Understanding Medicare Fee-for-Service Audits

A Guide for Health Care Providers and Practice Administration

Example EYLEA® (aflibercept) Injection Issues With Medicare Fee-for-Service Audits

Additional Documentation Request (ADR)

Issue: Navigating ADR.

Example scenario: Provider receives an ADR pursuant to a Medicare audit.

Provider Checklist

- Read ADR carefully
  - ADR must specify relevant documentation only
  - ADR request may not negatively impact provider
  - Provider must respond **within 45 days**
  - Provider may request a reopening if timely
  - Contractor will make determination **within 30 days**

Support

CMS Program Integrity Manual, Chapter 3, Section 3.2.3.1 states...

Contractor will specify in the ADR only the documentation needed to make a determination.

CMS Program Integrity Manual, Chapter 3, Section 3.2.3.4 states...

Contractor will ensure that the documentation requested does not negatively impact the provider's ability to provide care.

CMS Program Integrity Manual, Chapter 3, Section 3.2.3.2 states...

Provider will respond **within 45 days** or claim(s) may be denied.

CMS Program Integrity Manual, Chapter 3, Section 3.2.3.9 states...

If MACs receive the requested information from a provider after a denial has been issued but within a reasonable number of days (generally **15 days**), they have the discretion to reopen the claim.

CMS Program Integrity Manual, Chapter 3, Section 3.2.1.1 states...

Contractor will, **within 30 days** of receiving the requested documentation, make and document the review determination.

CMS = Centers for Medicare & Medicaid Services.

Targeted Probe and Educate (TPE)

Issue: Navigating TPE audit.

Example scenario: Provider is chosen for TPE program. MAC will review 20 to 40 claims and supporting medical records.

Provider Checklist

- Check common claim errors:
  - Signature of physician
  - Encounter notes must support Medicare eligibility
  - Documentation must meet medical necessity requirement
- Denied claims may result in provider education session
- Provider has 45 days to make changes and improve accuracy
- Failure to improve accuracy after 3 rounds will be referred to CMS
- If compliant, provider will not be reviewed for **at least 1 year** on the selected topic

For denials, see Provider Checklist in Appeals column.

- TPE audits may be prepayment or postpayment
- Practice may receive multiple ADRs if practice has multiple locations and multiple PTANs
  - A PTAN is a Medicare-only number issued to providers by MACs upon enrollment to Medicare. When a MAC approves enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider
  - Approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using MAC self-help tools (eg, IVR phone system, Internet portal, and online application status)
  - PTAN's use should generally be limited to provider's contacts with their MAC

Support

CMS Program Integrity Manual, Chapter 3, Section 3.2.5 states...

The purpose of TPE is to decrease provider burden, reduce appeals, and improve the medical review/education process. MAC will:

- Select probe samples of typically 20 to 40 claims. Probe samples of different sizes may be deemed appropriate on a case-by-case basis, with approval by CMS
- Provide a minimum of 45 days after each postprobe educational session, before selecting new claims for review, to allow time for provider/supplier to correct identified errors
- Typically handle any recoupments or payments
- TPE reviews can be either prepayment or postpayment and involve MACs focusing on specific providers/suppliers that bill a particular item or service

IVR = Interactive Voice Response; NPI = National Provider Identifier; PTAN = Provide Transaction Access Number.

Recovery Audit Contractor (RAC)

Issue: Navigating RAC audit.

Example scenario: Provider is audited by Medicare RAC.

Provider Checklist

See also Provider Checklist in MAC/SMRC Audit column.

- Number of ADR requests may be limited
- RAC audit topics are restricted in scope and limited to postpayment review
- Request reimbursement per CMS fee schedule for document production

Support

CMS Directive: Physician/Nonphysician Practitioner Additional Documentation Limits (February 14, 2011) states...

Number of additional documentation requests per 45-day period is limited based on practice ZIP code(s) and number of "rendering physicians" and "nonphysician practitioners":

Group/Office Size	Maximum Number of Record Requests
50 or more	50
25-49	40
6-24	25
5 or under	10

CMS reserves the right to give RACs permission to exceed the cap. Affected physicians/practices will be notified in writing.

CMS Program Integrity Manual, Chapter 3, Section 3.2.3.6 states...

Provider is entitled to reimbursement per fee schedule from RAC.

See http://bit.ly/2SJXCUS for CMS-approved RAC topics and http://bit.ly/37WRYG4 for proposed RAC topics.

Medicare Administrative Contractor (MAC)/Supplemental Medical Review Contractor (SMRC) Audit

Issue: Navigating MAC/SMRC audit.

Example scenario: Provider is audited by MAC or SMRC.

Provider Checklist

See also Provider Checklist in ADR column.

- Carefully review charts before sending
- Look for gaps in documentation:
  - Chief complaint
  - Missing exam elements
  - Documentation of medical decision-making
  - Diagnostic testing interpretation and report
  - Procedure notes
  - Signature requirements
- Cannot alter a chart; however, chart may be amended with additional or clarifying documentation
- Ensure electronic medical records system tracks any addendums
- Resulting overpayments can be appealed (see also Provider Checklist in Appeals column)

Support

CMS Program Integrity Manual, Chapter 3, Section 3.2.3.2 states...

When making review determinations, MACs and SMRC will consider all submitted entries that comply with the widely accepted record-keeping principles.

Appeals

Issue: Provider appeals adverse determination.

Example scenario: Medicare audit has resulted in an adverse determination to provider.

Provider Checklist

Comparison of standard and overpayment time frames of appeals:

- Rebuttal and discussion: **within 15 days**
- Redetermination
  - Standard appeal deadline: **120 days**
  - Appeal deadline to avoid recoupment: **30 days**
- Reconsideration
  - Standard appeal deadline: **180 days**
  - Appeal deadline to avoid recoupment: **60 days**
  - Full presentation of evidence
- Administrative Law Judge
  - Appeal deadline: **60 days**
  - CMS may recoup pending Administrative Law Judge decision
  - Presentation of new evidence is limited by rule
- Medicare Appeals Council
  - Appeal deadline: **60 days**
- Federal District Court
  - Appeal deadline: **60 days**

Medicare appeal request forms are available at http://bit.ly/2MRNW8B.

Support

CMS Program Integrity Manual, Chapter 3, Section 3.5.2 states...

MACs, CERT Outreach and Education Task Forces, RACs, and SMRC will document the rationale for denial and include the basis for revisions in each case.

42 Code of Federal Regulations Section 405.1018 states...

Any evidence submitted by a provider that is not submitted prior to the issuance of the QIC's reconsideration determination must be accompanied by a statement explaining why the evidence was not previously submitted.

42 Code of Federal Regulations Section 405.1028 states...

After a hearing is requested but before it is held, the Administrative Law Judge will examine any new evidence submitted with the request for hearing (or **within 10 days** of receiving the notice of hearing), as specified in Section 405.1018, by a provider to determine whether the provider had good cause for submitting the evidence for the first time at the Administrative Law Judge level.

CERT = Comprehensive Error Rate Testing; QIC = Qualified Independent Contractor.

Go to http://bit.ly/2UO7F3Y for compliance program guidance—applicable to individual and small group physician practices—from the US Department of Health and Human Services' Office of Inspector General.

Visit NavigatingPayerChallenges.com for state-specific and federal legislation or contact your Reimbursement Business Manager (RBM) for more information

This material is provided for informational purposes only, is subject to change, and should not be construed as legal or medical advice. Use of this information to challenge or appeal a coverage or reimbursement delay and/or denial by a payer is the responsibility of the provider.

Reference: Data on file. Regeneron Pharmaceuticals, Inc.

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