AUDIT ALPHABET

Presented by:
Ronda Tews, CPC, CHC, CCS-P, AAPC Fellow

Developed for:
PBCMS
Palm Beach County Medical Society
April 11, 2018

The Audit Alphabet

smh

roflol

brb

omw

ikr

jk

idlk

idc

nvm

The Audit Alphabet

smh **shaking my head*

roflol **rolling on floor laughing out loud*

brb **be right back*

omw **on my way*

ikr **I know right*

jk **just kidding*

idk **I don't know*

idc *I don't care

nvm **never mind*

Objectives

- Understand the acronyms that make up the audit alphabet
  - What they are and who they represent
  - What their functions are
- Why the increase in audit activity?
  - What has caused all of the scrutiny
- What does the future hold?
  - How does this affect the “good guys”?

Who are these agencies?

Federal program enforcers include:

- Office of Inspector General (OIG)
- Centers for Medicare & Medicaid Services (CMS)
- Department of Justice (DOJ)
- Federal Bureau of Investigations (FBI)
- Medicare Administrative Contractors (MACs)
- Quality Improvement Organizations (QIO)
- Program Safeguard contractors (PSC)

Who are these agencies?

- Medicare Zone Program Integrity Contractors (ZPIC)
- Medicare Unified Program Integrity Contractor (UPIC)
- Medicaid Fraud Control Units (MFCU)
- State Medicaid Inspector General
- State Attorney General
- Recovery Audit Contractors (RACs)
- Center for Program Integrity (CPI)
- Office for Civil Rights (OCR)

Why Audits?

- Healthcare costs continue to soar
- Investigations continue to find improper payments
- To combat these findings, the US (United States lol) Government has employed a taskforce of agencies to investigate and combat FWA (fraud, waste, and abuse)

Why Audits?

The efforts to identify and eliminate healthcare Fraud, Waste and Abuse is the on the rise…

In the News-

“OIG Utilizes Providers’ Data in Biggest Fraud Takedown Ever

EHR vendor’s shoddy software causes false claims- and a $155 million fine.

By leveraging advanced analytic techniques to detect potential vulnerabilities and fraud trends, says Inspector General Daniel R. Levinson in the Office of Inspector General’s (OIG) latest report on why the agency aggressively pursues offenders, “We are better able to target our resources at those areas and individuals most in need of oversight, leaving others free to provide care and services without unnecessary disruption.””

Part B Insider January 2018

OIG- Office of Inspector General

In its Semiannual Report to Congress, released on Nov. 29, 2017, the OIG reported that during FY 2017, the agency recorded a plethora of crimes and civil suits, exclusions, and recoveries.

Here is the breakdown for FY 2017 according to the report:

- Recovered funds: The OIG recouped $4.13 billion in investigative recoveries.
- Criminal actions: The federal watchdog found 881 individuals or entities guilty of crimes against HHS (Health and Human Services) programs.
- Civil actions: Civil suits were brought against 826 individuals or entities for fraudulent activities.
- Exclusions: The OIG also banned 3,244 individuals and entities from participating in federal healthcare programs in the future.

Part B Insider January 2018

HIPAA- Health Insurance Portability and Accountability Act

Enforcement Results as of January 31, 2018

Since the compliance date of the Privacy Rule in April 2003, OCR (Office of Civil Rights) has received over 173,426 HIPAA complaints and has initiated over 871 compliance reviews. They have resolved 97% of those cases (168,780).

OCR has investigated and resolved over 25,695 cases by requiring changes in privacy practices and corrective actions by, or providing technical assistance to, HIPAA covered entities and their business associates (BAs).

More on OCR

To date, OCR has settled or imposed a civil money penalty in 53 cases resulting in a total dollar amount of $75,229,182.00

OCR has investigated complaints against many different types of entities including: national pharmacy chains, major medical centers, group health plans, hospital chains, and small provider offices.

In another 11,399 cases, their investigations found no violation had occurred.

Additionally, in 25,714 cases, OCR has intervened early and provided technical assistance to HIPAA covered entities, their business associates, and individuals exercising their rights under the Privacy Rule, without the need for an investigation.

HHS.gov website as of 4/6/18

OCR Data

Compliance issues investigated most are:

- Impermissible uses and disclosures of protected health information;
- Lack of safeguards of protected health information;
- Lack of patient access to their protected health information;
- Lack of administrative safeguards of electronic protected health information;
- Use or disclosure of more than the minimum necessary protected health information.

HHS.gov website as of 4/6/18

OCR Data

The most common types of covered entities that have been required to take corrective action to achieve voluntary compliance are, in order of frequency:

- General Hospitals;
- Private Practices and Physicians;
- Outpatient Facilities;
- Pharmacies; and
- Health Plans (group health plans and health insurance issuers).

HHS.gov website as of 4/6/18

What are the programs?

- Comprehensive Error Rate Testing (CERT)
- Payment Error Rate Measurement (PERM)
- Targeted Probe and Educate (TPE)
- Children's Health Insurance Program (CHIP)
- Medicare Risk Adjustment Validation Program
- Recovery Audit Program
- Health Care Fraud Prevention and Enforcement Action Team (HEAT)

Research, Statistics, Data & Systems

CMS Information Technology

Access to CMS Data & Application

Agile Transformation

Blue Button API

CIO Resource Library

Data Administration

Database Administration

Division of Identity Management Enterprise Systems (EIDM)

Earned Value Management

Enterprise Architecture

Enterprise IT Investment Management

HIPAA Eligibility Transaction System (HETS) Help (270/271)

Information Security

MAPD Help Desk

Section 508

SPARC

Monitoring Programs

Medicaid and CHIP Compliance

Medicare Fee-for-Service Compliance Programs

Medicare Risk Adjustment Data Validation Program

Part C and Part D Program Integrity Program

Parts C and D Recovery Audit Program

Qualified Entity Program

Research

Actuarial Studies

Alliance to Modernize Healthcare FFRDC

Consumer Assessment of Healthcare Providers & Systems (CAHPS)

Consumer Research

Data and Statistical Resources on Dually Eligible Medicare-Medicaid Beneficiaries

Health Care Consumer Initiatives

Health Outcomes Survey (HOS)

acevedo consulting incorporated

CMS' Alliance to Modernize Healthcare

a.k.a. "Alliance" is the 1st Federally Funded Research and Development Center (FFRDC) dedicated to strengthening our nation's healthcare system.

CMS is the primary sponsor of the Alliance FFRDC. Together with HHS, they offer a single-award Indefinite Delivery Indefinite Quantity (IDIQ) contract vehicle to federal agencies at no additional administrative cost.

*smh

Medicare Fee for Service Recovery Audit Program

The Medicare Fee for Service (FFS) Recovery Audit Program's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that CMS can implement actions that will prevent future improper payments in all 50 states.

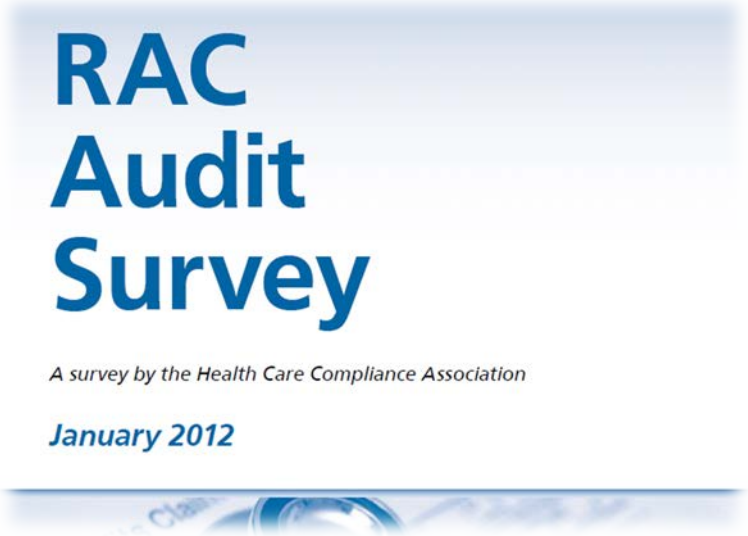
FFS RACs Data

In FY 2015, Medicare FFS RACs collectively identified and corrected 618,966 claims with improper payments that resulted in $440.69 million in improper payments being corrected. The total corrections identified include $359.73 million in overpayments collected and $80.96 million in underpayments repaid to providers. This represents an 82.8% decrease from program corrections in FY 2014, which were $2.57 billion. The Medicare FFS Recovery Audit Program returned over $141 million to the Medicare Trust Funds. This represents a 91% decrease from FY 2014, when the returned amount was $1.60 billion.

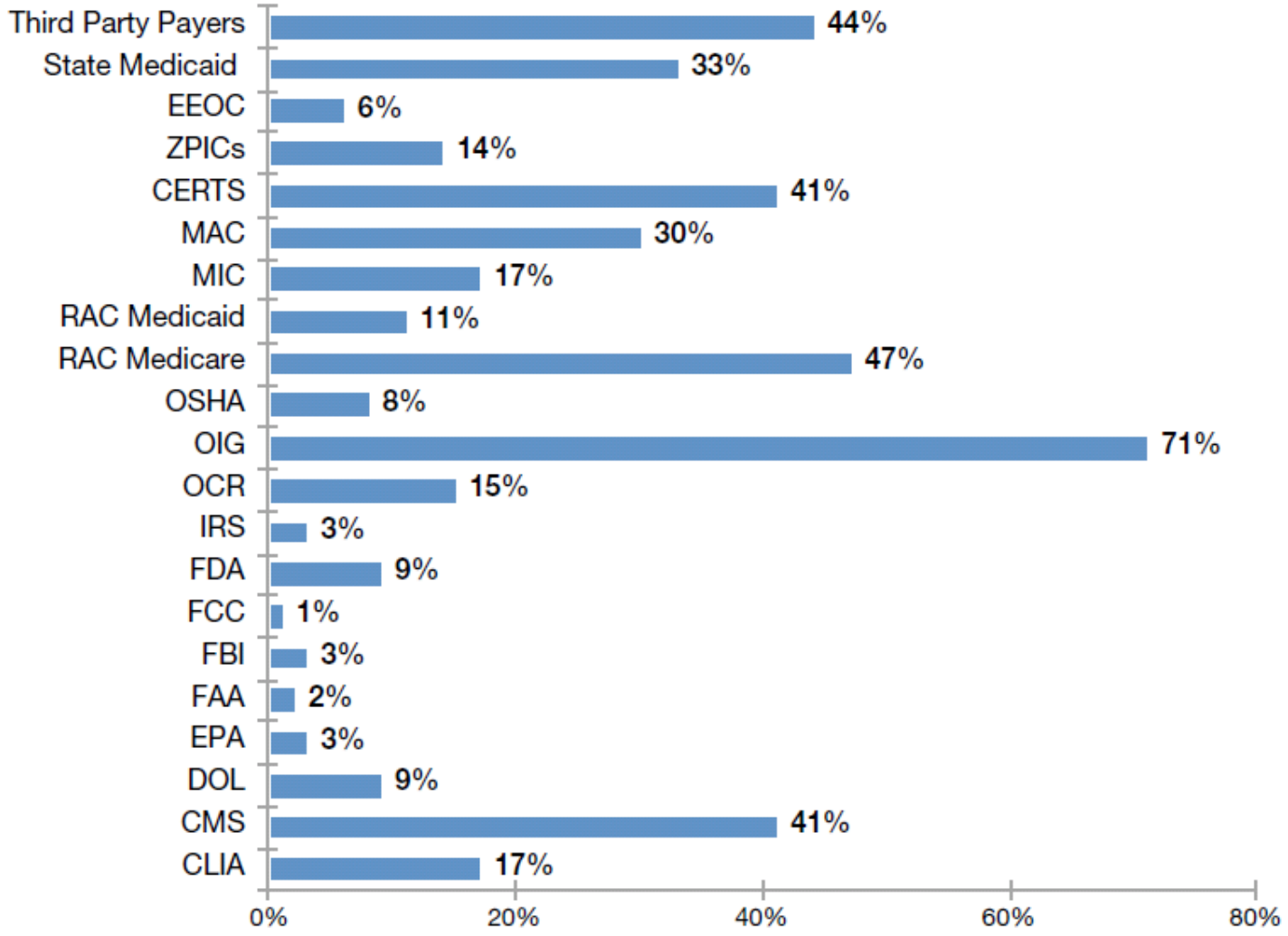
FY 2015 Report to Congress as Required by Section 1893(h) of the Social Security Act

HCCA- Health Care Compliance Association

In 2012, the HCCA launched a survey to assess the volume of audits. The goal was to determine the level of audit activity and the impact it is having on the compliance profession and the institutions they serve.



Percentage of Respondents Reporting at Least One Audit



Auditing *the Auditors*
A survey by the Health Care Compliance Association (2012)

HCCA 2012 Survey Overview

- In general, non-profits appeared to experience a heavier load of audits than for-profits.
- Larger institutions undergo more audits than smaller ones.
- Staffing levels to meet the demands of the audits are considerable across institutions, regardless of size.

*smh

CMS' Audit Goals

- ❑ **Detect** improper payments
- ❑ **Correct** improper payments
- ❑ **Measure** and pinpoint causes of improper payments
- ❑ **Provide** information to CMS and the Medicare claims processing contractors to prevent improper payments, thereby lowering the Medicare FFS payment error rate.

RAC Review Topics

On November 9, 2017 CMS began posting a list of review topics that have been proposed, but not yet approved, for RACs to review. These topics will be listed, in a monthly basis, on the CMS Provider Resources page along with details about the proposed reviews, such as:

- Name of the Review Topic
- Description of what is being reviewed
- State(s)/MAC regions where reviews will occur
- Review type (complex review/automated review)
- Provider type
- Affected code(s)
- Applicable policy references

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Provider-Resources.html

Targeting Medical Review

Targeted Probe and Educate- TPE

In October 2017 CMS launched a nationwide program to better target medical review, limit the number of medical records requested, and put an emphasis on education and assistance in correcting claims errors. This program focuses on providers who have unusual billing patterns or billing practices that vary greatly from their peers.

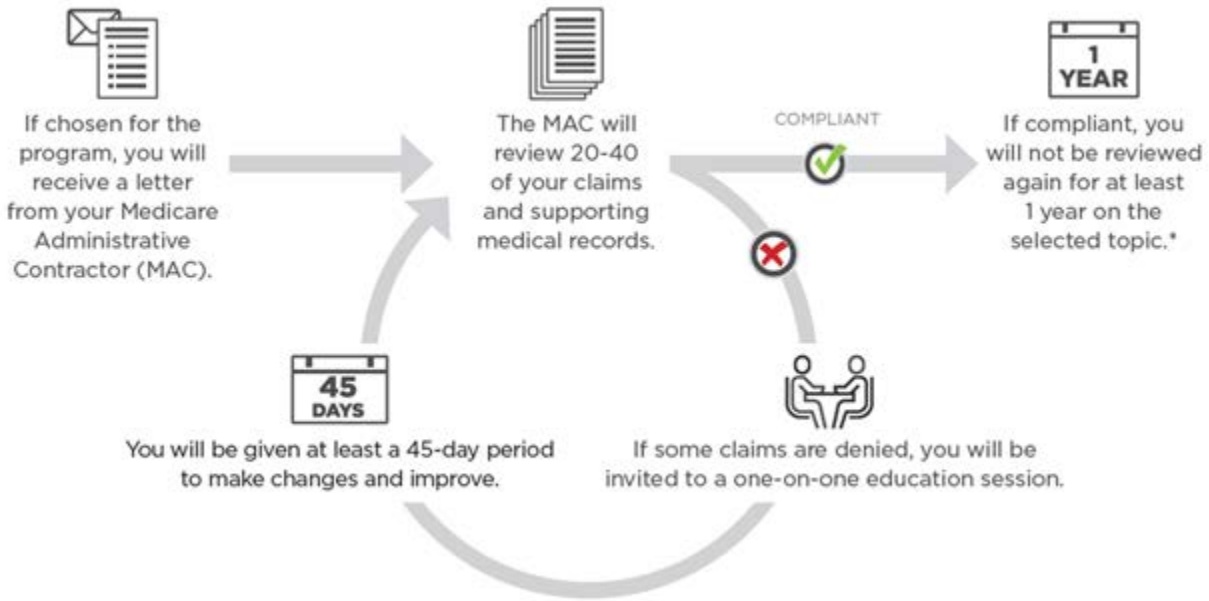
Providers whose claims are compliant with Medicare policy won't be chosen for TPE.

**sts (so they say)*

TPE – some common claim errors

- The signature of the certifying physician was not included.
- Encounter notes did not support all elements of eligibility.
- Documentation does not meet medical necessity.
- Missing or incomplete initial certifications or recertification.

How does TEP Work?



MACs may conduct additional review if significant changes in provider billing are detected

What if there is no improvement?

The majority that have participated in the TPE process increased the accuracy of their claims. However, any problems that fail to improve after 3 rounds of education sessions will be referred to CMS for next steps. These may include:

- ✓ 100% prepay review
- ✓Extrapolation
- ✓Referral to a Recovery Auditor
- ✓Or other action

Audits Affect All Providers

Home Health Medical Review Updated 8/14/17

On November 6, 2014, CMS issued a final rule CMS-1611-F, CY 2015 Home Health Prospective Payment System (HH PPS) Final Rule. The HH PPS final rule finalized a change that beginning January 1, 2015, requires home health agencies (HHA) to obtain documentation from the certifying physician's and/or the acute/post-acute care facility's medical record for the patient that served as the basis for the certification and eliminates the face-to-face encounter narrative as part of the certification of patient eligibility for the benefit. Home health agencies should obtain as much documentation from the certifying physician and/or the certifying facility as they deem necessary to substantiate that the home health patient eligibility criteria have been met. Home health agencies are required to provide this documentation to CMS upon request.

Audits Affect All Providers

On November 16, 2012 CMS issued a final rule titled:

"Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013". *(now you know why they create all the acronyms)*

This final rule was written to implement the statutory provision at Section 1834(a)(11)(B) of the Social Security Act that established requirements for a face-to-face encounter and written orders prior to delivery for certain items of DME. CMS developed a list of DME items subject to the Face-to-Face encounter requirements created by the rule. The list of DME items subject to Face-to-Face Encounter requirements may be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/DME_List_of_Specified_Covered_Items_updated_March_26_2015.pdf.

CERT- Comprehensive Error Rate Testing

CMS calculates the Medicare Fee-for-Service (FFS) improper payment rate through the CERT program. Each year, CERT evaluates a statistically valid stratified random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules.

The FY 2017 Medicare FFS program improper payment rate is 9.51%, representing $36.21 billion in improper payments, compared to the FY 2016 improper payment rate of 11% or $41.08 billion in improper payments.

CMS.gov website as of 4/6/18

CERT

The reporting period for this improper payment rate is July 1, 2015 – June 30, 2016.

Service Type	Improper Payment Rate	Improper Payment Amount (2)
Overall	**9.51%**	**$36.21 B**
Part A Providers (excluding Hospital Inpatient Prospective Payment System (IPPS))	11.31%	$18.24 B
Part B Providers	10.16%	$9.85 B
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	44.60%	$3.65 B
Hospital IPPS	3.91%	$4.46 B

CERT Abilities

- A CERT contractor can make an over- and under-payment determination and adjust claims accordingly.
- **It does not have the ability to determine fraudulent activity** because the contractor is often unable to see a pattern in the claims due to the random nature of the sample.

MAC- Medicare Administrative Contractor

MACs are employed to process claims submitted by physicians, hospitals, and other health care professionals and submit payment to those providers in accordance with Medicare rules and regulations. **They must also identify and correct underpayments and overpayments.**

MAC Abilities

When errors are identified, the MAC classifies the severity of the problem as minor, moderate or significant and imposes appropriate corrective actions. The corrective actions include provider feedback, pre-payment review, and post-payment review.

MACs don’t just identify improper payments through audits, they utilize the NCCI edits.

National Correct Coding Initiative (NCCI)

NCCI Edits- Prepayment

- CMS developed the NCCI to promote national correct coding methods and to control improper coding that leads to inappropriate payment in Medicare Part B claims. NCCI edits prevent improper payments when incorrect code combinations are reported. NCCI edits are updated quarterly.

Medically Unlikely Edits (MUE)

- CMS developed MUEs to reduce the paid claims error rate for Medicare claims. Just like the NCCI edits, the MUEs are automated pre-payment edits. The MAC's systems analyze the procedures on the submitted claim to determine if they comply with the MUE policy.
- A MUE for a HCPCS/CPT code is the maximum units of service that a provider would report, under most circumstances, for a single beneficiary on a single date of service (DOS).
- MUEs do not exist for all HCPCS/CPT codes. While the majority of MUEs are publicly available on the CMS website, CMS will not publish all MUE values because of fraud and abuse concerns. CMS updates MUEs quarterly.

RAC- Recovery Audit Contractor

- The Recovery Audit Program was mandated by the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 to find and correct inappropriate Medicare Part A and B payments.
- The three-year demonstration project was considered a resounding success, with collection of more than $1.03 billion in inappropriate payments.
- As a result, RACs were implemented nationally in 2010.

RACs Expanded

- In September 2011, CMS released the final rule expanding RAC activity to Medicaid claims.
- The Recovery Audit Program jurisdictions match the DME MAC jurisdictions.
- Section 641 1(b) of the Affordable Care Act (ACA) expanded the use of RACs to Medicare Parts C and D. A contract for Part D recovery auditing was awarded on January 13, 2011. Initial review focused on identifying improper payments for prescriptions written by excluded prescribers or filled by excluded pharmacies.

ZPIC- Zone Program Integrity Contractor

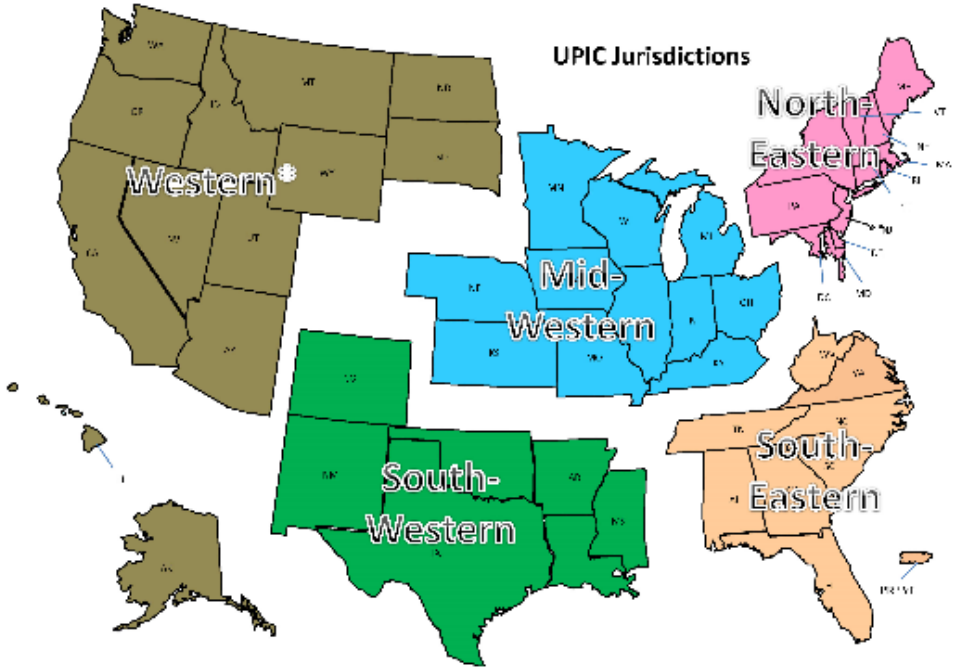
ZPICs- formerly the Program Safeguard Contractors (PSCs). The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC. Actions that ZPICs take to detect and deter FWA include:

- ✓ Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
- ✓ Conducting investigations in accordance with the priorities established by CPI's Fraud Prevention System;
- ✓ Performing medical review, as appropriate;
- ✓ Performing data analysis in coordination with CPI's Fraud Prevention System;
- ✓ Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits; and,
- ✓ Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.

MLN Matters Number: SE1204

UPIC- Unified Program Integrity Contractor

- Unified contractor that focuses on both Medicare and Medicaid integrity issues. Designed to share information and best practices to improve detection and prevent payment of fraudulent claims across a number of public and private payers.
- UPIC Contractor Names:
  - UPIC NE (Safeguard Services)
  - UPIC MW (AdvanceMed)
  - UPIC SW
  - UPIC SE
  - UPIC W (Noridian Healthcare Solutions)



Medicaid Integrity Program (MIP)

Section 1036 of the Social Security Act created the MIP and directed CMS to enter into contracts with Medicaid Integrity Contractors (MICs) to:

- Review Medicaid provider actions
- Audit claims to ensure that Medicaid claims were:
  - For services provided and properly documented
  - Billed properly with appropriate codes
  - For covered services
  - Paid according to Federal and State laws, regulations, and policies
- Educate providers and others on the Medicaid program
- MICs are assigned to CMS regions

Medicaid Recovered $1.8 Billion in 2017

The report is based on data collected from the mostly federally funded Medicaid Fraud Control Units (MFCU), which operate in 49 states and the District of Columbia.

More than 1,500 people or entities were convicted of Medicaid fraud or abuse and neglect in 2017, and prosecutors collected $1.8 billion in civil and criminal recoveries, federal auditors said in their annual report on the $565 billion program.

Of the 961 civil settlements and judgements in 2017, 426 (44%) involved pharmaceutical manufacturers, led by the $465 million Mylan settlement. Of the 1,157 fraud convictions in FY 2017, 523 (45%) involved personal care services attendants and agencies; 36 involved family practice physicians; 88 involved nurses, licensed practical nurses, physician assistants or nurse practitioners; 54 involved home health agencies; and 25 involved mental health facilities.

MFCUs recovered $6.52 for every $1 spent. Medicaid represents about 17% of the $3.3 trillion annual national healthcare expenditure, according to HHS.

HealthLeaders Media article by John Commins, April 2, 2018

3 Types of MICs

Review MIC

- Analyze Medicaid claims data to identify high risk areas, providers with aberrant billing practices and other potential vulnerabilities
- Provide leads to the audit MICs

3 Types of MICs

Audit MIC

- Conduct post-payment audits (field audits and desk audits)
- Any Medicaid provider may be audited, including but not limited to fee-for-service providers, institutional and non-institutional as well as managed care entities.
- A provider may be selected for audit through a number of ways, including:
  - Data analysis by other CMS contractors
  - Collaborative efforts between States and CMS

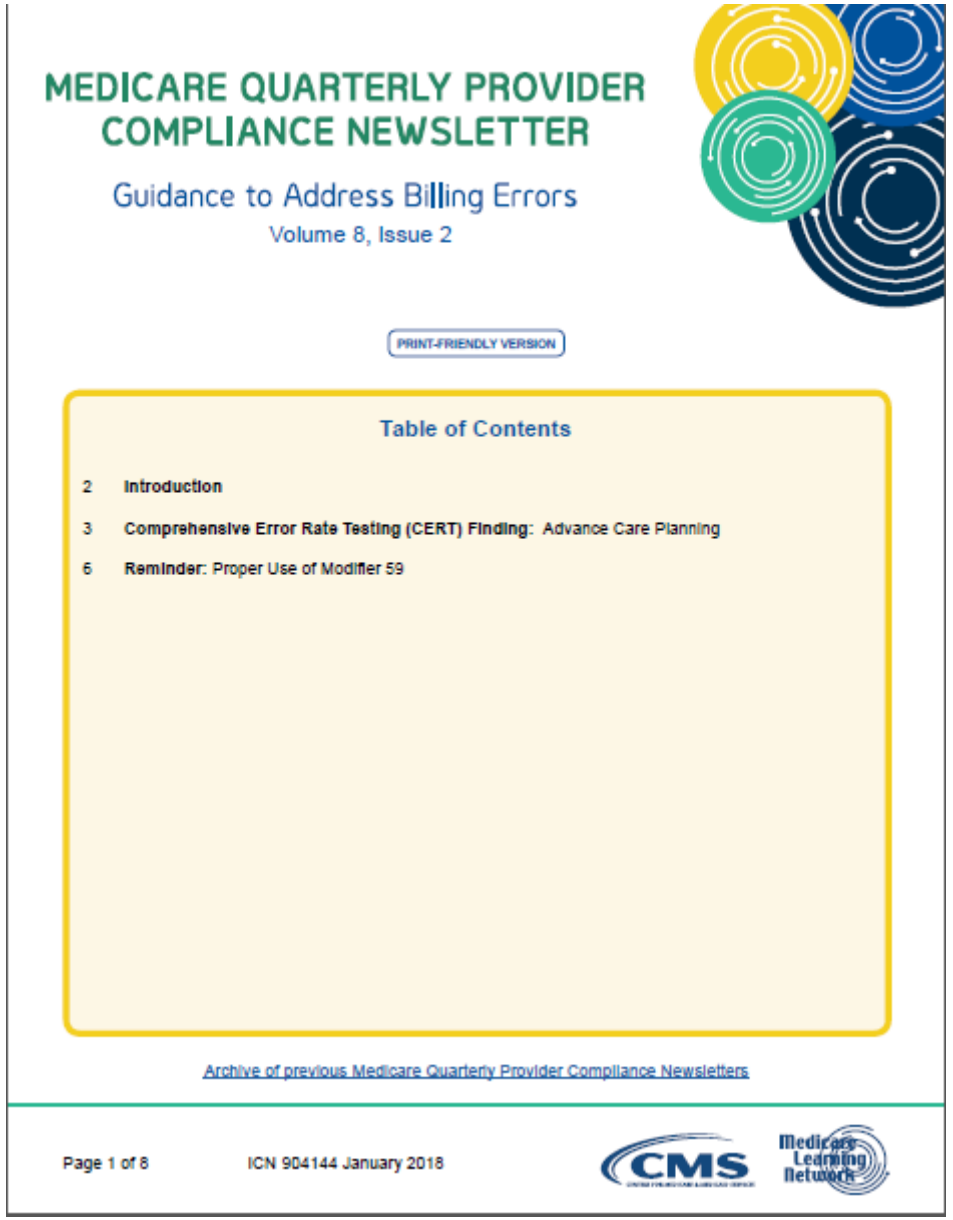
3 Types of MICs

Education MIC

- Use findings from Review and Audit MICs to identify areas for education
- Work closely with Medicaid partners and stakeholders to provide education and training
- Develop training materials, awareness campaigns, and conduct provider training

Updates

- The Centers for Medicare and Medicaid services (CMS) issues the "Medicare Quarterly Provider Compliance Newsletter", a Medicare Learning Network® (MLN) educational product to help providers understand the major findings identified by:
  - MACs
  - Recovery Auditors
  - Program Safeguard Contractors
  - Zone Program Integrity Contractors
  - The Comprehensive Error Rate Testing (CERT) review contractor
  - Other governmental organizations, such as the Office of the Inspector General



MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

Volume 8, Issue 2

PRINT-FRIENDLY VERSION

Table of Contents

Archive of previous Medicare Quarterly Provider Compliance Newsletters

Acevedo Consulting Incorporated
2605 West Atlantic Avenue, Suite D-102
Delray Beach, FL 33445
561.278.9328
info@acevedoconsulting.com
www.AcevedoConsultingInc.com