Physician Practice Compliance Conference

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Auditing and Monitoring in Clinics and Physician Practices

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Disclaimer

A presentation can neither promise nor provide a complete review of the myriad of facts, issues, concerns and considerations that impact upon a particular topic. This presentation is general in scope, seeks to provide relevant background, and hopes to assist in the identification of pertinent issues and concerns. The information set forth in this outline is not intended to be, nor shall it be construed or relied upon, as legal advice. Recipients of this information are encouraged to contact their Compliance Officer or legal counsel for advice and direction on specific matters of concern to them.

Catholic Healthcare West

- 42 hospital, 90 clinics, 19 Distinct Part Skilled Nursing, 17 Home Health/Hospice, 7 Behavioral Health Programs, 6 Inpatient Rehab. Facilities
- Clinics include:
  - Free Standing, Medical Foundation Clinics
  - For-profit Clinics
  - Facility Based Clinics
  - Residency Programs
  - Rural Health
  - Community Clinics
  - Hospitalist Programs

Catholic Healthcare West

- Qui tam involving about 30% of our clinics
- 2 years oversight of a defense audit
- 3 year Corporate Integrity Agreement
  - 30 days to education all staff involved in documentation, claims development, submission and reconciliation
  - Required education for new employees, including physicians and other healthcare providers
  - Required claim audits
  - Oversight by an Independent Review Organization (IRO)
  - Annuals “Systems Review” by IRO
  - Annual CIA Compliance review by the IRO
  - Annual report submission to the OIG

7 Elements of a Compliance Program

- Hospitals
1. Written Standards of Conduct
2. Designate a Compliance Officer
3. Effective education and training
4. A process to receive complaints, such as a hotline
5. System to respond to allegations, and enforcement of appropriate disciplinary action
6. **Use of audits and/or evaluation techniques to monitor compliance and assist in the reduction of identified problem areas**
7. Investigation and remediation of identified systemic problems via policies and non-employment of sanctioned individuals

- Physician Practices
1. **Internal auditing and monitoring**
2. Implement compliance and practice standards (Standards of Conduct and Policies)
3. Designate a compliance officer or contact
4. Conduct appropriate training and education
5. Respond to detected offenses and develop corrective action
6. Develop open lines of communication
7. Enforce disciplinary standards through well-publicized guidelines

OIG Guidance for Physicians – Auditing and Monitoring (Oct. 2005)

An audit is an excellent way for a physician practice to ascertain what, if any, problem areas exist and focus on the risk areas that are associated with those problems. There are two types of reviews that can be performed as part of this evaluation: (1) A standards and procedures review; and (2) a claims submission audit.

Policies and Procedures

- Do you have policies in place?
- Have they been reviewed recently?
- Are they accurate?
- Has staff been oriented to them?
- Have you audited for their effectiveness?

Audit/Monitor the 7 Elements - Scorecard

Any Specialty Medical Group	***Total Points:***				**823**
	Maximum Total Points:				**1110**
	Percentage:				**74.1%**

1. EDUCATION					
A. New managers receive compliance orientation within 60 days of date of hire.	# Employees Reached	# Employees Affected	%	Points	Maximum Points
	3	4	75%	0	100
B. Ensure employees complete required compliance education programs such as "Specific Education Module" and/or OCEP.	# Employees Completed Requirement	# Sample	%		
	10	10	100%	100	100
C. New employees receive Standards of Conduct orientation within 30 days of date of hire.	# Employees Completed Requirement	# Sample	%		
	10	10	100%	100	100
D. Clinic manager(s) or appropriate staff attend required annual education/conference	# Employees Completed Requirement	# Sample	%		
	2	2	100%	100	100
2. POLICIES AND PROCEDURES					
			%		
A. Compliance Policies & Procedures are communicated to affected employees within 60 days. MUST BE DOCUMENTED AND EASILY RETRIEVABLE FOR AUDIT.	9	10	90%	90	100
B. Policy 1 – All coding resources are current and present for audit	6	8	75%	38	50
C. Policy 2 – Documented process for obtaining Advanced Beneficiary Notices.	0	0		25	50
D. Policy 3 – Documentation of computer ICD9, CPT and HCPCS code changes is maintained and available for audit.	1	1	100%	50	50
E. Policy 4 – Encounter forms contain appropriate revision dates, and no obvious outdated incomplete codes.	1	1	100%	50	50
F. Policy 5 – Refund logs are maintained and reported a monthly basis.	2	11		0	100
G. Policy 6 – Medicare Carrier Program Memoranda, Bulletins and transmittals implemented within assigned timelines.	3	3	100%	60	60
H. Policy 7 – Clinic has a documented process for performing Medicare Secondary Payer Screening.	0	0		50	50
3. HIGH LEVEL OVERSIGHT			%		
Clinics' compliance activities are reviewed and approved by Compliance Committee.	0	0		100	100
4. AUDITS/REMEDIATION			%		
B. Corrective action plan elements created as outcome of audits (including coding, billing, HIPAA, education implementation, policy implementation) are implemented in agreed upon timeline. (Scoring consistent with President's Scorecard methodology. 60 – 89% = 60 points; 90% and above = 100 points.)	4	5	80%	60	100

Risk Assessment

Identify the risk areas

- OIG Compliance Guidance for Physicians and Small Group Practices
- OIG Work Plan
  - Incident to
  - Modifier -25
  - Place of Service
- New Service Lines
- New Technology
- Industry Trends
- Published Corporate Integrity Agreements
- Clinic Compliance and Operations Networks
  - HCCA
  - UMGA
  - AAPC
  - AHIMA

Risk Assessment

- **What would the be the impact, if the risk was realized?**
  - Risk to the mission/reputation
  - Financial Impact
  - Legal ramifications
- What is the vulnerability?
  - How likely is it the risk will occur
  - How easily can we detect the failure
- What controls are in place to prevent a failure?

Insert Enterprise Risk Management Scoring Definitions

Enterprise Risk Management
Scoring Definitions

	Impact to the Organization			Vulnerability		Controls
Score	**Mission/Reputation**	**Financial**	**Legal**	**Likelihood of Risk**	**Detectability**	**Controls**
1	Little or no risk	Little or no financial impact	Little or no fine probable.	**Low risk, unlikely to occur**. Historical and industry experience show low likelihood of occurrence.	**Failures are likely to be detected.** Process is directly supervised. Automated safeguards for identifying variations/errors.	**Controls are proven to be highly effective,**
2	Slight risk	Slight financial impact	Small civil fines and/or penalties up, but little risk of exclusion, CIA, loss of accreditation/licensure.	**Slight risk of occurence.** Historical industry experience shows some likelihood however not experienced in clinic to date; simple well understood process; competency demonstrated - less likely to fail	**Slight risk that failure will not be detected.** Failures; moderate safeguards in place; partially automated process with moderate management oversight	**Routinely audited and/or tested with little variation identified.** Performance metrics are established, routinely reviewed and show little variation. Current policies and procedures exist. Employee training and competency established. Well-prepared to manage this risk appropriately based on implemented risk management plans.
3	Moderate risk	Moderate financial impact	Moderate civil fines and/or penalties probable. Modest risk of exclusion, CIA possible.	**Moderate risk of occurrence** (in isolated areas)	**Moderate risk that failure will not be detected**. Limited safeguards in place to identify failure prior to occurrence. Partially automated process with limited management oversight.	**Periodically audited and/or tested**. Corrective action plans developed and tested for effectiveness. Limited performance metrics established. Risk management plans expected to manage the risks appropriately.
4	Significant risk	Significant financial impact	Significant civil fines and/or penalties probable. Loss of business unit licensure/accreditation. Exclusion possible. CIA probable.	**Significant risk of occurence.** Likelihood of occurrence is great, and in many areas.	**Significantly difficult to detect prior to failure.** Manual safeguards in place to identify failures; no automated processes; periodic management oversight	**Management Review and approval required**. Process not audited or tested or infrequently audited or tested. Limited policy or procedure guidance. Some risk management plans or steps undertaken; not reasonably expected to manage the risk appropriately or fully
5	Extensive risk	Extensive financial impact	Criminal conviction and/or exclusion probable. Fines, penalties and or legal exposure in extensive. CIA certain.	**High risk of occurrence**. Highly complex process with numerous hand-offs. Relies on extensive specialized skills. Note: should assume natural/manmade disasters are likely to occur in next year.	**Extremely hard to detect prior to failure.** Highly automated with little or no human intervention, oversight or control. No built-in safeguards, cross-checks, or other mechanisms to identify errors/failures prior to submission/completion.	No formal controls in place. No risk management plans or steps in place currently.

This is how we do it….

Identify the Auditor

- Coders should audit documentation and coding
- Managers and/or supervisors should audit adherence to operational policies and procedures
- Physicians should audit for medical necessity
- Clinicians should audit for adherence to clinical policies and procedures
- Would a self audit work?

Define the Audit

Background:

Urgent Care 1 and Urgent Care 2 are provider based clinics operated by Regional Hospital located in Anytown, USA. The facility employs and/or contract with approximately 15 (fifteen) providers to staff these clinics. Regional Hospital processes claims for the providers' professional fee services.

Purpose:

To validate medical record documentation by physicians and non-physician practitioners supports services billed. Specifically, the audit will confirm documentation supports CPT Code assignment for the level of Evaluation and Management, in-office procedures, diagnosis, and modifier assignment.

Define the Audit

Scope:

This audit will include a random sample of 10 (ten) Medicare and/or Medicaid encounters for each physician and non-physician practitioner.

Line item audit results will include:

* Patient identifying information (Name/MRN/Account)
* Date of Service
* Level of service indicated by the provider
* Level of service documented, per auditor
* Diagnosis assigned by provider
* Diagnosis documented, per auditor
* Modifier assigned
* Modifier supported by medical record

Services that are documented at a lower level of service will be submitted as supported by the medical record. Services documented at a higher level of service will be reviewed for medical necessity by a physician in the facility. No codes will be increased without provider approval.

BEWARE OF SCOPE CREEP!

Reports

Audit: Prospective Evaluation and Management Services and Documentation

Auditor: Stanley Auditor, CCS-P
Corporate Compliance
Coding Specialist/Auditor

Audit Date: December 2008

Background:

As part of the routine process required by the Compliance Program clinic audits will be performed annually. Urgent Care 1 and Urgent Care 2 are provider based clinics operated by Regional Hospital located in Anywhere, USA. The clinic's employs and/or contracts with approximately 15 (fifteen) providers for whom Regional Hospital processes claims for professional services.

November 2008, the clinics implemented an electronic medical record (EMR) which is utilized by all physicians and non-physician practitioners within both clinics. The Corporate Compliance Department would like to confirm that it encompasses all elements required for appropriate documentation and subsequent billing of services

Purpose:

To verify physician/or provider medical record documentation supports services billed. Specifically, the audit confirmed appropriate level of E&M service, in office procedures and modifier assignment.

In the recent months prior to this audit, the Chandler clinics have purchased an electronic medical record (EMR) which is utilized by all physicians within both clinics. The Corporate Compliance Department would like to confirm that it encompasses all elements required for appropriate billing of services

Scope:

The audit included a random sample of 10 (ten) pre-bill Private, Federal and State payor prospective encounters for each physician rotating within the clinic during the audit entrance date. The random sample included fee for service encounters with various insurance contracts. All cases reviewed in this audit were selected and prepared by the Director of the Clinics.

Verified the electronic medical record (EMR) utilized by both Urgent Care clinics allows for all data elements required (documentation) to support physician professional fee billing.

Line item audit results include:

Patient identifying information (Name/MRN/Account)

Date of service

Level of service indicated by physician

Level of service documented, per auditor

Modifier assigned by physician

Modifier supported by medical record, per auditor

Services that are documented at a lower level of service will be submitted as supported by the medical record. Services documented at a higher level of service will be reviewed for medical necessity by a physician in the facility. No codes will be increased without approval by a medical provider.

Summary Report Page 2

- **Major Issues Identified**:
- Issue 1 – **[Outline finding]**
- **[Include supporting documentation/source] such as:**
- *AMA and CMS Coding Guidelines State: A New Patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.*
- Issue 2 – **[Outline finding]**
- **[Include supporting documentation/source]**
- **Opportunities or Risks Identified**:
- Opportunity 1 – **[Outline opportunity]**
- Risk 2 – **[Outline Risk]**
- **Signatures:**
- ___________________________________ __________
- Clinic Director Date
- ___________________________________ __________
- Facility Compliance Liaison Date
- ___________________________________ __________
- CFO Date

Reporting your findings

- Who needs the information?
- What is the best way to report the findings?
- Is the data responsive to the "purpose" of your audit?

Responding to audit findings

- Corrective actions
- Assigning due dates
- Monitoring completion of the corrective actions
- Accountability

Corrective Action Plan

Report No. CHW- 1234

Name of Person Completing Findings & Action Plan:
Name of Facility: Urgent Care 1 and Urgent Care 2
Date Submitted:

	Implementation Needed	Action Plan	Responsible Party/ Due Date	Response/ Conclusion
1.	Correct EMR Templates to reflect necessary components of documentation. Date of Service Past/Family/Social History Review of Systems	**Work with IT to update all templates to allow documentation of all levels of service.**	**Compliance Liaison Due Date:**	
2.	Educate physicians regarding E&M guidelines, including determination of new and established category of codes	**Arrange for auditor to attend next provider meeting and present E&M documentation/coding guidelines**	**Clinic Director Due Date:**	
3.	Educate front office and coding/auditing staff to validate New vs. Established code categories prior to claim submission.		**Clinic Director Due Date:**	
4.	Review all encounters submitted with modifier -25 prior to claims processing.		**Business Services Director Due Date:**	
5.	Provide education to all physicians not achieving passing score, including all identified deficiencies.		**Compliance Auditor**	
6.	Schedule Follow- up audit for physicians not meeting passing audit scores		**Compliance Auditor Due Date:**	

Questions?

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