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Aggressive Audits Are Here to Stay: Radiology Practices Must Proactively Prepare for New Enforcement Environment

A major government push to uncover reimbursement errors, fraud, waste and abuse across the Medicare and Medicaid programs continues to gain momentum. New audit initiatives aimed at reducing improper provider payments totaling about $24 billion annually are being rolled out nationwide.[1]

To meet this more rigorous enforcement climate, physician groups should begin taking steps today to fully understand the range of emerging federal and state programs. Procedures and safeguards must be created to identify compliance risk and limit practice exposure. Finally, practices should establish internal systems to respond promptly and appropriately if they're contacted by auditing agencies.

By taking a proactive stance, practices can reduce the likelihood of costly and disruptive compliance problems. They can also enjoy the peace of mind that comes with a rigorous and well-conceived approach to compliance.

The Centers for Medicare and Medicaid Services (CMS) has acknowledged that most improper Medicare payments are due to errors, omissions or negligence and are not the result of fraud and abuse.[2] For example, CMS indicates that inpatient hospital providers made up about 85% of RAC-collected overpayments in 2007. Approximately 42% of overpayments were coded incorrectly; 32% were deemed medically unnecessary or an incorrect service; 9% had insufficient documentation; and 17% were listed as other (see Figure1).[3]

Physicians, therefore, should not be overly concerned that improper payments will automatically result in civil sanctions or criminal prosecution. Nevertheless, the rapid expansion of federal and state healthcare enforcement programs means that many, if not most, practices can expect to face some form of reimbursement scrutiny in the months and years ahead.

Multiple Initiatives

Among the most visible and far-reaching of the CMS programs is the Medicare Recovery Audit Contractors Program (RAC), www.cms.hhs.gov/RAC/. RAC, which relies on third-party contractors to identify waste, errors and abuse, uncovered improper payments of more than $1 billion during a three-year pilot program.[4] The initiative was launched nationally in 2009 with four contractors:

- Diversified Collection Services, http://www.dcsrac.com (Region A: Maine, N.H., Vt., Mass., R.I., Conn. N.Y., N.J., Md., Del., Pa.)
- GCI, http://racb.cgi.com/Default.aspx (Region B: Ky., Ohio, Mich., Ind., Ill., Wis., Minn.)
- Connolly Consulting, http://www.connollyhealthcare.com/RAC/pages/cms_RAC_Program.aspx (Region C: Ala., Ark., Colo., Fla., Ga., La., Miss., N.C., N.M., Okla., S.C., Tenn., Texas, Va., W.Va.)
- HealthDataInsights, https://racinfo.healthdatainsights.com/home.aspx (Region D: Mo., Kan., La., Neb., S.D., N.D., Wyo., Mont., Idaho, Utah, Ariz., Nev., Calif., Ore., Wash., Alaska, Hawaii)

All of the contractors have now published their initial targeted measures but continue

to add new areas. Their Web sites should be regularly monitored as new measures will continue to be added.

Under the RAC program, analysis is conducted and corrective plans are developed to help prevent future payment errors. The tools used to help prevent improper Medicare claims include:

- Data analysis
- Provider education
- Automated prepayment review (auto-deny edits)
- Pre-payment review (medical record review before a claim is paid)
- Post-payment review (medical record review after a claim is paid)

While the RAC program is currently the primary enforcement focus for many provider organizations, it is by no means the only initiative under way. Other major audit programs include:

- **Error Rate Reduction Plan (ERRP):** ERRP detection and prevention components include review of medical records prior to payment by Medicare intermediaries.[5] http://www.cms.hhs.gov/manuals/downloads/pim83c12.pdf#10

- **Comprehensive Error Rate Testing (CERT):** CERT relies on periodic review of sample claims to extrapolate the total number of improperly coded claims. Like many of the CMS initiatives, CERT relies on an independent contractor.[6] http://www.cms.hhs.gov/CERT/

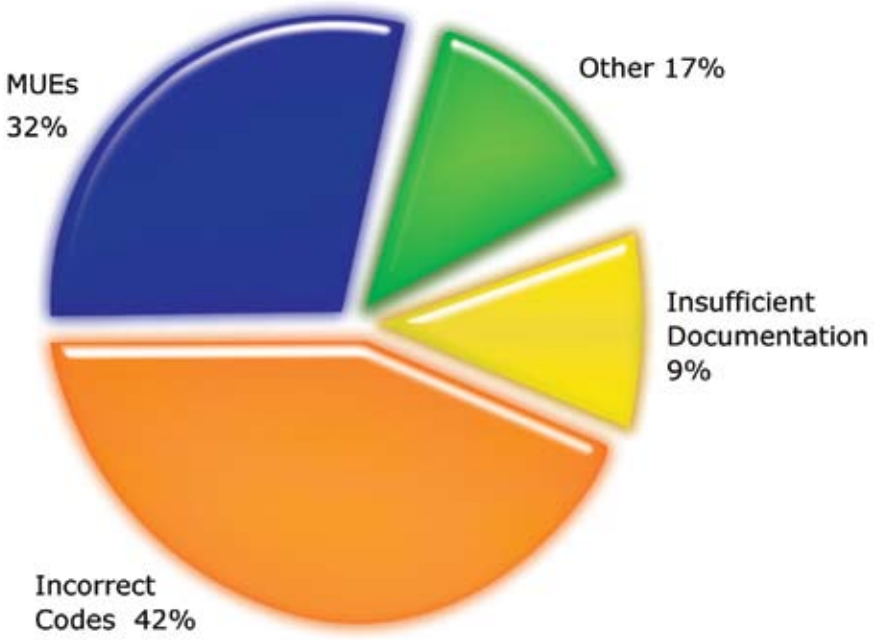
- **Zone Program Integrity Contractors (ZPICs):** CMS is replacing its Program Safeguard Contractors with seven regional ZPICs. The ZPICs help ensure that payments are appropriate and consistent with Medicare and Medicaid coverage and coding policy. ZPICs perform data analysis aimed at identifying potential problem areas, investigate potential fraud and develop fraud cases for civil and criminal referral.[7,8] http://www.cms.hhs.gov/manuals/downloads/pim83c04.pdf

- **Medicaid Integrity Program (MIP):** The Deficit Reduction Act (DRA) provides for CMS' first-ever national strategy to detect fraud and abuse in the joint state and federal Medicaid program. A companion program, known as Medicaid Integrity Contractors (MIC), relies on external contractors to perform audits, conduct data mining and develop reporting tools across Medicaid.[9] http://www.cms.hhs.gov/DeficitReductionAct/02_CMIP.asp

  http://www.cms.hhs.gov/ProviderAudits/Downloads/mipproviderauditfactsheet.pdf

- **Payment Error Rate Measurement (PERM):** This initiative, which also relies on independent contractors, was implemented to measure improper payment in the Medicaid program and the State Children's Health Insurance Program (SCHIP).[10] http://www.cms.hhs.gov/perm/

Figure 1. 2007 RAC Overpayments



Source: CMS RAC Status Document, FY 2007, Status on the Use of Recovery Audit Contractors (RACs) in the Medicare Program, February 2008, 13-14.

At the state level, emerging enforcement trends include the creation of independent Medicaid inspectors general, enactment or enforcement of state false claims acts, and new penal statutes.

Taken together, the various state and federal programs represent the most comprehensive governmental fraud, waste and abuse efforts to date. The creation of independent auditors and increased staffing levels to support the new efforts demonstrate that enforcement is a top priority at CMS. As a result, experts say, providers must become even more vigilant and proactive in their compliance efforts.

"In the long run, compliance is a lot less expensive than attempting to prove your innocence after an enforcement action has been launched," said Joe Lineberry, compliance officer, McKesson Revenue Management Solutions. "For physicians, hospitals and other providers, it is critical that coders be fully informed about the latest changes or directives. Ignorance is no defense."

Preparing for the Inevitable

Key steps for preparing to meet compliance investigations and inquiries include establishing internal protocols to better identify and monitor areas that may be subject to review. In addition, rigorous compliance programs for documentation and coding should be implemented. Practices should also ensure that all services provided are compliant with Stark regulations and other rules.

Enforcement information, articles and documents – such as the annual Office of Inspector General Work Plan – should be continually monitored. Any audit request letters should be tracked to glean additional, unpublished information. RAC and other enforcement program Web sites should be monitored to identify new areas of focus and to determine which areas may affect the physician practice. Groups should investigate and confirm the scope of any audit, including how many codes are affected, the dollar value and what percent has been found to be overpaid in order to determine the total potential risk. Finally, groups should be prepared to work with payors to resolve issues and be ready to promptly repay any confirmed Medicare overpayments.

Lynn Leoce, corporate director of Case Management for Adventist Health System, said that the key to success in overcoming a RACs audit is "developing an internal program that [can] meet the demands of the audits while also identifying and eliminating problem areas identified during chart audits, including record-keeping and billing." Adventist's two Florida divisions, with a total of 17 hospitals, experienced RAC audits as part of the RAC demonstration project. Leoce identified a number of lessons learned that are applicable to hospitals and physicians and are relevant for any enforcement program:

- **Communication is vital:** Develop a team approach throughout revenue cycle management. Individuals from patient financial services, case management and health information management must be actively engaged in the process of chart reviews and should be ready to submit appeals within specific time frames.

- **Identify your problem areas:** In many cases, you won't know what area the RAC is data mining for errors. Look for request patterns. Is the auditor reviewing coding errors, medical necessity or some other issue? Stay informed by contacting providers and hospital associations willing to share their experiences.

- **Stay consistent with your action plan:** Establish a well-defined process for conducting primary and secondary medical necessity reviews at all points of entry. Document outcomes in an action plan and re-educate to ensure compliance.

- **Use technology:** Technology is your greatest asset in a RAC audit. The electronic health record can assist in expediting accessibility, but it must be supplemented with a universal tracking method.[11]

Timely Response Is Critical

Because many of the federal and state investigative programs, including RAC, rely on independent contractors who are compensated based on the funds they recover, the new wave of inquiries are likely to be aggressive and sustained. Moreover, given the diversity of investigative programs, initial queries may be difficult to recognize due to a lack of familiarity with the program and/or its contractor.

It is therefore vital that providers doing business with government payors develop plans to respond promptly and

Enforcement Audit Focus-OIG, RACs

- Payments for diagnostic X-rays in hospital emergency departments (volume)
- Place of service errors (facility vs. nonfacility)
- Evaluation and management services during global surgery periods
- Areas with a high density of Independent Diagnostic Testing Facilities (IDTFs) (utilization, volume, ordering)
- Enrollment standards for IDTFs (technologists, equipment, supervision)
- Physician reassignment of benefits (fraudulent use of NPIs)
- Payment for services ordered or referred by excluded providers
- Duplicate payments for global/TC billing in hospital; picked up by RAC Region D
- HealthDataInsights
- Expect additional contractors as well

appropriately when initially contacted by an enforcement entity. First, they need to be sure the contractor for their area has the correct contact person and appropriate address on file. Additional strategies can include staff training and the creation of procedures to ensure that all regulatory queries and communications – whether they arrive via the postal service, e-mail or telephone – are immediately routed to the appropriate compliance group or individual. In addition, timely responses must be generated in accordance with previously determined internal policies and guidelines.

Sending the Wrong Signal

Failing to respond to investigative inquiries due to uncertainty or confusion about who should answer and in what fashion could have undesirable consequences. Tight deadlines could easily be missed. Alternatively, investigators might get the impression that the provider organization simply isn't taking the query seriously. It may also conclude that a nonresponse is evidence of a poorly run organization or, even worse, an attempt to stall the probe. The net result may be that what began as a routine request for information is escalated into a full-blown audit, investigation or unannounced site visit.

Promptly funneling all investigative requests to a centralized authority within the organization – be it the legal or compliance departments, or both – can also serve to mitigate potential problems at the outset of an inquiry. For example, investigators may have questions about a specific action or charge that, upon the surface, appears suspicious. However, informed managers or decision-makers within the organization may be able to provide a ready and reasonable explanation for the apparent anomaly, thus satisfying investigators and quelling further inquiry.

Devising a System

Mechanisms for ensuring a timely response to investigative inquiries obviously will vary depending on the size and complexity of the provider organization. In all cases, employees should be trained to forward external investigative communications immediately to the appropriate internal individual or department, regardless of the method, origin or content of the query.

By repeatedly reinforcing to employees the importance of timely responses, providers can meet the required time frames for responding to auditor inquiries while expediting the investigative encounter and minimizing its disruption to ongoing operations.

Appealing RAC Results

If an alleged payment violation identified in a RAC audit can't be confirmed, or the alleged overpayment is incorrect or unfounded, providers should consider appealing. It is important to remember that a claim denial or a finding of overpayment resulting from a RAC audit can be appealed through the standard Medicare appeals process.[12]

According to CMS, of the 525,133 overpayment claims, 22.5% were appealed with 34% ruling in the provider's favor and, of those, 7.6% were overturned (see Figure 2). Importantly, a provider win at any level in the appeals process reduces the RAC contractor contingency payment to zero.[13]

For example, Adventist Florida hospitals (excluding the Orlando facility and its campuses) appealed 43% of the 4,954

Figure 2. Updated Appeals of RAC Determinations
(Program to date through 8/31/2008)

Number of claims with overpayment determinations	525,133
Percent of claims where provider appealed (any level)	22.5%
Number of claims with appeal decisions in the provider's favor	40,115
Percentage of appealed claims with a decision in the providers favor	34%
Percentage of claims overturned on appeal	7.6%

Source: RAC invoice files, RAC Data Warehouse, and data reported by the Administrative Qualified Independant Contractor (AdQIC) and Medicare claims processing contractors.

overpayments identified by the RAC during the demonstration project and have been successful in overturning 24% of the appeals as of October 31, 2008. Appeals are still in process for 19% of the RAC-identified overpayments.[14] Therefore, a rigorous appeals stance is a vital tool for defending against and deterring ongoing audits of any type.

An Ounce of Prevention

Perhaps the most important step physicians can take in reducing the risk of an audit is to reduce or remove the incentive for a contractor to pursue the practice in the first place. That means eliminating overpayments and noncompliance. By establishing an effective, proactive plan that identifies and resolves issues before the auditor shows up, groups can mitigate potential risk.

Finally, it is worth remembering that audits can affect not only organizations but also individual employees. Lewis Morris, chief counsel to the Inspector General stated, "The Office of Inspector General strongly believes that, in addition to holding corporations accountable for healthcare fraud, individuals who caused the fraud should also be held accountable. Healthcare executives and compliance officers have a vital responsibility to ensure the compliance of the organizations that they serve."[15]

In summary, the permanent RAC program will focus annually on new areas where there is a high potential for claim or medical necessity errors. Focus on the previous areas will not go away, and their continued monitoring will remain important. However, more areas will be added and will require the same evaluation of audit risk. The need for performance analytics, evidence-based clinical documentation, effective utilization management activities, medical records supporting claim submissions and efficient tracking of the denial and appeal process will be ongoing. Scrutiny will only continue to increase as the government and payors look for ways to take cost out of the healthcare system. With any audit, the goal will be to proactively improve processes to avoid potential future take-backs.

What Can You Do?

- **Assess current risk**
- **Create and implement procedures and safeguards**
- **Ensure all services provided are compliant and documented in the patient's record**
- **Continually monitor enforcement information**
- **Investigate and confirm the scope of any audit**
- **Resolve confirmed issues *before* the auditor shows up**

1. *The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration*, Report, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, June 2008, page 6, http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

2. Centers for Medicare and Medicaid Services, "Overview of Medical Review (MR) and Benefit Integrity (BI) Programs," *Medicare Program Integrity Manual*, Chapter 1, page 6.

3. Centers for Medicare and Medicaid Services, "CMS RAC Status Document, FY 2007: Status on the Use of Recovery Audit Contractors (RACs) In the Medicare Program," February 2008, pages 13-14.

4. *The Medicare Recovery Audit Contractor Program.*

5. Centers for Medicare and Medicaid Services, "The Comprehensive Error Rate Testing Program," *Medicare Program Integrity Manual*, Chapter 12 and Section 12.3.9, http://www.cms.hhs.gov/manuals/downloads/pim83c12.pdf.

6. Centers for Medicare and Medicaid Services, Comprehensive Error Rate Testing, Overview, http://www.cms.hhs.gov/CERT/.

7. Michael Apolskis, "CMS Selects Zone Program Integrity Contractors," Blog, October 5, 2008, http://medicareupdate.typepad.com/medicare_update/2008/10/the-centers-f-1.html.

8. R - Zone Program Integrity Contractor (ZPIC, Solicitation Number: RFP-CMS-2007-0027, https://www.fbo.gov/index?tab=core&s=opportunity&mode=form&id=fe7dfb031088cc14f5502d0e88903c8b.

9. Centers for Medicare & Medicaid Services Center for Medicaid & State Operations Medicaid Integrity Group, "Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FY 2006 – 2010," July 2006, http://www.cms.hhs.gov/DeficitReductionAct/Downloads/CMIP%20Initial%20July%202006.pdf.

10. Payment Error Rate Measurement-Overview, http://www.cms.hhs.gov/PERM/.

11. Lynn Leoce, "Teamwork and Technology: Keys to Surviving the RAC Audit," *Performance Strategies 2*, no. 6 (February 2008).

12. Andrew B. Wachler and Jessica L. Gustafson, "Recovery Audit Contractors and Medicare Audits: Successful Strategies for Defending Audits," RBMA Bulletin (September-October 2008).

13. Ibid.

14. Leoce, "Teamwork and Technology."

15. Office of Inspector General, "OIG Enters into Civil Monetary Penalties Settlement with Former Hospital Executive Director," Press release, Office of Inspector General, Department of Health and Human Services, October 5, 2009.

Learn More

Centers for Medicare & Medicaid Services, RAC Permanent Program
www.cms.hhs.gov/RAC/

RAC Expansion Schedule
www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf

American Hospital Association on the RAC Program
www.aha.org/aha/issues/RAC/index.html

Healthcare Financial Management Association on the RAC Program
www.hfma.org/library/reimbursement/medicare/RAC.htm

The RAC Report
http://ezines.hcpro.com/publication/archives/11202009_6895.html

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McKesson Provider Technologies

5995 Windward Pkwy.
Alpharetta, GA 30005

www.mckesson.com/radiologyservices
1.866.217.4184

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