PPRC

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Payer Audits and Payment Recoupments

Medical Billing & Coding Audits and Investigations

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CME Disclosure

The Department of Continuing Education and Certification (DCEC) of the Massachusetts Medical Society has determined that none of the individuals in control of the content of the following CME activities, including faculty speakers, planners, and reviewers have any relevant financial relationships to disclose.

Elizabeth-Ann S. Foley

Elizabeth Foley is an Attorney in Donoghue Barrett & Singal's Health Law practice, whose clients benefit from her twenty-five years of specialized health care and litigation experience in health care fraud and abuse, Medicare, Medicaid and third-party payer billing and coding audits, white-collar civil and criminal investigations, and physician and other health care practitioner disciplinary matters. Elizabeth also counsels her clients on how to achieve corporate compliance with all state and federal rules and regulations.

Elizabeth has a wide range of experience handling civil and criminal complex matters before the trial courts throughout the Commonwealth of Massachusetts. She counsels hospitals, physician practices, and skilled nursing facilities with issues involving billing and coding audits, data security breaches, the Health Insurance Portability & Accountability Act (HIPAA), the Civil Monetary Penalties Law (CMPL), the Anti-Kickback Statute (AKS), and the False Claims Act (FCA), among others. Elizabeth has expertise in advising healthcare practitioners with licensing and/or disciplinary actions before various professional boards, such as the Massachusetts Board of Registration in Medicine, Division of Health Professions Licensure, and the Boards of Registration in Nursing and Pharmacy. She also guides clients through all phases of state and federal governmental inquiries and investigations, including responding to subpoenas, rendering grand jury testimony, and the execution of search warrants.

Prior to joining Donoghue Barrett & Singal, Elizabeth was Senior Counsel at Blue Cross Blue Shield of Massachusetts, Inc. where she co-managed the Fraud Investigation and Prevention Unit. Elizabeth also served as Assistant Attorney General for ten years, five of which were with the Medicaid Fraud Control Unit within the Office of the Attorney General.

PURPOSE

- **This presentation will:**
  - Identify who conducts medical billing and coding audits and investigations
  - Describe activities that lead to medical billing and coding fraud audits and investigations
  - Describe new enforcement tools used to combat medical billing and coding fraud
  - Provide recommendations in the event of an audit or investigation of your practice

Why is this Important to Health Care Practitioners?

- Violating federal and state health care fraud laws can result in:
  - Criminal penalties
  - Civil fines
  - Exclusion from federal healthcare programs
  - Termination of provider contracts with private health plans
  - Loss of medical license from the state medical board

- Heightened focus on combatting fraud

- Audits and investigations take lots of time!

Why is this Important to Health Care Practitioners?

FY 2014:

- Over $4.9 billion in expected recoveries from federal audits and investigations
- 4,017 individuals and entities excluded from participation in federal health care programs
- 971 criminal actions against individuals or entities that engaged in crimes against HHS programs
- 533 civil actions, including false claims and unjust enrichment lawsuits, civil monetary penalty settlements, and recoveries related to provider self-disclosure matters

Who Conducts Billing & Coding Audits and Investigations?

- Attorney General's Office, Medicaid Fraud Control Units (MFCU)
- U.S. Attorney's Office
- U.S. Dept. of Justice, Civil Division (DOJ)
- Office of Inspector General, HHS (OIG)
- CMS Recovery Audit Contractors (RAC)
- CMS Zone Program Integrity Contractors (ZPIC)
- Private Health Plan Fraud Investigation Units

Examples of False Claims

The following is provided for illustrative purposes only and is not an exhaustive listing:

- Billing for services or goods that were never rendered or delivered
- Performing medically unnecessary services solely for the purpose of generating insurance payments from Medicare, Medicaid or Private Payers
- Unbundling-Using multiple codes instead of one comprehensive billing code to increase payment
- Bundling-Billing for a panel of tests when only one or two tests are ordered and/or medically necessary
- Upcoding-Billing for more expensive services or procedures than were actually provided or performed

Common Areas of Billing & Coding Claims Review

- E/M services

- OIG Report - May 2014
  - Sampled 360M+ E/M claims for services from 2010

  - 55% of claims incorrectly coded and/or lacking documentation resulting in $6.7B in improper Medicare payments

  - “High-coding” physicians more likely to be incorrectly coding than other physicians

  - Although E/M payment rates are small they account for nearly 30% of Part B payments overall

Common Areas of Billing & Coding Claims Review - continued

- E/M Services and Modifier 25
- Significant and separately identifiable E/M service by the same physician on the same day of the procedure or other services
- Rheumatology/Oncology – patients receiving infusions with high frequency and complexity of comorbidities
- Dermatology/ Otolaryngology – medically necessary vs. cosmetic removals
- **Conflict between payer's business judgment and the physician's medical judgment**

Common Areas of Billing & Coding Claims Review - continued

- Outliers or “Low-hanging fruit”
- Significant variation in utilization of certain codes compared to others in physician’s specialty
- Commercial payers often focus on particular code group, such as E/M services, or particular issue, such as medical necessity
- Federal government audits and investigations often focus on billing errors identified in prior studies
  - Comprehensive Error Rate Testing (CERT) studies
    (e.g., CPT code 99214)
  - Identified in annual OIG Work Plan

New Tools to Discover Billing & Coding Errors

Fraud Prevention Themes

- Moving away from "Pay and Chase" model
- Use of predictive analytics
- Administrative actions
  - revoking billing privileges
  - suspension of payments
- Partnerships between public and private payers for detection

Healthcare Fraud Prevention Partnership (HFPP)

- Initiated by HHS and OIG in July 2012
- Voluntary public-private partnership between Federal government, State officials, law enforcement, private health plans and associations, and anti-fraud associations
- Purpose is to improve detection and prevention of fraud through data sharing and analytics
- Goal is to reveal and halt scams that cut across public and private payers
- More coordination and education between auditors and investigators

MassHealth Predictive Modeling

- Use of analytical techniques and technology to derive or predict patterns from large amounts of data
- Proactively identifies trends and behavior that prevent payment of suspect claims in real time through MMIS, and detects potential inappropriate post-payments
- Suspect claims generate an “alert” requiring human intervention and evaluation to make final decision regarding the payment status of the claim

MassHealth Predictive Modeling - continued

- Uses algorithms based on detection scenarios learned through post-payment reviews
- Uses analytics to identify outliers and abnormalities to build peer comparisons
- Aggregates data from the following sources:
  - Historical claims data
  - Member and provider reference files
  - OIG Exclusion List
  - Managed Care Encounter Data
  - SSA Death File
  - State Debarment list
  - Secretary of State Corporate Database
  - Prior Approvals

Mandatory Self-Disclosures

- Self-Reported Overpayment Refund Process ("60-Day Rule")
  - Section 6402(a) of the ACA
  - Requires that identified overpayments be refunded within 60 days of identification, or 60 days after cost report is reconciled
  - Consequences: civil monetary penalties and false claims liability

- Proposed Rule issued (Feb. 2012)
  - 60-day clock starts after provider has chance to undertake a "reasonable inquiry"
  - Look back period may extend 10 years

You Receive a Request for Records and/or an Investigative Subpoena – Now What?

Recommendations

- Don’t blindly produce the records!
- Forward document request letter to person in your practice capable of handling the request and establishing line of communication with the payer
- Have billing specialist review the documents requested
- Are there any patterns of activity in the claims requested?
  - Is there a high utilization of certain codes in this data set for your specialty?
  - Does the data set contain billing codes found to be frequently billed in error (CERT studies)?

Recommendations - continued

- Is it a criminal or a civil audit?
- Consider consulting an attorney
- Take note of the date for the response – comply or request extensions as necessary
- Keep records of everything that was produced
- Review audit/investigative findings and consider challenging the review and/or exercising your appeal rights

Extrapolation

- Use of statistical sampling to project amount of overpayment
- Does not deny the provider due process "so long as extrapolation is made from a representative sample and is statistically significant."
- Private payers: generally no limit on number of records requested and look back period ranges from 3 to 6 years
- Public payers: typically limited on number of records requested and scope of review

  (e.g., RAC auditor has 3 year look back period)

Extrapolation - continued

- Biased sample can result in over-calculation of overpayment

- Conduct your own analysis
  - compare average paid amount per claim for universe of claims with the average paid amount per claim for the sample requested

  - Compare the rank order or frequency of procedure codes in the sample to the same in the universe of claims

  - Check to see if a 90% confidence level was used by the auditors
    (is standard for most public payers but not necessarily for private payers)

  - Were claims with zero paid amount included in the sample?
    (these should be eliminated from the sample)

Be Proactive

- Annually review and revise compliance programs
- Take immediate remedial measures when issues are uncovered
- Periodically review and analyze your utilization of procedure codes and modifiers in comparison to others in your specialty
- Review CMS Comprehensive Error Rate Testing (CERT) findings to determine if your practice bills for any codes that have high error rates
- Understand each health plan's requirements as part of its claims review process

Case Examples of Fraudulent Billing

Case Examples of Fraudulent Billing - OIG

- A psychiatrist was fined $400,000 and permanently excluded from participating in the Federal health care programs for misrepresenting that he provided therapy sessions requiring 30 or 60 minutes of face-to-face time with the patient, when he had provided only medication checks for 15 minutes or less. The psychiatrist also misrepresented that he provided therapy sessions when in fact a non-licensed individual conducted the sessions.

- An endocrinologist billed routine blood draws as critical care blood draws. He paid $447,000 to settle allegations of upcoding and other billing violations.

Case Examples of Fraudulent Billing - OIG

- A dermatologist was sentenced to 2 years of probation and 6 months of home confinement and ordered to pay $2.9 million after he pled guilty to one count of obstruction of a criminal health care fraud investigation. The dermatologist admitted to falsifying lab tests and backdating letters to referring physicians to substantiate false diagnoses to make the documentation appear that his patients had Medicare-covered conditions when they did not.

Case Examples of Fraudulent Billing - OIG

- A cardiologist paid the Government $435,000 and entered into a 5-year Integrity Agreement with OIG to settle allegations that he knowingly submitted claims for consultation services that were not supported by patient medical records and did not meet the criteria for a consultation. The physician also allegedly knowingly submitted false claims for E&M services when he had already received payment for such services in connection with previous claims for nuclear stress testing.

Questions & Answers

Next Steps

- After 48 hours you will receive a link to the online evaluation
- Please complete the evaluation and provide your feedback
- After completing the evaluation, you will be directed to the MMS CME Certificate portal where physicians can claim CME credit (others receive a certificate of attendance)