A New Era of Government Enforcement:
Strategies for Preparing for and Responding to Government Audits

HCCA 2014 Clinical Practice Compliance Conference
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A New Era of Government Enforcement

- Overview of Regulatory Environment
- Risk Areas for Physician Practice Compliance
- Legal Perspective on Audits/Appeals
Overview of Regulatory Environment

The Affordable Care Act

- Strengthens the government’s ability to fight healthcare fraud and abuse through ample funding and a variety of amendments to criminal, civil and administrative laws:
  - Provides $350M over 10 years to help fight fraud
  - Strengthens the False Claims Act
  - Makes it easier for the DOJ to investigate fraud by expanding subpoena power and makes obstructing an investigation a crime
  - Requires the Secretary to expand the CMS integrated data repository
  - Establishes Mandatory compliance programs for practically all providers.
  - Directs Sentencing Commission to increase Federal Sentencing Guidelines for those convicted of health care offenses
  - Requires states to adopt RAC programs for Medicaid
  - Increases the OIG’s exclusionary authority
Improper payments are a small percentage of Medicare and Medicaid budgets, but aggressive enforcement affords a high return on investments

- In FY 2012, HCFAC returned $4.2 Billion in fraudulent payments
- In FY 2010-2012, the HCFAC has returned $7.90 for every $1 it spends
The Affordable Care Act mandates compliance programs for practically all healthcare providers and suppliers:

- Section 6102:
  - requires nursing facilities to have an effective compliance program in place by March 23, 2013
- Section 6401:
  - requires all providers and suppliers participating in federal health programs to establish compliance programs with certain core elements as a condition of enrollment in Medicare, Medicaid or CHIP (no effective date)

**COMPLIANCE PROGRAM: SEVEN FUNDAMENTAL ELEMENTS**

1. Implementing written policies, procedures, and standards of conduct.
2. Designating a compliance officer and compliance committee.
3. Conducting effective training and education.
4. Developing effective lines of communication.
5. Enforcing standards through well publicized disciplinary guidelines.
6. Conducting internal monitoring and auditing.
7. Responding promptly to detected offenses and developing corrective action.
Compliance Program Guidance

- Individual and Small Group Physician Practices:
  - “Unlike other guidance issued by the OIG, this guidance for physicians does not suggest that physician practices implement all seven components of a full scale compliance program.”
  - “Instead, the guidance emphasizes a step by step approach to follow in developing and implementing a voluntary compliance program. This change is in recognition of the financial and staffing resource constraints faced.”

Effective Compliance Programs

- **Updating** the Compliance Program to reflect past problems and corrective actions (“the Eighth element”)
  - Without constant assessment and revision, the compliance program will not effectively manage the risks the facility faces.
  - These risks change over time, and the compliance program should mirror those changes.
  - Bottom line: compliance programs are fluid, not static.
Enforcement Agencies

- Office of Inspector General (OIG)
- Department of Justice (DOJ)
- Medicaid Fraud Control Unit (MFCU)
- Quality Improvement Organization (QIO)
- Zone Program Integrity Contractors (ZPICs)
- Medicare Administrative Contractors (MACs)
- Recovery Audit Contractors (RACs)
- Medicaid Integrity Contractors (MICs)
- Medicaid RACs
OIG/DOJ Investigations

- Office of Inspector General (OIG)
  - Conducts investigations of fraud and misconduct to safeguard HHS’ programs
  - OIG has authority to exclude individuals and entities from participation in all federal healthcare programs
  - Authority to levy hefty administrative penalties and assessments against providers as punishment for filing false or improper claims under the Civil Money Penalties Law
  - Refers to DOJ for criminal prosecution and civil action
  - Establishes and enforces Corporate Integrity Agreements

- Department of Justice (DOJ)
  - Prosecutes legal actions against providers under Stark Law, Anti-Kickback, and False Claims Act
  - Civil and Criminal Jurisdiction
Columbia University Settles False Claim Suit

- Columbia University settled with the U.S. Attorney for $995,000
  - Complaint alleges Columbia University and New York Presbyterian Hospital failed to stop Dr. Goluboff’s fraudulent claims even though the university recognized “alarming compliance issues”
  - Dr. Goluboff, Director of Urology at Allen Pavilion of New York Presbyterian Hospital and Associate Professor of Clinical Urology at the College of Physicians and Surgeons at Columbia University, allegedly violated the False Claims Act by:
    - billing Medicare for more procedures than were possible to complete in a day and
    - billed for medically unnecessary diagnostic tests
  - “This case should serve as a reminder that regardless of how well-established or prestigious the entity or individual, this Office will pursue those who engage in Medicare Fraud, and they will bear the costs of their actions.” Preet Bharara, U.S. Attorney for the Southern District of New York

Largest Medicare Fraud Takedown in History

- October 2012: Arrested 91 defendants in 7 cities accused of $429 million in false billings.
- Involved more than 500 law enforcement agents from the FBI, OIG, and Medicaid Fraud Control Units.
- Those arrested included doctors, nurses, and health care company owners.
- HHS also used its power under the ACA to suspend payments to 30 other health care providers based on credible allegations of fraud.
Risk Areas for Physician Practice Compliance

OIG Work Plan 2013: Physicians

- Payments to Providers Subject to Debt Collection
- High Cumulative Part B Payments
- Physician-Owned Distributors of Orthopedic Implants Used in Spinal Fusion Procedures
- Anesthesia Services —Payments for Personally Performed Services
- Noncompliance With Assignment Rules and Excessive Billing of Beneficiaries
### OIG Work Plan 2013: Physicians

- Incident-to Services
- Place-of-Service Coding Errors
- E/M Services
- Use of Modifiers During Global Surgery Period
- Chiropractors—Part B Payments for Noncovered Services

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### Place-of-Service Errors

- Medicare reimburses differently depending on where the services are performed.
- For some procedures, a higher payment is allowed when a service is performed in a nonfacility setting, such as a physician’s office, than when the service is performed in a hospital outpatient, inpatient or ASC department.
- This is an easy target to assess.
  - Compare facility claims with physician claims
    - Inpatient vs. Observation
    - Inpatient vs. Swingbed
Place of Service (POS):

Example of different POS allowances: (VA 2013)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Pay in Non-facility (Office)</th>
<th>Pay in Facility</th>
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</thead>
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<tr>
<td><strong>New Patient Visits:</strong></td>
<td></td>
<td></td>
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<tr>
<td>99203</td>
<td>$105.64</td>
<td>$73.40</td>
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<tr>
<td>99204</td>
<td>$160.86</td>
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<tr>
<td>99205</td>
<td>$199.33</td>
<td>$161.10</td>
</tr>
<tr>
<td><strong>Established Patient Visits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>$71.31</td>
<td>$48.70</td>
</tr>
<tr>
<td>99214</td>
<td>$104.71</td>
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<tr>
<td>99215</td>
<td>$140.09</td>
<td>$105.85</td>
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<tr>
<td><strong>Other Services:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20670 (Removal implant)</td>
<td>$388.47</td>
<td>$146.48</td>
</tr>
<tr>
<td>58823 (Drainage pelvic abscess)</td>
<td>$899.61</td>
<td>$163.66</td>
</tr>
</tbody>
</table>

“Incident to” Services

- Physician must have personally performed the initial evaluation and plan for each patient problem.
- Physician must remain actively involved.
- There must be direct supervision to bill “incident to” services. (present in the office suite)
  - If you are a solo practitioner, you must directly supervise the care.
  - If you are in a group, any physician member of the group may be present in the office to supervise.
- “Incident to” does not apply when the patient comes in with new problem(s) and the physician does not see and evaluate the condition. In this case, the service must be billed by the NPP. (Reimbursed at 85% of fee schedule)
- “Incident to” does not apply in the hospital or SNF setting.
Modifier Use during Global Surgical Period

- CMS and OIG have identified improper use of modifiers during the global surgical period, which resulted in inappropriate payments.
- Review the CMS Fee Schedule Indicator List to determine the global period.
- Understand the rules related to the following modifiers:
  - Modifier 24: Unrelated E/M during postop period
  - Modifier 25: Significant, separately E/M service on same day as procedure.
  - Modifier 57: Decision for surgery
- Also understand NCCI edits and bundling policies.
  - Modifier 59: Distinct procedural service.

Incorrect E/M Service Billed

- New patient E/M billed incorrectly.
  - A New patient is one who has not received any professional services (i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.
  - Issue with hospital owned practices, same Tax ID, same specialty, in different locations.
- Appropriate E/M service for patients in Nursing Facilities.
  - Problem for patients in swingbeds.
## Trends of E/M & Other Services Billed

- OIG, RACs, and other auditors are performing provider profiles to look at the changes in level of E/M services billed in comparison to previous billing patterns and with like specialties. When a significant trend is identified, the provider will likely be audited.
  - Identify questionable billing patterns.
    - Has there been a change in your billing?
  - Compare your billing with peers.
    - Medicare “Comparative Billing Reports”
  - Understand the LCD and NCD guidelines for your services billed.
    - Someone in the practice should be responsible for knowing the specific guidelines/requirements related to the services billed by the practice.

## Improper E/M Payment

- OIG and CMS have identified inappropriate payments for E/M Services.
- Medicare contractors have noted an increased frequency of medical records with identical documentation across services. (Cloning)
- OIG has identified EHR documentation practices associated with improper payments.
Cloning and EHR Risks

- Cloned documentation does not meet medical necessity requirements due to the lack of specificity and the information documented is not unique for each patient.
  - Same type of ROS, Exam, etc. from different patient to patient.
  - Same HPI, ROS, Exam & MDM for same patient, visit to visit.
  - The HPI and Exam is only good for one visit and cannot be carried over to the next visit. Instead, providers should document what has occurred from the prior visit to current visit. Including old history information from a prior visit, is acceptable but this would be considered past medical history.

Cloning and EHR Risks

- Unnecessary and non-pertinent information documented in the note that does not relate to the patient’s current complaint or problem.
  - Example: Young healthy patient comes in with ingrown toenail.
    - Exam documents “Head: normocephalic and atraumatic”; Eyes: PERRL/EOM intact, conjunctiva and sclera clear without nystagmus”; “Ears: TM’s intact and clear with normal canals with grossly normal hearing”, etc.
    - Nothing in the medical note to warrant these exam elements.
    - Yet these exam elements are being used to help select the E/M level of service.
Cloning and EHR Risks

- Contradictory information in the note:
  - Example: Patient comes in with a complaint of depression and suicidal ideation. The Review of System (ROS) states denies any psychiatric issues/complaint. The examination documents a normal psych exam. The MDM lists major depression with SI, admit to psych facility.

- Each note needs to be individualized to the patient’s present visit.

- Medicare would rather see quality information instead of quantity just to get to a higher level of service. Medicare is discounting elements that do not relate to the patient’s condition.

Cloning and EHR Risks

- Be aware of templates, simple clicks for population of comprehensive exam, complete ROS and automatic insertion of a complete ROS and/or a comprehensive physical exam, with some expectation that the provider will delete those systems that were not included in the review or exam. (SEE HANDOUT)

- EHRs tend to encourage providers to bill a higher level of service than what is medically necessary and appropriate.
  - Do not automatically rely on the code selected by the EHR system. Medical necessity must be a key part of determining the correct level of service.
## Medical Necessity

- Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT code.
- It would not be medically necessary or appropriate to bill a higher level E/M service when a lower level of service is warranted.
- The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation must support the level of service reported.
- ICD-9-CM diagnosis codes help establish the medical necessity. Be sure to link diagnosis codes with specific procedures.

## Items to Assess in the Medical Record:

- These may be simple, but they effect claim denials:
  - Record should be complete and legible.
  - Patient name/demographics on every page, not just the first page.
  - Date of service on every page/form.
  - Date (including the year) and legible identity of the provider (including credentials).
Items to Assess in the Medical Record:

- Basic Evaluation and Management (E/M):
  - Chief complaint in every note.
  - History of Present Illness (HPI)
    - Must be documented by MD/NPP
    - What has occurred from prior visit to present visit.
    - Cannot be copied from prior visit.
  - Review of Systems (ROS)
    - An area lacking for many hospital notes
    - Assess for contradictions with HPI element.

- Past Medical, Family and Social History:
  - Needs to be pertinent to the patient and their problem(s)
    - Example of EHR note: “denies smoking, denies alcohol” for a 6 month old child.
  - Family history required for some comprehensive visits.
    - Do not use verbiage such as “unremarkable” or “noncontributory” – does not identify what was asked about the family history.
Items to Assess in the Medical Record:

o Basic Evaluation and Management (E/M):
  - An Examination also needs to be pertinent to the patient’s problems.
  - Just listing examination bullets to obtain a higher level of service is not appropriate.
  - Be sure to include all pertinent exam findings. If all exam elements are normal, insurance carriers may question the diagnosis, diagnostic tests ordered, and complexity of the visit.

Items to Assess in the Medical Record:

o Basic Evaluation and Management (E/M):
  - Medical Decision Making (MDM):
    - This element helps establish the medical necessity for the visit.
    - Record impressions, recommendations, plans, the patient’s progress, response to and changes in treatment, and anything pertinent to the treatment of the patient.
    - The CPT and ICD-9-CM codes reported on the claim must be supported by the documentation in the medical record.
### Items to Assess in the Medical Record:

**Basic Evaluation and Management (E/M):**
- Should “Time” be a factor in selecting the E/M level of care?
- Based on medical necessity for the overall visit, is the level of service billed correctly?
  - Just because a comprehensive history and examination were documented, does not mean the service should be billed at the highest level.
- Is the right type of E/M code selected:
  - New or Established, Initial or Subsequent, Inpatient or Outpatient, etc.

**What other services are documented in the note?**
- Can these services be billed separately or are they considered incidental?
  - Pulse oximetry
  - Cerumen removal
- Are “timed” codes properly documented? (i.e. discharge summary, critical care, prolonged services)
- Are there significantly separate services that can be billed with the E/M procedure?
  - Use of Modifier 25
  - Built into every procedure is some assessment and evaluation, but does the note support both a procedure and the E/M service?
Legal Perspective on Audits/Appeals

False Claims Act

- False Claims Act: 31 USC 3729
  - Primary civil statute used for prosecution of health care fraud related to billing issues
- Fraud Enforcement and Recovery Act (2009)
  - Greatly strengthened the False Claims Act by broadening providers obligations and expanding liability for overpayment
- The Affordable Care Act (2010)
  - Further strengthens the False Claims Act by providing a time limit on repayment
Under The Affordable Care Act, providers have 60 days to report “identified” overpayments to the applicable federal payor:

- When is an overpayment “identified”?  
- The report must include both an explanation of the reason the overpayment occurred and payment for any overpayments received

If the provider does not meet the 60 day repayment provision, the failure to report and repay may constitute a violation of the False Claims Act

- Due to the hefty penalties under the False Claims Act, providers should be careful to disclose overpayments in a timely manner

Providers discover billing errors in a number of ways:

- Planned self audits
- Reports from billing/coding staff
- Reports from patients

Once billing errors are discovered, providers have an obligation to make appropriate disclosures and repayments of any overpayments received to the applicable governmental payor.

To ensure the provider is in control of the release of billing error information, the provider should follow set guidelines for conducting self audits.
Conducting Self-Audits: Steps and Tips

1. Consider whether to the audit under the attorney client privilege.
2. Define criteria for determining the initial scope of the audit.
3. Set criteria for expanding the scope of the audit.
4. Determine what overpayments were received.
5. Conduct an internal investigation as to the reasons for the billing errors.
6. Put corrective measures in place and continue to monitor compliance.
7. Stop the inappropriate conduct.
8. Disclose the overpayments to the appropriate authorities.

Managing the RAC Appeals Process

Providers may appeal RAC denials through a 5+ step administrative and judicial appellate process:

- **Step 0**  Rebuttal Letter with the RAC
- **Step 1**  Redetermination (MAC)
- **Step 2**  Reconsideration (QIC)
- **Step 3**  Administrative Law Judge (ALJ)
- **Step 4**  Medicare Administrative Council (MAC)
- **Step 5**  Judicial Review (Federal District Court)

The entire process may take 12-36 months per claim.
Strategies for Successful Appeals

1. Be Organized—Track all denials, appeal deadlines, appeal outcomes and repayments in a centralized tracking tool.
   - Set internal working deadlines to ensure appeal deadlines are met.

2. Submit Organized Appeals—Organize the submission to make it easy for the fact-finder to follow your case.
   - Highlight important documentation;
   - Include a cover memo;
   - Organize the record submission by date or other relevant structure;
   - Include written statements from clinical or utilization review staff, where appropriate; and
   - Number pages for easy reference.

3. Keep Costs Low—Put policies and procedures in place now to streamline the appeals process.
   - Develop template letters;
   - Utilize CMS developed appeal forms;
   - Obtain assistance from available in-house resources; and
   - Obtain assistance from affordable outside resources (legal counsel/consultants).

4. Challenge Determinations—
   - Check to be sure the auditors correctly applied the Medicare or Medicaid regulations and guidance documents.
   - Verify that the regulations and guidance applied are applicable to your claim (the document in place at the time services were rendered and is from the correct jurisdiction).
Strategies for Successful Appeals

5. **Keep a Copy of all Communications and Documentation**—Make sure you can support the timely delivery and complete submission of required documentation.
   - Submit all appellate documentation via a traceable format (e.g. certified U.S. Mail, Federal Express)
   - Keep a copy of all submissions for later reference

6. **Challenge Statistical Analysis**—The RACs, Medicaid auditors, and MICs are all permitted to utilize extrapolation methodology.

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Strategies for Successful Appeals

7. **Challenge the Reviewer's Credentials**
   - Under the permanent RAC program, providers have the right to request and receive a copy of the RAC reviewer's credentials.
   - If the reviewer is not qualified to make the medical necessity or documentation determinations at issue in the denial, providers may be able to refute the reviewer’s findings by presenting opinions from appropriately trained and credentialed experts.
Audit the Auditors

- CMS’ auditors must work within the legal framework of the Medicare program, including statutes, regulations, CMS manual provisions, and informal guidance from Medicare contractors. Ensure that the policy the auditor is enforcing applies to your provider type, region, etc.

- RAC audit issues must be approved by CMS. In some instances, the RACs have audited issues that are not on the “approved list.” In these cases, an early challenge of the RAC’s authority to audit the issue may end the audit.

Voluntary Repayment

- In some cases, the auditor’s repayment demand is small compared to the cost of appeal, even if you believe the services were billed and paid appropriately.

- If making a voluntary repayment because of a cost/benefit analysis, indicate disagreement with the audit findings in the repayment letter.
QUESTIONS

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