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RAC, ZPIC and Other Audits: What to Do When They Knock at Your Door

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RAC, ZPIC and Other Audits: What to Do When They Knock at Your Door

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David T. Lewis
Husch Blackwell LLP
736 Georgia Avenue, Suite 300
Chattanooga, TN 37402
Telephone: (423) 757-5935
david.lewis@huschblackwell.com

Lori Baker
HORNE LLP
1020 Highland Colony Parkway
Ridgeland, MS 39157
Telephone: (601) 672-0452
lori.baker@horne-llp.com

Medicare Medicaid Provider Audit and Program Integrity Update

- Overview of the Medicare Recovery Audit Contractor (RAC) Program, the Medicaid Integrity Contractor (MIC) Program and the transition to the Zone Program Integrity Contractor (ZPIC) and Medicare Administrative Contractor (MAC) Programs
- Expansion of the RAC Program to Medicare Parts C and D and Medicaid
- Implementation of the ZPIC and MIC programs

Medicare Medicaid Provider Audit and Program Integrity Update (Con't)

- Preparing for and responding to contractor reviews
- Appeal of Denials-The Medicare and Medicaid Appeals Processes
- Question/Answer

Reality

- Increased number of government contractors actively trying to identify Medicare and Medicaid overpayments and potential fraud or abuse in federal health programs
- Contractors are using sophisticated data mining programs to identify suspect claims
- Government has recognized that use of contractors to identify incorrect and potentially fraudulent claims is cost-effective
- Healthcare organizations and providers need effective processes to facilitate proactive and reactive steps to prepare for and manage contractor inquiries and disputes

Low Hanging Fruit

- CMS estimates $10.4 billion in improper Medicare payments
- CMS estimates $18.6 billion in improper Medicaid payments
- FBI projects fraud and abuse represents 3 to 10 percent of total health spending
- 2010 Health Care Fraud and Abuse Control Program Annual Report states that $4.02 billion was deposited with federal agencies in 2010, including $2.86 billion transferred to the Medicare Trust Fund and $ over $1 billion in audit disallowances and restitution/ compensatory damages

Contractor and Enforcement Landscape

- Medicare Administrative Contractors (MAC)
- Zone Program Integrity Contractors (ZPIC)
- Program Safety Contractors (PSC)
- Medicare Drug Integrity Contractors (MEDIC)
- Medicare/Medicaid Recovery Audit Contractors (RAC)
- Qualified Independent Contractors (QIC)
- Medicaid Integrity Contractors (MIC)

Contractor and Enforcement Landscape (Con't)

- Federal Medicaid Integrity Group (MIG)
- Office of Inspector General (OIG)
- Department of Justice (DOJ)
- State Medicaid agencies and Medicaid Fraud Control Units (MFCUs)
- Comprehensive Error Rate Testing (CERT) Program

Audit Triggers

- Improper or inaccurate billing
  - High claim rejection rates
  - High claim recoupment rates
  - Utilization screens
  - Higher utilization than neighboring providers
  - High clinical case mix assignment
  - Medicare admission patterns
  - Claim mismatch with medical record
  - Lengths of stay outside industry norm
  - Use of data mining
  - Beneficiary complaints

CMS Recovery Audit Contractor Program

- Demonstration project authorized by Section 306 of Medicare Modernization Act of 2003
- RACs were tasked to identify and correct Medicare overpayments and underpayments
- RACs compensated on contingency fee basis
- Demonstration project was designed to determine whether RACs were a cost-effective method to identify and correct overpayments by Medicare

CMS Recovery Audit Contractor Program (Con't)

- Demonstration project started in California, New York and Florida and expanded in 2007 to South Carolina, Massachusetts and Arizona
- More than $1.0 billion dollars recovered, not counting operating costs and results of appeals
- CMS determined RACs were cost-effective as the demonstration project cost was $.20 for every $1.00 returned to the Medicare Trust Fund

RAC Project Expansion

- The Tax Relief and Health Care Act of 2006 made the RAC program permanent - required nationwide expansion by 2010
- CMS planned to expand to 19 states by October 2008, but bid protest by unsuccessful RAC bidders delayed implementation
- Bid protests were settled in early February 2009 and nationwide expansion is moving forward
- For most states, automated reviews began in late 2009 and complex reviews in 2010

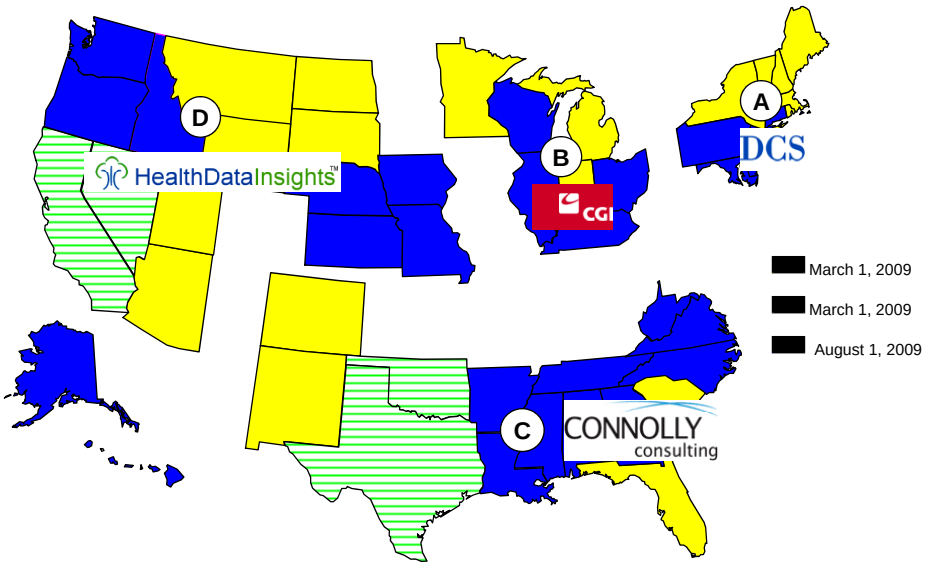
RAC Project Expansion (Con't)

- New issues initially posted to RAC website in August 2009 and have dramatically increased in recent months and include medical necessity
- Implementation has been slower than anticipated but avoid a false sense of security
- Patient Protection and Affordable Care Act expands RAC to Medicare Part C and D and to Medicaid (Section 6411)

Permanent RAC Rollout

- CMS will give pre-approval to each coding and medical necessity review, and will approve language in the RAC medical record requests and demand letters
- New RAC audits will be screened by CMS "new issues review board"
- CMS pledges to "cap" the number of medical records requests per month per provider or supplier
- CMS hired a validation contractor to audit RAC audit accuracy rates
- CMS will require RACs to provide more detailed information in denial letters
- RACs required to have websites with detailed review status information

RAC Jurisdictions



RAC Methodology

- "Automated Review"- review of claims data where there is "certainty" that the claim includes an overpayment and does not include medical record review. Written policy, article or sanctioned coding guideline exists. RACs have posted numerous automated reviews on their websites.
- "Complex Review"- review of medical and other records and is used in situations where there is "high probability" that the claim includes an overpayment. Medical necessity is an example of complex review.
- RACs do not randomly select claims for review but use proprietary software to determine claims likely to contain overpayments ("Targeted Reviews"). Used when there is no Medicare policy, article or sanctioned coding guideline.

Differences Between Demonstration and Permanent RAC Program

- Permanent RAC will expand to all provider and supplier types who bill Medicare Part A and B on a fee for service basis (2010 reform law expands to Part C and D and Medicaid)
- Permanent RAC will only be able to go back to claims paid beginning October 2007 and no more than three years past the date of initial payment
- Registered nurses or therapists are required to make medical necessity determinations and certified coders are required for coding determinations
- RACs required to employ contract medical director to provide guidance regarding interpretation of Medicare policy
- If provider succeeds in appeal at any level, RAC must pay back contingency fee

Focus Areas from the RAC Demonstration Project

- Inpatient admissions for procedures eligible to be performed in outpatient setting
- One day stays that would qualify as observation (chest pain, non-acute CHF, back pain, gastroenteritis, elective defibrillator implantation)
- Three day stays to qualify for skilled nursing facility care
- Treatment for heart failure and shock (setting)
- Services following joint replacement surgery
- Outpatient speech-language pathology
- Physical therapy, occupational therapy and speech-language pathology in SNF setting

Focus Areas from the RAC Demonstration Project (Con't)

- Excisional Debridement documentation
- Respiratory system failure with ventilator support
- Medical Back Problems
- Non-extensive OR unrelated to principal diagnosis
- Respiratory infections and inflammations
- Sepsis
- Nutritional and metabolic disorders

Target Areas

- RAC
  - Contractor approved issues
  - DRG assignment
  - Medical necessity
  - Inpatient vs. outpatient designation
  - Blood transfusions
  - Bronchoscopy
  - IV hydration and IV infusion therapy
  - Non-extensive O.R. procedures unrelated to primary diagnosis
  - Add-on codes

Focus on Patient Classification and Correct Setting

- Determination of patient status is reserved to the physician and should be based on the care the patient is expected to receive
- Physician should order an inpatient admission for a patient expected to need inpatient care for 24 hours or longer and treat other patients on outpatient basis
- RACs found that certain diagnoses and procedures (e.g., implantable cardiac defibrillators, chest pain admissions) do not support an inpatient admission and fall within the definition of outpatient observation
- Condition Code 44-Physician can change admission order to outpatient observation prior to discharge and hospital can bill for observation
- Improper patient classification and claims submission can lead to False Claims Act liability (settlement involving St. Joseph's in Atlanta, St. Joseph's in Towson, MD and recent settlements concerning kyphoplasty)
- Focus area for DOJ investigations and MAC reviews

Observation Services

- Observation services involve the use of a bed and periodic monitoring by the hospital staff as reasonably necessary to evaluate the patient's condition or determine need for inpatient admission
- Observation services should not be billed for diagnostic or therapeutic procedures for which active monitoring is part of the procedure (colonoscopy, chemotherapy)
- Observation must be medically necessary (immediate risk of deterioration if not cared for in the hospital) and not for the convenience of the patient or physician)
- In most cases, observation services are packaged services for which no additional payment is made
- Composite APC payment may be made when observation care is billed in conjunction with high level ED visit, critical care services or direct admission

Preparing for RAC Audits

- Organize your team and assign responsibilities. Coordinator of RAC process should be detail-oriented
- Evaluate patterns of current denials by Medicare/Medicaid contractors, areas identified in the RAC demonstration project, the new issues posted to the RAC web sites and any “vulnerabilities” identified internally through audit and compliance activities
- Review OIG Work Plan and audit reports and CERT reports
- Determine who in the organization coordinates the process and is the contact person for the RAC

Preparing for RAC Audits (Con’t)

- Educate physicians about medical necessity and maintain a functioning UR Committee to review medical necessity of admissions, required as a Medicare CoP (42 CFR 482.30)
- Develop tracking tools- track record requests, date of RAC response, whether there was an overpayment, date of recoupment, deadline for redetermination request, other key dates in appeals process

RAC Records Management

- Make sure entire record is submitted and review it before it is submitted (Is it legible, complete and do we think we can win on appeal?)
- See CMS Transmittal 47 (June 5, 2009) concerning requirements for complete medical records
- Number all pages, make sure they are legible and scan everything you are sending to the RAC
- Include NCDs, LCDs, coding guidance, letter from attending physician if applicable, etc.
- Sending records in electronic format is encouraged (encrypted CD, DVD)
- Send in manner where date of delivery can be confirmed
- Follow-up with RAC to confirm delivery

RAC Communication

- Following automated review, provider will receive a demand letter
- For complex review, provider will receive a “results” letter
- Following results letter will be a demand letter
- From results letter to demand letter, provider has opportunity for “discussion” with the RAC to submit additional documentation, etc., in hopes of a different conclusion
- Discussion period does not change deadline for submitting appeal

Strategies for Defending Audits

- Advocate the merits, particularly where medical necessity is involved
- Get treating physician involved- he or she has examined the patient and is most familiar with patient's condition absent substantial evidence to the contrary and the physician's judgment should receive deference
- Waiver of liability- payment may be made if provider or supplier did not know and could not have reasonably known payment would not be made. Generally applies to medical necessity and provider should support with carrier or FI communications
- Provider without fault- exercised reasonable care in billing and accepting payment, complied with pertinent regulations, disclosed material facts, etc.
- Challenges to reopening and use of statistical sampling

Provider and Supplier Options Following RAC Denials

- Providers will note FI/MAC Remark Code N432 on Remittance Advice (adjustment based on recovery audit)
- Allow recoupment starting 41 days after RAC notice of denial and file appeal within 120 days
- Pay by check by day 30 and avoid interest
- File appeal prior to recoupment starting (within 30 days of notice of determination)
- Discussion period available to convince the RAC to modify its decision, but does not change deadlines for submitting appeal
- Section 935 of the Medicare Modernization Act modified CMS's recoupment remedies (applies to all appeals, not just RACs) (see 74 Federal Register 47458-47470)

Medicare Appeals/ Collection Process

- Step 1-Request for Redetermination must be filed within 120 days of receipt of initial determination. However, if the provider or supplier wants to stop recoupment, redetermination request must be filed within 41 days of the date of the initial determination letter. In addition to CMS or FI form, prepare supporting letter on provider letterhead outlining medical evidence and legal authority supporting payment.
- Step 2-Reconsideration by Qualified Independent Contractor ("QIC"). This appeal must be filed within 180 days of the receipt of the redetermination decision, but to stop recoupment, appeal must be filed in 60 days. When filing a reconsideration request, providers and suppliers must be careful to present all evidence and arguments why the redetermination is incorrect.

Medicare Appeals Process, Con't

- Step 3- Administrative Law Judge ("ALJ")- must be filed within 50 days following QIC decision. Amount in controversy requirement is $120. May be live, via video conference or telephone (most by telephone).
- Step 4- Medicare Appeals Council ("MAC") Review-MAC review request must be filed within 60 days following receipt of ALJ decision. MAC will limit review to the issues raised in the written request for review.
- Step 5- Federal District Court- Request must be filed within 60 days of receipt of MAC's decision. There is an amount in controversy requirement of $1,180.
- Interest accrues while appeal is pending. New rule provides that if overpayment determination is reversed on appeal above the QIC level of appeal, CMS is liable for interest for the entire period of the recoupment

RAC Takeaways

- Document, document, document, etc.
- Medical necessity-ensure consistent application of medical necessity criteria (need functioning UR Committee)
- Provide access to case management staff at all entry points to collaborate on admission status
- Educate physicians and staff regarding medical necessity documentation for inpatient admissions and/or determination of observation status
- Be prepared and don't wait until you receive your first medical record request
- Get to work on developing the necessary tracking tools

RAC Resources

- Look for further communication from CMS and the RAC for your state as well as updates from provider associations
- Statement of Work for the Recovery Audit Contractor Program, available at www.cms.hhs.gov/RAC
- www.cms.hhs.gov/RAC- CMS site with FAQs, RAC updates and other information abut the RAC program. Questions can be submitted to RAC @cms.hhs.gov. This site also contains a link to the Statement of Work and contact information for each RAC
- RAC websites

Medicaid RACs

- States required to have RAC programs in place by December 31, 2010
- Contracts must be in place by April 1, 2011
- Proposed regulations issued November 10, 2010
- Comments from AHA, FAH and the Medicare RACs
- Appeal process may follow state law but must be approved by CMS
- RACs do not replace state program integrity or audit initiatives
- CMS projects savings from $80 million in 2011 to $330 million in 2015
- Medicaid RAC contingency fee may not exceed that of the highest Medicare RAC unless CMS approves waiver

Zone Program Integrity Program

- Medicare program integrity activities are being transitioned to ZPIC (PSCs will go away)
- CMS organized ZPIC procurement to correspond to MAC jurisdictions (7 separate “zones”)
- ZPICs in each zone will perform benefit integrity functions for Medicare Part A, B, C, D, DME, Home Health and Hospice, and Medicare/Medicaid Matching Project
- ZPICs are active in Zone 7 (Florida) and Zone 4 (which includes Texas) and becoming active in other zones

ZPIC Statement of Work Highlights

- Reactive and proactive identification of potential fraud through data analysis, evaluation of complaints, referrals from law enforcement and referrals from other contractors, including MACs
- Support for law enforcement during investigation and prosecution of healthcare fraud cases (medical review, data analysis, overpayment determination and expert testimony)
- Fraud, waste and abuse training for MAC and AC staff

ZPIC Implementation

- Combined oversight of all Medicare providers within a geographic "zone"
- CMS will award 7 umbrella contracts with each containing 2 task orders
- Task Order 1 is Part A, B, DME, and Home Health and Hospice
- Task Order 2 is the Medicare/Medicaid Matching Projects
- Future task orders will be awarded at CMS discretion
- Typically unannounced or with very little notice
- May be pre-payment or post-payment
- ZPICs may interview staff and beneficiaries
- You should assume it is not random
- ZPICs utilize statistical sampling and extrapolation to determine overpayment amounts

Current ZPIC Activities

- ZPICs have been very active in Florida, Texas and other “hot zones”
- Home health and DME have been a priority of ZPIC reviews
- Using statistical sampling and extrapolation to project overpayments
- In some cases, ZPIC works with CMS to issue payment suspension and CMS has new authority under ACA to suspend payments based on “credible allegations of fraud” (which are defined to include contractor data mining)
- Amounts of extrapolations and lengths of payment suspensions are potential business busters

Target Areas

- ZPIC
  - Medical Necessity
  - Upcoding
  - Billing for services or supplies not provided
  - Making claims for non-covered services as though they were covered
  - Soliciting or offering kickbacks

Applying and Attacking Extrapolation

- Dig out that statistics textbook
- Population size =100, sample size=10, error in 5 cases, 50 percent error rate for population
- Plan of attack on appeal- appeal whether the sample is representative and appeal individual claims in the sample
- The reversal of even one claim in the sample would result in major difference in the outcome

Medicare Contractors: Use of Extrapolation

- Medicare contractor may not use extrapolation to determine overpayment amounts unless the Secretary determines that
  - (a) there is a sustained or high level of payment error; or
  - (b) documented educational intervention has failed to correct the error
- 42 USC §1395ddd(f)(3)
  - See John v. Sebelius, E.D. AR, No. 4:09CV00552 SWW (October 6, 2010) (affirming use of statistical sampling and extrapolation) (attached)
  - No appeal from Secretary's determination

Medicare Administrative Contractors (MAC)

- Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Pub. Law 108-173, Subtitle B, Section 911 (42 USC 1395kk-1)
- Consolidated Fiscal Intermediaries and Carriers
- Different MACs for Home Health and DME

MACs Are. . .

- Responsible for:
  - Provider enrollment
  - Processing claims
  - Auditing providers
- Authorized to make Local Coverage Determinations (LCD)
  42 USC 1395kk-1(a)(4)
- Re-bid every five (5) years
  42 USC 1395kk-1(b)(1)(B)

Medicaid Integrity Program

- Established by the Deficit Reduction Act of 2005 to increase federal government's role and responsibility in combating Medicaid fraud and abuse
- Requires CMS to contract with eligible entities to serve as Medicaid Integrity contractors ("MICs") to review and audit Medicaid claims, to identify overpayments and to provide education on program integrity issues
- CMS also required to periodically publish its Comprehensive Medicaid Integrity Plan
- RAC expansion to Medicaid does NOT effect Medicaid Integrity Program (AHA seeking to change CMS position)

Medicaid Provider Audit Program

- Three types of MICs:
  - Review MICs: Analyze claims data to identify aberrant claims and potential billing vulnerabilities and provide leads to Audit MICs.
  - Audit MICs: Conduct post-payment audits of all types of Medicaid providers and identify overpayments.
  - Education MICs: Work with Review MICs and Audit MICs to educate health care providers, state Medicaid officials and others about Medicaid integrity issues.

The Medicaid Audit Process

- Identify potential audits through data analysis
- Coordinate potential audits with state Medicaid agencies and law enforcement
- Audit MIC receives audit assignment
- Audit MIC contacts provider, provides records request and schedules entrance conference
- Audit MIC performs audit
- Exit conference held and draft report prepared
- Review of draft report
- Draft report is finalized
- CMS issues report to state
- State issues report to provider and begins overpayment recovery

Comparing RAC and MIC Processes

- MICs not paid on contingent basis
- MICs identify but do not collect overpayments
- MICs more likely to use extrapolation to maximize take backs
- No limitation on number of MIC requests
- Sampling laws vary by state
- Different appeals process for MIC, which varies by state, with generally shorter appeal timeframes

MICs—How to Prepare and Organize

- Determine if audit will be “desk” audit or “field” audit
- Ensure there is an entrance and exit conference scheduled by the Audit MIC
- Get a good understanding of the appeals options for the state of your client
- State appeal timelines may be shorter than Medicare appeal timelines, which do not apply
- Ensure that MIC written request:
  - Is forwarded to the appropriate contact in the organization
  - Identifies the MIC point of contact

MICs—How to Prepare and Organize

- Influence of state law
  - Record retention requirements
  - Look back period
  - Limitations on records requested
  - Production expectations
  - Authority to extrapolate

MIC Target Areas

- Medical necessity
- Pregnancy cases
- Mental health
- Drug / alcohol abuse, dependence, etc.

Appeal Tips

- Work with clinicians and billings experts to develop the appeal
  - Procedural-Did auditor follow rules?
  - Substantive-Was the service medically necessary
- Think through your appeal strategy (do we appeal everything?)
- Document every communication with every agency or contractor
- Develop standard templates for specific denials (E & M, medical necessity)
- Include cover letter itemizing all information included

Appeal Tips

- Rely on other source documents such as AMA CPT Assistance and ICD-9-CM: AHA Coding Clinic
- Develop criteria-based case summaries for all appeals
- Submit all required documentation during first two stages of Medicare appeals
- Retain a copy of all documents provided to contractor

Appeal Considerations

- Is there clear guidance from CMS or the payer
- Sufficiency of clinical documentation
- Cost versus benefit of appeal
- Availability of clinical support and input
- Use the right people from the company
- Know the auditor's timetables
- Get specifics of what the auditors reviewed (i.e., physician offices records only, etc.)

Contact Information

For more information on this content, please contact:

Lori Baker, CPC, RHIA, CHCA-F
HORNE LLP
1020 Highland Colony Parkway
Ridgeland, MS 39157
Telephone: (601) 672-0452
lori.baker@horne-llp.com

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