THE WORLD OF CODING AUDITING

Who Audits
Why Carriers Audit
Risky Behavior
Audit Tips
Reducing Your Risks

WHY AUDITS ARE NECESSARY

- Medical claims payment program is on the honor system – only about 5% of submitted claims are reviewed
- The payment system is a target for deliberate, organized and systematic fraud
- A small amount of deliberately fraudulent entities responsible for a significant amount of dollars lost in the Medicare/Medicaid program
- May 2013: HEAT coordinated nationwide takedown – 89 participants in 8 cities involving $223 million in false billings
- Fraud investigations return $8 for every $1 invested

WHO AUDITS YOUR PRACTICE?

MEDICARE AUDIT ENTITIES		
ACRONYM	PROGRAM NAME	OREGON CONTRACTOR
MAC	Medicare Administrative Contractor	Noridian Healthcare Solutions
RAC	Recovery Audit Contractor	Health Data Insights
ZPIC	Zone Program Integrity Contractor	NCI, Inc
CERT	Comprehensive Error Rate Testing	AdvanceMed/Livanta

WHO AUDITS YOUR PRACTICE?

FEDERAL AGENCIES	
ACRONYM	PROGRAM NAME
DOJ	Department of Justice
OIG	Office of Inspector General
FBI	Federal Bureau of Investigation
HEAT	Health Care Fraud Prevention & Enforcement Action Team

WHO AUDITS YOUR PRACTICE?

MEDICAID AUDIT ENTITIES	
ACRONYM	PROGRAM NAME
MIC	Medicaid Integrity Contractor (HMS)
MEDICAID RAC	Medicaid RAC
MFCU	Medicaid Fraud Control Unit
MIP	Medicaid Integrity Program
OMIG	State Office of Medicaid Inspector General

WHO AUDITS YOUR PRACTICE?

OTHER AUDITING ENTITIES
Other local or national insurance carriers
OCR: Office of Civil Rights – audits for HIPAA
Also, your MAC or any other carrier can initiate an audit based on review of individual claims or whistleblower report

MAC

- The MAC is the regional Medicare carrier. In Oregon, the MAC is represented by Noridian Healthcare Solutions and the majority of Medicare claims are submitted directly to Noridian.
- The MAC puts claims through a pre-payment edit, that includes all LCDs, NCCI edits, MUE edits, etc. If they pass the edit, then the MAC employs formulas to determine and administer payment.
- Noridian works in conjunction with contractors conducting the CERT audit, which is an annual random audit of a statistically valid volume (about 50k) of Medicare FFS claims.
- Noridian also provides education through a variety of resources.

MAC AUDITS

- The MAC can audit any claim at any time, but does not audit all claims
- Focus on claims with the potential to be non-covered or incorrectly coded
  - High volume of services
  - High cost
  - Dramatic change in frequency of use
  - High risk problem-prone areas

CERT AUDITS

- Select a random sample of 50,000 claims received by Medicare
- Review the selected claims and associated medical record documentation to determine if the claim was appropriately adjudicated according to Medicare regulations/guidelines.

CERT AUDIT FINDINGS 2012

TOP 20 SPECIFIC SERVICE TYPES:
HIGHEST IMPROPER PAYMENTS: PART B

1	Chiropractic	11	Subsequent Inpatient Care
2	Initial Inpatient Care	12	Dialysis Services
3	Hospital: Critical Care	13	MRI/MRA
4	Lab Tests – Blood Counts	14	Other Tests
5	Lab Tests, other (non-MC fee schedule)	15	Established Office Visit
6	Minor Procedures	16	ED Visits
7	Oncology: Radiation Therapy	17	Lab Tests (MC Fee Schedule)
8	NP Office Visits	18	Ambulatory Procedures: Skin
9	Nursing Home Visits	19	Ambulance
10	Specialist: Psychiatry	20	Other Drugs

MIPS & MICS

- These are both Medicaid programs. The MIP was created under the Deficit Reduction Act of 2005. MIP is intended to help reduce provider fraud, waste and abuse in the Medicaid program.
- There are 3 primary MICs:
  - Review MICs to analyze Medicaid claims data looking for potential provider fraud, waste, and abuse
  - Audit MICs audit provider claims for overpayment
  - Education MICs furnish provider education
- CMS is responsible to hire the MIC contractors and to support the program in combating fraud and abuse

WHAT THE MIC AUDITS LOOK FOR

- Incomplete documentation
- Conflicting documentation
- Improper coding
- Duplicate billing
- Providing services that aren't medically necessary
- Patient privacy breaches

THE RAC

- The mission of the RAC is to reduce improper Medicare over-payments.
- Their methodology is data mining based on claims data. Based on this methodology, they also identify under-payments.
- RACs investigate specific measures identified and approved by Medicare
- RAC contractors are paid on a contingency basis – Contingency fees range from 9.0% - 12.5% for all claims except DME – Contingency for DME is from 14.0% to 17.5%
- The RAC may request up to 500 records every 45 days, which poses huge operational concerns for provider offices

RAC COLLECTIONS:

Time Frame	Overpayments (Collected)	Underpayments (Returned)
1st Quarter 2013	$774.8M	$34.4M
2012	$2.33B	$176.0M

RAC MEASURES

- As of 2/1/14, there 680 RAC measures
- New measures targeted at Physician/NPP professional services include:
  - Medically unlikely billed dosages of drugs and biologicals
  - Incorrect billing of drugs and biologicals
  - Excessive units of new patient visits
  - Outpatient hospital stays billed as inpatient
  - Post-payment review of therapy claims above $3,700 threshold
  - Other specialty-specific measures involving Urology, Radiology, Lab/Pathology, Ophthalmology, and Interventional Radiology.
  -

ZPIC

- ZPIC's role is to identify potential Medicare fraud within a service area by review of past and pending claims
- ZPIC's reviews are not random - the provider is under investigation for potential fraud
- Investigations are initiated by:
  - Data analysis
  - Complaints
  - Referral from other agency (MAC, RAC, etc)
- Auditor may come onsite
- May conduct interviews with beneficiaries or provider's employees, etc.

WHAT ZPIC AUDITS FOR

- Identify areas of potential errors (i.e., noncovered or incorrectly coded) that pose greatest risk.
- Establish baseline data for comparison
- Identify need for LCD and/or education
- Identify high volume services that are over-utilized
- Identify program errors or specific providers for possible fraud investigations
- Determine if findings by other MC auditing agencies represent significant problem areas
- ZPIC audits to confirm fraudulent behavior, not to discover it

OIG

- The OIG has been supervising audits and fraud/abuse investigations since 1993. These are not limited to Medicare – the intent is to minimize loss in all government programs.
- The OIG may work an investigation alone or in conjunction with other agencies (i.e., as part of a HEAT investigation)
- The OIG has the ability to determine fines, and to exclude individuals and entities who have engaged in fraud from Medicare/Medicaid/other federal health care programs.

OIG ENFORCEMENT ACTIONS 2012

- Opened 1,131 new criminal health care fraud investigations against 2,148 potential defendants
- 2032 investigations already opened, involving 3410 potential defendants; filed charges in 452 cases involving 892 defendants
- 826 individuals convicted
- 885 new civil investigations opened
- 1023 civil investigations pending at year end

- *Per OIG Annual Report for 2012*

2012 RESULTS

- Monetary Settlements:
  - Won or negotiated $3.0 billion in judgments & settlements

- Exclusionary Actions
  - Excluded 3,131 individual and entities

- *Per OIG Annual Report for 2012*

OIG AUDIT work PLAN 2014
(MEDICARE PART A & B: SPECIFIC TO PHYSICIANS)

Review includes:

- High cumulative Medicare Part B payments
- Non-compliance with assignment rules
- Excessive billing of beneficiaries
- Incident-to error rate
- Place of service coding errors
- Non-payable chiropractic services
- E/M services: modifiers reported during global surgery
- Claims processing errors related to modifiers GA, GX, GY, GZ

HEAT TASK FORCE

HEAT's MISSION

- To gather resources across the government to help prevent waste, fraud, and abuse in the Medicare and Medicaid programs.
- To crack down on the people and organizations who abuse the system and cost Americans billions of dollars each year.
- To reduce health care costs and improve quality of care by preventing fraudsters from preying on people with Medicare and Medicaid.
- To highlight best practices by providers and organizations dedicated to ending waste, fraud, and abuse in Medicare.
- To build upon the existing partnerships between HHS and DOJ to reduce fraud and recover taxpayer dollars.

- *Excerpt Stop Medicare Fraud website*

HEAT

- Case details posted by state

http://www.stopmedicarefraud.gov/aboutfraud/heattaskforce/

OCR

HIPAA Audits

- As of 12/31/13, HIPAA has investigated and resolved 22,206 Privacy cases
- As of 12/31/13, HIPAA has investigated and resolved 584 Security cases

- **For case details:**
- http://www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/index.html

THE AFFORDABLE CARE ACT & FRAUD INVESTIGATION

- The Affordable Care Act, the health care law, takes powerful steps toward combating health care fraud, waste, and abuse. The government has recovered a record-breaking $10.7 billion in recoveries of health care fraud in the last three years.
- **Tough new rules and sentences for criminals:** The law increases federal sentencing guidelines for health care fraud by 20-50% for crimes with over $1 million in losses.
- **Enhanced screening:** Providers and suppliers who may pose a higher risk of fraud or abuse are now required to undergo more scrutiny, including license checks and site visits.
- **State-of-the-art technology:** To target resources to highly suspect behaviors, the Center for Medicare & Medicaid Services now uses advanced predictive modeling technology.
- **New resources:** The law provides an additional $350 million over 10 years to boost anti-fraud efforts

- *Excerpt Stop Medicare Fraud website*

NY TIMES ARTICLE 1/25/14

"The Obama administration is cracking down on doctors who repeatedly overcharge Medicare patients and for the first time in more than 30 years the government may disclose how much is paid to individual doctors treating Medicare patients.

Marilyn B. Tavenner, the administrator of the Centers for Medicare and Medicaid Services, said that "recalcitrant providers would face civil fines and could be expelled from Medicare and other federal health programs."

"A new section of the Medicare Manual encourages the use of fines to penalize doctors who generate a pattern of claims for goods an services that they know or "should know" are not medically necessary. Providers can also be barred from Medicare if they bill the program for "excessive charges" or for services substantially in excess of patients' needs.

Most of the high billing doctors specialize in internal medicine, radiation oncology or ophthalmology."

NY TIMES ARTICLE 1/25/14

For the entire article:

http://www.nytimes.com/2014/01/26/us/doctors-abusing-medicare-to-face-fines.html?_r=0

The new Medicare Manual section:

100-08 Program Integrity

RISK FACTORS: MYTH vs REALITY

Myth:

1a. Only large groups get audited

1b. Only urban practices get audited

1c. Only specialists get audited

2. "I've never been audited"

Reality

1a.b.c Provider risk is based on provider practice patterns, regardless of the size, location, and type of practice

2. Any request by a carrier for a chart note is an audit – if you've submitted a chart note at the carrier's request, you've been audited

RISKY BEHAVIOR

- Reporting high volume of high level codes without the ability to support them
- High volume unsupported or unbelievable time coding
- Inappropriate use of prolonged service codes
- Inappropriate application of “incident to” or “shared/split services”
- Inappropriate use or authentication of “scribes” or authentication of scribe role
- Misinterpretation of guidelines when medical, NP, or PA students are involved in encounters
- Billing a payable code instead of the non-covered service actually accomplished
- Billing for ancillary diagnostic services without medical necessity
- Billing for procedures or ancillary diagnostic services and manipulating the diagnosis code to assure coverage

RISKY BEHAVIOR

- Specialty practice: every new problem is a new patient encounter
- Billing higher for work comp because of the “psycho-social considerations” involved and the support required
- Every surgical case is billed with a modifier 22
- Every post op encounter is a billed with an E/M code and a modifier 24
- Every pre-op is billed (even though the decision for surgery was made 2 weeks ago) and there is no medical necessity to support the service
- Billing time-coded psych services w/o documenting the time in the chart note
- Unbundling services
- Billing for services not accomplished
- Billing “never” events – like amputation on the same body part – multiple times
- Churning

RISKY BEHAVIOR: EHR VULNERABILITY

- Cloning
- Automatic “pull through” documentation
- “Click” documentation
- Contradictory documentation
- Unreviewed/incomplete documentation/garbled documentation (VRS errors)
- Poor documentation
- Authentication (not signed/no title, etc)
- Automatic inclusion “one size fits all” time-coding statement
- Time coding doesn’t match imbedded system time stamps
- Printed chart notes don’t contain patient identifier on each page
- Medical necessity not supported

NOTES REVIEWED IN A CERT AUDIT

- Excerpt from exam portion of E&M: “His liver alert and oriented x3 shows a deficit of cognitive function are thought physical psychosomatic eye pupils equal and rectal exams are normal her eczema with inflammation”.

- Excerpt from HPI: “She has insomnia-she takes her temazepam at HS-she is gestating at least 5 hours at night”

Excerpt from Noridian Part B News, July 2011

99214…….Really?

CC: follow-up

HPI: John returns, feeling great. No chest pain, no shortness of breath. No problems with meds; going to Arizona for the winter.

ROS: All other systems negative

PFSH: Meds reviewed and updated – no changes; still smoking

Exam:

Vital Signs: BP 120/80; Ht 6ft; Weight 205

General Appearance: NAD

Psych: Normal mood and affect

Labs: Normal

Assessment: Diabetes, Hypertension, Hypercholesteremia, all stable

Plan: No changes, follow-up in Spring after return from Arizona

TIME CODING STATEMENTS
(that don't work)

- I spent more than half of a 25 minute visit reviewing the management and treatment options for the conditions listed above."

  (stated on every patient encounter for the day)

- "More than half of a 45 minute visit spent face to face with the patient."

  (what did they do for the rest of the encounter?)

WHAT IS AN AUDIT?

- A request from a carrier for a chart note in order to make payment
- A request from an auditing entity to return money for an individual or multiple claim based on identified error
- A request from an auditing entity (i.e. OIG) for a volume of specific chart notes for review based on identified issues
- Appearance of a sanctioned auditor in the office with a request for specified chart notes for review
- Based on the situation, the audit may be either a pre-payment or a post-payment review

POTENTIAL MAJOR AUDIT CONSEQUENCES

- Return of overpayments
- Extrapolation
- Fines - up to treble damages per occurrence
- Exclusion from Medicare – and all other federally funded carriers (Medicare HMO, Medicaid, TriCare, etc)
- Development of a CIA (Corporate Integrity Agreement)
- Potential compromise of practice financial viability
- Criminal charges, if deemed appropriate
- IRS issues, if deemed appropriate
- Stripes?

FREQUENT AUDIT TRIGGERS FOR CREDIBLE MEDICAL PRACTICES

TYPE OF SERVICE	PROBLEM	IDENTIFIED BY
E/M Services	Consistent Over-Coding	Provider Profile vs national by-specialty profile
Surgery	Unbundling services	NCCI edits
Coding Guidelines	Inappropriate use of time coding	Chart review
Coding Guidelines	Inappropriate use of Incident to or shared/split services	Chart review
Coding Guidelines	Cloning	Chart review
Clinical Guidelines	Churning	Comparison to clinical standards of care
All of the above		Whistle blower

WHAT ELEVATES YOUR RISK

- Misunderstanding of coding guidelines
- Misunderstanding of levels of service application
- “Half-knowledge” or lack of knowledge
- Mistake by provider or staff
- “Don’t know, don’t want to know, won’t change”

AUDIT TIPS

- Treat every request seriously, even if it's a request for a single note for clarification of a service for claims payment – it's still an audit
- Educate based on audit request findings
- Pay attention to time lines for submission
- Clarify & communicate "chain of command" for incoming documents related to carrier communication
- Private carriers may audit just as actively as Medicare
- Know when to involve your health care attorney

WHAT AUDITORS MAY REQUEST

At minimum, auditors will require your chart notes for review. They may also request other information, including:

- Referenced data not initially provided
- Appointment schedules
- Time stamp logs
- Chart notes for dates before and after the reviewed date (looking for cloning)
- Diagnostic tests

SUBMISSION TIMELINES FOR AUDIT REQUESTS

MACs, RACs, CERT, & ZPICs

Pre-payment Review Time Frames

- Submit w/n 30 calendar days of request
- No extensions granted
- Claim denied if requested data not received by day 45

Post-payment Review Time Frames

- MAC, CERT, RAC: submit w/n 45 calendar days of request
- ZPIC: submit w/n 30 calendar days of request
- MAC, CERT, ZPIC have discretion to grant extensions

Refer to Medicare Program Integrity Manual, Chapter 3 for detailed guidelines on submission, including timelines, submission methods and additional information

REDUCING YOUR RISK: PREVENTION

- Oversight: Develop, Implement & follow a credible Compliance Plan

- Operational policies and procedures, including:
  - Development of an Audit/Provider Education Team
  - Identify an auditor (internal/external)
  - Receipt & Processing Audit Requests
  - Development of electronic reports & analysis of provide coding patterns
  - Development of electronic audit tracking tools
  - Development of action plans

- Operational actions, including:
  - Internal/External audits
  - Ongoing education
  - Documentation improvement

EDUCATION

You are required to know the rules,
regardless of how many rules there are,
and how many exceptions there may be to the rules

If a provider understands and applies the rules correctly,
mistakes that result in costly audits are less likely to occur

IMPORTANCE OF A COMPLIANCE PLAN

- Sets the tone of your program
- Base it on reality – you have to live up to it
- Set standards
- Address risk areas
- Address corrective action plan
- Develop policies and procedures in support
- Developing a corresponding training program
- Develop lines of communication

OIG: RECOMMENDED COMPONENTS OF A SMALL PRACTICE COMPLIANCE PLAN

1. Internal Auditing & Monitoring Practice & Procedures
2. Establish Practice Standards & Procedures
3. Designation of a Compliance Officer/Primary Contact
4. Conducting Education & Training
5. Responding to Identified Issues & Corrective Action Plans
6. Developing Open Lines of Communication
7. Enforcing Disciplinary Standards

- *See OIG Compliance Program for Individual and Small Group Physician Practices*

October 5, 2000

OTHER ACRONYMS USED IN THIS PRESENTATION

ACRONYM	TRANSLATION
CMS	Center for Medicare & Medicaid Services
LCD	CMS Local Coverage Determinations
NCCI	National Correct Coding Initiatives
MUE	Medically Unlikely Edits
FFS	Fee for Service
CIA	Corporate Integrity Agreement
HHS	Health & Human Services
ADR	Additional Documentation Request
AC	Affiliated Contractor
RA	Remittance Advice
MLN	Medicare Learning Network

RESOURCES & WEBSITES

- **Noridian Healthcare Solutions**
  https://www.noridianmedicare.com/
- **Health Data Insights**
  http://www.healthdatainsights.com/
- **OIG**
  http://www.oig.doc.gov/Pages/default.aspx
- **Medicare Program Integrity Manual**
  http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html
- **AHIMA**
  http://www.ahima.org/

RESOURCES & WEBSITES

- **Federal Register (OIG Compliance Plan)**
  https://oig.hhs.gov/authorities/docs/physician.pdf

- **Recovery Auditing Program for FY 2011**
  http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/FY2011-Report-To-Congress.pdf

- **HEAT**
  http://www.stopmedicarefraud.gov/aboutfraud/heattaskforce/

- **Senate Bill S.1012**
  http://www.govtrack.us/congress/bills/113/s1012#summary/libraryofcongress

- **2012 CERT ERROR TYPES top 20**
  http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/AppendicesMedicareFeeforService2012ImproperPaymentsReport.pdf

RESOURCES & WEBSITES

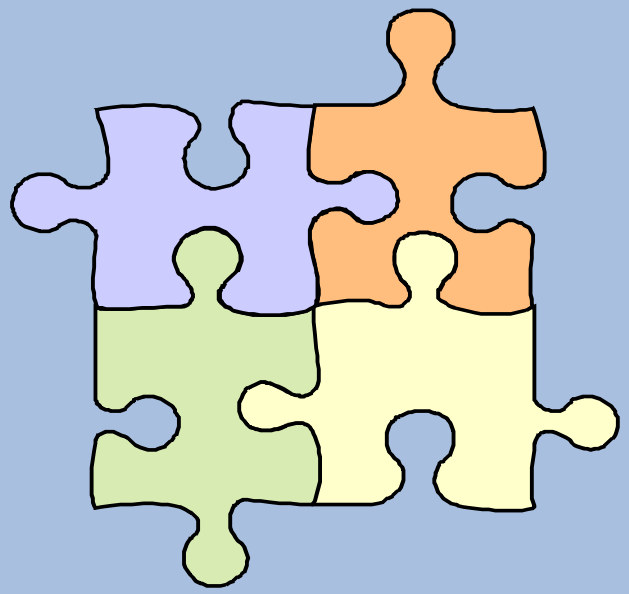
- **CMS MLN: The Medicare Appeals Process**

  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicareappealsprocess.pdf

- **CMS MLN: Medicare Claim Review Program**

  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf

HealthCare Management Consultants



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