Medicare's Claim Review Programs

Are You Prepared?

September 13 - 15, 2011

Presented By

First Coast Service Options, Inc.
Provider Outreach & Education

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Acronym List

- ADR – Additional Documentation Request
- CDC – CERT Documentation Contractor
- CERT – Comprehensive Error Rate Testing
- CMS – Centers for Medicare & Medicaid Services
- CRC – CERT Review Contractor
- E/M – Evaluation and Management
- FCSO – First Coast Service Options
- IOM – Internet Only Manuals
- MLN – Medicare Learning Network
- MR – Medical Review
- MUE – Medically Unlikely Edits
- NCCI – National Correct Coding Initiative
- PCA – Progressive Corrective Action
- RAC – Recovery Audit Contractor

Agenda Items

- Introduction and activity
- Administration efforts to reduce payment errors
- National Correct Coding Initiative Edits (NCCI)
- Medically Unlikely Edits (MUEs)
- Medical Review Program
- Recovery Audit Contractor (RAC)
- Comprehensive Error Rate Testing (CERT)
- Provider self audits
- Additional resource material
- Summary activity

Learning Objectives

- At the conclusion of this session you will be able to
  - Identify the mission and goals of the current Administration to reduce payment errors in the Medicare program
  - Discuss the five Medicare claim review programs
  - Evaluate system edits to reduce claim payment errors
  - Determine what contractors review your claims/records
  - Apply tips and tools to be proactive in your practice/facility
  - Utilize additional resources to assist you

Administration Efforts to Reduce Improper Payments

Presidential Memorandum

- Executive Order 13520
  - Reducing improper payments by
    - Refining error rate measurement processes
    - Improving system edits
    - Updating coverage policies and manuals
    - Conducting provider education efforts
  - 50% reduction in error rate by 2012

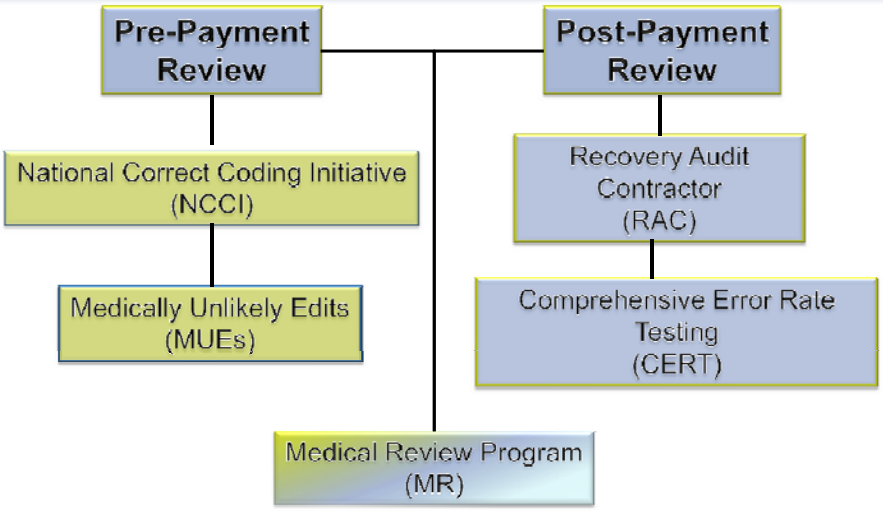
National MFFS Error Rates

Year	Error Rate	Total Dollars Paid	Total Improper Payments
2005	5.2%	$234.1 B	$12.1 B
2006	4.4%	$246.8 B	$10.8 B
2007	3.9%	$276.2 B	$10.8 B
2008	3.6%	$288.2 B	$10.4 B
2009	12.4%	$308.4 B	$35.4 B
2010	10.5%	$326.4B	$34.3 B

* These entries have been adjusted to account for the high provider non-response rate in 2003. Had the adjustment not been made, the improper payments would have been $21.5 B and the national paid claims error rate would have been 10.8%.

What are Medicare's Claim Review Programs?

Claim Review Programs



Contractors' Role

- Medicare Administrative Contractors (MACs)
  - Processes claims and makes payments in accordance with Medicare rules and regulations
- Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs)
  - Responsible for identifying cases of suspected fraud and taking appropriate corrective actions
- Recovery Audit Contractors
  - Identify and correct underpayments and overpayments on a postpayment basis
- Comprehensive Error Rate Testing (CERT) Contractors
  - Performs reviews on a sample of Medicare FFS claims

National Correct Coding Initiative (NCCI) Edits

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NCCI Table

A	B	C	D	E	F
			Column1/Column 2 Edits		
Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
99215	G0101		19980401	19980401	9
99215	G0102		20000605	*	0
99215	G0104		19980401	19980401	9
99215	G0105		19980401	19980401	9
99215	G0106		19980401	19980401	9
99215	G0107		19980401	19980401	9
99215	G0117		20020101	*	0
99215	G0118		20020101	*	0
99215	G0120		19980401	19980401	9
99215	G0245		20020701	*	0
99215	G0246		20020701	*	0
99215	G0248		20021001	*	1
99215	G0250		20021001	*	1
99215	G0270		20030701	*	0

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NCCI Edits

- Based on coding conventions defined in
  - American Medical Association's (AMA's) Current Procedural Terminology (CPT) Manual
  - Healthcare Common Procedure Coding System (HCPCS) Manual
  - National and local Medicare policies and edits
  - Coding guidelines developed by national societies
  - Standard medical and surgical practice
  - Current coding practice

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NCCI Edits Process

- Automated prepayment edits
  - Submitted procedures are analyzed to determine if compliant with NCCI edit policy
  - Systems test every pair of codes reported for
    - Same date of service
    - Same beneficiary
    - Same provider
  - If code pair hits NCCI edit
    - Column two code of edit pair is denied unless submitted with NCCI associated modifier allowed

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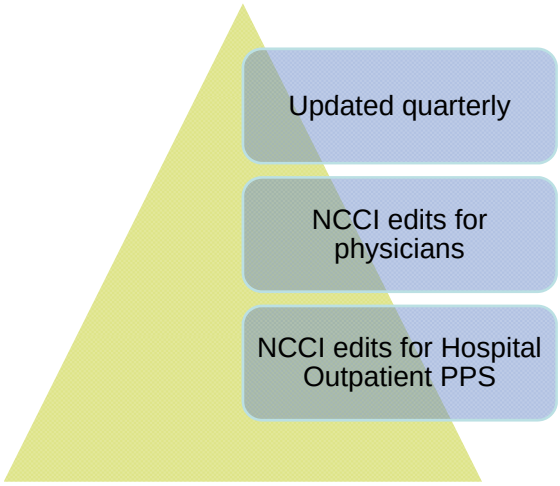
NCCI Tables



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NCCI Indicators

- Correct coding modifier indicators

0 – There are no modifiers associated with NCCI that are allowed to be used with this code pair; no circumstances in which both procedures of the code pair should be paid for the same beneficiary on the same day by the same provider.

1 – The modifiers associated with NCCI are allowed with this code pair when appropriate.

9 – NCCI edits do not apply to this code pair. The edits have been deleted for this code pair.

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NCCI Table 1 Example

Column 1 (More significant procedure or service)	Column 2	Modifier 0 = Not Allowed 1 = Allowed 9 = Not applicable
12001 (Simple wound repair, up to 2.5 cm.)	64470 (peripheral nerve/branch block injection, anesthetic agent or steroid)	0 (Column 2 is considered an integral part of the Column 1 service, and therefore not separately billable)
12001	G0168 (Dermabond repair)	1 (also considered an integral part of the simple laceration repair 12001 but in this case a modifier is allowed to bypass the NCCI/CCI edit
12001	64550 (Neurostimulators, Peripheral Nerve)	9 Not applicable

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CMS – NCCI Resources

- NCCI Edits Overview Web Page (including NCCI FAQs)
  - http://www.cms.gov/NationalCorrectCodInitEd
- Claims Processing Manual Chapter 23 - Section 20.9
  - http://www.cms.gov/manuals/downloads/clm104c23.pdf
- National Correct Coding Initiative

  Correct Coding Solutions LLC

  P.O. Box 907

  Carmel, IN 46082-0907

  Attention: Niles R. Rosen, M.D., Medical Director and Linda S. Dietz, RHIA, CCS, CCS-P, Coding Specialist

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Medically Unlikely Edits (MUEs)

MUE Edits

HCPCS/CPT Code	MUE
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0016T	2
0017T	2
0019T	1
0030T	2
0042T	1
0048T	1
0050T	1
0051T	1
0052T	1
0053T	1
0054T	2
0055T	2

MUE Edits

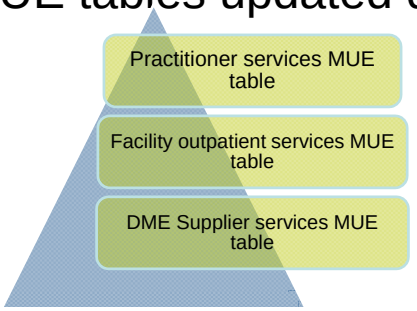
- Automated prepayment edits
  - Submitted procedures are analyzed to determine compliance with MUE policy
- Developed based on
  - Anatomic considerations
  - HCPCS/CPT code descriptors
  - CPT coding instructions
  - Established CMS policies
  - Nature of service/procedure, analyte, equipment
  - Clinical judgment

MUE Edits (Cont.)

- Process
  - All MUEs validated against 100% claims data from 6 month period
  - Claim lines pass the MUE edits
    - Continue to be processed
  - Claim lines reporting units of service greater than MUE value for HCPCS code
    - Claims are denied
    - Denials due to MUE may be appealed

MUE Edits (Cont.)

- MUE tables updated quarterly



- Denials for units in excess of MUEs
  - ABN form cannot be used to seek payment

MUE Table Example

HCPCS/CPT Code	Practitioner Services MUE Values
0019T - Extracorporeal shock wave involving musculoskeletal system, not otherwise specified	1 - Allowable units for a single beneficiary on a single date of service
27780 - Closed treatment of proximal fibula or shaft fracture; without manipulation.	2 – Allowable units for a single beneficiary on a single date of service
38100 - Splenectomy	1 - Allowable units for a single beneficiary on a single date of service
41820 - Gingivectomy, excision gingiva, each quadrant	4 - Allowable units for a single beneficiary on a single date of service

Requests for Reconsideration

- Request for MUE value to be modified
  - Should be addressed to:

    National Correct Coding Initiative
    Correct Coding Solutions, LLC
    P.O. Box 907
    Carmel, IN 46082-0907
    Fax #: 317-571-1745

CMS – MUE Resources

- CR 6712– Medically Unlikely Edits (MUEs)
  - http://www.cms.gov/transmittals/downloads/R652OTN.pdf
- CCI Edits: Medically Unlikely Edits (MUEs)
  - http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp

The Medical Review Program

Statutory Authority

- Social Security Act
  - Section 1833 (e)
    - No payment shall be made to any provider unless there has been furnished such information as may be necessary in order to determine the amounts due provider
  - Section 1842(A)(2)(B)
    - Requires MACs to assist in application of safeguards against unnecessary utilization of services furnished by providers
  - Section 1862(a)(1)
    - No Medicare payment shall be made for expenses incurred for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or to improve the functioning of a malformed body member”

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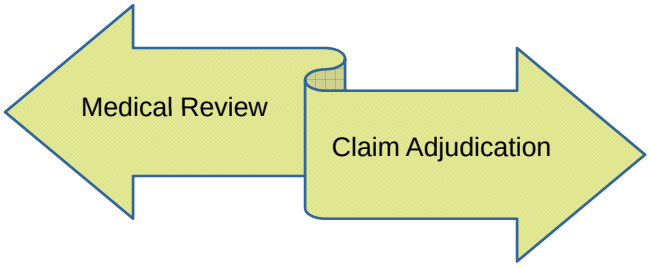
MR Program Goal

- Reduce payment errors by preventing initial payment of claims that do not comply with Medicare's coverage, coding, payment and billing policies by
  - Identifying provider noncompliance through analysis of data
    - Profiling of providers services or beneficiary utilization
  - Evaluation of other information
    - Complaints, enrollment and/or cost report data
  - Take action to prevent and/or address identified improper payments
  - Place emphasis on reducing paid claims error rate by notifying of review findings

Medical Review Process

- Use of data analysis as foundation for detection of aberrant billing practices
- Select most egregious problems for validation by probe review
- Implement appropriate corrective actions
- Work closely with Program Safeguard Contractors (PSC) - Zone Program Integrity Contractors (ZPIC) for fraud identification and referral

Pre-payment Review of Claims for Medical Review Purposes



Automated Prepayment

- Decisions made at system level
- Automated review must
  - Have clear policy that serves as basis for denial; or
  - Be based on medically unbelievable services; or
  - Occur when no timely response is received in response to ADR letter

Prepayment Edits

- Put into place to prevent payment for
  - Non-covered and/or incorrectly coded services
  - Select targeted claims for review prior to payment

Categories of MR Edits

- Service-specific edits
  - Select claims for specific services for review
- Provider-specific edits
  - Select claims from specific provider flagged for review

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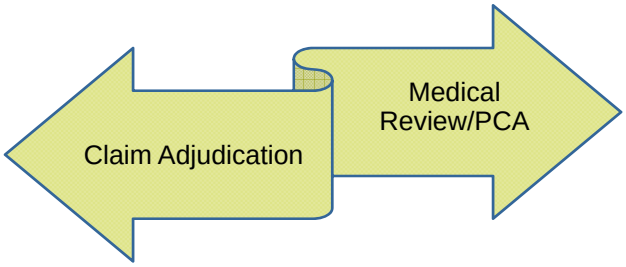
Post-payment Review of Claims for Medical Review Purposes



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Postpayment Review

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- Conducted on providers/suppliers
  - Who demonstrated aberrant billing and/or practice patterns
- Three types of post payment review
  - Error validation review
  - Statistical sampling for overpayment estimation review
  - Consent settlement review

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Postpayment Review Results

- Notification letter
  - Sent to provider/supplier of results within 60 days of receipt of medical records
    - Contains demand for repayment of any overpayments or notification of underpayments if applicable
    - Explains reason for review
    - Contains findings for each claim in sample
    - Explains rebuttal process
    - Explains appeals process

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Medical Review – Progressive Corrective Action (PCA)

Progressive Corrective Action

- Purpose
  - Identify, validate, determine level of, educate, and evaluate documentation, claims and educational needs
- Begins with data analysis
  - Records are requested to verify if billing problems exist through probe reviews
- Review of records
  - Establishes payment error rate/claim error rate indicating severity of problem
- Error rate above 10%
  - Review continues while education takes place until error rate lowers to acceptable level

ADR Requests

- For medical review purposes
  - Documentation to be submitted within 30 days of request
  - No response received within 45 days
    - Service will be denied as not reasonable and necessary

Direct Communication

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- Provider notification and feedback
  - Letter will include
    - Reasons for medical review
    - Previous review findings (if applicable)
    - Planned medical review (level and duration)
    - Potential for continuation of or increase in medical review levels
    - Description of specific actions provider must take to resolve

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Comparative Billing Reports

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Provider specific

- Useful to identify potential variances in coding within a code family
- Distributed in a bar graph depicting provider's percentage of allowed services per procedure code compared to Florida and nation

Service specific

- Useful for medical society meetings to show variance within a code family between Florida's provider specialties and nation
- Compares Florida's utilization of E & M codes to the nation by specialty

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Medical Review - Tips

- Provider should ensure that documentation is submitted timely (preferably within 30 days of request)
- Provider should implement very aggressive process to audit and monitor documentation of services
- Provider may request or be referred to the Provider Outreach and Education Department for additional education
- Provider may request an appeal of any denied services

CMS – MR Resources

- CMS Internet Only Manuals (IOM) Publication 100-08
  - Medicare Program Integrity Manual – Chapter 3
  - http://www.cms.gov/Manuals/IOM/list.asp

Recovery Audit Contractor (RAC)

Recovery Audit Program

- January 1, 2010
  - Permanent program implemented
- March 2010
  - Role of RAC expanded to
    - Medicaid
    - Medicare Parts C and D
    - Serve in program integrity capacity for Medicare Advantage and Part D plan's anti-fraud plan

RAC Program Process

- Detecting/correcting improper payments by
  - Applying statutes, regulations, national coverage policy, payment and billing policies, and LCDs developed by the MACs
  - Analyzing claims data using their proprietary software to identify claims that contain or likely to contain improper payments
  - Sending files to MACs to adjust claims and process recoupment on improper payments
  - Requesting medical records from providers and making determination

Region C RAC Contractor

- Connolly Consulting Associates, Inc.
  50 Danbury Road
  Wilton, CT 06897
  - www.connollyhealthcare.com/RAC
  - RACinfo@connollyhealthcare.com
  - 1-866-360-2507
- Sub-contractor Viant Payment Systems, Inc.

RAC Tips

- Conduct internal assessments
- Identify patterns of denied claims within your own practice or facility
- Review the RACs' websites to identity improper payments/approved issues
- Implement procedures to promptly respond to RAC requests for medical records
- When filing an appeal, submit before 120-day deadline
- Determine what corrective actions can be taken
- Ensure compliance with Medicare's requirements to avoid future incorrect claims

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RAC Review Findings

- To view types of improper payments found by the RACs
  - Demonstration findings: www.cms.gov/rac
  - Permanent RAC findings: http://www.connollyhealthcare.com/RAC/Pages/cms_RAC_Program.aspx
- To view types of improper payments reported in OIG reports
  - OIG reports: www.oig.hhs.gov/reports.html

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CMS - RAC Resources

- RAC Overview Web Page
  - http://www.cms.gov/RAC/01_Overview.asp
- RAC Demonstration Web Page
  - http://www.cms.gov/RAC/02_ExpansionStrategy.asp
- RAC Jurisdiction Contact Information
  - http://www.cms.gov/RAC/Downloads/RAC%20contact%20information.pdf
- Recent Updates
  - http://www.cms.gov/RAC/03_RecentUpdates.asp

Comprehensive Error Rate Testing (CERT) Process and Findings

CERT Error Rate Projections

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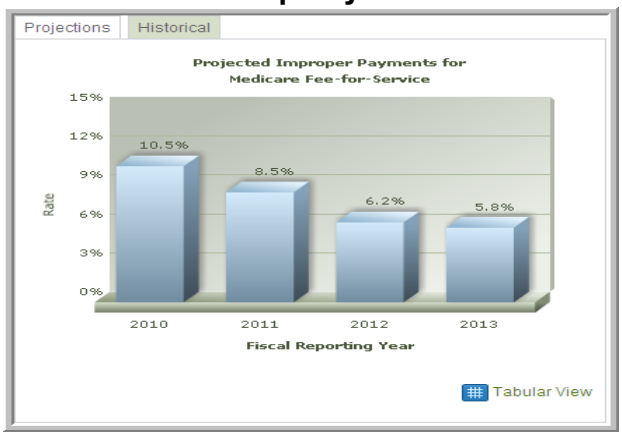
- National CERT projections:



https://www.cms.gov/CERT/Downloads/CERT_Report.pdf

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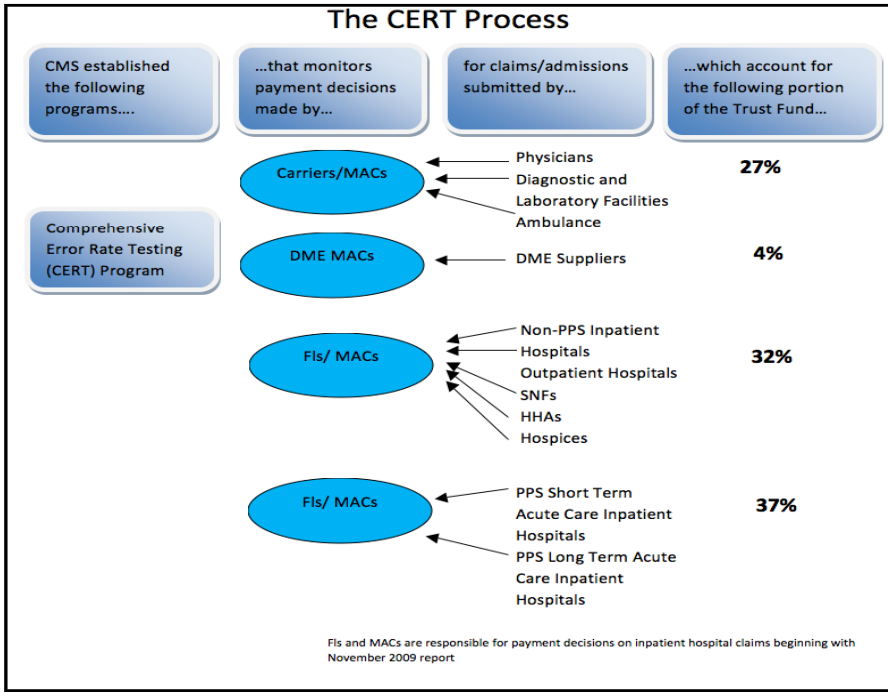
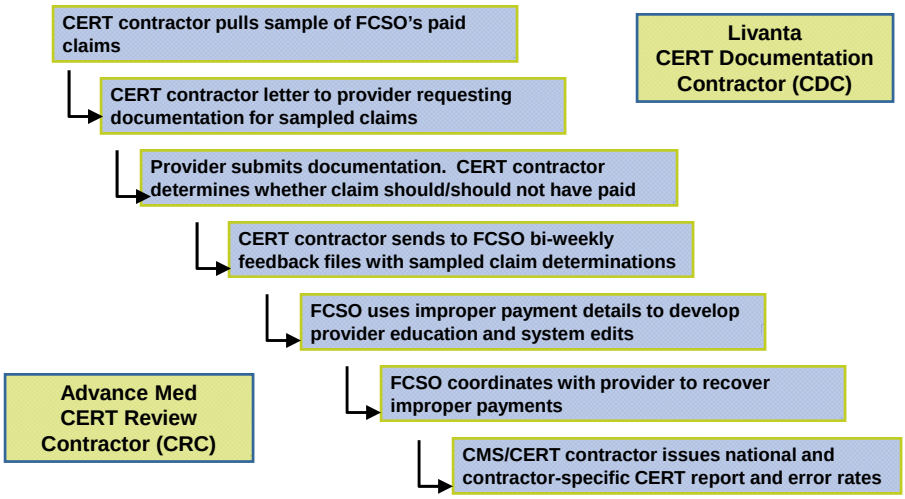
WHEN EXPERIENCE COUNTS & QUALITY MATTERS



CERT Process



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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Increased Error Rates

- Modifications to the review process by OIG and CMS advisory medical staff
  - Records from the treating physician not submitted or incomplete
  - Missing evidence of the treating physician's intent to order diagnostic tests
  - Medical records from the treating physician did not substantiate what was billed
  - Missing or illegible signatures on medical record documentation

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Five Categories of Errors

No documentation	Provider fails to respond to request
Insufficient documentation	Medical documentation submitted does not include pertinent patient facts
Medically unnecessary service	Services billed not medically necessary
Incorrect coding	Medical documentation supports lower or higher code
Other	Service not rendered, duplicate payment error, not covered or unallowable service

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Responding to CERT Request

- No response to the request

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No Documentation

- To avoid “no documentation” denials, providers should
  - Ensure all contractors have a central contact person for each provider entity for all documentation requests
  - Provide exact documentation requested to support services billed
  - Ensure claims are submitted with correct dates of service
  - Provide information within specified time frames
  - Procure information from third party providers timely
  - Identify each contractor’s preferred method of submission

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Insufficient Documentation

- To avoid “insufficient documentation” denials, providers should
  - Ensure medical records are documented based on medical policy
  - Submit correct and complete set of documentation to support services billed
  - Procure any necessary information from third party providers
  - Ensure legible identity and professional credentials of all who contributed to service or medical record is clear
  - Ensure Medicare signature guidelines are followed

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Medically Unnecessary Services

- To avoid “medical necessity” denials, service should
  - Be provided according to Medicare coverage guidelines
  - Be appropriate in duration and frequency
  - Meet but not exceed patient’s medical need
  - Be non experimental or investigational
  - Be performed by qualified personnel in an appropriate setting
  - Be documented with all pertinent information

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Incorrect Coding

- To avoid “service incorrectly coded” denials, providers should
  - Review evaluation and management (E/M) guidelines
  - Refer to CPT and HCPCS manual to ensure you are billing appropriate code
  - Ensure work of every CPT and HCPCS code reported for payment has been performed and documented in record
  - Select ICD-9 code clearly matching patient’s condition
  - Clearly document reasons for use of modifiers

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CERT – Tips

- Provide CERT contractor with designated contact person
- Be familiar with the timeframe to respond to request
- Identify the acceptable method of submission for your documentation
- Review letter for specific direction on what records are being requested
- Include all pertinent information in support of the service in question that will help support claim or level of service billed
- Utilize the CERT Center resource page on the FCSO website for additional tools that will assist you

CMS - CERT Resources

- CERT overview webpage
  - http://www.cms.gov/CERT/01_overview.asp
- CERT reports webpage
  - http://www.cms.gov/CERT/CR/list.asp
- New CERT 101 PowerPoint presentation
  - https://www.cms.gov/CERT/Downloads/CERT_101.pdf
- Publication 100-08 Medicare Program Integrity Manual
  - Chapter 12 – Comprehensive Error Rate Testing

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Additional Resources

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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medicare.fcso.com

medicareespanol.fcso.com

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

FCSO Resources

- FCSO University
  - http://medicare.fcso.com/Online_learning/
- CERT Center
  - http://medicare.fcso.com/Landing/203608.asp
- Self-audit resources page
  - http://medicare.fcso.com/EM/index.asp
- Evaluation and management webpage
  - http://medicare.fcso.com/EM/index.asp
- LCD/Medical coverage webpage
  - http://medicare.fcso.com/Landing/139800.asp

Downloadable MLN Products

- How to Use The National Correct Coding Initiative (NCCI) Tools
- MLN Special Edition (SE1024) RAC Demonstration High-Risk Vulnerabilities – No documentation or Insufficient Documentation Submitted
- Comprehensive Error Rate Testing (CERT) Evaluation and Management (E/M) Services: Overview Fact Sheet
- Comprehensive Error Rate Testing (CERT) Signature Requirements Fact Sheet
- Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC booklet

Question & Answer Session

- What questions do you have?

Summary of Today's Session

Today we have

- Identified the mission and goals of the current Administration to reduce payment errors in the Medicare program
- Discussed the five Medicare claim review programs
- Evaluated system edit resources to help you reduce claim payment errors
- Discussed what contractors review your claims/records
- Reviewed tips and tools to be proactive in your practice/facility
- Identified additional resources to assist you with all the above

Thank You for Participating

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- FCSO values your feedback
  - It is important that you complete the evaluation form and return it before leaving the class

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