Internal Monitoring: Keeping your Physicians on Track with Compliance

Connie Richards
Chief Executive Officer
Eye Specialists of Mid Florida

Mary Pat Johnson, COMT, CPC, COE, CPMA
Senior Consultant
Corcoran Consulting Group

Financial Disclosure

Connie Richards has no financial interest to in the subject matter of this presentation

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Who's watching?

- Office of Inspector General (OIG)
- Comprehensive Error Rate Testing (CERT)
- Recovery Audit Contractors (RAC)
- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Zone Program Integrity Contractors (ZPIC)
- Program Safeguard Contractors (PSC)

Indications of Non-Compliance

- Staff turnover
- Claims paid slowly
- Frequent problems with claims
- Problem claims unresolved
- Staff takes work home
- Poor morale
- Irregular accounting
- You are under scrutiny by Medicare or other payers

OIG Guidance

- Office of Inspector General (OIG), HHS
- Published “Compliance Program Guidance for Individual and Small Group Physician Practices”
- Not mandatory but advisable
- Mandatory CP is coming soon...

Source: Federal Register Vol 65, No 194, October 5, 2000

7 Elements of an Effective CP

- 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
The Best Defense is a Good Offense

• Be proactive
• Make compliance a priority
• Stress importance of accurate, complete documentation
• Get buy-in from management, physicians and staff
• Establish expectations and protocols
• Conduct training
• Monitor the results.....this is auditing!

Auditing and Monitoring

• Review standards and procedures
• Claims submission audit
  • Are bills accurately coded?
  • Is documentation complete?
  • Are services reasonable and necessary?
  • Any incentives for unnecessary services?
• Baseline audit within 3 mos of initial training, and thereafter on an annual basis
  • 5-10 records per physician

Source: Federal Register Vol 65, No 194, October 5, 2000

Things to Consider

• Select your reviewers
• Post-payment or pre-payment
• Review several components
  • Medical Records
    • Exams, tests, op-notes, correspondence
  • Financial Records
  • Forms
    • Consents, waivers, registration
  • Policies and procedures
• Legal and financial arrangements

Who Are Your Reviewers?

• Create a Quality Assurance Team
  • Physicians
  • Management
  • Staff
• Potential auditors in the practice
  • Understand ophthalmology
  • Understand documentation and billing rules
  • Consider a team approach
    • Members of clinical staff (technicians, nurses)
    • Members of the billing staff

Attitude

• Extremely important
• Choose auditor carefully
  • Objective
  • Reasonable
  • Respected
  • Moderate authority
• Goal is to educate and correct
• Don’t punish or intimidate

Prospective Audit

• Review before claims are filed
• Emphasis on prevention
• Identify improper billings – correct it
• Identify inadequate chart documentation – fix it
• Less time consuming
• Less costly
Retrospective Audit

- Reviewed after claims are filed
- Emphasis on remediation
- Response to a complaint or investigation
- Identify improper billing
- Identify improper reimbursement
- Make restitution for overpayments
- Initiate remedies to prevent future errors

Getting Started

What To Look For?

- Quality of documentation
  - Accuracy of notes
  - Appropriate forms
  - Appropriate signatures
  - Accuracy of claims
  - Efficiency or inefficiency of internal procedures

Summary of Common Mistakes

- Undercharging for services
  - Lost charges
  - Downcoding
- Coding errors
- Overcharging for services
  - Inadequate chart documentation
  - Missing documentation
  - Fragmentation

Source: CCG’s Chart Reviews

Computing the Score

- Two separate scores
  - Frequency of each error
  - Financial impact of errors

Discussing Your Findings

- Praise first
- Select your audience
- Limit your battles
- Have your facts ready
- Get back up if needed
- Stay calm
- Be prepared to offer solutions
What Next?

- Fix identified problems
  - Rebill
  - Refund overpayments
  - Train physicians and staff
  - Create or update practice policies
- Repeat chart review
  - Focus on problems previously identified
  - Look for new issues
  - Follow Compliance Program

Refunding Overpayments

- ACA §6402(a) provided that knowingly retaining an overpayment creates liability under the False Claims Act
- Final regulations published February 11, 2016 explains that a provider has 60 days to refund under the broad definition of an “identified” overpayment

Source:

Refunding Overpayments

- Regulation states that a provider has an obligation to conduct “reasonable diligence” once the provider has credible information of a potential overpayment, and that barring exceptional circumstances, that inquiry should take no more than 6 months
- 60 day refund clock begins once the overpayment amount has been calculated
- Lookback period is within 6 years of the date the overpayment was received

Source:

Refund Overpayments

- Solitary vs. broad overpayments
- Refund payer claim by claim
  - Send with letter and copy of EOB
  - Check for carrier instructions
  - Full refund with corrected claim
  - Refund claim difference
- Refund patients
  - 60 days for incorrectly collected
  - 30 days for services not covered (no ABN)
  - Violation of provider agreement if refunds not timely

Source:

Then, do it all again

- Repeat audit in timely manner based on the results
- Look for improvement from one audit to next
- If no improvement, what’s next?
  - More auditing
  - Training

Source:
Medicare Transmittal AB-00-41, May 2000
Business Description

• Located in Central Florida
• Seven locations
• One (1) Call Center
• Two (2) Surgery Centers
• Five (5) Ophthalmologists
• Twelve (12) Optometrists
• One hundred, seventy five (175) FTE’s

Compliance Mission

It is the policy of this Practice to maintain the highest degree of integrity in delivering health care to its patients.

• At all times strive to maintain compliance with all laws, rules, regulations and requirements affecting the practice of medicine and reimbursement.
• Bills only for services that are actually rendered, codes accurately to the best of our abilities, documents medical necessity and appropriateness, and adheres to all payor contracts.

Compliance Key Elements

• Current Formalized Compliance Plan
• Review plan annually
• Internal Auditing
• External Auditing
• Accountability

Compliance Auditing and Monitoring

To ensure ongoing compliance, compliance personnel will conduct regular audits of practice functions and operations subject to federal and state laws and regulations and private payor requirements. Those practice functions/operations include, but are not limited to, the following:

- Documentation & coding for services rendered
- Claim development and submission;
- Collection of copayments; and
- Overpayments.

Co-Payments Workflow

Pre-visit

- Patient-registration: initial
- Schedule appointment
- Verify insurance Preauthorization if necessary
- Patient called and notified of apt. and any co-pay or old balances due

Patient Appointment

- Patient Arrives
- Complete Registration
- Collect co-pay and old balances
- Batch Control

Internal Auditing Process

• All Doctors will have an internal routine audit every six months
• Cost of conducting an audit: $500
• Tech Audit Team (TAT)
• Audit Scoring
  • Favorable = 80% +
  • Unfavorable = 79% -
• Four (4) Levels of Auditing
## Internal Auditing Form

<table>
<thead>
<tr>
<th>Audit Level</th>
<th>Doctor Audited</th>
<th>Number Charts Audited</th>
<th>Audit By</th>
<th>Number of Errors</th>
<th>Date of Audit</th>
<th>Percent Errors</th>
<th>Audit Period</th>
<th>Percent of Accuracy</th>
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### Internal Auditing Process

#### Level 1 - Internal Auditing Process

**Level 1 – Step 1**
- Routine Audits for all doctors every six months
- Unfavorable results go to Level 2

**Level 1 – Step 2**
- 10 Charts selected at random per doctor every six months for routine audit
- Audit performed by TAT
- Audit findings sent to doctor and Medical Director
- Favorable Audit: Back to Level 1 – Step 1
- Unfavorable Audit: Go to Level 2

#### Level 2 - Internal Auditing Process

**Level 2 – Step 1**
- Unfavorable audit Level 1
- Review with Medical Director for corrective action plan
- Favorable Audit: Return to Level 1 – Step 1
- Unfavorable: Continue Level 2

**Level 2 – Step 2**
- 3 month audit performed by TAT
- Favorable Audit: Return to Level 1 – Step 1
- Unfavorable: Go to Level 3

**Level 2 – Step 3**
- 3 month audit performed by TAT
- Doctor pays $500 for cost of audit
- Favorable Audit: Return to Level 1 – Step 1
- Unfavorable: Go to Level 4

#### Level 3 - Internal Auditing Process

**Level 3 – Step 1**
- Unfavorable audit Level 2
- Review with Medical Director for formalize corrective action plan.
- Doctor responsible for all costs associated with plan

**Level 3 – Step 2**
- 3 month audit performed by TAT
- Favorable audit: Return to Level 1 – Step 1
- Unfavorable audit: Go to Level 4

**Level 3 – Step 3**
- Favorable audit: Return to Level 1 – Step 1
- Unfavorable audit: Go to Level 4

#### Level 4 - Internal Auditing Process

**Level 4 – Step 1**
- Unfavorable audit Level 3
- Review with Medical Director
- Intensive coaching and training plan
- Doctor responsible for all costs occurred

**Level 4 – Step 2**
- 3 month audit performed by TAT
- Doctor pays $1,000 for audit and administrative time

**Level 4 – Step 3**
- Favorable audit: Return to Level 1 – Step 1
- Unfavorable audit: Meet with Board of Directors
- Evaluate employment agreement and next steps
Quotes: by Bill Gates

“In our business, by the time you’re in trouble it’s too late to save yourself unless you’re running scared all the time, you’re gone”

“We all need people who will give us feedback. That’s how we improve”

More help…

For additional assistance or confidential consultation, please contact us.