



EDUCATIONAL RESOURCES

You Received an Overpayment – Now What?

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Pre-Payment Audits



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Pre-Payment Audits

- Cash flow stops.
- At a minimum, it will be 60-90 days before released.

Pre-Payment Audits

- What are the steps in the pre-pay audit review process?
 - The provider submits the claim, electronically or hard copy, to the DME MAC (Medicare Administrative Contractor).
 - An Additional Documentation Request (ADR) letter is sent to the provider.
 - The claim is reviewed by the medical review nurse and a determination on whether to pay or not is made.
 - An Explanation of Benefits (EOB) is provided to the provider.



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Post-Payment Audits



Post-Payment Audits

- Re-allocate resources.
- Can result in overpayment request for money already spent.
- Devastating effect on company.

Post-Payment Audits

- Claims previously paid are audited.
 - The process starts with a written notice and a request for review of a sample of the health care provider's medical records.

Post-Payment Audits

- Valid statistical random sample
 - Statistical sampling and extrapolation of the sample results to create an overpayment.
 - This approach allows the auditor to perform a minimal review that can yield maximum results.
 - Often results in allegations that a Medicare provider has been astronomically overpaid.
 - Statistical sampling and extrapolation of the sample results are used to establish an error rate.
 - This error rate is then applied to the “universe” of claims made by a provider in a given time period.

Post-Payment Audits

- Federal statute requires that before using extrapolation to determine overpayment amounts to be recovered by recoupment, offset or otherwise, there must be a determination of sustained or high level of payment error or documentation that educational intervention has failed to correct the payment error.
- The determination that a sustained or high level of payment error exists is not subject to administrative or judicial review.

Post-Payment Audits

- The contractor may determine that a high level of payment error exists based on the following (which is non-inclusive):
 - error rate determinations
 - probe samples
 - data analysis
 - provider/provider history
 - information from law enforcement investigations
 - allegations of wrongdoing by current or former employees of a provider or provider
 - audits or evaluations conducted by the OIG

Post-Payment Audits

- There are certain procedures that a contractor must follow to arrive at a probability sample.
- Basically, the sample must be statistically valid, and the contractor must maintain documentation on the sampling method followed.

Post-Payment Audits

- The records are reviewed by the reviewer who then makes a determination whether payment for the services were medically necessary and reasonable.
- A letter with an explanation of its findings, which usually involves a calculation of the amount that was deemed to be “overpaid,” will be sent to the provider.

Post-Payment Audits

- Medicare requires the health care provider to re-pay this overpayment amount, and CMS has the authority to recoup this amount if the health care provider does not successfully defend itself during the appeals process.

Post-Payment Audits

- The date the provider receives the demand letter usually starts the appeals clock.
- At the conclusion of each stage of the appeals process, the provider receives a written notice explaining the outcome of that stage and its appeal rights.

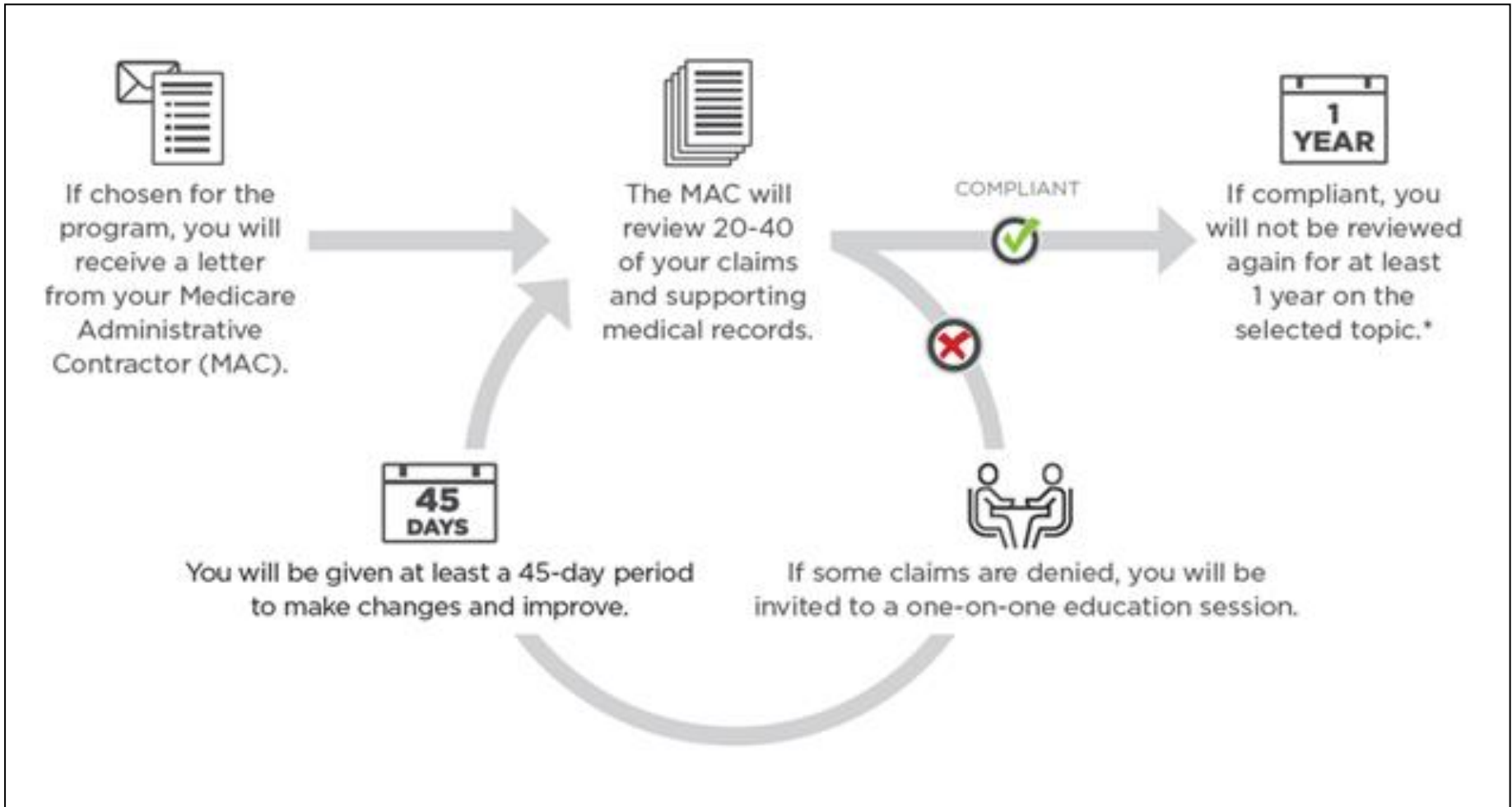
Targeted Probe and Educate (TPE)

- Launched on October 2, 2017, after short CMS pilot.
- Impacts all providers across all lines of business.
- Goal is to improve the claim payment error rate and reduce the volume of appeals through claim review and education.
- CMS touts a more “provider-friendly” approach, but appeal backlog is a big consideration in all auditing programs because of AHA court case requiring CMS to resolve appeal backlog.
- CERT errors, along with claim data analysis, are a big driver of who and what gets audited in TPE.
 - Items or services with high national error rates are considered a financial risk to Medicare.

CERT Audits

- CMS implemented the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare Fee-for-Service (FFS) program.
- The current CERT Contractors are:
 - CERT Review Contractor – NCI Information Systems, Inc.
 - CERT Statistical Contractor – The Lewin Group, Inc.
- CERT Reports

TPE Process



TPE Updates

- TPE 10-Claim Preview Probe
 - MACs to select 10 claims for TPE Round 1 for review.
 - If compliant with all 10 claims, the PTAN will be exempt from reviews for roughly one year.
 - If errors detected, suppliers go through TPE process.
- For Phase 2 and 3, claims will be chosen based on date of service, not date of submission.
- Allow 45 – 56 days between each education intervention and the next round for the provider/supplier to improve.

TPE Challenges

- Consistency across reviewers and jurisdictions.

TPE Challenges – Failing Round 3

- CMS may refer to UPIC for a more aggressive audit which sometimes results in:
 - Payment suspensions
 - Extrapolated overpayment
 - 100% prepayment review
- CMS may recommend review by RAC.
- CMS could exercise their revocation authority.

Revocations

- Under authority of the ACA, CMS can and will deny or revoke enrollment of entities and individuals that pose a program integrity risk to Medicare for the following:
 - “... providers and suppliers that have a **pattern and practice of billing for services that do not meet Medicare requirements**. This is intended to address providers and suppliers that regularly submit improper claims in such a way that it poses a risk to the Medicare program.”

Proving a Pattern or Practice



Language From Results Letters

- “Should you continue to fail to meet these requirements as described in this letter, your billing privileges may be revoked on this basis or any of the bases articulated in Per 42 CFR §424.535(a).”

TPE Response Strategies

- Appoint a primary contact.
- Establish a rapport (when possible) with the reviewer.
- Educate staff on process (what to expect and what to look for).
- Review current process for submitting claims on identified codes.
 - Checklists for intake, billing, and delivery staff to ensure all requirements met at each stage.
 - Verify modifiers to be appropriate.
 - Revisit LCDs/NCDs to be sure you understand and are meeting coverage criteria and guidelines.

TPE Response Strategies

- Organize packets in a logical and consistent manner.
- Review documentation prior to submission.
- Track audits and error rates.
- Appeal and track outcomes.

DME MAC Review

- DME MACs perform many activities including:
 - Process Medicare FFS claims.
 - Handle redetermination requests (1st stage appeals process).
 - Respond to provider inquiries.
 - Educate providers about Medicare FFS billing requirements.
 - Medical review.

Recovery Audit Contractor

- Purpose is to review claims and identify improperly paid claims. These can be overpayments or underpayments.
- Paid based on results.
- Region 5 RAC – Performant Recovery.
- <https://performantrac.com/cms-rac/cms-rac-resources/cms-rac-provider-resources/default.aspx>
- Must have review topics approved.
- Can review 10% of all paid claims, by policy group paid within previous 12-month period dividing into 8 periods (45 days).
- Automated vs. Complex Review.
- Discussion Period.

Supplemental Medical Review Contractor

- SMRC is Noridian Healthcare Solutions.
- The SMRC conducts nationwide medical reviews of Medicaid, Medicare Part A/B, and DMEPOS claims to determine whether claims follow coverage, coding, payment, and billing requirements.
- The focus of the medical reviews may include vulnerabilities identified by CMS data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations, and federal oversight agencies.
- At the request of CMS, the SMRC may also carry out other special projects to protect the Medicare Trust Fund.

Supplemental Medical Review Contractor

- Three types of SMRC reviews
 - Provider Compliance Group
 - Program Integrity Group
 - Healthcare Fraud Prevention Partnership
- Discussion and Education Session
 - Must request within 14 days
 - Aim to hold discussion within 14 days of request

Uniform Program Integrity Contractors

- UPIC is tasked with identifying and preventing fraud, waste, and abuse.
- Significant power
 - Referral to law enforcement.
 - Payment suspension.
 - Credible allegations of fraud.
 - Reasonable basis to believe an overpayment exists.
 - Extrapolated audits.

Appeals Process

- Redetermination
 - Must be filed within 120 days from date of initial determination.
 - To stop offsets, must file request within 30 days or recoupment will begin on 45th day.
 - Conducted by the DME MAC.
 - Must issue a decision within 60 calendar days.
 - 2021 statistics
 - 47% favorable
 - 49% unfavorable
 - 4% partially favorable

Appeals Process

- Reconsideration
 - Must file within 180 days of date of redetermination decision.
 - To stop offsets must file within 45 days.
 - Conducted by the Qualified Independent Contractor.
 - Maximus, Inc.
 - Must submit all evidence or show good cause to present it at a later date.
 - 2021 Statistics
 - 41% favorable
 - 58% unfavorable
 - 1% partially favorable

Administrative Law Judge

- Must file a request within 60 days of date of reconsideration decision.
- Amount remaining in controversy must be at least \$180.
- Backlog is being cleared.
- Projected that by end of 2022 will be able to issue decision within 90 days as required by statute.
- No ability to stop offsets.
- 2021 Statics
 - 20% favorable
 - 31% unfavorable
 - 2/1% partially favorable
 - 46.9% dismissed

Medicare Appeals Council

- Must file appeal within 60 days of ALJ decision.
- Generally, will issue a decision within 90 days.

District Court Review

- An individual can file for judicial review within 60 calendar days of receiving the MAC decision.
- Amount in controversy must be \$1,760

Questions?





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Thank you

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