Auditing and Monitoring in Clinics and Physician Practices

Dawnese Kindelt, CPC
System Compliance Director – Clinics
Catholic Healthcare West

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
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 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

<table>
<thead>
<tr>
<th>Impact to the Organization</th>
<th>Vulnerability</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Low risk, low financial impact</td>
<td>Low risk, low likelihood of occurrence</td>
<td>Manually, audited and tested corrective action plans developed and tested for effectiveness. Limited performance metrics established. Risk management plans in place.</td>
</tr>
<tr>
<td>2 Slight risk, slight financial impact</td>
<td>Slight risk of occurrence</td>
<td>Slight risk that failure will not be detected. Limited safeguards in place to identify failure prior to occurrence. Process is directly supervised. Automated safeguards for identifying variances.</td>
</tr>
<tr>
<td>3 Moderate risk, moderate financial impact</td>
<td>Moderate risk of occurrence</td>
<td>Moderate risk that failure will not be detected. Limited safeguards in place to identify failure prior to occurrence. Process is directly supervised. Automated safeguards for identifying variances.</td>
</tr>
<tr>
<td>4 Significant risk, significant financial impact</td>
<td>Significant risk of occurrence</td>
<td>Significant risk that failure will not be detected. Limited safeguards in place to identify failure prior to occurrence. Process is directly supervised. Automated safeguards for identifying variances.</td>
</tr>
<tr>
<td>5 Extensive risk, extensive financial impact</td>
<td>Extensive risk of occurrence</td>
<td>Extensive risk that failure will not be detected. Limited safeguards in place to identify failure prior to occurrence. Process is directly supervised. Automated safeguards for identifying variances.</td>
</tr>
</tbody>
</table>

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.

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 employing as well as contracting with approximately 15 (fifteen) providers for whom Regional Hospital processes claims for professional services. November 2008, the clinic 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 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. This 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

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

Dawnette Kindelt
530-669-5544