Medicare Audits
An overview of auditing contractors

May 2018
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This presentation may not be recorded for any reason.
Agenda

- Background & Foundation of Auditing Entities
- Medicare Administrative Contractors (MACs)
- Unified/Zone Program Integrity Contractors (UPICs and ZPICs)
- Supplemental Medical Review Contractor (SMRC)
- Comprehensive Error Rate Testing (CERT)
- Recovery Audit Contractor (RAC)
- Office of Inspector General (OIG)
- Audit Response Strategy
- What To Do With Unfavorable Audit Decisions?
Background & Foundation of Auditing Entities
What are the Auditing Entities?

Medicare Auditing Entities are composed of six (6) different contractors:

1. MAC Medical Review
2. UPIC/ZPIC – Unified/Zone Program Integrity Contractor
3. SMRC – Supplemental Medical Review Contractor
4. CERT – Comprehensive Error Rate Testing Contractor
5. RAC – Recovery Audit Contractor
6. OIG – Office of Inspector General
Purpose of Auditing Entities

- Auditing entities are established to reduce the improper payment rate of claims.

- The purpose of each auditing entity is to detect and correct improper payments so that CMS, Carriers, Fiscal Intermediaries and Medicare Administrative Contractors (commonly referred to as MACs) can implement actions that will prevent future improper payments.
  - Audit claims to ensure suppliers submit claims that comply with Medicare guidelines
  - Protect the Medicare Trust Fund
Benefits of Auditing Entities

What are some of the benefits of having Auditing Entities?

- **Suppliers:** Dollars will be repaid to health care suppliers when audits reveal underpayments; money can be overturned on appeal.

- **CMS:** For CMS, audits can lower its error rate.

- **Taxpayers:** Taxpayers and future Medicare beneficiaries are protected when Medicare payments are returned to the Medicare Trust Fund.
Medicare Administrative Contractors (MACs)
CMS encourages the MACs to conduct error validation reviews on a prepayment basis in order to help prevent improper payments (e.g., non-covered, incorrectly coded or incorrectly billed services) through data analysis.

The MAC Medical Review department consists of a Medical Director, registered nurses and other clinicians, and specially trained support staff.

The Medical Review Department of the MAC is one of the departments involved with preventing the initial payment of claims that do not comply with Medicare's coverage, coding, payment and billing policies.
Medicare Administrative Contractors (MACs)

- The **goal** of the MAC is to process claims.
- MACs identify supplier noncompliance with coverage, coding, billing, and payment policies through analysis of data.
- Takes action to prevent and/or address the identified improper payment.
Targeted Probe and Educate (TPE)

- Goal is to improve claims payment error rate
  - Reduce volume of appeals
- Existing data analysis determines suppliers to review
  - Claims with greatest financial risk
  - High error rates that vary from peers
- Written notification sent to suppliers
- Review of 20-40 claims
- One on one education to address errors
- Up to three rounds of probe reviews
Unified/Zone Program Integrity Contractors (UPICs and ZPICs)
Breakdown of UPIC Locations

UPIC Jurisdictions

- **Western**
- **North-Eastern**
- **Mid-Western**
- **South-Western**
- **South-Eastern**

* North-Eastern Jurisdiction includes Part B for counties of Arlington and Fairfax and the city of Alexandria in Virginia
* Other territories of the Western Jurisdiction include American Samoa, Northern Marianas Islands and Guam
## UPIC Location for Jurisdiction A

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<thead>
<tr>
<th>SafeGuard Services, LLC – UPIC NE</th>
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<td>▪ New Hampshire</td>
<td>▪ Counties of Arlington and Fairfax</td>
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<td>▪ New Jersey</td>
<td>▪ City of Alexandria in Virginia</td>
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# UPIC Locations for Jurisdiction D

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<td>Montana</td>
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<td>Nevada</td>
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<td>North Dakota</td>
<td>– Palau</td>
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<td>Oregon</td>
<td>– Marshall Islands</td>
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<td>South Dakota</td>
<td>– Federates States of Micronesia</td>
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## UPIC Locations for Jurisdiction D

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<tr>
<td>Iowa</td>
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<td>Missouri</td>
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<td>Nebraska</td>
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## UPIC & ZPIC Locations for Jurisdictions JB & JC

### *Qlarant – South-Western UPIC*
- Colorado
- New Mexico
- Oklahoma
- Texas
- Arkansas
- Louisiana
- Mississippi

* Transitioned to South-Western UPIC on 04/01/18

### *SafeGuard Services, LLC – Zone 7*
- Florida
- Puerto Rico
- Virgin Islands

* Transitions and merges with South-Eastern UPIC 06/01/18
# UPIC & ZPIC Locations for Jurisdictions JB & JC

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<th>*AdvanceMed – Zone 5</th>
<th>AdvanceMed – UPIC Midwestern</th>
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<td>▪ North Carolina</td>
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<td>▪ Tennessee</td>
<td>▪ <strong>Wisconsin</strong></td>
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<td>* Transitions to SafeGuard Services as South-Eastern UPIC effective 06/01/18</td>
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- West Virginia
- Virginia
- Virgin Islands
- **Arkansas, Mississippi & Louisiana moved to SW UPIC**

- **Transitions to SafeGuard Services as South-Eastern UPIC effective 06/01/18**
UPIC/ZPICs Websites

UPICs/ZPICs are responsible for ensuring the integrity of all Medicare-related claims under all lines of Medicare business

- Qlarant – (formerly Health Integrity, LLC), South-Western and Western UPICs
  - https://www.qlarant.com/
- AdvanceMed – Zone 5 and UPIC Mid-Western
- SafeGuard Services, LLC – Zone 7, North-Eastern and South-Eastern UPICs
  - https://www.safeguard-servicesllc.com
Unified/Zone Program Integrity Contractors (UPICs/ZPICs)

The primary goal of UPICs/ZPICs is to investigate instances of suspected fraud, waste, and abuse.

- Identify cases of suspected fraud, investigate them, and take action to ensure any inappropriate Medicare payments are recouped.
- Perform investigations that are unique and tailored to the specific circumstances and occur only in situations where there is potential fraud and take appropriate corrective actions.
Unified/Zone Program Integrity Contractors (UPICs/ZPICs)

### FRAUD

Fraud may include things such as:

- Billing for services not furnished
- Billing that appears to be deliberate for duplicate payment
- Altering claims or medical records to obtain a higher payment amount
- Billing non-covered or non-chargeable services as covered

### ABUSE

Abuse may include things such as:

- Misusing codes on a claim
- Charging excessively for services or supplies
- Billing for services that were not medically necessary
Supplemental Medical Review Contractor (SMRC)
Supplemental Medical Review Contractor (SMRC)

- The Supplemental Medical Review Contractor (SMRC) is the newest type of contractor that has an agreement with CMS to perform medical review activities.
  - StrategicHealthSolutions, LLC, a Supplemental Medical Review/Specialty Contractor (SMRC)
    - Mailing address: StrategicHealthSolutions, LLC
      4211 South 102nd Street
      Omaha, NE 68127
    - ATTN: Supplemental Medical Review Contract
    - Project ID: (i.e. Y1P1)
  - Telephone: 1.888.963.5527
  - Website: https://strategichs.com/smrc/
Supplemental Medical Review Contractor (SMRC)

- Their main focus is 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.
  - Determines if claims billed per Medicare coverage, coding, payment & billing regulations
  - Responsible for notifying CMS of any identified improper payments and noncompliance
  - Conducts nationwide medical reviews with documentation requests, as directed by CMS
  - [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/SMRC.html](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/SMRC.html)
Review Results

- SMRC allows 30 days following decision for a discussion period
- Unfavorable decision with no response is forwarded to the DME MAC
  - Overpayment demand letter issued by the DME MAC
- Supplier may appeal using the standard process
Comprehensive Error Rate Testing (CERT)
Comprehensive Error Rate Testing (CERT) Contractor

- CMS developed the CERT Program to produce a national Medicare FFS improper payment rate.

- CERT review professionals review the claim/s and the supporting documentation to determine whether the claim was paid appropriately according to Medicare coverage, coding, and billing rules.

- Goal: Collect documentation and perform reviews on a statistically valid random sample of Medicare FFS claims to produce an annual improper payment rate.
Decrease CERT Errors

- Educate staff
- Train coders/billers
- Submit correct information
  - Beneficiary name, HICN/MBI, date of service
- Submit legible and complete records
  - Dates, required signature, etc.
- Respond within the allotted timeframe
- Keep address information up-to-date
CERT Contact Information

- **AdvanceMed** is the CERT Documentation Center
- CERT Resources and Contacts
  - **Customer Service:** 1.443.663.2699 or 1.888.779.7477
  - **Fax:** 1.804.261.8100 or 1.443.663.2698
  - **E-mail:** certmail@admedcorp.com
  - **Website:** https://certprovider.admedcorp.com
Responding to a CERT Request

- There are five ways to respond to a request from the CERT contractor.
  
  - **Fax:** 1.804.261.8100 or 1.443.663.2698
  
  - **Mail:** CERT Documentation Center
    1510 East Parham Road
    Henrico, VA 23228
  
  - **esMD:** https://www.cms.gov/esMD
  
  - **Encrypted CD:** Must be in TIFF or PDF format
  
  - **Encrypted email:** Attachment must be in TIFF or PDF format
Responding to a CERT Request

Additional information on how to submit records to CERT can be found on the websites below:

- **CGS**
  - JB: [https://www.cgsmedicare.com/jb/claims/cert/updates.html](https://www.cgsmedicare.com/jb/claims/cert/updates.html)
  - JC: [https://www.cgsmedicare.com/jc/claims/cert/updates.html](https://www.cgsmedicare.com/jc/claims/cert/updates.html)

- **Noridian**
  - JA: [https://med.noridianmedicare.com/web/jadme/cert-reviews/cert;jsessionid=1E658033CB92D9406831679E61AC16F4](https://med.noridianmedicare.com/web/jadme/cert-reviews/cert;jsessionid=1E658033CB92D9406831679E61AC16F4)
  - JD: [https://med.noridianmedicare.com/web/jddme/cert-reviews/cert;jsessionid=1E658033CB92D9406831679E61AC16F4](https://med.noridianmedicare.com/web/jddme/cert-reviews/cert;jsessionid=1E658033CB92D9406831679E61AC16F4)
Recovery Auditing Contractor (RAC)
Recovery Audit Contractor

- **Recovery Audit Program**: This is a national Recovery Audit program.

- **Goal**: Recovery Auditors identify improper payments - Medicare overpayments and underpayments.

- In general, Recovery Auditors do not review a claim previously reviewed by another entity.

- **Mission**: The Recovery Audit Program’s mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to suppliers so that the CMS can implement actions that will prevent future improper payments in all 50 states.
Performant Recovery

Contact Information

- Toll free number: 1.866.201.0580
- Fax number: 1.325.224.6710
- Website address: https://www.performantrac.com
- E-mail address: info@performantRAC.com
- Hours of operation: 8:00 a.m. – 4:30 p.m. EST
- Mailing address: Performant Recovery, Inc. Records Department 2751 Southwest Boulevard San Angelo, TX 76904
RAC – Performant Recovery (Region 5)

Please see Performant’s website for a CURRENT list of approved issues: https://performantrac.com/audit-regions/region-5/
Recovery Audit Contractor

- The Medicare Fee For Service Recovery Audit program is a legislatively mandated program (Tax Relief and Health Care Act of 2006) that utilizes Recovery Auditors to identify improper payments paid by Medicare to fee-for-service suppliers;
- The Recovery Auditors identify the improper payments;
- The MACs adjust the claims, recoup identified overpayments and return underpayments.
- Recovery Auditors review Medicare FFS claims on a post-payment basis.
- CMS has limited the look-back period for RAC reviews to 3 years from the date the claim was paid.
Office of Inspector General (OIG)
Office of Inspector General (OIG)

- Established in 1976
  - Leads efforts to fight waste, fraud and abuse in Medicare, Medicaid and other programs

- Develops and distributes resources
  - Aimed at assisting the healthcare industry
    - Comply with fraud and abuse laws
    - Educate the public

- Reports to the Secretary and Congress
  - Program and management problems
  - Recommendations for correction
OIG Contact Information

- **Website:** [https://oig.hhs.gov/](https://oig.hhs.gov/)
- **To report potential fraud:** 1.800.HHS.TIPS (447-8477)
- **Mail address:** US Department of Health and Human Services
  Office of Inspector General
  ATTN: OIG HOTLINE OPERATIONS
  PO Box 23489
  Washington, DC 20026
Audit Response Strategy
Role of the Supplier

What can suppliers do to get ready?

- Have an audit response strategy.
  - This means having a thorough intake process in place. It begins with collecting and maintaining correct documentation.

- Maintain documentation on file for seven (7) years.

- Determine the root causes of denial problems or issues. This promotes compliance and identifies corrective actions needed.
Role of the Supplier

- Effectively track all claims submitted for payment to Medicare along with the corresponding claim decisions.
- Take corrective actions to track common errors and any possible trends.
- If you disagree with decisions, file an appeal.
- Respond to all Auditing Entities timely to avoid recoupment of funds.
How to Handle Additional Documentation Requests (ADRs)

- Obtain the requested documentation
  - Must be legible and signed
  - Must be current and pertain to code(s) being billed
  - Do not highlight information
  - If deadline missed, file a redetermination
  - Only send documentation once per ADR letter

- Respond within the timeframe specified
- Respond to the proper entity
What To Do With Unfavorable Audit Decisions?
Next Steps

- Contact the Review Entity with any questions regarding the decision

- If an overpayment was found, you will receive a demand letter after decision letter
  - Pay all debt within 30 days of date on demand letter to avoid interest charges

- If you disagree, file a redetermination within 120 of demand letter
  - Appeal within 30 days of date on demand letter to stop recoupment
  - Provide all documentation with appeals request

- If you agree to the post-pay unfavorable decision, submit payment or request immediate offset within 30 days of demand letter to avoid interest accruing
Questions?