Identified Compliance Risks, Investigations and Development of Corrective Action Plans

Consultants Corner

In the last article I wrote for BC Advantage I talked about the type of consulting projects our firm provides for clients all across this great nation. Many times I talk about what the potential problems are as well as how best to take action to correct the identified deficiencies. Like last time I am structuring my article a bit differently to help aid in your efforts to identify potential compliance risks, perform the necessary investigation and develop a corrective action plan that would be deemed acceptable by the OIG or DOJ if things for your practice ever got elevated to that level. This time I am writing about an issue that many of your practice or organizations can identify with.

Compliance Risk Identified:

A large medical practice in the State of Florida hired us to review documentation to identify potential compliance risks related to coding and billing practices. The review was on 45 providers in 6 different specialties. The review was to be done prospectively rather than retrospectively, which is fine until the point you recognize there is a problem. What is the difference between the two types of audits?

1. In a prospective billing audit, a designated practice staff person or internal compliance officer reviews the claims before they are submitted to the payer to ensure the appropriateness of the coding, documentation and adherence to health plan medical payment policies.
2. In a retrospective audit, a designated person reviews claims for appropriateness after they are paid. All overpayments and billing errors identified during a retrospective audit should be handled according to the payer's repayment guidelines.

The practice as a whole had a 60 percent error rate on their coding based on our auditors findings.

Background:

There are numerous types of audits (Probe, Focused, etc…) as well as audits performed by numerous entities (RAC, PSC, Carriers, etc…). As an example, did you know with Prepayment Reviews there are multiple types that take place? According to the CMS "Prepayment Reviews consist of Medical Review performed prior to payment and may or may not require submission of records. This may involve a system edit to prevent payment for non-covered and/or improperly coded services.

Types of prepay reviews:

AUTOMATED

In this type of review, decisions are made at the system level without the intervention of contractor personnel. Examples of this would be issues concerning the relationship between diagnoses, provider specialty, LCD and/or place of service.

ROUTINE REVIEW

This type review requires the intervention of MR staff because it cannot be automated. It may involve submission of attachments

other than medical records such as EKG strips or invoices and requires the reviewer to access the Claims History File and/or Internal Guidelines.

COMPLEX REVIEW

This type of review requires development for medical records and the evaluation of the documentation submitted. This requires a clinician who has a working knowledge of coverage and LCD's.

AUDITS

There are two types of prepay audits – services specific and provider specific.

SERVICE SPECIFIC AUDIT

This type of audit is put into place based on data analysis that identifies a problem. Typically, this audit will suspend claims based on the comparison of two or more element values on the same claim or they may compare dates with the medical record to determine medical necessity. In either case, documentation is requested and the claim may be denied or paid, depending on whether the documentation supports the service billed.

PROVIDER SPECIFIC AUDIT

This is the result of problem identification and may suspend all of the claims for a provider who has demonstrated unusual practice patterns. Documentation is requested and the claim may be denied or paid, depending on whether the documentation supports the service billed.

AUDIT MONITORING

Regardless of the type of audit, each audit implemented is evaluated at least quarterly for effectiveness. Audits are taken down when the denial rate falls to 20% or less. That said, this does not mean that every audit automatically runs at least a quarter. Provider response to correct problems expedites removal from audit and all results and recommendations are shared with CMS.

**Source: Pinnacle Medicare Services For the State of Rhode Island*

The issue we were running into with the practice was based on the fact that even if the prospective review showed areas of risk they were not interested in doing any sort of retrospective review due to the fact that it would in their opinion, "Open a can of

worms!"

While I tried to explain to the compliance officer the rationale behind converting to a retrospective audit and making voluntary refunds to avoid any criminal or civil monetary penalties or even more simply avoiding the interest that is tacked on to an overpayment when it is identified by the carrier, which could run in the thousands of dollars with what it was we were finding. No matter what I said, no matter what documentation I provided this individual they just did not want to hear it.

The investigation:

When we contracted with this client we agreed to perform the review of the physician documentation based on 10 dates of service per provider. Any provider falling below a 70% would have up to an additional 15 dates of service pulled for us to review. We do it this way to ensure that the sample pulled is a true representation for the provider's documentation and not just a bad sample.

While I respect the position of a compliance officer and I would never do anything to undermine their position, I also had to think not only about the organization as a whole but also my obligation to DecisionHealth in the event this provider was audited and then prosecuted for fraud or abuse. Our records would certainly be open to subpoena. I had suggested to the practice that prior to performing the audit they should consider running this through their legal counsel to ensure attorney client privilege. Again, the compliance officer was not interested in going down that path even though I explained that if this ever went to court and we were subpoenaed our summaries and reports were open to review for the other side and the information could come back to bite them if it was derogatory.

It became clear to me this compliance officer viewed us as nothing more that a pacifier for the physician leadership and ownership of the practice so, it was our obligation to speak directly with the Medical Director and the CEO of the organization to voice our concerns and potentially halt the review so we could speak with organization's legal counsel and try and figure out the best way to proceed.

During our call with the attorney for the group practice I explained that once we detected the pattern we made a recommendation to convert the audit to a retrospective review to ensure that if we identified any potential overpayments that we had options in front on us that were not only realistic but those that would work in the favor of the organization.

Recommendation(s) and Corrective Action Plan:

Correcting this problem was very challenging for a number of reasons.

1. With a 60% error rate we suggested that the attorney contact the carrier directly to set up a meeting to potentially self-disclose and make restitution to the carrier with the understanding that they would not reopen the case for any services specified in the patient universe being reviewed during the specific timeframe.
2. Keep in mind that self-disclosure does not always guarantee that you will not fall prey to prosecution or other potential penalties. However, most of the time it does work in the favor of the practice.
3. It was also recommended that all providers attend mandatory remedial CPT and ICD-9 training. All coders and billers were also required to attend the educational sessions.
4. Part of a compliance program requires education and training.
5. All providers in the group that scored below 70% were placed on an internal prepayment review of 10% of their total claims submitted for payment to the carrier weekly.
6. We did this internally due to the fact we would be able to review the documentation faster than the carrier would be able to and so it would not affect the revenue cycle for the group.
7. A thorough review of the compliance department needed to take place to identify deficiencies and/or noncompliance. A lengthy discussion took place with the attorney and the physician leaders of the practice to discuss our concerns with the compliance officer and the unwillingness to do things appropriately in our opinion.
8. Upon our review of the department we found that there really was no real compliance program in place, which was frightening due to the size of the practice and the fact this person was hired specifically to do that job. When we inquired as to why there were no real written policies or procedures or an actual plan, the compliance officer indicated that there were so many fires to put out that there just has not been enough time to develop a comprehensive program with specific policies and procedures.
9. The development of a comprehensive compliance program complete with specific policies and procedures needed to be created and that would be something our company would handle if they elected to have us do it.

Sean M. Weiss, *vice president of DecisionHealth Professional Services can be contacted directly at sweiss@dhprofessionalservices.com or at 770-402-0855. DecisionHealth Professional Services, is a service of DecisionHealth and provides full-scale medical consulting services in the areas of practice management, compliance and coding as well as health law services. To schedule a DecisionHealth Senior Consultant to come onsite to your practice or to learn more about our services visit us at www.dhprofessionalservices.com or contact us at 888-262-8354.*