Should the service be denied or down-coded?

Should provide citation or reference
ER Example: Automated Review

Denied based on review of Claim

- Observation code with <8 hours documented
- 99292 without 99291
- Radiology CODE with the following
  - Facility Global
  - Professional PC
ER Example: Comprehensive Review

Denied based on review of Medical Record

• 99284 or 99285
• Modifier 25 Usage
• Physician Billing for CPR
If You Receive a Notice from a Payor

DON’T PANIC
What if I Receive a Notice from a Payor?

- Read carefully: request, citation and demand (if any)
- **Are you already being audited:** HEDIS, QA
- 1st correspondence may be a request for records
  - You have 45 days to comply (complex review)
- Call the Payor and ask to speak with someone
  - If they refuse, document this in writing! Notify Society
- Once you have more information:
  - Review your Records. What can you find?
Is This a Request for Medical Records?

- **Check your contract**: What are you obligated to provide?
- Call Payor: Will they give you a reason? Letter?
- **Have an experienced person pull the records**
- Copy and send records (make a 2\textsuperscript{nd} copy)
  - Check against the maximum allowed
  - You usually have 45 days. You **must** send in records
- If you cannot locate a record, ask for more time
- Review the records: Is anything wrong?
- Send more not less: not just progress notes
What if I Receive a Finding from a Payor?

Findings: overpayment/error vs. Recovery

If first notice is a finding without a prior request for records, this is an **automated review**

- Limits scope to incorrect billing/coding
- Contact your billing company
- Run claims reports and review the services billed
- Review recent receivables: were you paid incorrectly
- Look for Medical Necessity: **Big Issue**
- See Automated Review Slides

**Don’t let them Extrapolate**
Why Fight Extrapolation with Automated Review?

Don’t let them Extrapolate

- Extrapolation $\rightarrow$ Large $$ Recoveries
- Extrapolation implies sample applied to universe
- For Automated Claims they have the universe
- They do not need a sample. They have it all
Notification of Audit

• READ IT CAREFULLY 10 TIMES
• THEN, determine the focus and scope of audit
• Is this potentially a recovery or fraud audit?
• If yes: Call together the team
• Name a project manager
• Expert to pull records
• Expert to review coding, billing & Medical Record
• Don’t confuse Heralding Letter with Notice of Audit
What if I Receive a Demand Letter?

A request for overpayment: Want the money back

- Must be received within X days of MR request
- Rationale for the review
- Justification for review and potential corrective action
- Explanation for each claim: incorrectly paid or coded
- Statistical Sampling if extrapolation

- How to repay the demanded overpayments
- Language on how to submit a statement of rebuttal prior to submitting overpayment
- Language on how to appeal the demand
What Action if I Receive a Demand Letter?

- Ask for time to review
- Understand the issues
- Use an expert
- The Facts – Just the Facts
- Ask for Clarification
- Informal Appeal – Appeal – Grievance
- Identify every error they made
- Determine their error rate
- Calculate your error rate and Exposure
Calling the Payor’s Medical Director

• You know you are right
• They are not accepting your explanation
• You believe you will win at arbitration

Putting your doc on the Phone

• Must be relaxed personality
• Must be prepared: know the facts
How Do I Appeal an Adverse Finding?

Coding Issue

• Review with professional/certified coder: great credentials
  – If the coder disagrees with the Payor, file an appeal

Clinical Issue

• Provide your clinical rationale supported by clinical literature issued by a third party (citations vs. opinions)
  – The clinical literature should be authoritative making it a standard for consideration
  – If this is a single issue (large claim), then have appropriate supporting clinical consultations that support the service
How Do I Appeal an Adverse Finding?

• CAREFULLY
• Informal appeal first, then appeal, then grievance
• How many appeals are allowed?
  • Informal
  • Appeal
  • Grievance
• Clear explanation
• Use of credentialed consultants
• **Focus on Citations, Rules & Guidelines vs. Opinions**
How Do I Appeal an Adverse Finding?

- Take your time and use all the tools
- Double check the records you sent
- Is the claim within the scope of the audit?
- Is the claim within the time period?
- Has an authoritative reference been provided?
- Is it incorrect or just suspicious?
- Focus on Citations, Rules & Guidelines vs. Opinions
- Total of all your sustained appeals → their error %
- If their error rate is > 5%, this is significant
Compromise or Settlement Offer

- Medicare RAC’s cannot settle but CMS can settle
- Medicaid RAC’s cannot settle but State can settle
- Private Payors settle all the time
- Before you settle:
  - Double check coding and billing
  - Double check sampling and extrapolation
- Some useful information on settling:
  - What was Payor’s error rate (based on your coder)?
  - Are you willing to commit to education and improving?
  - Are you willing to volunteer for follow up audit?
  - Will you provide community service (teaching docs)?
Compromise or Settlement Offer

The most important thing about a settlement

• **Avoid future look backs**
• Get 60 to 90 days to deploy improvements
• Future audits okay if DOS is 60 to 90 days after audit
• Agree to improve and volunteer for audit
• Make sure Fraud and/or Abuse is not cited
• Push for administrative error
• The Payor wants correct coding and quality providers
How Do I Prevent Future Audits?

Analyze your Practice: Are you an outlier

• How do you compare with your peers?
• Make sure you can explain outlier status
• **Double check your profile with Payors**
• Meet with Payors to explain unusual patterns
• Conduct a Chart Review: Audit
How Do I Prevent Future Audits?

- **Clinical Issue**: Make changes in your clinical practice
- **Coding Issue**: Improve your coding
- **Documentation Issue**: Improve your documentation
- Determine if procedures covered
- Avoid experimental procedures. Find alternatives
Pre-audit/Chart Reviews

Retain an expert team to assess your practice

• Appropriate, up-to-date codes and modifiers are being used
• The documentation in the MR supports the level of code used
• Time spent with the patient is documented on the medical record
• Level of Complexity of the MDM supports the code billed
  • You cannot bill a high level E&M for a O.M. or URI
Pre-audit/Chart Reviews

Retain an expert team to assess your practice

• Maximizing revenue in spite of insufficient documentation
• Identify cutting, pasting of documentation
• Identify setting EMR’s to Maximum
• Review Practice vs. OIG Work Plan
• Review Practice vs. RAC Issues
QUESTIONS?
THANK YOU

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APPENDIX
Diversified Collection Services, Inc. of Livermore, California, in Region A:

Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont

- Home Page:  www.dcsrac.com

- Current Issues:
CGI Technologies and Solutions, Inc. of Fairfax, Virginia, in Region B:

Michigan, Indiana and Minnesota, Wisconsin, Illinois, Kentucky, Ohio

- Home Page:  http://racb.cgi.com

Connolly Consulting Associates, Inc. of Wilton, Connecticut, in Region C:

Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia and the territories of Puerto Rico and U.S. Virgin Islands.

- Home Page:  www.connollyhealthcare.com/RAC

- Current Issues:  
Health Data Insights in Region D

Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa and Northern Marianas

- Home Page: https://racinfo.healthdatainsights.com
- Current Issues: https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx