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Compliance Workplan for Physician Practices

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Compliance Workplan for Physician Practices

- Put together a practical plan for your physician's practice
  - Internal resources to perform audits
  - External resources identified and cost allocated
  - Extent of compliance plan identified
  - Physician buy-in
- Identify the areas of highest risk
  - Single specialty or multi-specialty practice
  - Recent probe reviews done by Medicare and Medicaid
  - Midlevel providers
  - Denials

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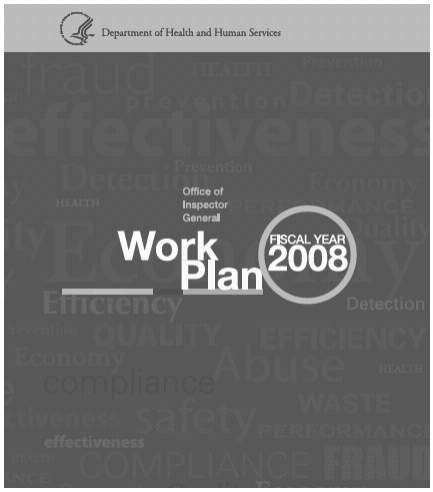
Where do you start?



Compliance Workplan for Physician Practices

- 2008 OIG Workplan
  - Medicare Physicians and Other Health Professionals
    - Place of Service Errors
    - Evaluation and Management Services During Global Surgery Periods
    - Medicare Payments for Psychiatric Services
    - Services Performed by Clinical Social Workers
    - Medicare Payments for Selected Physician Services
    - Medicare “Incident To” Services
    - Appropriateness of Medicare Payments for Polysomnography
    - Long Distance Physician Claims Associated With Home Health Agency and Skilled Nursing Facility Services
    - Assignment Rules by Medicare Providers
    - Business Relationships and the Use of Magnetic Resonance Imaging Under the Medicare Physician Fee Schedule
    - Medicare Payments for Interventional Pain Management Procedures
    - Geographic Areas With High Utilization of Ultrasound Services
    - Geographic Areas With a High Density of Independent Diagnostic Testing Facilities
    - Payments for High Frequency Chiropractic Treatments
    - Physician Reassignment of Benefits

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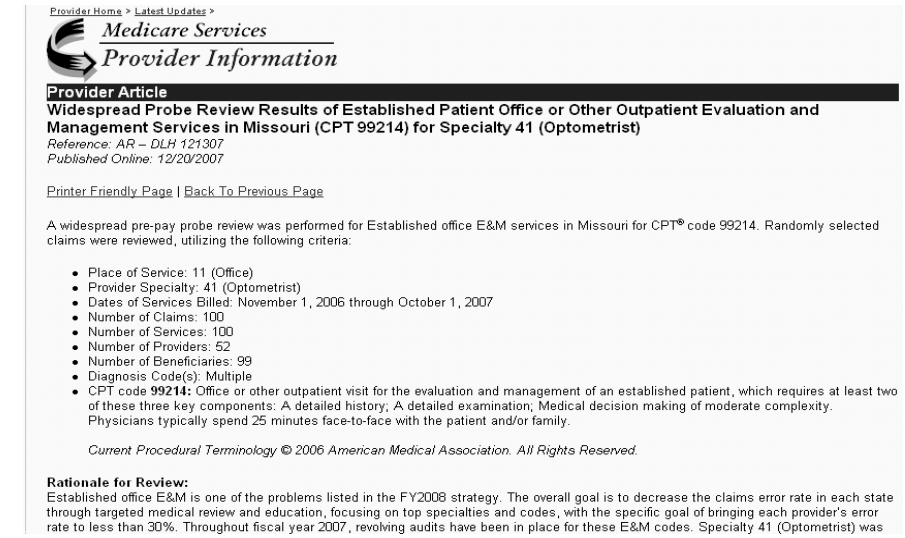

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Medicare Services Provider Information

Provider Article

Widespread Probe Review Results of Established Patient Office or Other Outpatient Evaluation and Management Services in Missouri (CPT 99214) for Specialty 41 (Optometrist)

Reference: AR – DLH 121307
Published Online: 12/20/2007

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A widespread pre-pay probe review was performed for Established office E&M services in Missouri for CPT® code 99214. Randomly selected claims were reviewed, utilizing the following criteria:

- Place of Service: 11 (Office)
- Provider Specialty: 41 (Optometrist)
- Dates of Services Billed: November 1, 2006 through October 1, 2007
- Number of Claims: 100
- Number of Services: 100
- Number of Providers: 52
- Number of Beneficiaries: 99
- Diagnosis Code(s): Multiple
- CPT code **99214:** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Current Procedural Terminology © 2006 American Medical Association. All Rights Reserved.

Rationale for Review:
Established office E&M is one of the problems listed in the FY2008 strategy. The overall goal is to decrease the claims error rate in each state through targeted medical review and education, focusing on top specialties and codes, with the specific goal of bringing each provider's error rate to less than 30%. Throughout fiscal year 2007, revolving audits have been in place for these E&M codes. Specialty 41 (Optometrist) was

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- Areas to look at within your practice
  - New providers
  - New services
  - New staff
  - Claim rejections
  - Statistical trends
  - E/M bell curves
  - Process of coding
    - Who is choosing the codes
    - Qualified individuals comparing coding with documentation
    - Up-to-date coding materials being used
    - Communication with physician regarding documentation concerns
    - Rules, regulations and Medicare information communicated to all

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- Identify your risks
  - Create a list of the risks identified
  - Discuss the list of risks (senior management, and if necessary, legal counsel need to agree that you should review the areas you have identified as risks)
- Prioritize your risks
  - Rate each risk with a score from 1-5 (1 being somewhat concerning and 5 causing you the biggest heartburn)
  - Now you can easily identify what should be reviewed first

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- Define your audit scope
  - Documentation review of all records or a sample size?
  - Internal resources available with the needed expertise can perform the audit?
  - External resources with needed expertise must perform the audit- funds available to pay for this?
  - Set timeline to complete the audit
  - Identify the format needed for the audit findings report
  - Identify how audit recommendations will be handled
    - Communication to physicians
    - Education and training to physicians and coworkers
    - Create policy and procedure
    - Restitution
    - Monitor area of audit for specified length of time

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- *SCENARIO*

  Let's say that you are the compliance officer for an orthopedic office with 10 physicians and 5 PAs in Missouri.

  You have 3 coders but only one has their coding certification.

  You have a board which consists of 3 of your orthopedic surgeons, legal counsel, the nursing director, the billing manager, the practice administrator and you- the corporate compliance officer.

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- *SCENARIO*

  You have finally gotten the okay to put together an official compliance workplan for the practice this year.

  You have a somewhat limited budget of approximately $5000 to use for the year to implement your compliance workplan.

  Where do you start?

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1. OIG is looking at place of service errors and some of your providers perform procedures in the ASC
2. OIG is looking at EM services during global surgery periods
3. OIG is looking at Medicare's "Incident To" guidelines
4. Your Part B Medicare carrier has performed many probe reviews on consultations
5. Your Part B Medicare carrier has performed one probe review on level 5 new patient office visits
6. You have a new PA that has never practiced in Missouri
7. Two of your physicians are performing a new spine procedure

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8. Your billing manager informs you that there has been a number of claim denials on joint injections
9. Your nursing director informs you that her nurses have been complaining about completing the physicians charge tickets for them
10. One of the physician's complains that one of his colleagues only bills level 3 established office visits
11. Your billing manager states that one of the physicians demands all claims are submitted within 7 days of the patient's visit; however, the physician's documentation is 90 days behind

Now what?

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- Get the "history" of the 11 issues to validate they are all areas that need to be on your workplan.
  1. After questioning your billing department you discover that your office is not doing the billing for the ASC procedures- this is being done by the ASC through a contract prepared by your legal counsel. This comes off your list because your billing department is only billing place of service 11 (doctor's office).
  2. EM services during global period and incident to billing would apply to your office so #2 and #3 remain on your list of concerns
  3. Your providers do perform consultations, so #4 remains on your list.
  4. You run a report on CPT 99205 to see how many have been billed the past year and there are zero so, #5 comes off your list.

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5. You speak with your new PA and ask them if they have seen their Missouri state statue and their reply is- "What's that?". So, you leave #6 on your list of concerns.
6. You speak with the coders regarding the new spine procedure that two of the physicians are performing and discover that your certified coder had researched this and gotten a letter of recommendation from Medicare as well as the AMA on the correct coding of the procedure- so you feel comfortable removing #7 from your list.
7. The coders are unaware of any claim denials on joint injections and the billing staff has not researched the problem so #8 remains on your list.

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8. You speak to Dr. Smith, the Physician Chair for the practice, about #9 and #11. Dr. Smith states that these are covered in current policies and procedures and he will go over them with the group of physicians at their executive meeting next week. You decide that you will follow-up with Dr. Smith on this but remove #9 and #11 from the list.
9. You run a report on the physician that is accused of only billing level 3 office visits and see that this is correct. You decide a review will need to be done to indicate if this is appropriate so you leave #10 on your list of concerns.

Now, let's see what your list looks like…

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These are the areas that you have identified for the workplan:

- **OIG is looking at EM services during global surgery periods**
- **OIG is looking at Medicare's "Incident To" guidelines**
- **Your Part B Medicare carrier has performed many probe reviews on consultations**
- **You have a new PA that has never practiced in Missouri**
- **Your billing manager informs you that there has been a number of claim denials on joint injections**
- **One of the physician's complains that one of his colleagues only bills level 3 established office visits**

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- Workplan presentation to the board with risk prioritization.
- First you will need to create your list so the board can take part in prioritizing the risks on a scale from 1-5.

  Example:

  Rate the following with a score from 1-5 (1 being somewhat concerned and 5 being very concerned):

_____ *EM services billed during global periods- on OIG workplan*
_____ *Incident-to guidelines- on OIG workplan*
_____ *Office consultations- CMS has done probe reviews*
_____ *PA scope of practice per MO state statue (5 PAs in practice)*
_____ *Joint injection coding and billing (number of denials)*
_____ *EM documentation review on all providers (recommended annually)*

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- You should also have a plan of action identified for each area of concern to share with the board after they help prioritize the risks.

Example:

EM services billed during global periods- on OIG workplan- can be performed internally by certified coder

Incident-to guidelines- on OIG workplan- need to outsource for expertise, approximate cost of this review along with the PA scope of practice is $3,000

Office consultations- CMS has done probe reviews- can be performed internally by certified coder if time allows- to outsource approx cost is $3,000

PA scope of practice per MO state statue (5 PAs in practice)- included in Incident-to review to be outsourced

Joint injection coding and billing (number of denials)- can be performed internally by billing department and coding staff

EM documentation review on all providers (recommended annually)- can be performed internally by certified coder

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- Define your audit scope so the board understands the number of records to be reviewed-
  - Example would be reviewing the consultations. You have 10 providers that perform consults so you have decided to review 10 consults for each provider which is 100 consults to be reviewed. What is the timeline for this? You need to ensure your certified coder will have time to perform each audit assigned to her and is it possible for her to devote all of her time to the workplan or will you need to outsource more?
  - Everyone needs to understand and agree on how the audit recommendations will be handled and if restitution needs to be made how this will affect the physicians and the practice.

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- Document, Document, Document
  - Always Document your auditing and monitoring activities
    - Even if findings are negative, still document you monitored it *as long as this is not an attorney client privileged audit. (If it is, the attorney will tell you what to document)
  - Document all education and training provided
    - Sign-in sheets to verify who was present
  - Document any restitution
    - Include “who” the payer was so you can show restitution was across the board
  - Document any “edit” put in place as a result of the audit
    - If possible, show statistics such as a decrease in denials

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QUESTIONS?

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