

Understanding and Preparing for Audits: **CERT, RAC, and ZPIC**

Doctors can better prepare for different audits when they understand the differences between them.

BY GEORGE A. WILLIAMS, MD

In 2012, Medicare expenditures were \$574 billion.¹ Every day, the Medicare Administrative Contractors (MAC) pay approximately 4.4 million claims to more than 1 million providers. The Federal Bureau of Investigation estimates that 3% to 10% of those payments are fraudulent.² Further, the Centers for Medicare and Medicaid Services (CMS) estimates that approximately \$65 billion was improperly billed to either Medicare or Medicaid.³ When you combine FBI and CMS estimates, you see that MACs improperly pay between \$82 billion and \$122 billion each year.

As a result of health care reform efforts, there is increased funding to fight fraud (defined as obtaining a benefit through intentional misrepresentation or concealment of material facts), waste (incurring unnecessary costs as a result of deficient management practices or controls), and abuse (excessively or improperly using government resources). Any money recovered from these efforts will be used to help pay for expanded coverage under the Affordable Care Act.

The Patient Protection and Accountable Care Act (\$10 million per year) and the Budget Reconciliation Act (\$250 million per year) fund new programs meant to detect fraud and abuse. These new programs are designed to look for patterns and trends in billing in order to detect Medicare and Medicaid fraud.

The CMS program to combat fraud, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), is a combined effort between the Department of Justice and the Department of Health and Human Services. If a HEAT audit shows evidence of fraud, a local Medicare Fraud Strike Force launches an investigation. There are 9 Medicare Fraud Strike Forces positioned throughout various cities in the United States, each led by a US attorney.⁴ In 2011, these efforts returned \$2.5 billion to the Medicare Trust Funds.⁵

TYPES OF AUDITS YOU MIGHT ENCOUNTER

With the federal government's renewed focus on detecting fraud, waste, and abuse, it is likely that you will encounter some type of audit in the near future. It is important to familiarize yourself with the different types of audits you might face and learn how best to deal with them.

CMS uses Comprehensive Error Rate Testing (CERT) audits to see if MACs are properly paying claims. CERT audits focus on logistical issues, such as whether or not coding and billing are correct, and are not audits focused directly at the physician. These are relatively simple audits. It is important that you do not ignore any request for records. If you fail to supply CERT auditors with requested records, they will notify Medicare of your failure and you will be flagged, which may result in additional audits. Additionally, you will have to repay CMS the cost of those visits. Maintaining accurate medical records and cooperating with the auditors are the keys to ensuring your CERT audit goes smoothly.

Whereas CERT focuses on mistakes made by carriers, Recovery Audit Contractors (RAC) focus on errors created by providers. The primary purpose of RAC is to detect and correct improper payments so that CMS/MACs can institute changes to prevent future improper payments. RACs are independently contracted third parties that are paid a percentage of the overpayment or underpayment they identify.

You may be selected for a RAC audit as the result of a CERT audit or due to high patient volume, as such volume suggests a high propensity for error.

As far as RAC is concerned, the United States is divided into 4 regions (regions A through D), with a different RAC assigned to each region. It is important to know the RAC assigned to your region. Go to the contractor's

website to see which services they emphasize so you can best prepare yourself for an audit. These audits are more complex than CERT audits. The majority of these, fortunately, do not find any error.

The RAC system is deeply flawed. The contingency fee payment system encourages RACs to find error. RAC methodology can burden low-volume providers, as they tend to focus on technical mistakes rather than true wrongdoing. Also, RAC audits tend to be inaccurate: The CMS Fiscal Year 2010 report to Congress stated that, while only 2.4% of RAC determinations were appealed, 46% of appealed cases were overturned.⁶ The American Medical Association estimates that the cost of appealing a RAC audit is \$110 per claim,⁷ not including the additional money and time spent on initial compliance with RAC requests. The appeals process for RAC claims is complex, and you will need experienced legal counsel to navigate any appeal.

Zone Program Integrity Contractors (ZPICs) deliver the most complex audits. They compare your billing with similarly situated providers. They are authorized to suspend payments, determine overpayments, and refer providers for exclusion from government programs. Also, they provide direct support to fraud investigations conducted by the FBI and the Office of the Inspector General.

ZPIC reviews are never random. They are performed under a presumption of fraud, and they often involve on-site inspections. They can be initiated by data analysis, high frequency of certain services, whistleblowers, or reports to various hotlines. They can also be referred from MACs, RACs, or your patients. They may review a small number of patient records and, if they find error, extrapolate the data in order to determine the sum of misappropriated funds. They can even conduct interviews with your patients, beneficiaries, or employees. Your employees have a distinct incentive to identify fraud through the whistleblower process because whistleblowers are eligible for a percentage of any recovered funds.

Dealing with a ZPIC audit requires experienced legal counsel, as this is the audit with the highest level of scrutiny.

BEST PRACTICES

Audits are the new normal. It is important that your practice conduct internal audits and reviews of its medical records. Your staff should focus on compliance as much as possible in order to make the audit process run smoothly. An ongoing education program in your office can help your staff better understand coding and billing rules. Also, you should review any comparative billing reports that you receive from CMS.

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Once you have been identified for an audit, you need to identify the auditor, the type of audit, and any deadlines. You should immediately conduct an internal review. Most important, you need to seek experienced legal counsel.

Additional resources on audits are available through the American Academy of Ophthalmic Executives website⁸ and the Ophthalmic Mutual Insurance Company (OMIC) website.⁹ OMIC-insured ophthalmologists have coverage for audit defense expenses arising from claims related to fraud and abuse allegations. Also, OMIC provides reimbursement for legal expenses and even helps defray the costs of some fines and penalties. ■

George A. Williams, MD, is Professor and Chair of the Department of Ophthalmology at Oakland University William Beaumont School of Medicine, Director of the Beaumont Eye Institute in Royal Oak, MI, and a member of the Retina Today Editorial Board. He is also the delegate for the American Academy of Ophthalmology to the American Medical Association's Specialty Society Relative Value Scale Update Committee and a consultant to the American Academy of Ophthalmology's Health Policy Committee. He can be reached via email at GWilliams@beaumont.edu.



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