

RACs, ZPICs and MACS-- Navigating Your Way Through The Medicare Audit Alphabet

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OBJECTIVES

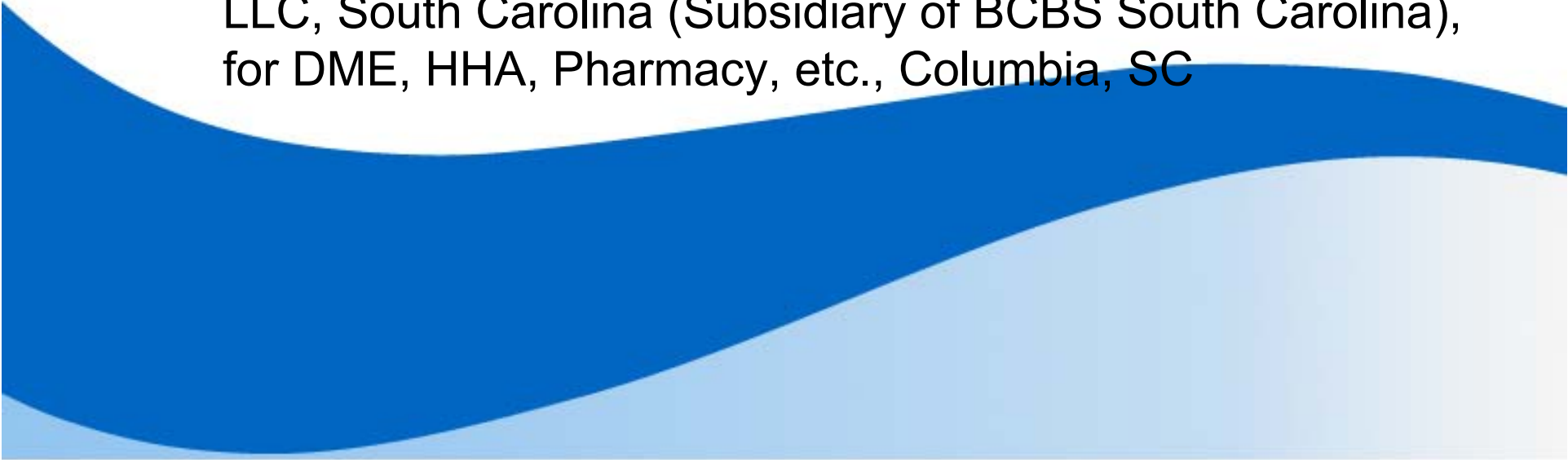
- 1. To understand basic concepts regarding Medicare audits.
 - 2. To have a basic knowledge regarding the different organizations that can conduct a Medicare Audit.
 - 3. To understand how to respond effectively to a Medicare audit.
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WHAT IS A MAC?

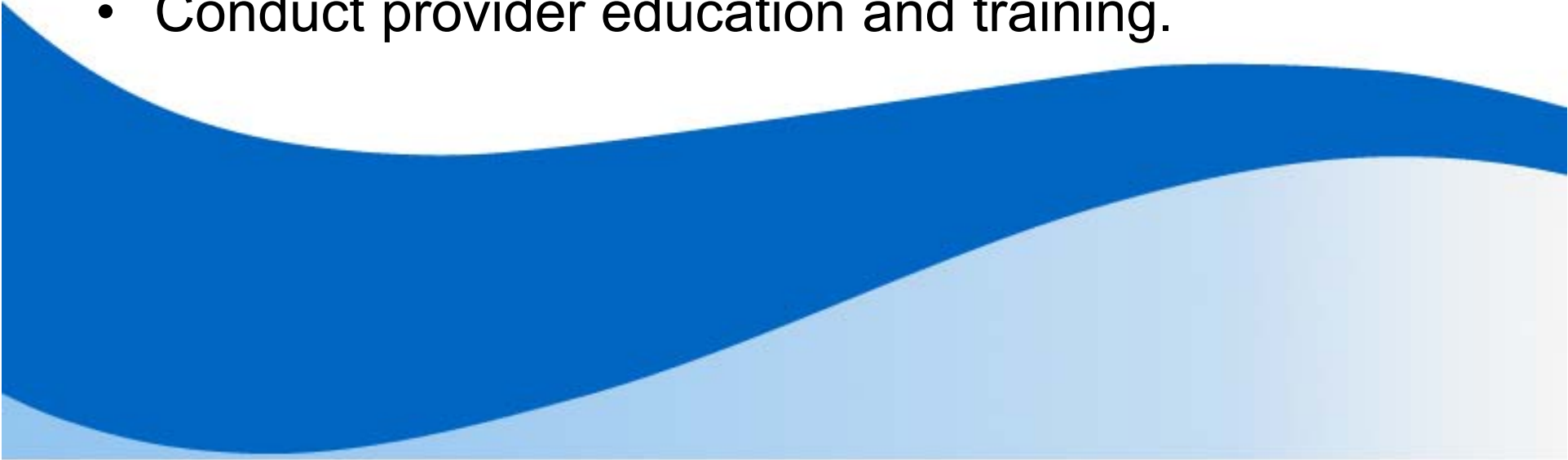
- Medicare Administrative Contractor=MAC
- MACs are private companies, usually subsidiaries of large insurance companies, that have contracted with the Centers for Medicare and Medicaid Services (CMS) to administer the Medicare Program.



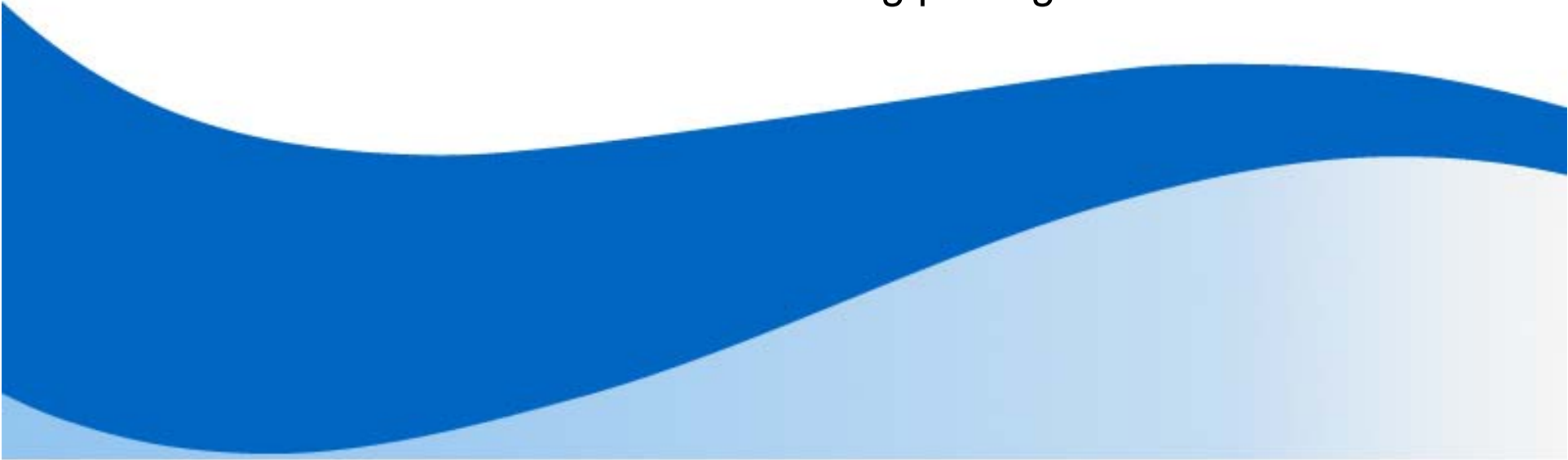
MACs?

- Formerly called “Carriers,” “Regional Carriers,” or “Fiscal Intermediaries.”
 - For Florida:
 - First Coast Service Options, Inc. (FCSO), Jacksonville, Florida, for most Part B.
 - Palmetto GBA [“Government Benefits Administrators”], LLC, South Carolina (Subsidiary of BCBS South Carolina), for DME, HHA, Pharmacy, etc., Columbia, SC
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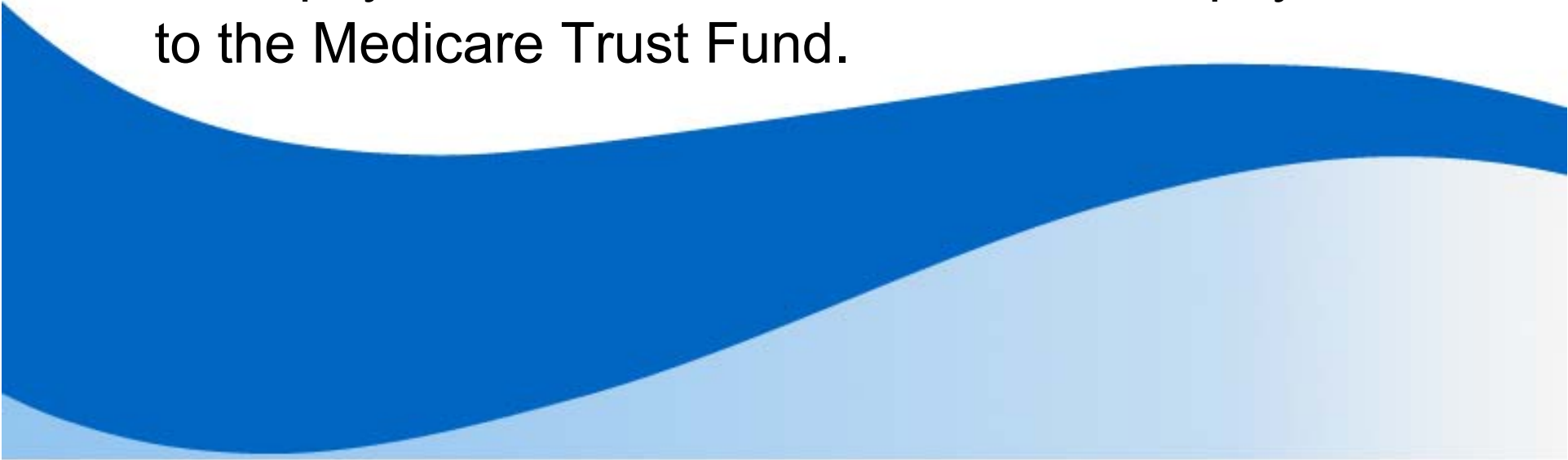
MACs:

- Process and grant or deny applications.
 - Process claims and make or deny payments.
 - Maintain Medicare claims data.
 - Issue Local Coverage Determinations (LCDs)
 - Conduct initial site visits and audits.
 - Conduct provider education and training.
- 


MACs also:

- Conduct audits.
 - Terminate Medicare billing privileges.
 - Conduct initial redeterminations and reconsiderations on audits.
 - Recoup payments from audits conducted by other companies.
 - Contract for Qualified Independent Contractor (QIC) reviews.
 - Terminate Medicare numbers.
 - Receive and review Corrective Action Plans (CAPs) and Requests for Reconsideration on Medicare billing privilege terminations.
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WHAT IS A RAC?

- Recovery Audit Contractor=RAC
 - Often referred to as “Bounty Hunters”
 - RACs are private companies contracted by the Centers for Medicare and Medicaid Services (CMS), used to identify Medicare overpayments and underpayments, and return Medicare overpayments to the Medicare Trust Fund.
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RAC LEGISLATION

- Medicare Modernization Act, Section 306
 - Required the three year RAC demonstration (included Florida)
 - Tax Relief and Healthcare Act of 2006, Section 302
 - Requires a permanent and nationwide RAC program by no later than 2010
 - Both Statutes gave CMS the authority to pay the RACs on a contingency fee basis.
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RACs

- The RAC for the region that includes Florida is:
 - ***Connolly Consulting Associates, Inc.*** of Wilton, Connecticut
 - Connolly's subcontractor is: ***Viant Payment Systems, Inc***



- RACs – focus the majority of efforts toward adoption of CMS evidence-based coverage policies and site-of-service issues (e.g., identifying overpayments).




RAC Trivia:

- A recovery audit contractor receives its payment on a contingency basis, earning a certain percentage of the overpayments and underpayments it successfully identifies and recovers from providers.
- The median hourly wage estimate for a RAC auditor is \$29.66, while the median annual wage is \$61,690.
- A RAC auditor may earn a higher or lower wage depending on region and experience.
- The states with the highest levels of recovery audit contractor employment are Calif. (ann. wage \$74,360), N.Y. (\$85,230) Texas (\$68,090), Penn. (\$68,610), and Florida (\$63,600).

WHAT RACS ARE LOOKING FOR

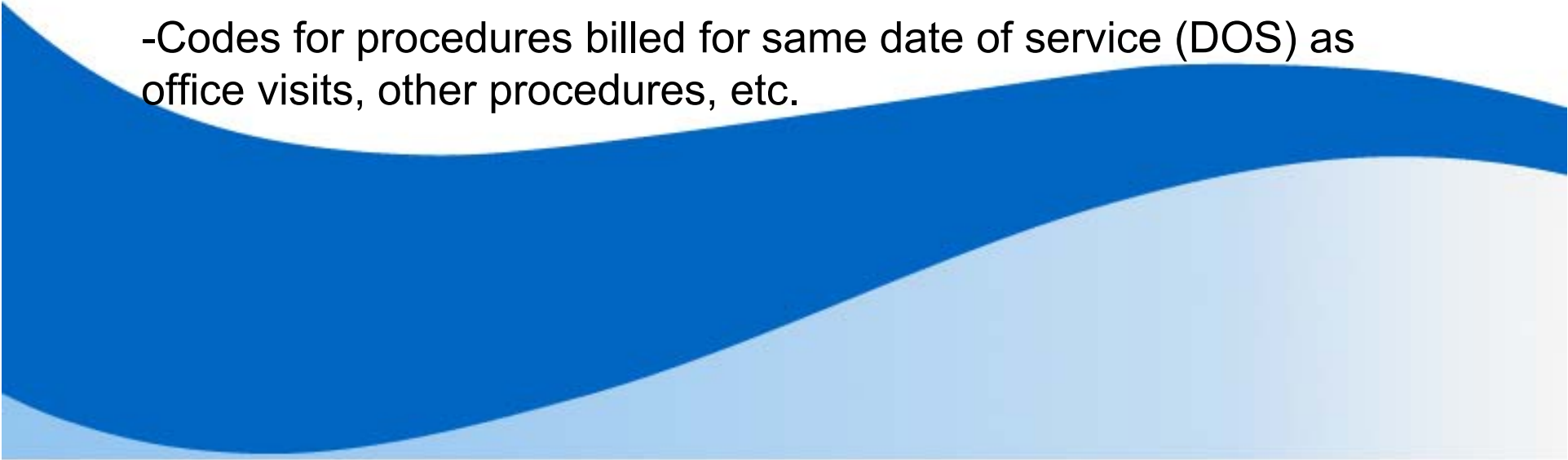
RACs may attempt to identify improper payments resulting from:

- Incorrect payments
 - Non-covered services (including services that are not reasonable and necessary)
 - Incorrectly coded services
 - Duplicate services
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WHAT RACS ARE LOOKING FOR


To a large extent, the RACs identify overpayments through “Data Mining.” Note: Think of “IRS Audit.”

Looking for:

- Codes that are commonly abused or misused.
 - Codes for services identified in OIG’s Annual Work Plan
 - Codes that are not routinely billed by the type of provider billing them.
 - Outliers (excessive dollar amounts, excessive codes billed, excessive number of high level codes (e.g., level fours and fives).
 - Codes for procedures billed for same date of service (DOS) as office visits, other procedures, etc.
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HOW TO PREPARE FOR RACS

Be prepared for RAC audits by doing the following:


- Attend educational programs produced by MACs and by prof. associations (FMA, FUS, etc.)
 - Be aware of and monitor codes, services, drugs, and areas that may be subject to RAC review.
 - Review Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) for any CPT codes you bill to ensure that you are accurately documenting as they require.
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HOW TO PREPARE FOR RACS

- Review OIG Work Plan each year.
- Review, update and revise internal “superbills” and codes billed to ensure accuracy.



HOW TO PREPARE FOR RACS


- Implement compliance efforts.
 - Make sure you are aware of and control what is being billed.
 - Establish systems to timely respond to RAC record requests within required time frames.
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HOW TO PREPARE FOR RACS

- Monitor claim denials and appeal these claims through the Medicare appeals process.



RAC APPEALS

- Documents provided with recovery actions and decisions will detail the appeal process.
 - Be sure to pay attention to deadlines.
 - Appeal documents must be received at the reviewing organization by the deadline given.
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WHAT IS A ZPIC?

- Zone Program Integrity Contractor = ZPIC.
- When you hear “ZPIC,” think “FRAUD.”

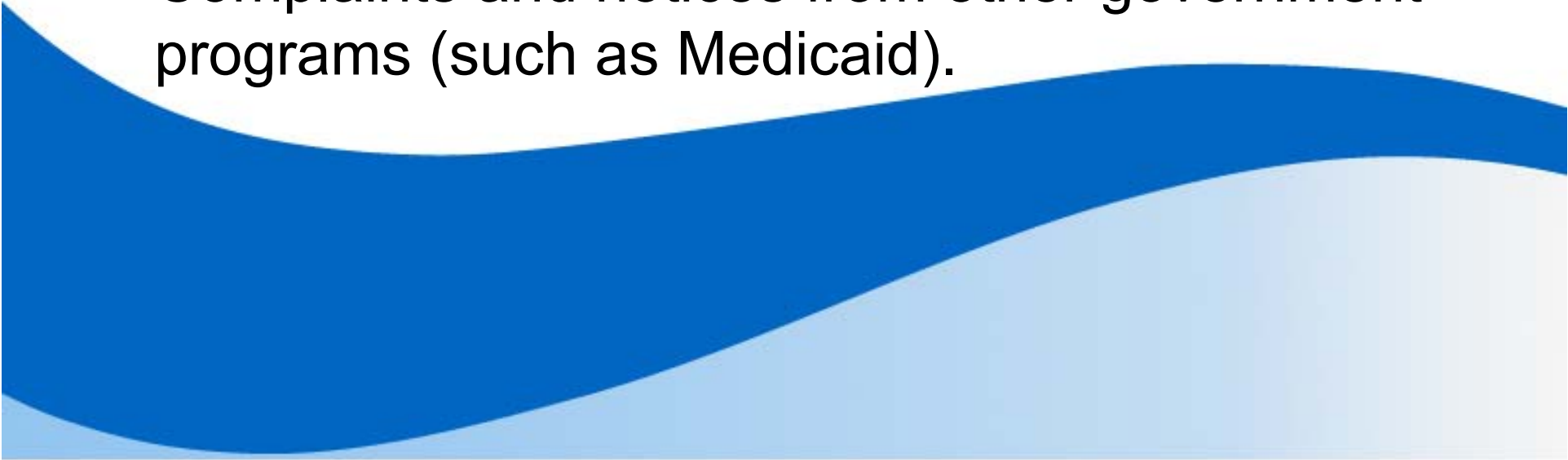


WHAT IS A ZPIC?

- ZPICs are private companies contracted by the Centers for Medicare and Medicaid Services (CMS), used to conduct audits for Medicare overpayments and detection of and recovery for possibly fraudulent activities.




ZPIC Audits Are Initiated By:

- “Whistle-Blower” or Qui Tam Lawsuits.
 - Probe Audits.
 - Other audit agency findings.
 - Beneficiary/patient complaints.
 - Hotline complaints.
 - Complaints and notices from other government programs (such as Medicaid).
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- ZPICs – target potential fraud in the Medicare program and can audit the integrity of all Medicare claims for a particular provider with both pre- and post-pay audits.
- While ZPICs are similar to other CMS audits, they do differ in one very important aspect – potential Medicare fraud implications.



What ZPICs Do:


- Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement for prosecution.
 - Performing reviews to determine whether or not services were “medically necessary.”
 - Identifying the need for administrative actions such as Medicare payment suspension and placement on Prepayment Review.
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What ZPICs Do:

- Identifying the need for administrative actions such as Medicare payment suspension and placement on Prepayment Review.
- Referring cases to law enforcement (U.S. Attorney's Office) for consideration and initiation of civil or criminal prosecution.

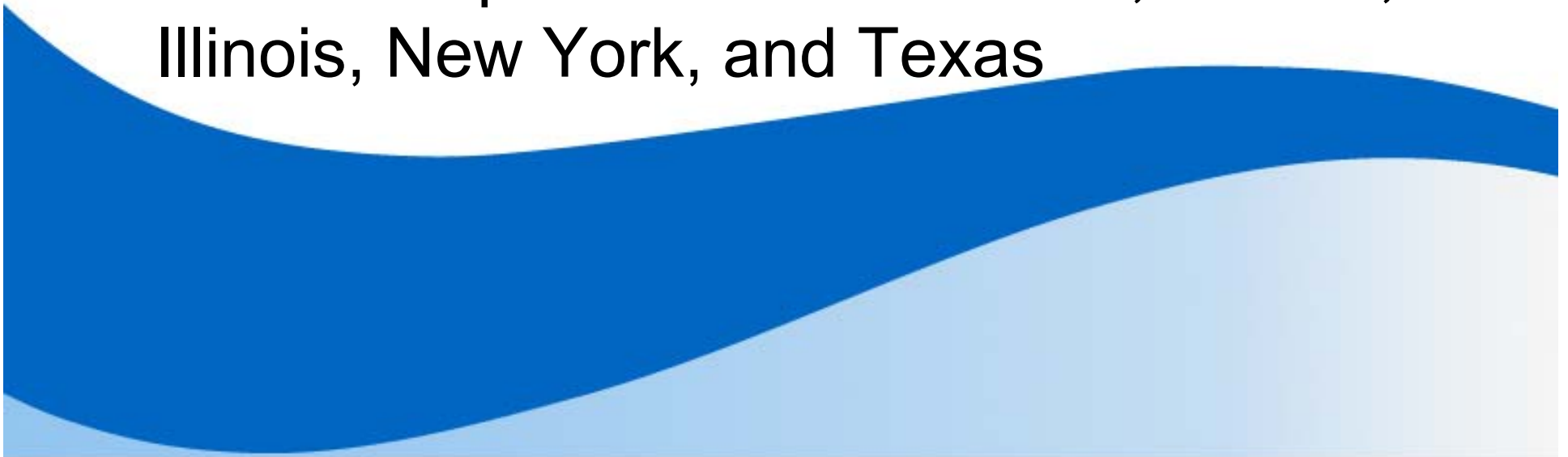


ZPICs also work closely with:

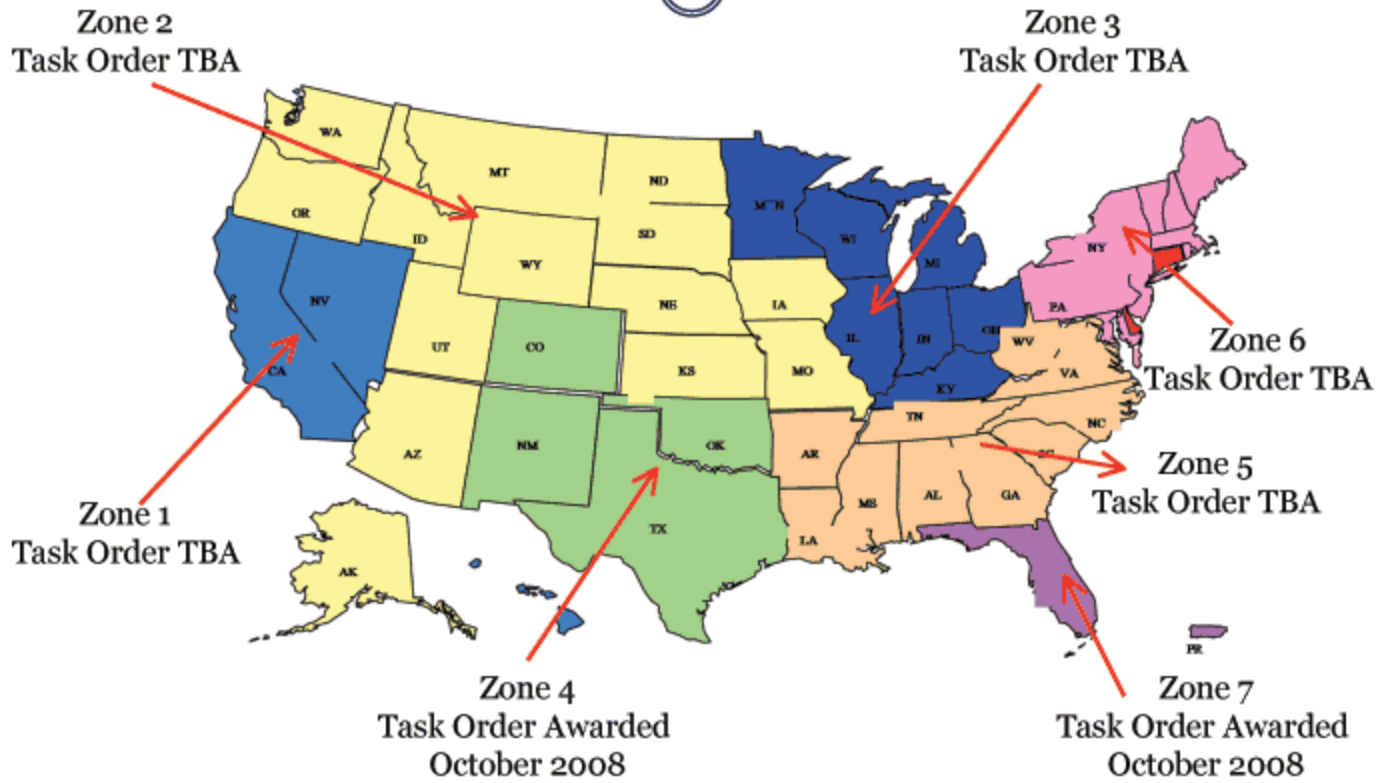
- Office of Inspector General (OIG)
 - United States Attorney's Offices (USAO)
 - Office of the Florida Attorney General (OAG)
 - The Federal Bureau of Investigation (FBI)
 - Agency for Health Care Administration (AHCA)
 - Medicare Drug Integrity Contractors (MEDICs)
 - Medicaid Fraud Control Unit (MFCU)
 - Office of the Statewide Prosecutor
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THE ZPIC ZONES

- ZPICs cover seven zones based on Medicare administrative contractors (MAC) jurisdictions.
- Five “hot spot” zones: California, Florida, Illinois, New York, and Texas

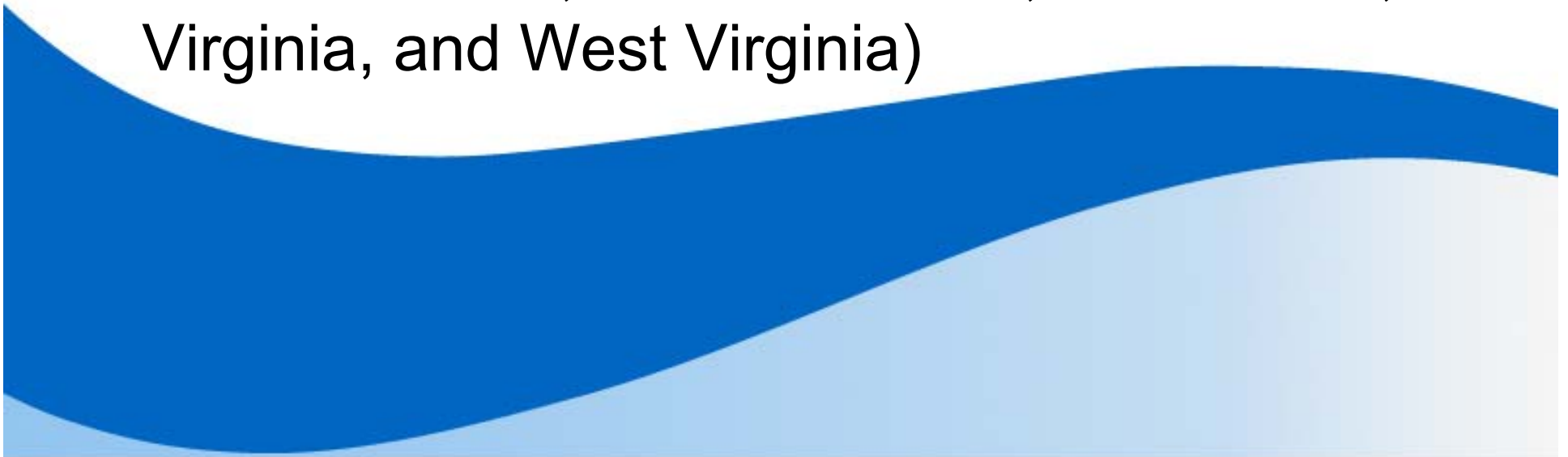


ZPICs' Jurisdictions



CMS ZPIC CONTRACTS

- Health Integrity LLC for Zone 4 (Colorado, New Mexico, Oklahoma, and Texas)
- Advance Med for Zone 5 (Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia)



- SafeGuard Services LLC for Zone 7
(Florida, Puerto Rico, and Virgin Islands)



ZPIC for Florida?

- Florida is Part of Zone 7
- The ZPIC for Zone 7 and Florida is SafeGuard Services, LLC:
 - Headquarters in Miramar, Florida
 - Offices in Jacksonville and Tampa



ZPIC NOTIFICATION PROCESS

- A ZPIC will routinely fax a letter to the practice shortly before close of business the day before a site visit/audit to that practice.
- The site visit/audit may be scheduled to occur at a branch office and not at the main office of the practice.



- Auditors will request to inspect the premises, will photograph all rooms, equipment, furniture, and diplomas on walls.
- They will usually request copies of several patient records to review later.



- They will request copies of practice policies and procedures, treatment protocols, all staff licenses and certifications, drug formularies, medications prescribed, and medications used in the office.
- They will inspect any medication/narcotic lockers or storage cabinets and will request drug/medication invoices and inventories.



- You will usually be contacted for follow-up information and documentation after the audit and will eventually be provided a report and, possibly, a demand for repayment of any detected overpayments.



ZPIC APPEAL PROCESS

- If the provider elects to appeal a claim reviewed by a ZPIC, then the ZPIC forwards its records on the case to the CMS affiliated contractor (typically a MAC) so that it can handle the appeal.




- First Level – Redetermination (Medicare Administrative Contractor)
- Second Level – Reconsideration (Qualified Independent Contractor)
- Third Level – Administrative Law Judge Hearing



- Fourth Level – Medicare Appeals Council (MAC)
- Fifth Level – U.S. District Court Review
- Bottom Line – ZPIC audits are won or lost with clinical documentation that clearly and concisely incorporates required CMS payment criteria.



Include in All Responses to Audits or Subsequent Appeals:

- Beneficiary names
 - Medicare Health Insurance Claim (HIC) number
 - Specific service or item for which the redetermination/reconsideration is being requested
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- Name and signature of the provider or the representative of the provider
- All available medical records documentation (history, physical, consultation request, lab reports diagnostic imaging reports, etc.)



- A transcription of any illegible handwritten notes, consults, etc.
- Any additional notes, explanations, statements, etc., to clarify or explain the services provided, the necessity of the services given, or any missing documentation.



What is a CERT Audit?

- Medicare Comprehensive Error Rate Testing (CERT) Program
 - The CMS created the CERT Program to measure the paid claims error rate for claims submitted to Medicare administrative contractors, carriers, durable medical equipment regional carriers, and Medicare Administrative Contractors (MACs).
 - CERT Documentation Contractors (CDCs) are retained by CMS.
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- CERT audits are aimed at measuring improper payments and errors being made by the other auditing organizations.

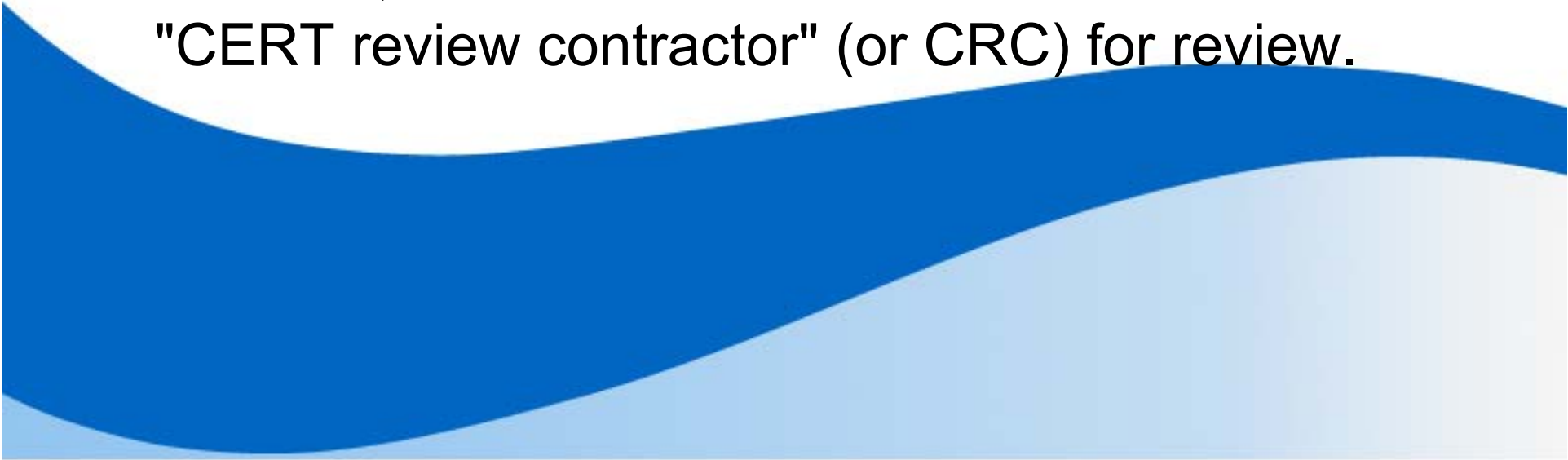


How CERT Claims Are Selected

- CMS receives in excess of two billion claims annually.
- The CERT program randomly selects approx. 120,000 of these claims for review to determine whether the claims were properly paid.
- CERT Audit for you may only request one or two records



HOW CERT AUDITS WORK

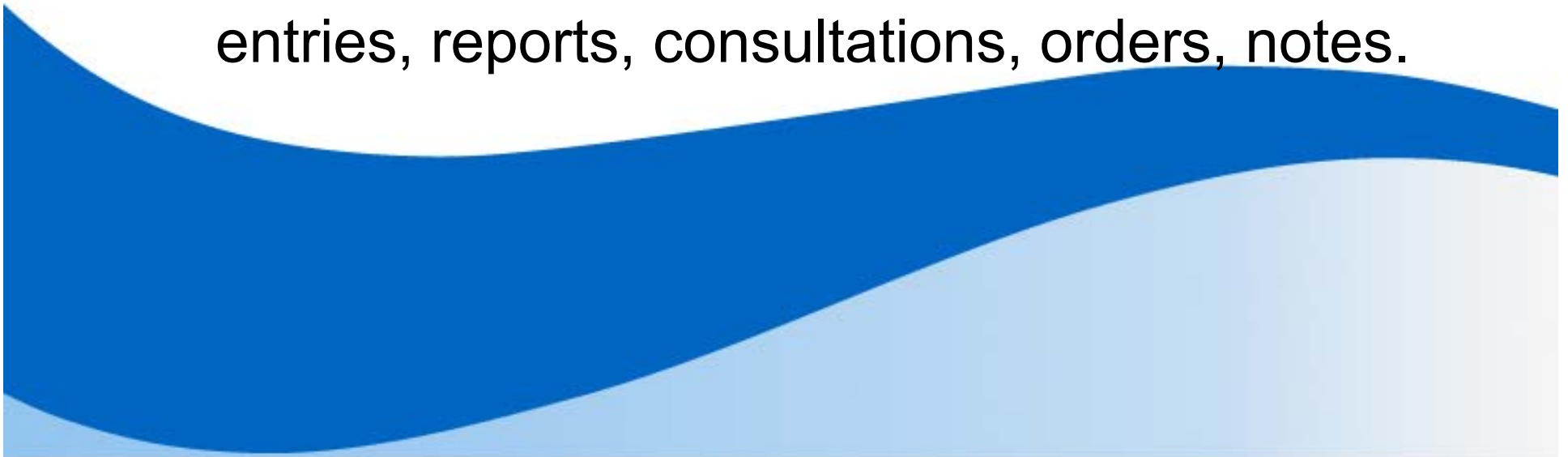
- Statistical samples are selected and the CERT documentation contractor (CDC) submits documentation requests to those providers who submitted affected claims.
 - Once the requested documentation has been received, the information is forwarded to the "CERT review contractor" (or CRC) for review.
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- The CRC will review the claims and supporting documentation to measure compliance with Medicare coverage, coding and billing rules.



Most Common Problems

- The most common problems being encountered in Medicare audits involve medical record errors, such as:
 - Documentation not supporting the code billed.
 - Absence of signatures on medical record entries, reports, consultations, orders, notes.



- Wrong dates of service being billed
- Wrong provider be billed
- Wrong location of service being billed for (e.g., office visit billed when patient was seen in hospital, ASC, nursing facility)
- Absence of medical record documentation
- Illegible records



CERT APPEALS

- CERTs may be appealed to the local Medicare Administrative Contractor (MAC).



PREPARING FOR AN AUDIT BEFORE IT HAPPENS

- Conduct an internal review of primary services you provide and make sure your documentation is in order.



- Review the Documentation Requirements section for each item you provide. Develop a documentation checklist for your files to assure you always have all the necessary documentation.



- Make sure your medical records are orderly and consistent.
- When possible, get as much clinical documentation up front for the services you provide from the referrer.



- Make sure your referral sources know the guidelines and conditions for which items they order are covered.
- Do not rely on supplier-generated forms to document medical necessity. They are not considered part of the medical record.



- Make sure all items are clearly listed on the orders prior to dispensing and make sure your delivery documentation is very detailed.
- Make sure your documentation is legible and ALL signatures are legible.




IF YOU OR YOUR PRACTICE IS BEING AUDITED

Here are some steps to keep in
mind.



Checklist for Responding to Audits:

1. Check your address on the audit letter to ensure it is the correct and complete physical address of the site visit.
 2. Call and make telephone contact with the auditors, if possible, to make sure they are coming to correct location and you know what they will be auditing.
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3. Immediately call and advise your health care attorney and have him/her present at the audit and site visit.
4. If the site visit is set for a branch office, make sure the appropriate administrative personnel and at least other person who sees Medicare patients are in that office.



5. Conduct a self-inspection of your office immediately; call for an emergency house-keeping visit to clean if necessary.
6. Make sure all displayed licenses, permits, certificates, are current.



7. Make sure all patient health records are properly secured and your medical record handling and storage are compliant with HIPAA standards.
8. Have a separate room set aside for the auditors to use with chairs and a flat surface for them to use as their meeting room, conference room and interview room.



9. Make sure your office is “photogenic.”

10. Require proper photographic identification of all audit personnel and obtain a business.

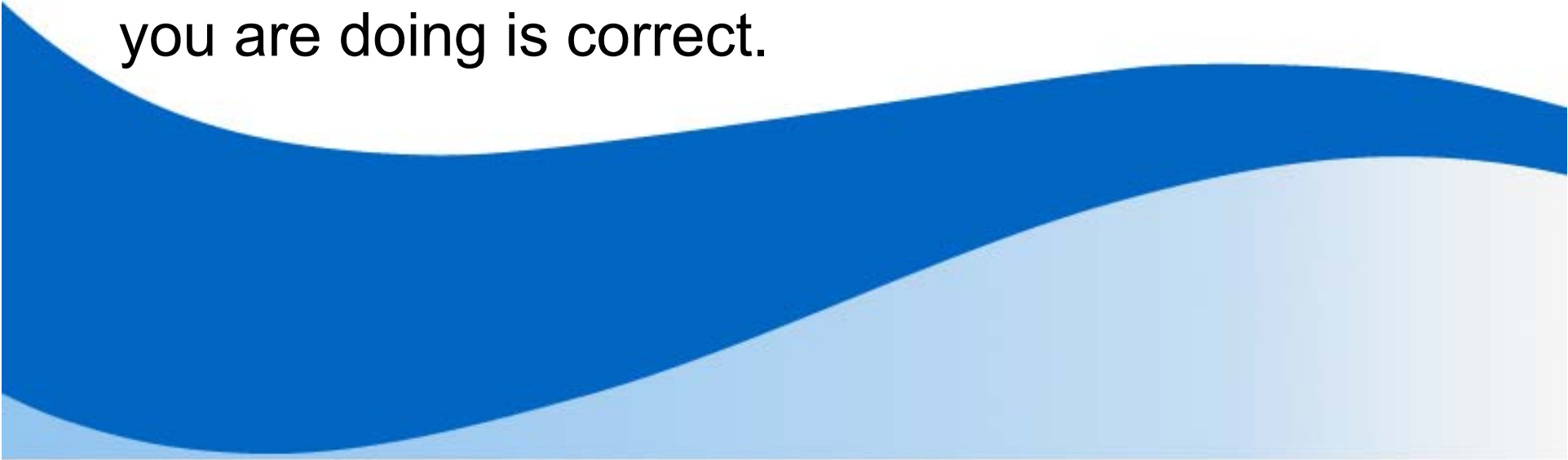


11. Assign one main staff person as communication point with the auditors (and your attorney).
12. Keep a copy of every document or paper you provide to the auditors during the site visit.



13. Be aware of auditors' being told to scrutinize any practice prescribing narcotics or pain medications.
14. If the records needed by the auditors are in a different office, don't kill yourself getting them during the site visit.
15. Don't guess at the answers to questions.



16. Expect to be asked for your drug list or formulary.
 17. Do ask questions of the auditors, regarding what they are auditing, any “hot issues”, timing of audit, etc.
 18. Do not voluntarily advise the auditors of your own suspicions of wrongdoing, incorrect billing or if what you are doing is correct.
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19. Keep good copies and document your transmittal of documents to the auditors.
20. If additional time is needed to forward records and documents requested by the auditors, request it by telephone and confirm it in writing.



21. Have your physicians available to speak with the auditors at least some time during the site visit, if at all possible.
22. Lend this matter your personal attention; do not delegate it to administrative staff.



WHEN PROVIDING RECORDS IN RESPONSE TO AN AUDIT:

1. All correspondence from Medicare, CMS or the contractor, should be taken seriously. Avoid the temptation to consider the request from Medicare, or the Medicare contractor, as just another medical records request. Avoid the temptation to delegate this as a routine matter to a low-ranked administrative employee.
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2. Read the audit letter carefully and provide all the information requested in the letter. (Auditors often ask for invoices and purchase orders for the drugs and medical supplies dispensed to patients.)



3. Include the complete record if at all possible; not just those from the dates of service requested in the audit letter. Include diagnostic tests and other documents that support the services provided. Include consent forms, medical history questionnaires, histories, physicals, other physicians' orders/consults. If hospital or nursing home discharge orders or other orders referred the patient to you, obtain these to provide to the auditors.




4. Make sure all records are legible and legibly copied. If the record is not legible, have the illegible record transcribed and include the transcription along with the hand-written or illegible records. Make sure that any such transcriptions are clearly marked as a transcription with the current date it is actually transcribed.



5. If your practice involves taking or interpreting x-rays or other diagnostic studies, include these studies. They are part of the patient's record. If the x-rays are digital, they can be submitted on a compact disc (CD).



6. Never alter the medical records after a notice of an audit. However, if there are consults, orders, test reports, prescriptions, etc., that have not been filed into the chart yet, have these filed into it, as you normally would, so that the record is complete. Altering a medical record can be the basis for a fraud claim including criminal penalties.




7. Make sure each page of the record is copied or scanned correctly and completely. If the copy of the record has missing information because it was cut off, the original needs to be recopied or rescanned to ensure it includes all the information. Don't submit copies that have edges cut off, have bottom margins cut off, are copied slanted on the page, or for which the reverse side is not copied.



8. Make color copies of medical records when the original record includes different colored ink, type or highlighting of significance. Colors other than blue and black rarely copy well and may be illegible on standard photocopiers.



9. If possible, include a brief summary of the care provided to the patient with each record. This is not a substitute for a medical record, but will assist an auditor that may not be experienced in a particular specialty or practice area. Make sure that any such summaries are clearly marked as summaries with the current date they are actually prepared.



10. Include an explanatory note and any supporting medical literature, clinical practice guidelines, medical/dental journal articles, or other documents to support any unusual procedures or billings, or to explain missing record entries.



11. When receiving a notice of a Medicare audit, time is of the essence. Be sure to calendar the date that the records need to be in to the auditor and have the records there by that date.

Note: the due date is not the last date on which you can mail the records but rather is the date that the records must be received at the auditor's office.



12. Any telephone communication with the auditor should be followed up with a letter confirming the telephone conference.

13. Send all communications to the auditor by certified mail (or express mail), return receipt requested so you have proof of delivery.



14. Properly label each copy of each medical record you provide and page number everything you provide the auditors, by hand, if necessary. Scanned copies and pdf files can have “bates numbers” or page numbers inserted into them.



15. Keep complete, legible copies of all correspondence and every document you provide. When we provide records to a Medicare auditor, we make a complete copy for the auditor, one for the client, one for us (legal counsel) and two for your future expert witnesses (to challenge or appeal any adverse audit results) to use.



16. Consult an experienced health law attorney early in the audit process to assist in preparing the response. The above check list is by no means comprehensive. It is for the purpose of illustrating the actions that should be taken to help protect your interests when you are subjected to a Medicare audit.



INCREASED MEDICARE AND MEDICAID FRAUD INCENTIVES

- Because of the severe state budget shortfalls and the federal deficit, we are seeing a tremendous increase in Medicare and Medicaid fraud initiatives, including:



- Audits by Medicare Program ZPICs and RACs
- Use of Medicaid Fraud Control Unit (MFCU)
Investigative Subpoenas to obtain records
- Medicaid Fraud Control Unit (MFCU) Search
Warrants used to seize patient records, billing
records and computers
- Medicaid audit letters from the Agency for
Health Care Administration (AHCA)



WARNING

- Under recently enacted Florida law, if Medicaid (not Medicare) audits your practice and determines an overpayment, you must repay the entire amount within thirty (30) days or your medical license will be suspended, even if you deny you owe the money and request a hearing.





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