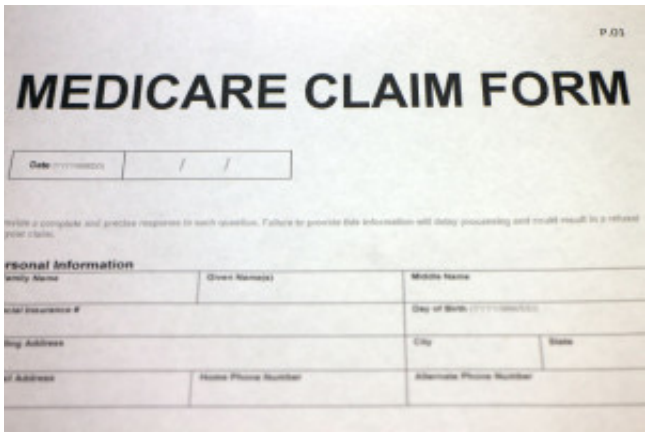
Understanding Prepayment Review in 2015



The Centers for Medicare & Medicaid (CMS) has instituted several methods to help combat the increase in waste, fraud, and abuse in the federal and state health care programs. One of the most recent trends involves pre-payment review of claims. In this process, government contractors will review a claim for problems *before* the claim may be paid. Unlike the traditional postpayment review process, if a health care provider is placed under prepayment review, there is very little you can do other try to identify the nature of deficiencies noted so that remedial action can be taken. Moreover, health care providers in prepayment review face expensive complications, including possible exclusion from Federal healthcare programs, if the problems which caused them to be subject to prepayment review go uncorrected. The key is to truly understand the prepayment review process and what you can do to minimize any potential problems.

I. The Prepayment Review Process Comes to Life

In 2012, CMS introduced the Recovery Audit Prepayment Review Demonstration, which allows Recovery Auditors (RACs) to conduct prepayment reviews on certain types of claims that historically result in high rates of improper Medicare payments. The demonstration focused on eleven states: California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, and Texas. Prepayment Claim Review Programs apply to the National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), and Medical Review (MR).

NCCI Edits are performed by Medicare Audit Contractors (MACs). CMS developed the NCCI to promote national correct coding methods and to control improper coding that leads to inappropriate payment in Medicare Part B claims. NCCI edits prevent improper payments when incorrect code combinations are reported. NCCI edits are updated quarterly.

MACs also perform MUEs, which were created to reduce the paid claim error rate for Medicare claims. MUEs and NCCIs are automated prepayment edits. MACs analyze whether the procedure on the submitted claim complies with MUE policy.

MRs are performed by MACs, Zone Program Integrity Contractors (ZPICs), and Supplemental Medical Review Contractors (SMRCs). These contractors identify suspected billing problems through error rates produced by the Comprehensive Error Rate Testing (CERT) Program, vulnerabilities identified through the Recovery Audit Program, analysis of claims data, and evaluation of other information, such as complaints. CMS, MACs, and other claim review contractors target MR activities at identified problem areas appropriate for the severity of the problem. A MAC can place a provider with identified problems submitting correct claims on prepayment review. If this happens, a percentage of the provider's claims undergo MR before the MAC authorizes payment. Once providers re-establish the practice of billing correctly, prepayment review ends at the discretion of the contractor.

II. Prepayment Review

A Medicare contractor will place a provider on prepayment review if they suspect the provider is billing the Medicare program inappropriately. Rather than paying these providers upon the submission of claims, the contractors require the providers to submit medical records and other documentation to support the claims. The records and documentation are then manually reviewed by nurses and other licensed practitioners. The submitted claims are then either approved or denied based on the manual review. Providers generally remain on prepayment review until their average rate of claims approval reaches a sufficiently high percentage, which is usually 80%.

CMS has directed its contractors to consider excluding physicians and other providers from Medicare and Medicaid if they have been on prepayment review for extended periods of time without correcting their "inappropriate behavior." Exclusion from participation in Federal healthcare programs typically leads to other adverse consequences, such as loss of hospital privileges and being dropped from managed care networks.

Providers must make exhaustive efforts to avoid ending up on prepayment review and potentially facing exclusion. To do so, providers need to understand what contractors have the authority to put a provider on prepayment review, and what the contractors are looking for.

III. Providers and Prepayment Review – A Real Concern

Unfortunately, even the mere allegation of fraud leads to prepayment review. This, in turn, can harm even the most innocent provider. Last year in New Mexico, fifteen behavioral health care providers were put on prepayment review based on "credible allegations of fraud." Because their Medicaid reimbursements were suspended, the providers could not afford to pay their staff, rent, or other bills. The providers tried suing the state and sought an injunction that would restore funding. The providers argued that they had been denied due process by not being told what the precise charges were against them, and that at the end of the day those suffering the most were their patients. However, they were denied the injunction.

As a result, the fifteen providers ended up filing for bankruptcy. Because the behavioral health care providers served 87% of New Mexico's Medicaid recipients, the state of New Mexico had to bring in providers from Arizona to service residents. This caused state infighting, as New Mexico's Legislative Finance Committee objected to the New Mexico Human Services Department moving $10 million from its budget to pay Arizona agencies to take over New Mexico providers. The deal with the Arizona providers eventually went through, and 2 of the fifteen New Mexico providers were ordered to make repayments to Medicaid.

IV. What Can Providers Do?

Unfortunately, health care providers may not be able to ignore the fact that being placed on prepayment review has become an inevitability. So what is a practitioner to do faced with this ordeal? Well, the best way for a provider to avoid a tragic situation that befell the providers in New Mexico is to have an ironclad and effective compliance plan that is followed by all provider employees and affiliates. It is best to prepare for the worst and have solid documentation of accuracy to show auditors than to lose one's livelihood over false allegations of fraud. Have you implemented your effective compliance plan? If not, you increase the risk that your claims may not be paid for the services you have provided. Even if you do have a compliance plan in place, the plan may no longer be up to date or may simply be ineffective. It is imperative that you take action now to reduce the risks that come along with the prepayment review process. Give us a call today and we would be more than happy to assist you with the prepayment review process as well as implementing an effective compliance plan for your organization.

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