



Partners in Compliance

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Part B



IMPORTANT



The information provided in this manual was current as of June 2010. Any changes or new information superseding the information in this manual, provided in newsletters/eBulletins, MLN articles, listserv notices, Local Coverage Determinations (LCDs) or CMS Internet-Only Manuals with publication dates after June 2010, are available at:

<http://www.trailblazerhealth.com/Medicare.aspx>

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DEFINITION OF COMPLIANCE

Compliance is a state of being in accordance with established guidelines, specifications, or legislation or the process of becoming so.

INTRODUCTION

With increasing expenditures, expanding federal benefits and a growing beneficiary population, the importance and challenges of safeguarding the Medicare Trust Fund are greater than ever. CMS stays committed to identifying program weaknesses and vulnerabilities to help prevent fraud, waste and abuse, and to improve quality of care in the Medicare program. These actions protect the taxpayers and future Medicare beneficiaries.

TrailBlazer Health Enterprises® is diligent in educating Medicare providers on CMS program safeguards through various publications, customer service “help lines,” education initiatives and its Web site. There are many compliance initiatives that are carried out on a smaller scale by the Medicare contractor to ensure providers have an understanding of the importance of being compliant, not only with documenting their services correctly but filing claims properly with the correct information while adhering to program guidelines and coverage policies (i.e., proper modifiers, diagnosis codes, etc.).

All of these efforts help ensure contractors and Medicare providers uphold and continue working toward “paying it right the first time, every time.”

This manual:

- Underscores the important aspects of compliance.
- Identifies CMS programs that relate to:
 - Quality.
 - Fraud and abuse.
 - Appropriate medical documentation.
 - Reporting and paying claims correctly.
- Outlines TrailBlazer’s widespread letter education.

COMPREHENSIVE ERROR RATE TESTING (CERT)

Overview

Medicare contractors receive more than 2 billion claims per year. To protect the Medicare Trust Fund and keep the Medicare program viable, CMS implemented the Comprehensive Error Rate Testing (CERT) program to measure the accuracy of Medicare Fee-for-Service (FFS) payments.

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Through CERT, CMS calculates specific error rates. These rates include:

- A provider compliance error rate (which measures how well providers prepared claims for submission).
- Paid claims error rates (which measure how accurately carriers, Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MACs) made coverage, coding and other claims payment decisions) for specific contractors, service types and provider types.

CERT Methodology

CMS uses the CERT program to measure and improve the quality and accuracy of Medicare claims submission, processing and payment. Under this program, numerous randomly selected claims are reviewed each year. The results of these reviews are used to characterize and quantify local, regional and national error rate patterns. CMS uses this information to address the error rate through appropriate educational programs.

CERT Request

The request for records, with the official CMS logo, will contain several documents the provider must read and utilize. They identify the specific service for which records must be submitted, a list of the medical documentation requested and explicit instructions on how to mail or fax the information.

When a Provider Is Selected for a CERT Review



Steps to follow when submitting medical records to the CERT contractor are:

- Photocopy each record (verify records are for the correct date of service).
- Make sure all copies are complete, legible and contain both sides of each page, including page edges.
- Complete copies should include specific records to support the services on the claim(s) identified on the pull list and include all documentation that supports medical necessity of the service as billed on the claim.
- Complete the CERT Operations barcoded cover sheet for each record (if the barcoded sheet is not available, write the CERT Claim ID (CID) number on each page of the documentation).

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- Attach the completed CERT Operations barcoded cover sheet to the corresponding photocopied chart and mail or fax to the CERT contractor.

The request for medical records/documentation is sent under a federally mandated program to monitor and improve the accuracy of Medicare payments to physicians and other providers. **It is imperative requests are responded to in a timely manner.**

The CERT Documentation Contractor (CDC) contacts providers for medical record documentation according to the following schedule:

Day 0: Call 1 and send letter 1 or fax 1
Day 30: Call 2 and send letter 2 or fax 2
Day 45: Call 3 and send letter 3 or fax 3
Day 60: Send letter 4
Day 76: Score claim as an error code 99 on the Claims Status Web site (Code 99 – If the claim paid, an overpayment will be assessed to the provider and an error will be applied to the contractor.)

What Happens Next?

After a claims payment determination has been made, all error findings are provided to TrailBlazer. Any overpayment or underpayment will be processed for all claims where TrailBlazer agrees with the CERT claims payment determination. CMS convenes a panel to resolve payment determination disputes between CERT and Medicare contractors. CMS' determination on disputed claims is final and binding on CERT and for all other Medicare contractors.

Should a claim be denied by CERT, the billing provider or the beneficiary can appeal it. **Appeals should be sent to the MAC (TrailBlazer).** Do not send appeals requests to the CERT contractor.

Appeals for CERT-denied claims follow the same course of appeals as all other claims TrailBlazer denies.

Questions

Providers may contact CERT contractor Customer Service at (301) 957-2380.

TrailBlazer Health Enterprises® CERT Education

TrailBlazerSM is determined to find new and improved ways to decrease the CERT error rates. The most effective approach is to extract information from the biannual CERT reports, determine the precise errors related to specific specialties and trends, and to offer educational guides that are disseminated to the provider community to review and utilize in their efforts to decrease their unique CERT scores.

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CERT reports define providers':

- Claim reporting errors (e.g., coding, modifiers, etc.).
- Record documentation errors.
- Comprehension of policy, rules and guidelines.

Additionally, the reports also allow CMS to determine how well the Medicare contractor is performing.

The TrailBlazer CERT Web site offers medical documentation tips (developed with information CERT error reports) and other beneficial guides. They include:

- Ambulance Transports.
- Chiropractic Services.
- Drugs and Biologicals.
- Diagnostic Imaging Services.
- Emergency Room/Observation.
- End Stage Renal (ESRD) Clinic.
- Inpatient Acute Facility (IAF) Services.
- Inpatient Rehabilitation Facility (IRF) Services.
- Orders for Diagnostic Testing.
- Outpatient Lab and Diagnostic Tests.
- Outpatient Therapy.
- Psychiatry Services.
- Skilled Nursing Facility (SNF), Part A.
- Signature Requirements.
- Scribed Services.

It is critical for TrailBlazer to continually demonstrate its commitment to paying claims correctly, which in turn, reduces the CERT error rate.

Providers are encouraged to visit the TrailBlazer CERT Web site at:

<http://www.trailblazerhealth.com/CERT/>

Additional Resources

CERT reports are found on the CMS Web site at:

<http://www.cms.gov/CERT/CR/list.asp>

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HEALTH INTEGRITY ZONE PROGRAM INTEGRITY CONTRACTOR (ZPIC)

Background

CMS continues its efforts to ensure the highest integrity of its programs and the health care security for all its beneficiaries. To help achieve these goals, CMS created new entities entitled Zone Program Integrity Contractors (ZPICs). The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) changed CMS' current contracting structure by phasing out the FIs and carriers while phasing in the MACs for Medicare claims processing. As a result, seven zones were created based on the newly established MAC jurisdictions.

CMS awarded the ZPIC contract for **Zone 4** (which encompasses **Colorado, New Mexico, Oklahoma and Texas**) to Health Integrity, LLC. On February 1, 2009, Health Integrity began performing the integrity functions for Medicare Parts A, B, Durable Medical Equipment (DME), home health and hospice, as well as the Medicare Medicaid Data Match project. These efforts include the following six tasks:

- Performing data analysis and data mining.
- Conducting medical reviews in support of benefit integrity.
- Supporting law enforcement and answering complaints.
- Investigating fraud and abuse.
- Recommending recovery of federal funds through administrative action.
- Referring cases to law enforcement.

Through these efforts, Health Integrity:

- Develops innovative data analysis methodologies for detecting and preventing abusive use of services early.
- Develops high quality fraud case referrals for law enforcement.
- Identifies appropriate corrective actions.

Health Integrity manages this workload from offices located in Dallas, Texas; San Antonio, Texas; Houston, Texas; Brownsville, Texas; Denver, Colorado; Oklahoma City, Oklahoma; and Albuquerque, New Mexico. **Health Integrity staff include data analysts, nurse reviewers and fraud investigators.**

Case Referrals

Fraud cases may involve beneficiaries, physicians or other providers, or other organizations. CMS requires referrals for fraud cases to be made within 30 days of detection. Timely referrals are necessary to take full advantage of leads in an investigation and as time progresses; important information in a case may become more

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difficult to track down.

Information regarding complaints, the screening process, and the responsibilities of the Beneficiary Contact Center (BCC), Affiliated Contractor (AC) and Medicare Administrative Contractor (MAC) regarding complaints can be found in the Program Integrity Manual, Chapter 4.

<http://www.cms.gov/manuals/downloads/pim83c04.pdf>

Federal Law Enforcement Requesting Information

Federal law enforcement agencies may submit a Request for Information (RFI) to obtain Medicare claims data. Upon receipt of an RFI from a federal agency, Health Integrity will provide the requested claims information and data analysis in graphs and tables.

Additional Resources

- Contact information: Health Integrity, LLC, (972) 383-0000.
- Health Integrity Web site:
<http://www.healthintegrity.org/index.html>
- ZPIC contacts and offices:
<http://www.healthintegrity.org/html/contracts/zpic/contacts.html>

RECOVERY AUDIT CONTRACTORS (RACs)

Background

CMS has taken the next steps in the agency's comprehensive efforts to identify improper Medicare payments and fight fraud, waste and abuse in the Medicare program by awarding contracts to four permanent Recovery Audit Contractors (RACs) designed to guard the Medicare Trust Fund.

According to the law, January 1, 2010, was the deadline to have a permanent and national RAC program in place. The national RAC program is the outgrowth of a successful demonstration program that used RACs to identify Medicare overpayments and underpayments to health care providers and suppliers in California, Florida, New York, Massachusetts, South Carolina and Arizona.

The goal of the recovery audit program is to identify improper payments made on claims for health care services provided to Medicare beneficiaries. This is done on a postpayment review. The claim processing contractors are the entities responsible for adjusting the claim, handling collections (offsets and checks) and reporting the debt on the financial statements.

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Improper payments may be overpayments or underpayments:

- Overpayments can occur when health care providers submit claims that do not meet Medicare's coding or medical necessity policies.
- Underpayments can occur when health care providers submit claims for a simple procedure but the medical record reveals that a more complicated procedure was actually performed.

The RAC is paid on a contingency fee basis on both the overpayments and underpayments they find.

Health care providers that might be reviewed include hospitals, physician practices, nursing homes, home health agencies, Durable Medical Equipment (DME) suppliers and any other provider or supplier that bills Medicare Parts A and B.

Region C RAC Contractor

CMS awarded **Connolly Healthcare** the contract to provide recovery audit services and is tasked with auditing Region C, which consists of the states of: Alabama, Arkansas, **Colorado**, Florida, Georgia, Louisiana, Mississippi, North Carolina, **New Mexico**, **Oklahoma**, South Carolina, Tennessee, **Texas**, Virginia, West Virginia and the territories of Puerto Rico and U.S. Virgin Islands.

The RAC employs a staff consisting of nurses, therapists, certified coders and a physician Contractor Medical Director (CMD).

Review Process Overview

The RAC will review claims on a postpayment basis and will use the same Medicare policies as carriers, FIs and MACs. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and CMS manuals will be utilized in determining whether the claim was paid correctly.

Issues identified by the RAC will be approved by CMS prior to a widespread review. Once an issue receives CMS' approval, the RAC will use its own proprietary software and systems as well as its knowledge of Medicare rules and regulations to determine what areas to review. Connolly Healthcare uses data analysis techniques to identify those claims most likely to result in underpayments or overpayments. This process is called "targeted review." Connolly Healthcare will target a claim because the claim contains information that leads them to believe it is likely to result in an underpayment or overpayment.

To prevent interference with potential fraud reviews being performed by other entities, such as CMS, the ZPIC, law enforcement, the OIG, etc., suppressed/excluded claims will be uploaded into an RAC Data Warehouse (a Web-based application that houses all RAC identifications and collections). Connolly Healthcare will input claims into the RAC

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Data Warehouse before attempting to identify or recover underpayments or overpayments.

Types of Reviews – Automated Versus Complex

Automated review – Occurs when an RAC makes a claim determination at the system level without a human review of the medical record.

Connolly Healthcare will communicate to the provider the results of each automated review that results in an overpayment determination and inform the provider of which coverage/coding/payment policy or article was violated. If the review does not result in an overpayment, the RAC may elect to not communicate the results to the provider.

Complex review – Occurs when an RAC makes a claim determination utilizing human review of the medical record. The RAC may use complex review in situations where the requirements for automated review are not met or the RAC is unsure whether the requirements for automated review are met.

Connolly Healthcare will complete its complex reviews within 60 days from receipt of the medical record documentation. There may be some instances where the RAC may request a waiver from CMS if more time is needed due to extenuating circumstances.

The results of the complex reviews will be communicated to the provider (i.e., every review where a medical record was obtained) in a detailed review (a Results Letter), including cases where no improper payment was identified. In cases where an improper payment was identified, the RAC will inform the provider of which coverage/coding/payment policy or article was violated.

Providers submitting medical records to the RAC should follow the published guidelines found on the Connolly Healthcare Web site at:

http://www.connollyhealthcare.com/RAC/pages/record_submission.aspx

Note: Whenever performing complex coverage or coding reviews (i.e., reviews involving the medical record), Connolly Healthcare will ensure that coverage/medical necessity determinations are made by RNs or therapists and coding determinations are made by certified coders.

Remittance Advice Messages

The RAC will supply various Claim Adjustment Reason Codes (CARCs) for adjusted claims. If a claim is adjusted due to an overpayment/underpayment, these reason codes will appear on the provider's remittance advice with the Remittance Advice Reason Code (RARC) N432, "Adjustment based on a Recovery Audit."

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RAC Appeals

The appeal process for RAC denials is the same as the appeal process for the MAC. When the RAC completes a medical record review (in the case of a complex review) or issues a demand letter (in the case of an automated review), providers then have two options:

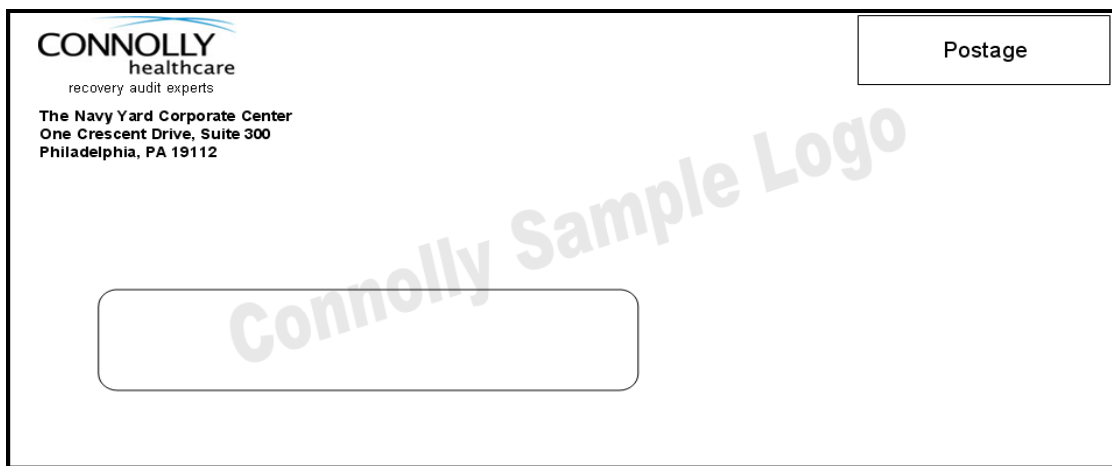
1. To initiate a discussion (a “discussion period”) with the RAC.
Or,
2. To file an appeal with the MAC (TrailBlazer).

Tips About Discussion Periods

- Do not confuse the “RAC Discussion Period” with the appeals process.
- This does not “stop the clock” on the 120-day time period during which a provider can request a redetermination (the first-level appeal) from the Medicare contractor on the interest accrued when money is not refunded within 30 days of request.
- Providers may want to track the status of the discussion and be prepared to file a request within 120 days since appeal time frames are critical.
- Providers must initiate a discussion within 15 days of the receipt of a demand letter (in an automated review) or a review results letter (in a complex review). The discussion period does not take away a provider’s right to appeal, nor does it affect his recoupment or appeal time frames.

Connolly Healthcare Envelope

Providers’ office staff, mailroom personnel and medical record departments should be familiar with the appearance and design of the RAC envelope.



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Recommendations for Providers

- Check the RAC Web site weekly for new issues and what improper payments were found.
- Conduct an internal assessment to identify if your office is in compliance with Medicare rules.
- Identify and implement corrective actions to promote compliance (e.g., initiate awareness in the mailroom, medical records and Medicare billing departments about RAC requests for medical records and be familiar with Connolly Healthcare's envelope logo).
- Appeal RAC decisions when necessary.
- Learn from past experiences (i.e., conduct post-audit findings meetings).
- Complete a Provider Contact Form so the RAC knows the precise address and the contact person it should use when sending Medical Record Request letters. The form is found under the Provider Contact Information tab on Connolly Healthcare's Web site at:
<http://www.connollyhealthcare.com/pdf/Connolly%20Contact%20Information%20Form.pdf>

Additional Resources

- Connolly Healthcare Web site:
http://www.connollyhealthcare.com/RAC/Pages/cms_RAC_Program.aspx
- Contact information: Connolly Healthcare, (866) 360-2507.
- RAC contractor award information, contingency fee percentages and the implementation schedule can be found on the CMS Web site at:
http://www.cms.gov/RAC/01_Overview.asp

NATIONAL CORRECT CODING INITIATIVE (NCCI) EDITS

CMS developed the NCCI to promote national correct coding methodologies and eliminate improper coding. NCCI edits are developed based on coding conventions defined in the American Medical Association's CPT book, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

MEDICALLY UNLIKELY EDITS (MUES)

To lower the Medicare fee-for-service paid claims error rate, CMS established units of service edits referred to as Medically Unlikely Edits (MUEs). The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs. This set of edits is based on anatomical considerations and addresses approximately 2,800 codes.

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Although CMS publishes most MUE values, other MUE values are confidential and are not published for public viewing.

An MUE is defined as an edit that tests claim lines for the same beneficiary, HCPCS code, date of service and billing provider against a maximum number of units of service. These MUEs will auto-deny claim line items containing units of service billed in excess of the MUE criteria.

NCCI and MUE Contractor

Correct Coding Solutions, LLC
Attention: Niles R. Rosen, MD, Medical Director
and Linda S. Dietz, Coding Specialist
P.O. Box 907
Carmel, IN 46082-0907
Fax: (317) 571-1745

Resources

CMS and TrailBlazer offer many instructional guides and materials about NCCI and MUEs. NCCI and MUE tables are found on the CMS Web site. Below are important links to information that will assist providers in understanding and adhering to the policies and guidelines associated with the NCCI and MUEs.

- TrailBlazer NCCI and MUE training manual:
<http://www.trailblazerhealth.com/Publications/Training%20Manual/NCCI.pdf>
- CMS National Correct Coding Initiative Edits Overview Web site:
<http://www.cms.gov/NationalCorrectCodInitEd/>
- NCCI Edits – Physicians Web site and tables:
<http://www.cms.gov/NationalCorrectCodInitEd/NCCIEP/list.asp>
- CMS Medically Unlikely Edits Overview Web site and Practitioner/DME Supplier MUE Table:
http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp

Providers are advised to be familiar with NCCI and MUE guidelines.

WIDESPREAD EDUCATION LETTERS

TrailBlazer mails thousands of education letters each year. They are not intended to cause undue concern or alarm, but to be used as a means for providers to evaluate their practice to ensure accurate billing. TrailBlazer, like all Medicare contractors, is responsible for reducing the paid claims error rate as determined by the Comprehensive Error Rate Testing (CERT) contractor, and widespread education is one of the most commonly utilized and effective methods to accomplish this goal.

Recipients of these letters are selected through data analysis that compares their billing practices to their peers for specific services/CPT codes.

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Example of Language Contained in a Widespread Letter

You were chosen to receive this letter because your practice billed E/M services using the established patient office or other outpatient visits CPT codes 99211–99215, subsequent hospital care CPT codes 99231–99233, consultation CPT codes 99241–99245 and 99251–99255, emergency department services CPT codes 99281–99285 and nursing facility services CPT codes 99304–99306 and 99307–99310 in a different pattern from your peers. The data used to compare your pattern of billing these services, which are the subject of this letter, are dates of service X and paid dates X.

The enclosed Comparative Billing Report(s) compare your billing of these services with your peers nationally.

Note: According to Change Request 6740, consultation codes are not reportable for dates of service on or after January 1, 2010. Information can be found at:

<http://www.cms.gov/transmittals/downloads/R1875CP.pdf>

The following errors have been identified through medical review of records and pertain to all E/M services:

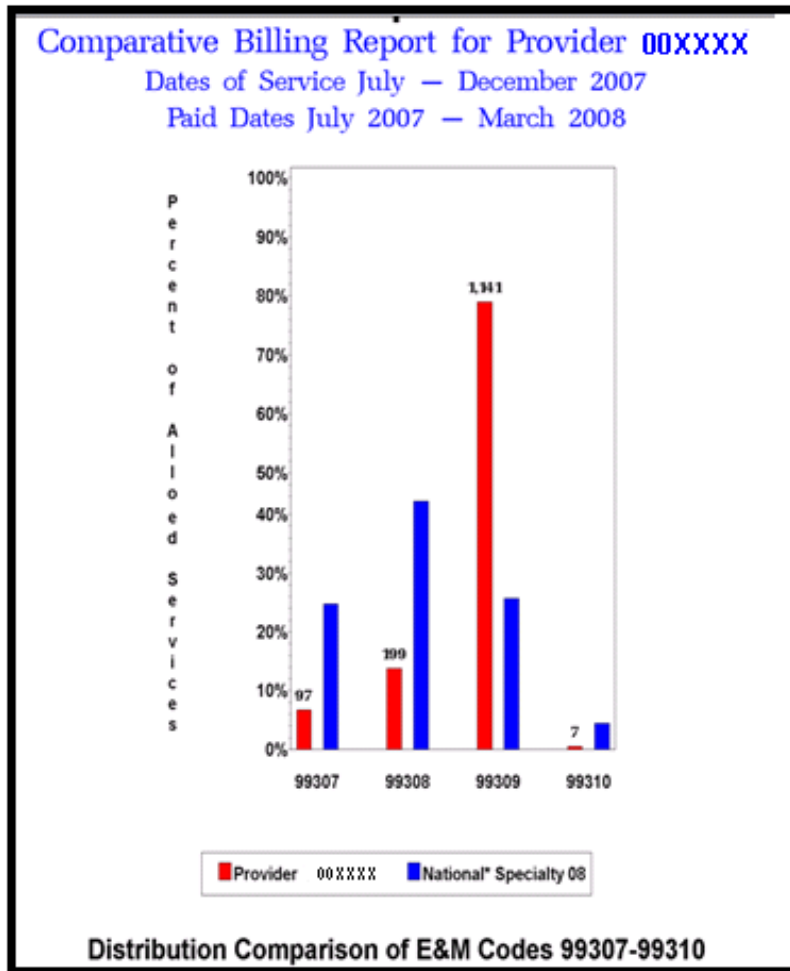
- Documentation was incomplete/insufficient:
 - Documentation did not support the level of service billed (i.e., upcoding or downcoding of services).
 - Required components were not documented in the medical record.
 - The history component was incomplete or absent.
 - The medical decision-making documented was inappropriate or incomplete.
- Documentation requested by Medicare was not provided.
- Services were rendered by one provider and billed by another provider.
- Documentation did not support a face-to-face encounter between physician and patient.
- Conflicting information was provided (e.g., the diagnosis on the claim was not consistent with the diagnosis in the medical record; documentation in the history conflicted with the examination; the date of service in the documentation was different from the date of service billed).
- The service was not performed on the date of service billed, not dictated on the date of assessment or not documented on the date of the visit.
- Medical documentation did not support medical necessity for the frequency of the visit.

Note: The letters are to provide education and stress the importance of appropriate documentation.

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Example of a Comparative Billing Report



TrailBlazer is confident that “working together, we can make a difference!”

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REVISION HISTORY

Date	Section	Revision
May 2010	Types of Reviews – Automated Versus Complex	Added remittance advice information.
<i>July 2010</i>	<i>Comprehensive Error Rate Testing (CERT) – Questions</i>	<i>Deleted the CMS portal link.</i>
	<i>Health Integrity Zone Program Integrity Contractor (ZPIC)</i>	<ul style="list-style-type: none"><i>Revised language to include Internet-Only Manual (IOM) reference.</i><i>Removed Fraud Referral Form and link.</i>
	<i>CMS links</i>	<i>Updated CMS links.</i>
	<i>RAC – Additional Resources</i>	<i>Removed RAC listserv link.</i>