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Part B Insider (Multispecialty) Coding Alert

Compliance: Get the Facts on the 4 Top Ways Medicare Audits Claims

Failure to comply with CERT auditors can lead to more scrutiny.

With so many avenues to scrutinize claims, sometimes it feels like Medicare auditors are coming at you from all directions. That's because there are four different types of auditors that can request your records - and impact your bottom line.

In a special Part B webinar series from NGS Medicare titled "Patients Over Paperwork - Moving Forward Together: Medicare Audit Contractors," the MAC homed in on the different audit types and how new CMS initiatives are impacting claims review. The primary purpose of the specific auditors is to "reduce improper payments by identifying and addressing coverage and coding errors for all provider types," note the NGS webinar materials.

Remember: Though the programs have similar endpoints, "each contractor has their own way of accomplishing these goals," reminded NGS provider outreach and education consultant **Lori Langevin** during the webinar.

Take a look at this overview of the different Medicare Audit Contractors and pocket it for your records:

1. Medicare Administrative Contractor (MAC)

Last October, the MACs "transitioned" to the Targeted Probe and Educate (TPE) strategy to review claims. Under the new program, MAC medical reviewers conduct three rounds of review, selecting 20 to 40 claims per round, and target at-risk providers as opposed to looking at 100 percent of claims. Then, Medicare providers receive a notification letter letting them know that their claims have been selected for an audit. The notice "will provide you all the details about your particular TPE," Langevin says.

MACs now do TPE claims reviews specifically "to reduce costs related to improper payments and appeals," NGS says. The new process is meant to reduce provider burden, suggests Langevin. "It [TPE] is a better process not just for contractors but for providers, too - more involvement, more education, and more 1-on-1." She adds, "The providers seem to like that feedback."

The MAC decides how many claims your practice must furnish and when to send them. As with start dates, providers' end dates for TPE rounds will vary due to this. CMS allows 45 days to respond to the ADR, but NGS recommends you respond in 30 - "claims will deny on day 46 if the records are not received," the NGS webinar materials state.

Post-payment: Though TPE is a prepayment review process, the MACs may still request provider records for post-pay probes, the NGS materials suggest. "We aren't saying that we are never going to do post-payment [reviews], but our goal is to keep it prepay leaning," Langevin counsels.

Tip: "Do not send documentation until you get your additional development request (ADR)," Langevin cautions. "It will include a list of specific elements needed to support the services we are reviewing."

2. Comprehensive Error Rate Testing (CERT) Auditors

The CERT audits are exclusively post-payment reviews. "The CERT program was designed to determine if Medicare contractors are processing and paying claims correctly," says **Laura Brown, CPC,** a provider outreach and education consultant with NGS.

Why does this apply to you? If the CERT finds errors involving money overpaid to your practice, it instructs your MAC to recoup the funds from you. In addition, errors that the CERT identifies can become issues of focus in future MAC and RAC

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audits.

Warning: One more thing - your error rate is picked up by MedPAC, OIG, GAO, and other federal organizations to be used to target you for further scrutiny outside CMS.

Your practice must put the highest priority on sending documentation back to the CERT auditors, Brown warns. "If you do not return documentation immediately, you will receive telephone contacts and letters about every 10 to 15 days for approximately 75 days." She adds, "If you don't respond by the 75th day, the claim will be cancelled and any Medicare pay will be recouped."

Tip: If an auditor asks for records from you, double-check that you're submitting every document she requested. Lack of documentation is a top finding in CERT reviews.

3. Recovery Audit Contractors (RACs)

The RACs only do post-payment reviews and follow the same review policies as the MACs. "They have to abide by National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and CMS manuals and regulations just like NGS does," Langevin stressed. "We just want providers to know that they [RACs] aren't looking at your claim any differently than we would."

Interesting: "The RACs don't just have anyone review the claims. They need to be well-qualified," says Langevin. The RACs use "nurses, therapists, certified coders, and a contractor medical director" for thorough and accurate reviews, notes the NGS guidance.

The auditors can look back for three years from the date your claim was paid with the option to perform two types of reviews. These include either an automated review, which looks specifically at previously submitted Medicare claims, or a complex review, where the auditor will request records from your practice.

Time frame: Once the process starts, RACs have 30 calendar days to review your information and return a decision to you. The MAC in your jurisdiction will receive the adjustment from the RAC 30 days after the initial determination letter was sent.

4. Zone Program Integrity Contractor (ZPIC) or Unified Program Integrity Contractor (UPIC)

The ZPICs and UPICs investigate potential Medicare fraud based on specific circumstances using data analysis, interviews, documentation, records, and onsite visits, indicate the NGS materials.

After their reviews, which do include looking into fraud and abuse, they can withhold Medicare payments and refer fraudsters to law enforcement, NGS says.

Important: ZPICs/UPICs "support victims of Medicare identity theft," relays Langevin. "If a provider believes he or she may have had their information stolen or used to submit Medicare claims, they can request a ZPIC/UPIC from their MAC."

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