North Carolina Foot and Ankle Society
2025 Winter Conference
Saturday, January 18, 2025
"Who is Held Liable"
and
"What Are the Most Common Medicare and Medicaid Audits?"

Michael G. Warshaw, DPM, CPC

michaelgwarshaw@gmail.com

Drmikethecoder.com

Presenter Disclosure

Michael G. Warshaw, DPM has no actual or potential conflict of interest in relation to this program

No off-label uses of any drugs or products will be discussed in this presentation

Disclaimer:

- **This course was current at the time the webinar was initially given on 01/18/2025. The author has made every reasonable effort to assure that the information was accurate and that no omissions were made.**
- **The author does not accept responsibility and or liability for possible errors, misuse, and misinterpretations. Medical coding policies and guidelines are frequently updated and revised. It is the responsibility of each practice/ provider to ensure that they are following the most current regulations. Each insurance company has its own policies and guidelines for reimbursements. Please check with the individual insurance carrier for its specific coding requirements.**
- **This publication is designed to provide accurate and authoritative information in-regard to the subject matter covered. The information contained herein is current as of the publication date and is subject to interpretation by the insurance carriers at any time. It is sold with the understanding that the publisher is not engaged in rendering legal or accounting services. If legal or other expert assistance is required, the services of a competent professional person should be sought. From *"A declaration of Principles" jointly adopted by a committee of the American Bar Association and a Committee of Publishers***

Part 1: “Who is Held Liable?”

Signature Requirements

- **Acceptable methods for handwritten signatures are:**
    1. **A legible full signature**
    2. **A legible first initial and last name**
    3. **An illegible signature accompanied by signature log or attestation statement**
    4. **Initials over a printed or typed name**
    5. **Electronic signature**

- **Unacceptable signature methods are as follows:**

  1. Rubber stamp signatures, except for clinical diagnostic tests when a treating physician who authenticates medical documentation by handwritten or electronic signature, I indicates that he or she intended the clinical diagnostic test be performed

  2. Illegible signatures with no additional documentation to identify the signature

  3. Initials with no additional documentation identifying them

  4. An unsigned note

  5. A note with the statement “signature on file”

Documentation Signature Requirements

- **The treating physician's signature must be present in the documentation associated with all services submitted to Medicare. Medicare requires that the signature be a legible identifier for the provided/ordered services. The physician's signature can be in the form of either a handwritten signature or an electronic signature. Stamped signatures (i.e. rubber stamps) are not acceptable signatures.**

Handwritten Signatures

- **A handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation. If the signature is illegible, the contractor shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.**

Signature Log

- **Providers will sometimes include a signature log that lists the typed or printed name of the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document.**

Attestation Statement

- **For an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the sufficient information to identify the beneficiary.**

Who is liable if signature is not found on the medical record?

- **Every entry in the medical record must be authenticated by the author – an entry should not be made or signed by someone other than the author. This includes all types of entries such as narrative/progress notes, assessments, flowsheets, orders, etc. whether in paper or electronic format**.

Repercussions if signature is not found on the medical record

- From an auditor's viewpoint, if it's not documented, it didn't happen. Medicare CERT (Comprehensive Error Rate Testing) audits have identified insufficient documentation errors as including the following:

  1. Incomplete progress notes (e.g., unsigned, undated, insufficient detail, etc.)

  2. Unauthenticated medical records – no provider signature, no supervising signature, illegible signatures without a signature log or attestation to identify the signer, an electronic signature without the electronic record protocol or policy that document the process for electronic signatures

  3. No documentation of intent to order services and procedures – incomplete or missing signed order or progress note describing intent for services to be provided

What happens when the doctor/provider leaves the practice before the record is signed?

- **In order to properly submit a claim for reimbursement, the patient's medical record encounter must be "closed" and include a valid physician signature.**

  1. Obtain Attestation from the Departed Physician

  The organization should attempt to have the departed physician attest to the medical record(s). The departed physician's attestation will stand in place of a physical signature. The attestation should be dated and signed by the departed physician, and the document should contain sufficient information to identify the patient. The departed physician will need to include accurate, true, and complete information regarding the treatment or diagnosis of the patient.

  2. Another Physician Should Appropriately Close the Encounter

  If the departed physician is not willing to attest to the medical record(s), another physician in the organization may access the medical record and take the appropriate steps to close the medical record.

Non-credentialed Providers

Can you bill under another credentialed provider in the practice?

- **You'll need to pay close attention to your payer contracts in order to bill for non-credentialed and non-contracted providers correctly. If your new provider is not replacing anyone and if the health plan requires only credentialed clinicians provide services, you cannot bill for services rendered by that provider.**
- **A practice would be in violation of their contract with the health plan if they billed for services not provided by a credentialed clinician or by a credentialed substitute filling in for a previously credentialed provider (even if the contract is under the practice's name). In some cases, the health plan will only require physicians be credentialed; in others, plans require all providers (physicians and mid-levels) be credentialed and tied to the contract.**
- **On the other hand, you *can* bill under clinic name for new clinicians if the health plan does not require individual credentialing. In those cases, most health plans just need an updated roster of providers offering services under the clinic agreement.**

- **Medicare Rule: Permanent full-time or part-time providers must be credentialed to bill for Medicare.**

The effective date is the later of the following two dates:

1. The filing date of an enrollment application that was subsequently approved, or

2. The date the provider first began furnishing services at a new practice location.

The provider may bill retrospectively for services when:

1. The supplier has met all program requirements, including state licensure requirements, and

2. The services were provided at the enrolled practice location for up to:

a. 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or

b. 90 days prior to their effective date if a presidentially-declared disaster precluded enrollment in advance of providing services to Medicare beneficiaries.

Medical Necessity

- **"Medically Necessary" or "Medical Necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient. The service must be: For the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms.**

1. In accordance with the generally accepted standards of medical practice

2. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease

3. Not primarily for the convenience of the patient, health care provider, or other physicians or health care providers

4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease

Part 2: “What are the Most Common Medicare and Medicaid Audits?”

Auditors: Who should we fear the most?

Types of CMS Contractor Audits

- **Common types of Medicare and Medicaid audits include:**
  - **Targeted Probe & Educate (TPE) Program audits.**
  - **Unified Program Integrity Contractor (UPIC) audits.**
  - **Supplemental Medical Review Contractor (SMRC) audits.**
  - **Comprehensive Error Rate Testing (CERT) audits.**
  - **Recovery Audit Contractor (RAC) audits.**

Targeted Probe & Educate (TPE) Program Audits

- **As the name suggests, TPE audits are intended to educate Providers on specific billing issues to increase accuracy and reduce claim denials and appeals, but they can also result in penalties. During TPE audits, Providers are subject to up to three rounds of claims reviews (both pre-payment and post-payment) and individualized education. Medicare Administrative Contractors (MACs) target Providers identified through data analysis as having high claim error rates or unusual billing practices compared to their peers.**

- **CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.**
- **The goal: to help you quickly improve. Medicare Administrative Contractors (MACs) work with you, in person, to identify errors and help you correct them. Many common errors are simple – such as a missing physician's signature – and are easily corrected.**

- **Most providers will never need TPE**
- **TPE is intended to increase accuracy in very specific areas. MACs use data analysis to identify:**
  - **providers and suppliers who have high claim error rates or unusual billing practices, and**
  - **items and services that have high national error rates and are a financial risk to Medicare.**
- **Providers whose claims are compliant with Medicare policy won't be chosen for TPE.**

- **What are some common claim errors?**
  - **The signature of the certifying physician was not included**
  - **Documentation does not meet medical necessity**
  - **Encounter notes did not support all elements of eligibility**
  - **Missing or incomplete initial certifications or recertification**

- **How does it work?**
  - **If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC)**
  - **The MAC will review 20-40 of your claims and supporting medical records**
  - **If compliant, you will not be reviewed again for at least one year on the selected topic**
  - **If some claims are denied, you will be invited to a one-on-one educational session**
  - **You will be given a least a 45-day period to make changes and improve**
  - **MACs may conduct additional review if significant changes in provider billing are detected**

- **What if my accuracy still doesn't improve?**
- **This should not be a concern for most providers. The majority that have participated in the TPE process increased the accuracy of their claims. However, any problems that fail to improve after 3 rounds of education sessions will be referred to CMS for next steps. These may include 100 percent prepay review, extrapolation, referral to a Recovery Auditor, or other action.**

Unified Program Integrity Contractor (UPIC) Audits

- **CMS established the UPICs to consolidate program integrity activities formally performed by the Zone Program Integrity Contractors (ZPICs), Program Safeguard Contractors (PSCs), and Medicaid Integrity Contractors. As a result, UPICs are the only program integrity contractors that monitor both the Medicare fee-for-service (FFS) and Medicaid programs. UPICs are responsible for identifying and protecting against fraud, waste, and abuse using both pre-payment medical reviews and post-payment audits. UPIC audits should be taken very seriously as they can result in high-dollar extrapolated overpayment demands, payment suspensions, and referral to law enforcement for additional review.**

- **What triggers a UPIC audit?**
  - **According to CMS, CMS often receives referrals of improper payments from MACs, UPICs and other investigative agencies.**
  - **UPICs primary goal is to investigate instances of suspected fraud, waste and abuse in Medicare or Medicaid claims.**
  - **They develop investigations early and in a timely manner, take immediate action to ensure Medicare Trust Fund Monies are not inappropriately paid.**
  - **They also identify any improper payments that are not to be recouped by the Medicare Administrative Contractor.**

- **UPICs do the following:**
  - **Investigate potential fraud and abuse of CMS administrative action or referral to law enforcement**
  - **Conduct investigations in accordance with the priorities established by CPI's Fraud Prevention System**
  - **Perform medical review, as appropriate**
  - **Perform data analysis in coordination with CPI's Fraud Prevention System, IDR and OnePI**
  - **Identify the need for administrative actions such as payment suspensions, prepayment or auto-denial edits, revocations, post-pay overpayment determination**
  - **Share information (e.g. leads, vulnerabilities, concepts, approaches) with other UPICs/ZIPCs to promote the goals of the program and the efficiency of operations at other contracts**
  - **Refer cases to law enforcement to consider civil or criminal prosecution**

- **In performing these functions, UPICs may, as appropriate:**
  - **Request medical records and documentation**
  - **Conduct interviews with beneficiaries, complainants, or providers**
  - **Conduct site verification**
  - **Conduct an onsite visit**
  - **Identify the need for a prepayment or auto-denial edit**
  - **Institute a provider payment suspension**
  - **Refer cases to law enforcement**

Supplemental Medical Review Contractor (SMRC) Audits

- **The purpose of the SMRC is to reduce improper payments in the Medicare FFS program, accomplished through post-payment audits of Medicare Part A; Part B; and Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) claims. The current SMRC is Noridian Healthcare Solutions, LLC (Noridian), which conducts nationwide medical review projects as directed by CMS. The projects are focused on issues identified through various means, including issues identified by CMS internal data analysis; the Comprehensive Error Rate Testing (CERT) program; professional organizations; and other federal agencies, such as the HHS OIG or Government Accountability Office (GAO). Providers should regularly consult Noridian's website for its list of current projects to determine whether they fit in one of the existing project categories to be prepared in the event of a future SMRC audit.**

- **The Centers for Medicare & Medicaid Services (CMS) contracts with a Supplemental Medical Review Contractor (SMRC) to help lower improper payment rates and protect the Medicare Trust Fund. The SMRC conducts nationwide medical reviews of Medicaid, Medicare Part A/B, and DMEPOS claims to determine whether claims follow coverage, coding, payment, and billing requirements. The focus of the medical reviews may include vulnerabilities identified by CMS data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations, and Federal oversight agencies. At the request of CMS, the SMRC may also carry out other special projects to protect the Medicare Trust Fund.**

- **Additional Documentation Requests**
  - **Noridian Healthcare Solutions, the current SMRC, will send requests to providers and suppliers for additional documentation on claims selected for medical review. These requests comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which allows for the release of information for treatment, payment, and healthcare operations. Sections of the Social Security Act provide guidance that prohibits Medicare from making Part A or Part B payments until sufficient information and/or documentation has been furnished to determine the amounts due.**

- **Overpayments**
  - **Noridian Healthcare Solutions will notify CMS of any identified improper payments and noncompliance with documentation requests. The Medicare Administrative Contractor (MAC) may initiate claim adjustments and/or overpayment recoupment actions through the standard recovery process.**

- **Questions**
  - **If you have questions about the overpayment recovery process or appeal rights, find and contact your MAC using the review contractor directory. For more details on the SMRC program, contact Noridian Healthcare Solutions at 1-833-860-4133, or visit Noridian Healthcare Solutions' SMRC website at https://www.noridiansmrc.com/.**

Comprehensive Error Rate Testing (CERT) Audits.

- **The CERT audit is a post-payment audit for Medicare Part A, Part B, and DMEPOS claims that CMS uses to estimate Medicare FFS improper payments. Unlike the other audit types discussed in this alert, CERT audits review a random sample of Medicare FFS claims. From that sample, CMS determines the estimated improper payment rate and extrapolates it to the universe of FFS claims. The CERT reviewers categorize improper payment claims into categories if underpayments or overpayments are found. These categories include the following:**

1. Insufficient documentation supporting the claim.

2. Incorrect coding.

3. Lack of medical necessity (as determined by Medicare program requirements).

4. No documentation.

5. Other.

- The CERT will notify the MAC in all cases of improper payment, which may recoup any overpayments. Providers may appeal adverse audit results.

- **History**
  - **The Medicare FFS improper payment rate was first measured in 1996. The Department of Health and Human Services (HHS) Office of Inspector General (OIG) was responsible for estimating the national Medicare FFS improper payment rate from 1996 through 2002. The OIG designed its sampling method to estimate a national Medicare FFS paid claims improper payment rate only. Due to the OIG's small sample size of approximately 6,000 claims, the OIG was unable to produce improper payment rates by contractor, contractor type, service type, or provider type. Following recommendations from the OIG, the sample size was increased when CMS began producing the Medicare FFS improper payment rate in 2003.**

- **Current Program**
  - **The CMS implemented the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare Fee-for-Service (FFS) program. CERT is designed to comply with the Payment Integrity Information Act of 2019 (PIIA).**
  - **CERT selects a stratified random sample of approximately 50,000 claims submitted to Part A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DMACs) during each reporting period. This sample size allows CMS to calculate a national improper payment rate and contractor- and service-specific improper payment rates. The CERT program ensures a statistically valid random sample; therefore, the improper payment rate calculated from this sample is considered to reflect all claims processed by the Medicare FFS program during the report period.**

- **The sample of Medicare FFS claims is reviewed by an independent medical review contractor to determine if they were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met or the provider fails to submit medical records to support the claim billed, the claim is counted as either a total or partial improper payment and the improper payment may be recouped (for overpayments) or reimbursed (for underpayments). The last step in the process is the calculation of the annual Medicare FFS improper payment rate, which is published in the Health and Human Services (HHS) Agency Financial Report (AFR).**
- **It is important to note that the improper payment rate is not a "fraud rate," but is a measurement of payments that did not meet Medicare requirements.**

Recovery Audit Contractor (RAC) Audits

- **What triggers a RAC audit?**
  - **RAC audits are not one-time or intermittent reviews and can be triggered by anything from an innocent documentation error to outright fraud. They are part of a systematic and concurrent operating process that ensures compliance with Medicare's clinical payment criteria, documentation and billing requirements.**
  - **First, the RAC identifies a risk pool of claims.**
  - **Second, the RAC requests medical records from the provider.**
  - **Once the records are received by the RAC, they will review the claim and medical records. Based on the review, the RAC will make a determination: overpayment, underpayment or correct payment.**
  - **RACs are able to look back three years from the dates the claim was paid.**

- **A Recovery Audit Contractor (RAC) is a third-party entity working on behalf of the United States government Centers for Medicare and Medicaid Services to identify and recover improper payments made in Medicare transactions between providers and payors.**
- **Also known as a Medicare audit or a MAC audit, the Recovery Audits Contract (RAC) program is an aggressive campaign seeking reimbursement from healthcare service providers. These audits have become increasingly frequent over the past few years, and they will continue to for the foreseeable future**

- **What is the difference between CERT audit and RAC audit?**
  - **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.**

- **Who conducts RAC audits?**
  - **The Centers for Medicare and Medicaid Services (CMS) contracts with private companies who conduct RAC audits**

Questions?

Thank You So Much!!!