Designing and Implementing an Auditing Program for Physician Practices

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Why aren’t practices auditing?

• “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

• Coding and Billing

• HIPAA

• Other areas such as Stark, Anti-Kickback, employment policy
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
• $5500-$11,000 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


• Signatures
• Orders for diagnostic testing
• Lack of documentation to support codes billed
Recovery Audit Issues
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.
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
  – It to be 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?

EHR Auditing Issues

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

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

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

## Other Areas

- CLIA
- OSHA
- Stark
- Anti-Kickback
- Exclusions List
- Employment Policy

All areas need to be reviewed on a regular basis – consider an umbrella approach, empowering staff involved in the specific area – report to Compliance Officer.
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