The Art of Auditing

PRESENTED BY:
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Sean Weiss, CPMA, CPC, CCP-P, ACS-EM
Shannon O. DeConda, CPC, CPMA, CEMC, CPC-I, CMICS

AGENDA

• Frank Cohen will be discussing consistency in auditing, E&M Utilization and CCRA.
• Sean Weiss will be discussing Compliance.
• Shannon O. DeConda will be discussing how to perform the audit.
The Art of Auditing
“Compliance”

Sean M. Weiss
Partner/VP & CCO

Monetary Results

- During Fiscal Year (FY) 2013:
  - The Federal government won or negotiated over $2.6 billion in health care fraud judgments and settlements

Enforcement Actions

- OIG’s 2014 Semiannual Report revealed expected recoveries of more than $3.1 billion consisting of:
  - $295 million in audit receivables and about $2.83 billion in investigative receivables from areas such as the states’ shares of Medicaid reallocation, which means you need to be extra careful to avoid billing errors and stay out of OIG hit list. Medicare fee schedule cuts threatening bottom lines.
  - $294.1 million in investigative receivables from areas such as the Medicare Fraud Strike Force efforts that resulted in the filing of:
    - charges against 94 individuals or entities;
    - 107 criminal actions, and;
    - $294.1 million in investigative receivables
- OIG reported:
  - 482 civil actions against individuals or entities that engaged in crimes against HHS programs; and
  - 360 civil actions, which include false claims and unjust enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements, and administrative recoveries related to provider self-disclosure matters.
Auditing is an Art not An Exact Science

- Is the above statement true?
- Is there a definitive when it comes to auditing?
  - Chief Complaints, HPI, ROS, PFSH, The Exam
  - What about the MDM?
    - There is a balance between what the guidelines recommend vs. what the provider tells us...
    - At the end of the day aren't guidelines just that... “Guidelines”
- What about “Medical Necessity”
  - Services are performed in accordance with generally accepted standards of medical practice
  - What about the “Treating Physician” Rule?

WHO DETERMINES WHAT IS “MEDICALLY NECESSARY”?

A. *Treating Physicians* - The first section of the Medicare statute is the prohibition “Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.”

From this, one could conclude that the beneficiary’s physician should decide what services are medically necessary for the beneficiary, and a substantial line of authority in the Social Security disability benefits area holds that the treating physician’s opinion is entitled to special weight and is binding upon the Secretary when not contradicted by substantial evidence.

Some courts have applied the rationale of the “treating physician” rule in Medicare cases, and have rejected the Secretary’s assertion that the treating physician rule should not be applied to Medicare determinations.

- In *Holland*, the court concluded:
  - Though the considerations bearing on the weight to be accorded a treating physician’s opinion are not necessarily identical in the disability and Medicare context, we would expect the Secretary to place significant reliance on the informed opinion of a treating physician and either to apply the treating physician rule with its component of “some extra weight” to be accorded that opinion, even if contradicted by substantial evidence, or to supply a reasoned basis, in conformity with statutory purposes, for declining to do so.

How Does Auditing Impact Compliance

- What we learn from our audits should translate into compliance...
  - Policies and Procedures are derived from audits or in theory should be
    - If we use out of the box P&Ps without modification are we really compliant?
    - If we are not updating our P&Ps based on our audit findings do we have P&Ps?
  - As a result of audit findings, providers as always can expect to see increased efforts by the federal government to prevent, identify, and punish healthcare fraud.

CMS’ action plan:
  - Increased number of prepayment reviews
  - Increased post-payment reviews of medical necessity and medical record documentation supporting claims
  - Overpayment recovery
  - Providers identified by the audit as submitting improper claims will be targeted for more extensive investigation
  - Increased review of evaluation and management claims (2010 study shows that more than 55% of levels selected were incorrect.)
  - Demand for more documentation from providers who submit claims
CMS’s Breakdown of Errors

Executive Order 13520 on reducing improper payments states that the Federal Government must make every effort to ensure that the right recipient receives the right payment for the right reason at the right time.

Assignment of Error Categories

Based upon the review of the medical records, claims identified as containing improper payments are categorized into the appropriate error category. The five improper payment categories in the CERT program are outlined below.

- No Documentation Errors—Claims are placed into this category when either the provider or supplier fails to respond to repeated requests for the medical records or the provider or supplier responds that they do not have the requested documentation.
- Insufficient Documentation Errors—Claims are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the reviewers at the CERT contractor could not conclude that some of the allowed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed by someone other than the billing provider.
- Medical Necessity Errors—Claims are placed into this category when the reviewers at the CERT contractor receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based on Medicare coverage policies.
- Incorrect Coding Errors—Claims are placed into this category when the provider or supplier submits medical documentation supporting (1) a different code than that billed, (2) that the service was performed by someone other than the billing provider, (3) that the billed service was unbundled, or (4) that a beneficiary was discharged to a site other than the one coded on a claim.
- Other Errors—Claims are placed into this category if they do not fit into any of the other categories (e.g., duplicate payment error, non-covered or unallowable service).

OIG Releases EM Services Study

56 percent of claims for E/M services in 2010 were incorrectly coded and/or lacking documentation

- Medicare inappropriately paid $6.7 billion for these claims, representing 21 percent of Medicare payments for E/M services in 2010
- 26 percent were upcoded and 15 percent were downcoded
- Nearly 7 percent of claims for E/M services in 2010 were both incorrectly coded and insufficiently documented

Coding Policies & Procedures to Consider

- Annual Coding Audit Elements—These are based on the OIG Work Plan for the FY or in past years
- Annual Coding Review and Escalation Process—This helps us to determine acceptable thresholds for providers compliance scores
- Provider Billing Review—This defines the process of how we ensure accuracy with claims submission
- Documentation Guidelines—This ensures E/M levels of service are documented in accordance with CMS and MAC standards
- Incident-to Procedural Billing for Medicare—This provides guidance on how to properly merchandise services.
- Split/Shared Services—See above
- Unbundling—This ensures we are not providing services that are considered to be inclusive of

- Modifiers—This ensures proper application of the most over-used modifier, such as those that are a bit obscure
- Credentialing of Non-Physician Practitioners—This ensures we are following requirements of commercial and governmental payors
- Locum Tenens and Reciprocal Billing Arrangements—This ensures that the Q5 and Q6 modifiers are appended appropriately to the claims to identify use of the these services and providers
- Advance Beneficiary Notice—This ensures the correct usage and verbiage on the form
- Medical Decision Making and Medical Necessity—This outlines the methodologies used to determine the complexity of decision making from a quantification standpoint and speaks to the overarching criteria used to determine Medical Necessity.
Thank You!

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Performing the Audit

Shannon O. DeConda,
CPC, CPMA, CEMC, CPC-I, CMSCS
President and Founder of NAMAS,
Partner, DoctorsManagement, LLC

Why are internal audits performed?

• To make sure your physicians and extenders are not under-coding and/or over-coding?
• You are responsible for identifying revenue opportunities (coding) for your practice?
• Because your compliance plan tells you that you must?
• To avoid going to E&M coding jail – or the real one?
How will internal audits help your practice?

• Maintain a high level of compliance
• Educational resource for the providers and staff
• Ensure reimbursement is accurate
  o Not too much
  o Not too little
  o APPROPRIATE

TARGETED SERVICES- E&M

• E&M services are the easiest to audit
• Due to the subjectivity of E&M services, and the frequency of reporting they are easy to request refunds for
• Most common miscoded service
  • 60% of providers do not have a clue of what or how to document
  • 20% of providers do not care
  • 10% are so paranoid they automatically under-code
  • Only about 10% of providers get it right

The 3 Views of Documentation

• Think about the average patient encounter
• Now let me ask you....
  o Who creates the documentation?
  o Who scores the documentation?
  o Who evaluates the documentation?
• Do each speak the same language?
This is How the Office Visits Looks

Doctor - work involved 99214
Coder - Document content 99214
Auditor - Medical Necessity 99213

Why the Difference

• It's very simple and it actually makes very good sense....
• The doctor values the amount of work he put into seeing that patient—
  ○ This may very SIGNIFICANTLY from what is written in the documentation
• The coder is taught to use an audit grid, and most audit grids do not include medical necessity
• The auditor has been taught that Medical Necessity is the overarching determining factor when choosing and E&M level of service

For These Reasons

• We MUST audit!
  ○ The 3 voices must come together
  ○ All 3 can support the same code selection if they are all evaluated properly
• We MUST maintain compliance
  ○ Fraud
  ○ Abuse
  ○ Reimbursement
How does the note come together?

History of the Encounter

- Chief Complaint
- HPI
- Symptoms caused by the Chief Complaint
- ROS
- How the body is affected systemically
- PHIS
- Historical information that may affect treatment or that may be affected by treatment

Exam of the Encounter

Objective + Exam performed today = Exam Documentation
Medical Decision Making

- All 3 help to identify the level of severity according the provider and his/her analysis

<table>
<thead>
<tr>
<th>Number of Diagnosis</th>
<th>Points for reviewing test and or records</th>
<th>Points for ordering tests</th>
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</thead>
<tbody>
<tr>
<td>New to the provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Established to the provider</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complexity of Data Ordered or Reviewed</th>
<th>Assigning the overall risk of patient care based on the full analysis of the patient</th>
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The Plan of Care MUST...

"Paint a Portrait of the Patient," per CMS
Interpret the findings and analysis of the patient
To Summarize it best, Document the thought process of the physician

But, they all must speak to the same level of medical necessity
Connecting the Dots

- CMS reference:
  - Paint a portrait of the patient
  - Chronological health and medical events

- Coders and auditors may NOT assume or interpret
  - Providers are reimbursed for their analysis of a patient
  - Providers are reimbursed for professional interpretations

Medical Necessity

OVERARCHING
WHY
KEY FACTOR
APPROPRIATNESS

Planning your internal audit…
Monitoring & Auditing Policy

- Inclusive of:
  - Types of service to be audited
  - Number of records to be audited
  - Dates of records to be reviewed
  - Providers to be reviewed
  - Education policies
  - Pre-bill policies
  - Frequency/schedule of future audits

Monitoring & Auditing Policy

- What all should be included?
  - Billing
  - Documentation
  - Coding
  - Modifier usage
  - Daily Processes
  - Staff interviews

Auditing and Monitoring Reminders

- EMR/EHR concerns:
  - Over-coding typically due to over-documenting
  - Does not include proper emphasis on the presenting problems and MDM
  - Cut & paste
  - Cloning
  - Carry forward

- Should EMR/EHR produced documentation be subject to a different auditing policy?
Planning Your Audit

- Refer to your monitoring and auditing compliance policy
  - Specifications on 1995 vs. 1997 Documentation Guidelines?
  - What are the parameters defined in the policy?

- Define the purpose:
  - Compliance Audits (to assess compliance)
  - Prospective (to notify before claim submission)
  - Retrospective (most common for MD practices)
  - Focused Audit (specific problem/target/trigger)
  - Risk Management Audit (entire patient care process)

Who should perform the audit?

- Certified Auditors
- Internal auditors
- External auditors/Third Party

Determine providers at risk
- Identify compliance concerns
- Identify miscoding that resulted in lost revenue
- Educate your provider

Tools Needed for the Audit

- 95/97 Guidelines
- Carrier Contracts
- CMS Guidelines
- Local Coverage Policies
- Audit Grid
- Code Books
- Claim Form
- MOST Importantly--
Best Practices for Audit Success

• Do not forget to audit the billing!
  • Review at least one month of remittance advice (aka explanation of benefits) for apparent billing/coding mistakes, routine denials and coding patterns
  • Verify fee schedules used
  • Review modifier usage
  • NOTE: NPI numbers used
• Integrate the findings into learning objectives for all providers
• Maintain the findings in the Compliance Plan

The Importance of Productivity Reports

Productivity reports help:
• Identify outliers and aberrancies in providers’ coding
• Identify monies left on the table
• Focus attention to areas calling out for attention
• Show physicians’ vulnerabilities in the practice
• Most importantly, they help us find issues before carriers do.

CEU INDEX # 38860ORT