MAYNARD NEXSEN

Preparing For and Defending Against Payor Audits: Tips and Strategies to Increase Success

South Carolina SCHFMA Fall Conference

Presented by Matthew B. Roberts and Alice V. Harris

October 26, 2023

Today's Agenda

- **Who is Auditing**
- **How to Find Current Audit Topics**
- **Life of an Audit: Practical Tips**
  - Ensuring Timely Receipt and Review
  - Producing the Medical Record
- **Defending an Audit**
  - Building a Response Team
  - Strengthening the Medical Expert Report
  - Adding Legal Arguments
- **Tips to Prevent Audits**

Who is Auditing Healthcare Claims?

- Office of the Inspector General for Department of Health and Human Services ("**OIG**")
- Medicare and Medicaid Recovery Auditor Contractors ("**RACs**")
- Supplemental Medical Review Contractor ("**SMRC**")
- CMS Targeted Probe and Educate ("**TPE**")
- Post-Payment Medical Review by **MAC**
- Uniform Program Integrity Contractor ("**UPIC**")
- Commercial and Managed Care Auditors
- Prosecutors

Federal HHS OIG

- **U.S. Department of Health and Human Services - Office of the Inspector General**
  - Largest IG in the federal government with 1,650 personnel
  - Established in 1996

- **Tasked with combatting fraud, waste, and abuse and improving efficiency in the federal health care programs**
  - Conducts and supervises audits and investigations
  - Identifies systemic weaknesses
  - Leads and coordinates activities to prevent and detect fraud & abuse

https://oig.hhs.gov/about-oig/

How to Identify OIG Audit Topics

- **Work Plan**
  - Sets forth projects including OIG audits and evaluations that are underway or planned
  - Conducted by OIG's Office of Audit Services and Office of Evaluation and Inspections
  - Projects include:
    - Centers for Medicare & Medicaid Services (CMS)
    - Public health agencies such as the Centers for Disease Control and Prevention (CDC)
    - National Institutes of Health (NIH)
    - Administration for Children and Families (ACF) and the Administration on Community Living (ACL)
  - OIG also plans work related to issues involving departmental programs, including State and local governments' use of Federal funds, as well as the functional areas of the Office of the Secretary of Health & Human Services (HHS)

- **Work Plan which is updated monthly and is searchable**
  - https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp

Example Active OIG Work Plan Items

- **"Audit of Health Centers' Use of COVID-19 Supplemental Grant Funding and Reimbursement From the HRSA COVID-19 Uninsured Program"**
  - Extent to which health centers improperly charged COVID-19 supplement grant funding or submitted claims for costs covered by HRSA Uninsured Program (UIP)

- **"Audit of Selected, High-Risk Medicare Hospice General Inpatient Services"**
  - GIP care - This audit focuses on claims for enrollees who were transferred to GIP care immediately after an inpatient hospital stay and exceed expected length of stay. These hospice GIP claims are at high risk for inappropriate billing because GIP care may exceed an enrollee's needs or may not be provided.

- **"Opioid Use in Medicare Part D in 2022: Annual Review"**
  - Identifying patients at risk for overdoses or abuse is key to addressing the opioid crisis. It provides 2022 data on the number of enrollees who received extreme amounts of opioids through Part D, identifies prescribers who ordered opioids for large numbers of these enrollees, provides data on the number of enrollees who received drugs to treat opioid use disorder, the number of enrollees who experienced an opioid overdose, and the number of enrollees who received opioid overdose-reversal drugs.

Who is Auditing Healthcare Claims?

- Federal Contractors – Types of Reviews

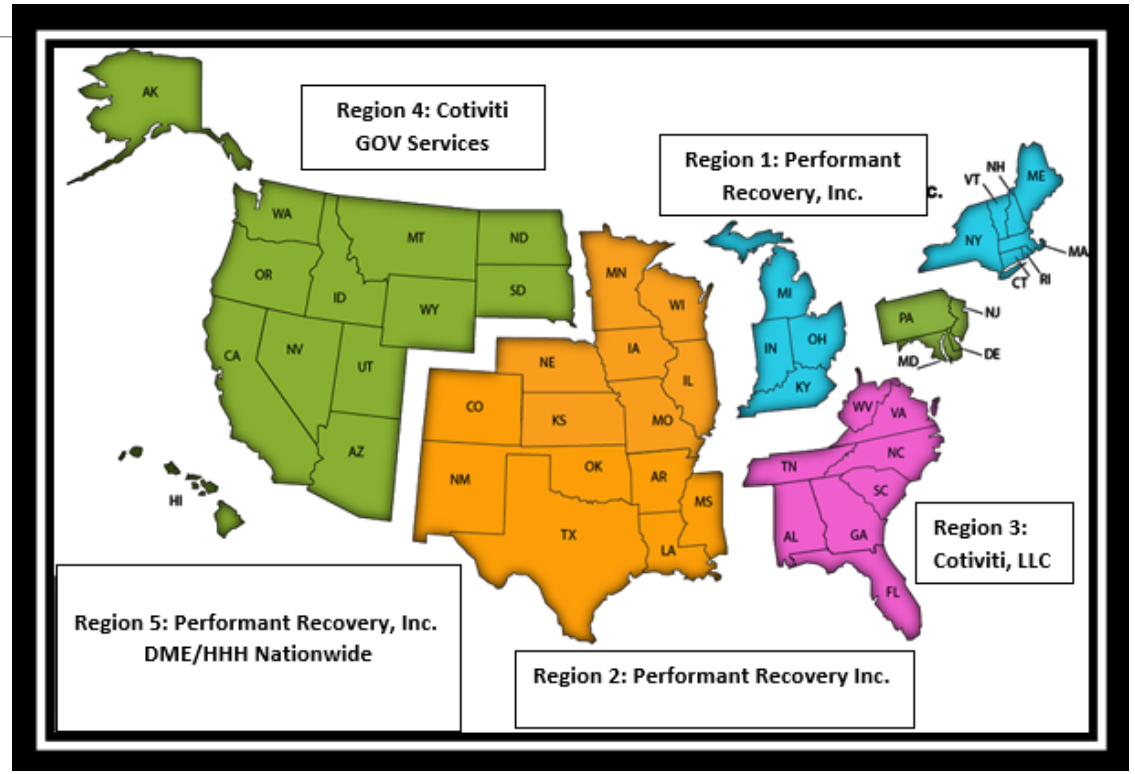
Prepayment				Postpayment	
Contractor Type	Medical Record Review	Non-Medical Record Review	Automated Reviews	Medical Record Review	Non-Medical Record review
MACs	Yes	Yes	Yes	Yes	Yes
CERT	No	No	No	Yes	No
RACs	No	No	No	Yes	No
SMRC	No	No	No	Yes	Yes
UPIC	Yes	No	No	Yes	Yes

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf

Medicare RACs

- **CMS contractors who are incentivized to detect improper payments via post-payment reviews**

- **For Part A and Part B claims, the RAC is determined by state**
  - Performant Recovery, Inc. – Region 1 &3
  - Cotiviti, LLC – Region 3
  - Cotivit Gov Services – Region 4



- **One DME/HHH RAC - Performant Recovery, Inc.**
  - **DME includes:**
    - ✓Durable Medical Equipment
    - ✓Prosthetics, Orthotics, and Supplies
    - ✓Home Health/Hospice

https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medicare-fee-service-recovery-audit-program

How to Identify Medicare RAC Audit Topics

- **Cotiviti, LLC – Covers South Carolina**

- **May 23, 2023 – RAC returned to normal Medicare Fee-For-Service medical review activities**

- **Examples**
  - 0219 - **Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac Joint**: Medical Necessity and Documentation Requirements
    - Outpatient Hospital, Ambulatory Surgery Center (ASC), and Professional Services (Physician/Non-Physician Practitioner)
  - 0217 - **Muscle Flap with Breast Reconstruction or Breast Prosthesis Insertion: Unbundling** Documentation will be reviewed to determine if CPT code 15734 warranted separate reimbursement given that a flap is considered inclusive to breast reconstruction (19357-19364, 19367-19369) or breast prosthesis (19340, 19342).
    - Physician/Non-physician Practitioner (NPP)
  - 0207 - **Spinal Cord Stimulation**: Medical Necessity and Documentation Requirements
    - Outpatient Hospital; Ambulatory Surgical Center (ASC); Professional Services (Physician/Non-Physician Practitioners)
  - 0205 - **Next Generation Sequencing**: Medical Necessity and Documentation Requirements
    - Laboratory Services
    - https://www.cotiviti.com/cms-approved-issues-cotiviti - searchable by claim type

How to Identify Medicare RAC Audit Topics

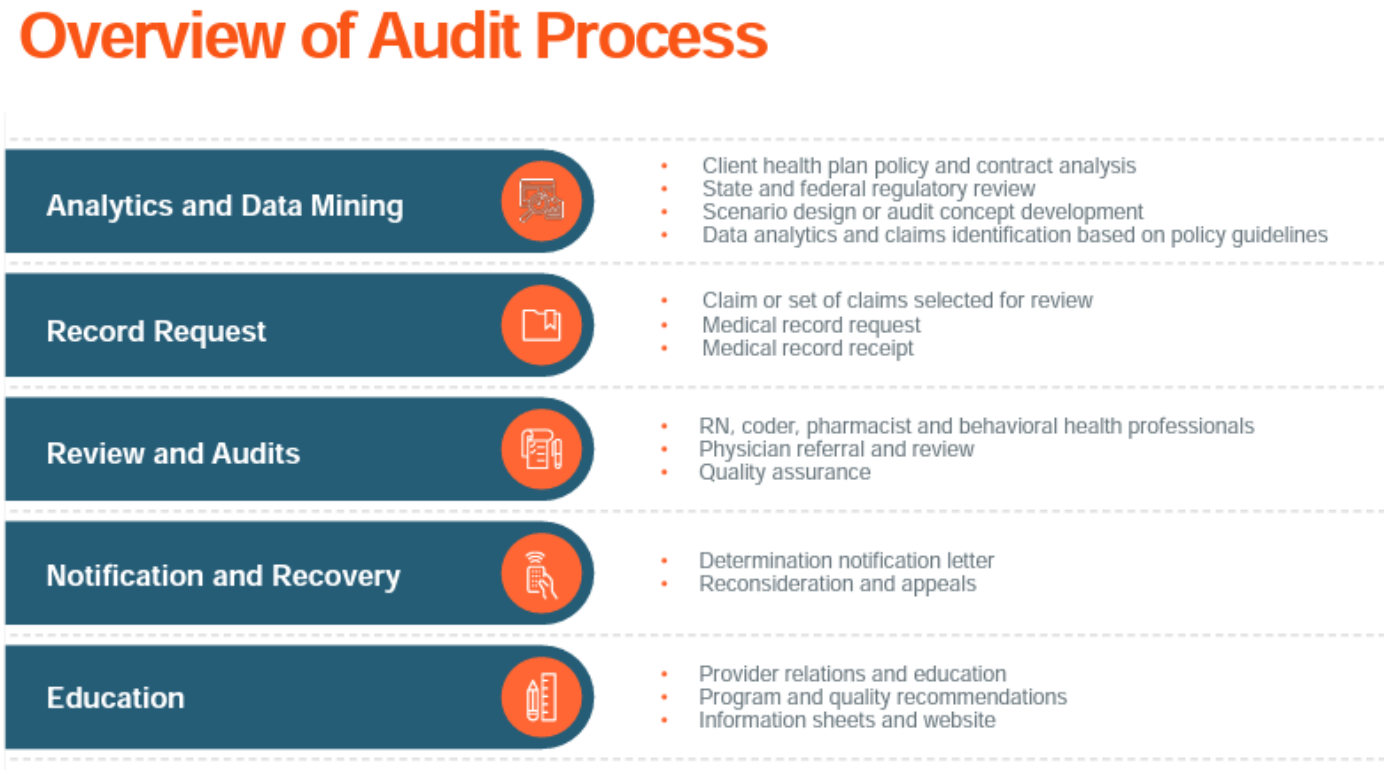
Performant Recovery, Inc. – Nationwide

Example Issues

- **Hip Orthoses** within the Reasonable Useful Lifetime: Excessive Units
- **Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac Joint**: Medical Necessity and Documentation Requirements
- **Medical Supplies Billed from Consolidated Billing List During a Home Health Episode**: Unbundling
- **Muscle Flap with Breast Reconstruction or Breast Prosthesis Insertion**: Unbundling
- **Wearable Automatic External Defibrillators**: Medical Necessity and Documentation Requirements
  - https://www.performantcorp.com/cms-rac/cms-rac-resources/cms-approved-audit-issues/
  - All links are searchable by claim type

Medicaid RACs

- SCDHHS RAC is Health Management Systems (HMS)



https://www.scdhhs.gov/sites/default/files/ProviderOutreachandEducation_POS_%20SC%20RAC_04062021_FINAL.pdf

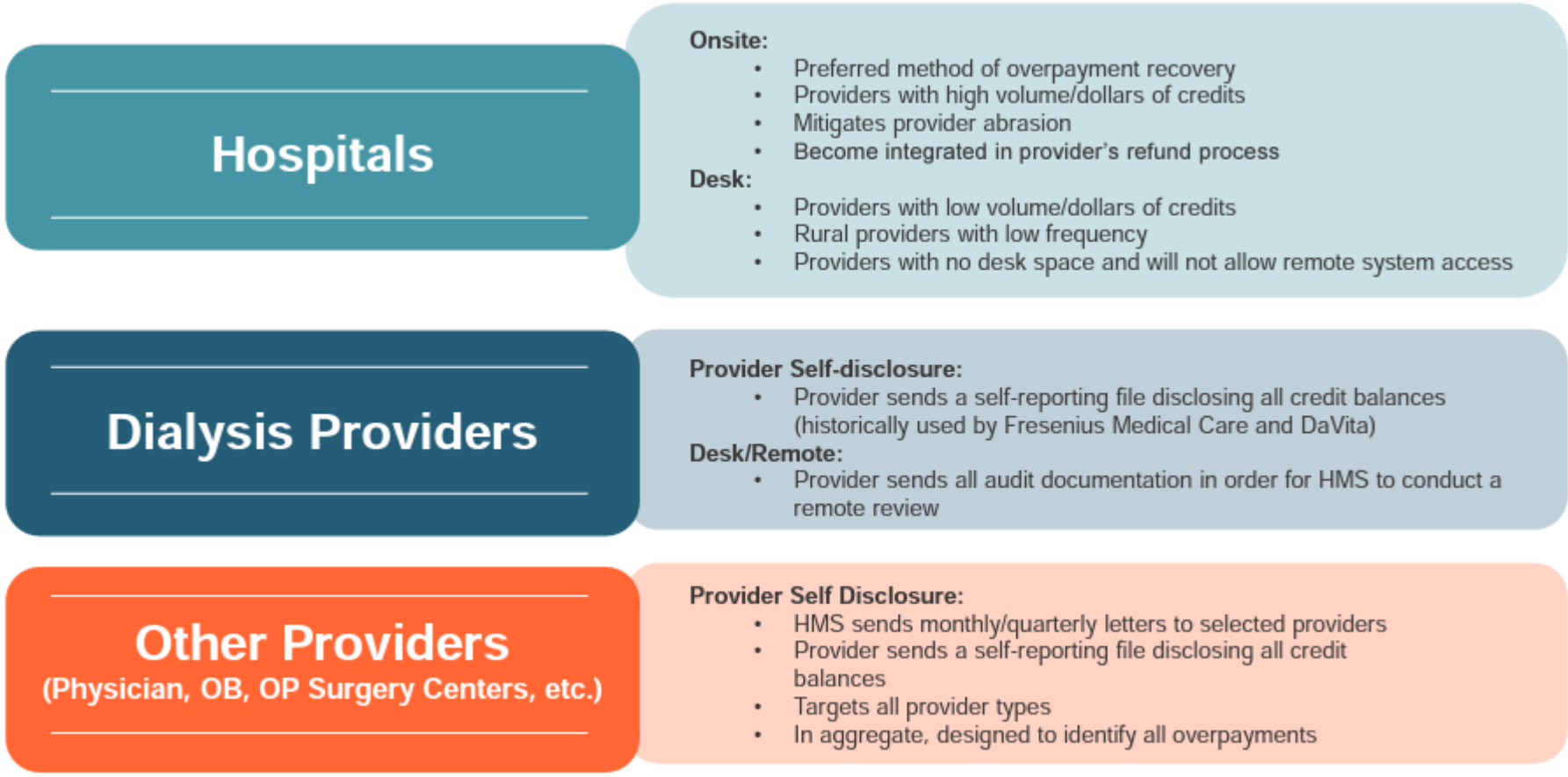
Medicaid RACs

- **SCDHHS RAC is Health Management Systems (HMS)**

- **Projects include:**
  - **Place of Service Review:** Verifies that the place of service billed was consistent with the patient's condition and the care and services provided, as well as the documentation in the medical record
  - https://www.scdhhs.gov/sites/default/files/HMS%20RAC%20-%20Place%20of%20Service%20Review%20Information%20Sheet%20-%20Final.pdf
  - **DRG Validation Review:** Reviews targeted DRG claims to verify that all diagnoses and procedure codes were billed appropriately
  - https://www.scdhhs.gov/sites/default/files/HMS%20RAC%20-%20DRG%20Validation%20Review%20Information%20Sheet%20-%20Final.pdf

Medicaid RACs: SC HMS Credit Balance Audits

Providers and Audit Types



https://www.scdhhs.gov/sites/default/files/ProviderOutreachandEducation_POS_%20SC%20RAC_04062021_FINAL.pdf

Medicaid RACs: SC HMS Credit Balance Audits

Process Flow High Level Overview

- Notification Letters are mailed to Providers requesting Credit Balance (ATB) and Debit Reports, where applicable, on the agreed upon mailing frequency
  - Based on volume of accounts reported, the review is conducted either onsite or remote "desk" audit
  - Some Providers allow onsite Day 1 review; others allow remote access
- During the audit, the PSA performs an analysis of the financial records in or to determine if an overpayment exists. For all refunds found, the PSA:
  - Enters claims into our Internal Platform, InVision
  - Obtains all required supporting backup documents
  - Reviews findings with Provider, providing Root Cause Analysis
  - Obtains sign-off approval from Provider
  - Coordinates repayment to client with Provider
- PSA look for trends during reviews for data mining opportunities

https://www.scdhns.gov/sites/default/files/ProviderOutreachandEducation_POS_%20SC%20RAC_04062021_FINAL.pdf

Supplemental Medical Review Contractors (SMRC)

- **Medicare SMRC - Noridian Healthcare Solutions**

  - **Conducts Nationwide medical reviews of Medicare Part A/B and DME claims** to determine whether the claims have been compliantly billed
  - Reviews are assigned through CMS formal notifications and focus on national claims data issues identified by federal agencies, such as OIG, GAO, CERT programs, etc.
    - **Can extrapolate**
    - Even if not extrapolated, number of claims and related amounts may be high
    - Appeals process is the same as the CMS Administrative Appeal Process

https://noridiansmrc.com/

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

Supplemental Medical Review Contractors (SMRC)

Current Projects

- Carotid Artery Screening/Testing
- Dental Bone Grafting
- Hyperbaric Oxygen of Lower Extremities Diabetic Wounds
- IRF (Inpatient Rehab Facility)
- Home Health PDGM (Patient-Driven Groupings Model)
- OIG Facet Joint Denervation
- SNF PDPM (Patient Driven Payment Model)
- Cryosurgery of the Prostrate
- Mohs Surgery
- Select Carotid Artery Screening
- Hospice 90 Day Stay
- Echocardiography Select Code
- OIG Psychotherapy Services
- OIG Genetic Testing
- Lumbar-Sacral Orthoses
- CAA Telehealth Services

https://noridiansmrc.com/current-projects/

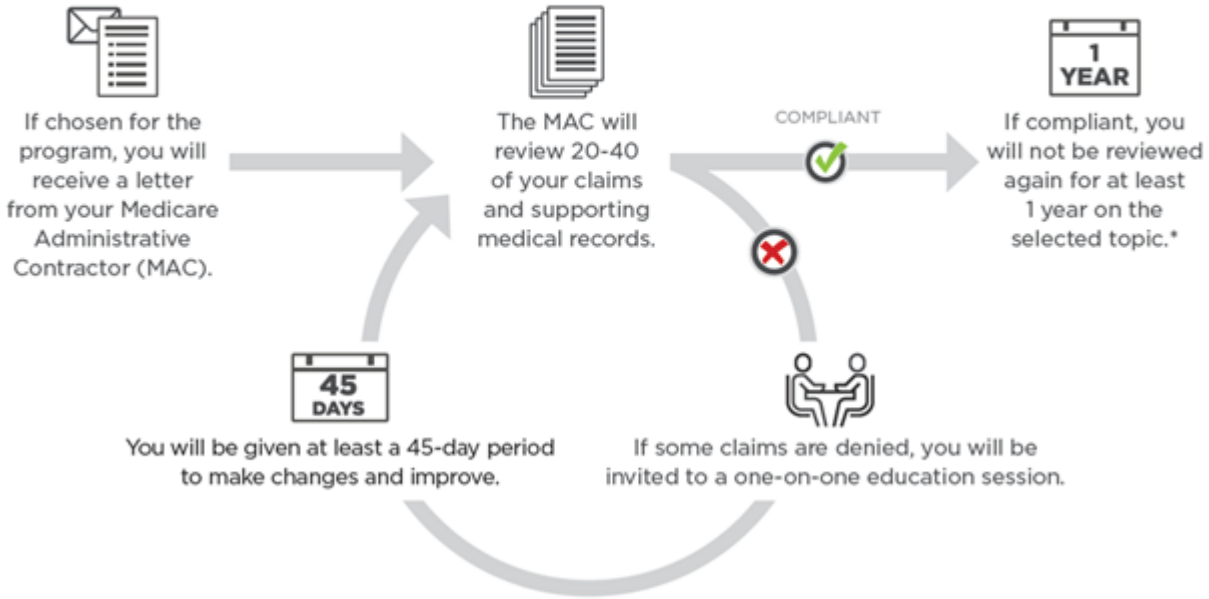
CMS Targeted Probe and Educate ("TPE")

- **CMS Program**
- **Designed to help providers and suppliers reduce claim denials and appeals through one-on-one help**
- **MACs use data analysis to identify:**
  - Providers and suppliers who have high claim error rates or unusual billing practices
  - Items and services that have high national error rates and are a financial risk to Medicare
  - MACs work with providers to conduct audits and help providers correct errors
- **Common issues:**

https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/targeted-probe-and-educate-tpe

CMS Targeted Probe and Educate ("TPE")

How does it work?



**MACs may conduct additional review if significant changes in provider billing are detected*

CMS Targeted Probe and Educate ("TPE")

- **IF found compliant before three rounds of education are completed, the provider will not be audited on same topic for a year**

- **IF not compliant after 3 audits, provider is referred to CMS:**
  - 100 percent prepay review
  - Extrapolation
  - Referral to a Recovery Auditor
  - **Or "other action"**

https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/targeted-probe-and-educate-tpe

CMS Targeted Probe and Educate ("TPE")

PALMETTO GBA
A CELERIAN GROUP COMPANY

Jurisdiction M Part B

- **Current TPE Audit Topics can be found on the MAC websites**
- **Palmetto GBA Jurisdiction M Part B (includes SC) Audit Topic Examples:**
  - Home Health and Hospice Medical Review
  - Pre-Payment Review for Surgical Debridement
  - Postpayment Review for Presumptive Drug Testing
  - Pre-Payment Review for Echocardiography with Contrast
  - Pre-Payment Review for Monthly Outpatient End-Stage Renal Disease
  - Pre-Payment Review for Therapeutic Exercises

https://www.palmettogba.com/palmetto/jmb.nsf/DID/ATZP575724

CMS Targeted Probe and Educate ("TPE")

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Jurisdiction M Part A

- **Current TPE Audit Topics can be found on the MAC websites**
- **Palmetto GBA Jurisdiction M Part A (includes SC) Audit Topic Examples:**
  - Home Health and Hospice Medical Review
  - Pre-Payment Review for Therapeutic Exercise
  - Pre-Payment Review for Skilled Nursing Facilities
  - Pre-Payment Review for Manual Therapy
  - Pre-Payment Review for Inpatient Rehab Facilities
  - Pre-Payment Review for Remicade
  - Pre-Payment Review for IRF Stroke

https://www.palmettogba.com/palmetto/jma.nsf/DID/ATZP3S5504

NATIONWIDE SKILLED NURSING FACILITY TPE

- **The Comprehensive Error Rate Testing Program (CERT) identified an improper payment rate of 15.1 percent for SNF services in 2022 (up 7.79% in 2021)**
- Increase in overpayments may be due to change from the Resource Utilization Group (RUG IV) to the Patient Driven Payment Model (PDPM) for dates of service after October 1, 2019. CMS is using this audit to identify and educate SNFs on misunderstandings in billing under the PDPM.
- As part of the effort to lower the SNF improper payment rate, **MACs will be reviewing 5 claims from every Medicare-billing SNF in the country** (submitted after 10/1/19).
- Instead of the 1-3 rounds of review a provider receives through TPE, each SNF will undergo only 1 round of review
- Claims containing COVID-19 diagnosis will be excluded

https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/skilled-nursing-facility-5-claim-probe-and-educate-review

Medicare Administrative Contractor (MAC) Post-Payment Medical Reviews

- The MAC conducts medical review activities to identify inappropriate payments
  - Medical review is the collection of information and clinical review of medical records to ensure that payment is made only for services that meet all Medicare coverage, coding and medical necessity requirements
- **Medical review activities begin by the MAC's identification of potential billing errors through data analysis and/or complaints**

Palmetto GBA Post-Payment Medical Reviews

- Jurisdiction M Part A (includes South Carolina)
- **Includes TPEs and other Audits, including:**
  - Medicare Medical Records: Signature Requirements
  - Reason Code 5D505: Certification Not Valid
  - Expedited Review of Prior Authorization
  - Facet Joint Interventions for Pain Management
  - Blepharoplasty and Medical Necessity

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Jurisdiction M Part A

https://www.palmettogba.com/palmetto/jma.nsf/DID/9G7MNM1328

Unified Program Integrity Contractor

- UPICs perform **fraud, waste, and abuse** detection, deterrence and prevention activities for **Medicare and Medicaid claims** processed in the United States
- Specifically, the UPIC's perform integrity related activities associated with the following:
  - Medicare Part A,
  - Medicare Part B,
  - Durable Medical Equipment (DME),
  - Home Health and Hospice (HH+H), Medicaid, and
  - The Medicare-Medicaid data match program (Medi-Medi).

https://www.cms.gov/node/1243226

Unified Program Integrity Contractor

- **UPICs Activities include:**
  - **Investigate potential fraud and abuse** for CMS administrative action or referral to law enforcement
  - **Conduct investigations** in accordance with the priorities established by CPI's Fraud Prevention System
  - **Perform medical review**, as appropriate
  - **Perform data analysis** in coordination with CPI's Fraud Prevention System, IDR and OnePI;
  - **Share information** (e.g. leads, vulnerabilities, concepts, approaches) with other UPICs/ZPICs to promote the goals of the program and the efficiency of operations at other contracts
  - **Refer cases to law enforcement to consider civil or criminal prosecution**

Unified Program Integrity Contractor

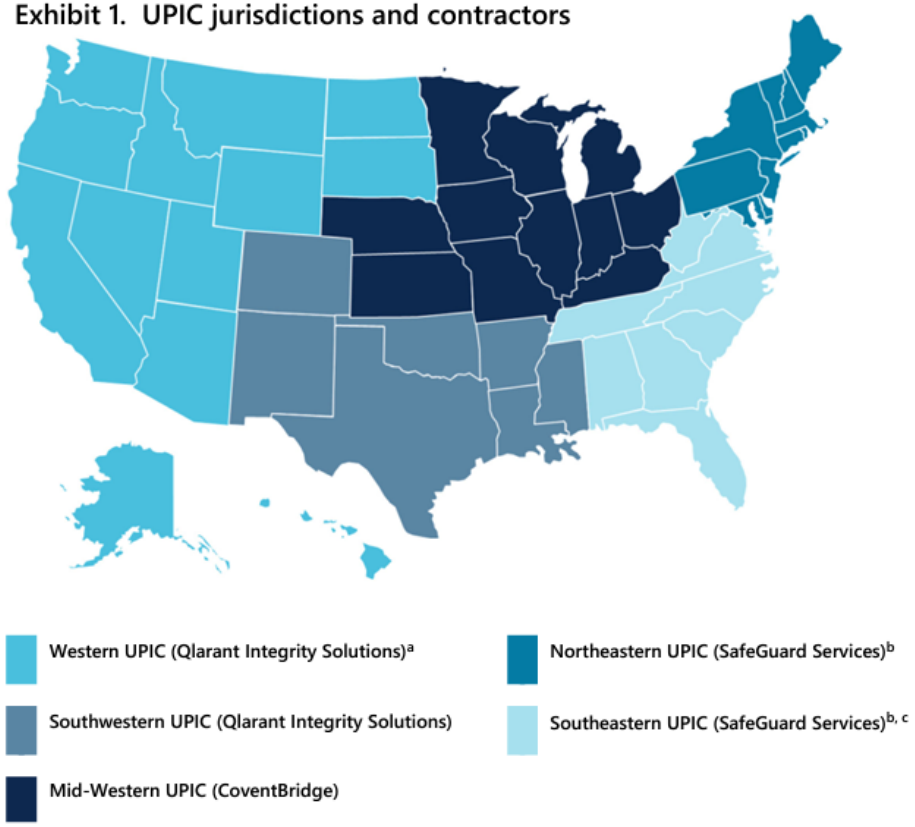
- **UPICs Activities include:**
  - **Conduct interviews** with beneficiaries, complainants, or providers
  - Conduct site verification
  - **Conduct an onsite visit**
  - Identify the need for **administrative actions** such as **payment suspensions, prepayment or auto-denial edits, revocations, post-pay overpayment determination**
  - **Extrapolate overpayments**

Five UPIC Contractors by Jurisdiction

South Carolina UPIC

Unified Program Integrity Contractors (UPICs)	**SE UPIC** SafeGuard Services (SGS) http://www.safeguard-servicesllc.com Mailing Address: SGS Suite 201 3450 Lakeside Drive Miramar, FL 33027 (954) 988-2851 SGS Accepts esMD transactions

Exhibit 1. UPIC jurisdictions and contractors



South Carolina UPIC

- **Safeguard Services - Common Issues Examined**
  - The acceptance or offering of “Kickbacks”
  - The routine waiver of co-payments
  - Falsifying certificates of medical necessity, plans of care and other records
  - Billing for services not rendered
  - Misrepresenting the diagnosis to justify payment
  - Beneficiaries sharing Medicare cards are just some of the more common schemes

https://www.safeguard-servicesllc.com/Home/faq

Commercial and Managed Care

- Standard for **Commercial Payors** to reserve right to conduct audits in provider agreement
- Example: BCBS Healthy Blue –
  - "The submission of a clean claim should not be misconstrued as being a proper claim for payment. Audits (pre and post payment) can occur by different departments for which a repayment may be requested"
  - "At any time, a request may be made for on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews"

https://provider.healthybluesc.com/docs/gpp/SCHB_CAID_ProviderManual.pdf?v=202101291853b

Life of an Audit: Practical Tips

- Ensuring Timely Receipt of an Audit Request
- Producing the Medical Record
- Defending an Overpayment

Ensuring Timely Receipt and Proper Review of the Audit Request

- ***Where*** are Requests arriving?
  - Consistent address?
  - Update address changes?
  - Timely handling?
  - *The case of the mishandled requests*
    - *Many hands*
    - *Color confusion*

Ensuring Timely Receipt and Proper Review of the Audit Request

- ***Who*** is it from?
  - Federal or State Healthcare Program?
  - Federal or State Healthcare Program Contractor?
  - Federal or State Managed Care?
  - Commercial payor?
  - Prosecutor?
- ***Who*** should it go to?

Ensuring Timely Receipt and Proper Review of the Audit Request

- ***When** is the deadline*?
  - Does the deadline fall on a weekend or holiday?
  - What needs to be produced?
    - Medical records
    - Provider credentials
    - State licensure
    - Corporate documents
  - **Understand the consequences of not producing**
    - Lose appeal rights
    - Overpayments/Recoupment

Ensuring Timely Receipt and Proper Review of the Audit Request

- ***What*** does it mean?
  - Tied to ***Which Auditor?***
  - Limited claims and exposure?
    - Routine audit / auditor
    - Limited number of claims
  - Extrapolation?
  - Potential payment suspension?
  - Fraud & Abuse?
    - Damages
    - Penalties
    - Criminal prosecution

Producing the Medical Record

- Ensure the production is **complete**
  - Make sure all records are included
    - From all systems
    - Is there paper in addition to electronic?
    - Laboratory Tests /DME /Prescription/Medication Referrals/Consultation Reports
    - Certifications, attestations, patient consents, etc.

Producing the Medical Record

- Does the audit request ask for **other documentation or information** besides medical records?
  - Provider credentials
  - State licenses
  - Supervision Agreements
    - Prepare this information completely and in a legible manner
- **Do not alter the medical record**
  - An addendum with the present date might be appropriate
- **Produce records by the deadline** unless you can get an extension

Producing the Medical Record

- **Analyze the records produced as quickly as possible**
- **Do your records support the claims billed?**
  - If Yes
    - Vigorously defend and appeal
  - If No
    - Can it be cured by a supplemental production?
  - If No
    - What caused the problem?
    - Corrective actions
      - Overpayment refunds
      - Are additional reviews needed?
      - Education
      - Systemic fixes
      - Disciplinary actions

Defending an Overpayment

- Building an Audit Response Team
- Medical Expert Reports
- Legal Arguments

Building an Audit Response Team

- Members and their roles
  - Clinicians
  - Administration
  - Provider Support
  - Attorneys
  - Experts
    - Medical necessity
    - Statistician

Building an Audit Response Team

- **Internal Expert (Medical Director/Providers Involved in Care) vs. External Expert**
  - Cost
  - Time away from clinical duties
  - Credentials of person who issued denials
  - Amount at stake
  - Complexity of issues
  - Level of appeal

Ways to Strengthen Medical Expert Reports

- **What is a template? Why use a template?**
- **How to structure the template?**
  - Paint the picture of the patient's condition during the dates of service at issue
  - Address the denial reasons raised by the contractor
  - Bate stamp records and cite to specific pages in the medical record for support
  - Understand any LCDs that are applicable and show that they were met
  - If needed, explain why LCD is not applicable
  - Highlight the medically necessary services provided even if technical requirements were not met
  - Add support for legal arguments

Legal Arguments

- Peer-reviewed studies and articles
- Statutory and Regulatory Framework
- Payor Manuals, Policies, etc.
- Technical denials
- Challenging statistical extrapolation

Legal Arguments

- **Case law**
  - **Value of the practitioner who saw the patient vs retrospective review**
    - Can you present viewpoint of practitioner who knew the patient?
    - Or does documentation support argument?
  - **Denials based on beneficiary stabilization or lack of suffering**
    - In certain settings, stabilization for a period signals quality of care not lack of qualification for services
  - **Custodial vs. skilled care**
    - An expert may also help to explain why the services were skilled

Legal Arguments

- **Case law**
  - ***Escobar:*** **Fair value for value received**
    - Helps with technical denials
  - ***Escobar:*** **Materiality**
    - Was the error **material** to the payment
  - Arguing for **offsets**
    - Even if there is a technical error or downcoding should retain value for services rendered

Tips for Preventing Audits

- **Compliance and/or Revenue Cycle**
  - Stay updated on current payor coding and documentation requirements
  - Stay updated on current audit topics
  - Monitor contractor and auditing activities
  - Conduct routine internal/external audits of your providers' billing and documentation even if you use a billing company
  - Use CAPs, Peer to Peer, etc. if needed to address issues
- **What does your denial rate look like?**
- **Do you understand time-based codes and are you properly documenting time-based codes?**

Tips for Preventing Audits

- **Understand how you or your providers compare** in each specialty
  - Run internal reports or gather data from groups like MGMA or AHIMA
  - If outlier, why?
- **Constantly educate** providers and staff – onboarding, annually, as needed, for important updates
- **Keep up with your EMR**
  - Is it provider friendly?
  - Is it up to date?
  - Do copies of the electronic records reflect the work performed?

Tips for Preventing Audits

- **As you audit, how does the documentation look?**
- **Does it support the services rendered?**
  - Is it easy to read and interpret?
  - Is template use appropriate?
  - Is the template being modified to reflect the patient each time?
  - Does it instead look copy and pasted or cloned?
  - The case of the “minor”

Questions?

Matthew B. Roberts
Shareholder | Health Care & Life Sciences
P: (803) 253-8286
MRoberts@maynardnexsen.com

1230 Main Street
Suite 700
Columbia, South Carolina 29201

Alice V. Harris
Shareholder | Health Care & Life Sciences
P: (803) 253-8284
AHarris@maynardnexsen.com

1230 Main Street
Suite 700
Columbia, South Carolina 29201