The Age of Audits

Is this the Golden Age of audits?

Joe W DeLoach, OD, FAAO
CEO, Practice Compliance Solutions
I am CEO of Practice Compliance Solutions. I have no financial interest in the company but this lecture does reference training products available from PCS.
The Bipolar World of Coding Experts

**PRACTICE CENTRIC BILLING**

- MAXIMUM use of examinations, testing and technology
- Twist the system in an attempt to get around the rules
- Do what puts the most money in the bank

**RESULT**
Indefensible care – often “worthless” per CMS (more later)
Massive audit exposure
Doctors getting severely hurt
Sleepless nights

**PATIENT CENTRIC BILLING**

- Medically necessary use of examinations, testing and technology
- 95% of rules are pretty clear – just follow them
- Do what’s right for the patient and the money will follow

**RESULT**
Defensible, medically necessary care
Minimal audit exposure
Very likely to make as much money just doing what’s right
Sleep like a baby
“Practice Centric Billing” has forced the payer world’s hand – the focus is now on fraud and abuse
Summary of the intense focus on fraud and abuse

It’s all about doing what is right for the patient, the right way, without any influence from real or perceived monetary gain
And doctors aren’t doing that?

2014 estimates of loss from fraud and abuse in the Medicare system alone

$71 BILLION

guess they aren’t…
2015 OIG Work Plan

• 77…count them…77 health care items
• Fraud and abuse cited by the OIG as the number one concern in health care today
• Please listen! Not the uninsured, not ACAs, not Medicaid expansion

IT IS DOCTORS, INCLUDING OPTOMETRISTS, ABUSING HEALTH CARE REIMBURSEMENT!
Per CERT 2013 Results

IMPROPER Payment to Us

Examination services $ 57,875,452
Diagnostic services $114,388,586
DMERC services $ 3,491,580

$175 MILLION

THINK THEY MAY WANT IT BACK???
Per CERT 2013 Results

#1 Insufficient documentation (65.5%)
#2 Incorrect coding (25.7%)
#3 NO documentation (4.3%)
#4 Lack of medical necessity (3.6%)

70% Of denials are based on medical record documentation issues

Reasons for Overpayment
What Did PCS Training Audits in 2013-15 Reveal?

After evaluating *THOUSANDS* of patient encounters:

- Average payback on “mini” audit (20 records) - 28.5% of receipts
- Average 5-yr recoupment penalty - $397,650.00
What We Have All Done Wrong

• Too much CE on making money
• Too much CE on “turning medical”
• Too much CE on making sure you have an “allowable diagnosis”

• Not enough CE on medical necessity, reason for the visit, record documentation and coding ethics
• Too much “opinion”
• Too much “someone else said so”
• Too little information based on *regional* payment policies
• “Experts” don’t do it
• “Experts” don’t audit

**Biggest problems....RESULT?**
Five Main Fraud and Abuse Laws

- False Claims Act
- Anti-Kickback Statute
- Provider Self-Referral Law
- Exclusion Statute
- Civil Monetary Penalties Law

If you don’t know what these laws say, you need to do some personal homework or I can make it easy for you with the PCS Fraud and Abuse Manual
So, how much of a liar are you?

Well I contend most all of you are!!!

*Wow, Joe….that’s pretty nervy coming from an old, short guy from Texas*

Well, I told you I would prove what I say, so here it is!
In submitting this claim for payment from federal funds, I certify that 1) the information on this form is true, accurate and complete 2) I have familiarized myself with all laws, regulations and program instructions available from the Medicare contractor 3) I have provided or can provide sufficient information required to allow the government to make an informed eligibility and payment decision 4) this claim complies with all Medicare program instructions and...

lists all five Federal F/A laws you can’t name!
But this is news to me, Joe!

“My signature is to certify that the foregoing information is true and accurate. I understand that any false claims or statements or concealment of a material fact may be prosecuted under applicable Federal and Stark laws.”

GOOD LUCK TRYING TO SAY YOU DIDN’T KNOW BETTER!
The Age of Audits

Optometry has never been a big “target” – has that changed?

If you are filing claims, you are a target!
And some of your colleagues are making you a bigger target!
The Age of Audits

What Has Changed?

• First and foremost – if you hadn’t heard, the government IS broke and looking for money!
• Health care reform – major emphasis on fraud, ABUSE and WASTE
• Change in False Claim Statute language from “knows or has reason to know” to “knows or should know”
• Qui Tam – The Whistleblower Act
• Predictive Analysis– the witch hunt is ON?
In order... the culprits in our world

1. Medicare
2. Aetna
3. VSP
4. BCBS
5. EyeMed
Auditing is VERY good business!

“Auditing has become one of our most profitable lines of business”

Medical Director, Aetna 2012

Take home message...
Types of Audits

Historical: Post-Payment (“Pay and chase”)

- Medical Review – review of medical record to evaluate record documents medical necessity for money already paid
- Statistical Monitoring – contracted agent (CERT, RAC) reviews claim based on statistical analysis of billing patterns and “mini” samples

The Future (October 2016): Predictive Analysis (“Guilty until proven innocent”)

- Records review by cognitive software – “predicted” improper payment withheld until medical record produced
The Age of Audits

What Triggers an Audit

• Specialization
• Success (The “Ladder Principle”)
• Repetition
• High utilization of single codes
• Billing codes not commonly used by the majority of your colleagues
• Billing codes at a higher percentage rate than the majority of your colleagues

None inherently wrong, but...
Important point...

Number 1 reason you will be audited

BILLING AND CODING PRACTICES

Number 1 reason you will LOSE an audit

POOR MEDICAL RECORDS DOCUMENTATION
Per Frank Cohen, EMG Inc.  
National audit authority

“You’re going to get audited, so…”

Top Five Reasons Doctors Lose Audits

1. No documentation
2. Inadequate documentation
3. Lack of medical necessity (per payment policy)
4. Incorrect / non-specific diagnosis code
5. Provider issues (lack of signature, attending physician not the billing physician)
Audit Defense

The best defense is always a great offense!

• Keep exquisite medical records
• Know your payor rules and policies (remember they are REGIONAL!!)
• Keep updated by signing up for payer website listserves and newsletters
Audit Defense - Two New Tools

• “Training” audits (now Federal mandate under Fraud and Abuse Compliance)
• If you do not have exquisite expertise in billing, coding and payer rules, consider
  • Outsourcing billing services to professionals or
  • Find someone to train your staff how to do this correctly
Defending an unfavorable audit

So how does this work…

- FIRST AND FOREMOST – always fight back (well, almost always…)
- First audit (nurse or lay person) – simply denied
- Peer appeal (must be optometrist) – you must justify every examination and test performed based on
  - Medical necessity
  - Preferred practice patterns
  - Standards of care
  - Prove not “worthless” (remember how CMS defines that)
Let’s look at the biggest problems encountered in most audits
Problem #1
Illegible Paper Records

- This one is easy – can’t read it, automatic denial
- EXTREMELY difficult audit defense
- Documentation is next to impossible with ICD-10
- Is the idea that “they can’t make me use an EHR” valid?
Problem #2
Unclear Review of History

CPT states that on established visits, it must be clear to an auditor that the attending physician PERSONALLY conducted the HPI and applicable history elements were reviewed and updated. You have two choices:

• Make changes, if present, to the patient’s history and hope that an auditor recognizes the changes made (without the previous record? Good luck!)

• Make a note in your history section that you personally conducted the HPI and reviewed all other history elements, and INITIAL it
This one is easy to fix

• If the history is brought forward and you make and initial a “reviewed” statement, your level of history is credited as the same as the history you reviewed (*IF it was medically necessary!*)

• The DOCTOR, not the staff must initial the review

EXAMPLE REVIEWED STATEMENT

“I personally conducted the HPI and reviewed the patient’s history elements and made changes where appropriate. JWD 1/1/16”
Every diagnostic test must have an associated interpretation and report. Without an interpretation and report, an auditor can deny reimbursement for the test. Here’s the rub…CPT did not bless us with directions on what should be included in an interpretation and report.
WHAT SOME SAY AND THE “BIG FOUR”

- Statement of reason test was run
- Brief summary of results
- Statement of reliability of the data
- Statement of cooperation of the patient
- Diagnosis associated with the test
- Statement of how the results will assist in diagnosis and management of condition
Problem #3 subset
Orders for Diagnostic Tests

- CPT says that for every diagnostic test…
  - It must be clear to the auditor from the medical record why you performed the test
  - OR -
  - The record must include a physician “order” for the test
- The first one is deadly – the second is much better!
Three Places for Orders

- In the plan of the previous examination (that the auditor does not have!)
- In the reason for visit for the current examination
- In the plan of the current examination or in an order section noting the test is to be performed that day

All OK… but suggest #1 (for your tech’s sake) AND #2 or #3 (for the auditor’s sake)
Problem #5
Medical Record Signatures

• CPT / CMS require that patient encounters must contain a signature of the examining physician – easy with EHR
• Although not mandated, could be best if on every page of the examination (easy with most EHRs)
• For a paper record, a signature is just that….your written signature – MUST be legible (or claim DENIED!). For that matter, if ALL your written recordings are not legible, claim denied. Can attest with signature log or printed signature (no stamps or “signature on file”).
Problem #6
Documenting a Contact Lens Evaluation

- Vision companies, especially the big ones, have specific requirements for documenting a billable contact lens evaluation. See the next slide for what they are!
- Without proper documentation, companies will take back the contact lens fitting fee
- One of the companies will take back the contact lens fitting fee AND the money your patient paid out of pocket for contact lens services
Documenting a Contact Lens Evaluation

1. History needs to include the lenses worn, how they are worn, solutions used
2. Examination needs to document the fitting characteristics of the lenses (NOTE: Simply documenting WHAT trial lenses were used is not sufficient – need to note the fit)
3. Findings should include K’s and SOR (mandate of VSP)
4. The assessment needs to state how the patient is doing with the lenses
5. The plan needs to state what you are doing going forward, even if that is no change
Problem #7
Template Mis-Use

- Templates are completely legal and proper – if used properly
- You need to assure that the findings recorded were actually from observations performed THAT VISIT (appropriate findings can look very similar visit to visit – not your fault)

How do you do that?
“Suspicious” Templates

First of all, by definition, they all are – but:

- Lack of “except as noted” language
- No signed review of history
- OVER or inappropriate documentation of case history (“over”- really?)
- Impossible findings (best example – retinal periphery is stated as normal but patient was not dilated)
- Diagnosis with no abnormal clinical findings
- The obvious – EVERY chart looks the same

EVER HEARD OF AN “AUDIT TRAIL”?
Problem #8
Wrong Diagnosis(es)

- Doesn’t answer the reason for the visit (denied)
- Not backed up by clinical findings (“blurred vision”)
- There is a big difference between documentation of a medical record and what goes on your insurance form. This is not opinion, CPT directs us what to do here.
Three Coding Tenets re: diagnoses – Per CPT

Primary Diagnosis
Primary diagnosis is the diagnosis that answers the primary reason for the visit. Should correlate with your procedure code(s) on your insurance submission.

Subsequent Diagnosis
Subsequent diagnoses are those revealed during the encounter. They may or may not be included on the insurance submission but may demonstrate increased complexity of the encounter or justify medical necessity of other services.

Existing Diagnoses
Existing diagnoses are those conditions the patient has or has had in the past. They SHOULD NOT be included in the insurance submission unless the physician took action on them during the encounter.
Problem #8
Mis-Use of -59 and -25 Modifiers

-59 THE MOST ABUSED MODIFIER IN ALL OF HEALTH CARE – SETTLED EASILY – PER CPT: “It is not appropriate to use the -59 modifier unless dealing with serious ocular conditions where delay in obtaining information from two edited procedures could result in acute harm to the patient”

-25 PER THE OIG: “In general, a provider should not bill evaluation and management codes on the same day as a procedure or other service unless the evaluation and management service is unrelated to such procedure or service.”
Problem #9

LOTS of testing is good...and necessary

The Sources of the Problem

• BAD practice management advice. *Translation: Greed*
• BAD instrument company advice. *Translation: Double Greed*
• Unsure of diagnosis / “chasing unicorns”. *Result: Testing too much and too often; over-referrals*
• Defensive medicine – confusion between medical necessity, preferred practice patterns and “standard of care”. *Result: Over-testing and over-referrals*

ULTIMATE EXAMPLE: THE ASSAULT OF GLAUCOMA
WHAT IN GENERAL IS THE HEALTH CARE FIELD UP TO

Quantia Report 2014

- $750 Billion wasted per year (1/3 of healthcare expenditures)
- 2011 data shows $210 billion spent on unnecessary testing – worse now
- 25% of patients said providers reordered tests for more accurate diagnosis – *with no evidence that happened*
WHAT IN GENERAL IS THE HEALTH CARE FIELD UP TO

Quantia Report 2014 – Drivers of Abuse

- Fee for Service structure *(Greed?)*
- Some patients / doctors equate more testing with better care *(Mis-information or Marketing?)*
- Glamor of technology *(More marketing?)*
- Defensive medicine *(Necessary or excuse?)*
- Easier to order a test than write an Rx / use cognitive skills *(OUCH)*
“Confirmatory” Testing – Just a few examples to make you think

- The American College of Physicians estimates excessive testing costs the health care system between $200-$250 BILLION every year (2012 number – and just getting worse)

- The American Cancer Society - Dr. Brawley (ex-Director) states the $10 stool test has been shown to save lives equally, but in the United States, the $3,000 colonoscopy is mostly commonly used. “Everyone is getting the expensive test, even though the cheaper test is better. But the cheaper test involves handling shi… and no one can make money off of it,” Brawley said.

- Closer to home…

  In the United States, despite the barrage of increased technology, some likely worthless, the overall incidence of blindness from glaucoma has not changed in over two decades
Forget all that...bottom line - over testing is just flat WRONG

Per CMS:
Medical record documentation must clearly indicate rationale which supports the medical necessity for performing each test. Documentation should also reflect how the test results were used in the patient’s plan of care.

“It would not be considered medically reasonable and necessary to perform any diagnostic procedure simply to provide additional confirmatory information for a diagnosis or treatment which has already been determined.” (my emphasis added)
Optometry does not understand the concept of problem specific care, a fundamental tenet of medical necessity.

The only care medically necessary is that care that is needed to answer the reason for the visit.

And the rest of the medical world does get it?