Physicians Being Placed on Non-Random Prepayment Review in Unprecedented Numbers. Are You Ready for an Audit?

(January 3, 2013): Zone Program Integrity Contractors (ZPICs) are aggressively relying on prepayment reviews in their efforts to identify and deter improper coding and billing practices. Why has this recent audit activity occurred? As the Government Accountability Office (GAO) recently reported, prepayment edits saved Medicare at least $1.76 billion in fiscal year 2010. While these savings were substantial, GAO noted that savings could have been even greater if the use of prepayment tools had been expanded. Notably, Recovery Audit Contractors (RACs) have also now jumped on the proverbial non-random prepayment review bandwagon and have been authorized by the Centers for Medicare for Medicaid Services (CMS) to utilize this audit tool. It is therefore essential that home health agencies, physician practices and other health care practices develop and implement an effective Compliance Program, designed to assist them in their efforts to endure that claims billed fully comply with applicable rules and regulations.

I. Legislative Background:

With the passage of the Medicare and Medicaid programs in 1965, the Centers for Medicare and Medicaid Services (CMS)[1] became authorized to perform a myriad of Medicare program functions, either directly or by contract. Moreover, on August 21, 1996, the Congress enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Section 202 of HIPAA added section 1893 to the Social Security Act, thereby establishing the Medicare Integrity Program (MIP Program). This legislation also permitted CMS to contract with eligible contractors (such as Intermediaries, Carriers and Program SafeGuard Contractors) to perform program integrity activities.

On December 8, 2003, Congress subsequently enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The MMA included a new subsection regarding both random prepayment reviews and non-random prepayment complex medical reviews. Today, prepayment reviews of Medicare claims are now conducted by ZPICs and RACs around the country.

II. Reasons Providers are Targeted for Non-Random Prepayment Review:

Contrary to popular belief, CMS and its contractors ***do not*** conduct ***"**random**"*** prepayment audits of health care providers. As CMS expressly set out in the Federal Register:

> ***"Although section 934 of the MMA sets forth requirements for random prepayment review, our contractors currently do not perform random prepayment review. However, our contractors do perform non-random prepayment complex medical review. We are cognizant of the need for additional rulemaking should we wish our contractors to perform random review."***

As a result, if your practice or agency has been subjected to non-random prepayment complex medical review by a ZPIC or RAC, it is because of one or more reasons. In most instances, non-random prepayment reviews are the result of data mining efforts used by ZPICs and RACs to identify potentially inappropriately billed claims. The data mining runs may have been initiated by:

- ***National or local claims data comparisons.***
- ***An analysis of utilization practices.***
- ***Beneficiary complaints.***
- ***Competitor complaints.***
- ***Department of Health and Human Services, Office of Inspector General (HHS-OIG)***
- ***Government Accountability Office (GAO) reports.***
- ***Department of Justice (DOJ) investigations.***

Regardless of the reason for review, once a ZPIC or RAC conducts a data mining run and identifies a likelihood of sustained or high level of payment error, the contractor will typically place a health care provider on prepayment review and immediately request supporting medical documentation in support of any claims submitted by the provider for payment.

III. Types of Non-Random Prepayment Review:

Essentially, there are three types of non-random prepayment medical review to which a health care provider may be subjected. These three types include ***"automated," "routine,"*** and ***"complex"*** medical reviews. All three of these types of review are targeted and non-random in

nature. Examining each of these types of reviews:

1. **Automated:** An ***"automated"*** non-random prepayment medical review is one involving a review where decisions are made at the system level using available electronic information, without the intervention of contractor personnel. Importantly, automated non-random prepayment reviews do not disrupt a health care provider's practice and do not typically require that any additional documents must be submitted.

2. **Routine:** A ***"routine"*** non-random prepayment medical review is limited to rule-based determinations performed by specially trained non-clinical medical review staff. As with "automated" reviews, a "routine" review does not typically result in any additional work for health care providers. In fact, most providers are unaware that their claims have been subjected to non-random prepayment medical review in this fashion. In fact, payments for covered, reasonable and necessary claims are paid without delay.

3. **Complex:** Generally, a ***"complex"*** non-random prepayment medical review involves that review and assessment of any and all supporting documentation associated a claim prior to deciding whether the claim qualifies for coverage and payments. Contractors do not typically place a health care provider on non-random complex prepayment review prior to conducting a ***"probe sample"*** (as opposed to a full-blown statistically-relevant sample) of the provider's claims. A probe sample generally consists of an assessment of 20 – 40 claims. The purpose of a probe sample is to confirm that it appears that a problem exists (either in terms of documentation, medical necessity, billing or coding).

In contrast to ***"automated"*** and ***"routine"*** non-random prepayment medical review, a ***"complex"*** medical reviews will, in fact, typically result in significant delays in having claims processed and paid. Typically, once a claim is submitted, a contractor will submit a request to the health care provider seeking any and all supporting documentation. This documentation is then reviewed by a qualified medical reviewer. In some instances, it has appeared that claims the documentation was forwarded to a second contractor for review.

IV. Considerations if Your Practice or Agency is Placed on Non-Random Prepayment Review:

Importantly, once a provider is placed is placed on prepayment review, it is highly unlikely that the review will be lifted any time soon without significant work on your part. Please keep in mind:

- ***There is no "silver bullet" approach to getting off of prepayment review.***
- ***There is no administrative appeals process in which to contest the placement of your organization on prepayment review.***
- ***Be wary of consultants who claim to "know someone" that can have you removed from prepayment review.***

Once you have been placed on prepayment review, your first task is to figure out "why?" your claims were placed on this status to begin with. Were you placed on prepayment review because of your utilization practices, documentation deficiencies or another reason? Ultimately, getting off of prepayment review is just plain hard work.

Over the years, our firm has been contacted by numerous providers whose approach consisted of "holding" their claims in the mistaken belief that the review would eventually be lifted, at which time they would submit their claims for payment. You need to understand – health care providers are placed on prepayment review because a ZPIC or RAC has reason to believe (rightly or wrongly) that their claims are not in full compliance with applicable coverage, documentation, medical necessity, coding or billing rules. The best approach to having a prepayment review lifted is to carefully analyze each aspect of your claims, compare your practices with those set out in the applicable rules and correct any deficiencies. Sounds simple doesn't it? Unfortunately, it can be quite difficult, depending on the types of claims involved. Our firm has worked with a number of health care providers over the years, assisting them in getting removed from prepayment review and incorporating these steps into an effective Compliance Plan.

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[1] At the time of passage, the Health Care Financing Administration (HCFA) was responsible for the management of the Medicare and Medicaid programs. In September 2001, the Secretary, Health and Human Services, Tommie Thompson, changed HCFA's name to the Centers for Medicare and Medicaid Services [2] Federal Register /Vol. 73, No. 188 / Friday, September 26, 2008 /Rules and Regulations, 55753