AUDITS AND APPEALS
PRE- AND POST-AUDIT STRATEGIES

FOR MORE INFORMATION

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WHAT IS AN AUDIT?

- An audit is a review of medical claims submitted to a government or private payer.
- Audits can be conducted due to:
  - A random event
  - A Qui Tam event
  - Benchmarking event
- At times, it may be impossible to determine what triggered an audit, but you must always be prepared

THE AUDIT PROCESS

- Pre-audit risk assessment
- Audit notification – demand for payment
  - All but RAC
- Response to audit notification
- Post-audit risk assessment
- Post-audit review
TYPES OF AUDITS

• RAC
• ZPIC
• MIC
• MAC
• CERT
• HEAT
• PSC
• OIG
• DOJ
• Private payer audits

RECOVERY AUDIT CONTRACTORS

• There are three types of RAC audits
  • Automated Reviews
    • Use edit logic to process large numbers of claims without any review of the medical record
  • Semi-Automated Reviews
    • Begin as automated reviews but if a pattern of problems are discovered, quickly advance to complex reviews
  • Complex Reviews
    • Claims identified as having a high probability of error are manually reviewed
• RAC auditors are paid a commission based on how much they are able to recover from a provider
• 47.5% of claims determined to have been overpaid are reversed on appeal
ZONE PROGRAM INTEGRITY CONTRACTORS

- Pursue cases of suspected fraud
- All cases of potential fraud are referred to OIG
- Not paid on commission, but can get bonuses
- Audits can be caused by:
  - Trend analysis
  - Referrals
  - Statistical outliers

MEDICARE ADMINISTRATIVE CARRIER

- Pre-payment medical reviews
- Integrates the administration of Medicare Parts A and B for the fee-for-service benefit
- Ensures services are covered and medically necessary
- Reviews subject to results of the CERT audits
- Prospective audits of limited number of claims for high-risk services
- Document requests are sent to affected providers
- Documents reviewed for potential overpayment demands
MEDICAID INTEGRITY CONTRACTORS

- Unique from RAC and MAC in several ways
  - Appeals are managed at the state level and vary state-to-state
  - Appeals process may also vary based on organization type
    - Provider, pharmacy, MCI, IPA, etc.
  - Not bound by limits on the number of claims requested
- There are three types of contractors for this program:
  1. Review MICs, that analyze claims data to identify payment vulnerabilities;
  2. Audit MICs, that conduct post-payment audits of documentation to identify overpayments; and
  3. Education MICs, that educate the provider community as needed based on discovered issues.

CERT

COMPREHENSIVE ERROR RATE TESTING
OIG-APPROVED METHODOLOGY

- CERT randomly selecting a sample of approximately 100,000 claims submitted to Carriers, FIs, and MACs during each reporting period.
- Requesting medical records from the health care providers that submitted the claims in the sample.
- Where medical records were submitted by the provider, reviewing the claims in the sample and the associated medical records to see if the claims complied with Medicare coverage, coding, and billing rules, and, if not, assigning errors to the claims.
- Where medical records were not submitted by the provider, classifying the case as a no documentation claim and counting it as an error.
- Sending providers overpayment letters/notices or making adjustments for claims that were overpaid or underpaid.

SUMMARY RESULTS FOR 2011

Summary Table: Adjusted Improper Payment Rates and Projected Improper Payments by Claim Type in 2011 (Dollars in Billions)

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Total Paid Amount</th>
<th>Overall Improper Payment</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Improper Payment (in Billion)</td>
<td>Improper Payment Rate</td>
</tr>
<tr>
<td>Part A (Total)</td>
<td>$242.2</td>
<td>$17.1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Part A (Excluding Acute Inpatient Hospital)</td>
<td>$140.7</td>
<td>$5.1</td>
<td>4.4%</td>
</tr>
<tr>
<td>Part A (Acute Inpatient Hospital)</td>
<td>$125.5</td>
<td>$10.9</td>
<td>7.9%</td>
</tr>
<tr>
<td>Part B</td>
<td>$84.4</td>
<td>$7.8</td>
<td>9.2%</td>
</tr>
<tr>
<td>DMEPOS</td>
<td>$9.7</td>
<td>$5.9</td>
<td>61.0%</td>
</tr>
<tr>
<td>Overall</td>
<td>$336.4</td>
<td>$29.8</td>
<td>8.6%</td>
</tr>
</tbody>
</table>
TYPES OF ERRORS REPORTED

- No documentation — the provider fails to respond to repeated attempts to obtain the medial records in support of the claim.
- Insufficient documentation — the medical documentation submitted does not include pertinent patient facts (e.g. the patient’s overall condition, diagnosis, and extent of services performed).
- Medically unnecessary service — claim review staff identify enough documentation in the medical records submitted to make an informed decision that the services billed were not medically necessary based on Medicare coverage policies.
- Incorrect coding — providers submit medical documentation that support a lower or higher code than the code submitted.
- Other — Represents claims that do not fit into any of the other categories (e.g. service not rendered, duplicate payment error, not covered or unallowable service).

SERVICES WITH OVER CODING ERRORS

<table>
<thead>
<tr>
<th>Service Billed to Carrier (HCPCS)</th>
<th>Overcoding Errors</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient services (H0020)</td>
<td>19.1%</td>
<td>$65,235,294</td>
</tr>
<tr>
<td>Office, Other (H0021)</td>
<td>0.6%</td>
<td>$84,333,660</td>
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<tr>
<td>Emergency department (H0025)</td>
<td>5.5%</td>
<td>$47,540,615</td>
</tr>
<tr>
<td>Office/suppatient visit, ext. (H9211)</td>
<td>1.1%</td>
<td>$64,335,149</td>
</tr>
<tr>
<td>Office/suppatient visit, nurse (H9211)</td>
<td>10.4%</td>
<td>$44,331,460</td>
</tr>
<tr>
<td>Office/suppatient visit, max (H9219)</td>
<td>24.2%</td>
<td>$25,691,181</td>
</tr>
<tr>
<td>Nursing fac w/att, suboth (H0109)</td>
<td>9.3%</td>
<td>$26,238,147</td>
</tr>
<tr>
<td>Initial hospital care (H9222)</td>
<td>0.7%</td>
<td>$25,259,023</td>
</tr>
<tr>
<td>Nursing fac/wt, suboth (H9210)</td>
<td>24.5%</td>
<td>$29,345,645</td>
</tr>
<tr>
<td>Critical care, first hour (H9299)</td>
<td>3.2%</td>
<td>$33,344,297</td>
</tr>
<tr>
<td>Inpatient consultation (H9231)</td>
<td>7.4%</td>
<td>$18,813,327</td>
</tr>
<tr>
<td>All Other Codes</td>
<td>0.8%</td>
<td>$21,218,430</td>
</tr>
<tr>
<td>Overall</td>
<td>2.3%</td>
<td>$1,751,244,296</td>
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</table>
## Error Rates by Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Inpatient Non-Response Claims</th>
<th>Outpatient Allowed</th>
<th>Error Rate</th>
<th>Provider Compliance Error Rate</th>
<th>Services Processed Error Rate</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Proposed $78,706,925 11.0% 6.4%</td>
<td>Examine $20,898,214 12.2% 6.4%</td>
<td>0.6% 18.9% 11.0% 11.0%</td>
<td>0.6% 18.8% 11.0% 11.0%</td>
<td>0.6% 18.8% 11.0% 11.0%</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>18.9%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>25.8%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>32.5%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Independent Laboratory Billing in Canada</td>
<td>12.0%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Other Carrier Bills</td>
<td>16.0%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>17.7%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Surgery</td>
<td>16.0%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Anesthesiology/Oncology</td>
<td>9.0%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Family Practitioner</td>
<td>16.0%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Gastroenterologist</td>
<td>19.0%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Pathology</td>
<td>8.0%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>12.0%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>All EMR/HCPCS</td>
<td>12.0%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>9.0%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Ambulance (Billing in Canada)</td>
<td>9.0%</td>
<td>11.0%</td>
<td>6.4%</td>
<td>11.0%</td>
<td>11.0%</td>
</tr>
</tbody>
</table>

## The Pre-Audit Analysis

**Quantitative Methods**

2/1/2013
UTILIZATION ANALYSES

• Utilization of both procedure codes and modifiers have gained in analytical importance over the past three years
• OIG and carriers benchmark utilization data to determine potential for fraud and abuse
• Practices benchmark utilization data to identify areas of compliance risk, provider performance, and financial opportunities

DATA REQUIREMENTS

• Production report with frequency
  • Aggregate for single provider or global analysis
  • Segregated for more in-depth analysis
  • By provider and/or location and/or department
• Daily transaction report
  • For time-series analyses
• Comparative data for control group
PROCEDURE CODE UTILIZATION

- Comparisons are conducted against national averages by specialty
  - Uses the P/SPS Master file from CMS
- Critically, top 10 - 25 codes are compared with national CI levels to determine significance of variability (aberrancies)
- Harvard/RUC time assessments are assigned to each code in order to assess believability of reported provider work load is hours
- OIG allows 2 times FMV before investigating

2/1/2013

TOP 25 COMPARISON

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Work RVUs</th>
<th>National Rank</th>
<th>National Percent</th>
<th>Practice Rank</th>
<th>Practice Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Office/outpatient visit, est</td>
<td>0.97</td>
<td>1</td>
<td>10.46%</td>
<td>1</td>
<td>20.89%</td>
<td>3,654</td>
</tr>
<tr>
<td>20610</td>
<td>Drain/inject, joint/bursa</td>
<td>0.79</td>
<td>2</td>
<td>7.28%</td>
<td>2</td>
<td>8.34%</td>
<td>1,458</td>
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<tr>
<td>97110</td>
<td>Therapeutic exercises</td>
<td>0.45</td>
<td>3</td>
<td>3.52%</td>
<td>16</td>
<td>5.00%</td>
<td>180</td>
</tr>
<tr>
<td>99212</td>
<td>Office/outpatient visit, est</td>
<td>0.48</td>
<td>4</td>
<td>3.43%</td>
<td>6</td>
<td>5.00%</td>
<td>784</td>
</tr>
<tr>
<td>99214</td>
<td>Office/outpatient visit, est</td>
<td>1.6</td>
<td>5</td>
<td>5.00%</td>
<td>5</td>
<td>4.67%</td>
<td>692</td>
</tr>
<tr>
<td>99203</td>
<td>Office/outpatient visit, new</td>
<td>1.42</td>
<td>6</td>
<td>5.00%</td>
<td>5</td>
<td>4.67%</td>
<td>816</td>
</tr>
<tr>
<td>73560</td>
<td>X-ray exam of knee, 1 or 2</td>
<td>0.17</td>
<td>7</td>
<td>2.63%</td>
<td>5</td>
<td>4.67%</td>
<td>384</td>
</tr>
<tr>
<td>73562</td>
<td>X-ray exam of knee, 3</td>
<td>0.18</td>
<td>8</td>
<td>1.00%</td>
<td>4</td>
<td>4.06%</td>
<td>72</td>
</tr>
<tr>
<td>73030</td>
<td>X-ray exam of shoulder</td>
<td>0.18</td>
<td>9</td>
<td>1.00%</td>
<td>21</td>
<td>1.65%</td>
<td>72</td>
</tr>
<tr>
<td>73150</td>
<td>X-ray exam of hip</td>
<td>0.21</td>
<td>10</td>
<td>1.49%</td>
<td>19</td>
<td>1.65%</td>
<td>144</td>
</tr>
<tr>
<td>99204</td>
<td>Office/outpatient visit, new</td>
<td>2.43</td>
<td>11</td>
<td>1.25%</td>
<td>14</td>
<td>1.65%</td>
<td>252</td>
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<tr>
<td>72170</td>
<td>X-ray exam of pelvis</td>
<td>0.17</td>
<td>12</td>
<td>1.22%</td>
<td>20</td>
<td>1.65%</td>
<td>144</td>
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<tr>
<td>97140</td>
<td>Manual therapy</td>
<td>0.43</td>
<td>13</td>
<td>1.09%</td>
<td>18</td>
<td>1.65%</td>
<td>72</td>
</tr>
<tr>
<td>73564</td>
<td>X-ray exam, knee, 4 or more</td>
<td>0.22</td>
<td>14</td>
<td>0.97%</td>
<td>17</td>
<td>1.42%</td>
<td>84</td>
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<tr>
<td>72100</td>
<td>X-ray exam of lower spine</td>
<td>0.22</td>
<td>15</td>
<td>0.97%</td>
<td>16</td>
<td>1.42%</td>
<td>84</td>
</tr>
<tr>
<td>73610</td>
<td>X-ray exam of ankle</td>
<td>0.17</td>
<td>16</td>
<td>0.63%</td>
<td>15</td>
<td>1.25%</td>
<td>84</td>
</tr>
<tr>
<td>73830</td>
<td>X-ray exam of foot</td>
<td>0.17</td>
<td>17</td>
<td>0.63%</td>
<td>14</td>
<td>1.25%</td>
<td>84</td>
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<td>73505</td>
<td>X-ray exam of knees</td>
<td>0.17</td>
<td>18</td>
<td>0.58%</td>
<td>13</td>
<td>1.09%</td>
<td>84</td>
</tr>
<tr>
<td>27447</td>
<td>Total knee arthroplasty</td>
<td>2.25</td>
<td>19</td>
<td>5.57%</td>
<td>12</td>
<td>1.71%</td>
<td>224</td>
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<tr>
<td>99202</td>
<td>Office/outpatient visit, new</td>
<td>0.93</td>
<td>20</td>
<td>0.50%</td>
<td>7</td>
<td>0.42%</td>
<td>108</td>
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<tr>
<td>02283</td>
<td>Elec stim other than wound</td>
<td>0.18</td>
<td>21</td>
<td>0.48%</td>
<td>6</td>
<td>0.42%</td>
<td>48</td>
</tr>
<tr>
<td>73110</td>
<td>X-ray exam of wrist</td>
<td>0.17</td>
<td>22</td>
<td>0.47%</td>
<td>5</td>
<td>0.39%</td>
<td>40</td>
</tr>
<tr>
<td>73506</td>
<td>X-ray exam of hip</td>
<td>0.17</td>
<td>23</td>
<td>0.46%</td>
<td>4</td>
<td>0.33%</td>
<td>24</td>
</tr>
<tr>
<td>73100</td>
<td>X-ray exam of wrist</td>
<td>0.16</td>
<td>24</td>
<td>0.42%</td>
<td>3</td>
<td>0.27%</td>
<td>16</td>
</tr>
<tr>
<td>95202</td>
<td>Intake hospital care</td>
<td>2.61</td>
<td>25</td>
<td>0.38%</td>
<td>2</td>
<td>0.16%</td>
<td>8</td>
</tr>
</tbody>
</table>
EXPECTED V. OBSERVED ANALYSIS

MODIFIER UTILIZATION

- Comparisons are done by code category and by specialty
  - E/M-only modifiers are compared to E/M codes
  - All other codes are compared to total levels
- Global comparison shows modifier utilization by specialty for all specialties
- Specialty comparison shows utilization for that specific specialty
- Provider comparison shows utilization for each provider by specialty
- Data is used to identify potential compliance problems for high-risk modifier usage

2/1/2013
HIGH RISK MODIFIERS

-24 Use of E/M during Post-op Period
-25* Separately Identifiable E/M Service
-58 Staged/Related Procedure – Same Doc during post-op
-59* Distinct Procedural Service (specific for CCI edits)
-62 Two Surgeons
-63 Procedure performed on infant <4kg
-76 Repeat procedure by same physician
-78 Return to OR for related procedure during post-op
-80 Assistant Surgeon
-AS Assistant Surgeon – NP or PA
-GE Performed by resident without physician supervision

* See OIG Reports

MODIFIER UTILIZATION - SUMMARY

<table>
<thead>
<tr>
<th>Vascular Surgery</th>
<th>Modifier Utilization Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifier</td>
<td>National Utilization</td>
</tr>
<tr>
<td>22</td>
<td>0.02%</td>
</tr>
<tr>
<td>24</td>
<td>0.60%</td>
</tr>
<tr>
<td>25</td>
<td>2.50%</td>
</tr>
<tr>
<td>26</td>
<td>20.15%</td>
</tr>
<tr>
<td>50</td>
<td>0.27%</td>
</tr>
<tr>
<td>51</td>
<td>3.96%</td>
</tr>
<tr>
<td>52</td>
<td>0.07%</td>
</tr>
<tr>
<td>57</td>
<td>0.60%</td>
</tr>
<tr>
<td>58</td>
<td>0.45%</td>
</tr>
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<td>59</td>
<td>5.33%</td>
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<td>62</td>
<td>0.14%</td>
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<td>76</td>
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<td>78</td>
<td>0.50%</td>
</tr>
<tr>
<td>79</td>
<td>0.77%</td>
</tr>
</tbody>
</table>
GRAPHING MODIFIER UTILIZATION

Expected Utilization versus Observed

Utilization Variance

THE POST-AUDIT ANALYSIS

STATISTICAL METHODS

2/1/2013
SAMPLING

- Random sample
  - Every sample has an equal chance of being selected
    - Selecting claims to study payer behavior
- Stratified sample
  - Can still be random, however, distribution of sample is based on distribution of the population
    - Breaking the sample up based on paid amounts
    - Selecting E/M charts for audit based on distribution of codes
MEASURES OF CENTRAL TENDENCY

- In the study of statistics there are three types of averages, called the mean, median, and mode.
- As a group, these averages are called measures of central tendency.
- These metrics are used to identify the approximate location of the center of the data.

ARITHMETIC MEAN (AVERAGE)

- Create a metric for each code using the same method.
  - i.e., divide the charge by the RVU
- Add each of the results together to get a grand total.
- Divide the grand total by the number of samples.
- Pros:
  - Easy to calculate
  - Eliminates frequency bias
- Cons:
  - Does not take into account the frequency of occurrence
  - Not accurate if data is not normally distributed

<table>
<thead>
<tr>
<th>Code</th>
<th>CF</th>
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<td>99201</td>
<td>60.83</td>
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<td>81.61</td>
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<td>81.67</td>
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<td>106.79</td>
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<td>78.81</td>
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<td>86.96</td>
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<td>87.78</td>
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<tr>
<td>99213</td>
<td>68.43</td>
</tr>
<tr>
<td>99214</td>
<td>70.59</td>
</tr>
<tr>
<td>99215</td>
<td>75.73</td>
</tr>
<tr>
<td>Total</td>
<td>819.20</td>
</tr>
<tr>
<td>Count</td>
<td>10.00</td>
</tr>
<tr>
<td>Average</td>
<td>81.92</td>
</tr>
</tbody>
</table>
### MEDIAN

- The **median** is the middle number in a set of data that is arranged in either ascending or descending order.
- One-half of the numbers will be on either side of the median.
- The median is good for use with non-normally distributed data as it is far less affected by outliers.
- Order the data in ascending order.
- Count the number of records and divide by two.
- Pick the middle number.
- If an even number of records, get the average of the middle two.

### EXAMPLE OF MEAN V. MEDIAN

<table>
<thead>
<tr>
<th>$480.00$</th>
<th>$360.00$</th>
<th>$240.00$</th>
<th>$120.00$</th>
<th>$0.00$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>Mean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$100.00$</td>
<td>$90.00$</td>
<td>$80.00$</td>
<td>$70.00$</td>
<td>$60.00$</td>
</tr>
</tbody>
</table>

**Summary for Sum of overpay**

- Anderson-Darling Normality Test: $A^2=3.83$, $P$-Value $<0.005$
- Mean: $84.544$, SD: $94.569$
- Variance: $8943.360$
- Skewness: $2.38405$
- Kurtosis: $7.54134$
- Minimum: $0.000$
- 1st Quartile: $19.435$
- Median: $59.715$
- 3rd Quartile: $109.589$
- Maximum: $522.263$
- 95% Confidence Interval for Mean: $64.315$ to $104.772$
- 90% Confidence Interval for Median: $34.425$ to $82.155$
- 95% Confidence Interval for SD: $82.373$ to $112.467$
EXAMPLE OF MEAN V. MEDIAN

Summary for Overpayment - Strat 2

Anderson-Darling Normality Test
A-Squared: 1.30
P-Value: 0.905

Mean: 195.46
StDev: 83.52
Variance: 6978.84
Skewness: -0.148480
Kurtosis: -0.966371
N: 30

Minimum: 0.00
1st Quartile: 130.18
Median: 166.60
3rd Quartile: 278.69
Maximum: 795.45

90% Confidence Interval for Mean: 164.85 - 216.37
90% Confidence Interval for Median: 149.15 - 273.35
90% Confidence Interval for StDev: 60.75 - 106.80

90% Confidence Intervals

EXAMPLE OF MEAN V. MEDIAN

Summary for OVER PAYMENT

Anderson-Darling Normality Test
A-Squared: 10.14
P-Value: 0.001

Mean: 41.705
StDev: 38.112
Variance: 1452.533
Skewness: 1.80378
Kurtosis: 2.94633
N: 100

Minimum: 0.000
1st Quartile: 16.490
Median: 25.590
3rd Quartile: 71.500
Maximum: 164.390

90% Confidence Interval for Mean: 31.440 - 50.977
90% Confidence Interval for Median: 21.133 - 29.552
90% Confidence Interval for StDev: 24.361 - 43.202

90% Confidence Intervals
EXTRAPOLATION

SHOOT – DON’T SHOOT

RULES OF ENGAGEMENT

• Section 1842(a)(2)(6) of the Social Security Act requires the government to review, identify and/or deny inappropriate, medically unnecessary, excessive or routine services. Extrapolation techniques are used when the size of the universe of claims prohibits a complete review of every claim. In this case, a statistically valid random sample is drawn from that universe of claims in order to estimate potential payment error. In their “Standard of Work”, CMS states that extrapolation may be used when there has been a determination that, within the universe of claims, there is a “sustained or high level of payment error” and again, this determination should be based upon a statistically valid random sample drawn from that universe.
METHODOLOGICAL APPROACH

- Extrapolations are normally conducted in one of two ways:
  - Proportion of overpaid claims, or
  - Point estimate of overpaid amount per claim
- For proportions, it requires blending sample error for both the percent of claims and the point estimate per claim
- This is a bad methodology and very few auditors use this
- In most audits, per claim estimates are based on the lower bound of the 90% confidence interval

EXAMPLE OF A PROPORTION FINDING

Template for overpayment estimate

Fill in the values for the shaded boxes

\[
\bar{X} - Z \left( \frac{s}{\sqrt{n}} \right) \left( \frac{N - n}{N - 1} \right) = 0.5805 - 0.0879 = 0.4926
\]

Total paid to provider

$1,160,412.85

Estimate of overpayment

$1,160,412.85 \times 0.4925670 = 571,581.02 \text{ Total due}
WHAT IS A CONFIDENCE INTERVAL (CI)?

- The purpose of a confidence interval is to validate a point estimate; it tells us how far off our estimate is likely to be.
- A confidence interval specifies a range of values within which the unknown population parameter may lie.
  - Normal CI values are 90, 95%, 99% and 99.9%.
- The width of the interval gives us some idea as to how uncertain we are about an estimate.
  - A very wide interval may indicate that more data should be collected before anything very definite can be inferred from the data.

EXTRAPOLATION CASE STUDY

- In this case, the average overpayment estimate per claim is higher than the average paid amount per claim.
- This means that the practice would be required to pay back more than they were paid.
Summary for Sum of overpay

$64.315 \times 12,011 = \$772,487$

$34.425 \times 12,011 = \$411,376$

Summary for Overpayment - Strat 2

$164.55 \times 4,293 = \$706,413$

$149.15 \times 4,293 = \$640,300$
$35.44 \times 10,256 = \$363,473$

$21.510 \times 10,256 = \$220,607$

APPEALING CLAIMS

REMEMBER, IT'S NOT THEIRS UNTIL A JUDGE SAYS IT'S THEIRS
WHY APPEAL?

- All auditors are motivated to find as many errors as possible
  - RAC auditors get paid a commission
  - ZPIC auditors can get a bonus
  - MICs and MACs are evaluated for contract renewal on performance
  - Private payers pad their profits with recoupments
- There is little to no incentive for auditors to ‘do the right thing’.
- Anywhere between 35% and 80% of findings are reversed in favor of the provider

HOW TO APPEAL

- For most audits, there should be specific instructions on how to submit an appeal
- In most cases, audits go through three levels:
  - Redetermination
  - Reconsideration
  - Administrative Law Judge (ALJ)
- The highest rate of reversal (in our studies) occurs at the level of the ALJ
  - This is particularly true for medical necessity issues
APPEAL TIPS

1. Designate someone within the organization to handle all correspondence
2. Pay particular attention to dates and times
3. Be sure to file appeals timely
4. Verify all information on the audit (NPI, claim number, line number, etc.)
5. Have an accountable contact at the other end
6. Date, time and page-stamp all correspondence
7. Document all violations with regard to the auditor providing information within designated time limits

FOR MORE INFORMATION

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