Compliance Issues in Physician Practices

Developing and Implementing an Audit Program

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for
Louisiana MGMA
August 17, 2016

First Rule of Healthcare Compliance

If it makes sense from a business standpoint, you generally can't do it in healthcare.

Physician Responsibility

Physicians are responsible for knowing Medicare (federal health care) policy if:

- The Medicare contractor (MAC) gives written notice to the particular physician
- The Medicare contractor (MAC) provides general notice to the medical community concerning the policy or rule
- The policy or rule is in the Federal regulations.

Mandatory Compliance Plans?

PPACA – "A provider of medical services shall establish a compliance program as a condition of enrollment in Medicare, Medicaid, and CHIP…."

But CMS has not released the regulations and requirements and has indicated that they have many other higher priorities.

Seven Steps to Compliance

OIG Compliance Program Guidance for Individual and Small Group Physician Practices

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a compliance officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication
- Enforcing disciplinary standards through well-publicized guidelines

https://oig.hhs.gov/authorities/docs/physician.pdf

Compliance Mistakes

- Not checking the exclusion list(s)
- Not auditing or auditing with the wrong focus
- Not refunding overpayments
- Not evaluating the gray areas in coding and billing
- Not monitoring relationships
- Extending “professional courtesy”
- Not conducting exit interviews
- Believing everything a vendor tells you/Getting coding information from the wrong source
- Implementing electronic medical records without coding/compliance involvement
- Discontinuing care improperly and illegally

Excluded from Medicare

Cannot employ anyone who has been excluded from the Medicare program

Cannot receive funds from any federal program during period of exclusion

Check exclusion list for all employees

http://oig.hhs.gov/fraud/exclusions/listofexcluded.html

Possible penalty of $10,000 for each claim/service

Separate exclusion list for Medicaid – some states require that this be checked monthly

Not Auditing?

- *Head in the Sand* approach

- Many smaller practices have no guidance with coding issues – that could be provided by an outside auditor.

Auditing

- Coding and Billing
- HIPAA
- CLIA
- OSHA
- Stark and Anti-Kickback
- Employment Law
- Etc.

Monitoring Relationships

Must be concerned with relationships your physicians may have with other entities –

Stark and Anti-Kickback Implications

Stark

The physician referral law (section 1877 of the Social Security Act) prohibits a physician from referring patients to an entity for a designated health service (DHS), if the physician or a member of his or her immediate family has a financial relationship with the entity, unless an exception applies.

Stop
That
Ain't
Real
Kosher

Anti-Kickback Statute

- Prohibits the offer or receipt of certain remuneration in return for referrals for or recommending purchase of supplies and services reimbursable under government healthcare programs
- Do you waive copays or provide 'professional courtesy' to other physicians and their employees?
- Intent requirement relaxed under PPACA

Exit Interviews

One of the best ways to head off a qui tam suit is to conduct an exit interview –

- *qui tam pro domino rege quam pro se ipso in hac parte sequitur* he who brings a case on behalf of our lord the King, as well as for himself
- The False Claims Act allows a private individual with knowledge of past or present fraud on the federal government to sue on the government's behalf to recover compensatory damages, civil penalties, and

  triple damages - 'Relator' eligible for up to 30% of recovery

Also beneficial to see the practice from another viewpoint

Vendors

Remember that their primary purpose is to sell something to your physicians

Verify any reimbursement or coding information given to you

If it sounds too good to be true….

In general, consider the source of coding guidance.

EHR Implementation

The vendor is not a coding and compliance expert!

Beware of imbedded coding programs – they can only count “beans”

Many issues with diagnosis coding as well.

Ethically, Legally, Appropriately Dismissing Patients

- Will be based on state law

May violate state patient abandonment laws

Back to Seven Steps to Compliance

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Conducting Internal Monitoring and Auditing

Use staff in each area to review their areas

- Lab – CLIA
- Nursing – OSHA
- HR – Employee Law

Overseen by one person

- Outside audits on a periodic basis

Implementing Compliance and Practice Standards

- Don't say it if you can't/won't do it
- Off the shelf plans available but must be personalized
- Consider an umbrella approach with different employees/areas taking ownership of the regulations involving their area

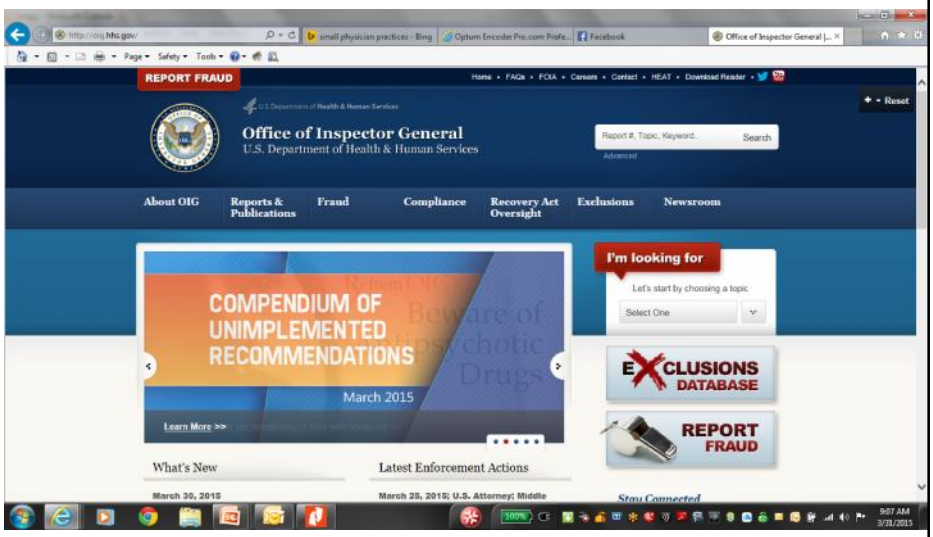
Compliance Officer or Contact

Smaller practices cannot usually afford to hire a Compliance Officer – consider:

- Contracted compliance services
- Investing in a promising employee – coder?
- Split duties
- Hazards of employee with financial pressures serving as Compliance Officer
- Personality and attitude are important! "open lines of communication"

Conducting Appropriate Training and Education

- PPACA mandates initial training within 90 days of hire and annual training thereafter
- Resources available on OIG website
- Other options
  - MGMA
  - Hospital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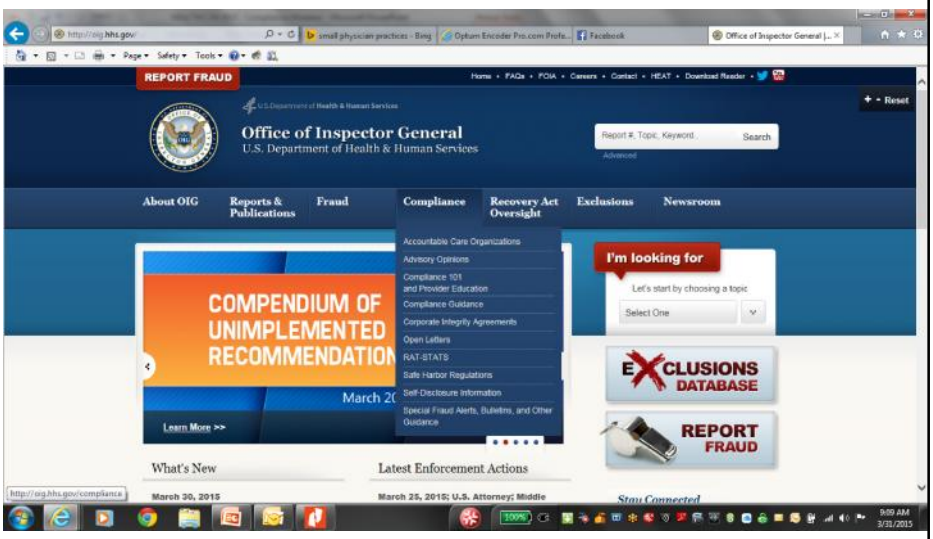
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Responding Appropriately to Detected Offenses and Developing Corrective Action

- Don't say it if you can't do it!
- Corrective action specific to the offense – may also vary by job duties.

Developing Open Lines of Communication

PPACA – "a strong ethical culture and commitment to compliance"

Enforcing Disciplinary Standards through Well-Publicized Guidelines

- Don't say it if you can't – or won't do it
  - Contractual issues
  - Employment law requirements

HIPAA Audits

Office of Civil Rights enforces HIPAA – now undertaking audits –

Audit Protocol –

http://www.hhs.gov/ocr/privacy/hipaa/enforcement/audit/protocol.html

Tiered Civil Penalties

Circumstance of Violation	Minimum Penalty	Maximum Penalty
Entity did not know (even with reasonable diligence)	$100 per violation ($25,000 per year for violating same requirement)	$50,000 per violation ($1.5 million annually)
Reasonable cause, not willful neglect	$1,000 ($100,000)	$50,000 ($1.5 million)
Willful neglect, but corrected within 30 days	$10,000 ($250,000)	$50,000 ($1.5 million)
Willful neglect, not corrected	$50,000 ($1.5 million)	None

Developing and Implementing an Audit Program

Why not audit?

- "Head in the Sand" approach
  "I'd have to do something with it"
- Many smaller practices have no guidance with coding issues
- Minimal amount spent on auditing today could save maximum amounts of money in recoupments

Auditing with the Wrong Focus?

- Internal auditing only
- Choosing the wrong auditor
- Auditing based on the wrong parameters
- Not repaying or resubmitting after audit
- No follow-up education
- Thinking that Attorney-Client privilege provides unlimited protection

Internal Auditing Only?

- "Fox watching the henhouse" effect
- Physicians may listen more attentively to an outside consultant
- Outside auditors bring experience and ideas from other clients
- Expertise that the practice may not be able to afford on a daily basis

Choosing The Wrong Auditor?

Although you want to have at least some of your audits performed by an outside auditor, you want to choose someone with:

1. Experience in your specialty/specialties
2. Familiarity with your payers

Why Audit?

- As part of compliance plan
- Concurrent with payer review
- Because you think you ought to?
- The WHY determines the scope, the sample, the methodology, the reporting….

Federal False Claims Act

- Filing a claim that you knew or should have known was “false” – i.e., codes billed not matching documentation
- No proof of specific intent to defraud is required
- As of August 1, 2016, fines increased to $10,781-$21,563 per claim plus treble damages and paying attorneys fees for whistle blowers
- HITECH makes not refunding overpayments within 60 days a false claim
- Many states have False Claims Acts that may be even more stringent.

Have you read the back of the CMS-1500 claim form?

"I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were furnished by me, or were furnished incident to my professional services by my employee under my immediate supervision. NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws."

Medicare Claims Processing Manual Section 30.6.1

"…Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported…."

Discussion

- Is a coder qualified to judge – and to discuss with a physician – medical necessity issues?

Determining the Scope of the Audit

- OIG Work Plan
- CERT Issues
- RAC Issues
- Top ten denials for the practice
- Top ten services billed for the practice
- Specific issues brought to your attention

2016 OIG Work Plan

- Physician home visits–reasonableness of services

  We will determine whether Medicare payments to physicians for evaluation and management home visits were reasonable and made in accordance with Medicare requirements. Since January 2013, Medicare made $559 million in payments for physician home visits. Physicians are required to document the medical necessity of a home visit in lieu of an office or outpatient visit. Medicare will not pay for items or services that are not "reasonable and necessary." (Social Security Act, §1862(a)(1)(A)) (OAS; W-00-15-35754; expected issue date: FY 2016)

2016 OIG Work Plan

- Prolonged services–reasonableness of services

  We will determine whether Medicare payments to physicians for prolonged evaluation and management (E/M) services were reasonable and made in accordance with Medicare requirements. Prolonged services are for additional care provided to a beneficiary after an evaluation and management service has been performed. Physicians submit claims for prolonged services when they spend additional time beyond the time spent with a beneficiary for a usual companion evaluation and management service. The necessity of prolonged services are considered to be rare and unusual. The Medicare Claims Process (MCP) manual includes requirements that must be met in order to bill a prolonged E/M service code. (MCP manual, Pub. 100-04, Ch. 12, Sec. 30.6.15.1(OAS; W-00-15-35755; expected issue date: FY 2016)

CERT Issues

http://www.cms.gov/CERT/Downloads/CERT_Report.pdf

- Signatures
- Orders for diagnostic testing
- Lack of documentation to support codes billed

Recovery Audit Issues

http://www.connolly.com/healthcare/pages/ApprovedIssues.aspx

Examples of Current Physician Issues

- PTCA
- Major Joint Replacement
- Sacral Nerve Stimulation for Urinary Incontinence
- Chemotherapy Administration and Specific Drugs
- Co-surgery not billed with modifier 62
- Pulmonary Diagnostic Testing with E&M
- Multiple Surgery Reduction
- Duplicate Claims
- Photophoresis
- Hospice Related Services
- Global Period
- Etc., Etc., Etc.

Auditing for Diagnosis Coding

- Often ignored in physician audits
- In the past has not affected physician payment
- Review for the correct code assignment and correct code sequence
- Will affect the payment more often in the future
- ICD-10-CM provides for more specificity

Choosing the Audit Sample

This will depend on the type of audit

- If there is no specific problem being investigated – 10 encounters per provider for a proactive or compliance audit
  - "Random" sample – one days' visits, first 10 on EOB, etc.
  - Also called a judgment sample – cannot be extrapolated to a larger population since it is not truly random

OIG recommends 5 per provider per federal payer per year

- If investigating a specific problem, may consider a statistically valid random sample
- Probe sample followed by larger sample with a targeted confidence and precision
  - Probe usually 30, 40, or 50 items
- CMS requires that the sampling methodology be reviewed by a statistician or someone with equivalent experience.

Time Frame?

- The time frame to be reviewed will also depend on the reason for the audit
  - Proactive or compliance audit – may be more helpful to choose recent claims – if the purpose is education, better to work with recent visits that the provider may remember – there may have also been changes in documentation patterns
  - Audit for a specific problem will need to be for the time frame for which the problem is suspected.

RAT-STATS

- Software program used by the OIG to identify statistically valid random samples

http://oig.hhs.gov/organization/oas/ratstats.asp

CIA?

Corporate Integrity Agreement

- "Forced" compliance plan when an organization had entered into a settlement for fraud allegations
- Require periodic audits to ensure that the coding/billing problems are resolved
- Requires a 95% accuracy.

What You Need To Look At

- Documentation of Encounter
- Superbills/Encounter Forms
- Claim Forms
- EOBs/Remittance Advice
- Payer Policies

- Depending on service audited, may also need to review other documentation –
  - Ex: For incident-to services, you will need to review entire chart for plan of care and ongoing care by supervising physician.

Shadow Audits

- Observing/listening to the physician-patient interaction
- Review the physician documentation and code choice
- Discuss missing elements and make recommendations

Can also be helpful to discuss documentation with provider immediately after visit even if auditor does not actually shadow.

Involve An Attorney?

- Some protection may be provided by auditing under attorney-client privilege
- Requires:
  - Attorney-client relationship
  - Attorney acting in capacity as attorney
  - Communication made in confidence between the attorney and client
  - For the purpose of securing legal advice.

Work-Product Doctrine:

- Documents tangible things – interview memos and notes
- Prepared in anticipation of litigation – temporal and intent
- By or for a party's attorney are protected against discovery unless the party seeking disclosure can demonstrate:
  - Substantial need
  - That it would produce undue hardship without discovery

Routine audit reports may not be protected.

Attorney-Client Privilege

- Attorney contracts with the auditor/consultant
- Report is delivered to the attorney
- Communication between the auditor and the client is at the direction of the attorney

Simply marking a report "Attorney-Client Privilege" does not make it protected.

Questions?

- What is an error?
  - Just overpayments or any deviation
- Prospective or retrospective?
- What will be your acceptable error rate?
  - CIAs allow 5%
  - In other situations, CMS has stated 7%
- What will you do with the results?
  - Education, follow-up auditing, penalties?

Gray Areas

Coding, especially evaluation and management coding, is full of gray areas. How will your practice interpret these?

Examples –

- Which components are accepted or mandatory for established patients?
- Is “non-contributory” acceptable documentation?
- What is a detailed examination under the 1995 CMS Documentation Guidelines?

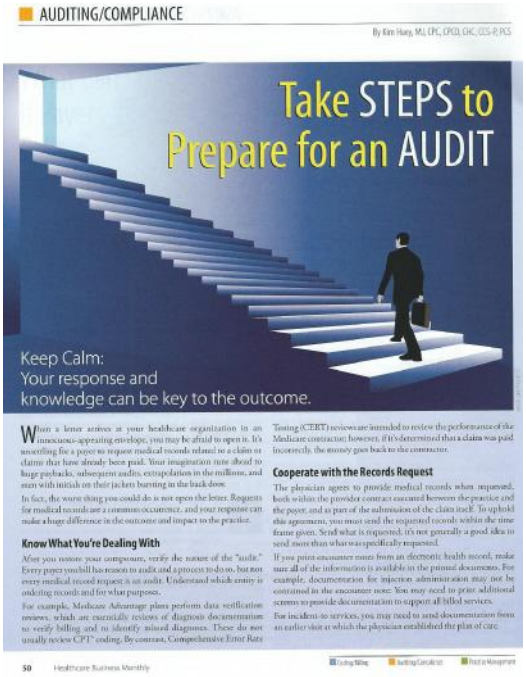
Some of these may be answered by your MAC – but will you extend those definitions to all payers?

Followup Education?

How effective is this compliance and auditing program if you never educate the providers on how to “do it right”?

Education should be:

- Timely
- Targeted
- Group or Individual?



AUDITING/COMPLIANCE

By Kim Hany, MJ, LPC, CPCO, CHC, CCS-P, PCS

Take STEPS to Prepare for an AUDIT

Keep Calm:
Your response and knowledge can be key to the outcome.

When a letter arrives at your healthcare organization in an innocuous-appearing envelope, you may be afraid to open it. It's unsettling for a payer to request medical records related to a claim or claims that have already been paid. Your imagination runs ahead to huge paybacks, subsequent audits, extrapolation in the millions, and men with initials on their jackets bursting in the back door.

In fact, the worst thing you could do is not open the letter. Requests for medical records are a common occurrence, and your response can make a huge difference in the outcome and impact to the practice.

Know What You're Dealing With

After you restore your composure, verify the nature of the "audit." Every payer you bill has reason to audit and a process to do so, but not every medical record request is an audit. Understand which entity is ordering records and for what purposes.

For example, Medicare Advantage plans perform data verification reviews, which are essentially reviews of diagnosis documentation to verify billing and to identify missed diagnoses. These do not usually review CPT® coding. By contrast, Comprehensive Error Rate Testing (CERT) reviews are intended to review the performance of the Medicare contractor; however, if it's determined that a claim was paid incorrectly, the money goes back to the contractor.

Cooperate with the Records Request

The physician agrees to provide medical records when requested, both within the provider contract executed between the practice and the payer, and as part of the submission of the claim itself. To uphold this agreement, you must send the requested records within the time frame given. Send what is requested; it's not generally a good idea to send more than what was specifically requested.

If you print encounter notes from an electronic health record, make sure all of the information is available in the printed documents. For example, documentation for injection administration may not be contained in the encounter note. You may need to print additional screens to provide documentation to support all billed services.

For incident-to services, you may need to send documentation from an earlier visit at which the physician established the plan of care.

Responding to Audits

1. Know what you're dealing with – what is the auditor looking for?
2. Cooperate!
3. Play detective – be smart about who responds to the records request.
4. Consider whether to engage an attorney.
5. Know your rights!
6. Learn from the findings

Who can audit your records?

Anyone who pays you money! But what they are looking for and the approach will differ –

- Medicare Advantage plans – verify diagnoses and look for missed diagnosis opportunities
- Recovery Audit Contractors
- Zone Program Integrity Contractors
- Medicare Administrative Contractors
- Medicaid
- Private Payers

Compliance Issues in the Electronic Medical Record

Issues

- Is meaningful use really meaningful?
- Is information available between entities?
- Is the quality of care improved – or even maintained?
- Is the health information secure?
- **Are medically necessary services provided, documented, billed for, and reimbursed appropriately?**

Balancing Medical Necessity and Meaningful Use

- Bringing forward medical history in an EMR is an important aspect of meaningful use
- Does this mean that you can count that comprehensive history toward the level of service for every encounter now and forevermore?
- What about medical necessity of elements? For example, vitals on every patient?

Physician Response

What do physicians dislike most about their EMR?

- 28.1% interferes with Face to Face/patient time
- 21.9% lack of clinical interoperability
- 18.8% slows down productivity

Physician Response

Study: What Do Physicians Read (and Ignore) in Electronic Progress Notes?

- Most attention given to Impression and Plan
- Very little attention given to vital signs, medication lists, and laboratory results

"Optimizing the design of electronic notes may include rethinking the amount and format of imported patient data as this data appears to largely be ignored."

Applied Clinical Informatics

http://aci.schattauer.de/en/home/issue/special/manuscript/21088/show.html

Concerns with electronic records and overcoding

The Center for Public Integrity –

September 2012

"coding levels may be accelerating in part because of increased use of electronic health records…."

"easy to create detailed patient files with just a few clicks"

"longer and more complex visits are easier to document"

It's a New World

Paper Records: Not documented, not done.

Electronic Records: You documented it, but did you really do it?

Sebelius-Holder Letter

September 24, 2012

"False documentation of patient care is not just bad patient care; it's illegal. The indications include potential 'cloning' of records in order to inflate what providers get paid."

http://www.nytimes.com/interactive/2012/09/25/business/25medicare-doc.html

Congressional Response

October 4, 2012 letter to HHS Secretary Sebelius

"…your EHR incentive program appears to be doing more harm than good."

Request –

- Suspension of EHR bonus payments and delay penalties for providers who don't use EHR
- Increase what's expected of meaningful users
- Block business practices that prevent exchange of information

OIG Workplan for 2012

"We will assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service based upon the content of the service and have documentation to support the level of service reported."

Previous OIG Reports

- 2011 – measured EHR use –
- 2012 – measured EHR use and specified which system

Neither study analyzed effectiveness or impact on coding

OIG 2016 Compendium of Unimplemented Recommendations

- ONC and CMS should collaborate to develop a comprehensive plan to address fraud vulnerabilities in electronic health records (EHR).

This recommendation relates to
Top Management Challenge

Meaningful and Secure Exchange and Use of Electronic Information and Health IT

Expected Impact

improved program integrity

protecting beneficiaries

personalized/tailored information

HEALTH INFORMATION TECHNOLOGY

Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology

RECOMMENDATION

ONC and CMS should collaborate to develop a comprehensive plan to address fraud vulnerabilities in electronic health records (EHR).

OUR OBJECTIVE was to determine how hospitals that received EHR Medicare incentive payments, which are administered by CMS, had implemented recommended fraud safeguards for EHR technology. We found that nearly all hospitals with EHR technology had RTI International (RTI)–recommended audit functions in place, but they may not be using them to their full extent. We also found that nearly all hospitals were using RTI-recommended data transfer safeguards, and all hospitals employed a variety of RTI-recommended user authentication and access controls. ONC, which coordinates the adoption, implementation, and exchange of EHRs, contracted with RTI to develop recommendations to enhance data prevention, increase data validity, accuracy, and integrity, and strengthen fraud protection in EHR technology.

We found that only about one-quarter of hospitals had policies regarding the one of the copy-paste features in EHR technology which, if used improperly, could pose a fraud vulnerability.

Implementation Status

CMS and ONC concurred with the recommendation. CMS stated that it continues to work with ONC to develop a comprehensive plan to detect and reduce fraud. CMS also stated that it is conducting prepayment audits as well as postpayment edit checks. Although we acknowledge the usefulness of conducting audits and prepayment checks as a strategy to detect fraud and abuse, these efforts do not address our recommendation to work with ONC on strengthening its collaborative efforts. ONC stated that it is committed to providing technical assistance to Federal agencies that have health care fraud enforcement authority. We believe that all divisions of the Department have a shared responsibility for the integrity of departmental programs, regardless of whether they have health care fraud enforcement authority.

Report OEI-01-11-00570 • December 2013

OIG / OIG Compendium of Unimplemented Recommendations | April 2016 | 41

What are the auditors looking for?

- Authentication – signatures, dates/times – who did what? (metadata?)
- Contradictions – between HPI and ROS, exam elements and impression and plan
- Wording or grammatical errors/anomalies
- Medically implausible documentation

Code Generators

- Is the coding software programmed for the 1995 or 1997 Documentation Guidelines?
- Has the coding software been programmed to account for medical policies specific to the local Medicare contractor?
- How does the coding software manage dictated portions of the encounter such as History of Present Illness?
- How does the coding software distinguish between the levels of medical decision-making?

Templates

- Is the provider able to choose only part of a template or to personalize a template?
- Are there multiple templates, personalized for complaint or diagnosis?
- Are the various contributors to the encounter identified? Nursing staff, physician, etc.

Cloned Notes

"Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

First Coast Service Options, Medicare Part B newsletter 2006

(Definitions published by Medicare contractors as early as 1999.)

Cloned Notes

November/December 1999 Medicare Bulletin:

"Cloned notes are notes that have little or no change from day to day and patient to patient. These types of notes do not support the medical necessity of a visit. More importantly, in some cases, they may not actually support that a visit occurred. Cloned notes may be construed as an attempt to defraud the Medicare program."

Cloned Notes

Whether the documentation was the result of an Electronic Health Record, or the use of a pre-printed template, or handwritten documentation, cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. Identification of this type of documentation will lead to denial of services for lack of medical necessity and the recoupment of all overpayments made.

- NGS Medicare -

Copy and Paste

AHIMA Position Statement – March 17, 2014

Called on industry stakeholders, EHR system developers, the public sector, and healthcare providers to work together to implement standards for the appropriate use of copy and paste

Why copy and paste?

"…most physicians use the functionality simply to save time. They have not been given the time and training needed to become fully proficient with their new systems, so they create workarounds to help them get through their day."

Heather Haugen, PhD

"Overcoming the Risks of Copy and Paste in EHRs"

Journal of AHIMA, June 2014

June 2014 – JAMA Internal Medicine – University of Wisconsin School of Medicine and Public Health and the University of Wisconsin Hospital and Clinics:

- "it is too easy, and often mistaken, to equate a physician's routine use of copy-and-paste with fraud. Data replication is a feature of electronic health records; facts beyond the mere use of duplicated text are required to establish that a note may be fraudulent."
- It can be efficient and clinically useful when used properly, and that EHRs are "not to blame for the carelessness of individual physicians."

Issues with Copy and Paste

- Outdated or redundant information
- Inability to identify the author or date of origin of information
- Unnecessarily lengthy notes
- Appearance of fraudulent activity – e.g., billing twice for the same "work"
- Quality of care and medico-legal integrity are compromised

Diagnosis Coding

- Have the physicians been educated in diagnosis coding?
- Has the diagnosis code listing been personalized for that practice and that physician?

As more physician payment mechanisms are based on severity of illness, correct and specific diagnosis coding becomes more important – to the physician.

Finalizing the Documentation

Code Selection

- Is the physician able to override the code selected by the EHR?
- Can he/she override the code to a higher level or only to a lower level of service?

Signatures

- Is the provider able to sign off on multiple items with one “sign-off” – multiple encounters, test results, phone calls, prescriptions

Timing of Billing

- Is the documentation complete before the encounter is billed?
- For ancillary services, is the bill "dropped" based when the order is entered or when the test is performed and results entered?

Live Compliantly in this Complex World!

- Understand the compliance risks you face
  - What is unique about your practice?
- Know what is going on – audits find what we don't know – and that leads to fixing it!
- Be prepared for someone else to look into your practice
- Live fully and peacefully in the electronic world!

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