



February 2011 Edition

There are now so many government agencies whose main mission in life is to review, audit, evaluate, assess and, if found necessary, prosecute providers who are not in “compliance”, that providers are finding it difficult to actually “treat patients”. Most healthcare professionals have undoubtedly been exposed to the increased government audit initiatives created to reduce fraud and abuse within the Medicare and Medicaid systems. Each day’s e-mails bring a barrage of names and organizations identified by the Office of Inspector General, Department of Justice or the Federal Bureau of Investigations as having been found guilty of committing fraud.

Medicare Program Integrity audits now include Medicare Recovery Audit Contractors (RAC), Comprehensive Error Rate Testing Audits (CERT), Medicaid Integrity Contractors (MIC), Zone Program Integrity Contractors (ZPICs), Program for Evaluating Payment Patterns Electronic Report (PEPPER), Medicare Administrative Contractor (MAC) as well as Medicaid Recovery Audit Contractors (Medicaid RAC). While this is not the complete list of audits currently underway, it is easy to feel overwhelmed when reading all these acronyms. RACs, CERT, ZPICs, MACs, and whatever alphabetical conglomerates you can come up with...correct billing and coding has never been more scrutinized.

Chargemaster Corner will dedicate its February edition to exploring a few integrity audits that have the potential to be extremely problematic, time-consuming and damaging to the financial viability of your organization and practice. If it is not already apparent, healthcare providers are under Medicare and Medicaid’s microscope.

Medicaid MIC and Medicaid RAC

Medicare Recovery Audit Contractors (RAC) audits have been in full swing across the nation for some time now. Savings to the Medicare Trust Fund are proudly published by the governmental agencies overseeing these specific audit activities. In 2003, in a report to Congress (2003 U.S. General Accountability Office report (GAO))ⁱ noted there was insufficient oversight of the Medicaid program, at both the federal and state level, and the program was at significant risk for paying billing mistakes, abuse and fraud. It took an additional two

years for Congress to address this issue when they passed the Deficit Reduction Act (DRA) of 2005ⁱⁱ, essentially establishing the Medicare Integrity Program (MIP), making it their main impetus to prevent and reduce provider fraud, waste and abuse within the Medicaid system.

As if healthcare providers don’t have enough to worry about, particularly with the current Medicare RAC Program, the facility’s Medicaid reimbursements will be or are currently subject to similar scrutiny. The Medicaid Integrity Program (MIP) focuses on identifying and recoupment of overpayments as well as the identification of underpayments.

When the Deficit Reduction Act of 2005 (DRA) was passed, it established a focused five-year plan to help eliminate fraud and abuse in the Medicaid program, beginning in the fiscal year (FY) 2006. The MIP establishment of the Medicaid Integrity Contractors (MICs) whose primary focus was to audit claims and ensure that the paid Medicaid claims were: 1) For services provided and properly documented, 2) For covered services, 3) For services billed properly using appropriate procedure codes, and 4) Reimbursed appropriately according to state policy guidelines. CMS established several other entities responsible for implementing the Medicaid Integrity Program (MIP), but those MIC’s operational functions impacting healthcare providers will be the focus of this article.

There are three organizations within the MIP program: **Review** of Provider MICs, **Audit** of Provider MICs, and **Education** MICs. Similar to other governmental auditing agencies, the MIP uses claims data to identify fraud trends. The Medicare Integrity Group (MIG) Data Engine became operational in January 2009 and houses claim data from all 50 States. Using advanced data mining algorithms and techniques, the Review MICs examine all paid Medicaid claims and identify potential areas that are risk for overpayments. It has been said there are over 300 state specific algorithms included in the analysis process. The **Review** MICs use this data to identify specific providers for the **Audit** MICs to focus their efforts. Analyses that would have previously taken days, possibly weeks, can be generated in minutes. The **Audit** MICs are contracted to conduct claims audits that can be either desk audits or field audits. **Audit** MICs also have the authority to request interviews with key hospital billing personnel as well as have access to other staff such as coding and physicians among others. **Education** MICs work with both the **Review** and **Audit** MICs providing educational opportunities for State Medicaid officials and health care providers. The **Audit** MIC develops training materials on payment integrity

and quality of care issues as well as the prevention of fraud and abuse.

Prior to the national implementation of the MIC program, test audits were conducted in Florida, Texas, Washington, Mississippi and the District of Columbia. Completed in 2009, test audits identified approximately \$13 million in overpayments and State-imposed fines of an additional \$9,000. (**Reference:** Report to Congress on the Medicaid Integrity Program for Fiscal Year 2009)ⁱⁱⁱ

The national Medicaid provider audit program is now fully operational. The CMS Medicaid Integrity Group awarded contracts for the ten MIC regions across the country. **Review** MIC Contractors consist of Thomson Reuters (Regions I, II, III, IV) while AdvanceMed was awarded Regions V, VI, VII, VIII, IX and X. **Audit** MIC contractors are IPRO (Regions I, II), Health Integrity (Regions III, IV, V and VII), and HMS (Regions VI, VIII, IX and X). **Education** MIC was awarded to Strategic Health Solutions, LLC for all regions. Note: For a breakdown of MIC contractors and Regions, see <http://www.cms.gov/ProviderAudits/>.

Originally, the Medicaid MICs contained no statutory limitation on the time period that an Audit MIC could look-back at claims when conducting audits. This was very alarming to many providers, particularly for those using off-campus record storage facilities. Effective October 1, 2010, however, the general policy of five (5) year look-back period was adopted and begins on the date of issuance of the Notification Letter to the provider. When the **Audit** MIC initiates an audit by forwarding an engagement letter to the provider, the specific records requested are detailed. The revised policy now allows the provider thirty (30)-business days to produce these requested records. The **Audit** MIC can authorize a fifteen (15)-business day extension if the provider requests. Should additional time be requested, however, CMS' approval is required. **Audit** MIC does not have a record limitation and providers have often felt overwhelmed by the volume of medical records and encounters requested for the announced **Audit** MIC reviews.

Most audits are desk audits where the requested documentation will be reviewed at the **Audit** MIC's office. Occasionally field audits are conducted, in which the audits will be conducted at the provider's location. The **Audit** MIC notification letter will specify if the audit will be a desk or field audit. For the field audit, the **Audit** MIC schedules an entrance conference to communicate all relevant information required during the audit, an overview of the audit scope and objectives. Additionally, the audited healthcare provider must

complete an intake-questionnaire. Responses to the intake-questionnaire should be answered very carefully. Clarification as to whether these questions are relevant to current or past operational practices should be made, if necessary. It may be appropriate to have legal and/or compliance staff involved in the provider's responses. This questionnaire could be the potential springboard for the possibility of additional focused audits. At the conclusion of the audit, an exit conference will be scheduled where preliminary audit findings are reviewed. The provider has an opportunity to comment on the preliminary audit findings and, if necessary, provide additional information. If the **Audit** MIC determines, based on the audit findings, there is a potential overpayment, the **Audit** MIC prepares a draft report. CMS as well as the state are both provided with a copy of the draft report. If additional information is submitted by either the state or provider that changes the audit results, the revised report is given to the provider for review and comment. CMS has the ultimate responsibility for determining the final amount of recovery based on overpayments identified during the audit. At this point, the report is considered finalized. CMS returns the final audit report to the state that must repay the federal share of the overpayment to CMS. The provider may exercise whatever appeal rights are available under state law when/if the state seeks to collect the overpayment identified in the report.

The **Education** MIC contractor, Strategic Health Solutions, as required by section 1936 of the ACT, provides support and assistance to states concerning provider fraud, waste and abuse. Based on the findings from the **Audit** and **Review** MICs, the **Education** MIC will provide education and training materials, generate awareness campaigns and conduct provider training. In addition, the **Education** MICs will develop a website for all states and providers containing all MIG-related educational training material. Sanitized audit results of claims data showing utilization and trends will be available, hopefully containing issues identified during the various conducted audits.

Unlike the RAC contractors, the MIC contractors have yet to publish any audit findings nor release any areas of focused reviews. Providers that have survived a MIC audit have also not shared experiences or provided "words of wisdom". Or, they may be too busy preparing their appeals to the **Audit** MIC's final report.

What issues are the Medicaid MICs focusing on? Again, this can differ from state to state. One provider indicated a MIC audit focused on the hospital's clinic visits, where a large number of higher E/M codes were reported which varied from the bell curve of its peers. The **Audit** MIC focused on documentation for the higher clinic levels.

Additional claim issues that can trigger a focused MIC audit include duplicate claims, the unbundling of codes, as well as outpatient claims paid which have overlapping claim dates with an inpatient. Other potential Medicaid billing issues may include: 1) provider eligibility, 2) services billed but not provided, 3) billing for services provided by unlicensed or untrained personnel; 4) procedures billed but not medically necessary; as well as 5) billing for unapproved drugs. The MIG is working with multiple states to hopefully conduct national projects, which would include cross-bordering states. Examples of projects being considered include an analysis of all claims submitted throughout the country for services reported after a recipient or provider's death.^{iv}

Appeal processes are anything but uniform throughout the country. The provider may exercise whatever appeal or adjudication rights are available under State law when the State adjudicates and seeks to collect the overpayment identified in the **Audit** MIC's final audit report.

The Centers for Medicare & Medicaid Services (CMS) & the U.S. Department of Health and Human Services (HHS) has dedicated \$255 million dollars in funding for the MIP over five years. With that amount of resources dedicated to this program, providers can be sure CMS and HHS expects to reap the benefit of their funding dollars.

In addition to MIP activities, states are now required to contract with at least one **Medicaid RAC** no later than December 31, 2010. CMS requires states to have their RAC programs implemented and begin auditing Medicaid providers and suppliers by April 1, 2011. The Proposed Rule for *Medicaid Program; Recovery Audit Contractors*, published November 10, 2010 (Federal Register, 42 CFR Part 455)^v states that, similar to the Medicare RAC Program, Medicaid RACs would be paid on contingency-based fee arrangements when they discovered program overpayments. Unlike the Medicare RAC Program, each state may determine the appeal process, compensation structure for the Medicaid underpayments identified during the RAC audit, the qualifications of RAC staff, contract duration, task deadlines, look-back periods as well as the coordination with other contractors and law enforcement.

Providers are very worried about yet another layer in the Medicaid audit program, which may be disruptive, and an added costly administrative burden. Medicaid RAC audits may be more aggressive than MIC audits, particularly since the RACs are paid based on contingency. By expansion of the RAC program to Medicaid, many provider audits may be overlapping or

include claims that are under review by a MIP contractor or other entity. It is important to note that the Medicaid RAC activities will not replace existing State program integrity MIP activities, but rather, will supplement ongoing audits. Additionally, should the MIP program activities detect evidence of fraud, waste and abuse that goes unreported by the Medicaid RACs, CMS would work closely with the States to identify focus areas for Medicaid RACs to improve their efficacy. The Office of Inspector General of U.S. Department of Health and Human Services (HHS-OIG) recently reported that the Medicare RACs identified over \$1 billion in improper payments while referring only two cases of potential fraud to CMS. States are cautioned in the design of their Medicaid RAC programs to ensure that the Medicaid RACs do report instances of fraud or criminal activities in addition to pursuing overpayments. The Medicaid RACs are expected to report providers to law enforcement officials.

No provider is exempt, as the Medicaid RAC will eventually review any provider submitting claims for reimbursement on behalf of the Medicaid beneficiary. Be aware, be prepared.

CERT Audits

Another program CMS implemented to evaluate the integrity of the Medicare contractor's payment accuracy is the Medicare Comprehensive Error Rate Testing (CERT) Program. This program has been in existence since 1996 but has undergone significant revisions and improvements since its inception. CMS receives in excess of 2 billion claims per year and the CERT Program was initially designed to measure the overall error rates for fee for service (FFS) fiscal intermediaries, carriers, DMERCs, and quality improvement organizations. To measure the accuracy of the payment processes of each of these entities, CMS decided to audit paid claims and publish the error rates, as mandated by the Improper Payments Information Act. To better measure the various Medicare claims processing contractors' performance in paying claims accurately as well as identifying the cause of these payment errors, CMS uses this data to calculate not only a national Medicare FFS paid claims error rate but also a provider compliance error rate. These results are now published annually on CMS website: <http://www.cms.gov/cert>.

The CERT audits are primarily focusing on errors in payments made by Medicare contractors. Hospitals and other providers are all impacted when the CERT looks at their claims and must submit requested medical records. If the CERT uncovers an error, the CERT will take money back from the facility. While this type of audit is not structured to detect fraud, it is able to identify billing

patterns that could lead to the impression there has been or is fraudulent behavior.

To accomplish the huge auditing task, CMS uses two contractors: the CERT Review Contractor (CRC) and the CERT Documentation Contractor (CDC). AdvanceMed, (CRC), selects random samples of claims from each Medicare claims processing contractor for medical review. For each claim selected, Livanta (CDC) requests the medical record from all providers who billed for the selected services. A request letter is sent to the provider explaining the purpose of the CERT program, requirement for the provider to respond, a list of detailed documents from the medical record requested, as well as the listing of patients and specific dates of service requested. The letter also includes instructions for submitting the requested information to the CERT Documentation Office. Livanta tracks the records as well as prepares the documentation for review by AdvanceMed, which then verifies the accuracy of billed services as well as payments made were based on sound Medicare policies. Any claim identified as paid incorrectly is categorized as error.

Two additional contractors are involved in the CERT program: The Statistical Contractor (The Lewin Group) and Web Contractor (Fu and Associates). The Lewin Group helped CMS develop the program by which the determination is made for the accuracy of Medicare payments made to providers by developing the algorithms for sampling claims and calculation of the payment error rate.

CMS issued the latest CERT report in early February 2010 for the calendar year 2009, which revealed the year's paid claims error rate as well as a summarization of results for all Medicare contractors. The CMS CERT website will contain the report results for calendar year 2010 when they become available.

The CERT program focuses primarily on claims submitted by FFS providers. In the November 2009 reporting period CMS changed the way it reviewed inpatient hospital claims for error rate measurement. In the past, inpatient hospital claims were reviewed under a separate program than other Medicare FFS claims. CMS consolidated the programs and the review procedures for acute inpatient hospital claims are now consistent with the procedures used for review of all other Medicare FFS claims. Hospitals are also impacted by the CERT program for outpatient claims submitted containing laboratory services (reimbursed by Laboratory Fee Schedule), rehabilitation services (reimbursed by MPFS Fee Schedule) as well as physicians, anesthesiologists/CRNAs, nurse practitioners and other professional billings submitted on a CMS-1500 claim form.

With the release of the November 2009 Improper Medicare Fee-For Service Payments Report^{vi}, claims submitted between April 1, 2008 and March 31, 2009 identified a national paid claims error rate for FY2009 of 7.8%. CMS's CERT contractor conducted medical record reviews of a random sample of paid claims from all types of providers. The sample consisted of 99,480 claims valued at about \$71 million. The CERT contractor found that 19,754 sampled claims resulted in improper payments valued at about \$4.7 million. Based on these sample results, the national paid claim error rate for FY 2009 was 7.8 percent (\$24.1 billion), a significant increase over the FY 2008 error rate of 3.6 percent (\$10.4 billion). According to CMS's FY 2009 Improper Medicare Fee-for-Service Payments Report, the increase in the error rate was attributable to substantial changes in the CERT medical record review methodologies. **Reference:** Analysis of Errors Identified in the Fiscal Year 2009 Comprehensive Error Rate Testing Program (A-01-10-01000), July 2010, <http://oig.hhs.gov/oas/reports/region1/11001000.pdf>.

Each MAC's website contains regional CERT claims error data. Statistics, FAQ links, references and resources are available for providers to help recognize reporting issues identified with the regional claim audits. Based on the review of the provided medical records, claim errors are categorized into five different error categories. 1) **No documentation**—Claims are placed into this category when the provider fails to respond to repeated attempts to obtain the medical records in support of the claim. 2) **Insufficient documentation**—This category is used when the medical documentation submitted does not include pertinent patient facts (e.g. the patient's overall condition, diagnosis, and extent of services performed), 3) **Medically unnecessary service**—Claims are placed into this category when claim review staff identify enough documentation in the medical records submitted to make an informed decision that the services billed were not medically necessary based on Medicare coverage policies, 4) **Incorrect coding**—This category is used when providers submit medical documentation that support a lower or higher code than the code submitted, and 5) **Other**—Represents claims that do not fit into any of the other categories (e.g. service not rendered, duplicate payment error, not covered or unallowable service).^{vii}

Some examples of claim denials for the error categories are as follows:

1. **No documentation** –Provider does not have a record to support billed charges. Services billed may have been posted with the incorrect date of service or the service was not provided.

2. **Insufficient Documentation**-Records do not contain a signature or legible identifier for very service reported. Physician's signature can be either handwritten or electronic, but stamped signatures are not acceptable. If the provider includes a signature log if signature isn't legible and an attestation statement if there is no signature at all, this will avoid this error category. Unfortunately, at the present time physician documentation and signature issues are the leading cause of CERT errors. Submitted records were often found incomplete, were for the wrong date of service, missing results for diagnostic or laboratory test, missing documentation to support therapy services or therapy minutes/units did not match.

3. **Medically unnecessary service**-Documentation did not contain a valid physician's order for diagnostic services. An FI MAC paid \$4,698.94 for a one-day inpatient hospital stay. The patient was admitted with a diagnosis of abdominal pain and stayed less than 12 hours. The patient failed to meet medical necessity criteria for an inpatient admission. Service could have been provided with the patient in an outpatient observation status. The FI recouped the entire amount.

4. **Incorrect Coding**-An FI paid \$741.32 for a transthoracic echocardiography with contrast, real time, with exercise stress test. Upon receipt of additional documentation it was determined that the diagnostic study was performed without the use of contrast material. This coding error resulted in an overpayment to the provider of \$141.93, which was recouped by the contractor. A Carrier paid \$130.00 to a provider for initial nursing facility care, per day. CPT code 99306 requires three of three key components: a comprehensive history, a comprehensive exam, and high complexity medical decision-making (MDM). Upon review it was determined that documentation supported a down code to CPT code 99304 due to a detailed history, comprehensive exam, and moderate complexity MDM; failing 2 or the 3 key components for the billed 99306. The overpayment collected was \$54.17.

5. **Other**-An FI MAC paid \$675.23 for a routine dental extraction. Per Medicare Benefit Policy - Basic Coverage Rules (PUB. 100-02) Chapter 16 - General Exclusions From Coverage §140 - Dental Services Exclusion. An FI paid \$73.43 to a provider for a clinic visit. The claim was a duplicate to another claim by the same provider, with the same diagnosis, and same date of service. The medical records received were also identical. "The error categories do seem ambiguous and a little confusing," observes Joe Martinez, CPC, Senior Healthcare Consultant. "However, it is painfully evident that if the documentation is not absolutely complete, the CERT auditor can certainly deny reimbursement."

What providers may not realize is the important role each CERT audit plays in the facility/provider's overall

claim accuracy rate. Because of the relatively low volume of claims in the CERT sample (compared to the amount of claims annually submitted by the facility/provider), each claim and dollar reviewed by CERT is extremely important. For example, in Part B, a single CERT error of \$100 becomes approximately \$3,000,000 in reported errors after extrapolation. In Part A, the multiplicative factor used in extrapolating is less drastic, but since Part A claims are generally much more costly to begin with, they are no less important. For example, a Part A error of just \$1,000 would lead to about \$5,000,000 in error upon extrapolation. While the individual physician/provider is not responsible for repayment of this extrapolated amount, that entire amount is reflected against the physician/provider's specialty or facility type when analysis is done by CMS. Nonetheless, the 7.8% national paid claims error rate notes Medicare's contractors overpaid approximately \$23 billion dollars^{viii}:

Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		Over/Under Improper Payments		Error Rates
		Payment	Rate	Payment	Rate	Payments		
Carrier/MAC	\$78.7B	\$7.6B	9.70%	\$0.1B	0.20%	\$7.8B	9.90%	
DME MAC	\$10.4B	\$5.4B	51.90%	\$0B	0.00%	\$5.4B	51.90%	
FI/MAC - Non-Inpatient	\$108.2B	\$4B	3.70%	\$0.2B	0.20%	\$4.2B	3.90%	
FI/MAC - Inpatient	\$111.2B	\$6.1B	5.50%	\$0.8B	0.70%	\$6.8B	6.10%	
All Medicare FFS	\$308.4B	\$23B	7.50%	\$1.1B	0.40%	\$24.1B	7.80%	

Over half of the CERT errors identified were paid to DME providers. It is rather alarming that the combined national Medicare FFS paid claims error rate for hospitals is noted to be approximately 10%, while physician and professional services claimed 9.9% of the national error rate. Hospitals still appear to have room for improvement when it comes to charging, billing, coding and claim submission processes. CMS reports the CERT payment error rate to Congress each year and the OIG does further analysis of the data. Using the reported error rate data for FYs 2005 through 2008, the OIG identified 740 error-prone providers. Specifically, an analysis of the HPMP (Hospital Payment Monitoring Program) error rate data disclosed that 554 providers accounted for 59 percent of the dollars in error for those providers. A similar analysis of the CERT error rate data for the same period disclosed that 186 providers (1.81 percent of all CERT providers with at least 1 claim sampled in each of the 4 years) accounted for 25 percent of the dollars in error for those providers. The OIG recommended to CMS they use available error rate data to identify error-prone providers, require error-prone providers to identify the root causes of claim errors and to develop and implement corrective action plans, monitor provider-specific corrective action plans; and share error rate data with its contractors (QIOs, RACs, and PSCs) to assist in identifying improper payments.^{ix}

When performing reviews, the CERT contractor must follow Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and Local Coverage Determinations (LCDs) made by the applicable Medicare claims processing contractor. The CERT contractor does not develop or apply its own coverage, payment, or billing policies. If the CERT contractor determines that the records and claims do not substantiate payment, it sends the provider a letter denying the reviewed claims. Moreover, negative findings from a probe audit often lead to a more extensive post-payment audit and subsequent repayment demands for “erroneous” claims.

Recent audits Ingenix Consulting has conducted identified the same findings published in recent MAC CERT audits. Penny Allison, BSN, RN, Consulting Practice Director states: “Facilities have to take corrective action now to identify and resolve their documentation issues. When we identified a physician’s signature stamp on a requisition/order it was brought to the facility’s attention. Should the claim be part of a CERT audit, the entire service will be denied for payment. Other issues noted were the consistent reporting of CPT 85025 *Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count*. The physician’s order simply stated “CBC”. To bill a complete blood count with differential, the physician’s order must be that specific. The CERT audit will adjust the facility’s payment to reflect the test the physician ordered, that is, CPT 85027 *Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)*. Extrapolate that payment reduction over a facility’s Medicare outpatient volume can be a substantial amount of reimbursement loss.” Penny cautions facilities by stating “If laboratory protocols support the performance of CPT 85025, be sure and submit that protocol with the medical record requested in the CERT audit. Usually protocols are not included in individual patient medical records but these protocols are “orders” and it is proven during CERT audits that when orders are found missing or incomplete, the results lead to recoupment of the facility’s Medicare payment.”

Providers can appeal any claim they believe were wrongly denied by a CERT audit. Providers can appeal denials (including no documentation denials) following the normal appeal processes by submitting documentation supporting their claims. All contractors in the CERT program have the opportunity to ensure that all overturned appeals are entered into an appeals tracking system in sufficient time for production of the error rates. After the calculation of the error rate, appeal

decisions are not considered. The CERT program deducted \$1.1 billion in projected appeals reversals from the error rates contained in November 2009 Medicare FFS Improper Payments Report.

Facilities and providers are finding that continual focused medical audits are more important than ever. A thorough familiarity with the types of Medicare audits is essential to successfully navigating the ins and outs of a focused CERT audit. However, proactive compliance with the Medicare rules, regulations, and policies is the best defense to an audit.

ZPICs, The New Weapon For Medicare

Zone Program Integrity Contractors (ZPICs) will not conduct random audits. Instead, they will have information in hand and know exactly what they want to review when conducting on-site audits because the ZPICs MAY already have evidence there is a problem. Replacing Program Safeguard Contractors (PSCs), ZPIC contractors will audit providers and suppliers submitting claims for Part A, Part B, Part C and Part D, DMEPOS, home health, and hospice. ZPICs aggressively place healthcare providers on pre-payment reviews, post-payment audits, recommend suspensions of payment and are extrapolating amounts of overpayments identified. “I’ve not seen any criteria published by which the ZPICs conduct their audits,” John Arno, RT, (R), ARRT, CPC-A, MPA states. “While ZPICs are ‘fraud-busters’, my contacts tend to believe these auditors apply their own unwritten standards. This could lead to the denial of claims based on inaccurate interpretations.”

ZPICs are not “bounty hunters” nor are they paid contingency fees like RACs; rather, are paid by CMS based on a contractual basis. AdvanceMed Corporation, the Zone 5 ZPIC contractor, was awarded a \$107,957,737 five-year contract, a zone covering 10 states. With a \$100 million contract for one ZPIC contractor, what does CMS expect in return?

ZPICs will cover seven zones based on MAC jurisdictions with identified “hot spot” zones of California, Florida, New York, Illinois and Texas. As of July 16, 2010 ZPIC contractors have been awarded to the following zones: Zone 2 and Zone 5 – AdvanceMed Corporation, Zone 4-Health Integrity and Zone 7 – Safeguard Services. Zones 1, 3 and 6 have yet to be awarded. Where ZPIC contracts remain pending, Program SafeGuard Contractors (PSC) are typically still operating and are conducting essentially the same duties as their ZPIC counterparts. For a complete list of states

within each of these zones, see: <http://www.goa.gov/decisions/bidpro/4011065.htm>.

ZPICs can use claim data analysis to identify trends in billing or those of high frequency of certain procedures that are aberrant when compared to national patterns, complaints (patients or employees), referrals from MACs, mismatch of the hospital's claim with physician records or even lengths of stay outside the industry norm. A sample of claims can be reviewed by ZPIC prior to contacting a provider, and the ZPIC may even conduct interviews with beneficiaries and the provider's employees.

If audit results have identified overpayments, ZPICs refer these to the MAC who will send the provider a demand letter for recoupment of the overpayment. If a strong likelihood of fraud becomes evident after the audit, a referral is made for civil and criminal follow-up. CMS typically uses a statistical sampling of claims to extrapolate the overpayment made on claims. The appeals process from a ZPIC audit is very similar to that of the RAC, which includes the pursuit of a ruling up to the U.S. District Court. Transmittal 141, September 12, 2008, (100-06, Medicare Financial Management) details the recoupment process of overpayments.

What can trigger a ZPIC audit? With 4 of the 7 zone contractors named, some zone audits are ramping up but final audit results scarce. Some focused fraud issues identified would hopefully not be allowed by facilities and physician practices to even occur; however, they have shown up on the radar of Program Integrity audits. These issues have been identified: 1) Billing for "Phantom Patients" (Patients that do not exist), 2) billing for services not provided; 2) billing for services provided on the same calendar day which would collectively take more hours than are in a day; 3) double billing, 4) potential criminal, civil or administrative law violations, as well as 5) cost report falsifications. Additionally, misrepresenting the diagnosis to justify the service, misrepresenting the type or place of service or who rendered the service, billing for outpatient individual services instead of outpatient group services (the service actually performed) in order to obtain more money are additional hot buttons that could trigger an audit.

How should providers prepare for potential ZPIC audits? Glenda Schuler, RHIT, CPC, CPC-H has some sound advice to follow. "Providers should audit themselves regularly. Even the most aware and careful staff can make billing mistakes. Make sure the claims submitted contain correct codes and medical documentation support what is billed. If an error is discovered, correct it promptly and repay any overpayments. This will definitely demonstrate the facility is striving to remain

compliant with all government programs. Find out what company is the ZPIC contractor in your jurisdiction and focus on any discussions about audits being conducted in your state. Also pay close attention to the OIG work Plan. Should your facility receive an audit notification letter, prioritize it to make sure the facility has enough time to review the record(s) included in the audit. If the notification doesn't get to the right place in your facility, your organization runs the risk of missing the deadline, which could result in a demand for refund." Glenda continues, "Because ZPICs have usually done their homework and come on-site as a result of suspected fraud and abuse, the facility should immediately notify their legal team and compliance staff of the impending audit. An in-depth knowledge of the Medicare program as well as familiarity of governing federal regulations can certainly put the facility in a better position when meeting with ZPIC staff and throughout the audit process."

Are you feeling overwhelmed? When was the last time you conducted an internal or external review of your billing/coding practices? Have you analyzed your facility's entire claim database for MS-DRGs, outpatient observation services, clinics, professional data and all outpatient services for which your facility received reimbursement? Given the potential consequences, providers should take a proactive approach for inevitable future potential Medicare and Medicaid Integrity Audits. Facility should consider an external agency to conduct a chart-to-bill, bill-to-chart audit. Yes, some hospitals can do this type of audit on their own, but it is a bit like proofreading your own work, an outside eye will not overlook "assumed" elements and can present challenging scenarios often overlooked by internal staff.

Ingenix Consulting would like to share with its *Chargemaster Corner* readers some helpful suggestions and recommendations that have been identified from the numerous compliance and integrity audits performed in the recent past. When performing Ingenix' National Compliance & Integrity Suite engagement, Ingenix uses a proprietary software program to analyze the facility's 837 claims data files (a year/two years of data) which identify areas of risk. The scheduled NCIS audit then focuses on specific departments, procedures and medical charts identified in the claims data analysis. Could you be a potential target for a future audit? It may be inevitable, but without knowing your weak areas, what potential financial impact could you be facing?

Ingenix Consulting can certainly assist your facility in preparing for governmental integrity audits. Ingenix' National Compliance & Integrity Suite (NCIS) Audits are structured to target and review the same areas the

above government audits are focusing. At Ingenix, we've partnered with ERIS Medical Technologies to deliver the next-generation solutions, a tool that has more than 400,000 code pairs, regulatory guidelines and predictive logic routines to data-mine the facility's claim data. Ingenix Consulting will then target specific claims for the NCIS Audit and focus on areas of risk (overpayment) as well as opportunities (underpayments). Proactively plan your strategies, the government already is.

Please feel free to call Penny Allison, BSN, RN, Practice Manager at 1-801-910-4417 or e-mail at penny.Allison@ingenixconsulting.com for additional information on Ingenix' National Compliance & Integrity Suite. Prepare now.....you will be audited.

Hope you enjoy receiving the *Chargemaster Corner* from Ingenix. Each month Ingenix will circulate this newsletter via e-mail to those interested parties who have provided contact information either via e-mail request or who have completed an informational form when attending a number of educational seminars conducted nationwide. Please share this e-mail with your co-workers and encourage them to contact Ingenix via *Chargemaster.corner@gmail.com*. Contact information will not be shared with any other organization and used *only* for means of distributing this monthly newsletter. For direct contact concerning receipt of this newsletter, please e-mail your comments to the above noted e-mail address. Thank you for your interest in this monthly chargemaster newsletter and hope you find it helpful.

Ingenix Consulting offers a variety of services to assist hospitals in the inpatient and outpatient coding and chargemaster functions including: 1) Focused and comprehensive chargemaster review; 2) continual chargemaster maintenance; 3) CPT Coding Audits; 4) Chart-to-claim audit; 5) MS-DRG audits; 6) Educational opportunities via audioconference/onsite; 7) Physician audits, 8) Denials Management, and 9) physician educational opportunities. If you wish to receive information about any of the consulting services Ingenix offers, please forward your inquiry to Joe.Martinez@ingenixconsulting.com or phone 866-867-4248. Ingenix – bringing you insight and expertise to your chargemaster reporting challenges. In addition, e-mail your questions and subjects you would like to be included in future articles to: *Chargemaster.corner@gmail.com*.

ⁱ GAO testimony, <http://www.gao.gov/pas/2003/d03101.pdf>. Major Management Challenges and Program Risks, Department of Health and Human Services

ⁱⁱ Deficit Reduction Act of 2005,

<http://www.govtrack.us/congress/bill.xpd?bill=s109-1932>

ⁱⁱⁱ <https://www2.cms.gov/DeficitReductionAct/Downloads/fy09reporttocongress.pdf>

^{iv} Ibid

^v Medicaid Program; Recovery audit contractors, Center for Medicare & Medicaid Services, <http://edocket.access.gpo.gov/2010/2010-28390.htm>

^{vi} <http://www.cms.gov/CERT/CR/list.asp#TopOfPage>

^{vii} http://www.cms.gov/CERT/Downloads/CERT_Report.pdf

^{viii} Ibid, page 10

^{ix} Office of Inspector General, Center For Medicare & Medicaid Services' Use of Medicare Fee-For-Service Error Rate Data To Identify And Focus on Error-Prone Providers, A-05-08-00080, October 2010, <http://www.oig.hhs.gov/oas/reports/region5/50800080.pdf>