

# **Medicare Audits**

## **A Survival Guide for**

## **Skilled Nursing Facilities**

**Maureen McCarthy, RN, BS, RAC-MT, CQP-MT**

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# **Medicare Oversight of Skilled Nursing Facilities**

There are public and private entities with the authority to audit claims filed by a skilled nursing facility (SNF) to Medicare Part A. The primary responsibility for oversight of Medicare falls on the federal government and the U.S. Department of Health and Human Services (HHS). However, HHS does contract certain services out to private companies, and, as a result, some of these companies also share responsibility in oversight of SNFs.

## **Government Oversight**

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The Centers for Medicare & Medicaid Services (CMS) is a component of HHS and is responsible for the overall administration of the Medicare program. In 2011, CMS announced its Triple Aim, which addresses healthcare reform and will focus on three main areas:

1. Improving healthcare of the population
2. Reducing costs
3. Improving patient and caregiver experience

In addition to the Triple Aim, CMS:

- Oversees the administration of The Affordable Care Act and the Improving Medicare Post-Acute Transformation Act of 2014 (IMPACT Act)
- Develops coverage policies
- Implements payment methodologies

- Processes claims
- Ensures proper payments
- Provides education to providers and beneficiaries
- Monitors providers
- Ensures that the beneficiaries receive high-quality healthcare

CMS contracts with private companies to conduct many of the tasks associated with these responsibilities, as noted in this chapter. Many people outside the industry are unaware that private contracts administer almost every aspect of the Medicare program.

## **Fighting Healthcare Fraud**

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On December 14, 2015, the Obama Administration made fighting healthcare fraud one of its top priorities. In Medicare and Medicaid, these efforts are already paying off. In 2015, CMS announced a record recovery of \$4.1 billion in taxpayer dollars. Four years prior, that number was only a little more than \$1 billion.

These efforts reflect a broad range of steps taken to improve the government's ability to detect and go after fraud. For example:

- Under the Affordable Care Act, there are new authorities to fight fraud. This includes additional scrutiny for higher-risk categories of providers and suppliers before they're able to bill Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) and new authority to suspend payments during the investigation of fraud.
- CMS instituted tougher new rules and sentences for criminals. From 2008 to 2011, there has been a 75% increase in individuals charged with criminal healthcare fraud.
- CMS is implementing a groundbreaking Healthcare Fraud Prevention Partnership, where the federal government and private and state organizations, including insurers, work together to prevent healthcare fraud.

- CMS has implemented a new Fraud Prevention System that uses predictive modeling technology, similar to the technology that credit card companies use to flag suspicious activity, to review medical claims before they are paid.

CMS has released a report on the first-year results of the Fraud Prevention System (FPS) ([www.stopmedicarefraud.gov/fraud-rtc06242014.pdf](http://www.stopmedicarefraud.gov/fraud-rtc06242014.pdf)). Since the technology was first rolled out in 2011, all Part A and B Medicare claims—over one billion—have run through the system. In the first year in operation, the system initiated 536 new investigations and helped stop, prevent, or identify an estimated \$115 million in fraudulent payments. In fiscal year 2013, CMS took administrative action against 938 providers and suppliers due to the FPS. During this time, the FPS identified or prevented more than \$210.7 million through administrative actions taken due to the FPS or through investigations corroborated, augmented, or expedited by information in the FPS.

## Command Center Speeds Up Antifraud Efforts

July 31, 2015

*By Dr. Peter Budetti, CMS Deputy Administrator and Director of the Center for Program Integrity*

On July 31, 2015, CMS and HHS announced the new CMS Program Integrity Command Center that is speeding up the process of identifying fraud and stopping criminals from defrauding Medicare and Medicaid.

The new Command Center is bringing together Medicare and Medicaid officials, as well as law enforcement partners from the HHS Office of Inspector General (OIG), the Federal Bureau of Investigation, and CMS's antifraud investigators. The Command Center will gather experts from all different areas—clinicians, data analysts, fraud investigators, and policy experts—into the same room to build and improve our sophisticated new predictive analytics that spot fraud and to then move quickly on a lead once potential fraud is identified. The technology also allows us to connect with field offices to track down leads in real time.

The result is that investigations that used to take days and weeks can now be done in a matter of hours. And this new technology can help detect and prevent potential problems and payments. That can mean millions of taxpayer dollars staying out of the hands of fraudsters. This is one more part of the Obama Administration's effort to fight fraud and waste in our healthcare system. The health reform law gives law enforcement more tools to go after fraudsters and establishes tougher sentences once we catch those criminals. We're already seeing results. Four years ago, the government recovered just over \$1 billion in fraudulent payments; this year, it's over \$4 billion, a record number. We had the largest healthcare fraud busts in history in 2012.

CMS is working to continue improving the system and refine the way to track the results. Law enforcement partners have made important suggestions on how to improve metrics for reporting these savings, and the Medicare Administrative Contractors are working to implement their recommendations. They agree that this is an important system that will strengthen our efforts to fight fraud, waste, and abuse.

### ***Office of Inspector General***

The OIG is another component of HHS. The primary responsibility is to protect the integrity of HHS programs, most notably the Medicare program. In addition, the OIG protects the welfare of the beneficiaries of these programs. The OIG reports Medicare program management problems and offers recommendations to fix them to the secretary of HHS and to Congress. It achieves these duties by conducting audits, investigations, evaluations, and reports. There are several agencies with different responsibilities under the OIG.

### ***The Office of Management and Policy***

The Office of Management and Policy (OMP) formulates and executes the OIG budget, develops general management policies and procedures, and oversees information technology resources. In simple terms, the OMP provides management and administrative support to the Inspector General.

### ***The Office of Evaluation and Inspections***

The Office of Evaluation and Inspections (OEI) essentially evaluates the efficiency and effectiveness of the Medicare program. The OEI will evaluate the program to detect potential vulnerabilities in the system. In its reports, it recommends changes in policies, laws, and regulations and then monitors those changes to determine the effects on the overall effectiveness and efficiency in reducing fraud, waste, and abuse in the Medicare program.

### ***The Office of Counsel to the Inspector General***

The legal counsel to the Inspector General is provided by the Office of Counsel to the Inspector General (OCIG). The OCIG is responsible for overseeing legal issues and providing legal advice for all departments in the OIG. This includes the proposal and subsequent litigation involving civil monetary penalties and cases in which the OIG has recommended that individuals or entities be excluded from participating in any federal government entitlement programs, such as Medicare.

The OCIG also assists in coordinating issues related to the False Claims Act, matters related to civil and administrative law enforcement, and cases in which providers have voluntary disclosed overpayment or OIG violations through their self-disclosure protocol. The OCIG is instrumental in providing guidance to all types of providers on how to successfully implement an effective compliance program within their organizations. Also, as part of a settlement agreement, if a provider has agreed to a corporate integrity agreement (CIA) with the federal government to avoid future issues, the OCIG is responsible for monitoring that provider's adherence to the details of the CIA. Further, the OIG is responsible for issuing various types of guidance and alerts to contractors, providers, and beneficiaries, such as advisory opinions, fraud alerts, and special advisory bulletins. As legal counsel, the OCIG reviews all these documents before they are released. Examples of these types of alerts and guidance are found on the OIG's website at [www.oig.hhs.gov](http://www.oig.hhs.gov).

### ***The Office of Audit Services***

The Office of Audit Services (OAS) is responsible for developing, conducting, and overseeing comprehensive audits of various HHS programs, including Medicare. This includes audits on the effectiveness of contractors involved in the administration and oversight of the Medicare program. OAS is also responsible for conducting quality assurance reviews of other OIG components to ensure that policies were followed appropriately and that laws, regulations, and standards are applied in their operations and audit activities.

### ***The Office of Investigations***

Lastly, the OIG Office of Investigations (OI) is responsible for investigating fraud and abuse in HHS programs, such as Medicare. The OI employs analysts and special agents that investigate providers, beneficiaries, grantees, contractors, and HHS employees in performance of their official duties. The cases they investigate are referred to the U.S. Department of Justice for criminal or civil prosecution. The agents employed in the OI are federal law enforcement officers. The OI serves as a liaison between individuals or entities that have been excluded and CMS, state licensure boards, and other organizations. The OIG has other enforcement duties and works closely with federal and state investigative agencies, such as the FBI and State Medicaid Fraud Control Units, in support of its mission to investigate healthcare fraud and abuse.

A summary map of all the OIG components that illustrates the expansiveness of the organization is available at [https://oig.hhs.gov/organization/files/component\\_map.pdf](https://oig.hhs.gov/organization/files/component_map.pdf).

## Government Contractors

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CMS contracts with private businesses to assist in administering and conducting oversight activities of the Medicare program. Essentially, all aspects of the Medicare program, from claims processing and provider enrollment to medical review and fraud investigations, are contracted by CMS to government contractors.

### ***Medicare Administrative Contractors***

When it comes to SNF services billed under Medicare Part A, CMS has contracted with entities called Medicare Administrative Contractors (MAC). These entities, previously called fiscal intermediaries, were born out of section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which called for Medicare contracting reform, in accordance with the Federal Acquisition Regulation.

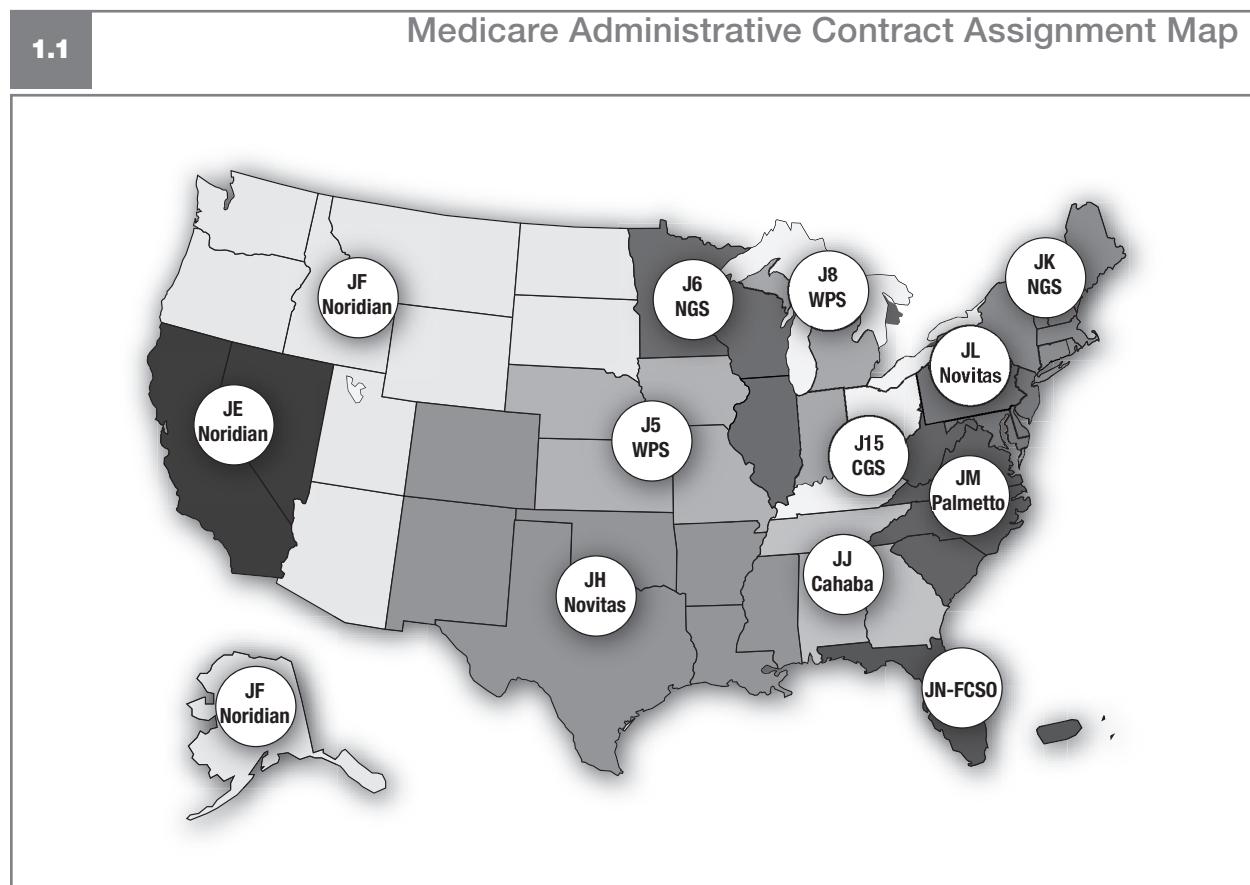
The reform included identifying specific jurisdictions for these contractors to operate in. The jurisdictions were designed by CMS “to balance the allocation of workloads, promote competition, account for integration of claims-processing activities, and mitigate the risk to the Medicare program during transition to the new contractors.”

MACs conduct administrative functions related to Medicare. The major functions conducted by MACs include claims processing, beneficiary and provider customer service functions, appeals, education and outreach, financial management, provider enrollment, reimbursement, information systems security, and payment safeguards. The payment safeguard function listed includes medical review and audit functions, which will be addressed more comprehensively in Chapter 3. In order to perform these safeguard functions, a MAC is authorized to audit a provider’s claims to determine that the services billed were medically reasonable and necessary. The jurisdictions were supposed to be reduced to 10 for the country, but the last two (J13 and J15) consolidations were postponed in 2014, so there are currently 12 MACs. They are as follows:

- National Government Services J-K, J-6

- Novitas, J-H, J-L
- Noridian, J-F, J-E
- Wisconsin Physician Services, J-5, J-8
- CGS, J-15
- Palmetto, J-M
- Cahaba, J-J
- First Coast (FCSO), J-N

See Figure 1.1 for MAC assignments throughout the country. ([www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-July-2016.pdf](http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-July-2016.pdf))



### ***Recovery Audit Contractors***

The Medicare Modernization Act of 2003 instructed HHS to conduct a three-year demonstration project in five states involving private companies contracted to review Medicare claims to detect improper payments. This includes both overpayments and underpayments. This demonstration project was conducted in California, Florida, Massachusetts, New York, and South Carolina. After it ended March 27, 2008, the Recovery Audit Contractors (RAC) identified and corrected more than \$1.03 billion in improper payments. An overwhelming majority of the improper payments (96%, or \$992.7 million) were overpayments that providers were required to refund, whereas the remaining amount (4%, or \$37.8 million) were underpayments for which providers were reimbursed correctly. Although this is a large amount of money, it accounted for only 0.3% of all the claims that were available for review. The RACs were authorized to review about \$317 billion worth of claims in the demonstration project. About \$16.3 million (2%) in identified overpayments were related to SNF services.

The Tax Relief and Healthcare Act of 2006 made the RAC program permanent and required that HHS expand the program to all 50 states by 2010. The contracts were divided geographically into four regions and awarded to private contractors.

As part of their processes and functions to detect improper payments, RACs audit healthcare facility records to determine whether claims were paid appropriately. Their tasks are outlined in greater detail in Chapter 4 of this book. There has been a lot of concern among the provider community regarding RACs because, for the first time, CMS is reimbursing these contractors on a contingency basis. Therefore, there is seemingly an incentive for these types of contractors to identify overpayments made to facilities in an effort to maximize their own profits. Specifically, the contingency fees run between 9% and 12.5%. Although this concern is certainly understandable and legitimate, the program does call for any contingency payments made to the RAC to be offset from future payments if the decisions are overturned at any level of appeal. Also, CMS will conduct routine oversight and monitoring of these contractors to ensure compliance with Medicare policies.

### ***Program Safeguard Contractors and Zone Program Integrity Contractors***

The purpose of these contractors is two-fold; however, in the late 1990s, CMS began using the terms “benefit integrity” and “program integrity” more widely to describe the functions of the

antifraud unit in an effort to perhaps appear more provider-friendly. CMS and its contractors, after all, were not law enforcement and had no authority to conduct comprehensive law enforcement investigations. However, CMS still had responsibility in the administration of the Medicare program, which included oversight functions. Therefore, the oversight responsibilities were part of the functions of the fiscal intermediaries at the time, now known as the MACs.

CMS has announced interest in combining Zone Program Integrity Contractors (ZPIC) and Medicaid Program Integrity Contractors, which will be known as UPICs (Universal Program Integrity Contractors). These contractors have not yet been assigned or announced.

The Health Insurance Portability and Accountability Act of 1996 added section 1893 to the Social Security Act. This section removed funding from the fiscal intermediaries' budgets to perform benefit integrity and medical review audits and created the Medicare Integrity Program (MIP). Essentially, MIP was established to help strengthen CMS' ability to detect and deter fraud committed against the Medicare program. CMS was provided the authority to contract with a broader group of entities to conduct these activities. Private contractors competed for an umbrella contract to become a PSC. Although the intent was to have new and independent entities conducting payment safeguard activities, many of the PSC umbrella awards were made to companies that also served as carriers and intermediaries and processed claims for Medicare.

Regardless, CMS awarded individual contracts to PSCs to conduct the activities outlined in the *Medicare Program Integrity Manual* (Publication 100-8). These contractors focused mainly on a specific line of business, such as Medicare Part A, in a specific region. So in any given state, there might be one PSC that would investigate fraud in Medicare Part A claims, a second company investigating fraud in Medicare Part B claims, a third company investigating home health and hospice claims, and a fourth company reviewing claims for medical equipment.

With the implementation of the prescription drug benefit, Medicare Integrity Contractors started investigating Part D claims, and Medicare Managed Care plans were responsible for their own oversight. Although this system allowed for companies to focus on specific areas and gain significant expertise, it also created a very disjointed system. The PSCs were private companies in competition with one another, and, as a result, the sharing of information was not widely practiced, and scams or schemes across multiple lines of business were nearly impossible to detect, because these companies were unable to or did not share claims data with each

other. So, independently of each other, PSCs conducted investigations to detect fraudulent behavior, determine the magnitude of the fraud, and refer cases to the OIG or other law enforcement entities.

In July 2007, the OIG conducted an analysis of the effectiveness of PSCs and their activities to detect and deter fraud and abuse. The overall findings were not very favorable of the actions conducted by the PSCs or of the oversight that CMS had of these contractors. More specifically, they found a wide disparity between the workload of each individual contractor, which did not correlate with the size of its budget or its oversight responsibilities. Also, despite a push from CMS for PSCs to focus on this, the OIG found that most PSCs had minimal results from analyzing claims data proactively to detect aberrancies.

Because Medicare contracting reform had been implemented and MACs had been identified to conduct administrative responsibilities (e.g., claims processing, customer service, provider enrollment, education, appeals), CMS decided to change the program integrity functions performed by PSCs. As a result, they created seven zones to align more closely with the MAC jurisdictions and identified new entities called ZPICs. The zones were again designed to evenly distribute workload among all zones. These ZPICs identify, detect, and investigate potentially fraudulent behavior across all lines of business within a certain jurisdiction.

For an interactive map of the current ZPIC contractors, go to [www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-FFS-compliance-programs/review-contractor-directory-interactive-map](http://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-FFS-compliance-programs/review-contractor-directory-interactive-map).

In addition to the Medicare investigations, Medicaid also has an auditing entity on the state side that monitors payment error rates in the Medicaid system. These auditors measure payment error rates and are called payment error rate measurement (PERM) auditors. PERM auditors were assigned based on the Improper Payment Information Act (IPA) of 2002, amended in 2010.

The PERM auditors assigned to all 50 states are as follows:

- The Lewin Group (statistical contractor)
- A+ Government Solutions (review contractor)

To further illustrate the difference in the PSC environment and the ZPIC environment, among other things, the ZPICs will perform the following major tasks across each line of business:

- Data analysis and data mining
- Medical review in support of benefit integrity
- Fraud and abuse investigations
- Law enforcement support
- Recommending administrative actions
- Referring cases to law enforcement

More details on the types of reviews conducted by these entities are included in Chapter 5 of this book.

## **Comprehensive Error Rate Testing Program**

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In 2003, CMS implemented the Comprehensive Error Rate Testing (CERT) program as a tool to calculate provider and contractor error rates. CMS selected a contractor that would review approximately 120,000 randomly selected claims filed with the Medicare program. The CERT contractor sends letters to providers requesting records to support the claims filed. The contractor will then review the claims and the documentation submitted by the provider to determine whether Medicare coverage policies and billing rules were applied appropriately and coding was valid.

Essentially, the CERT contractor is trying to determine how well providers prepare their claims for submission as well as how the contractors that process the claims perform. It will utilize a sampling methodology approved by the OIG to calculate a provider compliance error rate among all fee-for-service claims. The purpose of this is to estimate improper payments. The OIG estimates that up to 10% of Medicare payments are improper. If the CERT contractor determines the claim was paid incorrectly, the claims are adjusted accordingly, and an overpayment may be initiated.

## Medicare Advantage Plans

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If a beneficiary chooses to purchase a Medicare Advantage plan through a private insurer, then the insurer has the authority to conduct reviews of facilities included in its network to make sure that claims are being filed and paid appropriately. Historically, the extent to which a private insurer reviews providers in its own network varies greatly. Many Medicare Advantage plans have special investigation units and medical review departments that are responsible for reviewing allegations of fraud or to determine whether services billed are medically reasonable and necessary.

CMS is making significant moves to obtain better control and monitoring of Medicare Advantage claims. Most notably, it requires that all Medicare Advantage plans implement fraud, waste, and abuse training to all entities that they are partnering with to provide benefits and services in the Part C program. Additionally, in the *Statement of Work* for the ZPICs discussed previously, there is a separate task order listed that would require them to investigate fraud in Medicare Part C. Although these task orders are not yet implemented with any of the ZPICs, it does show that CMS is interested in taking on more of this responsibility in the future. As a result, facilities may see more audits and reviews being conducted on Medicare Advantage claims.

# **Medicare Audits**

## **A Survival Guide for Skilled Nursing Facilities**

**Maureen McCarthy, RN, BS, RAC-MT, CQP-MT**

Reduce the fear of an impending audit and take a proactive approach to preparedness. **Medicare Audits: A Survival Guide for Skilled Nursing Facilities** provides detailed guidance on the various Medicare audits SNFs face. Author Maureen McCarthy, RN, BS, RAC-MT, CQP-MT, breaks down RAC, MAC, and ZPIC audits; CERT reviews; and more. Detailed descriptions, case studies, and example scenarios provide readers with the tools to understand how to prepare for each phase of an audit and what to expect once the audit is over.



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