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Navigating Today's World of Coding and Compliance Audits

Northern New England Chapter – HFMA
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Learning Objectives

At the completion of this educational activity, the learner will be able to:

- Identify current commercial and government audit activity.
- Explain how to appropriately respond to payer audits.
- Describe best practices for appeal processes and audit tracking.

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Agenda

- Types of audits – external
- Responding to the audits
- Managing the audit process
- Post-audit education
- Resources
- Questions

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Types of Audits - External

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Recovery Audit Contractors (RAC)

- Began in 2005—paused briefly due to the pandemic
  - Auditors are paid on a contingency basis
  - Due to the pandemic delay from March to April 2020, the recovered amounts decreased to $2.2 billion for the amount collected through violations of the False Claims Act (“2021 Audit forecast: Cloudy with a chance of storms.” *Proactive Medical Review*)
- CMS website - Medicare Fee for Service Recovery Audit Program | CMS
  - Lists the RACs, regions, and the respective states covered
  - Perform post-payment reviews
  - Topics updated on a monthly basis
  - Important to stay aware of the updated topics

- Five levels of RAC audit appeal
  - Pay close attention to the deadlines and the monetary thresholds

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Examples of RAC Audit Focuses for 2023

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/R...

An official website of the United States government Here's how you know

Medicare Fee for Service Recovery Audit Program

Approved RAC Topics
Proposed RAC Topics
Resources

Approved RAC Topics

Do you have questions or concerns about the Recovery Audit Program? Please e-mail us at RAC@cms.hhs.gov. Please Do Not send Personal Health Information to this e-mail address.

Note: CMS often receives referrals of potential improper payments from the MACs, UPICs, and Federal investigative agencies (e.g., OIG, DOJ). At CMS discretion, CMS may require the RAC to review claims, based on these referrals. These CMS-Required RAC reviews are conducted outside of the established ADR limits.

Show entries: 10 per page | Filter On | Apply

Showing 1-10 of 176 entries

Issue Name	Review Type	Provider Type	MAC Jurisdiction	Date Approved
0001 - Inpatient Hospital MS - DRG Coding Validation	Complex	Inpatient Hospital	All A/B MACs	2017-02-01
Cataract Removal: Medical		Ambulatory Surgical Center	J6, J15, JE, JF, JH, JJ,	

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-MedicaidCoordination

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Examples of RAC Audit Focuses for 2023

- All services have the component of medical necessity needing to be supported in the medical record

- 0028 – Annual wellness visits (AWV): excessive units
- 0037 – Hospital Services – Excessive Units
- 0042 – Evaluation and management (E/M) for office or other outpatient visit billed for hospital IPS – Incorrect coding
- 0176 – AWV incorrect coding

- COVID - COVID-19 Current Procedural Terminology (CPT®)vaccine and immunization codes | American Medical Association (*ama-assn.org*)

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Examples of RAC Audit Focuses for 2022 Parts C and D

“This document outlines the program audit process for 2022. CMS will send engagement letters to initiate routine audits beginning February 2022 through July 2022. Engagement letters for ad hoc audits may be sent at any time throughout the year.

The program areas for the 2022 audits include:

- CDAG: Part D Coverage Determinations, Appeals, and Grievances
- CPE: Medicare Part C and Part D Compliance Program Effectiveness
- FA: Part D Formulary and Benefit Administration
- MMP-SARAG: Medicare-Medicaid Plan Service Authorization Requests, Appeals, and Grievances
- MMPCC: Medicare-Medicaid Plan Care Coordination
- ODAG: Part C Organization Determinations, Appeals, and Grievances
- SNP-CC: Special Needs Plans – Care Coordination”
- 2022 Program Audit Process Overview (*cms.gov*)

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Coding Clinics and *CPT Assistant* Articles on COVID

- *CPT Assistant* is being updated almost monthly
- Stay abreast of changes, new codes, changed codes
- Immunizations, administration of drugs such as tocilizumab, and diagnosis codes which have changed since the beginning of the pandemic

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Medicare Administrative Contractors (MAC) Med Reviews

- Reviews done to protect the Medicare Trust Fund and to avoid improper payments.
- Performed using claims data along with medical record reviews. Part of the process is to also provide education.
- These include:
  - MACs
  - SMRCs
  - RACs and others
- Findings may be from Comprehensive Error Rate Testing (CERT), RACs, Office of Inspector General (OIG), or the Government Accountability Office (GAO).
- Medical Review and Education | CMS

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Comprehensive Error Rate Testing (CERT)

- Created by CMS to evaluate and measure the error rate of claims for fee-for-service claims which were improperly paid
  - While the error rate identified might be indicative of incorrect coding/billing, it does not imply fraud is being committed
  - CERT contractor will select and review a sample of claims
    - If claims are not coded correctly OR provider does not reply to request for medical records, the CERT auditors can conclude that these claims were either a partial or total incorrect payment
    - Can result in recoupments
    - MACs then use the data to identify areas to review, educate and update their processes

    - What's the Comprehensive Error Rate Testing (CERT) Program? | CMS

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Supplemental Medical Review Contractors (SMRC)

- Reviews may come from data analytics performed or issues identified by the CERT program
  - These audits are driven by other agencies, not from SMRC themselves
  - Many agencies focus on high dollar and services with the high utilization
  - This is where the risks lie for practices and hospitals

- One contractor for SMRC audits – Noridian
- Review Medicaid, Medicare Part A/B, and durable medical equipment (DME) services

- Noridian will send request for medical records to suppliers and providers—important that these are responded to!

  - Supplemental Medical Review Contractor | CMS

Targeted Probe and Educate (TPE)

- Intent of TPE is to provide support to suppliers and providers to be submitting clean claims, denial reduction and appeals
- Most providers should never be on a TPE according to CMS
- Many of the items identified by MACs are easily corrected such as missing signatures
- Those put on a TPE may be identified if they have a high number of claim errors or they are billing at higher rates than the national averages which can be a risk to Medicare due to the financial implications
  - Three rounds of review and education will be performed for those who do fall into criteria
- Intent is to also increase accuracy of identified coding/billing/documentation areas

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Audits Proactive

- Perform an internal bell curve analysis and identify the outliers
  - Look at providers and services:
    - Who are billing too many or two few high levels, compared to their peers
    - The providers who always (or almost always) bill an E/M service with a procedure in the office
    - Those providers who bill only high levels in the hospital encounters

- Audit for COVID cases
  - Standardized criteria with policies and procedures should have been established

- Best practice is to audit five cases per federal payer per provider, per year

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Legal Audits

- Anonymous tips to compliance hotlines
  - Investigation should be performed to validate if truly a concern
  - Evaluation of provider(s), departments or hospital billing/coding may need to be performed

- Attorney client privilege (ACP)
  - Contacted by attorney or legal department to perform audits
  - As auditor, must be engaged with attorney (may not be the client)
  - Findings and communication are done through attorney and with attorney's direction
  - Important to engage attorney early in the process
  - Cannot just "use" hospital or clinic attorney and/or mark the reports ACP

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Modifier 25 Audits

- Commercial payers
  - Cigna
  - Anthem – BCBS
  - United Healthcare

- Best preventive method – refer to the National Correct Coding Initiative (NCCI) manual for the modifier 25 examples
  - Perform internal audits to identify issues with providers frequently or always reporting E/M services with procedures
  - Provide education to providers pro-actively

  - Modifier 25 Tip Sheet (*novitas-solutions.com*)
  - Healthicity Modifier 25 Cheatsheet

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COVID Audits

- Focus audits
- Patients being seen for COVID
  - Is it a sequelae?
  - Is it a new infection?
  - Is it long COVID?
  - If patient is isolated, consider current treatment.
  - Sepsis.
  - Respiratory failure.
  - MIS-C in pediatric patients.

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Responding to Audits

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Who Should Be Involved in the Audit Response?

- Business office, compliance, department directors, providers, HIM and coding directors and coders, as needed
- Process should be outlined and defined by leadership so audit response can be thorough and timely – audit oversight plan
- Education should be provided to all departments as to how to handle requests for documentation from payers
- Requests need to be routed to HIM to ensure that the request can be logged, responded to appropriately and follow up education of the staff and/or providers done as necessary

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Reading the Advanced Documentation Requests (ADR)

- ADRs may be triggered by abnormal coding/billing patterns or if additional information is needed in order to determine if the services were medically necessary, etc.

- ADR should be carefully reviewed for provider, dates of service and documentation requested.
    - Requests only allow 45 days to respond, therefore, timing is critical in responding.
    - The date is 45 days from the date the letter was sent, not received by the hospital or provider's office.

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Responding to ADRs and Prep of Packets

- ADR should be carefully reviewed for provider, dates of service, and documentation requested
  - Requests only allow 45 days to respond, therefore, timing is critical in responding
  - The date is 45 days from the date the letter was sent, not received by the hospital or provider’s office

- Request needs to be logged in tracking method (to be discussed on later slide)
- Method of response should also be logged (electronic submission on portal or sent via mail securely and with tracking)

- Copies of all documentation sent with copy of the ADR should be kept in the event an appeal is necessary

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Who Is Involved in Processing and Responding

- Main concern is that those involved understand the request and what needs to be sent in response
  - If there are records available for dates of service on prior dates, those should also be sent as the records may support medical necessity of continued care

- Person responding should have a thorough knowledge of the medical record documentation, be able to understand what is being requested, and know who to contact if there are questions or clarification is needed
  - The documentation should be reviewed prior to the records being sent to be certain that they are complete
  - Records should be compiled in a logical order
  - Numbering pages will assist if there is a future discussion with auditing entity

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Reviewing the ADR Reply

Copy both sides of the documents → Organize the documents → Paginate the documents → Cover letters are at the discretion of the provider → Quality review the documents → Provide a signature log (if applicable) → Attach the ADR to the top of the records → Return records to the MAC within 45 days (suggest mailing in 30 days)

- Avoid two-sided copies (copy each side if necessary)
- Arrange the packet so that it clearly supports the flow and treatment progression
- Number the pages (in ink)
- Additional letters of medical necessity may be needed
- Confirm all the documents are legible
- Keep a copy and put the ADR on top
- Set a 30-day response time

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Managing External Audits

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Managing External Audits

- Know who is auditing what and why
  - Use that information to help drive proactive education or reviews
- Identify areas or departments with high audit potential
- Review other published audits or reviews
  - Most MACs and other contractors will publish results or general findings
- Know or establish internal processes
- Use this information
- Track all external audit activity

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Who Is Auditing What and Why

- Known topics and services are identified
- Drives internal review plan
- Provides opportunity for department specific review
  - High likelihood for external audit activity
- Provides direction for internal plans
  - Educational activities
  - Proactive and responsive
  - Effective and supportive
- Confirm internal team members
- Confirm reporting structure

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Who Is Auditing What and Why

- Most contractors publish what is being audited
  - Check routinely for changes and updates
  - Part A/Part B
  - DME/HHA
- Keep your “topic” list current and dated
- Recommend monthly update

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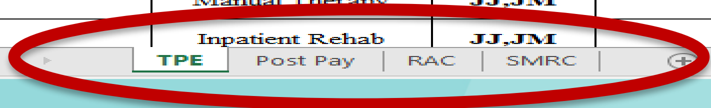
A	B	C	D	E	F	G
Noridian	**Surgical Debridement**	JE	N			
Novitas	OP OT/PT	JL, JH	Y	ESRD	JL, JH	Y
	ESRD	JL, JH	Y	Outpatient Rehab	JL, JH	Y
	Debridement 11042	JL, JH	Y	Cataract removal	JH	Y
	Prolia Injections	JL, JH	Y	Drugs/Biologicals	JL, JH	Y
				Psychiatric services	JL, JH	Y
				Moh's surgery	JL, JH	Y
				Nail Cutting and Debridement	JL, JH	Y
				Anesthesia services for diagnostic procedures	JL, JH	Y
				Trigger point injections	JL, JH	Y
				Paravertebral facet joint injections	JL, JH	Y
				Epidural injections for pain mangement	JL, JH	Y
Palmetto	**HBO -G0277**	**JJ, JM**	Y	Drug Assay testing	**JJ, JM**	
	Manual Therapy	**JJ,JM**		Therapeutic Exercise	**JJ, JM**	
	Inpatient Rehab	**JJ,JM**		Ambulance	**JJ, JM**	



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SMRC Current Projects

- Noridian
  - https://www.noridiansmrc.com/
  - Current and completed projects
  - Includes required documentation
  - Discussion and education

Access current projects below.

If the project is not listed, please see the Completed Projects.

NOTE: At CMS discretion, not all projects will be made available on this website.

Project ID	Project Title
01-034 Phase I and II	Transforaminal Epidural Injections
01-045	Malnutrition
01-047	Electrodiagnostic Testing Axial Muscles and Spinal Levels
01-049	Vitamin D Testing
01-054	Carotid Artery Screening/Testing
01-055	Audio Only Telehealth Services During the PHE
01-057	Potentially Unnecessary Surgeries
01-058	Traditional Telehealth
01-060	E&M No Response Providers DME Part II
01-062	EDX Diabetes

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SMRC Completed Projects

- Noridian
  - https://www.noridiansmrc.com/
  - Current and completed projects
  - Includes required documentation
  - Discussion and education

When a project is completed, Noridian will forward the identified improper payments to CMS. CMS will direct the appropriate Medicare Administrative Contractor (MAC) to initiate the claim adjustments and/or overpayment recoupment actions.

Access completed projects below.

Project Number	Project Title	Error Rate
01-002	Kwashiorkor	4%
01-003	Hospital Outpatient Dental Services	91%
01-004	Specimen Validity	78%
01-005	Spinal Fusion	25%
01-006	Inpatient Bone Marrow and Stem Cell Transplant Procedures	86%
01-008	Electrodiagnostic Testing	58%
01-009	General Inpatient Hospice	36%
01-010	PAP Replacement Supplies and Accessories	68%
01-012	Emergency Ambulance	98%
01-013	Hospice Portfolio	38%
01-015	Non-Emergency Ambulance	79%
01-019	Spinal Cord Stimulator	36%
01-020	Outpatient Hyperbaric Oxygen (HBO)	38%
01-021	No Response Provider DME-DTS	86%
01-022	Emergency Ambulance	92%

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SMRC Completed Projects

- Noridian
  - https://www.noridiansmrc.com/
  - Completed project
  - Audit results
    - Common denial reasons
    - What NOT to do

01-020 Outpatient Hyperbaric Oxygen (HBO) Findings of Medical Review

Noridian Healthcare Solutions, LLC, as the Supplemental Medical Review Contractor (SMRC) for the CMS, has conducted post-payment review of claims for Medicare Hyperbaric Oxygen (HBO) Therapy billed on dates of service from January 1, 2018 through December 31, 2018. Below are the review results:

Project ID	Project Title	Error Rate
01-020	Outpatient Hyperbaric Oxygen (HBO)	38%

Background

Over the years, HBO therapy services formed the basis of several Office of Inspector General (OIG) reports. Findings from these OIG reports note that Medicare beneficiaries received treatments for noncovered conditions, medical documentation did not adequately support treatments, and that Medicare beneficiaries received more treatments than were considered medically necessary. Recent OIG findings in two 2018 reports (A-01-15-00515 and A-04-16-06196) noted that documentation frequently did not support medical necessity of the services.

Reason for Review

CMS tasked Noridian, as the SMRC, to perform data analysis and conduct medical review. Noridian completed medical record review on claims in accordance with applicable statutory, regulatory, and sub-regulatory guidance.

Common Reasons for Denial

- No Response to the Documentation Request
  - CMS Internet-Only Manuals, Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.2.3.8 requires providers/suppliers to respond to requests for documentation within 45 calendar days of the additional documentation request. The documentation was not submitted or not submitted timely.
- Insufficient Documentation
  - CMS Internet-Only Manuals, Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.6.2.2 outlines a service is to be considered reasonable and necessary when it is furnished in accordance with accepted standards of medical practice. In addition, Local Coverage Determinations (LCDs) L3521, *Hyperbaric Oxygen (HBO) Therapy*, and L36504, *Hyperbaric Oxygen (HBO) Therapy*, indicate that documentation must include, "Documentation of the procedure (logs) including ascent time, descent time and pressurization level." Documentation of the procedure was not submitted or missing one or more required elements.
- Standard Wound Therapy
  - Medicare National Coverage Determinations (NCD) Manual, Pub. No. 100-03, Chapter 1, Section 20.29 states "HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30-days of treatment with standard wound therapy and must be used in addition to standard wound care." The documentation did not support the beneficiary failed an adequate course of standard wound therapy.

RAC Approved Services

- RAC reviewed services/topics must be approved
- Regional contractors
- Will generally provide follow up education
- Stay a step ahead

A	B	C	D	E	F	G	H
0158-Outpatient Therapy Services During Home Health: Unbundling	Automated	Outpatient facility	All A/B Macs	6/4/2019	On claims submitted by providers using the institutional claim format, CWF enforces consolidated billing for outpatient therapies by recognizing as therapies all services billed under revenue codes 042X, 043X, 044X.	CPT/HCPCS codes billed with Revenue codes 042x, 043x or 044x	
0169-Outpatient Services within 3 days prior to and including the date of a Hospital Admission: Unbundling	Automated	Outpatient facility	All A/B Macs	11/5/2019	All diagnostic (including clinical diagnostic laboratory tests) services and related non-diagnostic services provided to a beneficiary by the admitting hospital within 3 days (for IPPS Hospitals) prior to or 1 day (NON IPPS Hospitals) prior to including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment.	All diagnostic and non-diagnostic CPT/HCSPCS codes.	
0161-Therapeutic, Prophylactic, and Diagnostic Injections and Infusions: Medical Necessity and Documentation Requirements	Complex	Outpatient facility	All A/B Macs	11/5/2019	Documentation will be reviewed to determine if correct billing, coding, and medical necessity guidelines for Therapeutic, Prophylactic, and Diagnostic Injections and Infusions were met.	96365, 96366	
0173- Surgical Dressings: Medical Necessity and Documentation Requirements	Complex	DME by supplier/DME by physician	All DME Macs	12/10/2019	Description This review will determine if the Surgical Dressing is reasonable and necessary for the patient's condition based on the documentation in the medical record. Claims that do not meet the indications of coverage and/or medical necessity will be denied.	A6010, A6021, A6196, A6197, A6210, A6211, A6212	
0193-Bioengineered Skin Substitutes: Excessive or Insufficient Units Billed	Complex	Outpatient Hospital, Professional Services	All A/B Macs	9/8/2020	*Drug and Biological products as defined by HCPCS Level II Codes and are billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed must be assigned based on the dosage increment specified in that HCPCS long descriptor, and correspond to the actual amount of the skin substitute applied to the patient, including any appropriate discarded waste. If the quantity of skin substitute applied to the wound used in the treatment plan of a patient is less than a multiple of the defined billing unit for the supported HCPCS code dosage descriptor, the provider must round to the next highest whole unit. The quantity used in the application of the skin substitute is billed on a separate line item of the allowable wastage appended with the JW modifier. When multiple sizes of a specific skin substitute product are available, the provider shall utilize and bill for the size that most efficiently fits the wound for application with the least amount of wastage. *Documentation must support the service provided with the number of units billed as it correlates to the dosage increment specified in the HCPCS long descriptor. Units billed must also correspond to the actual quantity of skin substitute product applied to the wound during the treatment plan of the patient, including any appropriate discarded waste. The skin substitute product applied in the treatment of the patient must correlate with the appropriately rendered HCPCS code paid. *Claims for skin substitute products billed with excessive and/or insufficient units are reviewed by a registered nurse, pharmacist, certified pharmacy technician, or certified coder to determine the correct number of billable and payable units for the associated HCPCS code utilizing the package size that best fits the wound with the least amount of wastage.	Q4100, Q4101, Q4102, Q4104, Q4105, Q4106, Q4107, Q4108, Q4110, Q4111, Q4112, Q4113, Q4114, Q4115, Q4116, Q4117, Q4121, Q4122, Q4123, Q4124, Q4125, Q4126, Q4127, Q4128, Q4130, Q4131, Q4132, Q4133, Q4134, Q4135, Q4136, Q4137, Q4138, Q4140, Q4141, Q4142, Q4143, Q4146, Q4147, Q4148, Q4150, Q4151, Q4152, Q4153, Q4154, Q4156, Q4157, Q4158, Q4159, Q4160, Q4161, Q4163, Q4164, Q4165, Q4166, Q4167, Q4169, Q4170, Q4172, Q4173, Q4175, Q4186, Q4195, Q4196, Q4197, Q4205, Q4209, Q4210, Q4211, Q4220, Q4221, Q4222, Q4226	

TPE | Post Pay | RAC | SMRC

Managing Audit Results and Common Errors

Common claim errors

- Signature of ordering and/or performing provider not included
- Encounter notes do not support elements of eligibility
- Documentation does not meet medical necessity
- Missing or incomplete plan of care/treatment timeline and goals
- Inconsistent documentation
    - Laterality
    - Wound etiology
    - Comorbid conditions
        - Diabetes Type 1 or Type 2?
- What to do about these errors?

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Managing Audit Results and Common Errors

What to do about errors or unfavorable findings?

- Provide clear direction
- Education
  - Providers
  - Staff (clinical and non-clinical)
  - Administrative team
- Establish corrective action plans
  - Include detailed follow up plan
  - Notate improvement
- Written process improvement plan may be required

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Manage Audit Prep and Game Plan

- Establish internal team
  - HIM/coding
  - Revenue cycle/billing
  - Revenue integrity
  - Compliance
  - Prepare complete packet/reply
- Monitoring request/monitor outcome/track all external audit activity
- Appeal (if needed)
- Be proactive: look before someone else looks
  - Internal audit plan
- Services/random sample
- Consider using OIG resources

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Manage Audit Prep and Game Plan

What do you need

- Documentation of encounter
- Superbills/encounter forms/charge capture documents
- Claim forms
- EOB/remittance advice
- Payer polices
  - Complete repository of all related Local Coverage Determinations (LCD), National Coverage Determinations (NCD), payer policies
- Depending on service audit, review other documentation

What do you do with the results/findings

- Documented education
- Who was educated and why

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Tracking External Audits

- All external activity must be tracked or logged
- Strive for automation
- Suggest notification form
  - Required date/information fields
- Notification form
  - Feeds tracker (spreadsheet)
  - Easy set up
- Determine what information is really needed for the tracker
  - Audit type, # patients, #DOS, contractor, coding info, status/outcome

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Post-Audit Education

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Who Offers Education?

- Education more readily available
- SMRC
  - D&E (Discussion and education)
  - Must be requested
- TPE
  - Education/End of each round
- RAC
  - Post audit education available
  - Must be requested
- Unified Program Integrity Contractor
  - Detailed education available
- MAC pre- and post-reviews
  - Can also include education

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Do I Need the Education?

- YES, regardless of the findings!
- Consider appeal process
- Always take the education
- Never skip time with the auditor
- Opportunity to point out any oversights by the auditor
- Better understanding of contractors' general claims processing guidelines
- May require
  - Corrective Action Plan (CAP)
  - Process Improvement Plan (PIP)
    - Clear format
    - Identify each error or concern

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Who Should Participate in the Education?

- Everyone, if possible (but we know it’s not)
- Internal audit team
  - Revenue integrity
  - Revenue cycle
  - Compliance
- Provider of service
  - Provider’s staff if possible
- Coding and/or billing staff
- Targeted department
  - Clinical and non-clinical staff
- Track education (external and internal)
- Note improvements and all follow up action

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Resources and References

- 2022 Program Audit Process Overview (cms.gov)
- Supplemental Medical Review Contractor | CMS
    - https://www.noridiansmrc.com/
- What's the Comprehensive Error Rate Testing (CERT) Program? | CMS
- Targeted Probe and Educate | CMS
    - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE
- Medical Review and Education | CMS
- Each MACs website:
    - Noridian
    - Novitas Solutions
    - First Coast Service Options
    - NGS
    - CGS
    - Palmetto GBA

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Thank you!

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