WELCOME TO THE
ALPHABET SOUP OF MICS,
MACS, ZPICS AND RACS

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Disclaimer

☐ This material is designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner.

☐ The author is not providing or offering legal advice but, rather, practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding.

☐ Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful.

☐ Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.
Agenda

- Overview of the Governments hold on healthcare today-getting to know the various agencies involved
- Benefit Integrity Programs-using your claims data to prepare
- Following the Rules-Official Coding Guidelines, Medicare Manuals, Medicaid Guidelines
- Hot Topics in the 2013 OIG Work Plan
- The Appeals Process
- Take Away Strategies
Let’s Start with the MAC

- Medicare Administrative Contractor
  - Began in 2006, completed in 2008
- Replaces the old Fiscal Intermediary/Carrier—now combined for Part A and Part B
- Contracts will be reviewed every 5 years
- 15 MACs under the new structure
  - 4 MACs process Home Health and Hospice Claims
  - 4 MACs process DME Claims
Current MAC Part A/B Jurisdictions

A/B MAC Jurisdictions
Original MAC Jurisdictions

- Jurisdiction 1 (J1) – American Samoa, California, Guam, Hawaii, Nevada, Northern Mariana Islands- Awarded to Palmetto GBA
- Jurisdiction 2 (J2) - Alaska, Idaho, Oregon, Washington Awarded to National Heritage Insurance Company
- Jurisdiction 3 (J3) - Arizona, Montana, North Dakota, South Dakota, Utah, Wyoming- Awarded to Noridian Administrative Services
- Jurisdiction 4 (J4) - Colorado, New Mexico, Oklahoma, Texas- Awarded to Trailblazers Health Enterprises
Original MAC Jurisdictions cont.

- Jurisdiction 5 (J5) - Iowa, Kansas, Missouri, Nebraska - Awarded to Wisconsin Physician Services Health Insurance Corporation
- Jurisdiction 6 (J6) - Illinois, Minnesota, Wisconsin Award date - To Be Determined
- Jurisdiction 7 (J7) - Arkansas, Louisiana, Mississippi Awarded to Pinnacle Business Solutions Inc.
- Jurisdiction 8 (J8) - Indiana, Michigan Award date - To Be Determined
Home Health and Hospice MACs

Home Health/Hospice Medicare Administrative Contractor Jurisdictions

(HH MAC)
Home Health Specialty MACs

- Jurisdiction 6 will include home health and hospice Jurisdiction D
- Jurisdiction 11 will include home health and hospice Jurisdiction C
- Jurisdiction 14 will include home health and hospice Jurisdiction A
- Jurisdiction 15 will include home health and hospice Jurisdiction B.
DME MACs

Durable Medical Equipment Medicare Administrative Contractor Jurisdictions
DME Specialty MAC Carriers

- Jurisdiction A- Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
- Jurisdiction B- Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin
DME Specialty MAC carriers cont.

- **Jurisdiction C-** Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia

- **Jurisdiction D-** Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming
MAC Consolidations (15 to 10)

- Jurisdictions 2 and 3 will be consolidated
- Jurisdictions 4 and 7 will be consolidated
- Jurisdictions 14 and 13 will be consolidated to become Jurisdiction K. They will process home health and hospice claims (HH&H)
MAC Consolidations (15 to 10) cont.

- Jurisdictions 5 and 6 will be consolidated to become Jurisdiction G. They will process home health and hospice claims (HH&H)
- Jurisdictions 8 and 15 will be consolidated to become Jurisdiction I. They will process home health and hospice claims (HH&H)
Final MAC Jurisdictions-No Additional Consolidation

- CMS intends to re-compete five A/B MAC contracts/jurisdictions based on their present area boundaries, as the current A/B MAC contracts run their course. These five contracts/jurisdictions will not be increased or reduced in size by CMS's consolidation strategy. The five A/B MAC contracts/jurisdictions that will not be further consolidated are:

  - **A/B MAC Jurisdiction 1** (California, Hawaii, Nevada, Pacific Islands)
  - **A/B MAC Jurisdiction 9** (Florida, Puerto Rico, US Virgin Islands)
  - **A/B MAC Jurisdiction 10** (Alabama, Georgia, Tennessee)
  - **A/B MAC Jurisdiction 11** (North Carolina, South Carolina, Virginia, West Virginia)
  - **A/B MAC Jurisdiction 12** (Delaware, Maryland, Pennsylvania, New Jersey, Washington DC)
Consolidating to 10 MACs
(In Process)

Consolidated A/B MAC Jurisdictions
On to the RACs

- RACs are CMS’s Recovery Audit Contractors
- Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC permanent and required the secretary to expand to all 50 states no later than 2010
- Each of the RACs are responsible for identifying both over and underpayments in ¼ of the country. The RAC jurisdictions match the DME MAC jurisdictions
- The RACs detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions that will prevent future improper payments
RAC Jurisdictions

- Region A: Diversified Collection Services (DCS)/Performant Recovery
  http://www.dcsrac.com/PROVIDERPORTAL.aspx

- Region B: CGI
  http://www.cgi.com/

- Region C: Connolly, Inc.
  http://www.connolly.com/healthcare/Pages/CMSRACProgram.aspx

- Region D: HealthDataInsights, Inc.
RAC Jurisdictions

Region A: Performant Recovery

- States: CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI and VT
- Info@performantrac.com
- 1-866-201-0580

Region B: CGI

- States: IL, IN, KY, MI, MN, OH and WI
- http://racb.cgi.com
- racb@cgi.com
- 1-877-316-7222
RAC Jurisdictions cont.

Region C: Connolly, Inc.
- States: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and U.S. Virgin Islands
- www.connollyhealthcare.com/RAC
- RACinfo@connollyhealthcare.com
- 1-866-360-2507

Region D: HealthDataInsights
- States: AK, AZ, CA, HI, ID, IA, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, Guam, American Samoa and Northern Marian
- http://racinfo.healthdatainsights.com
- racinfo@emailhdi.com
- Part A: 866-590-5598
- Part B: 866-376-2319
CMS recently issued an RFP for a 5th RAC

Current RAC contracts are expected to expire in February 2014. The deadline for RFP submittal was April 4, 2013. The new RAC contract period is to extend from 2014 to 2018.
The fifth “nationwide” RAC will be responsible for identifying overpayments among home health hospice facilities and durable medical equipment (DME).

Under the plan, the four regional RACs no longer will handle improper payments for home health, hospice or DME.
Another change to the RAC program is that CMS is requiring recovery auditors to support the agency throughout the entire appeals process, including at the administrative law judge (ALJ) level.

The time frame for completing claims reviews is cut in half, from 60 to 30 days, and the new program will give CMS more teeth to stop work with a contractor that does not follow guidelines.
5 RACS-Jurisdictions

Region A: 296,310,751
Region B: 291,614,015
Region C: 283,971,318
Region D: 302,523,912

5 Recovery Auditors; 4 A/B (avg. 293,606,999) and 1 DME
RAC Audit & Recovery Periods

- RACs audit a percentage of claims based on volume criteria specific to provider/supplier type.
- RACs can audit claims paid by Part A & B during a fiscal year retroactive three years from the date the claim was paid.
- RAC Data Warehouse with claims data created by CMS.
- RAC paid a contingency fee of 9-12.5% from amounts recovered.
- As of 1/1/12, Demand Letter sent by MAC not RAC.
Medicaid RACs

- Implementation date was effective January 1, 2012.
- Review claims up to 3 years from date claim was filed (unless extension is received via state plan amendment-ex. 5 years in Ohio).
- Subject matter is state dependent.
Medicaid RACs cont.

- Must coordinate with (1) U.S. Department of Justice; (2) Federal Bureau of Investigation; (3) Office of Inspector General of U.S. Department of Health and Human Services; (4) State Medicaid Fraud Control Units; and (5) CMS.

- Must afford providers appeal rights (State dependent).
Medicaid RACs cont.

- Paid based on contingency fee unless State law does not permit (must request exception from CMS).
- Medicaid RAC fees must be returned if overpayments are identified at any level of appeal.

Medicaid RACs
1. Perform post-payment review to identify Medicare claims that contain overpayments or underpayments for which payment was made under Part A or B of Title XVIII of the Social Security Act.
   - This includes review of all Medicare claim and provider types (excluding DME and Home Health/Hospice) and a review of claims/providers that have a high propensity for error based on the Comprehensive Error Rate Testing (CERT) program and other CMS analysis.
2013 Statement of Work for the RACs cont.

2. Perform prepay review under the Recovery Audit Prepayment Review Demonstration to identify Medicare claims that contain overpayments or underpayments for which payment was made under Part A or B of Title XVIII of the Social Security Act (excluding DME and Home Health/Hospice).

- This task will only be active when CMS has authority to use Recovery Auditors to conduct prepayment review.
2013 Statement of Work for the RACs cont.

3. For any Recovery Auditor identified improper payment that is appealed by the provider, the Recovery Auditor shall provide support to CMS throughout the administrative appeals process and, where applicable, a subsequent appeal to the appropriate Federal court.

- This includes participating or taking party status at the Administrative Law Judge (ALJ) level of appeal in a minimum of 25% of the cases that reach this level.
4. For any Recovery Auditor identified vulnerability, the Recovery Auditor shall support CMS in developing an Improper Payment Prevention Plan to help prevent similar improper payments from occurring in the future.

- This includes the sharing of recovery audit methodologies, algorithms, and edit parameters used to identify improper payments with CMS and the appropriate MAC.
- Sharing this information may assist CMS and its contractors in conducting provider education, and implementing system edits to prevent current and future improper payments.
5. Recovery Auditors shall perform the necessary provider outreach to notify provider communities of the Recovery Auditor’s purpose and direction.

6. Recovery Auditors shall maintain a quality customer service center to provide accurate and timely responses to CMS and provider inquiries.
7. Recovery Auditors shall ensure compliance with all SOW and CMS system requirements, including Information Technology (IT) systems security policies, procedures and practices.

8. Recovery Auditors shall collaborate with other CMS contractors and partners.
The RAC may obtain records by going onsite to view/copy the records or may request that the provider mail/fax or securely transmit the records.

When onsite reviews result in an improper payment finding the RAC shall copy relevant portions of the MR and retain them for future use.
Records limits may apply for different provider types and for hospitals the limit may be based on number of beds. The most recent limit is 2% of the claims submitted in the prior fiscal year divided by 8. The maximum amount is 400 per 45 days for hospitals with less than $100M revenue and 600 per 45 days for hospitals with over $100M revenue.
The MR request limit may not be superseded by bunching the medical record requests. For example if the limit is 50 per month and the RAC doesn’t request records in January and February, they can’t request 150 records in March.
CMS lowers RAC minimum record request limit for hospitals, other providers

- Effective April 15, 2013

- The Centers for Medicare & Medicaid Services has reduced the minimum number of medical records that Recovery Audit Contractors may request from Medicare providers other than physicians and suppliers.
Effective April 15, RACs may issue a minimum request of 20 records in a 45-day period from hospital and other provider campuses, down from a previous minimum of 35 records.

In addition, only 75% of a hospital’s record request limit may be used for a particular type of claim, such as inpatient, down from 100% previously.
The AHA-supported Medicare Audit Improvement Act (H.R. 1250), introduced March 19, would limit RAC medical record requests by campus to 2% of the Medicare claims submitted for a particular care setting, such as inpatient, outpatient, skilled nursing facility or inpatient rehabilitation.
# ADR Request Limits-Changes

<table>
<thead>
<tr>
<th>Old</th>
<th>New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campus Concept</td>
<td>Campus Concept</td>
</tr>
<tr>
<td>100% of any claim type</td>
<td><strong>75% Limit on any particular claim type</strong></td>
</tr>
<tr>
<td>400 ADR cap /maximum every 45 days</td>
<td>400 ADR cap /maximum every 45 days</td>
</tr>
<tr>
<td>• If &gt;$100M annual revenue, then 600</td>
<td>• If &gt;$100M annual revenue, then 600</td>
</tr>
<tr>
<td>35 minimum record request</td>
<td><strong>20 minimum record request</strong></td>
</tr>
<tr>
<td>2% of Medicare claims volume</td>
<td>2% of Medicare claims volume</td>
</tr>
<tr>
<td>Exceptions allowed</td>
<td>Exceptions allowed</td>
</tr>
</tbody>
</table>
Paying for Medical Records

- RAC’s must pay for medical records
  - .12/page for reproduction of PPS provider records
  - .15/page for non-PPS institutions
  - RACs must pay for these records on a monthly basis
  - CMS has the right to institute a maximum payment amount per medical record. Update-As of 4/1/12 the maximum per record charge is .12 per page up to a maximum of $25. This is for paper or electronic records. This also includes postage.
Complex Coverage/Coding Reviews

- Medical necessity determinations must be made by RNs or therapists
- Coding determinations must be made by certified coders
Complex Coverage/Coding Reviews cont.

- Reviews must be completed within 60 days from receipt of the medical record documentation.
- RACs will not receive a contingency fee in cases where more than 60 days elapse between receipt of the medical record documentation and issue of the review results letter.
DRG Validation vs. Clinical Validation

- DRG Validation is the process of reviewing physician documentation and determining whether the correct codes and sequencing were applied to the billing of the claim.
- Certified coders perform the reviews. They must ensure they are not looking beyond what is documented by the physician and are not making determinations that are not consistent with the guidance in Coding Clinic.
- Clinical Validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented. A clinician performs these reviews.
Determining the Overpayment Amount

- **Full denials** - occurs when the RAC determines:
  - The submitted service was not reasonable and necessary and no other service would have been reasonable or necessary, or
  - No service was provided
Determining the Overpayment Amount cont.

- Partial denials—occurs when the RAC determines:
  - The submitted service was not reasonable and necessary but a lower level service would have been reasonable and necessary
  - The submitted service was upcoded or an incorrect code was submitted that caused a higher payment to be made
  - Failure to apply a payment rule that caused an improper payment

- Any identified underpayments are referred to the administrative contractor for resolution
RAC Prepayment Reviews

☐ Overview

- August 27, 2012- August 26, 2015
- Applicable to 7 fraud and error-prone states (FL, CA, MI, TX, NY, LA, and IL) and 4 states with high volumes of inpatient stays (PA, OH, NC, and MI)
- Will not replace MAC prepayment review
- Contractors will coordinate review areas to not duplicate effort
Prepayment Review DRGs

- August 27, 2012
  - MS-DRG 312 SYNCOPE & COLLAPSE
- TBD
  - MS-DRG 069 TRANSIENT ISCHEMIA
  - MS-DRG 377 G.I. HEMORRHAGE W MCC
  - MS-DRG 378 G.I. HEMORRHAGE W CC
  - MS-DRG 379 G.I. HEMORRHAGE W/O CC/MCC
  - MS-DRG 637 DIABETES W MCC
  - MS-DRG 638 DIABETES W CC
  - MS-DRG 639 DIABETES W/O CC/MCC
Operational Details

- ADRs will come from the FI/MAC
- Providers will have 30 days to send documentation
- Recovery Auditors will review and communicate payment determination to FI/MAC
  - Providers will receive determination within 45 days
  - Recovery Auditors will also send detailed review results letter
- For now, Limits on prepayment and post-payment reviews won’t typically exceed current post-payment ADR limits
- Providers may appeal the denial
  - Same appeal rights as other denials
- Claims will be off-limits from future post-payment reviews by a CMS contractor
Medicare Administrative Contractors (MACs) will conduct prepayment review on claims reaching the $3,700 threshold with dates of service January 1, 2013 to March 31, 2013. CMS requested MACs conduct these manual medical reviews within 10 days. At this time, there is no advance request for an exception process. Effective April 1, 2013, the Recovery Auditors will conduct review for all claims processed on or after April 1, 2013. Recovery Auditors will complete two types of review.

- Prepayment Review:
  - Claims submitted in the Recovery Audit Prepayment Review Demonstration states will be reviewed on a prepayment basis. These states are: Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina and Missouri.
  - In these states, the MAC will send an ADR to the provider requesting the additional documentation be sent to the Recovery Auditor (unless another process is used by the MAC and the Recovery Auditor).
  - The Recovery Auditor will conduct manual medical review within 10 business days of receiving the additional documentation and will notify the MAC of the payment decision.
Postpayment Review:

- In the remaining states, CMS will grant an exception for all claims with a KX modifier and pay the claim upon receipt. The Recovery Auditors will then conduct postpayment manual medical review on the claim.

- In these states, the Recovery Auditor will request additional documentation and conduct postpayment review and will notify the MAC of the payment decision.
What is a ZPIC?

- Medicare Zone Program Integrity Contractors (ZPIC)
  - ZPICs are responsible for ensuring the integrity of all Medicare claims (parts A, B, C and D) and are not limited to review of durable medical equipment prosthetic and orthotic supplier (DMEPOS) claims. A ZPIC’s main focus is to identify fraud and abuse. ZPICs are divided into 7 zones across the country.
What is a ZPIC?

- Who are the players?
  - SafeGuard Services
  - AdvanceMed
  - Health Integrity
  - Integriguard

- They have been focusing on physicians, hospices, SNFs, PT billing and DME providers.
ZPIC Audits

- Section 911 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 authorized CMS to replace Fiscal Intermediaries and Carriers with Medicare Administrative Contractors (MACs)
CMS created ZPIC zones that coincide with the MAC jurisdictions. The ZPIC program divides the country into 7 jurisdictions and in each jurisdiction 1 ZPIC is responsible for program integrity oversight and functions for all Medicare claims. As such ZPICs will replace the PSCs.

Both PSC and ZPICs are paid a fixed fee for identified overpayments.
What is a PSC?

- Medicare Program Safeguard Contractor
  - Section 202 of HIPAA authorized CMS to establish a Medicare Integrity Program and to contract with private entities (PSC’s) to carry out the program integrity functions
  - The goals of the Medicare Integrity Program are to detect and deter Medicare fraud and abuse and facilitate provider adherence to CMS payment criteria
What is a PSC? cont.

- Medicare Program Safeguard Contractor
  - PSCs perform various functions, including fraud case development, data analysis and medical review to support fraud and abuse cases
  - Upon completion of an audit, PSCs refer all identified overpayments to the MAC who subsequently sends the provider a demand letter for recoupment of the alleged overpayment
What is CERT?

- Medicare Comprehensive Error Testing (CERT)
  

- CMS implement CERT to measure improper payment in the Medicare fee-for-service (FFS) program.
CERT is designed to comply with the Improper Payments Elimination and Recovery Act of 2010 (IPERA).

The OIG designed its sampling method to estimate a national Medicare FFS paid claims error rate using a sample size of 6,000 claims.
 Defines “improper payment” as:

– Payments that should not have been made, or payments made in an incorrect amount (including over and underpayments)

– Payment to an ineligible recipient

– Payment for an ineligible service

– Any duplicate payment

– Payment for services not received

– Payments for an incorrect amount
CERT History

- 1996-2002
  - OIG drew a sample of claims
  - OIG asked the DMERCS, Carriers, FIs, and QIOs to review the claims against all coverage, coding and payment rules
- OIG calculated a single National Claims Payment Error Rate
- CMS took over error rate calculations from the OIG
  - The transition began in 2001
  - CMS first reported an error rate in November 2003
- CMS increased the sample size from 6,000 to 160,000 claims per year
CERT History cont.

- Multiple error rates computed:
  - Nationally
  - By contractor
  - By service
  - By provider type
CERT Process

- CMS established the following program that monitors payment decisions made by Carriers/MACs, DME MACs, FIs/MACs
  - Carriers/MACs include physicians, diagnostic and laboratory facilities and ambulance providers and account for 27% of the Trust Fund
  - DME MACs include DME Suppliers and account for 4% of the Trust Fund
  - FIs/MACs include non-PPS hospitals, Outpatient hospitals, SNFs, Home Health Agencies and Hospices and account for 32% of the Trust Fund
  - FIs/MACs include PPS short term acute care inpatient hospitals, PPS long term acute care inpatient hospitals and account for 37% of the Trust Fund
CERT Process cont.

- Claims are selected randomly
- The CERT Documentation Contractor requests for medical records
  - If a provider fails to submit a requested record, it counts as an error
- Reviews conducted by at least one RN at the CERT Review Contractor. Claims determined to be paid incorrectly are scored as errors.
  - Insufficient documentation
  - Medical necessity
  - Incorrect coding
  - Other (duplicate payments, no benefit category, other billing errors)
CERT Process cont.

- Error rates are calculated and reported in the DHHS Agency Final Report, CMS Financial Report, and semi-annual Improper Payment Reports.
- In 2010 the error rate was reported at 10.5%, accounting for 34.3 billion in improper payments.
CERT Corrective Actions

- CMS and contractors analyze error rate data and develop Error Rate Reduction Plans to reduce improper payments
- Corrective actions include:
  - Refining error rate measurement processes
  - Improving system edits
  - Updating coverage policies and manuals
  - Conducting provider education efforts
## CERT FY 2012 Projected Improper Payment Rates

### Projected Improper Payment (in Billions $) by Type of Error for DRG Length of Stay

<table>
<thead>
<tr>
<th>DRG Length Of Stay</th>
<th>Error Rate (%)</th>
<th>Projected Improper Payment (in billions)</th>
<th>Insufficient Documentation</th>
<th>No Documentation</th>
<th>Medically Unnecessary</th>
<th>Incorrect Coding</th>
<th>Overall Incorrect Coding</th>
<th>Over-payment Due to Incorrect Coding</th>
<th>Under-payment Due to Incorrect Coding</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>1. &lt;1 day</td>
<td>30.1</td>
<td>$3.43</td>
<td>$0.60</td>
<td>$0.03</td>
<td>$2.62</td>
<td>$0.15</td>
<td>$0.15</td>
<td>$0.11</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>2. 2 days</td>
<td>13.2</td>
<td>$1.56</td>
<td>$0.07</td>
<td>$0.00</td>
<td>$1.36</td>
<td>$0.13</td>
<td>$0.02</td>
<td>$0.11</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>3. 3 days</td>
<td>13.1</td>
<td>$2.03</td>
<td>$0.20</td>
<td>$0.09</td>
<td>$1.00</td>
<td>$0.14</td>
<td>$0.05</td>
<td>$0.08</td>
<td>$0.00</td>
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</tr>
<tr>
<td>4. 4 days</td>
<td>8.0</td>
<td>$0.96</td>
<td>$0.23</td>
<td>$0.01</td>
<td>$0.53</td>
<td>$0.20</td>
<td>$0.11</td>
<td>$0.10</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>5. 5 days</td>
<td>6.2</td>
<td>$0.62</td>
<td>$0.04</td>
<td>$0.00</td>
<td>$0.45</td>
<td>$0.12</td>
<td>$0.08</td>
<td>$0.04</td>
<td>$0.01</td>
<td></td>
</tr>
<tr>
<td>6. &gt;=5 days</td>
<td>3.5</td>
<td>$1.91</td>
<td>$0.14</td>
<td>$0.00</td>
<td>$1.20</td>
<td>$0.53</td>
<td>$0.22</td>
<td>$0.31</td>
<td>$0.04</td>
<td></td>
</tr>
</tbody>
</table>
What is the PERM?

- The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program.
- The error rates are based on reviews for fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review.
What is the PERM? cont.

- FY 2008 was the first year in which CMS reported error rates for each component of the PERM program.
- CMS uses a 17 state review for PERM. Each state is reviewed once every 3 years.
PERM Components and Sample Sizes

- Medicaid
  - FFS: 500 line items
  - Managed Care: 250 capitation payments
  - Eligibility: 504 active cases, 204 negative cases
PERM Components and Sample Sizes cont.

- CHIP
  - FFS: 500 line items
  - Managed Care: 250 capitation payments
  - Eligibility: 504 active cases, 204 negative cases
PERM Corrective Actions

- Each state submits a Corrective Action Plan (CAP) to CMS after they receive their error rates.
- A CAP is a narrative of steps taken to identify cost-effective actions that can be implemented to correct error causes.

http://www.cms.hhs.gov/PERM
What is a QIO?

- CMS’s Quality Improvement Organizations
- CMS contracts with one organization in each state, as well as the District of Columbia, Puerto Rico and the US Virgin Islands
- QIOs are private, mostly not-for-profit organizations staffed by doctors and other health care professionals who are trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.
- QIO contracts are 3 years in length, with each 3 year cycle referenced as an ordinal “SOW”
What do QIO’s do?

- CMS identifies the core functions of the QIO Program as:
  - Improving quality of care for beneficiaries
  - Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
  - Protecting beneficiaries by addressing individual complaints, provider based notice appeals, violations of EMTALA, and other responsibilities as articulated in the QIO related law.
What do QIO’s do? cont.

- CMS is required to publish a report to Congress every fiscal year that outlines the administration, cost and impact of the QIO program

- QIO Directory:
  http://www.qualitynet.org/dcs/ContentServer?c=Page&page name=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793
What is MIP?

- CMS Medicaid Integrity Program

- CMS has two broad responsibilities under the MIP:
  - To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and education providers and others on Medicaid program integrity issues
  - To provide effective support and assistance to States in their efforts to combat Medicaid fraud and abuse
What is MIP? cont.

☐ Each state has a Medicaid Fraud Control Unit
  – Conducts criminal investigations of Medicaid providers who are suspected of defrauding the Medicaid Program
  – The unit also investigates allegations of physical abuse and neglect in health care facilities that receive Medicaid funding
  – The unit employs investigators, auditors and attorneys who conduct investigations and assist in the prosecution of Medicaid providers
Medicaid Integrity Contractors (MICs)

- Three types of MICs
  - Audit
  - Review
  - Education
Five Jurisdictions
- New York (CMS Regions I & II)
  - Thomson Reuters & IPRO
- Atlanta (CMS Regions III & IV)
  - Thomson Reuters & Health Integrity
- Chicago (CMS Regions V & VII)
  - AdvanceMed & Health Integrity
- Dallas (CMS Regions VI & VIII)
  - AdvanceMed & HMS
- San Francisco (CMS Regions IX & X)
  - AdvanceMed & HMS
Objectives of MICs

- Ensure that paid claims were:
  - For services provided and properly documented
  - For services billed properly, using correct and appropriate procedure codes
  - For covered services; and
  - Paid according to Federal and State laws, regulations and policies
Review MICs

- Analyze Medicaid claims data to identify high-risk areas and potential vulnerabilities
- Provide leads to the Audit MICs
- Use data-driven approach to ensure focus on providers with truly aberrant billing practices
Audit MICs

- Conduct post-payment audits
  - A combination of field and desk audits

- Fee-for-service, cost report and managed care audits

- Audits will identify overpayments; States will collect overpayments and adjudicate provider appeals

- Audit MICs: Booz Allen Hamilton, Fox & Associates, IPRO, Health Management Systems, Health Integrity, LLC
Education MICs

- Use findings from Audit and Review MICs to identify areas for education
- Work closely with Medicaid partners and stakeholders to provide education and training
- Will develop training materials, awareness campaigns and conduct provider training
- Highlight value of education in preventing Medicaid fraud, waste, and abuse
- Information MICs: Information Experts and Strategic Health Solutions
MIC Audit Process

- Claims reviewed for billing aberrancies
- List of providers identified for audit vetted with State and law enforcement
- Audit MIC performs audit
- Audit MIC prepares draft report
- Draft report is shared with the State
- Draft report sent to provider after State review
- CMS finalizes & issues final report to the State with the identified overpayment amount
Data Mining

- Federal agencies are making significant investments in technology and data analytics tools.
- There are significant federal efforts underway to build data sources that house Medicare/Medicaid data.
Many of the outsourced companies that are contracted by the Federal agencies have a talent pool of public health experts, healthcare administrators, investigators, nurses, physicians, statisticians, network engineers, medical trainers and IT specialists that can create data mining tools that analyzes claims data to detect potential fraud (resulting in automated audits)
Benefits of Data Mining

- The huge amounts of data generated by healthcare transactions are too complex and voluminous to be processed and analyzed by traditional methods. Data mining provides the methodology and technology to transform these mounds of data into useful information for decision making.
  - Can help healthcare insurers detect fraud and abuse
  - Can help healthcare organizations make customer relationship management decisions
  - Can help physicians identify effective treatments and best practices
  - Can assist in patients receiving better and more affordable healthcare services
What Can We Do?

- Review your claims data on an ongoing basis
- View claims who fail due to system edits, MUE’s, and provider defined edits
- Coding Compliance software can help track potential issues
- Make sure issues that are identified are addressed
- If the RAC can do it, so can you!
Following the Rules

- Official Coding Guidelines—these are updated on an annual basis. Make sure that your staff is provided with the most recent OCGs. Have a coding meeting to discuss the latest OCGs.
- Create policies and procedures as needed using guidance from the OCGs.
- Coding Clinic and CPT Assistant are also invaluable in educating staff on current guidelines.
Medicare/Medicaid Manuals

- Depending on your provider type, make sure that you have reviewed the Medicare/Medical Manuals and shared with your staff.
- Stay on top of CMS Transmittals.
- There are a number of vendors that provide daily updates for a set fee (MediRegs, Code Correct, and Ingenix are a few).
- Make sure your encoder is providing the latest CCI edits (remember they are updated quarterly). Part A edits are one version behind Part B edits.
- Make sure the business office software is on the latest version.
The OIG and the 2013 Work Plan

- The mission of the Office of Inspector General (OIG) is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.
- Established in 1976. Works with Medicare, Medicaid and more than 300 other HHS programs.
- HHS OIG is the largest inspector general’s office in the Federal Government with more than 1,700 employees.
Hot Topics in the 2013 OIG Work Plan-New

- New for Hospitals in 2013
  Hospitals—Diagnosis Related Group Window (New)
  - OIG will analyze claims data to determine how much CMS could save if it bundled outpatient services delivered up to 14 days prior to an inpatient hospital admission into the diagnosis related group (DRG) payment. This policy is commonly known as the “DRG window.”
  - Prior OIG work identified improper payments in the DRG window. OIG work has also concluded that CMS could realize significant savings if the DRG window was expanded from 3 days to 14 days. (OEI; 05-12-00480; expected issue date: FY 2013; work in progress)
Hot Topics in the 2013 OIG Work Plan

Hospitals—Hospital-Owned Physician Practices Using Provider-Based Status (New)

- OIG will determine the impact of hospital-owned physician practices billing Medicare as provider-based physician practices. They will also determine the extent to which practices using the provider-based status met CMS billing requirements.

- Provider-based status allows a subordinate facility to bill as part of the main provider. Provider-based status can result in additional Medicare payments for services furnished at provider-based facilities and may also increase beneficiaries’ coinsurance liabilities.

- In 2011, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services. (OEI; 04-12-00380; 04-12-00381; expected issue date: FY 2013; work in progress)
Hot Topics in the 2013 OIG Work Plan

Hospitals—Compliance With Medicare’s Transfer Policy (New)

☐ OIG will review Medicare payments made to hospitals for beneficiary discharges that should have been coded as transfers. They will determine whether such claims were appropriately processed and paid.

☐ They will also review the effectiveness of the MAC’s claims processing edits used to identify claims subject to the transfer policy.

☐ Pursuant to Federal regulations, a hospital discharging a beneficiary is paid the full DRG amount. (42 CFR § 412.4 (e).) In contrast, a hospital that transfers a beneficiary to another facility is paid a graduated per diem rate, not to exceed the full DRG payment that would have been made if the beneficiary had been discharged without being transferred. (42 CFR§ 412.4(f).) (OAS; W-00-12-35102; various reviews; expected issue date: FY 2013; work in progress)
Hospitals—Payments for Discharges to Swing Beds in Other Hospitals
(New)

☐ OIG will review Medicare payments made to hospitals for beneficiary discharges that were coded as discharges to a swing bed in another hospital. Swing beds are inpatient beds that can be used interchangeably for either acute care or skilled nursing services.

☐ Pursuant to Federal regulations, a hospital discharging a beneficiary is paid the full DRG amount. (42 CFR § 412.4 (e).)

☐ In contrast, Medicare pays hospitals a reduced payment for shorter lengths of stay when beneficiaries are transferred to another prospective payment system (PPS) hospital (42 CFR § 412.4(f).) This is based on the assumption that acute care hospitals should not receive full DRG payments for beneficiaries discharged "early" and then admitted to additional care in other clinical settings.

☐ However, Medicare does not pay the reduced graduated per diem rate if that patient was discharged to a swing bed in another hospital. If appropriate, they will recommend that CMS evaluate its policy related to payment for hospital discharges to swing beds in other hospitals. (OAS; W-00-13-35700; various reviews; expected issue date: FY 2013; new start)
Hot Topics in the 2013 OIG Work Plan

Hospitals—Payments for Canceled Surgical Procedures (New)

☐ OIG will determine costs incurred by Medicare related to inpatient hospital claims for canceled surgical procedures. Their preliminary analysis of Medicare claims data for inpatient stays demonstrated significant occurrences of an initial PPS payment to hospitals for a canceled surgical procedure followed by a second, higher PPS payment to the same hospitals for the rescheduled surgical procedure.

☐ For these claims, the canceled surgical procedure was the principal reason for the initial hospital admission. For these short-stay claims, few, if any, inpatient services (i.e., laboratory or diagnostic tests) were provided by the hospitals because the surgical procedure was canceled.

☐ Medicare makes two payments to hospitals that generate two bills unless the patient is readmitted to the hospital on the same day, in which case a single payment is made.

☐ Their analysis also identified inpatient claims with canceled surgical procedures for stays of less than 2 days that were not followed by subsequent inpatient admissions to the same hospitals for the rescheduled surgical procedures. Current Medicare policy does not preclude payment for these claims. (OAS; W-00-13-35626; various reviews; expected issue date: FY 2013; new start)
Hot Topics in the 2013 OIG Work Plan

Hospitals—Payments for Mechanical Ventilation (New)

☐ OIG will review Medicare payments for mechanical ventilation to determine whether the DRG assignments and resultant payments were appropriate. OIG will review selected Medicare payments to determine whether patients received fewer than 96 hours of mechanical ventilation. Mechanical ventilation is the use of a ventilator or respirator to take over active breathing for a patient. CMS requires that claims be completed accurately to be processed correctly and promptly. (Medicare Claims Processing Manual, Pub. No. 100-04, ch. 1, § 80.3.2.2.)

☐ For certain DRG payments to qualify for Medicare coverage, a patient must receive 96 or more hours of mechanical ventilation. (OAS; W-00-12-35575; various reviews; expected issue date: FY 2013; work in progress)
Hot Topics in the 2013 OIG Work Plan

Hospitals—Quality Improvement Organizations’ Work With Hospitals (New)

- OIG will determine the extent to which Quality Improvement Organizations (QIO) worked with hospitals either to conduct quality improvement projects or to provide technical assistance. OIG will also assess the barriers QIOs experience when engaging hospitals.

- CMS is required to enter into contracts with QIOs, formerly called utilization and quality control peer review organizations. (Social Security Act§ 1862 (g).) The purpose of the QIOs is to improve the efficiency, effectiveness, economy, and quality of services delivered to Medicare beneficiaries.

- Medicare spends about $1.1 billion for each 3-year QIO contract period, and each contract calls for QIOs to provide technical assistance to providers and specifies clinical areas for the quality improvement projects. (OEI; 01-12-00650; expected issue date: FY 2014; work in progress)
Hot Topics in the 2013 OIG Work Plan

Hospitals—Acquisitions of Ambulatory Surgical Centers: Impact on Medicare Spending (New)
- OIG will determine the extent to which hospitals acquire ASCs and convert them to hospital outpatient departments.
- OIG will also determine the effect of such acquisitions on Medicare payments and beneficiary cost sharing.
- Medicare reimburses outpatient surgical services performed in hospital outpatient departments at a higher rate than similar services performed in ASCs. Hospitals may be acquiring ASCs and providing outpatient surgical services in that setting. (OEI; 06-12-00590; expected issue date: FY 2014; work in progress)
The Medicare Appeals Process

- Currently a 5 step process as defined by CMS in December of 2009 (74 Federal Register 65296)
  - First Level-Redetermination
  - Second Level-Reconsideration
  - Third Level-Administrative Law Judge Hearing
  - Fourth Level-Medicare Appeals Council
  - Fifth Level-Federal District Court
Success Rates in Appeals as of 2012

<table>
<thead>
<tr>
<th>Overpayments Collected</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012 1st Quarter</th>
<th>FY 2012 2nd Quarter</th>
<th>FY 2012 3rd Quarter</th>
<th>Total National Program</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$75.4M</td>
<td>$797.4M</td>
<td>$397.8M</td>
<td>$588.4M</td>
<td>$657.2M</td>
<td>$2.5B</td>
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<tr>
<td>Underpayments Returned</td>
<td>$16.9M</td>
<td>$141.9M</td>
<td>$24.9M</td>
<td>$61.5M</td>
<td>$44.1M</td>
<td>$289.3M</td>
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<tr>
<td>Total Corrections</td>
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<td>$939.3M</td>
<td>$422.7M</td>
<td>$649.9M</td>
<td>$701.3M</td>
<td>$2.8B</td>
</tr>
</tbody>
</table>
In response to the demand letter from a PSC, ZPIC or RAC, providers may file a “request for redetermination.” (42 CFR section 405.940). The request for redetermination must be filed with the Medicare Contractor indicated in the demand letter.
First Level of Appeal: Redetermination cont.

- The request for redetermination must be filed within 120 days of the provider’s receipt of the demand letter. For purposes of the filing deadline, the date of receipt will be presumed to be 5 calendar days after the date of the demand letter, unless there is evidence to the contrary.

- The Medicare contractor may extend the 120 filing deadline upon showing of good cause.
Some examples of good cause:

- The provider was prevented by serious illness from contacting the contractor in person, in writing, or through a friend, relative or other person
- The provider had a death or serious illness in his or her immediate family
- Important records of the provider were destroyed or damaged by fire or other accidental cause
Examples cont.

- The contractor gave the provider incorrect or incomplete information about when and how to request a redetermination
- The provider did not receive notice of the determination or decision; or
- The provider sent the request to a government agency in good faith within the time limit, and the request did not reach the appropriate contractor until after the time periods to file a request expired.
□ Requests for redetermination must be in writing and must include:
  – The beneficiary’s name
  – The Medicare health insurance claim (HIC) number
  – The specific services and/or items for which the redetermination is being requested and the specific dates of service
  – The name and signature of the provider or the provider’s representative
First Level of Appeal: Redetermination cont.

- The provider should include any evidence that the provider believes should be considered by the contractor in making its redetermination
In conducting the redetermination, the contractor will review the evidence and findings upon which the initial determination was based, and any additional evidence the provider submits. There is no hearing at the redetermination stage; rather the contractors decision is based solely on the written evidence.

The contractor is required to issue its redetermination decision within 60 days of its receipt of the request for redetermination.
Providers who wish to appeal a redetermination decision may file a “request for reconsideration” with a Qualified Independent Contractor (QIC).
The request for reconsideration must be filed within 180 days of the provider’s receipt of the redetermination decision. For purposes of the filing deadline, the date of receipt will be presumed to be 5 calendar days after the date of the notice of redetermination, unless there is evidence to the contrary.

The QIC may extend the 180 day filing deadline upon showing of good cause.
The request for reconsideration must be in writing, and must include:

– The beneficiary’s name
– The Medicare Health Insurance Claim (HIC) number
– The specific services and items for which the reconsideration is requested and the specific dates of service
– The name and signature of the provider or the provider’s representative; and
– The name of the contractor that made the redetermination
Second Level of Appeal: Reconsideration cont.

- The provider must submit all necessary evidence in support of its appeal. Evidence may be submitted at any time before the QIC issues its decision. New evidence cannot be submitted at subsequent levels of appeal absent a showing of good cause.
Second Level of Appeal: Reconsideration cont.

- There is no hearing at the reconsideration stage; rather, the QIC will conduct an on-the-record review of the written evidence.
- The QIC is not bound by LCD’s or CMS program guidance but the QIC must give substantial deference to these policies if they are applicable to the particular case.
The QIC is required to issue its reconsideration decision within 60 days of its receipt of the request for reconsideration. If the QIC does not issue its decision within 60 days, the provider may escalate the appeal to the ALJ level.
Third Level of Appeal: ALJ Hearing

- Under certain circumstances, a provider may appeal the reconsideration decision of the QIC to an Administrative Law Judge (ALJ)
  - The amount in controversy must be $100, adjusted annually by the medical care component of the consumer price index for all urban consumers
  - The amount in controversy can be met by aggregating two or more claims that were reviewed by the QIC
Third Level of Appeal: ALJ Hearing

cont.

- The request for an ALJ hearing must be filed within 60 days of the provider’s receipt of the reconsideration decision. For purposes of the filing deadline, the date of receipt will be presumed to be 5 calendar days after the date of the notice of reconsideration, unless there is evidence to the contrary. 42 CFR section 405.1002(a)
Third Level of Appeal: ALJ Hearing cont.

- The ALJ may extend the 60 day filing deadline upon showing of good cause.
- The request for an ALJ hearing must be in writing, and must contain:
  - The name, address and Medicare health insurance claim (HIC) number of the beneficiary whose claim is being appealed;
  - The name and address of the appellant, when the appellant is not the beneficiary;
  - The name and address of the designated representatives if any;
  - The document control number assigned to the appeal by the QIC, if any;
  - The dates of service
  - The reasons the appellant disagrees with the QIC’s reconsideration or other determination being appealed; and
  - A statement of any additional evidence to be submitted and the date it will be submitted
Third Level of Appeal: ALJ Hearing cont.

- The ALJ hearing may be conducted in person, by video teleconference or by telephone; hearings are typically conducted by telephone.
- Providers are permitted to present oral testimony and call witnesses. Written evidence not submitted prior to the QIC’s reconsideration decision will only be admitted upon showing good cause.
Third Level of Appeal: ALJ Hearing cont.

- In some cases, the QIC may participate in the ALJ hearing.
- The ALJ must issue a decision within 90 days of the provider’s request for an ALJ hearing. If the ALJ does not issue its decision within 90 days, the provider may escalate the appeal to the Medicare Appeals Council.
The ALJ will issue its decision in writing, and the decision will include:

- The specific reasons for the determination, including, to the extent appropriate, a summary of any clinical or scientific evidence used in making its determination
- The procedures for obtaining additional information concerning the decision; and
- Notification of the right to appeal the decision to the Medicare Appeals Council, including instructions on how to initiate such appeal
Occasionally, ALJs will require the contractors to disregard their extrapolation and only collect overpayments from the specific claims at issue, where they find the sampling and extrapolation have not been conducted in a manner that was fair to the provider, or that the methodology was not sufficiently documented to allow the provider to evaluate its fairness.
Fourth Level of Appeal: Medicare Appeals Council

- The provider may appeal the ALJ’s decision to the Medicare Appeals Council (MAC). The MAC is a component of the Department of Health and Human Services Departmental Appeals Board.
The request for MAC review must be filed within 60 days of the provider’s receipt of the ALJ decision. For purposes of the filing deadline, the date of receipt will be presumed to be 5 calendar days after the date of the ALJ decision, unless there is evidence to the contrary.

The MAC may extend the 60 day filing deadline upon showing of good cause.
Fourth Level of Appeal: Medicare Appeals Council cont.

- The request for MAC review must be in writing, and must contain:
  - The beneficiary’s name
  - The Medicare health insurance claim (HIC) number
  - The specific services or items for which the review is requested
  - The specific dates of service
  - The date of the ALJ’s decision
  - If the provider is requesting escalation from the ALJ to the MAC, the hearing office in which the appellant’s request for hearing is pending
  - The name and signature of the provider or the provider’s representative
Fourth Level of Appeal: Medicare Appeals Council cont.

- The request for MAC review must identify the parts of the ALJ decision with which the provider requesting review disagrees and explain why he/she disagrees with the ALJ’s decision.
- The MAC may also decide on its own motion to review an ALJ’s decision.
Fourth Level of Appeal: Medicare Appeals Council cont.

- The MAC will limit its review to the evidence contained in the record of proceedings before the ALJ.
  - Upon request, the MAC will give the provider a reasonable opportunity to file briefs or other written statements about the facts and law relevant to the case.
The MAC may grant a request for oral argument if it decides that the case raises an important question of law, policy, or fact that cannot be readily decided based on written submissions alone. If the MAC decides to hear oral argument, it will inform the provider of the time and place of the oral argument at least 10 calendar days before the scheduled date.
The MAC must issue a final decision or dismissal order within 90 calendar days of its receipt of the provider’s request for MAC review. The MAC may adopt, modify, or reverse the ALJ hearing decision, or may remand the case to an ALJ. If the MAC does not issues its decision within 90 days, the provider may escalate the appeal to the Federal District Court. 42 CFR section 405.1132(a)
Fifth Level of Appeal: Federal District Court

- The provider may appeal the MAC’s decision by filing a civil action in Federal District Court. The required amount in controversy is $1000, adjusted annually by the medical care component of the consumer price index for all urban consumers.
The action must be filed within 60 days of the provider’s receipt of the MAC’s decision. For purposes of the filing deadline, the date of receipt will be presumed to be 5 calendar days after the date of the MAC’s decision unless there is evidence to the contrary.
Fifth Level of Appeal: Federal District Court cont.

- The civil action must be filed in either the US District Court for the judicial district in which the provider resides or has its principal place of business, or the US District Court for the District of Columbia.
The civil action must name the Secretary of Health and Human Services, in his/her official capacity, as the defendant. If the complaint is erroneously filed against the US or against any agency, officer, or employee of the US other than the Secretary, the provider will be notified that he or she has named an incorrect defendant and will be granted 60 calendar days from the date of receipt of the notice in which to commence the action against the correct defendant, the Secretary.
Take Away Strategies-Tips for Preparation

- Immediately check your address on the letter to ensure it is the correct and complete physical address
- Call and make contact with the auditors
- Call and advise your health care attorney and have him/her present at the audit and/or site visit
- Conduct a self-inspection immediately
- Make sure all patient health records are properly secured and your medical record handling and storage are compliant with HIPAA standards
Take Away Strategies-Tips for Preparation cont.

- Set aside a room for auditors if an onsite audit is requested
- Require photographic identification and identifying information for each member of the audit team
- Assign a contact person to service as the communication liaison between the auditors and your attorney
- Keep a copy of every document or paper you provide for the audit
- Do not voluntarily advise the auditors of suspicions of wrong doing or ask if what you are doing is correct
Take Away Strategies-Tips for Preparation cont.

- Keep good copies of and document your transmittal of any documents to the auditors.
- Make sure your policies and procedures are current.
- Contractors and their agents frequently use statistical sampling and extrapolation to estimate the amount of overpayment. The Medicare Program Integrity Manual, CMS Pub. 100-08, Ch. 3, Section 3.10, contains requirements for contractors using statistical sampling, which are generally very permissive. It can be beneficial to engage a statistics expert to challenge the methodology.
Questions/Answers?

- Questions?
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Save the Date
September 21-24, 2014

33rd Annual Conference
Austin, Texas