Medicare Audits Need High Index of Suspicion

BY MARY ELLEN SCHNEIDER

LAS VEGAS — The federal government is stepping up its audit activities in Medicare, and that could mean greater scrutiny of billing practices, including the use of observation codes.

One development that physicians should keep a close eye on is the recent nationwide rollout of Medicare's Recovery Audit Contractor (RAC) program, said Edward R. Gaines III, vice president and chief compliance officer at CBIZ Medical Management Professionals Inc. The program, known as the RAC, began as a demonstration project in New York, California, and Florida.

Under the program, private contractors are given contingency fees for identifying improper Medicare payments to health care providers, including over- and underpayments.

But Mr. Gaines said the experience in the demonstration project showed that the contractors concentrated much more on detecting overpayments made to providers.

Now that the RAC program has been rolled out nationwide, four private contractors, each assigned to different regions of the country, will use data mining, outlier analysis, and referrals to root out improper payments. The RACs will earn contingency fees for finding errors, with fees that vary from around 9% to 12%.

Physicians need to be aware of the RAC activities and do their own outlier analyses so they can be ready to defend against an audit, Mr. Gaines advised during a meeting on reimbursement sponsored by the American College of Emergency Physicians.

One area that could be part of the review by the RACs is observation services. The RACs focused on that area during the demonstration phase, Mr. Gaines said. One option available to RACs is to perform a concordance review, in which they compare the consistency of hospital and physician claims for the same patient. That may be one way for RACs to evaluate whether observation services were appropriate, he said.

The RACs also will look at evaluation and management services. During the demonstration project, evaluation and management services were exempt from audit—but that is not the case now that the program is permanent.

Medicare is raising the bar for audits because they are in a financial squeeze, Mr. Gaines said.

Right now, Medicare receives more than 1.2 billion medical claims a year—and that's before the bulk of the baby boomer generation has entered the program. Add to that recent news reports that the Medicare and Medicaid programs are hemorrhaging tens of billions of dollars to fraud, and the federal government is in a position in which it needs to act to contain costs.

The RAC program makes financial sense for the government, he said. During the pilot phase of the program, the RACs collected $1 for every 20 cents spent by the government. "So, if you can get five times the rate of return and you're the federal government, this is a no-brainer," Mr. Gaines said.

One area of specific concern with the RACs is that they have the power, at least in certain limited circumstances, to extrapolate an error rate across a larger number of Medicare claims. For example, if a RAC finds a 10% error rate on 50 medical records, extrapolation would allow the contractor to apply that error rate across all of a physician's Medicare patients over multiple years—potentially dramatically increasing the penalty.

There are restrictions to that power. For example, it can't be applied during the initial audit phase, and officials at the Centers for Medicare and Medicaid Services have stated that it can only be used in cases where there is a sustained or a high level of payment error, or a failure to correct the error. In addition, penalties cannot be applied to claims before Oct. 1, 2007.

But the ability to perform extrapolation at all is making physicians uneasy.

Although there are restrictions on when extrapolation could be applied, Mr. Gaines said, it's unclear how CMS would put it into practice. And the fact that the RACs would earn contingency fees on extrapolated claims seems to increase the likelihood that the method will be used, he said. "That's where the money is," Mr. Gaines noted.

Physicians who are audited by the RAC and have errors in 1 out of 50 charts would likely be at low risk for extrapolation, Mr. Gaines said. However, the risk likely is higher for a physician or group that has been subject to corrective action or audits in the past.

The best defense is to be prepared by knowing how the physicians in your group compare with others in the area by performing your own internal outlier analysis, he said. If you are audited, consider doing a case summary of the clinical presentations and the code choices. Write up a narrative of what the patient presented with, how the coder viewed the case, and the medical decision-making involved, Mr. Gaines said.

While the standard Medicare appeals process applies to the RACs, the timelines for stopping recoupment of an improper payment are shorter than some of the standard appeals deadlines.

So, if physicians are dealing with an RAC dispute, they must file the request for redetermination within 30 days to halt recoupment of the payment, rather than the 120 days allowed for most Medicare disputes, Mr. Gaines said. ■

Incentives for Health IT Might Be Shunned, Rather Than Embraced

BY JOYCE FRIEDEN

WASHINGTON — Although government health officials are hoping that most physicians will get on the "meaningful use" bandwagon, that's not likely to happen easily.

"I don't think [health care] professionals have any idea what's coming," said Dr. Len Lichtenfeld, deputy chief medical officer of the American Cancer Society during a panel discussion at an eHealth Initiative conference. "[Federal officials] are risking failure because doctors will say, 'Are you kidding? I don't want to have anything to do with this.' I hope that [doesn't] happen, but I tell you, be prepared."

Under the Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of last year's federal stimulus law, physicians who treat Medicare patients can be awarded up to $44,000 over 5 years for the meaningful use of a certified health information system. For physicians whose patient populations are at least 30% Medicaid patients, the incentive is as much as $64,000.

But physicians who already have computers could find that they don't meet the requirements for the incentive, Dr. Lichtenfeld said. "Doctors have invested in these systems and now they're worthless. They don't have the time, they don't have the money, they don't have the expertise. And to have to get [a new system] up and running in 2-3 years—they won't do it. Something simpler would've gotten us to where we have to go."

Despite a few patient-driven efforts, no one has figured out how to use information technology to get patients more involved in their care, said Dr. Lichtenfeld. "A couple of years ago, personal health records … were going to get everybody on board. Patients were going to run to various Web sites and fill out their health information. Health plans were going to get together and figure out how to bring their data so it would be downloadable and easily accessible."

But none of that has come to pass, he said.

In the meantime, the Department Health and Human Services is trying to get physicians to meet some meaningful use criteria that aren't even written yet, said Dr. Steven Stack, an emergency physician and member of two work groups of the department's HIT Policy Committee.

Two criteria "were supposed to be finished on Dec. 31, 2008, by statute. It's 2010 and they're not done, and it may be a year before we get something. A lot of these things aren't ready for prime time," he said.

Instead of requiring physicians to meet many criteria, "if we focus on the smallest of things, then doggedly persist until we knock down those barriers, and then require people to meet those [expectations]—with the proper incentives, we can make a really great step forward," Dr. Stack said.

Ingenix, the American Medical Association, and several other industry groups sponsored the conference. The speakers reported that they had no relevant disclosures. ■

Cut in Medicare Physician Pay Delayed for a Month

BY ALICIA AULT

On March 2, a day after a 21% reduction in Medicare physician pay went into effect, Congress passed—and President Obama signed—a measure that would delay the implementation of the cut until April 1.

The Temporary Extension Act of 2010 (H.R. 4691) extends the zero percent update in the Medicare sustainable growth rate (SGR) formula through March 31. That zero percent increase went into effect Jan. 1, but expired March 1.

Just before the expiration date, the Centers for Medicare and Medicaid Services (CMS) instructed its contractors to hold all claims submitted from March 1 through at least March 12. This was because the agency anticipated a temporary extension to be approved by Congress.

After the extension, the CMS said that all claims were being immediately released for payment.

With the debate on health care reform ongoing, the fate of the SGR has been largely an afterthought on Capitol Hill.

The House passed a permanent repeal of the formula as part of its health reform package. The Senate, however, included only a temporary fix in the proposal it passed in late December. As part of February legislation to raise the national debt limit, the Senate made a fiscal promise to delay the SGR-mandated cuts for 7 months.

But the solution that passed political muster was the 1-month extension that was included in a package that also extended unemployment benefits.

In a statement issued shortly after the temporary fix was approved, Dr. J. James Rohack, president of the American Medical Association, directed his ire at the Senate.

"The Senate should use this time to permanently repeal the flawed Medicare physician payment formula that puts access to care for seniors and military families at risk," Dr. Rohack said in the statement. ■