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Complete Healthcare Compliance Manual
Revenue Cycle: Government Audits

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What Are Government Audits?

In 2019, US healthcare spending reached a whopping $3.8 trillion, or $11,582 per person.[2] That's impressive. But what's even more impressive is the amount recovered by the government for the same year. According to the U.S. Department of Health & Human Services (HHS) and the U.S. Department of Justice (DOJ) *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2019*, an astounding $3.6 billion were recovered through governmental auditing and investigative activities.[3]

To ensure federal money is not wasted or lost due to fraud, the US federal government routinely conducts investigations and audits on federal programs such as Medicare and Medicaid. These audits are conducted through multiple and various agencies and programs, such as through the Recovery Audit Program and recovery audit contractors (RAC), Medicare administrative contractors (MAC), Comprehensive Error Rate Testing (CERT) program, and Targeted Probe and Educate (TPE).

RACs conduct post-payment claim reviews to ensure healthcare providers are submitting correct and appropriate claims for reimbursement. If a claim is deemed as inappropriately paid, overpayment or underpayment, the RAC refers the claim to a MAC that then adjusts the payment and recoups any overpayment. The recovered payment is transferred to the Medicare Trust Fund (MTF). MACs are responsible for reimbursing healthcare entities for Medicare and Medicaid claims but also have the added advantage of conducting prepayment audits. Through MAC's prepayment reviews, if a claim is deemed inappropriate or incorrectly billed, the MAC can deny payment to the provider. The CERT program allows the government to review fee-for-service (FFS) claims for correctness and generate an improper payment rate from the audit results. TPE is more like a review and educate program where government auditors conduct limited audits on healthcare providers and, based on the audit results, provide customized education and training. The aim of a TPE program is to help healthcare providers improve on their deficiencies to avoid future government audits.

It is important for healthcare entities to understand the different types of government audit programs currently active and the tools used to identify improper payment. The zeal and aggressive auditing approach deployed by HHS and DOJ in recent years makes it evident that if healthcare entities want to survive the ever-increasing government auditing requests, they need to have a solid and quick auditing response system in place.

CMS and OIG Audits

Healthcare entities or individual providers enrolled in Medicare and Medicaid programs may be subject to audits and investigations by the Centers for Medicare and Medicaid Services (CMS) and Office of the Inspector General (OIG). Under the False Claims Act (FCA), civil and criminal liabilities in the form of fines, imprisonment, or both can be imposed for submitting false, fraudulent, or fictitious claims to the federal government.

Healthcare fraud, waste, and abuse is a persistent costly problem for both the federal government and commercial payer. CMS works with state and federal law enforcement agencies such as the OIG to detect and

deter fraudulent activity by conducting audits and investigations on Medicare and Medicaid claims. OIG either conduct audits using its internal audit resources or oversees audits done by other agencies. CMS partners with a range of contractors such as CERT, RAC, or unified program integrity contractors to help prevent, detect, and investigate potential fraud.

CERT Audits

Under the Payment Integrity Information Act of 2019 (PIIA),[4] the CERT program computes national, by contractor, by service, and by provider type improper payment rate on Medicare FFS claims submitted to Part A and B MACs and durable medical equipment MACs (DMACs). Through stratified random sampling, some 50,000 claims are selected for complex medical review to determine whether the claims were paid appropriately under Medicare's coverage, coding, and billing rules.[5] If documentation is missing or lacking, medical reviewers reach out to the provider to request additional or supporting documentation. These complex medical reviews are performed by nurses, medical doctors, and certified coders, who perform a thorough review of each claim.

Improper payment rate is calculated by the statistical contractors upon completion of complex record review. It is pertinent to note that the improper payment rate identifies overpayment as well as underpayment, meaning if a claim is deemed underpaid, it will be counted as an error. The improper payment rate is not an indication of fraud but rather an estimate of payment that didn't meet Medicare's coverage, coding, and billing policy and rules. The CERT program publishes its Medicare FFS program improper payment rate in HHS's Agency Financial Report (AFR), which comes out in November of each year.[6]

TPE Audits

In 2014–2015, MACs began reviewing hospital inpatient and home health status cases and providing education to providers on CMS chosen topic. The medical review included all providers who billed Medicare for that chosen topic under a process known as "Probe and Educate." The Probe and Educate program was a success for CMS, resulting in significant reduction in billing and denial errors. In 2017, CMS expanded to include all types of Medicare claims, and modified the Probe and Educate program to allow MACs to (i) identify the topic for probe based on CERT or other data analysis procedures, and (ii) target providers that are at higher risk of submitting noncomplaint claims or improper errors—hence the name "Targeted Probe and Educate."[7] The TPE program's goal is to help providers understand their errors and how to correct them through one-on-one education. CMS has determined that the targeted probes, education, and reviews have resulted in improved claim accuracies and reduced claim denials and appeals, ultimately reducing burden off MACs' and providers' shoulders.

Either prepayment or post-payment review, the TPE program begins with MAC selecting a topic identified through the CERT report and/or other data analysis techniques. If a provider is chosen for review, MAC will send out a notification letter stating the intent to carry out the probe on the chosen topic and the reason why the provider was selected for review. For prepayment reviews, providers will receive a Notice of Review letter, while for post-payment reviews, providers will receive an Additional Documentation Request (ADR) letter. An entire TPE program is based on three rounds of probe, review, and educate; each round consists of 20 to 40 claims and supporting medical documentation, allowing MACs to establish whether a provider represents a certain risk behavior or not. At the conclusion of the first review, if a provider is deemed compliant, then the provider is not moved to the second review and is not reviewed on that chosen topic for at least one year. If, however, some claims are denied or deemed noncompliant, the provider is invited for a one-on-one education session.[8] There is, at least, a 45-day gap before the second round of 20–40 claims reviews is performed, allowing the provider to make necessary changes and improve on its processes. If the provider is deemed compliant after the second round of reviews, it is not moved to the third round of reviews and not reviewed on the same topic for at least one

year. If, however, the provider fails the second round, it is moved to the third and final round of reviews. A provider that is unable to show improvements after the third round of review is referred to CMS for further actions, which may include 100% prepayment review, referral to a recovery auditor, or extrapolation of overpayment.

MAC Audits

CMS relies on private health insurers—MACs—to process Medicare Part A & B claims and durable medical equipment (DME) claims and handle coverage or payment appeals. Each MAC spans over a defined geographic area known as a jurisdiction, where each jurisdiction includes multistate. There are 12 MACs responsible for processing Part A & B claims, four MACs processing the DME claims, and four MACs processing home health and hospice claims. Part A & B MACs process institutional providers, physicians, practitioners, and suppliers. DME MACs process durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) (see **Table 1: MAC—Medicare Part A & B**, **Table 2: MAC—Durable Medical Equipment**, and **Table 3: MAC—Home Health and Hospice**).[9]

Table 1: MAC—Medicare Part A & B

MAC	Jurisdiction	States
Noridian Healthcare Solutions LLC	JE, JF	**JE**: California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands **JF**: Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming
Novitas Solutions LLC	JH, JL	**JH**: Arkansas, Colorado, New Mexico, Oklahoma, Texas, Louisiana, Mississippi **JL**: Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania (includes Part B for counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia)
Palmetto GBA LLN	JJ, JM	**JJ**: Alabama, Georgia, Tennessee **JM**: North Carolina, South Carolina, Virginia, West Virginia (excludes Part B for the counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia)
National Government Services (NGS) Inc.	J6, JK	**J6**: Illinois, Minnesota, Wisconsin **JK**: Connecticut, New York, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
First Coast Service Options (FCSO) Inc.	JN	Florida, Puerto Rico, U.S. Virgin Islands

Wisconsin Physicians Service (WPS)	J5, J8	**J5**: Iowa, Kansas, Missouri, Nebraska **J8**: Indiana, Michigan
CGS Administrators LLC	J15	Kentucky, Ohio

Table 2: MAC—Durable Medical Equipment

MAC	Jurisdiction	States
Noridian Healthcare Solutions LLC	DME A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
	DME D	Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, American Samoa, Guam, Northern Mariana Islands
CGS Administrators LLC	DME B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin
	DME C	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, Puerto Rico, U.S. Virgin Islands

Table 3: MAC—Home Health and Hospice

MAC	Jurisdiction	States
National Government Services (NGS) Inc.	J6, JK	**J6**: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Northern Mariana Islands, Oregon, Puerto Rico, U.S. Virgin Islands, Wisconsin, Washington **JK**: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

CGS Administrators LLC	J15	Delaware, District of Columbia, Colorado, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, Wyoming
Palmetto GBA LLN	JM	Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas

Per CMS, MACs are responsible for processing, making, and accounting for Medicare FFS claims and payments.[10] MACs work as the primary operational contact in enrolling providers in the Medicare FFS program, handling provider reimbursement services, auditing institutional provider cost reports, and redetermination requests (1st stage appeals process). MACs respond to provider inquiries, educate providers about Medicare FFS billing requirements, establish local coverage determinations (LCDs), review medical records for selected claims, and coordinate with CMS and other FFS contractors.

MACs have the ability to perform prepayment and post-payment reviews on Medicare claims.

RAC Audits

RACs are the most notoriously known government auditing agency out there that almost all healthcare facilities have dealt with. No audit or compliance meeting is complete without mentioning RAC targets and RAC activities. Starting out as a pilot program in 2005, Congress permanently expanded and implemented the RAC program nationally to review Medicare Part A & B claims. In 2010, under the Affordable Care Act (ACA), the RAC program was further expanded to also include Medicare Part C (Medicare Advantage) & D (prescription drug) programs.[11] CMS has awarded Medicare RAC contracts to four contractors (see **Table 4: Recovery Audit Contractors**).

Table 4: Recovery Audit Contractors

RAC	Region	States
Performant Recovery Inc.	1	Connecticut, Indiana, Kentucky, Maine, Massachusetts, Michigan, New Hampshire, New York, Ohio, Rhode Island, Vermont
Cotiviti LLC	2	Arkansas, Colorado, Iowa, Illinois, Kansas, Louisiana, Missouri, Minnesota, Mississippi, Nebraska, New Mexico, Oklahoma, Texas, Wisconsin
	3	Alabama, Florida, Georgia, North Carolina, South Carolina, Tennessee, Virginia, West Virginia, Puerto Rico, U.S. Virgin Islands

HMS Federal Solutions	4	Alaska, Arizona, California, District of Columbia, Delaware, Hawaii, Idaho, Maryland, Montana, North Dakota, New Jersey, Nevada, Oregon, Pennsylvania, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, Northern Marianas
Performant Recovery Inc.	5	Nationwide (all 50 states) for DMEPOS, home health, and hospice

RACs' mission is to safeguard taxpayer money and protect the Medicare Trust Fund by detecting, identifying, and correcting improper payment rate. The Medicare FFS established improper payment rate has been below 10% as established by the Improper Payments Elimination and Recovery Act of 2010.[12] RAC has been able to bring the improper payment rate down to 7.25% in 2019 as compared to 8.12% from 2018.[13] How do RACs bring the improper payment down? They conduct vigorous post-payment reviews on all types of Medicare claims, which sometimes end up a hospital's bottom line.

RACs review submitted claims data and medical record documentation against Medicare manuals, National Coverage Determination (NCD), and LCD to determine whether a claim was paid appropriately. RACs' lookback period is three years from the time the claim was paid and, just like with CERT reviews, RACs are required to employ certified coders, physicians, nurses, and therapists to conduct complex medical reviews.