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National Government Services

NGSMedicare University Virtual Conference

Medicare 2021
A Journey to a Healthier Future and Partnership

Medicare Audit Contractors

5/11/2021

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Laura Brown, CPC
  - Provider Outreach and Education Consultant
- Lori Langevin
  - Provider Outreach and Education Consultant

Disclaimer

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- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- Know the difference between the Medicare audit contractors
- Understand the provider's role in the Medicare audit process

Agenda

- Medicare Audit Contractors
  - Supplemental Medical Review Contractor
  - Unified Program Integrity Contractor
  - Recovery Auditors
  - Medicare Administrative Contactors
  - Comprehensive Error Rate Testing
- How to Prepare for a Medicare Audit

Medicare Audit Contractors

- Several initiatives to prevent or identify improper payments before CMS processes a claim, and to identify and recover improper payments after paying a claim
- The overall goal is to reduce improper payments by identifying and addressing coverage and coding billing errors for all providers types
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 1

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Supplemental Medical Review Contractor (SMRC)

SMRC

- Mission
  - 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. The focus of the reviews may include but are not limited to issues identified by CMS internal data analysis, the CERT program, professional organizations and other Federal agencies, such as the OIG/GAO and comparative billing reports.

SMRC

- Noridian Healthcare Solutions, LLC is the SMRC under contract with CMS
- The SMRC contact center is available
  - Monday–Friday
  - 8:30 a.m.–6:00 p.m. ET/ 7:30 a.m.–5:00 p.m. CT
  - Telephone: 833-860-4133
  - Noridian SMRC website

SMRC Process

- Identify provider noncompliance with coverage, coding, billing, and payment policies through the research and analysis of data related to assigned task (e.g., profiling of providers, services, or beneficiary utilization)
- As directed by CMS
  - Perform medical review
  - Perform extrapolation
- Notify the individual billing entities of review findings identified and make appropriate recommendations for POE and UPIC referrals

Role of SMRC

- Serving as a readily available source of medical information to provide guidance in questionable claims review situations
- Providing the clinical expertise and judgment to develop LCDs and internal MR guidelines
- Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse
- Providing clinical expertise and judgment to effectively focus MR on areas of potential fraud and abuse
- Serving as a readily available source of medical information to provide guidance in questionable situations

Role of MAC

- MACs may initiate claim adjustments and/or overpayment recoupment actions through the standard overpayment recovery process

Unified Program Integrity Contractor (UPIC)

UPIC

- Mission
  - To help address fraud, waste and abuse by performing Medicare data analysis and comprehensive problem identification and research to identify potentially fraudulent Medicare providers and coordination of benefit integrity activities among MACs in the region, and dissemination of relevant benefit integrity information to the respective MACs

UPIC Northeastern
Safeguard Services, LLC – Jurisdiction K

- UPIC Northeastern
- Safeguard Services, LLC
- States in UPIC Northeastern
  - Pennsylvania, **New York**, Delaware, Maryland, D.C., New Jersey, **Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut**

UPIC Midwestern
CoventBridge Group – Jurisdiction 6

- UPIC Midwestern
- CoventBridge Group
- States in UPIC Midwestern
  - **Minnesota**, Missouri, **Illinois,** Indiana, Iowa, Kansas, Kentucky, Michigan, Nebraska, Ohio, **Wisconsin**

UPIC Process

- Perform data analysis
- Request medical records and documentation
- Conduct interviews
- Conduct onsite visits
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation
- Withhold payments
- Refer cases to law enforcement

Role of UPIC

- Investigate instances of suspected fraud, waste and abuse
- Develop investigations early, and in a timely manner
- Take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid
- Identify any improper payments that are to be recouped by MACs

Role of MAC

- Claim processing, including paying providers/suppliers
- Provider outreach and education
- Recouping monies lost to the Medicare Trust Fund
  - The UPICs identify these situations and refer them to the MACs for the recoupment
- Medical review not for benefit integrity purposes
- Complaint screening
- The MAC will refer to the UPIC if fraud is suspected
- Claims appeals of UPIC decisions
- Claim payment determination and claims pricing
- Auditing provider cost reports

Recovery Auditors

RA Program

- Mission
  - 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 providers so that the CMS can implement actions that will prevent future improper payments

RA Region 1 - Jurisdiction K

- Performant Recovery, Inc.
  - Website
  - Email
  - Telephone: 866-201-0580
- Please visit their website for
  - Issues under review
  - Forms and sample documents
  - FAQs
  - Review provider contact Information for accuracy

RA Region 2 - Jurisdiction 6

- Cotiviti, LLC
  - Website
  - Email
  - Telephone: 866-360-2507
- Please visit their website for
  - Issues under review
  - Forms and sample documents
  - FAQs
  - Review provider contact Information for accuracy

RA Process

- Issue selected for review
- CMS approves issue
- RA requests claims
- RA reviews documentation (complex review) or claim (automated review) and makes determination
- If an error is found, a file is sent to the claims processing MAC to be adjusted for over or underpayment

Time Frames

- RA has 30 calendar days to complete the review and send a decision letter
- RA may look back up to three years from the claim paid date to review claims
- RA will forward the adjustment to the MAC 30 days after the initial findings letter or after a **discussion period** has been completed

Role of RA

- Review claims on a postpayment basis using the same Medicare policies as MACs
  - NCDs
  - LCDs and
  - CMS manuals/regulations
- To ensure accuracy, RA is required to employ nurses, therapists, certified coders and a contractor medical director

Role of MAC

- After a RA post pay review, an electronic file of claims to be adjusted is sent to claims processing contractor
  - Marked as RA adjustments in claims processing system
- Electronic reports are sent to RA on daily basis to notify them that an adjustment has been processed

Provider Tips

- Identify RA demand letter
  - Right corner will contain letter number that begins with “R” For example: R-1234567
  - The first paragraph says: “This finding was a result of a Recovery Audit Program review.”
- Review the demand letter sent from the MAC
- Providers need to review their remittance advice
  - If they see a N432 that means an adjustment was done due to a RA review

Provider Tips

- Request rebuttal
  - Opportunity to provide a statement and accompanying evidence indicating why overpayment action will cause financial hardship and should not take place
    - Not disagreeing with overpayment decision
    - No review of supporting medical documentation will take place
  - Must be submitted by the 15th day from date on demand letter

Provider Tips

- Appeal with local MAC
  - Include specific reason why you feel RA determination should be overturned

MAC Medical Review

MAC Medical Review

- Mission
  - To reduce costs related to improper payments and appeals, therefore reducing provider burden

MAC Medical Review

- National Government Services
  - Our website
  - Fax
    - J6: 315-595-4364
    - JK: 315-442-4231

MAC Medical Review Process

- TPE strategy and the NGS medical review process
  - The purpose is to reduce costs related to improper payments and appeals
    - This will reduce provider burden
  - Providers selected for TPE will receive a notification letter from NGS

MAC Medical Review Process

- Postpayment probes
  - MR may conduct postpayment claim reviews
  - A sample of paid claims is selected and a request for medical records is requested from the provider
  - Providers must submit medical records as directed by the medical review notice letter within 45 days of the record request

Time Frame

- Prepayment decision timeline
  - Claims will suspend
  - Documentation requested via ADR
  - Return documentation – 45 days (recommend 30 days)
    - Claims will deny on day 46 if records not received
  - NGS will make review determinations within 30 calendar days of receiving the provider's requested documentation
  - Detailed results letter
    - One-on-one education

Role of MAC Medical Review

- TPE notification and ADR letters
  - Notification outlines the TPE process
  - Reason for review
    - Why your facility was selected
    - Procedure code/HCPCS code – short description of what is being reviewed
  - Do not send documentation until you receive an ADR letter
    - Will include a list of specific elements needed to support the service being reviewed

Provider Tips

- Responding to TPE ADRs
  - NGS recommends responding to ADRs within 30 days
    - CMS allows providers 45 days of the ADR date
  - Forward the requested documentation to the correct address
  - Send responses separately and attach a copy of the corresponding ADR
  - Include all records necessary to support the services for the dates requested
  - Do not include unrelated correspondence
  - Records must be complete and legible
  - NGSConnex allows providers to respond to ADRs electronically
  - Ensure services include necessary signatures and credentials of professionals

Provider Tips

- What can you do?
  - Review all contractor provider publications and LCDs
  - Understand Medicare coverage requirements
  - Ensure office staff and billing vendors are familiar with claim filing requirements
  - Perform self-audits of medical records against billed claims using coverage criteria, LCD and coding guidelines
  - Ensure documentation is legible and demonstrates that the patient's condition warrants the services being reported and billed

Comprehensive Error Rate Testing

CERT

- Mission
  - Designed to monitor and improve Medicare payment accuracy, evaluate provider claim submission practices and protect the Medicare Trust Fund

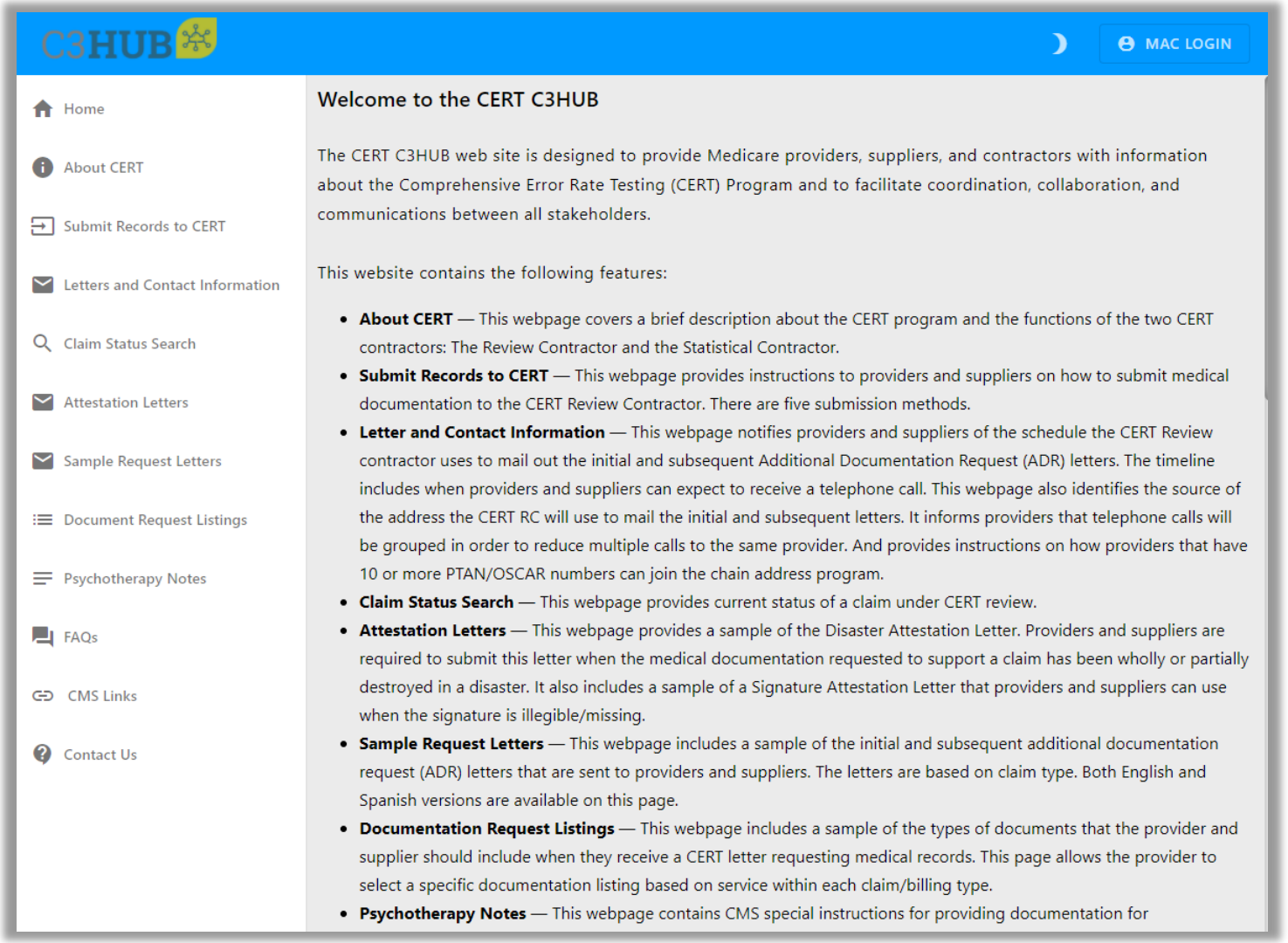
CERT

- Contact Information
  - CERT Documentation Center
    1510 East Parham Road
    Henrico, VA 23228
  - Fax: 804-261-8100
  - Telephone: 443-663-2699 or toll free 888-779-7477
  - Website: CERT C3HUB
  - Email: certprovider@nciinc.com (general questions)
  - Email: certmail@nciinc.com (medical records and passwords)
    - Include barcoded coversheet with CID number with medical record submissions

CERT Provider Website

- CERT C3HUB
  - Submit records to CERT
    - Submission methods
  - Letter and contact information
    - Schedule for initial and subsequent request
  - Claim Status Search
    - Current status of claim under CERT review
  - Sample request letters
    - Copies of documentation request letters and envelope
  - Documentation request listings
    - Sample of the types of documents based on service within each claim/billing type

CERT Provider Website



CERT Process

- CERT selects a stratified random sample of paid or denied claims from all Medicare contractors
- CERT requests medical records from the billing and ordering provider by letter, phone and fax
  - If some of the requested records are housed at another site
    - Providers should forward a copy of the request to the other site
    - Or, give CERT other site contact information; CERT will follow up with other site with additional record requests

Requesting Medical Records

- Based on each individual CID
  - All **FIRST** ADR letters are sent to the address the provider has on file with Medicare
    - For information on updating addresses with PECOS, please see MLN Matters® *SE1617: Timely Reporting of Provider Enrollment Information Changes* for additional information
  - All **SUBSEQUENT** ADR letters for that CID can be sent to a specific address designated by the provider by calling CERT, after you receive the first ADR letter

Requesting Medical Records

- Chain Address Program*
  - Providers having at least ten PTAN numbers can elect a single point of contact to participate in the “chain address” program
    - Call CERT office: 888-779-7477
      - Provide all PTAN numbers and the designated point of contact information
    - CERT will email/call the point of contact with a list of outstanding CID numbers
- Group Calls*
  - When a provider has multiple CIDs with the same phone number, CERT will group together to discuss all outstanding requests
- ***Important note:** These processes are only in regard to the CERT program

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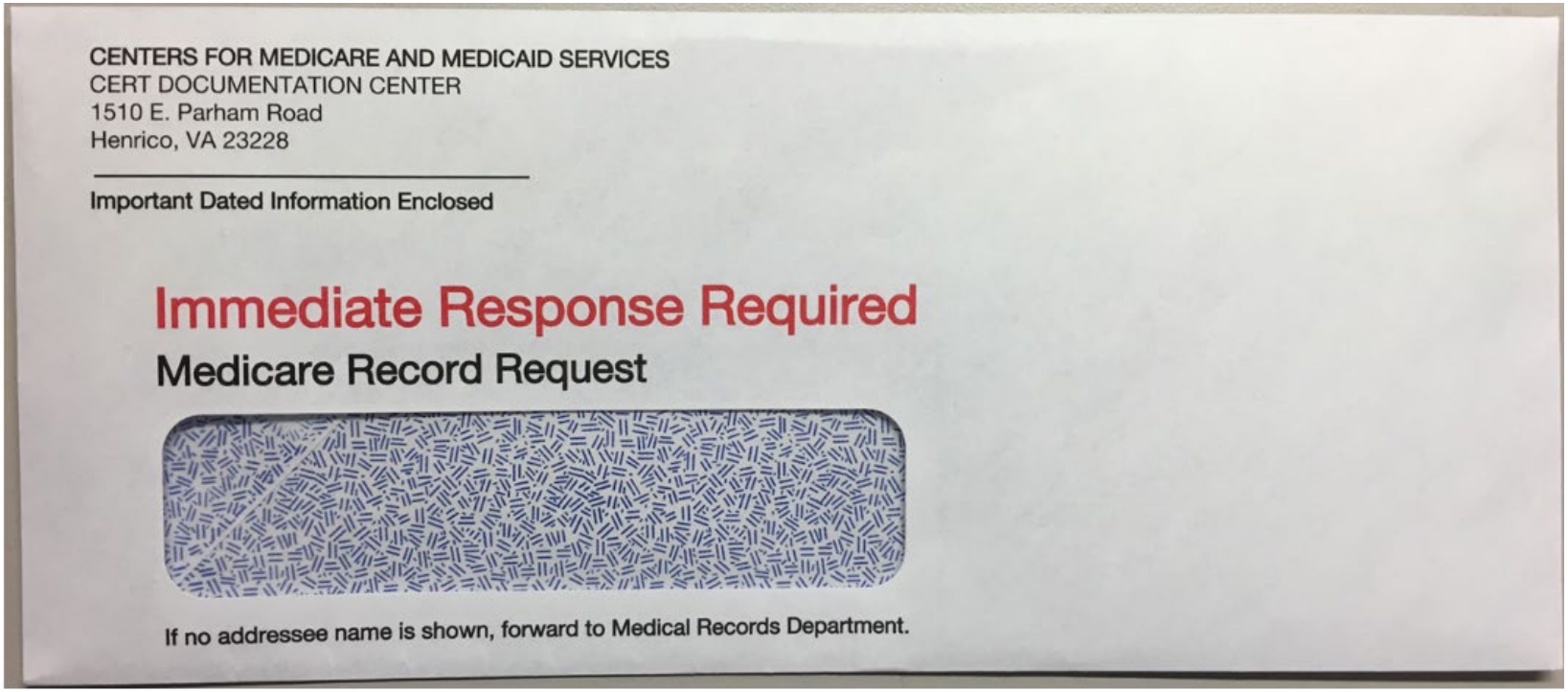
CERT Documentation Center Envelope



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Provider Name
Address 1
Address 2
City ST 00000

Date: 1/1/1900
Reference ID: CID #: 1555555
NPI/Provider #: 0000000000
Phone:
Fax:

Request Type & Purpose: First Letter
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.[1] The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit www.cms.gov/CERT.

Reason for Selection

The CMS' CERT program has randomly selected one or more of your Medicare claims for review.

Action: Medical Records Required

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. **Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified on the attached Bar Coded Cover Sheet. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

When:1/1/1900

Please provide the requested documentation by 1/1/1900 . A response is still required by 1/1/1900 even if you are unable to locate the requested information.

Consequences

If the provider/supplier fails to send the requested documentation or contact CMS by 1/1/1900 , the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

[1]Social Security Act Sections 1833 [42 USC §1395l(e)] and 1815 [42 USC §1395g(a)]; 42 CFR 405.980-986

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PLACE THIS BARCODED COVER SHEET IN FRONT OF THE RECORD

Medicare CERT Review Contractor
GS-00F-263CA CERT

CID: 1555555

Due Date: 1/1/1900 Medicare Part B Provider

Patient Name: Patient Name

Claim Control Number: CCN0000000000

Request Date: 1/1/1900 **Date(s) of Service: 1/1/1900 - 1/1/1900**

NPI/Provider #: 0000000000 Universe Date: 1/1/1900

Contractor: 99999 Contractor Type: B

Patient Date of Birth: 1/1/1900

Letter Sequence: First Letter

Providers and suppliers are required to maintain documentation supporting the submission of Medicare claims and to submit this documentation upon request. The documents listed in the following chart may be needed to support Medicare payment of the claim with the date(s) of service specified above. Please provide all of the pertinent medical records/documentation and any additional documentation needed to support this claim. If any pertinent documentation is missing, incomplete, or requires explanation, please include this information in the comments section.

Documents that may be required

CERT Documentation Center - Attn: CID # 1555555
1510 East Parham Road, Henrico VA 23228
FAX 804-261-8100 PH 888-779-7477 or 443-663-2699

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Timeframe

- Respond to requests timely
  - Be sure staff places a high priority on responding to requests
    - 45 days – response is due
    - 46 days – response is overdue
    - 76 days – receive non-response error 99 and subject to overpayment recovery by MAC
  - National Government Services may contact to remind you

CERT Timetable – Watch the Days

- Initial Request Schedule
  - Day 0: Send letter 1 requesting documentation. The provider has 45 days from this letter to furnish the requested documentation.
  - Day 25: Telephone contact to follow-up on request and/or offer assistance.
  - Day 30: Send letter 2. The provider has 15 days left to complete the request.
  - Day 40: Telephone contact to follow-up on request and/or offer assistance.
  - Day 45: Send letter 3. **(Response is due)**
  - Day 55: Telephone contact to follow-up on request and/or offer assistance. **(Response is overdue)**
  - Day 60: Send letter 4. **(Response is overdue)**
  - Day 76: Claim is counted as **non-response** error and is subject to **overpayment recovery** by the MAC.

Role of CERT

- The documentation is reviewed by independent medical reviewers to determine if the claim was paid properly under Medicare coverage, coding and billing rules
- If the documentation does not support that the rules were met, the claim is counted as either a total or partial improper payment

Role of CERT

- The error is then categorized into one of five major categories
  1. No documentation
  2. Insufficient documentation
  3. Medical necessity
  4. Incorrect coding
  5. Other
- Report sent to MACs with CERT errors

Role of MAC

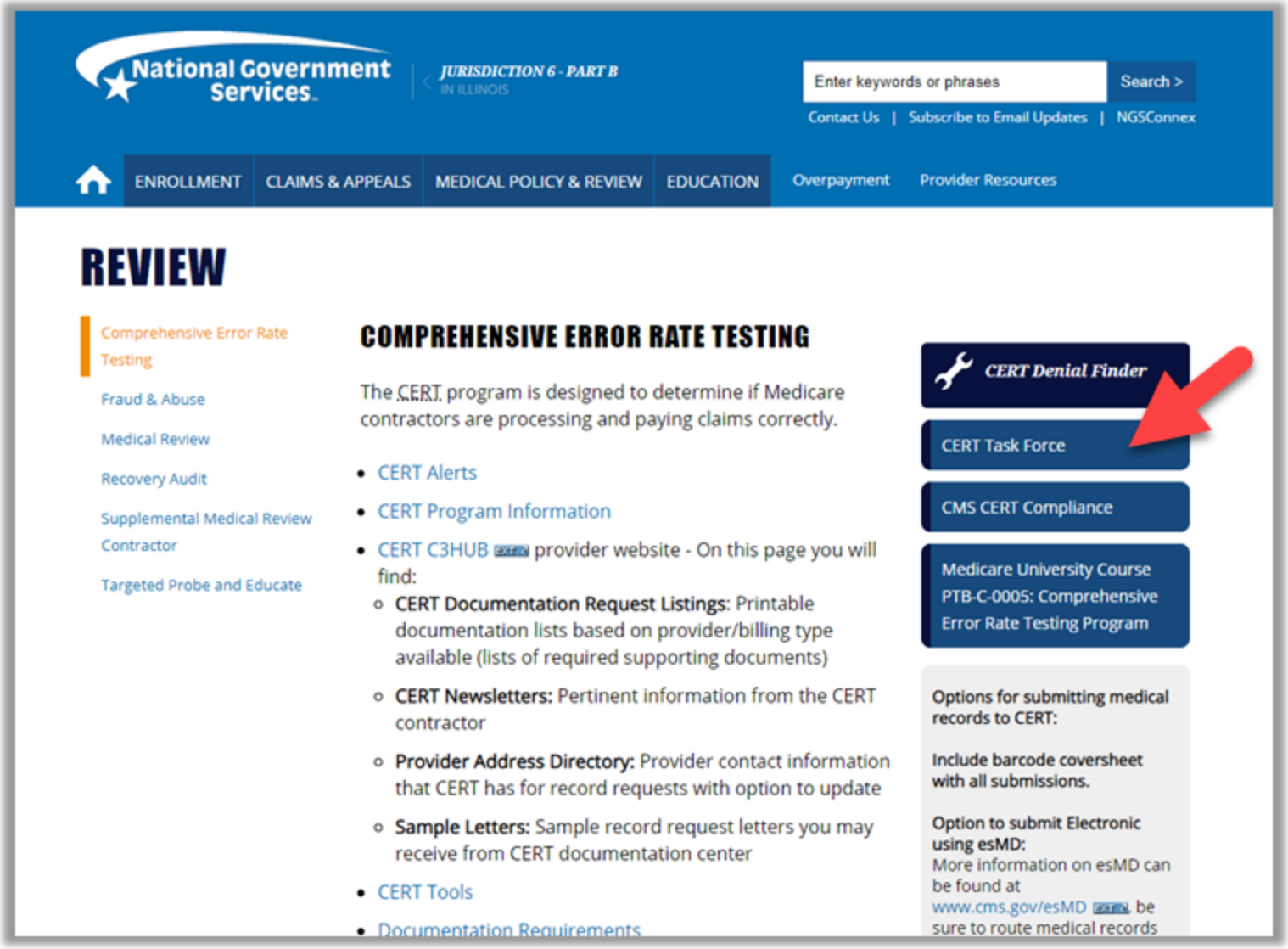
- NGS receives a CERT notification report of review results and responds to all identified errors (over and underpayments)
- Claims will be adjusted through normal claim adjustment process to allow additional payment if underpaid or recoup any overpayments
- Providers will be notified through the normal adjustment process that will include appeal rights

Role of Provider

- Verify all addresses are up-to-date with Medicare
  - Update by using PECOS or the appropriate CMS-855 application
- Identify and respond timely to ADRs
  - Within 45 days
- Be familiar with documentation requirement
  - CERT Document Request Lists
  - NGS Policy Education Topics
  - NGS Medical Policy Center (Local Coverage Determinations)
- Submit documents to support **all** services and dates of service on claim

Role of Provider

- Obtain documentation from third party
  - Forward a copy of the request to other provider's office, hospital or health care facility
  - Or, give CERT the other facility's contact information
    - CERT will follow up by sending an ADR letter
- If you disagree with CERT decision
  - Use local MAC's appeal process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ENROLLMENT
CLAIMS & APPEALS
MEDICAL POLICY & REVIEW
EDUCATION
Overpayment
Provider Resources
REVIEW
Comprehensive Error Rate Testing
Fraud & Abuse
Medical Review
Recovery Audit
Supplemental Medical Review Contractor
Targeted Probe and Educate
COMPREHENSIVE ERROR RATE TESTING
The CERT program is designed to determine if Medicare contractors are processing and paying claims correctly.
CERT Alerts
CERT Program Information
CERT C3HUB provider website - On this page you will find:
CERT Documentation Request Listings: Printable documentation lists based on provider/billing type available (lists of required supporting documents)
CERT Newsletters: Pertinent information from the CERT contractor
Provider Address Directory: Provider contact information that CERT has for record requests with option to update
Sample Letters: Sample record request letters you may receive from CERT documentation center
CERT Tools
Documentation Requirements
CERT Denial Finder
CERT Task Force
CMS CERT Compliance
Medicare University Course PTB-C-0005: Comprehensive Error Rate Testing Program
Options for submitting medical records to CERT:
Include barcode coversheet with all submissions.
Option to submit Electronic using esMD:
More information on esMD can be found at www.cms.gov/esMD be sure to route medical records

CERT A/B MAC Outreach & Education Task Force

CERT A/B MAC Outreach & Education Task Force

- The goal of the A/B MAC Outreach & Education Task Force is to ensure consistent communication and education to reduce the Medicare Part A and Part B error rates
  - A joint collaboration of the A/B MACs to communicate national issues of concern regarding improper payments to the Medicare Program
  - Partnership to educate Medicare providers on widespread topics affecting most providers and complement ongoing efforts of CMS, the MLN and the MACs individual error-reduction activities within its jurisdictions
- **Disclaimer:** The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate

CERT A/B MAC Outreach & Education Task Force

- CMS works closely with the CERT A/B MAC Task Force and the CERT DME MAC Outreach & Education Task Force
  - CMS has a web page dedicated to education developed by the CERT A/B MAC Outreach & Education Task Force
- NGS CERT Task Force Web Page
  - Go to our website; in the About Me drop down box, select your provider type and applicable state, click on Next, accept the Attestation. Choose the Medical Policy & Review tab, then choose CERT, the CERT Task Force link is located to the right of the web page

How to Prepare for a Medicare Audit

How to Prepare

- Determine who is accountable for specific roles within office and ensure an understanding of their goals and objectives
- Be familiar with the documentation requests
  - Required documentation lists will indicate components needed to review claim (letter or website)
  - Documentation submission method
  - Contact information

How to Prepare

- Documentation submitted is
  - The contractor's only picture of the patient and the care you provided
  - The proof that the claim is accurate
    - The services billed were delivered
    - The services delivered and billed met Medicare standards of medical necessity
- If it wasn't documented, it did not happen

How to Prepare

- Review details of medical records
  - Signature, legibility, clarity, complete
  - All lab tests and other pertinent information included in medical record
  - Ensure documentation supports the level of coding
  - Check to be sure number of units documented are the same in the medical record as submitted on claim

How to Prepare

- Missing or Illegible Signatures
  - Signature log or signature page
  - Signature attestation
    - "I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability." M.D. Signature _____
  - Reference
    - CMS IOM Publication 100-08, *Medicare Program Integrity Manual,* Chapter 3, Section 3.3.2.4

How to Prepare

- Know how to locate resources
  - ICD-10; CPT/HCPCS; documentation requirements
- Know local and national coverage determinations that apply
- Understand Medicare rules and regulations
- Know your appeal rights with local MAC
- Establish a quality assurance program for your practice

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How to Prepare

- Final Check
  - Timely response is critical
  - Provide all requested records
  - Records must be legible
  - Include appropriate signatures and credentials
  - Check right beneficiary, right service, right date of service
  - Clear copies of both sides of document
  - Verify mailing address and/or fax numbers are correct

Resources

Resources

REVIEW

- Comprehensive Error Rate Testing
- Fraud & Abuse
- Medical Review
- Recovery Audit
- Supplemental Medical Review Contractor
- Targeted Probe and Educate

MEDICAL REVIEW

Targeted Probe and Educate Strategy and the NGS Medical Review Process

As directed by CMS, effective 10/1/2017, NGS Medical Review will transition all lines of business to a Targeted Probe and Educate (TPE) strategy. The purpose of this transition is to reduce costs related to improper payments and appeals, therefore reducing provider burden. Home health and SNF demand bill review are CMS mandated reviews and will not transition to TPE.

Providers selected for TPE will receive a notification letter from us (enclosed in a pink envelope) via USPS or fax. The

LCD/Policy Search

LCD or article Search

Illinois Non-emergent Hyperbaric Oxygen Prior Authorization Requests

Medical Review Focus Areas

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Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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