Hot Topics In CMS Program Integrity

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ALPHABET SOUP: RACs, MACs, ZPICs

CMS Efforts to Reduce Medicare Improper Payments

- Data analysis
- Prepayment claim review
  - New edits (automated review)
  - Medical record review (complex review)
- Postpayment claim review
- New/clarified national policies
- Provider education

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Recovery Audit Contractors "RACs"

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RAC Program Mission…

- to detect and correct past improper payments,
- to implement actions that will prevent future improper payments.
  - Providers can avoid submitting claims that don't comply with Medicare rules
  - CMS can lower its error rate
  - Taxpayers & future Medicare beneficiaries are protected

Dispelling The Myths

Myth	Fact
• RACs make up their own rules & policies	• RACs use the same policies as the Medicare claims processors
• RACs use unqualified staff	• RACs use nurses, therapists & coders and each has a Medical Director
• All RAC reviews are done by "black box" computer edits	• Much RAC review involves clinician review of medical records
• RACs will replace QIOs	• The job of educating hospitals about how to avoid submitting future claims with incorrect coding or medical necessity errors will remain with QIOs and FIs/MACs

MYTH & FACT

- **MYTH**: RACs randomly choose cases for review.
- **FACT**: RACs choose areas of focus based on data mining techniques, OIG & GAO reports, CERT reports and the experience and knowledge of staff.

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MYTH & FACT

- **MYTH: Most RAC determinations are overturned on appeal.**
- **FACT: Only 5% of RAC determinations are overturned on appeal.**

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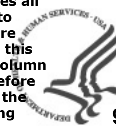
Claim RACs Appeals Data

Provider Appeals of RAC-Initiated Overpayments
Cumulative through 9/30/07 – Claim RACs Only

	Number of Claims with Overpayment Collections (A)	Number of Claims Where Provider Appealed (any level) (E)	Percentage of Claims Where Provider Appealed (any level) (E/A)	Number of Claims with Appeal Decisions in Provider's Favor (F)	Percentage of Overpayment Determinations Overturned on Appeal (F/A)
Part A	159,230	13,393	8.4%	3,083	1.9%
Part B	199,535	27,190	13.6%	14,868	7.5%
All RACs	358,765	40,583	11.3%	17,951	5.0%

SOURCE: RAC Data Warehouse and data reported by Medicare claims processing contractors. Appeals include both completed and those currently in the appeals process. There is a delay between the time when an appeal is filed and when it is reported to CMS. This table includes all appeals that had been filed on or before 9/30/07 and communicated to the RAC prior to 10/31/07. The table excludes a small number of appeals that had been filed on or before 9/30/07 but were not brought to the RAC's attention until 11/1/07 or later. In addition, this table does not reflect claim determinations made or appeals filed after 9/30/07. The first column in this table is a count of all overpayment determinations that had been recouped on or before 9/30/07. There may have been a significant number of claims that were appealed after the provider received the overpayment notification letter but prior to the overpayment being recouped.

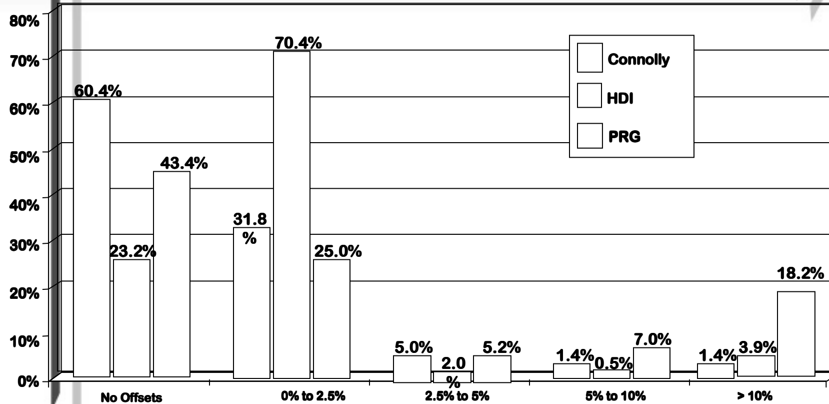


MYTH & FACT

- **MYTH: RACs collect money from providers without any consideration to the financial impact on the provider.**
- **FACT: The majority of hospitals in a RAC jurisdiction had their FY 07 Medicare revenue impacted by less than 2.5%**

RACs Impact on Hospitals in FY 07

Percent of Hospital FY 2007 Medicare Revenue Impacted by RACs

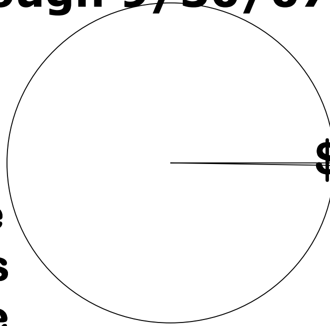


SOURCE: Self-Reported by the RACs

- ✓ Over 90% of hospitals in Connolly and HDI's jurisdictions had their FY 07 Medicare revenue impacted by less than 2.5%
- ✓ 68% of hospitals in PRG's jurisdiction had their FY 07 Medicare revenue impacted by less than 2.5%

Cumulative

tage of All Medicare Payments Affected
mulative through 9/30/07 – Claim RAC



FY 07 Findings

Overpmts Collected:	$357.2 m
Less Underpmts Repaid: -	($14.3 m)
Less $ Overturned on Appeal: -	($17.8 m)
Less Costs to Run Demo: -	($77.7 m)
BACK TO TRUST FUNDS ⇨	**$247.4 m**

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FY 07 Overpayments vs. Underpayments

	Overpmts Collected[1]		Underpmts Repaid[2]		Total Improper Payments Corrected
Conl	$ 112.5 m	+	$ 1.8 m	=	$ 114.3 m
HDI	$ 124.6 m	+	$ 4.1 m	=	$ 128.7 m
PRG	$ 120.1 m	+	$ 8.4 m	=	$ 128.5 m
Totl	**$ 357.2 m**	+	**$ 14 .3 m**	=	**$ 371.5 m**

SOURCE: RAC Data Warehouse

[1] ***Collected*** **is defined as overpayments that have been recovered from providers and deposited.**

[2] ***Repaid*** **is defined as underpayments that have been paid back to the provider.**

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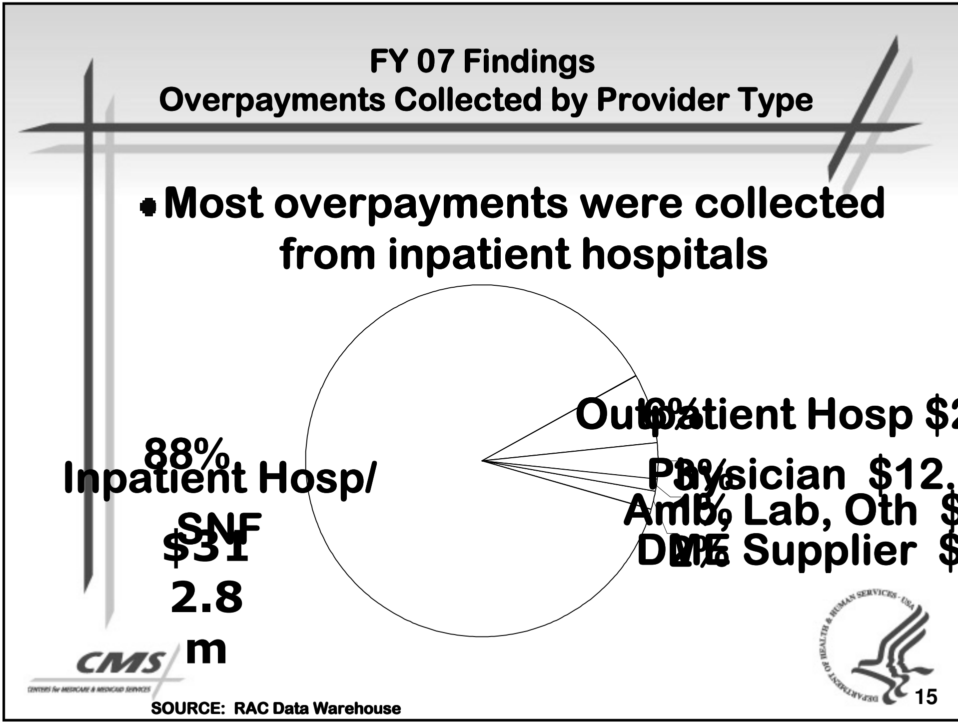
FY 07 Findings
Overpayments Collected by Provider Type
Most overpayments were collected from inpatient hospitals
88%
Inpatient Hosp/ SNF
$312.8 m
6%
Outpatient Hosp $2
3%
Physician $12.
1%
Amb, Lab, Oth $
2%
DME Supplier $
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SOURCE: RAC Data Warehouse
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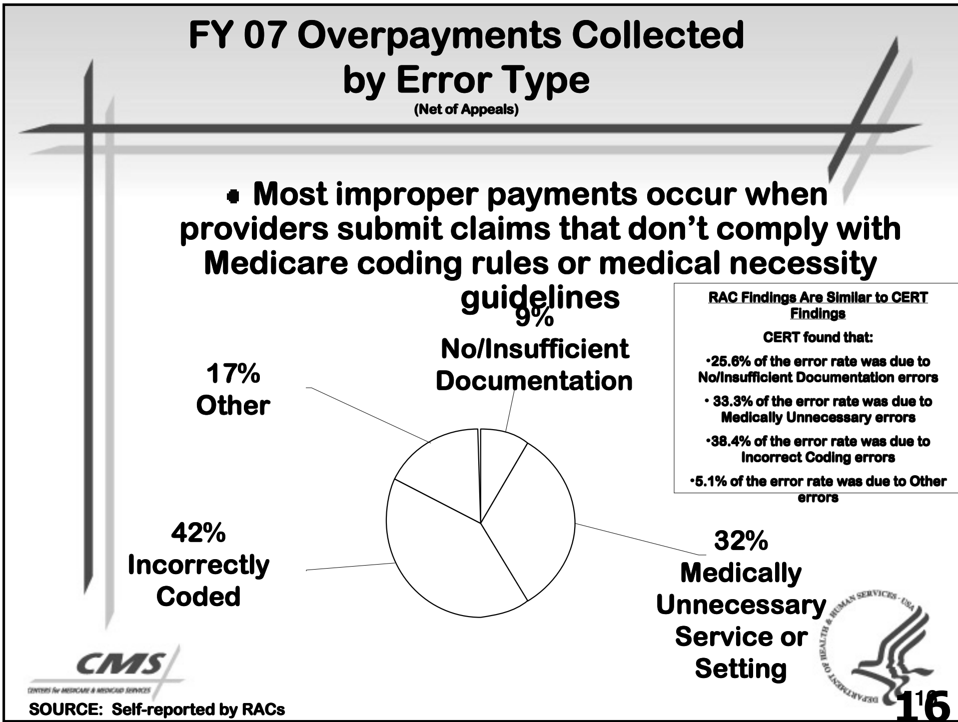
FY 07 Overpayments Collected by Error Type
(Net of Appeals)
Most improper payments occur when providers submit claims that don't comply with Medicare coding rules or medical necessity guidelines
9%
No/Insufficient Documentation
17%
Other
42%
Incorrectly Coded
32%
Medically Unnecessary Service or Setting
RAC Findings Are Similar to CERT Findings
CERT found that:
•25.6% of the error rate was due to No/Insufficient Documentation errors
• 33.3% of the error rate was due to Medically Unnecessary errors
•38.4% of the error rate was due to Incorrect Coding errors
•5.1% of the error rate was due to Other errors
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SOURCE: Self-reported by RACs
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Service Specific Examples of Medically Unnecessary Service/Setting

- **Excessive Units**
  - **Hospital submits one claim for 3 colonoscopies for same beneficiary on same day (overpayment for dollar value of 2nd & 3rd colonoscopies)**
  - **Physician claim for 6 vials of Neulasta when patient only needed or received 6 milligrams of Neulasta (overpayment for dollar value of 5 vials of Neulasta)**
- **Very Short Stay Hospital**
  - **The beneficiary presents to the emergency room with shortness of breath. EKG normal. Chest x-ray rules out pneumonia. The hospital admits the beneficiary for a one day hospital stay. RAC reviews the medical record, determines there is no documentation that meets criteria for inpatient admission (overpayment for full amount of stay)**

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Service Specific Example of Incorrect Coding

- DRG improper up-coding for hospital care
  - Provider submits claim with "septicemia" as a diagnosis
  - The medical record shows diagnosis of urosepsis, not septicemia; blood cultures were negative
  - Had the diagnosis been coded correctly, the claim would have been paid at a lower DRG amount

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Service Specific Example of Other Improper Payments

- Patient discharged from hospital with improper discharge status on claim
  - Hospital submits claim with discharge status code indicating that beneficiary was discharged to home (which gave the hospital the full DRG payment); but the beneficiary was actually transferred to another acute care inpatient hospital (which would have given the each hospital only part of the DRG payment).
- Duplicate Claims
  - Physician submits 2 claims for same beneficiary for same service; the Medicare claims processing contractor paid both claims.

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Transition to National Program

- **Goal**
  - **Move from 3 states to 50 states**
  - **By 2010**
  - **Gradually**
- **Timeline**
  - **Winter 07: Released final RFP**
  - **Spring 08: Award/Announce 4 Winning Permanent RACs**

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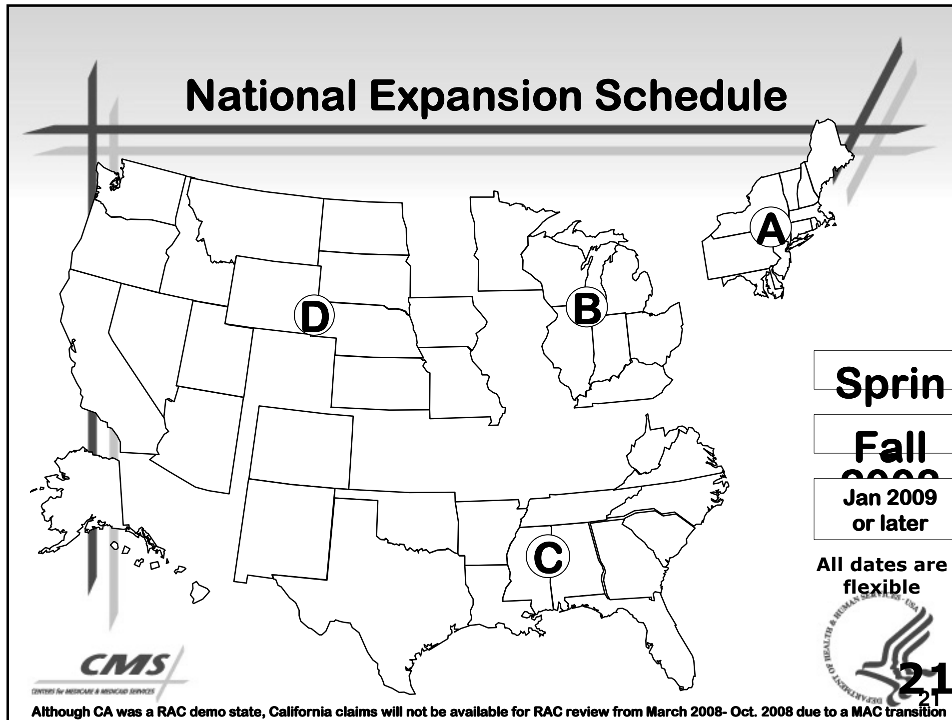

Lessons Learned: CMS Changes to RAC Program

	Demonstration RACs	Permanent RACs
Look back period (from claim pmt date – date of medical record request)	4 years	3 years
Maximum look back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
RAC medical director	Not Required	Mandatory
Coding experts	Optional	Mandatory
Discussion with RAC medical director regarding claim denials if requested	Not Required	Mandatory
Credentials of reviewers provided upon request	Not Required	Mandatory
Vulnerability reporting	Limited	Mandatory
RAC must payback the contingency fee if the claim overturned at…	…**first** level of appeals	…**all** levels of Appeal
Web-based application that allows providers to customize address & contact	None	Mandatory by Jan. 1, 2010
External validation process	Not Required	Mandatory

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Preventing Future Improper Payments: Provider Education is Key

RACs share findings with:

- **Regular Medicare claims processing contractors which adjust their local provider education strategies as needed.**
- **CMS which takes action in terms of national provider education as needed.**

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Medicare Contracting Reform

Status of Implementation

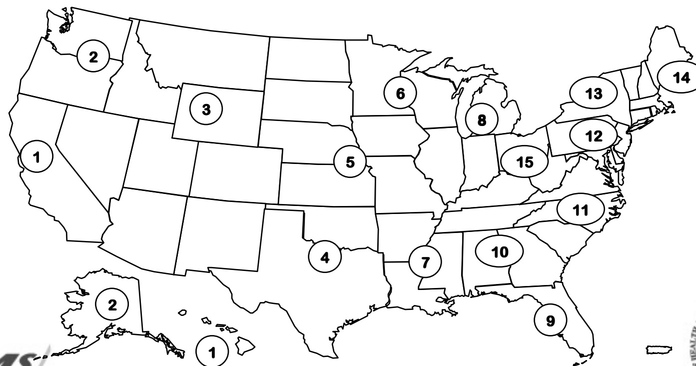
3/11/08

Medicare Administrative Contractors

- Medicare Administrative Contractors (MACs) will perform work currently administered by fiscal intermediaries (FIs) and carriers, resulting in greater integration of Medicare Part A and Part B
- Competitive award of performance-based contracts with award fees; MACs rewarded when CMS operational and policy objectives met
- MAC contracts must be recompeted every 5 years

15 A/B MAC Jurisdictions

- Developed in 2002 as framework for cost model/business case for contracting reform implementation
  - Plan made public in February 2005



Benefits to the Medicare Program

- Medicare Contracting Reform Provides:
  - Improved efficiency in program administration,
  - Reduced Medicare payment error rate,
  - Platform for information technology improvements,
  - Better able to meet future programmatic challenges and changes, and
  - Opportunities to save both administrative and Trust fund dollars.

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Providers Will Benefit from New Operational Structure

- Competitive process selects for:
  - Strong customer service,
  - Improved provider education and training, and
  - Increased payment accuracy and consistency in payment decisions.
- A single A/B MAC will serve as point-of-contact for both Part A and Part B claims.
- Providers will have input in evaluation of MAC's performance through satisfaction surveys.

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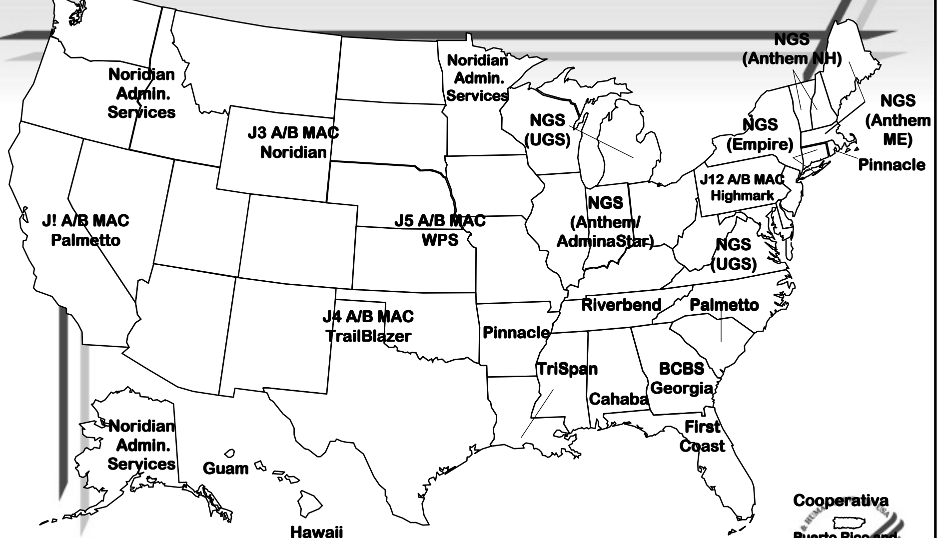
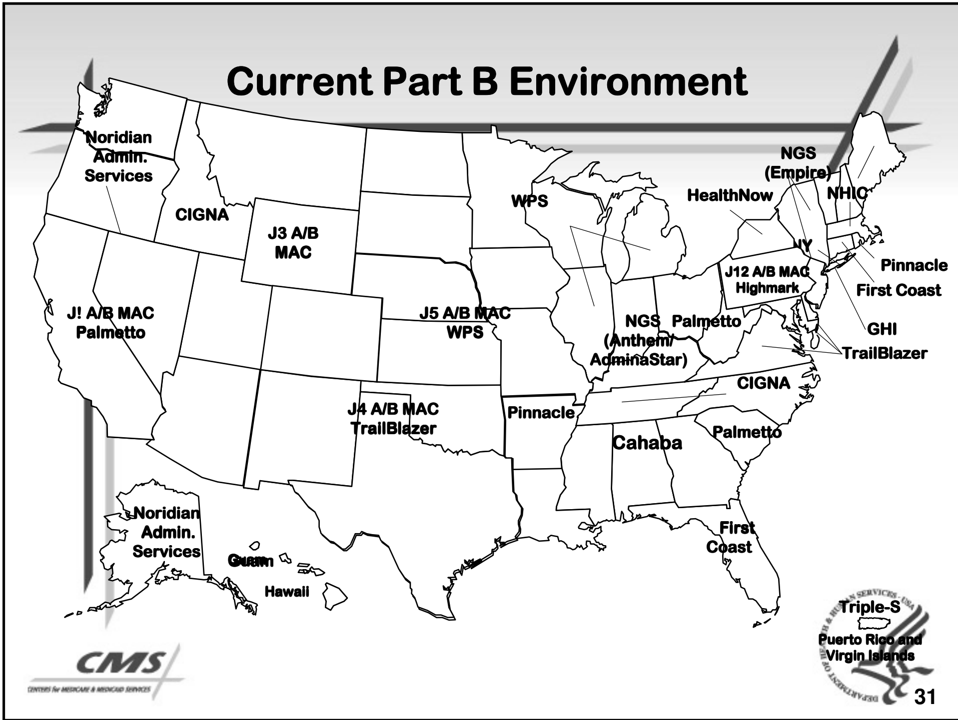
Today's Contracting Structure

In Transition…

Current Part A Environment



WPS (Mutual of Omaha) serves as a Fiscal Intermediary to providers in all states except NY and PR.


Current Part B Environment
Noridian Admin. Services
CIGNA
J3 A/B MAC
J! A/B MAC Palmetto
J5 A/B MAC WPS
WPS
HealthNow
NGS (Empire)
NHIC
Pinnacle
First Coast
J12 A/B MAC Highmark
NGS (Anthem/ AdminaStar)
Palmetto
GHI
TrailBlazer
CIGNA
J4 A/B MAC TrailBlazer
Pinnacle
Cahaba
Palmetto
First Coast
Noridian Admin. Services
Guam
Hawaii
Triple-S
Puerto Rico and Virgin Islands
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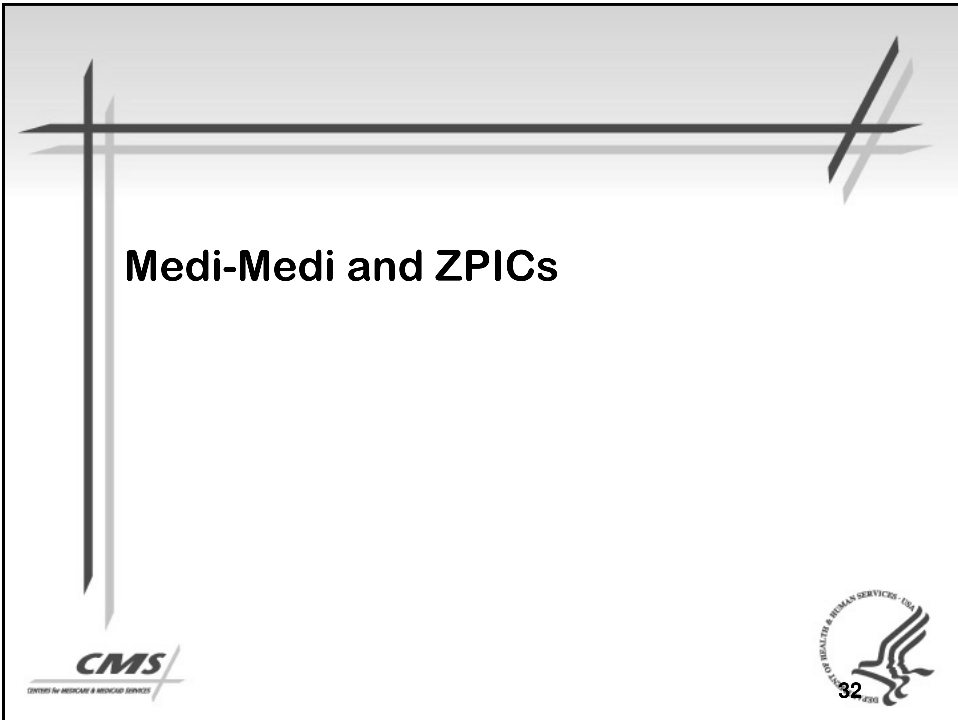
Medi-Medi and ZPICs
CMS
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Medicare Medicaid Data Match Program

The "Medi-Medi" program:

- is a major effort to identify fraud, waste, and abuse.
- is a partnership between the states and CMS.
- allows for the matching of Medicare and Medicaid claim data to detect fraudulent patterns.
- identifies fraudulent patterns that may not be evident when billings for either program are viewed in isolation.
- CMS contracts with PSCs to perform Medi-Medi tasks.

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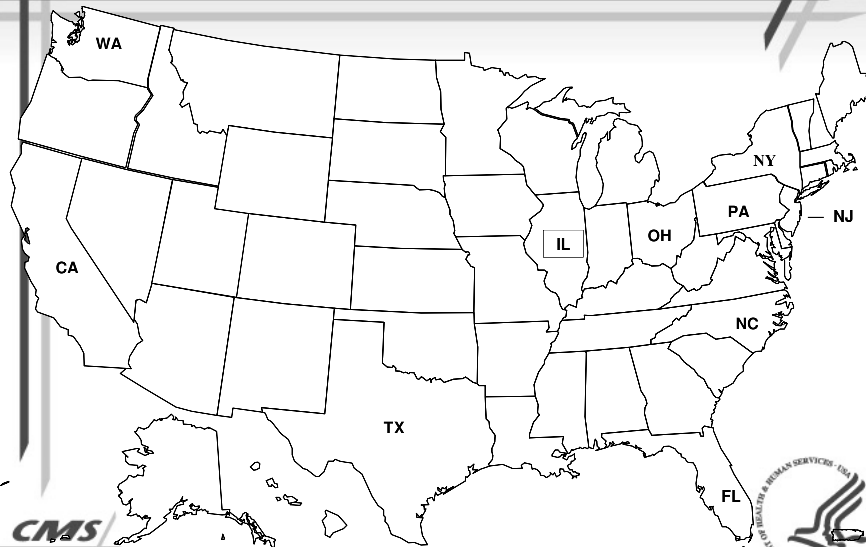
Current Medi-Medi States



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Implementing DRA

- Medi-Medi expansion will begin in 2008.
- CMS will award Zone Program Integrity Contractors (ZPICs), which will consolidate Medicare Parts A, B, C, D, and Medi-Medi Benefit Integrity Activities.
- CMS is considering a regional approach to Medi-Medi.

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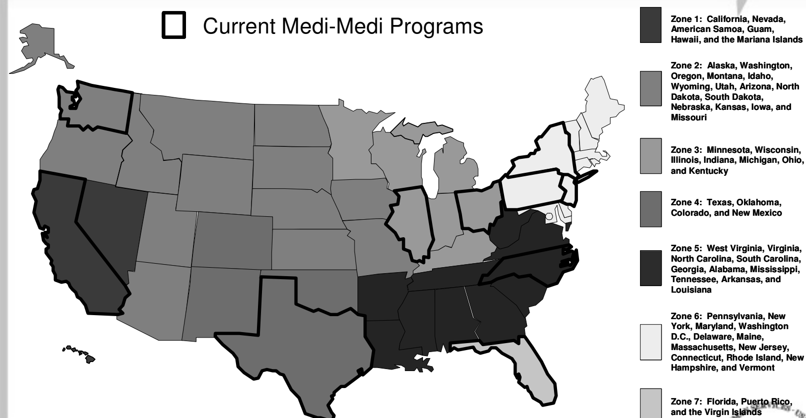
ZPIC Jurisdictions



Zone 1: California, Nevada, American Samoa, Guam, Hawaii, and the Mariana Islands

Zone 2: Alaska, Washington, Oregon, Montana, Idaho, Wyoming, Utah, Arizona, North Dakota, South Dakota, Nebraska, Kansas, Iowa, and Missouri

Zone 3: Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, and Kentucky

Zone 4: Texas, Oklahoma, Colorado, and New Mexico

Zone 5: West Virginia, Virginia, North Carolina, South Carolina, Georgia, Alabama, Mississippi, Tennessee, Arkansas, and Louisiana

Zone 6: Pennsylvania, New York, Maryland, Washington D.C., Delaware, Maine, Massachusetts, New Jersey, Connecticut, Rhode Island, New Hampshire, and Vermont

Zone 7: Florida, Puerto Rico, and the Virgin Islands

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Additional Benefits

- Medi-Medi National Coordinator
  - Improved information sharing through a secure website
  - Catalog of data analysis projects
  - Document sharing
  - Implementation support
- Cross Training
  - Medicare and Medicaid
  - Data analysis tools
- One PI

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