The Changing Landscape of Scrutiny and Audits: Know the Rules of Engagement

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Financial Disclosure

William T. Koch
• Advisory Boards
  • Allergan
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• Speaker Bureaus
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Medicare Program Integrity

The primary principle of Program Integrity (PI) is to protect the Medicare Trust Fund from fraud, waste and abuse. In order to meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers.

Source: Medicare Program Integrity Manual, Chapter 1 §1.1

Types of Audits

- HEDIS
  - Healthcare Effectiveness Data and Information Set
- RADV
  - Medicare Advantage Risk Adjustment Data Validation

Types of Audits

- Recovery Audit Program (RACs)
- CMS awarded new FFS RAC contracts on October 31, 2016 to:
  - Region 1 – Performant Recovery, Inc.
  - Region 2 – Cotiviti, LLC
  - Region 3 – Cotiviti, LLC
  - Region 4 – HMS Federal Solutions
  - Region 5 – Performant Recovery, Inc.
Recovery Audit Program

Medicare Fee-for-Service RAC Regions

Office of Inspector General (OIG) 2013 Work Plan

Ophthalmological Services—Questionable Billing (New)

We will review Medicare claims data to identify questionable billing for ophthalmological services during 2011. We will also review the geographic locations of providers exhibiting questionable billing for ophthalmological services in 2011. Medicare payments for Part B for physician services, which include ophthalmologists, are authorized by the Social Security Act, § 1832(a)(1), and 42 CFR § 410.20. In 2010, Medicare allowed over $6.8 billion for services provided by ophthalmologists. (OEI; 04-12-00280; expected issue date: FY 2014; work in progress)

Findings

QUESTIONABLE BILLING FOR MEDICARE OPHTHALMOLOGY SERVICES

Four percent of providers billing for ophthalmology services in 2012 demonstrated questionable billing on at least one of our measures; Medicare paid them $171 million for services related to these measures

OIG: QUESTIONABLE BILLING FOR MEDICARE OPHTHALMOLOGY SERVICES
September 2015 OEI-04-12-00280
Findings

Table 1. Providers With Unusually High Billing by Category and Measure of Questionable Billing, 2012

<table>
<thead>
<tr>
<th>Category and Measure of Questionable Billing</th>
<th>Number of Providers Ongoing Thoroughly</th>
<th>Amount Medicare Paid for Services Provided with Malpractice*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly payments more than 100 times per quarter</td>
<td>500</td>
<td>$5 million</td>
</tr>
<tr>
<td>Current payments beyond the maximum annual payments, reasonable or not</td>
<td>50</td>
<td>$22 million</td>
</tr>
<tr>
<td>Claims with excess hospital supplies</td>
<td>40</td>
<td>$2 million</td>
</tr>
<tr>
<td>Unusually high billing for non-ophthalmic procedures</td>
<td>100</td>
<td>$19 million</td>
</tr>
<tr>
<td>Billings for services not to degree</td>
<td>100</td>
<td>$25 million</td>
</tr>
<tr>
<td>Billings for services not to Medicare</td>
<td>100</td>
<td>$19 million</td>
</tr>
<tr>
<td>Total</td>
<td>500</td>
<td>$179 million</td>
</tr>
</tbody>
</table>

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/SMRC.html

Findings

CMS Audits

- Strategic Health Solutions, LLC
- Contracted by CMS as a Supplemental Medical Review Contractor (SMRC) in September 2012
- Conducting nationwide medical review as directed by CMS
- Includes Part A, Part B, and DME providers and suppliers

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/SMRC.html
Supplemental Medical Review Contractor (SMRC)

As the Supplemental Medical Review Contractor (SMRC), Strategic has been contracted to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid programs. One of the primary tasks will be conducting nationwide medical review as directed by CMS. . . . determine whether Medicare claims were billed in compliance with coverage, coding, payment and billing practices.

http://www.strategichs.com/wpcms/home-smrc/

SMRC – Current Projects

• Project Y3P0225 – Blepharoplasty and other related facial procedures
• Project Y4P0435 – Ranibizumab (Lucentis)
• Project Y3P0239 – Ophthalmology Services
  • Including a focus on cataract surgery


SMRC – Current Projects

• Project Y3P0225 – Blepharoplasty and other related facial procedures
• The Center of Public Integrity Report (May 19, 2014), “Eyelid lifts skyrocket among Medicare patients costing taxpayers millions”, which states, “the public health insurance program for people over 65 typically does not cover cosmetic surgery…. In recent years, though, a rapid rise in the number of so-called functional eyelid lifts, or blepharoplasty, has led some to question whether Medicare is letting procedures that are really cosmetic slip through the cracks – at a cost of millions of dollars.”

SMRC – Current Projects

• Project Y4P0435 – Ranibizumab (Lucentis)
• “According to Medicare guidelines, medications administered for the treatment of a disease in excess of indicated acceptable standards of medical practice are not covered. CMS has identified a possible overutilization of the intraocular injection, Lucentis. The Food and Drug Administration (FDA)-approved guidelines for Lucentis injections is once a month or every 28 days for the treatment of certain eye conditions.”


SMRC – Current Projects

• Project Y3P0239 – Ophthalmology Services
• “The OIG found that Medicare paid $22 million for ophthalmology claims in 2012 that were potentially inappropriate, according to national and local coverage requirements. Specifically, $14 million was paid despite the presence of national requirements that were designed to prevent these payments. Similarly, $18 million was paid despite the presence of local coverage requirements that were designed to prevent these payments. Additionally, two of eleven Medicare contractors paid a disproportionate amount of the potentially inappropriate Medicare Payments.”


SMRC – Current Projects

• StrategicHealthSolutions
• Supplemental Medical Review Contractor (SMRC)
  • Project Y3P0239 – Ophthalmology Services
    • 92005 Level 5 NP E/M Code
    • 92014 EP Comprehensive Eye Code
    • 92134 OCT
    • 67028 Intravitreal Injection
    • J2778 Lucentis
    • J0178 Eylea
    • (almost anything)
SMRC Request Submission

- Read the complete request
- Follow their instructions as close as possible
- Submit everything to support the services
- Do not assume anything
- Summary for each case
- Submit color copies (e.g. photos, OCTs, etc...)
- Discussion and Education period (30 day to submit)

http://www.strategichs.com/wpcms/home-smrc/

Types of Audits

- Targeted Probe & Educate with Extrapolation (TPEE)
- Noridian Healthcare Solutions Pilot Program
  - Prepayment review
    - Three rounds
    - Educate
    - Fourth round if high denial rate continues?
      - Post payment review with extrapolation
      - Possible referral to Zone Program Integrity Contractor (ZPIC)

Types of Audits

- Provider Self-Audit with Validation and Extrapolation (PSAVE)
  - Noridian Healthcare Solutions Pilot Program
PSAVE

Noridian, the Jurisdiction F Medicare Administrative Contractor (MAC), is expanding the Provider Self-Audit with Validation and Extrapolation (PSAVE) program, a new pilot authorized by CMS. The PSAVE program will allow participants to perform their own self-audit and allow the Contractor (Noridian) to validate the voluntary self-audit findings and extrapolate an overpayment or determine an underpayment. Upon completion of program requirements, the claims included in the PSAVE pilot would receive immunity from MAC and Recovery Auditor (RA) reviews.

Enrollment in the program will be allowed on a first come first served basis and at the discretion of CMS and Noridian. Availability is limited so please contact Noridian PSAVE immediately if interested.

Qui Tam Complaint

• Whistleblower complaint
• False Claims Act
  • Unnecessary diagnostic tests
  • Over coding
• Ophthalmology services that are not medically necessary
• Treatments that are not medically necessary

Qui Tam Complaint

• Civil Investigative Demand (CID)
  • Relevant time period
    • January 1, 2009
Qui Tam Complaint

- Civil Investigative Demand (CID)
- Documentation Requests
  - Documents sufficient to identify facility
  - Documents sufficient to reflect the complete organizational structure
  - Documents sufficient to show, for each claim billed to a government payer
    - All claims data!

Qui Tam Complaint

- Civil Investigative Demand (CID)
- All documents and communications related to protocols, procedures, policies, guidance, standards, rules, requirements, training, or instructions regarding:
  - (a) billing;
  - (b) procedure coding;
  - (c) compliance with Medicare regulations;
  - (d) use of electronic medical record system;
  - (e) use of OCT testing and fundus photography;
  - (f) use of intravitreal injections.

Qui Tam Complaint

- Civil Investigative Demand (CID)
- Documentation Requests
  - All documents and communications related to:
    - The use of OCT testing and fundus photography on patients...
    - Intravitreal injections of medications such as Avastin, Eylea and Lucentis but not limited to appropriate frequency of injections...
Qui Tam Complaint

- Civil Investigative Demand (CID)
- Documentation Requests
  - All documents and communications related to:
    - Time stamps
    - Diagnosis coding
    - Chief complaint
    - Billing
    - Treatment notations

Qui Tam Complaint

- Civil Investigative Demand (CID)
- Documentation Requests
  - 2,300,000 lines of claims data
  - In addition to other requested documentation

Medicare Advantage Organizations

- Medicare PART C Compliance Requirements
  - MAO – must have compliance plan

Medicare Managed Care Manual Chapter 21 §30 Overview of Mandatory Compliance Plan

FWA – fraud, waste and abuse
Medicare Advantage Organizations

- MAOs must insure that FDRs (First Tier Downstream or Related Entity) are compliant by 1/1/16¹
- 3 Options for MAOs to ensure FDRs are compliant²
  - Web based training through CMS MLN network
  - Incorporate CMS modules into current training materials
  - Incorporate CMS training into written documents (policies, manuals, BAAs, etc...)


Components of an Effective Compliance Program

- Conducting internal monitoring and auditing
  - Focused review
  - General review
  - Prospective review
    - Claims to be filed
  - Retrospective review
    - Claims already filed
  - Missed charges
  - Overpayments

OIG Compliance Guidance

An ongoing evaluation process is important to a successful compliance program. This ongoing evaluation includes not only whether the physician practice's standards and procedures are in fact current and accurate, but also whether the compliance program is working, i.e., whether individuals are properly carrying out their responsibilities and claims are submitted appropriately.

OIG Compliance Program for Individual and Small Group Physician Practices
Documentation

*If it’s not written down it wasn’t done*

Medical Decision Making (MDM)

- Medical Decision Making
  - Diagnoses – number of diagnosis
  - Tests – amount of data reviewed
  - Risk – severity of disease

Source: 1997 Evaluation and Management (E/M) Guidelines

Example

- 99204 New Patient Level 4 E/M Code
  - Comprehensive history
  - Comprehensive examination
  - Moderate Level of Medical Decision Making
  - Management of multiple diagnosis with associated risk
  - Elective major surgery

1997 Evaluation and Management Guidelines
Example

• 99205 New Patient Level 5 E/M Code
  • Comprehensive history
  • Comprehensive examination
  • High level of Medical Decision Making
  • Emergent major surgery
  • Same or next day surgery
  • Higher level of documentation

1997 Evaluation and Management Guidelines

Diagnostic Tests

• Physician’s order
• Ancillary Staff
• Reliability of test
• Patient cooperation
• Findings
• Assessment
• Impact on treatment
• Physician’s signature

Case Study

• Medicare audit
• Missing documentation
• Illegible documentation including abbreviations
• Extrapolated overpayment determination
• Practice received overpayment demand letter

$4,000,000.00
Case Study

- 3 year battle with Medicare audit contractor
- Redetermination
- Reconsideration
- Administrative Law Judge (ALJ)
- Medicare appealed ALJ decision
- Cost to practice was considerable

$2,000.00

Summary

- Know your audit contractor
- Additional Documentation Request (ADR)
  - How many charts?
  - What are they looking for?
  - Review charts before responding.
  - Add addendums if necessary.
  - Keep in mind the charts and documentation can land on anyone's desk.

Summary

- Audits are not going away (anytime soon).
- Numerous entities that follow common guidelines
  - Published by payer
  - Standard of care
- Assume nothing, provide details
- The auditors are not working for you, do not expect the benefit of the doubt
Thank You!

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