

What is Medicare up to now???????

HMWC G.A.B. Session
June 3, 2009

Palmetto Review

- › MAC J1 conversion September 2008
- › Conversion issues
 - Overpayments - Palmetto paid some claims that NHIC paid. Requesting refunds within 30 days or offsets.
 - Computer system errors - Palmetto computer system has rounded lab results causing denials for not medically necessary. Did not memo the error but buried it in the LCD's.

Medicare Program Update Agenda

- › Medicare Integrity Program
- › Medicare Modernization Act
- › Recovery Audit Contractors
- › Improper Payments Information Act
- › Comprehensive Error Rate Testing (CERT)
- › Physician Quality Reporting Initiative
- › E-Prescribe Reporting Initiative

Medicare Integrity Program

- › Compliance Program
- › Correct Coding Initiative
- › Accurate billing of services
- › Focus on E/M services
- › Internal Audits
- › Monitor and Process Improvements

Internal Billing Audits

- ▶ Vital to the health of the medical practice
- ▶ Auditing physician charges and billing practices allows;
 - Improved claims management processes, cash flow, and compliance with insurance carriers.
 - An annual audit allows the medical practice to identify specific coding and payment issues
 - Insurance carriers are auditing and reviewing coding practices, expect more denials from third-party payors and commercial payors

Internal Audits

- ▶ An internal audit provides information to the practice that identifies recurring coding errors, over utilization of procedures and services
- ▶ Insures appropriate payment from third party payors with contracted payment requirements
- ▶ Improves;
 - Coding
 - Cash flow
 - Documentation

Internal Audit

- ▶ Now that you have done an internal audit, what do you do with the information....
- ▶ Create an audit policy before you begin;
 - Medicare audits - errors should be corrected and submitted to Medicare
 - Submit with a letter of explanation
 - Document your findings and what new processes have been implement to prevent future errors

Data Mining

- ▶ Insurance carriers generate profiles
- ▶ Gathers data for utilization
 - How often is a procedure performed
 - Where is the procedure performed
 - What CPT codes are reported
- Insurance carriers maintain data for comparison:
 - When a provider orders tests (lab, imaging)
 - What is ordered
 - Dx code reporting frequency and medical necessity
 - Insurance carrier generates provider profiles and compares information across specialties.

Medicare Modernization Act

- › Three-year demonstration project
- › Recover overpayments and identify underpayments
- › Payment made on a contingency fee basis (RAC incentivized for payment recovery)
- › Three states selected based on highest per capita utilization: California, Florida, N.Y.
- › Tax Relief and Health Care Act 2006:
 - Expanded to all states by 2010

RAC's Selecting Claims

- › RAC's choose issues to review based on data mining techniques, OIG & GAO reports
- › Two types of review:
 - Automated (no medical record)
 - Complex (medical records)
- › New issues for review will be posted on the RAC's Web site
- › California RAC = Health Data Insights
- › RAC's will be able to look back three years from the date the claims was paid (not before 10/1/2007)

RAC Errors by Provider Type

- › \$828.3 Million In-patient Hospital
- › \$16.3 Million Skilled Nursing Facility
- › \$59.7 Million In-Patient Rehabilitation Facility
- › \$44.0 Million - Out-patient Hospital
- › \$19.9 Million - Physician
- › \$5.4 Million - Ambulance/Lab/other
- › \$6.3 Million - DME

Identified Errors by Type

- › \$391.3 Million - Medically Unnecessary
- › \$331.8 Million - Incorrectly Coded
- › \$160.2 Million - Other (benefit)
- › \$74.3 Million - No or insufficient Documentation

Stop Work Order Lifted

- ▶ CMS is continuing with permanent RAC program as of February 4, 2009
- ▶ The national permanent RACS are:
 - Diversified Collection Services, Inc. of Livermore, California, in Region A, Main, New Hampshire, Vermont, Mass, Rhode Island and New York
 - CGI Technologies and Solutions, Inc. of Fairfax, VA, Region B, Michigan, Indiana and Minnesota
 - Connolly Consulting Associates, Inc. of Wilton, Connecticut, Region C, South Carolina, Florida, Colorado and New Mexico
 - Health Data Insights, Inc. of Las Vegas, Nevada, Region D, California, Arizona, Utah, Wyoming, Montana, N. Dakota, S. Dakota

Improper Payments Information Act (IPIA)

- ▶ CMS has established the Comprehensive Error Rate Testing (CERT) program and Hospital Payment Monitoring Program (HPMP) to sample and review randomly claims submitted to Medicare
- ▶ Paid claims are reviewed by independent reviewers; denied claims validated to ensure that the decision was appropriate
- ▶ Project results in national paid claims error rate, claims processing error rate, provider compliance rate and paid claims benefit specific error rate

CERT Program

- ▶ 2008, CERT program utilized following methodology:
 - CERT randomly selecting sample of 129,875 claims submitted to Carriers/DMERC's/FI's during reporting period
 - HPMP randomly selecting sample of 39,841 acute care inpatient hospital discharges
 - Requested medical records from the health care providers that submitted claims to be included in the sample
 - Where medical records were submitted by provider, reviewing the claims in the sample and the associated medical records to see if the claims complied with Medicare coverage, coding and billing rules, and, if not, assigning errors to the claims
 - Where medical records were not submitted by the provider, classifying the as a "no documentation" claim and counting it as an error
 - Sending providers overpayments letters/notices or making adjustments for claims that were paid in error.

Physician Quality Reporting Initiative (PQRI)

- ▶ Voluntary reporting of certain types of services related to clinical conditions
 - i.e. Diabetes, Stroke, seizures, etc
- ▶ Will be tracked by MAC's for in-patient services, matching claims made by providers and hospitals
- ▶ Will be mandatory by 2011
- ▶ Medicare pays "bonus" for participating

E-Prescribe

- ▶ Medicare has a voluntary reporting initiative for reporting the use of existing E-Prescribe system. If you do not have a E-Prescribe system, do not report activity.
- ▶ E-Prescribe is the use of an electronic device to transmit a prescription electronically directly to a pharmacy.
- ▶ Faxing prescriptions do not qualify as E-Prescribe if you do not have an E-Prescribe system that faxes the scripts.

Medpac

- ▶ MEDICARE PAYMENT ADVISORY COMMISSION
 - Established by the Balanced Budget Act 1997.
 - GAO oversees MedPAC - commissioners appointed May 8, 2009
 - Advise congress on Medicare payment issues, utilization, Medicare programs, providers.
 - www.medpac.gov

WHERE ARE WE GOING WITH ALL THIS?

- ▶ FIRST came HIPAA (simplification) Transaction Standards - everyone reports the same
- ▶ THEN came PQRI (you are paid for reporting certain outcomes)
- ▶ NOW we have MACs adjudicating both PART A and PART B claims....

Compliance Program

- ▶ A working compliance program:
 - Insures proper coding
 - Improves cash flow
 - Improves documentation
 - Demonstrates to payors that you are not intentionally ignoring rules
 - Helps to organize third party payors and their payment methods
 - Provides policies and procedures and guidance to the medical practice providers and staff

Responding to a Commercial, Managed care or Third Party Payor Audit

- › Tip #1
 - Review the provider contracts to determine how to respond to the refund request
 - Provider contracts should outline claim and utilization review process
- › Tip #2
 - If contract does not outline time frame for refund requests
 - Renegotiate contract to include an amendment setting a time limit insurance carrier has to request a refund
 - One "rule of thumb" for negotiation is that the carrier should have the same amount of time to recoup as you have to file the claim

Responding to a Commercial, Managed care or Third Party Payor Audit

- › Tip #3
 - Provider contracts should be reviewed for mention of "offset" provisions that allow carriers to deduct from future reimbursement
 - If such a clause exists, it may be wise to have it eliminated during your contract negotiations
- › Tip #4
 - If you are not a participating provider with the carrier requesting the refund and your state law does not have specific guidance
 - You may contest the request because you may not be contractually bound to abide by the carrier's claims and payment policy

Conclusion

- › Any provider of service should be aware that any audit by an insurance carrier or government payor has many pitfalls and can have serious repercussions not only in relation to his/her status with the carrier, but concerning the practitioners medical license and/or possible civil liability exposure
 - Any request by an insurance carrier, request for overpayment, and/or audit request should be treated very seriously

Websites to put in "Favorites"

- › Office of the Inspector General:
<http://www.oig.hhs.gov>
- › Centers for Medicare and Medicaid Services (CMS); <http://cms.hhs.gov>
- › Recovery Audit Contractors:
<http://www.cms.hhs.gov/RAC>
- › CERT website: www.cert.org
- › Comprehensive Error Rate Testing:
<http://www.cms.hhs.gov/CERT>