



# Identified Compliance Risks, Investigations and Development of Corrective Action Plans

For years I have been writing for BC- Advantage 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. However, this time I have decided to structure 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.

Am I giving away my secrets for how we do things at Decision-Health Professional Services? Somewhat, but honestly, this is why you subscribe to a publication like BCA and it is the reason why they ask health care professionals such as myself to continue writing for them.

So, with all of that said, I have set this article up for you just as if I were performing an actual project for your practice! I hope you enjoy the article and it provides you with the necessary information you require to be successful in your organization at identifying potential risks and minimizing the affects through strong investigation and the development of effective corrective action plans.

## **Compliance Risk Identified:**

A large integrated delivery health system located in the Pacific Northwestern part of the United States hired us to perform prospective and retrospective audits for more than 350 providers. The problem identified within their subspecialties was the overwhelming number of level four and five Evaluation and Manage-

ment Services being billed out.

Like many of the subspecialists and super-subspecialists out there these providers believe they are entitled to always bill at the highest possible levels even when the patient is returning for a simple follow-up where everything for all intensive purposes is stable.

## **Background:**

Documentation should be based upon the nature of the patient's presenting problem(s) or what might be referred to as the Chief Complaint.

Many times providers believe the level of service is dependant upon how much documentation is contained within the patient's progress note for that encounter or how much time it took them in the room with the patient overall (not basing it on counseling and/or coordination of care).

What many providers fail to recognize is that regardless of the amount of documentation they amass during a visit with the patient, if it is not medically necessary the services will be reduced to an appropriate level for what the chief complaint actually supports.

The Social Security Act, Section 1862 (a)(1)(A) states: "No payment will be made ... for items or services ...not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member." This medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare.

Providers frequently “over document” and consequently select and bill for a higher-level E/M code than medically reasonable and necessary.

According to Medicare “Word processing software, the electronic medical record, and formatted note systems facilitate the “carry over” and repetitive “fill in” of stored information.” It should be noted that even if a “complete” note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service.

Information that has no pertinence to the patient’s situation at that specific time cannot be counted.

The current audit methodology we are employing with this client and many others that we are working with, is to perform a statistically valid sampling of the provider’s charts. Keep in mind there are really three different ways to perform an audit.

1. Pull 10 encounters for each provider. This is used as a good educational sampling. In the event the provider scores lower than 70% on the audit it is advised you increase the number of encounters being reviewed. This number can escalate to 45 encounters.
2. Pull 10% of the provider’s entire patient universe. This provides the most accurate sampling.
3. Pull 45 encounters per provider. This also provides a strong statistical sampling.

### **The investigation:**

When we perform audits or chart reviews as many of our clients want us to refer to them as in front of providers to assist them with understanding their potential risk as an organization as well as to assist them in identifying potential revenue opportunities, our first goal is to try and understand the providers thought process with regard to code selection.

Many times we find that providers are choosing levels of service based on all the wrong reasons or they are simply choosing a level of service because they just do not understand the criteria for selection of Evaluation and Management Service codes.

Regardless of the size of a practice or health care organization it is imperative providers are selecting levels of service that most accurately define what they have provided as a service to their patients.

It should also be noted that many times when we looked through

the charts or in the EMR/EHR system we were unable to find any documentation to support the fact the encounter even took place. Medicare expects the documentation to be generated at the time of service. Delayed entries within a reasonable time frame (24-48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service. Eugene J. Winter, M.D., Medical Director for First Coast Service Options, Inc provided the information contained in this paragraph.

Those of you with providers refusing to get their documentation completed within 24 hours of a patient visit need to share with them the fact they are actually in violation of Medicare Law as stated in the above paragraph.

The last item that we reviewed to ensure proper claims were being submitted to the carrier was the assignment of ICD-9-CM codes. It is not enough to link the procedure or service code to a correct, payable ICD-9-CM code. The diagnosis or clinical signs/symptoms must be present for the procedure or service to be paid.

### **Recommended Corrective Action Plan:**

Where Medicare provides clarity on this situation of how to properly document for levels of Evaluation and Management Services, DecisionHealth Professional Services made these recommendations to eliminate the compliance risk at this practice:

1. An internal policy should be developed as part of the overall compliance program to ensure compliance by all providers with this responsibility.
2. A baseline audit done at random of all providers will be performed annually to ensure a strong statistical sampling. Those providers falling below 70% will be re-reviewed within three (3) months after formal one-on-one training and provider shadowing has taken place. Those scoring below 80% will be re-audited within 9 months after one-on-one training with the provider. Those providers scoring 90% and above will be audited annually and required to attend an annual coding/billing and compliance course to ensure they remain up to date with all relevant changes.
3. A policy was to be created to provide clear guidance on documentation completion requirements. All documentation related to a patient encounter is to be completed within 24 hours of the patient visit or shortly thereafter.
4. Failure on the part of a provider to comply with this policy may result in the withholding of paychecks and/or bonuses due the provider.

It was also pointed out to the client and the problematic provid-

ers that Medicare takes the following stance in these areas of concern that were raised during the project:

- The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.
- Every note must stand alone, i.e., the performed services must be documented at the outset. Delayed written explanations will be considered. They serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.
- If the provider elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter must be documented in the medical record. Generally, the time must be documented when billing for all time-based codes, such as critical care, prolonged services, hospital discharge services, and others.
- All entries must be legible to another reader to a degree that

a meaningful review may be conducted. All notes should be dated, preferably timed, and signed by the author. In the office setting, initials are acceptable as long as they clearly identify the author. If the signature is not legible and does not identify the author, a printed version should be also recorded.

The client and the problematic providers in the group were reminded that they recently came out from under a CIA agreement and that they were still susceptible to being reviewed and having their documentation scrutinized by the carriers. The providers and the heads of the compliance department were also made aware of the False Claims Act and its potential impact on the organization. 

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