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Surviving Medicare's Recovery Room - Tips for Physician Practices

By Stacie L. Buck, RHIA, LHRM

It is estimated that in the last two fiscal years, billions of dollars have been inappropriately paid out by Medicare and there is growing concern that the Medicare Trust Funds may not be adequately protected against erroneous payment through current administrative procedures. Because of this, the Center for Medicare & Medicaid services continues to step up its recovery efforts this year with its Recovery Audit Contract (RAC) initiative. Mandated under the Medicare Modernization Act of 2003, this program is designed to provide additional resources for identifying over and underpayments, and recouping any identified overpayments.

The program which began back in May of 2005, is being piloted in three states—Florida, California & New York—the three states receiving the highest percentage of Medicare dollars. This pilot program is designed to determine whether the use of RACs will be a cost-effective means of adding resources to ensure correct payments are being made to providers. Private contractors have been selected to carry out these recovery efforts and will be paid on a contingency fee basis. The pilot program will last for three-years.

In addition to the RAC initiative, physicians will continue to be scrutinized through the Comprehensive Error Rate Testing Program (CERT), first implemented in 2003. Historically the Office of the Inspector General under the Department of Health and Human Services calculated Medicare FFS error rates that estimated only a national FFS paid claims error rate, the percentage of dollars that Carriers/DMERCs/FIs/QIOs erroneously allowed, utilizing a random sample of only 6,000 claims. Under the CERT program, the sample size has increased significantly and CMS decided to calculate additional error rates. Approximately 128,000 claims will be reviewed each year, and in order to better measure the performance of the Carriers, DMERCs, and FIs and in order to gain insight into the causes of errors, CMS elected to calculate a provider compliance error rate (which measures how well providers prepared claims for submission) and a services processed error rate (which measures whether the Carrier/DMERC/FI made appropriate payment decisions on claims) in addition to the national paid claims error rate.

Physicians also must not forget that Florida Medicare will also continue to perform Comprehensive Data Analysis to identify aberrancies in billing and coding practices. Depending on the outcome of CDA, Medicare will elect to do one or more of the following—conduct provider education, develop a Local Coverage Determination, conduct a widespread probe review, or an individual probe review. If the Medicare carrier elects to conduct an individual probe review, a physician practice could be facing recoupment of overpayments as well as being placed on a pre-payment review.

Due to the scrutiny at both the national and state levels, conducting chart audits and performing ongoing monitoring has never been as important to physician practices as it is today, especially in the state of Florida. A physician practice should take the following proactive measures to ensure a positive outcome for any audit:

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Stacie L. Buck, RHIA, LHRM

Vice President, Southeast Radiology Management



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Implement an auditing and monitoring process. Your best defense is a good offense. If you are not currently performing chart audits, it is highly recommended that you begin to do so. The initial audit should serve as a baseline audit against which progress can be measured. An effective chart audit will not only seek to validate correct code assignment based on documentation in the medical record, but will also investigate if final claims are being submitted correctly. Ongoing monitoring may occur by tracking and trending your denials and keeping a close eye on your accounts receivable.

Request a copy of a Comparative Billing Report from your Medicare carrier. Comparing your coding distribution data with national, state and local benchmarks will assist you in identifying potential instances of both under utilization and over utilization (downcoding or upcoding) of certain CPT codes. By identifying patterns that are out of the norm, you can circumvent an audit from your Medicare carrier by taking necessary corrective action, or be prepared to defend your billing and coding practices with accurate and complete medical record documentation in the event of an audit.

Engage an independent third party to conduct an audit. While many physician practices may shy away from hiring a consultant to perform a chart audit because they would rather not incur an additional expense, use of an independent consultant is usually a more effective means of conducting a chart audit. Not only is an independent third-party able to perform an audit in an unbiased manner, but he or she has expert knowledge of billing, coding and documentation requirements and often has extensive experience in providing education and implementing corrective action.

To learn more about the Recovery Audit Contractors and how to utilize CMS data to identify your risk areas, attend “Surviving Medicare’s Recovery Room: Monitoring Your Vital Signs for a Successful Operation” presented by Stacie L. Buck, RHIA, LHRM on February 18, 2006.

Created by:
Stacie L. Buck, RHIA, LHRM
Vice President, Southeast Radiology Management