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NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Part A Fall 2024 Virtual Conference:

Keeping Compliant with Medicare Starts With You

November 12th, 14th, and 19th

Introduction to Medicare Contractors

Who They Are And What They Do

11/12/2024

NGSMU
NGS Medicare University

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Objective

Learn about the various Medicare contractors including who they are and what they do

Today's Presenters

- Jean Roberts, RN, BSN, CPC
- Christine Janiszcak
  - Provider Outreach and Education Consultants

Agenda

- CMS Contractors Introduction: MACs and More
- Appeals Contractors
- Medicare Audit (Review) Contractors
- Comprehensive Error Rate Testing (CERT)
- Additional Contractors
- Office of Inspector General (OIG)
- Suggestions and Audit Preparation
- Resources

CMS Contractors Introduction: MACs and More

Centers for Medicare & Medicaid Services (CMS)

- Central office located in Baltimore, MD
  - Ten regional offices
- Oversees Medicare, Medicaid and SCHIP
  - Establishes policies for paying health care providers
    - Responsible for writing Medicare rules and regulations
  - Assesses quality of health care facilities and services
  - Assures Medicare is run properly by contractors
    - Coverage regulations: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*
    - Billing regulations: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*

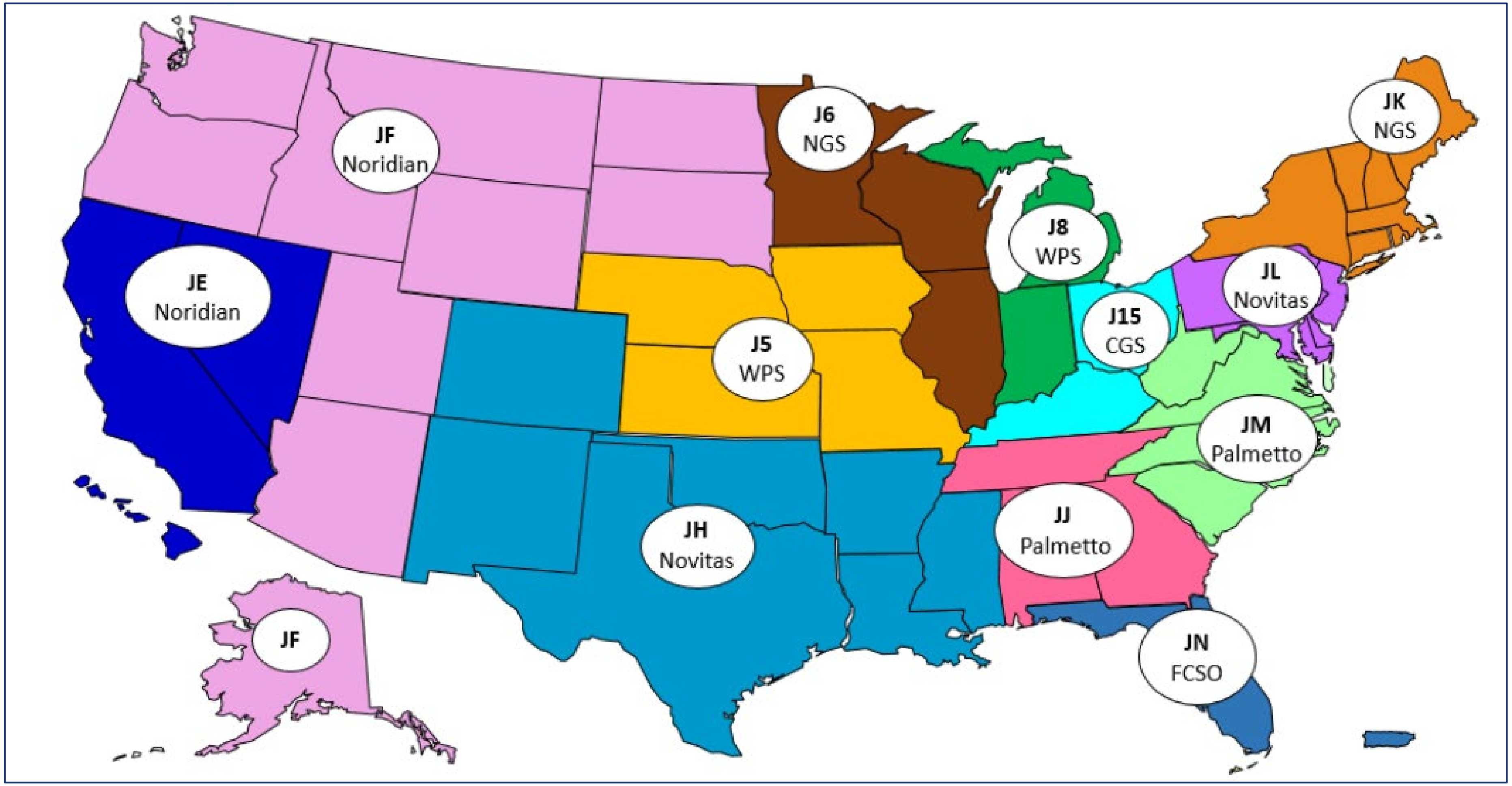
Medicare Administrative Contractors (MACs)

- Private health care insurer awarded specific geographic jurisdiction – Federal government contract
  - Process and pay FFS Part A and B medical or DME claims for Medicare beneficiaries
  - Also:
    - Enroll providers in FFS Medicare program
    - Handle provider reimbursement services and audit institutional provider cost reports
    - Handle redetermination requests (1st stage appeals process)
    - Respond to provider inquiries
    - Educate providers about Medicare FFS billing requirements
    - Establish local coverage determinations (LCD's)
    - Review medical records for selected claims
    - Coordinate with CMS and other FFS contractors

MACs

- Twelve A/B MACs
  - Four of these A/B MACs also process HHH claims
    - HHH jurisdiction areas do not coincide with associated A/B MAC jurisdiction areas
- Four DME MACs
  - Process Medicare DMEPOS claims for defined geographic jurisdictions
- MACs work with multiple Medicare contractors to administer full FFS operational environment
- CMS: What's a MAC

A/B MAC Jurisdictions



NGS MAC States

- J6 Region
  - **Part A & B:** Illinois, Minnesota, Wisconsin
  - **HHH:** Alaska, Arizona, California, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Oregon, Washington, Wisconsin and the U.S. Territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico and U.S. Virgin Islands
  - **FQHC:** 44 states, District of Columbia and five U.S. territories.
- JK Region
  - **Part A & B:** Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont
  - **HHH:** Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont

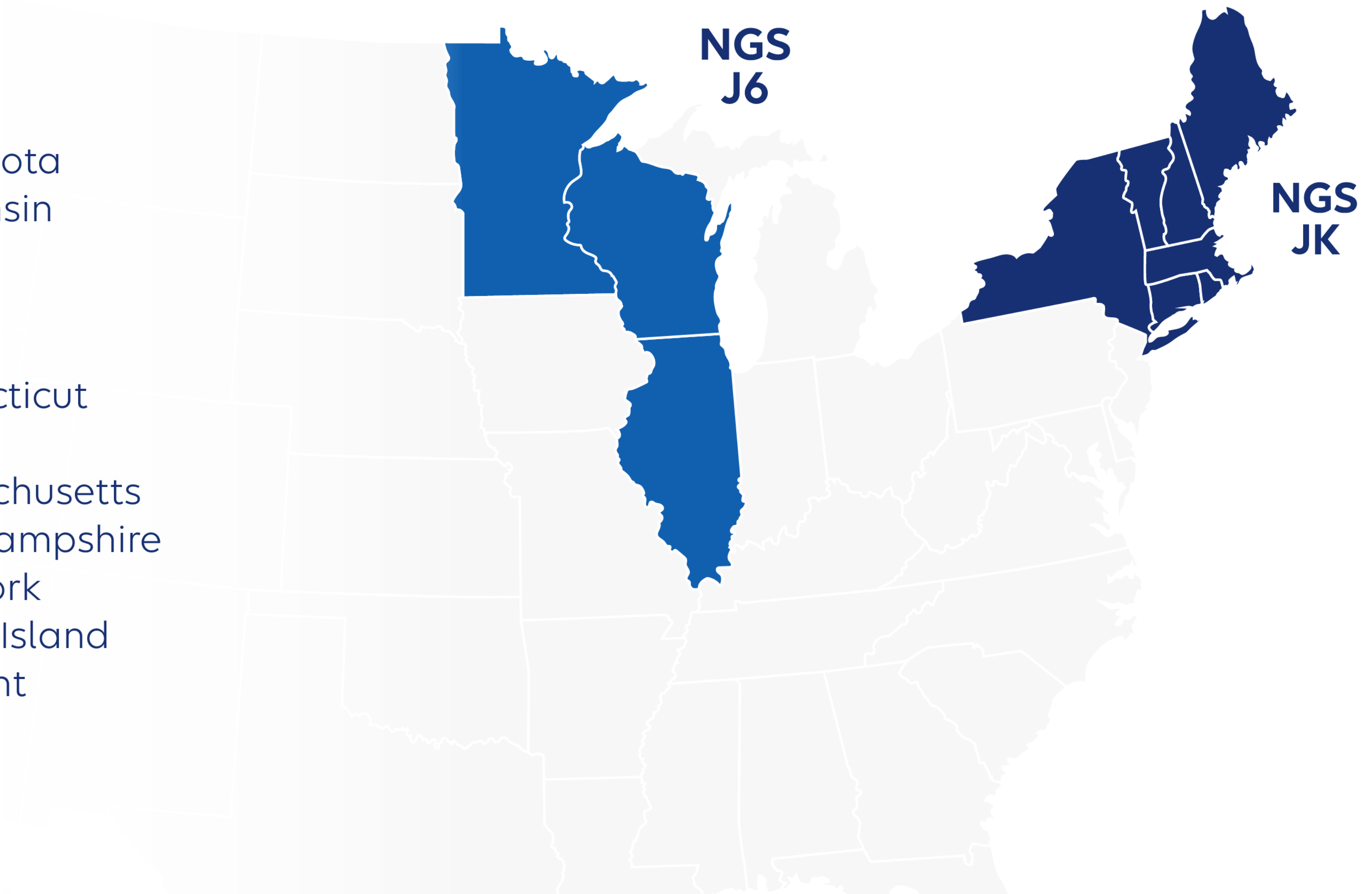
NGS Part A/B Jurisdictions

NGS J6

- Illinois
- Minnesota
- Wisconsin

NGS JK

- Connecticut
- Maine
- Massachusetts
- New Hampshire
- New York
- Rhode Island
- Vermont

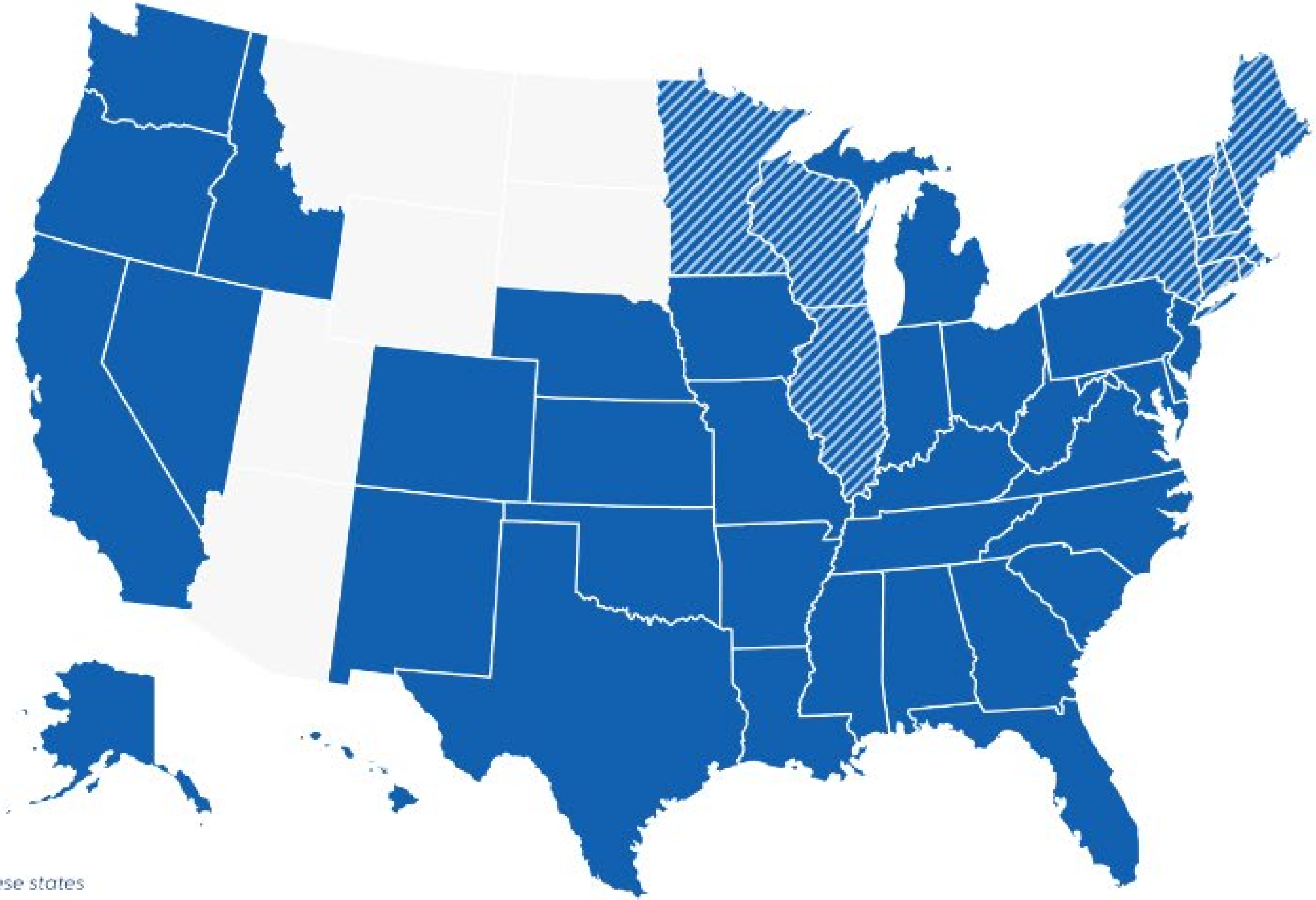


NGS FQHC-RHC

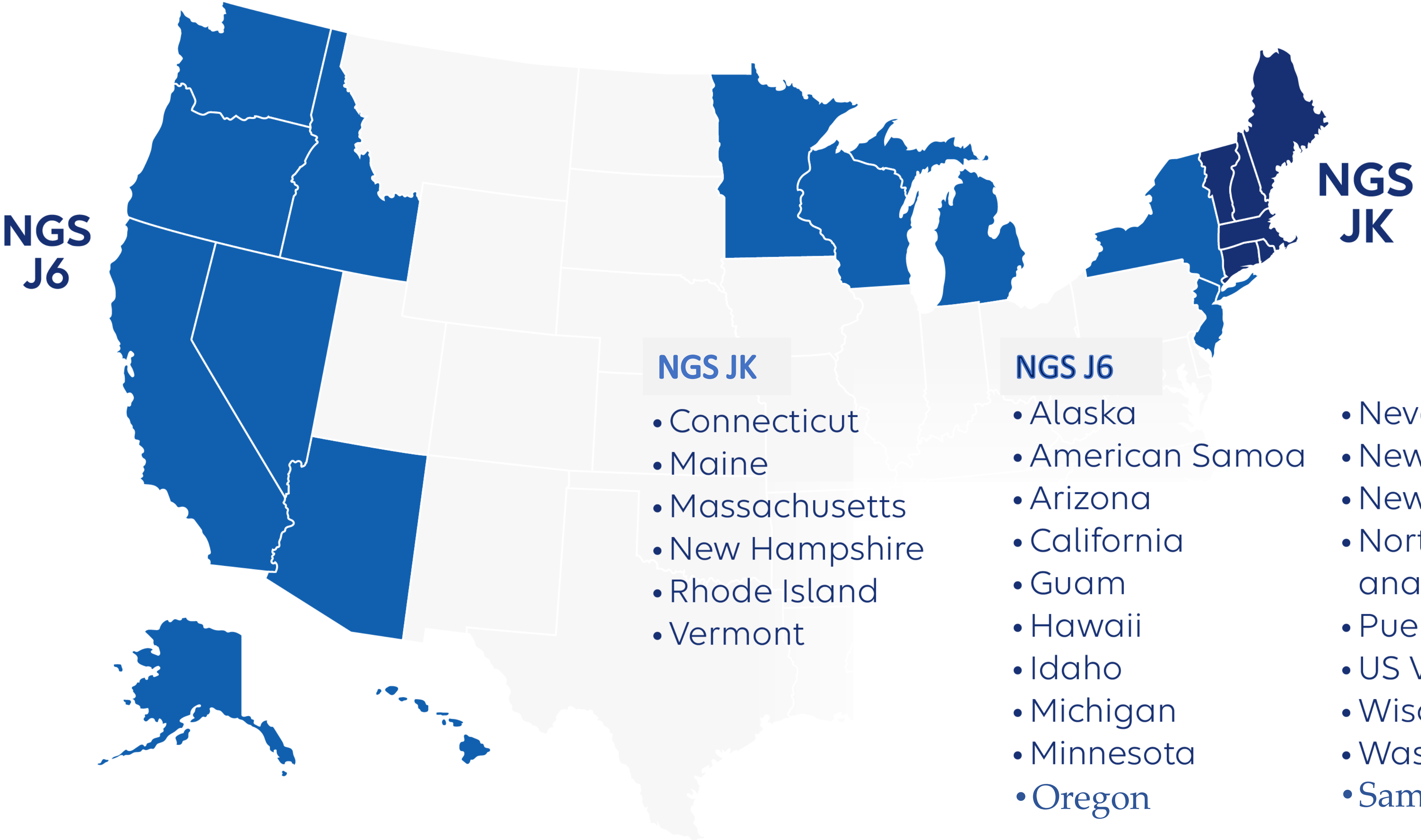
NGS J6 & JK

- Alabama
- Alaska
- American Samoa
- Arkansas
- California
- Colorado
- **Connecticut***
- Delaware
- Florida
- Georgia
- Guam
- Hawaii
- Idaho
- **Illinois***
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- **Maine***
- Maryland
- **Massachusetts***
- Michigan
- **Minnesota***
- Mississippi
- Missouri
- Nebraska
- Nevada
- **New Hampshire***
- New Jersey
- New Mexico
- **New York***
- North Carolina
- Northern Mariana Islands
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico
- **Rhode Island***
- South Carolina
- Tennessee
- Texas
- **Vermont***
- Virginia
- Washington
- Washington D.C.
- West Virginia
- **Wisconsin***

** NGS is the FQHC & RHC for these states*



NGS Home Health & Hospice Jurisdictions



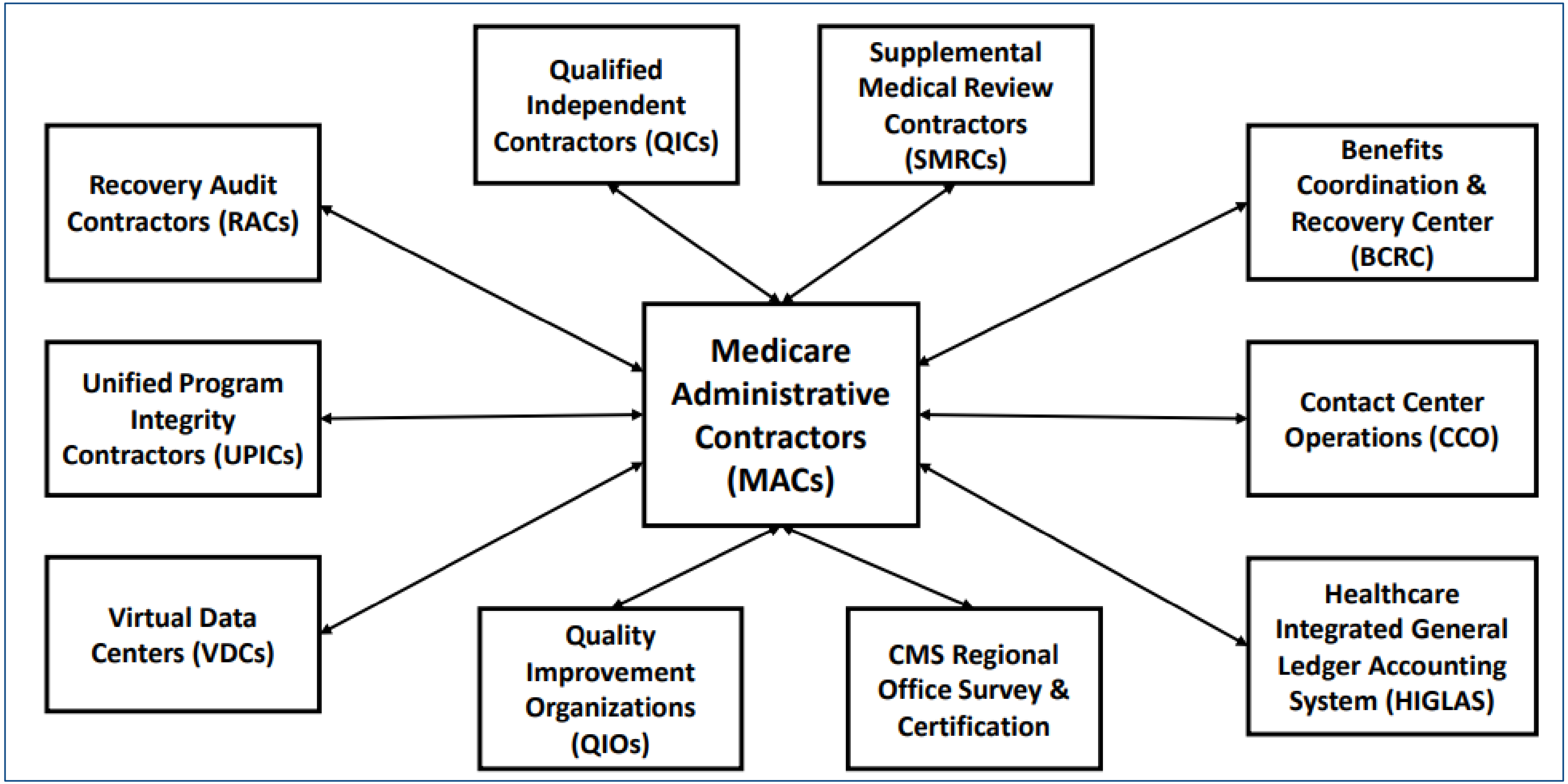
NGS JK

- Connecticut
- Maine
- Massachusetts
- New Hampshire
- Rhode Island
- Vermont

NGS J6

- Alaska
- American Samoa
- Arizona
- California
- Guam
- Hawaii
- Idaho
- Michigan
- Minnesota
- Oregon
- Nevada
- New Jersey
- New York
- Northern Mariana Islands
- Puerto Rico
- US Virgin Islands
- Wisconsin
- Washington
- Samoa

MACs as Hub of Medicare FFS Program



Contact Center Operations (CCO)

- Contractor: Maximus Federal Services, Inc.
- Responds to inquiries from Medicare customer service population
  - Handles over 35 million customer inquiries each year for CMS programs
    - Examples: 1-800-MEDICARE and Health Insurance Marketplace
  - 24/7 customer service
  - Range of services and quality assurance across multiple customer contact channels
    - Telephone, mail, email, TDD/TYY, fax, and web chat
- Fact Sheet: Contact Center Operations Contract Award

Healthcare Integrated General Ledger Accounting System (HIGLAS)

- Component of the Department of Health and Human Services (DHHS), Unified Financial Management System (UFMS)
  - Single, integrated dual-entry accounting system
  - Standardizes and centralizes federal financial accounting functions for all of CMS programs
  - Enhances CMS oversight of all financial operations
    - Achieve accurate, reliable, and timely financial accounting and reporting for all CMS's programs and activities
  - Supports CMS business
    - Medicare FFS
    - MSP
    - Federal Facilitated Marketplace (FFM)
    - Administrative Program Accounting (APA) activities

Virtual Data Centers (VDCs)

- VDC serves as platform for claims processing software systems for Medicare claims
  - CMS previously migrated entire FFS claims processing workload to VDCs - reduced number of data centers from more than one dozen separate smaller centers to two large VDCs

CMS Regional Office - Survey & Certification

- Division of Survey and Certification Operations
  - Part of Consortium for Quality Improvement and Survey and Certification Operations (CQISCO)
- CQISCO strives to improve health and quality of care via dual mission of quality improvement and quality assurance
  - Partnership with Center for Clinical Standards and Quality
    - Field focal point for survey and certification
    - Quality improvement
    - Clinical and medical science issues and policies for agency's programs

Social Security Administration (SSA)

- Beneficiaries should contact SSA for
  - Medicare enrollment
  - Premium billing and payment
  - General Medicare questions (not claim-related) and questions regarding enrollment
  - Replacement Medicare cards
- [Social Security Administration]
  - Telephone number: 800-772-1213
- SSA: [Manage your Medicare Benefits]
- Beneficiary online access: [Get Started with Medicare]

Appeals Contractors

- MLN® Booklet: *Medicare Parts A & B Appeals Process*
- CMS website: Original Medicare (Fee-for-service) Appeals

Five Appeal Levels

- Level One - Redetermination by your MAC
  - Amount in controversy (AIC): No minimum
- Level Two - Reconsideration
  - AIC: No minimum
- Level Three - ALJ
  - AIC: Minimum $180 remaining
- Level Four - Review by Medicare Appeals Council (MAC)
  - AIC: No minimum
- Level Five - Judicial Review in Federal District Court
  - AIC: Minimum $1,840 remaining

Level One: MAC

- NGS Appeals information
- Tip Sheet for Medicare Providers on First Level of Appeals (Redeterminations)
- Ways to submit appeal request
  - Submit an Appeal Electronically with NGSConnex
  - Submit an Appeal Electronically via esMD
  - Via mail – download/complete form
    - Address on form
- Additional NGS Appeal-related forms
- NGS Appeals Calculator

Level Two: Qualified Independent Contract (QIC)

QIC Jurisdiction	Contractor
Part A East **(JK)**	C2C Innovative Solutions, Inc.
Part A West **(J6)**	Maximus, Inc.
Part B North **(J6 & JK)**	C2C Innovative Solutions, Inc.
Part B South	C2C Innovative Solutions, Inc.
DME	Maximus, Inc

Appeals Levels Three, Four, Five

- Level Three: ALJ
  - ALJ hearing request must be filed with Office of Medicare Hearings and Appeals (OMHA)
  - Office of Hearings and Appeals
    - OMHA e-Appeal Portal allows electronic submission of Medicare Part A and B Level three appeal requests only
      - Upload documentation, and obtain information on appeal status
- Level Four: Medicare Appeals Council
- Level Five: Judicial Review in Federal District Court

Medicare Audit (Review) Contractors

Medicare Audit Contractors

- CMS Center for Program Integrity (CPI) oversees various contractors' medical reviews and audits
  - CPI conducts contractor oversight activities including
    - Providing broad direction on medical review policy
    - Reviewing/approving Medicare contractors' annual medical review strategies
    - Facilitating Medicare contractors' implementation of recently enacted Medicare legislation
    - Facilitating compliance with current regulations
    - Ensuring Medicare contractors' performance of CMS operating instructions
    - Conducting continuous monitoring and evaluation of Medicare Contractors' performance in accord with CMS program instructions as well as contractors' strategies and goals
    - Provide ongoing feedback and consultation to contractors regarding Medicare program and medical review issues

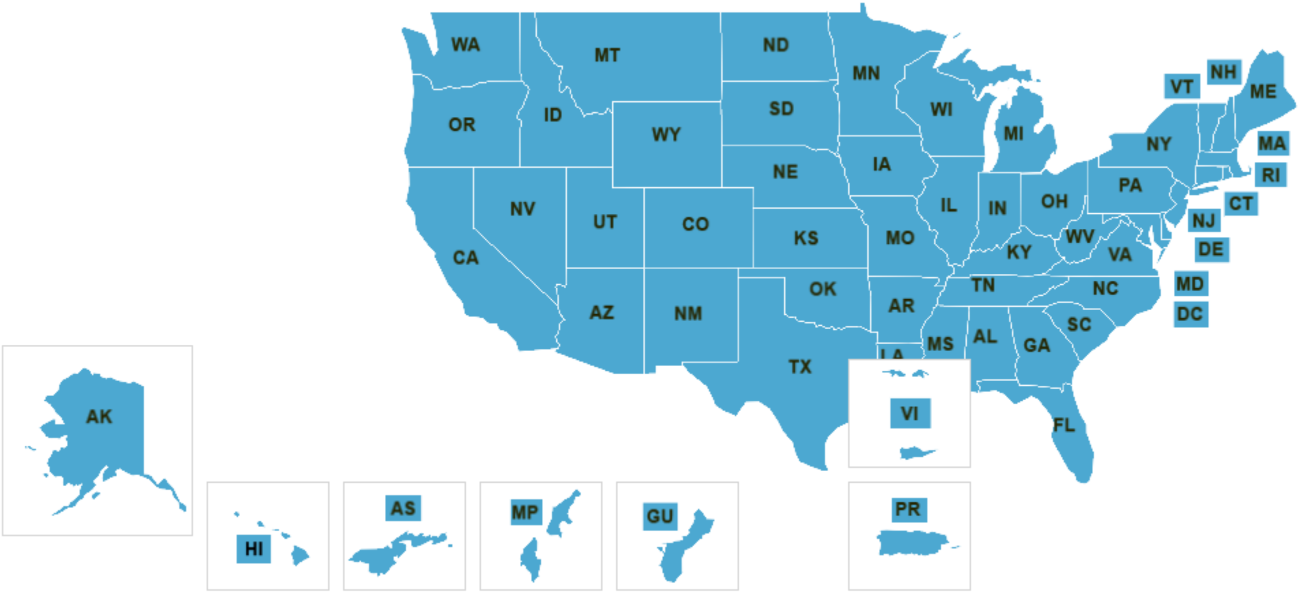
CMS as Hub for Medicare Contractors

Social Security Administration (SSA)	Department of Health & Human Services (DHHS)		Department of Public Health Services (DPHS)
	Centers for Medicare & Medicaid Services (CMS)		
Benefits Coordination & Recovery Center (BCRC)	Medicare Administrative Contractors (MACs) - **J6 & JK NGS** -	Zone Program Integrity Contractors (ZPIC)	Office of the Inspector General (OIG)
Supplemental Medical Review Contractor (SMRC)	Quality Improvement Organization (QIO)	Recovery Audit Contractor (RAC)	Comprehensive Error Rate Testing (CERT)

Review Contractor Directory - Interactive Map

Map: Review Contractor Directory - Interactive Map

The Review Contractor Directory - Interactive Map allows you to access state-specific CMS contractor contact information. You may receive correspondence from one or several of these contractors in your state. They may request medical records from you, as they perform business on behalf of CMS. You can use this website to access their contact information including emails, phone numbers and websites.



Select a State:

- Select a state -

CMS Divisions Responsible for Contractors

CMS Audit Contractor Strategies

- CMS follows three parallel strategies and contracts with various review contractors to:
  - Prevent improper payments through **MACs** and **SMRC** evaluation of program vulnerabilities and taking action to prevent identified vulnerabilities
  - Correct past improper payments through postpayment claim review by **Recovery Auditors**
  - Measuring improper payments and pinpointing causes of improper payments by calculating service specific, provider type and contractor specific error rates by **CERT** contractors
  - Recover improper payments
    - Improper payment may be due to coverage, coding, and/or billing errors

CMS Audit Contractors

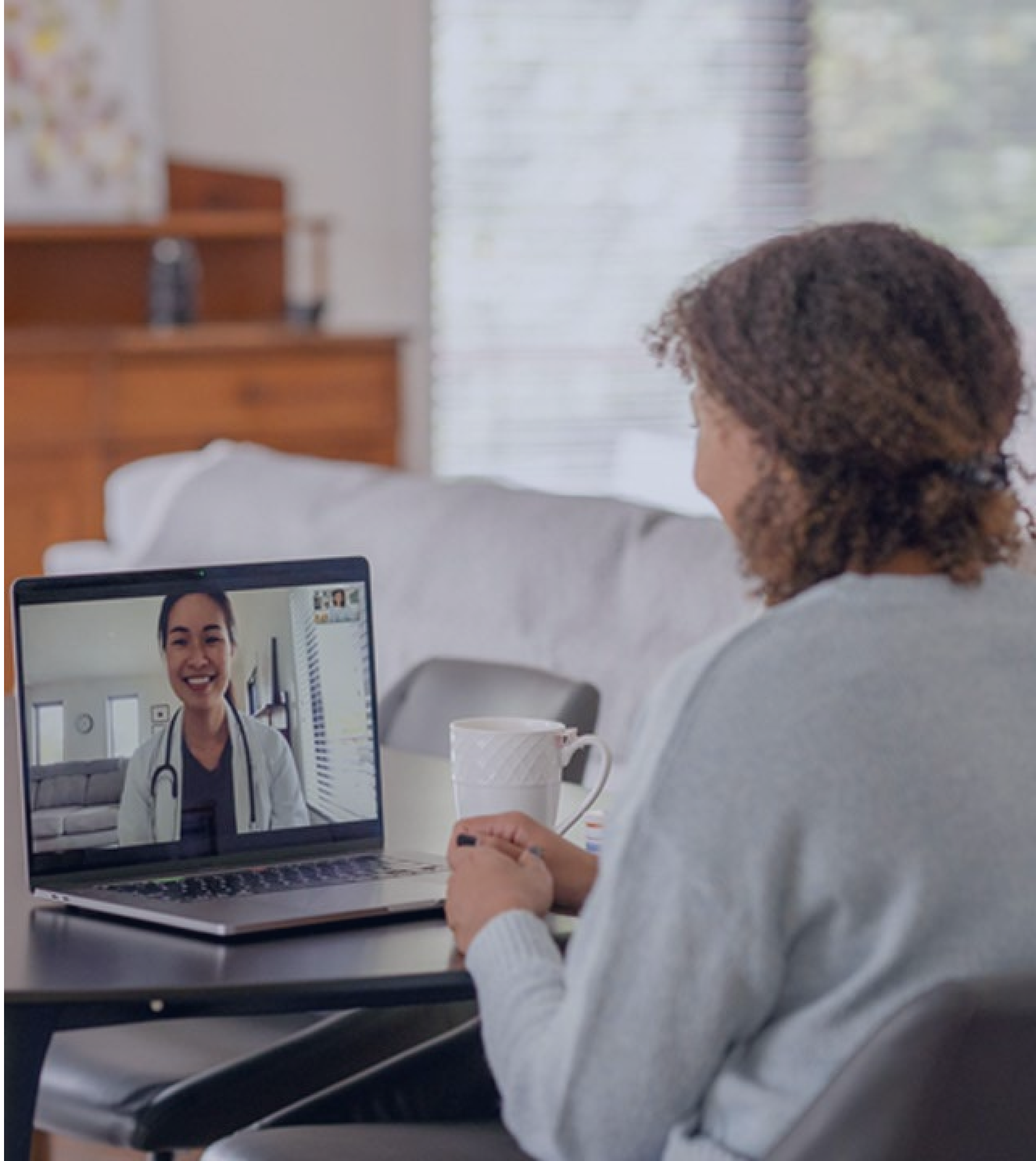
- Medicare FFS compliance programs prevent, reduce, and measure improper payments in FFS Medicare through medical review
  - Increase provider compliance and protect the Medicare Trust Fund
  - CMS strives to pay right amount to legitimate provider for covered, correctly coded and correctly billed services provided to an eligible beneficiary
  - Identify and recover improper payments
- Resource
  - CMS IOM 100-08, *Medicare Program Integrity Manual*, Chapter 1 - Medicare Improper Payments: Measuring, Correcting, and Preventing Overpayments and Underpayments

NGS MAC Medical Review

- NGS Medical Review
- NGS TPE
  - Conduct prepay and postpay review
  - Conduct medical review and education
  - Goal: Reduce costs related to improper payments and appeals
- When selected for review, records are requested via NGS letter/ADR
  - Submit records within 45 days of dated request
  - Submit medical records via NGSConnex, USPS, UPS/FedEx/Fax
    - Check NGS J6 or JK website for specifics
- NGS Mailing Addresses
- NGS Resources > Contact Us > Contact Information

Benefits Coordination & Recovery Center (BCRC)

- Goal: Improve quality of health care for all people with Medicare
- CMS [Coordination of Benefits & Recovery Overview]



BCRC

- Contracted by CMS effective 2/1/2014
- Consolidates activities that support collection, management, and reporting of other insurance for Medicare beneficiaries
- Takes actions to identify health benefits available to beneficiary and coordinates payment process to prevent Medicare mistaken payments
- Maintains MSP records in CWF and handles most corrections to such records
    - Note: BCRC does not process claims or handle claim-specific inquiries

Contacting BCRC

- MACs contact BCRC to request
  - Correction to existing MSP record in CWF using explanatory coding (indicating reason Medicare primary) from incoming claims
  - Set up of new MSP record in CWF using data from incoming claims
- Beneficiaries and other parties may contact BCRC to report
  - Employment/insurance corrections (to MSP records in CWF)
  - New MSP information (set up new MSP records in CWF)
- Providers contact BCRC to ask
  - General MSP questions
  - Questions regarding secondary claim development questionnaires

BCRC Contact Information

- Providers
  - Do not contact BCRC to request set up of new or corrections to existing MSP records
    - Refer to [MLN Connects® Newsletter 10/26/2023, "Conditional Payment Claims: Continue to Submit to Your Medicare Administrative Contractor"]
  - May refer beneficiaries and other parties to BCRC
    - In addition to or instead of reporting such information on claims, if applicable
- [BCRC Contact]
  - 855-798-2627
  - TTY/TDD: 1-855-797-2627
  - FAX: 405-869-3307

Resources

- MLN® Booklet: *Medicare Secondary Payer*
- Beneficiary involved in an accident: Medicare Secondary Payer Recovery Process Your Rights & Responsibilities

Quality Improvement Organization (QIO)

- One of largest federal programs dedicated to improving health quality for people with Medicare
- Protect integrity of Medicare Trust Fund
  - Ensures Medicare pays only for reasonable and necessary services and goods provided in most appropriate setting
- Responsible for potential quality of care issues

QIO Program Priorities

- Data-driven initiatives bring stakeholders together at local, community and tribal levels to improve:
  - Behavioral health outcomes and decrease opioid utilization and misuse
  - Chronic disease management
  - Care coordination and quality of care transitions
  - Immunizations against influenza, pneumonia and COVID-19
  - Patient safety
  - Infection control and decrease impact of COVID-19

QIO Program Initiatives

- Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs)
- Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs)
- Hospital Quality Improvement Contractors (HQICs)
- American Indian Alaska Native Healthcare Quality Initiative (AIANHQI)
- Opioid Prescriber Safety & Support initiative (OPSS)

QIO

- One QIO in each state including District of Columbia, Puerto Rico, and U.S. Virgin Islands
  - Serves as state/jurisdiction's QIO contractor
- Staffed by health care professionals
  - Trained to review medical care
  - Protect and assist beneficiaries with complaints about quality of care
    - Individual complaints
    - Provider-based notice appeals
    - EMTALA violations
    - Other related responsibilities as articulated in QIO-related law
  - Implement quality of care improvements throughout spectrum of care

QIO Working with Other Contractors

- MACs, CERT, Recovery Auditor, UPICs and SMRC required to refer quality of care issues to QIO, State licensing/survey and certification agency, or other appropriate entity in service area
  - Repeated violations
- CMS Quality Improvement Organizations

QIO Contact

- Quality Improvement Organizations website
- Locate your QIO - Search by issue
  - Quality of care concerns → BFCC-QIO
  - Quality improvement support for nursing home, community or outpatient care setting → QIN-QIO
- BFCC-QIO
  - J6: Livanta
  - JK NY: Livanta
  - JK CT, ME, Mass, NH, RI, VT: Acentra Health Telephone 1-888-319-8452 (toll-free) or 1-216-447-9604 (local)

Livanta BFCC-QIO: Effective 10/7/2024

- Helpline Number Update

CMS Region	States and Territories	Phone	TTY
2	New Jersey, New York, Puerto Rico, U.S. Virgin Islands	866-815-5440	711
3	Delaware, Maryland, Pennsylvania, Virginia, West Virginia, Washington, D.C.	888-396-4646	711
5	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	888-524-9900	711
7	Iowa, Kansas, Missouri, Nebraska	888-755-5580	711
9	Arizona, California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands	877-588-1123	711

Livanta BFCC-QIO: Effective 10/7/2024 (2)

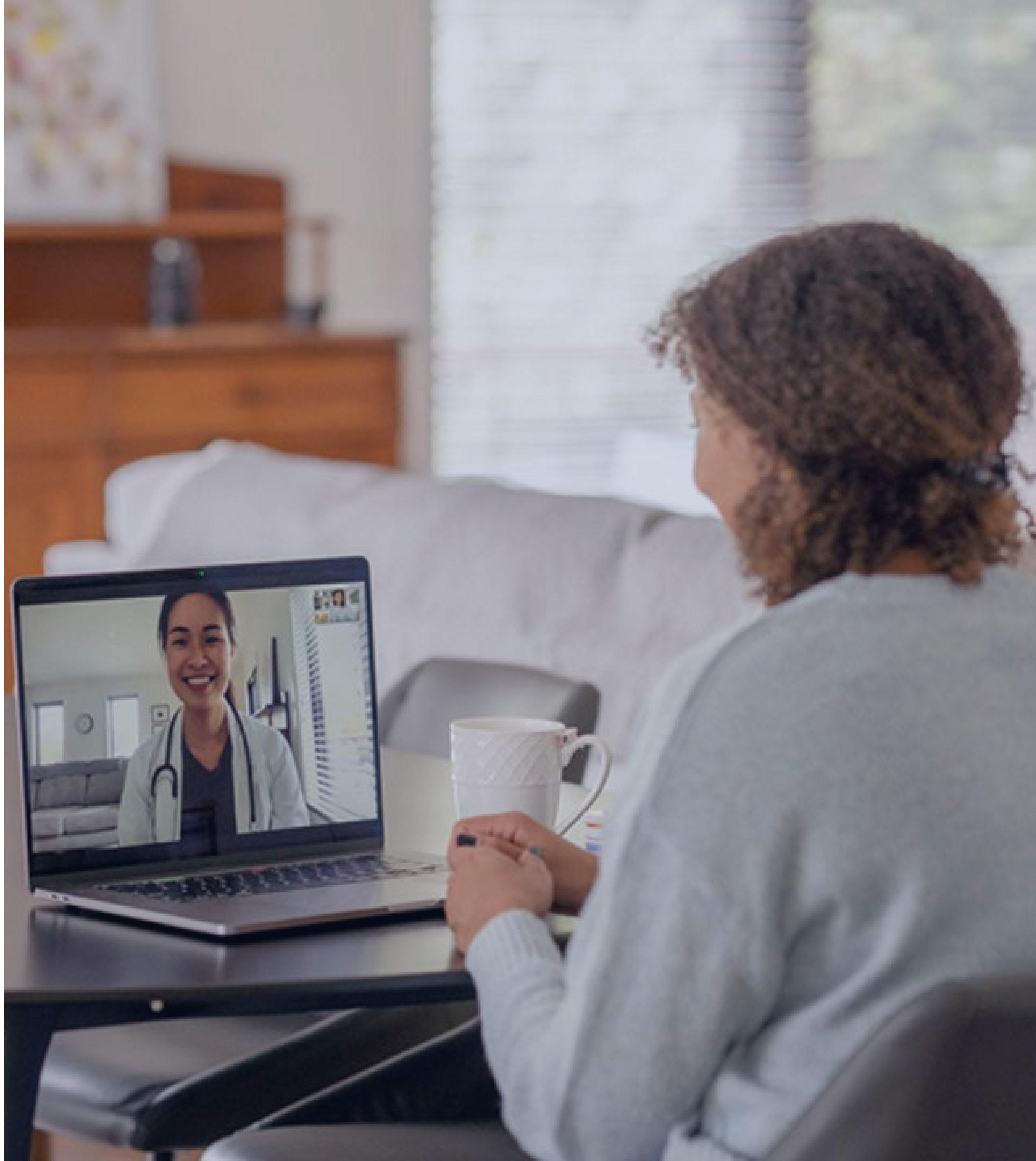
- New BFCC-QIO correspondence mailing address (U.S.P.S.):

  BFCC-QIO Program
  Livanta LLC
  P.O. Box 2687
  Virginia Beach, Virginia 23450

- Reminder: Effective 10/1/2020, Medicare-certified healthcare providers are required to transmit medical records electronically to the BFCC-QIO
  - Use any approved method
    - More information: Livanta Medical Records

Supplemental Medical Review Contractors (SMRCs)

- Contracts with CMS
- Conducts nationwide medical reviews of Medicaid, Medicare Part A/B and DMEPOS claims
- Goal: Lower improper payment rates and increase efficiencies of Medicare and Medicaid MR program functions



SMRC

- Primary task to conduct nationwide medical review
  - Evaluate medical records and related documents
  - Determine whether Medicare claims were in compliance with coverage, coding, payment, and billing practices
- Identify provider noncompliance with coverage, coding, billing, and payment policies through research and analysis of data related to assigned task (e.g., profiling of providers, services or beneficiary utilization)
- NGS [Supplemental Medical Review Contractor]

SMRC Focus

- May include:
  - Vulnerabilities identified by CMS data analysis, CERT program, professional organizations, and Federal oversight agencies such as OIG/GAO
  - Carry out other special projects to protect Medicare Trust Fund
  - May result in claim adjustments and/or overpayment recoupment
  - Notifies CMS of identified improper payments and noncompliance with documentation requests
- Notify individual billing entities of review findings identified and make appropriate recommendations for POE and UPIC referrals

SMRC and MAC Roles

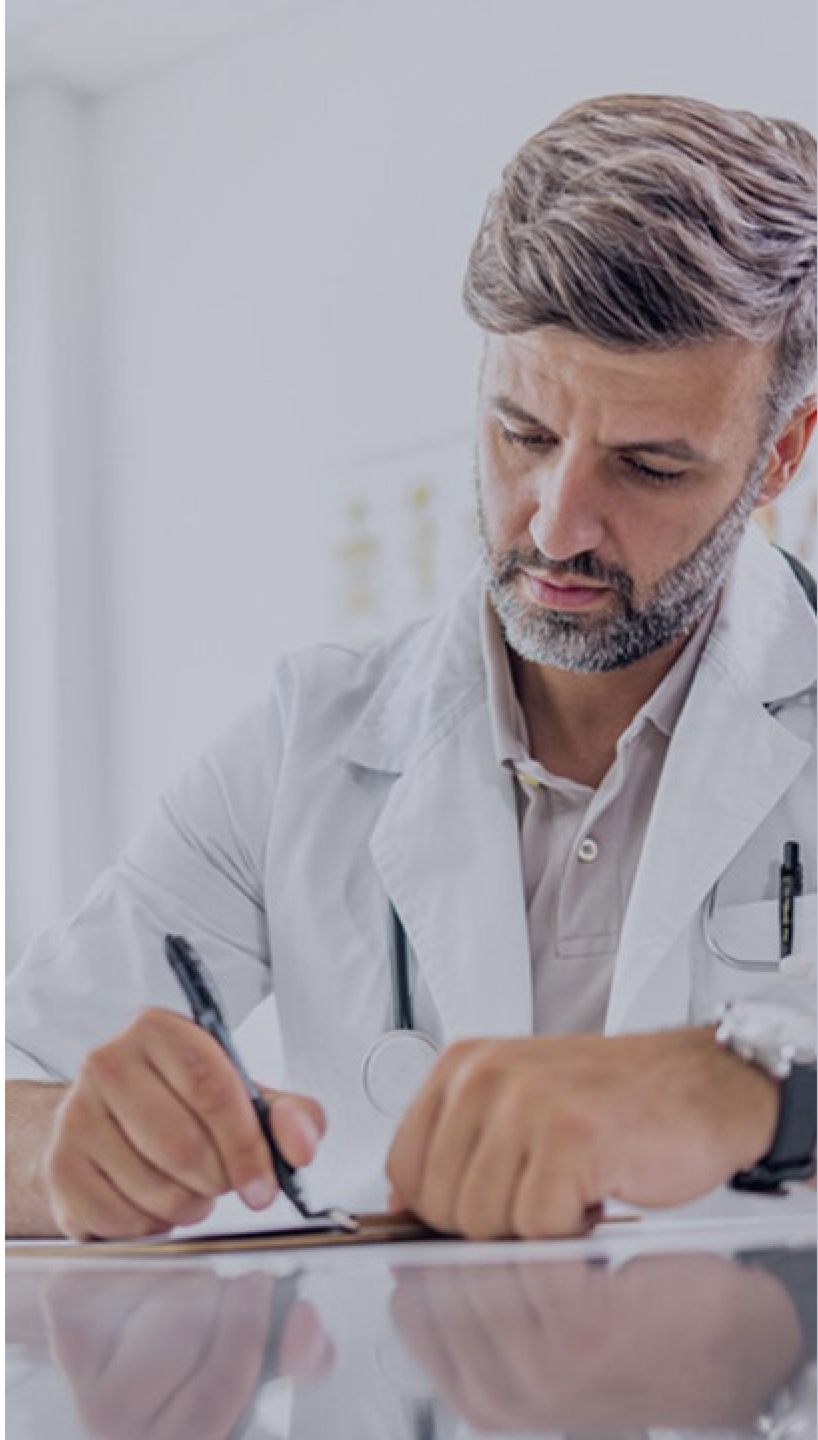
- Serves as readily available source of medical information to provide guidance in questionable claim review situations
- Provides clinical expertise and judgment to develop LCDs and internal MR guidelines and effectively focus MR on areas of potential fraud and abuse
- In-touch with medical practice and technology changes that may result in improper billing or program abuse
- MAC may initiate claim adjustments and/or overpayment recoupment actions identified by SMRC using standard overpayment recovery process

SMRC Contact

- Current SMRC under contract with CMS: Noridian Healthcare Solutions
- SMRC Contact Center: 833-860-4133
  - M – F: 8:30 AM – 6:00 PM ET / 7:30 AM to 5 PM CT
- Questions: SMRCMail@Noridian.com
  - Include:
    - Project ID
    - NPI, PTAN, State
    - Question
    - Company/Organization
    - Contact Phone Number

Recovery Audit Contractor (RAC) Program

- Contract with CMS to identify Medicare improper payments
- Mission: Detect and correct Medicare improper payments made on health care claims for services provided to Medicare beneficiaries
- Goal: Assist CMS and MACs implement actions to prevent future improper payments



RAC Process

- Responsible for reviewing paid Medicare claims to identify improper Medicare payments made to healthcare providers
  - Select review issues approved by CMS
  - May look back three years from date claim was paid
  - Postpayment review using same policies as MAC
      - NCDs, LCDs, CMS Manuals, CMS regulations
  - Two review processes: (30 days to complete review)
    - Automated - No medical record needed
      - Based on review of claims
    - Complex - Medical record required
      - Requests and reviews records
  - Initial findings letter; Discussion period

RAC Overpayment

- Identified errors sent to MAC for collection of overpayments and adjustment
- Overpayment
  - RAC submits clam adjustment to MAC
  - MAC issues automated demand letter to initiate overpayment recovery
    - If you agree with RAC determination:
      - NGS issues recoupment offset on RA advice
      - Unless you submitted check or valid appeal
  - RA recoupment offsets identified on RA ANSI remark code N432 (adjustment based on recovery audit)

RAC Contact

- Performant Recovery, Inc.
  - Region 1 includes JK: **CT**, IN, KY, **MA, ME**, MI, **NH**, **NY**, OH, **RI,** and **VT**
  - Region 2 includes J6: AR, CO, IA, **IL**, KS, LA, MO, **MN**, MS, NE, NM, OK, TX, and **WI**
    - Telephone 866-201-0580
    - Email: info@Performantrac.com
- Performant website includes:
  - Issues under review
  - Forms and sample documents
  - FAQs
  - Review provider contact Information for accuracy
- RAC information on NGS website and CMS website
  - Recovery Auditor Timeliness Calculator

Comprehensive Error Rate Testing (CERT) Contractor

- Two CERT contractors: CERT RC and CERT SC
  - CERT Review Contractor (RC)
    - Samples claims
    - Requests and receives all medical records
    - Reviews medical records
    - Compiles data (using CERT SC)
  - CERT Statistical Contractor (SC)
    - Calculates improper payment rates and amounts
    - Designs sampling strategy
- CMS [Comprehensive Error Rate Testing (CERT)]

CERT Process

- Selects stratified random sample of claims submitted to all Part A/B MACs and DME MACs during each reporting period
  - Independent professionals review medical records
- Requests medical records
- Reviews claims and medical records
- Determines whether claim and service processed correctly and comply with Medicare policies, procedures and guidelines
- CMS calculates national improper payment rate as well as contractor and service-specific improper payment rates based on CERT review results
  - Improper error rate ≠ fraud rate

Submitting Records to CERT

- Provide medical records within 45 days via any of following methods
  - Address: CERT Documentation Center
    8701 Park Central Drive, Suite 400-A
    Richmond, Virginia 23227
  - Fax: 804-261-8100
  - esMD
  - Encrypted CD – format must be TIFF or PDF
- All medical record submission methods **must** include barcoded coversheet with CID number
- Additional medical records submission information
  - NGS CERT or C3HUB

CERT Contact Information

- Website: CERT C3HUB
- CERT Customer Service
  - Telephone: 443-663-2699 or Toll-Free Telephone: 888-779-7477
  - Email:
    - General questions certprovider@empower.ai
    - Medical records and passwords: certmail@empower.ai
- Claim status search using seven-digit claim identifier (CID)
  - C3HUB > Claim Status Search tab
- CERT Denial Finder on NGS website Tools & Calculators
- HHS publishes Annual CERT Report

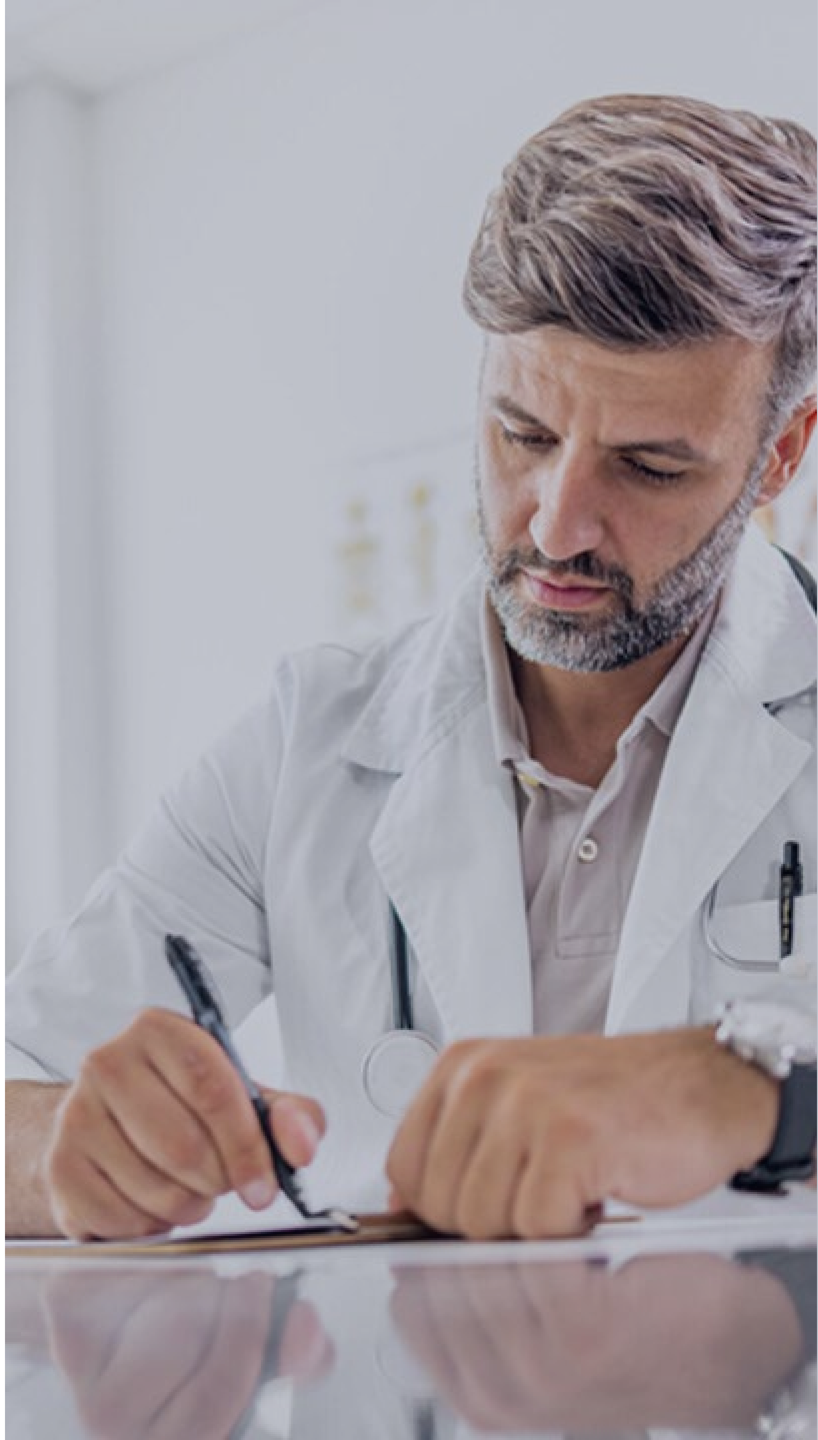
Additional Contractors

Zone Program Integrity Contractor (ZPIC)

- Investigate potential Medicare fraud, waste, and abuse
  - Parts A, B, HHH and DMEPOS
- Formerly: Program Safeguard Contractor (PSC)
- Most ZPIC work has been transferred to UPIC Program

Unified Program Integrity Contractors (UPICs)

- Primary goal
  - Detect, prevent and proactively deter fraud, waste and abuse in Medicare and Medicaid Programs to ensure Medicare and Medicaid program integrity
- Coordinates benefit integrity activities among MACs and disseminates relevant benefit integrity information to MACs



UPICs

- Performs Medicare data analysis and comprehensive problem identification and research to identify program vulnerabilities and potentially fraudulent Medicare providers
- Take immediate action to ensure Medicare Trust Fund monies are not inappropriately paid
- MAC interacts with UPIC contractor in support of
  - CMS audit, oversight, and anti fraud, waste and abuse efforts
  - Recoups overpayments identified by UPIC

UPIC Functions

- Request medical records
- Conduct interviews and onsite visits
- Investigate allegations of fraud, waste or abuse
  - Providers, beneficiaries, MACs, OIG, CMS
- Initiate appropriate administrative actions to support evidence of fraudulent activity
  - May include prepayment or post payment medical review, payment suspensions and/or revocations
- Referrals to MAC or law enforcement

MAC Role with UPIC

- Claim processing
- Provider outreach and education
- Recouping monies lost to Medicare Trust Fund
  - UPIC identifies improper payments and refers to MACs for recoupment
- Complaint screening
- Cases of suspected fraud are referred to UPIC
- Initial appeal of UPIC decisions

UPIC Contacts

UPIC Name	Region	States in Region
CoventBridge Group	Midwestern (includes J6)	Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin
Safeguard Services, LLC (SGS)	Northeastern (includes JK)	Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut

Office of Inspector General (OIG)

- Mission: Provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs, as well as health and welfare of people they serve
  - Drive positive change
  - Fight waste, fraud and abuse and to improving efficiency of Medicare, Medicaid and more than 100 other DHHS programs

OIG

- OIG includes:
  - Office of Audit Services (OAS)
  - Office of Evaluation and Inspections (OEI)
  - Office of Investigations (OI)
  - Office of Counsel to the Inspector General (OCIG)
  - Mission Support and Infrastructure (MSI)
- Work includes:
  - Advanced data analytics and modeling
  - Criminal, civil, and administrative investigations
  - Compliance guidance and education
  - Technical expertise on program integrity issues
  - Cyber security oversight

OIG

- OIG's legal and investigative efforts:
  - Investigating Fraud, Waste and Abuse
  - Facilitating Compliance in the Health Care Industry
  - Excluding Bad Actors from Participation in Federal Health Care Programs
- Authority to exclude individuals and entities from federally funded health care programs for variety of reasons
  - Example: Conviction for Medicare or Medicaid fraud

OIG Additional Information

- OIG website
- OIG Fact Sheet
- OIG Workplan
- OIG Hotline webpage
  - Learn more about types of tips: Before You Submit a Complaint
  - How to submit a tip via OIG Hotline
- Exclusions Program
  - List of Excluded Individuals/Entities (LEIE)

Suggestions and Audit Preparation

- Provider responsibilities
  - Specific roles at your facility
  - Prompt response to documentation requests
- Be proactive by performing periodic self-audits and providing education
  - Continuous improvement

Reminder

- Medicare and NGS have edits to ensure propre claim submission; however, it is impossible to edit for everything!
- Just because a claim paid does not necessarily mean it was a proper payment!

Provider Responsibilities

- Verify all addresses are up-to-date with Medicare
  - Update by using PECOS or appropriate CMS-855 application
- Ensure your staff is familiar with Medicare coverage, documentation, and billing requirements
  - CMS Medicare
  - Internet-Only Manuals
  - NCD Coverage Database
  - CMS Transmittals, MLN Matters Articles, MLN Publications & Multimedia
  - NGS website
  - NGS Medical Policies

Be Proactive

- Perform self-audits
  - Compare medical records to billed claims
    - Use coverage criteria, LCD and billing/coding guidelines
  - Ensure documentation is legible, clear, and demonstrates Medicare medical necessary and coverage requirements
    - Ensure orders, treatment records, test results included
    - Signatures when required
- Educate staff with audit results
  - What was good/great - examples
  - Any deficiencies
  - Suggestions for improvement

Prepare for Audit

- Determine who is accountable for specific roles within facility/office and ensure an understanding of their goals and objectives
  - Ensure mail room understands medical records requests must be sent to appropriate staff timely
- Staff should be familiar with documentation requests
  - Required documentation lists indicate components required for review
  - Documentation submission method
  - Contact information
    - May be in letter and/or on website

Audit Preparation: Respond Promptly

- Review all contractor websites
- Identify and respond timely to ADRs
  - Typically, within 45 days – Review request for details, timeframe, and address
- Ensure all records are submitted including any documentation with third party
  - All DOS and services per request
  - Ensure records submitted in correct format to correct address
- Understand Overpayment process
- If you disagree with results, you can appeal
  - NGS Appeals information

Medical Records

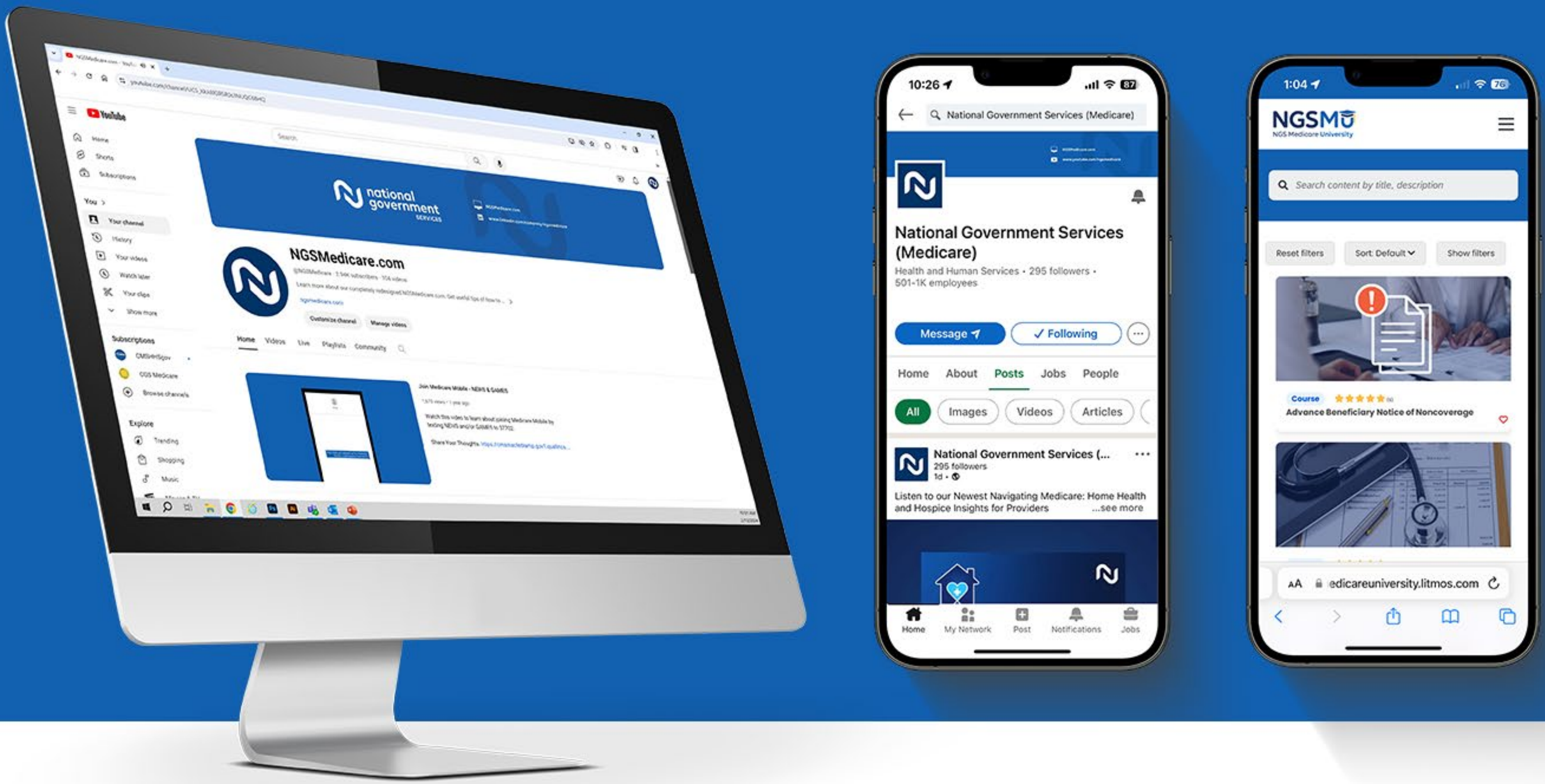
- Documentation submitted should provide reviewer proof
  - Beneficiary's condition, treatment, and response to treatment
  - Services rendered
  - Medial necessity
  - Compliance with Medicare rules and regulations
- Denials management
  - Regularly check claims for any RTPs or rejects to determine issue(s)
  - Correct errors and educate staff to prevent future similar errors
- If it wasn't documented, it did not happen

Resources

- CMS Medicare Fee-for-Service Compliance Programs
- CMS IOM 100-08, *Medicare Program Integrity Manual*
- MLN® Educational Tool: *Medicare Provider Compliance Tips*
- MLN® Fact Sheets:
  - *Complying with Medical Record Documentation Requirements (MLN909160)*
  - *Complying with Medicare Signature Requirements (MLN905364)*
  - *Medicare Overpayments (MLN006379)*
  - *Checking Medicare Eligibility (MLN8816413)*
- CMS YouTube Video: Provider Minute: The Importance of Proper Documentation

Questions?

Thank you!



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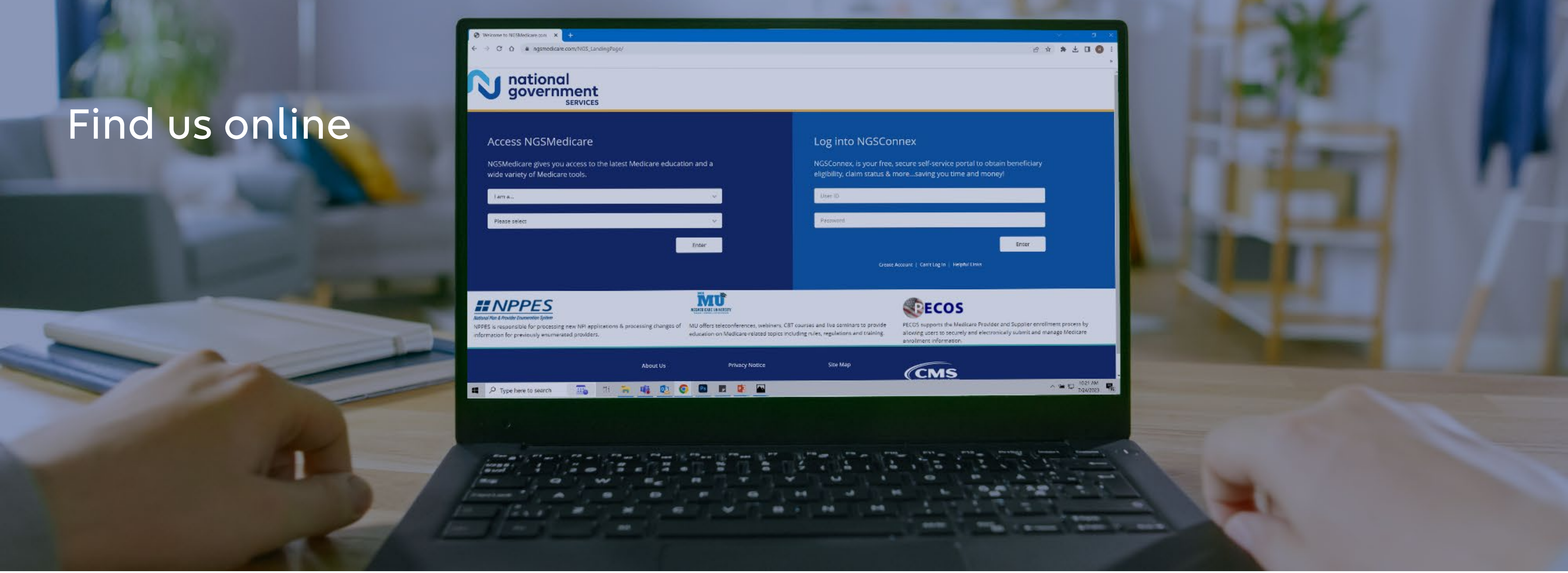

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

NGSConnex
Web portal for claim information

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