# Audits Types Providers Need to Understand

## Rebecca Wartman OD November 2024

A few months ago, Risk Adjustment Audits were reviewed in detail. However, there are many other types of audits with which providers must be familiar. Almost all insurance companies perform some types of audits. Some private payers use artificial intelligence to review claims prepayment and will change the codes originally filed. This tactic has been used by both Aetna and Anthem BCBS. Other insurers audit records by actually requesting the medical records for review. Medicare and Medicaid plans are required to perform specific types of audits.

Statistics show that a majority of audits are failed because providers do not respond to the requests for records and/or provide incomplete information. The audit result in these cases is an automatic failure and, most likely, a recoupment of payments. The best advice that can be provided is to always:

1. Know the rules - remember that not knowing is not an acceptable excuse
2. Complete the medical record documentation at the time of service
3. Develop a method to ensure documentation is completed and the record is appropriately signed
4. Promptly respond to any request for records received from a payer

Keep in mind that all payments resulting from fraud are considered improper payments but not all improper payments are fraudulent. The following is a review of the types of audits that Medicare typically performs along with some details any provider should know.

### Targeted Probe and Education (TPE) Reviews by Medicare Carriers (MACs)

These reviews target potentially overused or misused codes. Each carrier, using data, claims reviews and other information, determine which services could be subjected to pre- or post- payment reviews. TPE reviews typically consist of up to three rounds of reviews with education to ensure the provider understands the coding guidelines and is properly following all carrier rules. Once the carrier deems the provider is properly coding and applying the rules, they will be removed from the TPE review process. However, if a provider either fails to respond or continues to have a significantly high error rate, that provider will be referred to CMS for further action. You can find more information on the Novitas TPE process here. Currently Novitas has the following TPE that might impact Optometry: Surgical services: Cataract extraction (CPT 66982-66984), Removal of benign skin lesions (CPT 11102-11103, 11200-11201, 11300-11303, 11305-11313 and 11401-11406, 11421-11424, 11426, 11440-11446) and Evaluation & management (E/M) services: Established office/outpatient visits (CPT 99215, 99214, 99213). The complete list of TPE along with resources and results of TPE can be found here.

### Comprehensive Error Rate Testing (CERT)

This type of audit is used to improve accuracy of Medicare payments and review paid claim error rates. These are random audits under CMS and thus cannot be considered a measure of fraud. The CERT program was developed to comply with the *Improper Payments Elimination and Recovery Act of 2010*. This type of audit looks for any claim that was paid but should have been denied or was paid at an amount that is considered as overpayment or underpayments. Documentation must support the rules laid out by the Medicare Carrier (MAC). Claims reviewers classify errors in one of five ways: insufficient documentation, medical necessity, incorrect coding, no documentation and other. For 2023, the national CERT error rate was 7.38% - representing $31.23 Billion. You can find the Novitas CERT page here. This page has check lists, educational resources and much more. You can also access the CERT C3HUB page here for other resources. You can find other information and the Novitas QUESTCERT email address here for questions specific to the CERT program. More CMS CERT information can be found here. The current CERT contractors are:

CERT Review Contractor – Empower AI, Inc. (formerly known as NCI Information Systems, Inc.)
CERT Statistical Contractor – The Lewin Group, Inc.

### Recovery Audit Contractors (RAC)

The purpose of the RAC audits is to identify improper over and under payments due to provider billing errors. For example, a claim for a patient on hospice that was filed and paid without the appropriate modifier attached or a hysterectomy filed and paid for a male patient. The RAC audits use post-payment claims reviews. These reviews can be

automated - where no medical records are required, semi-automated - where data is used but may involve review of the medical records by a person, or a complex review - where medical records are required. A RAC audit has a three-year look back period. The recoupment is typically via payment offsets using the Remark Code N432 (Adjustment Based on Recovery Audit. You can learn more about RAC audits here and here. The current RAC auditor for Mississippi is Performant Recovery, Inc.

**Supplemental Medical Review Contractor (SMRC)**

These audits are designed to lower inappropriate payments and increase medical review efficiencies with the goal of protecting the Medicare Trust Fund. Claims are reviewed via medical records to determine if the proper coverage, coding, payment, and billing requirements were used in paying a claim. The medical record requests will include additional documentation on claims selected for medical review. The medical reviews often focus on vulnerabilities identified by CMS data analysis, CERT audits, professional organizations, and federal oversight agencies such as the OIG. One recent SMRC audit involved cataract surgery including Optometrists providing post-operative care. The contractor for SMRC audits is Noridian. You can learn more about these audits here.

**Unified Program Integrity Contractor (UPIC) (Formerly Zone Program Integrity Contractor (ZPIC))**

The purpose of the UPIC is to engage in activities to identify perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims across the United States**.** The UPIC contracts operate in five (5) separate geographical jurisdictions in the United States and combine and integrate functions previously performed by the Zone Program Integrity Contractor (ZPIC), Program Safeguard Contractor (PSC) and Medicaid Integrity Contractor (MIC) contracts. You do NOT want to be on the receiving end of this type of targeted audit. Typically, an audit of this type means that a provider has billing patterns that are statistically different from their colleagues creating concern for *potential* Medicare or Medicaid fraud, waste or abuse. Mississippi is in the UPIC Southwestern Jurisdiction and more information can be found here and here. (Please note that Railroad Medicare, DME, and Indian Health Services may have other contractors used for the different audit types.)

Here is some "fun" bedtime reading on fraud cases:

https://natlawreview.com/article/san-diego-physician-and-medical-practice-pay-38-million-resolve-fca-allegations
https://www.justice.gov/usao-edny/pr/queens-and-brooklyn-based-eye-doctor-settles-health-care-fraud-claims-more-24-million
https://oig.hhs.gov/fraud/enforcement/eye-care-provider-convicted-of-medicare-and-medicaid-fraud/
https://oig.hhs.gov/fraud/enforcement/eye-care-associates-agreed-to-pay-19000-for-allegedly-violating-the-civil-monetary-penalties-law-by-employing-an-excluded-individual/

Happy coding…