Introduction

- Medicare relies on physicians and staff to submit accurate claims for payment
  - Most practices do work very hard to make sure claims are submitted properly
- Dishonest healthcare providers created need for laws and administrative actions to combat fraud and abuse
  - Audit contractors are among those administrative actions

What is Medicare Fraud?

- Medicare fraud typically includes:
  - Knowingly submitting, or causing to be submitted, false claims
  - Billing for appointments the patient failed to keep
  - Knowingly billing for services at a level higher than actually provided or documented in the chart
  - Billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items
  - Paying for referrals of Medicare beneficiaries
- Committing Medicare fraud exposes providers to:
  - Criminal and civil liability, and may lead to imprisonment, fines, and penalties
  - Any practice not consistent with providing patients with services that are medically necessary, meet professionally recognized standards, and are priced fairly
  - Billing for unnecessary medical services
  - Charging excessively for services and supplies
What is Medicare Abuse?

– Misusing codes on a claim, such as upcoding or unbundling codes
  • Abuse can also expose providers to criminal and civil liability
  • Causes of improper payments
    – Mistakes
      • Result in errors such as incorrect coding

What is Medicare Abuse?

– Inefficiencies
  • Result in waste such as ordering excessive diagnostic tests
– Bending the Rules
  • Result in abuse such as improper billing practices (like upcoding)
– Intentional Deceptions
  • Result in fraud such as billing for services or supplies that were not provided

Medicare Contractors

• Medicare Administrative Contractor (MAC)
  – Processes claims and submits payment to providers according to Medicare rules and regulations
    • Includes identifying and correcting underpayments and overpayments
• Zone Program Integrity Contractor (ZPIC)
  – Performs investigations or specific issues
    • Only when there is potential fraud and takes action accordingly

Medicare Contractors

• Supplemental Medical Review Contractor (SMRC)
  – Conducts nationwide medical review as directed by CMS
    • Includes identifying underpayments and overpayments
• Comprehensive Error Rate Testing (CERT) Contractor
  – Performs review on statistically valid random sample of claims for improper payment

Medicare Contractors

• Medicare FFS Recovery Auditors (RAs)
  – Reviews claims to identify potential underpayments and overpayments
    • Part of Recovery Audit program
• Each contractor conducting claim review must apply all Medicare policies to the claim under review
  • A different contractor cannot reopen that claim

Audit Proofing Your Practice
Red Flags

- **Assignment of Benefits**
  - No signed form at all
  - Or hard to find
  - Form missing
    - Patient’s printed name
    - HIC number
    - Secondary Insurance/Medigap
    - Patient signature
    - Date form signed

Red Flags

- Inadequate Medicare language
- Out of date
  - Practice details
  - New providers not included
    - Includes names of providers no longer with practice
  - Remember, Assignment of Benefits is lifetime form
    - Only need to sign one time

Red Flags

- **CCI Bundling Edits**
  - Improper coding leads to incorrect payment
    - NCCI edits prevent improper payments when incorrect code combinations are reported
  - Before billing multiple procedures check the CCI bundling edits for each procedure
  - Example
    - OCT (92134) not bundled with fundus photo (92250), but
    - Fundus photo, 92250, is bundled with 92134

Red Flags

- **Medically Unlikely Edits (MUEs)**
  - MUEs developed to reduce paid claim error rate
    - Automated pre-pay edits on claims submitted for payment
  - MUE is a maximum number of units a provider can report on a specific service on a single patient on a single date of service

Red Flags

- **Poor documentation**
  - “If it’s not documented, It wasn’t done”
    - Therefore, it won’t get paid
  - Good documentation protects against billing errors and possible refund requests
  - Work with technicians and physicians
    - Hold in-services if needed to go over issues noted in internal audits
    - Strive to maintain pristine medical records
## Red Flags

• The basis for proper billing  
  – Is the documentation…  
    • Accurate?  
    • Representation of what was really performed?  
    • Medically necessary for the reason for the visit?  
  – As a legal document, is documentation…  
    • Accurate?  
    • Believable?  
    • Specific to that particular patient?

• Medical necessity not documented  
  – Inadequate information in chart  
    • Does not support Medicare requirements  
    • Habitual abusers need to be re-trained  
  – No chief complaint to support billing  
  – Lifestyle impairment missing for cataract, YAG, blepharoplasty  
  – No medical necessity for test  
    • Not ordered, no interpretation and report

• Duplicate claims  
  – Continually billing duplicate claim will raise red flag  
    • Could get practice audited  
  – Follow-up with billing supervisor regularly  
    • Run report to see if duplicate claims are being submitted and why  
    • Re-train billing staff if needed

• Incorrect coding  
  – Different code than was billed  
  – Service performed by someone other than billing provider  
  – Billed service was unbundled  
  • Insufficient E/M documentation  
    – Exam does not meet level billed  
    – History does not meet level required

• Service does not meet definition of a new patient  
  – Patient has not been seen by any physician or other qualified healthcare practitioner in the practice in the past 3 years  
    • Some MACs automatically deny  
    • Others do not which puts practice in a refund situation  
  – Run new patient report and audit 10 dates of service

• History of Present Illness Must Be Obtained by Rendering Provider  
  • Can be Dictated – Documented as such  
    – HPI Dictated by I.C. Well, MD  
    – HPI Scribed Ida Wright, COA  
  • Mental Status Must be Observed & Documented by Rendering Provider  
    • Oriented to Person, Place & Time or not  
    • Mood & Affect Appropriate or not
Red Flags

• **Inadequate provider identification**
  - Handwritten signatures continue to be concern of CMS and the OIG
    - Should include provider’s name or first initial and full last name on the medical record
      - Can be typed or written under the signature line for the physician
    - Also keep physician signature log for record requests
  - Electronic signatures are permitted for electronic medical records

Red Flags

• **Overuse of modifiers**
  - Modifier -24
    - Only use during global fee period for unrelated office visits
      - CME, Iritis, conjunctivitis are related
    - Don’t use for second eye exam unless patient presents with new symptoms
      - Or it’s been over 90 days since last visit
    - On OIG radar

Red Flags

– Modifier -25
  - Only used with office visits performed same day as minor office surgeries
    - 0 or 10 day global fee period
  - Must be over and above the usual preoperative workup for the procedure
    - Patient presents for Lucentis injection and has complaint in fellow eye
  - Reporting visit and procedure when evaluation is limited to assessing the specific problem (e.g., eyelash removal) is double billing for the pre-service evaluation

Red Flags

• **Use with office visits only**
  - Not on tests or surgeries
  - Can’t use on re-evaluations when patient asked to return for surgery
  - Is not to be used as “the decision for surgery” like modifier -57 with major surgeries
  - Continually appending -25 modifier on all minor surgery exams will result in audit
  - On CMS and OIG radar

Red Flags

– Modifier -59
  - Unbundling CCI coding edits routinely is big red flag
  - Should not be appended to subsequent procedures performed at the same session and in the same segment of the eye
    - Only if separate lesion or separate injury
  - Should not be used just to obtain additional payment for bundled procedures
  - On OIG radar

Red Flags

• **Diagnostic Tests**
  - Missing altogether
  - Incomplete
    - Lacks Indication, Specifics of Test
  - Ordering provider not treating provider
  - Orders in previous plan not performed
    - “Return 6 mo glaucoma FU and VF”
    - Lost Revenue
Red Flags

- Interpretation and Report
  - Missing Altogether
  - Embedded within the Assessment/Plan
  - Only Measurements Found
    - "Normal"
    - "WNL"
    - "Baseline"
    - "Bad Test"
  - No Impact of Test on Treatment

Red Flags

- At minimum Interpretation and Report should include:
  - Date of test and diagnosis (if known)
  - What was seen or not seen but anticipated
    - Glaucoma, for example
  - What findings suggest as to status of illness
    - Stable, worsening, improving
  - What impact results have on treatment
    - Continue present meds, surgery as indicated, etc.
  - Signature of physician
    - Physician MUST sign I&R

Overpayments

- Payment received in excess of amounts properly payable under Medicare regulations
  - Becomes debt a provider owes to CMS
  - CMS is bound by federal law to recover all identified overpayments
  - Overpayments usually occur due to:
    - Insufficient documentation
    - Medical necessity errors
    - Administrative processing errors

Source: MLN ICN 006379 October 2016

Notification

- If overpayment identified by the practice
  - Must report it
  - Must arrange to return payment no later than 60 days after date overpayment identified
  - When Medicare identifies overpayment of $25 or more
    - MAC initiates overpayment recovery process
    - Sends initial demand letter requesting overpayment

Source: MLN ICN 006379 October 2016

Demand Letter

- Options to respond to demand letter
  - Make immediate payment
  - Request immediate recoupment
  - Request standard recoupment process
    - Automatic offset/withholding
  - Request Extended Repayment System (ERS)
  - Submit rebuttal
  - Request redetermination to appeal overpayment

Source: MLN ICN 006379 October 2016
Demand Letter

– If no rebuttal or appeal requested by practice and overpayment not made in full
  • Will receive Intent to Refer (IRL) letter 60-90 days after initial demand letter
  • IRL advises that unless overpayment is refunded or steps taken to establish an ERS, MAC will refer overpayment to Federal level for collection
    – Treasury or Treasury-designated Debt Collection Center
  • If still not paid, debt referred to private collection agency
    – May include salary offset and administrative wage garnishment

Source: MLN ICN 006379 October 2016

EHR Documentation

• Copy and Paste Functions
  – Can be fraud and abuse risk
    • May result in a more extensive chart note and make it appear as though a more intensive exam was performed
    • Treatment notes or patient histories may appear as though patient received treatment for a certain condition when, in effect, condition was already resolved

• Menus
  – May limit available options for diagnoses or procedure codes
    • May only list codes that lead to the highest exam level or payment rate

• Default Settings
  – Could automatically insert text into a note when a note is opened or other action taken
    • User may be unaware of the default which could be inaccurate

EHR Documentation

• Inserting standardized text into medical record
  – Usually inserted from a pre-selected list of options
  – Could automatically insert text that affects billing and may not be accurate for that patient
    • May appear as though physician reviewed or otherwise treated every condition on the list
    • Is a Risk Adjustment audit issue

EHR Documentation

• To prevent possible exposure and aid in compliance
  – If automated text function used, request that allied staff and physicians always go back and review chart notes for that visit
    • Chart note should show what was meant and extra, unwarranted words were not added
  – When using menu function, make sure EHR allows physicians to pick code he/she wants
**EHR Documentation**

- If the EHR has an incomplete set of options, work with your IT person or EHR vendor to get this resolved and add more codes
  - If EHR has “audit log” function, make sure it’s on
    - This allows you to see who entered what information into the medical chart, who changed the information, and when it was done
    - This function invaluable in determining what should be in chart and why and how errors were made

- EHR systems certainly not error free
  - In some respect, causes more problems as noted
  - Employees should be able to report concerns about upcoding and other EHR issues to the Compliance Officer
    - This helps identify problems and resolve compliance issues before Medicare or other payer action is required

**Cloned Documentation**

- In Summary
  - Do not “Copy-Paste” exam information
    - Especially “Whole Notes”
  - Only Document What Was Done
    - As Medically Necessary
  - Review Documentation Prior to Closing
    - Accuracy, Provider Requirements

- Cloned Documentation
  - Previous visit findings brought forward including typos & misspelling
  - Pre-populating Fields
    - Load exam with pre-programmed findings
  - Causes documentation to look dubious
    - Creates contradictions
    - Was the element actually performed
    - Makes it difficult to code

**Avoiding Audits**

- To help avoid CMS audits, perform audits
  - External audits
    - Provides basis for internal audits and training
  - Helps avoid billing mistakes and provided up-to-date information on billing rules
    - Every 1 - 2 years is recommended
  - Internal audits
    - Use findings to provide education and training of physicians, technicians, coders, and billers
      - Create set schedule and stick to it