

# Compliance (Risk) Auditing vs. Forensic Auditing

Understanding the difference.

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# PRESENTATION GOALS

- Understand the difference between “Compliance (Risk)” and “Forensic (Error)” based audits
- Understand How to Identify and Classify Appropriate Criteria
  - Controlling vs. Persuasive Criteria
  - Conditions of Participation vs. Conditions of Payment
  - Coding vs. Reimbursement Rules
- Understand how to build unassailable credibility and effectively communicate your audit results

# SO YOU'VE BEEN ASKED TO PERFORM AN AUDIT...

- Compliance (Risk) Auditing vs. Forensic Auditing
  - Compliance (Risk) Auditing: An audit that is performed to evaluate not only compliance with binding standards, but where those standards are either non-existent or ambiguous, the degree of compliance with other industry standards even though not adopted by the payer.
  - Forensic (Error) Auditing: An audit that is performed to determine objective error (or compliance) with the express written standards imposed by the payor as either a condition of participation or condition of payment.
- Understanding the Type of Audit is Critical
  - Identification of Appropriate Criteria
  - Legal implications of the results

# IDENTIFICATION OF APPROPRIATE CRITERIA

- Criteria Analysis is the Most Critical and First Step in Any Audit
  - HHS OIG Office of Audit Services – *The Audit Process*, 2<sup>nd</sup> Ed. January 2005.
    - In compliance/risk auditing, this step is called Risk Analysis
    - In forensic auditing, this step is called Standards Analysis
- Two Types of Criteria
  - Binding – Establishes a Legal Performance Obligation
  - Persuasive – Generally Accepted Industry Guidance.

# IDENTIFICATION OF APPROPRIATE CRITERIA

- Binding Criteria/Controlling Standards is/are Found...
  - Commercial Payers
    - Applicable Statutes, Regulations
    - Contractual provisions
      - Possibly Medical Policies if Incorporated Under the Contract
  - Medicare
    - Medicare Statute
    - Implementing Regulations
    - Medicare Pubs / Internet Only Manuals

# CONTROLLING VS. PERSUASIVE STANDARDS

- The Nature of Controlling Standards
  - Establish what you **must** do as opposed to what you **should** do.
  - Legal duty to perform - established expressly by statute/regulation or by express contractual provision
  - Controlling standards trump everything else, no matter how common or how well accepted in the industry.
  - Segregating “musts/shalls” from “shoulds” within the standard.



# CONTROLLING VS. PERSUASIVE STANDARDS

- Types of Controlling Standards
  - What is “Law”?
    - Legislature Makes the Laws (Statutes)
    - Executive Branch Agency Charged with Enforcement is Empowered to Implement Regulations for Enforcement.
      - Regulation must be within the scope of the statute.
      - Cannot create new rules by regulation.



# CONTROLLING VS. PERSUASIVE STANDARDS

- Types of Controlling Standards
  - Case Law – Courts Interpret the law and by doing so, can sometime change how the law is applied either generally or in specific fact scenarios.
    - Understanding Jurisdiction
    - State Courts
      - Statewide Appellate and Supreme Court Decisions have Binding Effect Across the State and Potentially Persuasive Effect Elsewhere.
    - Federal Courts
      - District Courts (Decisions are potentially controlling in the District and persuasive elsewhere).
      - Nine Circuit Courts of Appeal (decisions controlling in the Circuit only, persuasive elsewhere)
      - Supreme Court (decisions are controlling over all lower federal and state Courts relative to federal law and/or constitutional issues).

# CONTROLLING VS. PERSUASIVE STANDARDS

- Types of Controlling Standards
  - Contractual Terms
    - Commercial Carrier Contracts
      - Provider – Carrier: Defines standards for participation primarily and may include coding and reimbursement standards as well.
      - Subscriber – Carrier: Defines carrier coverage obligations.
      - The Subscriber Contract Always Trumps the Provider Contract relative to issues of coverage.
    - Incorporated Standards
      - CPT?
      - CMS?
      - Medical Policies and Provider Billing Manuals?
    - What Happens in the Event of a Breach?

# CONTROLLING VS. PERSUASIVE STANDARDS

- **Persuasive “standards”**

- Provide guidance in the absence of statutory, regulatory or contractual provisions.
- Not all are of equal value or validity. The quality of the source and the quality of and basis for the opinion will determine its value.
- Coding Decisions
  - Persuasive standards can be used by providers to explain why a particular code was used but only in the absence of a binding standard to the contrary.
- Audit Determinations:
  - **Persuasive Standards cannot be imposed as a basis for error but can be used to identify potential risk**

# ASSESSING CREDIBILITY OF PERSUASIVE STANDARDS

- Commonly relied on in the industry?
- Credibility of the Author?
- CPT Assistant
  - Who authors CPT – Who authors the CPT Assistant?
  - Consider the Disclaimer:
    - *“CPT® Assistant is designed to provide accurate, up-to-date coding information. We continue to make every **reasonable effort to ensure the accuracy of the material presented.** However, this **newsletter** does not replace the CPT codebook; it only serves as a guide.”*
- Is the justification for the opinion expressed disclosed?

# IDENTIFICATION OF APPROPRIATE CRITERIA

- **Potentially** Persuasive Criteria is Found...
  - LCDs
  - Carrier Publications (MedLearn, Commercial Carrier Provider Newsletters)
  - Industry Publications (CPT Expert, CPT Assistant, CPT Changes)
  - Carrier Training Materials
  - Blogs
  - Forums
  - Periodicals
  - Conference Presentations

# UNDERSTANDING A CONTROLLING STANDARD'S SIGNIFICANCE

- Identifying the Significance of the Standard
  - Does the Rule Establish:
    - Condition of Participation?
    - Condition of Payment?
    - Coding Rule?
    - Reimbursement Rule?
  - What is the difference?
  - How to you tell?
  - What impact will this have on your audit result?



# CONDITION OF PARTICIPATION OR PAYMENT?

- **Conditions of Participation:**

- A condition or performance standard that must be met in order to be a participating provider.
  - Common examples include licensure, having malpractice coverage, etc.
  - Depending on the language of the contract, may include compliance with provider billing guide or medical policy standards.

- **Conditions of Payment**

- In commercial plans these are usually fundamental coverage requirements found in the beneficiary agreement but could include (depending on the contractual language) compliance with other standards; e.g. medical policies and/or documentation content or other standards establishing preconditions to coverage.



# CONDITION OF PARTICIPATION OR PAYMENT?

- Commercial Plans:
  - Look to the contract for a performance obligation and identify the remedy for non-performance.
  - Also look for recoupment provisions – standalone or incorporated into a UR provision.
- Medicare
  - Conditions of payment are usually statutorily based; e.g.
    - Physician certification must exist for PT/OT/Home Health
    - Chiro – Subluxation must be demonstrated by PART exam or X-Ray
  - In many cases, documentation guidance is written as a condition of participation but applied as a condition of payment.

# CONDITION OF PARTICIPATION OR PAYMENT?

- Does non conformance with interpretive guidance mean that you are not entitled to payment?
  - FCA Case law:
    - *Universal Health Services v. United States ex rel. Escobar* – US Supreme Court held:
      - the precise label that the government affixes to the relevant law or contract such as, compliance is a “condition of payment”—is not determinative of whether the claim is “false or fraudulent”
      - Instead, it ruled that an implied certification theory can be a basis for FCA liability only if two conditions are satisfied:
        - (1) “the claim does not merely request payment, *but also makes specific representations about the goods and services provided*”; **and**
        - (2) the defendant must fail to disclose its noncompliance with a provision that is “material” to the government’s decision to pay.
    - Identifying standards that establish truly binding payment criteria.
    - Application to LCDs – especially those with guidance beyond the permissible scope of an LCD.

# CODING VS. REIMBURSEMENT RULES

- **Coding Rules:**

- A coding rule addresses how a service is to be reported.
  - Not all payers publish clear code utilization rules.
  - In the absence of specific guidance, risk analysis might have to address CPT Editorial Panel Rules (relative to code selection but possibly not as to bundling)

- **Reimbursement Rules:**

- A reimbursement rule addresses whether a service, properly represented, is compensable under the circumstances
  - e.g. Bundling rules such as CCI
  - In the absence of a payer specific reimbursement rule, a compliance audit may need to contemplate other reimbursement standards that a payer might attempt to impose in a post-payment audit (e.g. bundling under CCI where CCI has not been adopted by the payer).

## EXAMPLE - RESOLVING A CODING DISPUTE – WHO IS RIGHT AND HOW DO YOU PROVE IT?

- Most disputes result from the application of unincorporated standards by one side of the dispute or the other.
  - Reliance on the “everyone knows” standard
  - Reliance on published guidance that is not incorporated by the statute, regulation, provider contract or medical policy that is applicable to the payer involved.
  - Failing to differentiate between coding rules and reimbursement rules.
- Some disputes are the result of legitimate ambiguity in a binding standard.

# THE FUNDAMENTAL CODING RULE

- Health Insurance Portability and Accountability Act of 1996
  - Code Set Standard
    - Published by HHS as mandated by HIPAA on Aug 17, 2000, Effective Date Oct. 16, 2000 and Compliance Date of Oct 16, 2002.
    - Diagnosis Codes – ICD-9-CM Vol 1 & 2 (ICD-10CM 10/1/2015)
    - Inpatient Procedures – ICD-9-CM Vol 3 (ICD-10-PCS 10/1/2015)
    - Physician Services – CPT/HCPCS Level II
    - Drugs and Biologicals – NDC
    - Dental – CDT

# THE FUNDAMENTAL CODING RULE

- Relevant Sections from the Official Comments
  - Covered entities must use code sets
    - All carriers are covered entities and most all providers are as well (transmit PHI data in ANY electronic form).
  - Code set limited to code/description
    - Correlation with transaction standards
  - How codes are used is defined by the carrier
  - In Summary – Codes/Descriptions are standard – the rules for how the codes are used are not.



# CODE UTILIZATION STANDARDS

- **Controlling Standards**

- State statutes may impose binding standards
  - workers compensation
  - health insurance
  - Auto insurance
  - general fraud laws
- Federal statutes/Regulations
  - Medicare/Medicaid – HHS
  - TriCare - DOD
  - Federal Workers Comp - OPM
  - ERISA – Deferring to plan document
- Auditors must recognize when a statutory provision applies and become familiar with these standards so that coding determinations and audit results are legally defensible.



# CODE UTILIZATION STANDARDS

- Commercial Payers:
  - CPT and HCPCS guidelines are not binding unless expressly adopted by the payer. In many cases, there is not a wholesale adoption of these code utilization rules.
  - CPT and HCPCS guidelines can be adopted, modified, or ignored by payer contracts/medical policies or by laws that impose coding standards
  - Where no code utilization guidelines are specified by the payer, CPT guidance, as an industry standard, is nonetheless a persuasive standard and can provide a solid basis for justifying code choices or identification of risk in an audit.
- Medicare:
  - CMS relies on CPT Editorial Panel guidance in the CPT Manual for resolving code selection issues. See Pub 100-8, Ch. 3, §3.6.2.4.

# BUILDING CREDIBILITY IN YOUR CODING DECISIONS AND AUDIT RESULTS

- **Expressing Audit Findings**
  - Forensic Analysis – Identification of Controlling Standards
    - Condition of Participation?
    - Condition of Payment?
    - Appropriateness of Codes Reported?
      - Reimbursement Implications?
  - Risk Analysis – Can be based on Persuasive Standards where Controlling Standards don't exist or are ambiguous or where experience tells you that “enhanced” standards are commonly applied by the payer.

# LEGALLY ACCURATE CODING / AUDIT RESULTS

- Takeaway Points for Coders/Auditors
  - Code selection is “Legally Accurate” where the code was derived from application of a binding code utilization standard.
  - Code selection is “Legally Justifiable,” in the absence of a binding standard, where the code was derived from application of a persuasive code utilization standard.
  - An audit result is “Legally Accurate,” as an expression of error, where the result is based on application of binding conditions of participation or payment.
    - Error has overpayment implications on when the standard is a condition of payment.
  - An audit result based on a persuasive standard is at best a statement of potential risk.

# COMPLIANCE VS. FORENSIC AUDITS

- Compliance (“Risk”) Audits
  - The purpose of the audit is to identify where potential risk might exist. Auditors can apply binding standards and any other persuasive standard that experience tells you will be applied by the payer.
    - e.g. E/M Coding Audits
- Forensic (“Error”) Audits:
  - The purpose is to identify non-conformance with established and binding standards.
    - Violation of conditions of payment creates overpayment liability.
    - Violations of conditions of payment creates administrative sanctions liability.
  - Justification of error by reference to an unincorporated and therefore persuasive standard is not proper.

# COMPLIANCE AND FORENSIC AUDITS

- Audit of Claims Submitted to Commercial Carriers
  - Impact of Non Participation
    - Commercial Carriers – Policies Relevant?
      - *Schoedinger v. United Healthcare of Midwest, Inc.*  
Carrier medical policies irrelevant with respect to non-par provider. Provider could not enforce terms against carrier and carrier would therefore be prohibited from enforcing them against the provider.
  - Implication in a Risk / Error Based Audit

# COMPLIANCE AND FORENSIC AUDITS

- Takeaway Points
  - Don't ever fail to test the validity of a persuasive standard – no matter how commonly accepted it is.
  - Coders:
    - May use persuasive standards to justify the reasonableness of their code selection choices and/or internal coding policies only where binding guidance does not exist.



# COMPLIANCE AND FORENSIC AUDITS

- Takeaway Points
  - Auditors:
    - May not apply a persuasive standard as a means of justifying a declaration of error.
    - May not apply a persuasive standard to interpret a controlling standard as a means of justifying a declaration of error.
    - May not argue that a provider's failure to conform to a persuasive standard is justification for an error
    - Cannot apply a condition of participation as a basis for declaring an overpayment.



# REPORTING TIPS – COMPLIANCE (RISK) AUDITS

- Identify the Concern
  - Code selected by the provider vs. the proposed correct code.
- Identify the Code Utilization Standard
  - If Binding
    - The specific statutory, regulatory or contractual provision that makes that utilization standard binding.
    - The reason that the proposed correct code is objectively correct under that standard.
    - Identify the reimbursement implications.

# REPORTING TIPS – COMPLIANCE (RISK) AUDITS

- Identify the Code Utilization Standard
  - If Persuasive
    - Identify the reason for selection of the persuasive standard chosen.
    - The reason that the proposed correct code is objectively correct under that standard.
    - Identify other standards (if they exist) that might provide a more favorable result and why that standard was not chosen.
- Provide a specific recommendation for corrective action.
- This information will permit the provider to make an informed decision.

# REPORTING TIPS – FORENSIC AUDITS

- The Audit Report:
  - Present the factual findings objectively.
    - For each allegation of error, identify the specific provision of the binding standard that was applied as well as the factual findings supporting the allegation of error.
      - Where overpayments resulted, identify the statutory or contractual requirement that permits recoupment (where it exists) and advise accordingly. Where no such requirement exists, consider recommending a refund in any event.
    - Present any risk concerns and the persuasive standard applied as the basis for those concerns. Identify the reason for selection of the persuasive standard chosen. Identify other standards (if they exist) that might provide a more favorable result and why that standard was not chosen.
      - Make appropriate corrective action recommendations.

# COMMUNICATION TIPS - AUDITS

- The Audit Report:
  - Drafting Tips
    - Avoid Being Overly Negative. Don't forget to point out what the provider did well.
    - Do not overstate potential risks - present concerns objectively. Present options and associated risks of each potential course of action.
    - Corrective action recommendations should include specific solutions for mitigating risk.
    - Do not render legal conclusions.

# COMMUNICATION TIPS – COMPLIANCE AUDITS

- Verbal Discussions of Audit Results:
  - Should only occur **AFTER** the provider has reviewed the audit report.
  - **LISTEN** to the concerns or questions of the auditee.
  - Remain unemotional and objective.
  - Be helpful and supportive when discussing options and recommendations for corrective action.
  - Focus on the solution rather than the problem.
  - With respect to issues of compliance risk – be sure to understand the provider's compliance objectives and be willing to accept a decision that is different than what you are recommending.

# SUMMING UP

- Criteria Analysis Must Come First
  - We need to know the appropriate code utilization rules to code and certainly must know those rules to perform an audit.
  - Understand how to differentiate conditions of payment and participation to determine risk.
  - Understand how to identify and apply coding vs. reimbursement rules
  - Learn how to find and differentiate binding from persuasive standards
    - Remember - There are no universal truths in coding or reimbursement.



# SUMMING UP

- Whether coding or auditing, learn how to differentiate issues of potential error from those involving risk and make recommendations accordingly.
- Communicating Concerns:
  - Continually improve your written and verbal communication skills so that your concerns are understood.
  - Be objective and remember that your obligation is merely to provide an accurate and defensible assessment of either error, risk or both.
  - Be open to potential alternative conclusions where ambiguity in a binding standard or where multiple persuasive standards exist.



# SUMMING UP

- **Compliance Auditing:**
  - The objective of a compliance/risk audit is to supply the physician/provider with sufficient information so that he or she can make an informed choice about how to proceed.
- **Forensic Auditing:**
  - The objective of a forensic audit is to develop a legally defensible statement of error.



# Questions? **CEU Code:**