HEALTH LAW ALERT

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WILL PREPAYMENT AUDITS DESTROY YOUR PRACTICE?

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For years attorneys representing health care providers have warned their clients about the "pay and chase"; that is that the insurers may pay your claims today but chase you tomorrow to get their money back. Insurers, including Medicare, have decried a system that requires the payor to pay a claim within a reasonable time period, and then chase after the practitioner when fraud, abusive billing or erroneous billing is found. The Center for Program Integrity, a division of the Centers for Medicare and Medicaid Services ("CMS") has identified the pre-payment review of claims as a key strategy to prevent improper reimbursement, thereby moving CMS away from the "pay and chase" approach currently in place. The prepayment audit will enable CMS to suspend payment as it reviews claims and documentation submitted by the provider in support of its claims.

CMS has implemented a Fraud Prevention System ("FPS"), which is described as "a predictive modeling technology" that is designed to screen all Medicare fee-for-service claims before payment is made. The FPS can generate profiles on beneficiaries, providers and suppliers, which profiles will be used by CMS in identifying unusual billing patterns and the likelihood of fraudulent or suspicious activity. The FPS is intended as a tool for CMS to examine claims pre-payment and to enable CMS to focus on the areas of highest risk.

In November 2011, CMS announced three demonstration projects, one of which will allow Medicare Recovery Auditors (RAC's) to review claims before they are paid to ensure that the provider complied with all Medicare rules, including national and local coverage determinations. The Pre-payment review was delayed twice this year but CMS has recently announced that the demonstration will commence as of **August 27, 2012**. Under the demonstration project, the RAC's will focus on eleven states (including New York) based on CMS' findings that the states targeted have high instances of fraud and erroneous billing, and the will target those services and items that pose the greatest financial risk to the Medicare program. In 2011, CMS reported nearly $29 billion made in improper payments. In an effort to reduce its error rate, CMS has stated that it will focus on the prevention of improper payments, which result from lack of proper or sufficient documentation, incorrect coding, medically unnecessary services, services that were billed for but never provided, and intentional fraud.

CMS can and will suspend reimbursement until the prepayment review is completed and the claim has been approved. These prepayment audits can choke off your cash flow, imperiling the survival of your practice. The prepayment audit is coming, but to survive it, and avoid a demand for overpayment, recoupment, or worse, it is incumbent upon every practitioner to take steps today to ensure that CPT codes are used properly, that documentation of all services is sufficient and evidences that all services were performed and medically

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For additional information on this or any health law related issue, please contact RMF's Health Law Department co-chairs: Alexander G. Bateman, who can be reached at 516-663-6589 or abateman@rmfpc.com or Jay B. Silverman, who can be reached at 516-663-6606 or jsilverman@rmfpc.com

necessary. For practitioners who do not bill Medicare or Medicaid, it is vital to remember that the commercial insurance carriers always take their cues from CMS, and will follow the prepayment audit trail blazed by the federal government.

Contact your health care counsel today to implement effective coding compliance programs, including training and ensure that your claims will pass muster and your labors will be recompensed.