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On the topic:
Effectively Responding to an Audit

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Effectively Responding to An Audit

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Taking the Business of Medicine to the Next Level
Overview

• The purpose of an audit – why are you getting audited?
• Who can audit you?
• Guidance on proper documentation practices
• Steps to assure compliant billing practices
• Prepare for an audit
• What are the auditors looking for?
• How to respond to an audit letter

Why Are You Getting Audited?

• Having multiple claims submitted for the same date of service may cause you to be audited.
• Submitting claims for CPT codes outside of your medical specialty area might cause you to be audited.
• Having the dollar amount of claims greater than the average for a similar health practitioner in the same geographic area of the country may cause you to get audited.
• Having a greater number of claims submitted than the average for a similar health practitioner in the same geographic area of the country may cause you to get audited.
• Filing claims for services that are on the Office of Inspector General’s (OIG) annual work list may cause you to be audited.
Why Are You Getting Audited?

• Issues Identified During Monitoring
• History of Prior OIG Audits
• OIG Risk Assessment
• OIG Hotline Tips
• OIG Experience/Interactions
• Single Audit Report Results

Need to Know

• If an audit letter or audit notice is from a Zone Program Integrity Contractor (ZPIC), the matter is very serious and should not be treated as a routine audit.
• If the “audit” comes in the form of a subpoena, then it is extremely serious.
• If any FBI agent or OIG special agent is involved in it, then it is extremely serious. In any of these three cases, an experienced health attorney should be retained immediately.
Who Can Audit You?

• Medicare Administrative Contractors (MACs)
• Recovery Audit Contractors (RACs)
  – Medicare has RACs & Medicaid aka MIC’s
  – DME, Home Health and Hospice RAC
• Zone Program Integrity Contractors (ZPICs)
• Comprehensive Error Rate Testing (CERT)
• Supplemental Medical Review Contractor (SMRC)
• Unified Program Integrity Contractors (UPICs)
• Office of Inspector General (OIG) audits

MACs
Medicare Administrative Contractors

• MACs are private companies that serve as contractors performing claims administration for Medicare Part A and Part B.
  – 12 Contracts for Parts A and B
• These groups are charged with overseeing claim completion and accuracy in addition to determining correct payments for services.
• Since MACs review both facilities' Part A claims and the professional provider Part B claims related to the same beneficiaries and services, CMS feels that the MACs will be able to review discrepancies between the two sets of claims, revise payments and/or increase denials.
RACs
Recovery Audit Contractors

• Purpose
  - Detect Medicare improper payments (overpayments and underpayments)
  - Correct Medicare improper payments
    ▪ Repay underpayments
    ▪ Collect overpayments

• Scope: Medicare Fee for Service payments
  - Incorrect payment amounts
  - Claims for non-covered services
  - Incorrectly coded claims
  - Duplicate claims/services
RACs Compensation

- CMS pays RACs on the basis of a contingency fee
  - Initially, the fee was based only upon the amount of overpayments identified
  - Currently RACs will earn contingency fees ranging from 9% to 12.5% of the payments they collect from health care providers
  - Underpayments were added as a basis of payment in 2006

MICs
Medicaid Integrity Contractors

- MICs will review Medicaid claims to see whether inappropriate payments or fraud may have occurred. In addition, the MICs will audit Medicaid claims and identify overpayments and areas of high risk for payment errors or fraud.
- Similar to the RACs, the MICs will use a data-driven approach to focus efforts on aberrant billing practices.
**MICs**
Medicaid Integrity Contractors

- MICS also will review medical records to verify that paid claims were for:
  - Services actually provided are properly documented in accordance with *medical necessity*
  - Services billed properly, using correct and appropriate diagnosis and procedure codes
  - Covered services
  - Services paid for in accordance with federal and state laws, regulations and policies

**ZPICs**
Zone Program Integrity Contractors

- This group, formerly known as Program Safeguard Contractors (PSCs), serve the same jurisdictions as the Medicare Administrative Contractors.
- The ZPICs are authorized to conduct investigations, provide support to law enforcement and conduct audits of Medicare Advantage plans.
ZPICs
Zone Program Integrity Contractors

• According to the Medicare Program Integrity Manual, Chapter 2, the goals of the ZPIC’s data analysis program are to identify provider billing practices and services that pose the greatest financial risk to the Medicare program.

• Some ZPICs will concentrate on various Medicare billing "hot" targets.

(SMRC)
Supplemental Medical Review Contractor

• The Centers for Medicare & Medicaid Services (CMS) contracted with Noridian Healthcare Solutions LLC on February 13, 2018 to help lower improper payment rates and increase efficiencies of Medicare and Medicaid medical review.
  – The SMRC conducts medical review of Medicare Part A and B claims nationwide.
  – The SMRC evaluates medical records to determine whether Medicare claims were billed in compliance with coverage, coding, payment, and billing practices.
  – The focus of the medical reviews may include vulnerabilities identified by CMS internal data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations and Federal oversight agencies.
  – The SMRC may also carry out other special projects to protect the Medicare Trust Funds as directed by CMS.
Proper Documentation Practices

Eliminating Potential Areas of Vulnerability Documentation

- Timely, accurate and complete documentation is important to clinical patient care. This same documentation serves as a second function when a bill is submitted for payment; namely, as verification that the bill is accurate as submitted.
- Therefore, one of the most important physician practice compliance issues is the appropriate documentation of diagnosis and treatment.
- Physician documentation is necessary to determine the appropriate medical treatment for the patient and is the basis for coding and billing determinations.
Statement regarding Record Cloning....

• According to the 1997 Documentation Guidelines for Evaluation and Management Services, "Medical record documentation is required to record pertinent facts, findings, and observations about an individual’s health history... (Emphasis added)" Medical record cloning will not satisfy that E/M requirement.

• Physicians’ documentation must support the medical necessity and appropriateness of the services they provide. Electronic medical record templates can assist them in this process, if care is taken to edit records to accurately reflect the condition of a patient at every patient/physician encounter. In the absence of such editing, cloning of records will most likely lead to denial of services due to lack of medical necessity and may lead to investigation of potentially fraudulent practices.
Medical Record Documentation

• **Medical Record Documentation Should:**
  – Be Complete and Legible
  – Include:
    - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
    - assessment, clinical impression or diagnosis
    - plan for care
    - date and legible identification of the provider

Medical Record Documentation

• **Medical Record Documentation Should:**
  – Include (continued):
    - rationale for ordering diagnostic and other ancillary services
    - past and present diagnoses
    - appropriate health risk factors
    - the patient’s progress, response to and change in treatment, and revision of diagnosis

  – Support the CPT and ICD-10-CM codes reported on the Health Insurance Claim Form or Billing Statement
Medical Record Documentation

• It not just enough to list a diagnosis in your A/P.
• When documenting your diagnosis make sure you indicate:
  – If there is severe exacerbation, progression, or side effects of treatment
  – Acute or chronic condition that may pose a threat to life or bodily function
  – If the problem is not stable, indicate it as worsening or failing to progress

Steps to Assure Compliant Billing Practices
Why Billing and Documentation Compliance?

• The creation of compliance program guidance has been a major initiative of the OIG in its effort to engage the private health care community in preventing the submission of erroneous claims and in combating fraudulent conduct.
• The OIG developed and issued compliance program guidance directed at a variety of segments in the health care industry.
• The development of these types of compliance program guidance is based on the belief that a health care provider can use internal controls to more efficiently monitor adherence to applicable statutes, regulations and program requirements.

7 Steps to Being Complaint

The OIG indicates a practice’s compliance program should contain seven components that will provide a solid basis upon which a physician practice can adhere to compliance.
7 Steps to Being Complaint

• 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

Eliminating Potential Areas of Vulnerability

The practice’s self-audits can be used to determine whether:

• Bills are accurately coded and accurately reflect the services provided (as documented in the medical records)
• Documentation is being completed correctly and in a timely manner
• Services or items provided are reasonable and necessary
Eliminating Potential Areas of Vulnerability

Coding and Billing

• A major part of any physician practice’s compliance program is the identification of risk areas associated with coding and billing.

• The following risk areas associated with billing have been among the most frequent subjects of investigations and audits by the OIG:
  - Meeting medical necessity in the medical record documentation
  - Billing for items or services not rendered or not provided as claimed
  - Submitting claims for equipment, medical supplies and services that are not reasonable and necessary
  - Double billing resulting in duplicate payment
Questions to ask prior to an audit:

- Who will be engaged in audit process?
- What is each individual’s role?
- How will we coordinate with subrecipients, if applicable?
- How will we document the audit process?

Things to review prior to an audit:

- Policies & procedures
- Criminal history checks (NSCHC)
- Match documentation
- Timesheets
- Monitoring tools/protocols
Care & Feeding Of Auditors

- Apply the platinum rule to your interactions.
- Ensure the auditors have a comfortable, well-lit place to work from.
- Maintain an open door and be flexible with your schedule.

- Communication is key to a positive audit experience.
- Ask questions to ensure that you are clear on the process, auditor requests and expectations.
- Auditors will often communicate concerns as they arise (in writing and/or verbally).
Why Are you Being Audited and What are They Looking For?

- Historically, CMS used the "pay and chase" model paying claims before investigating if those claims were proper.
- In 2011, CMS announced it would use predictive modeling in an attempt to move away from the "pay and chase" model, but still timely pay proper claims:
  - Using risk scoring technology to identify fraud using real-time data before the claim is paid.


What Happens in the Audit

Elements of a finding:

- **Criteria**: What should the provider be doing?
- **Condition**: What is happening/What is being seen?
- **Cause**: Why is this condition happening?
- **Effect**: What is the impact of the findings?
- **Recommendation**: What should be done to resolve the findings?
What Happens in the Audit?

• For each provider identified as "at risk", the potential error is validated with prepayment or postpayment probe review of generally 20-40 potentially erroneous claims.
• The error is categorized as either minor, moderate or major concerns.

Examples:
• **Minor**: provider with a low error rate and relatively low financial impact. Education and collection of overpayment would be sufficient.
• **Moderate**: provider with a low error rate, but substantial financial impact. Prepayment review would be tracked and adjusted or eliminated according to provider's response.
• **Major**: provider with a high error rate (generally 10% or greater) and no mitigating circumstances. This would call for stringent administrative action, including possible payment suspension or referral to the ZPICs or OIG.
How to Respond to an Audit Letter?

- When receiving a notice of a Medicare audit, time is of the essence.
- Be sure to calendar the date that the records need to be in to the auditor and have the records there by that date.

**Note:** the due date is not the last date on which you can mail the records but rather it is the date that the records must be at the auditor’s office.

How to Respond to an Audit Letter?

- Read the audit letter carefully and provide all the information requested in the letter.
- Include a copy of the record for the dates of service requested and include any diagnostic tests and other documents from the chart that support the services provided.
- Make sure all the medical records are legible and legibly copied.
- Never alter the medical records after a notice of an audit.
  - Altering a medical record can be the basis for a fraud claim including criminal penalties
How to Respond to an Audit Letter?

• Include a brief summary of the care provided to the patient with each record.
  — The summary is not a substitute for the medical records, but will assist an auditor that may not be experienced in a particular specialty or practice area. Make sure that any such summaries are clearly marked as summaries with the current date they are actually prepared. Label it accurately. Do not allow any room for there to be any confusion that this new portion was part of the original record.

• Include an explanatory note and any supporting medical literature, clinical practice guidelines, local coverage determinations (LCDs), medical/dental journal articles, or other documents to support any unusual procedures or billings, or to explain missing record entries.

• Consult an experienced health law attorney early in the audit process to assist in preparing the response.
How to Respond to an Audit Letter

• Any telephone communication with the auditor should be followed up with a letter confirming the telephone conference.
• Send all communications to the auditor by certified mail (or express mail), return receipt requested so you have proof of delivery.
• Properly label each copy of each medical record you provide and page number everything you provide the auditors, by hand, if necessary. Medical record copies often get shuffled or portions lost or damaged during copying, storage, scanning or transmission.
• Keep complete, legible copies of all correspondence and every document you provide.

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