Coding Experts and Attorneys:

*From The Trenches – A Collaborative Approach to Audit Response*

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Stories From the Trenches

- “The five year wait”
- “The wrong address”
- “Changing tunes”
Lots Of $$$$$$ At Stake

Overview
- According to HHS and DOJ annual reporting, the Department of
  Treasury recovered $2.7 billion in 2017
- HHS-OIG pursued 818 civil actions

Audits are thought to be not only a means to recoup improper
overpayments, but also an attempt to extend the life of Medicare and
Medicaid
- Medicare has approximately $34 billion in unfunded liabilities
- Bottom line: State and Federal governments need $$$, and auditors
die getting it for them

Who Is Auditing?
- Federal Payers
- Private Insurance
- OCR (HIPAA Audits)
Medicare Audits

CODING EXPERTS AND ATTORNEYS:
FROM THE TRENCHES – COLLABORATIVE APPROACH TO AUDIT RESPONSE

What Is The “Audit?”

• Claims reviewed on a post-payment basis
• Typically use same Medicare policies as FIs and Carriers
• Can only review claims made after a given period
  • Permitted to look back three years from the date the claim was paid
  • Beware of “car salesman math”
• What are auditors really doing?
  • Between 2014 and 2016:
    • OIG issued 153 audit reports related to Medicare
    • $648 million in recommendations
Proper Response Is Essential

- Auditor sends Medical Record Request Letters for Complex Reviews
- Provider has time (# of days dependent on payer guidelines) to submit copied charts
- Auditor must notify provider of decision within specified time period of receipt of records (depending on payer)
- “Demand Letters” are sent when an overpayment is identified with reason for determination
- Provider can pay by check, opt for recoupment, appeal or declare bankruptcy

CMS Appeals Are Complex

- **Level 1**: Request for Redetermination
  - Made to Fiscal Intermediary
  - 30 Days from receipt of demand to freeze money!
- **Level 2**: Request for Reconsideration
  - Made to Qualified Independent Contractor
  - 60 days from receipt of redetermination to freeze money!
- **Level 3**: Administrative Law Judge (ALJ)
  - 60 days from receipt of reconsideration
- **Level 4**: Medicare Appeals Council (MAC)
  - 60 days from receipt of ALJ decision
- **Level 5**: Federal District Court
  - 60 days from MAC decision
What Else Can Happen?

- Loss of Medicare billing privileges
- Pre-payment review
  - Typically saved for high error rates
  - Based upon specific codes
  - Can be electronic or in writing
  - Fiscal intermediary has discretion to remove pre-payment review
- Corrective Action Plan
  - Required action to achieve compliance
- Corporate Integrity Agreement
  - Can include required compliance plans, communications hotlines, fines, etc.
- Prison

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Medicaid Audits

- Who Is Watching?
  - State agency
  - MICs
  - ZPICs
  - RACs (as of January 1, 2012)
  - Other third party reviewers
    - Another alphabet soup

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FROM THE TRENCHES – COLLABORATIVE APPROACH TO AUDIT RESPONSE
Medicaid Audit Process
*(may vary by state)*

- Formal Records Request
- Preliminary Audit Report
  - “What we think you owe us”
- Final Audit Report

**State Sanctions**

- May be added sanctions to most Final Audit Reports
- Can include fines, licensure revocation and suspension, exclusion, public reprimand
- Money comes and goes, sanctions stay forever
Private Insurance Audits

• Audit rights and restrictions of payor outlined in the agreement
• Provider appeal rights also dependent on the managed care agreement

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There Was No Audit, But We Found A Billing Error. What Do We Do Now?

• Did you follow your compliance plan?
• Was remedial action taken?
• Is there a record of remedial action taken?
• Was it a billing error?
• Was a refund made?
• Was your attorney notified?
• Expert coder reviewed?

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What Should I Do?

- Keep detailed and legible medical records
- Implement and adhere to a written compliance plan
- Update, update, update!
- Coding and documentation review
- Medical necessity review
- Respond promptly to records request - all supporting information
- Notify your attorney right away
- Assemble the team members necessary to promptly and effectively respond

CODING EXPERTS AND ATTORNEYS:
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Reporting And Returning Overpayments

- Part of health care reform law
- An overpayment must be reported and returned within 60 days after the date the overpayment was identified
- Examples
  - Payments for non-covered services
  - Payments in excess of the allowable amount
  - Duplicate payments

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How Do I “Know” If An Overpayment Exists?

• “Overpayment” is defined as any funds that a person receives or retains from Medicare or Medicaid to which the person, after any applicable reconciliation, is not entitled

• “A person has identified an overpayment if the person has actual knowledge of the existence of an overpayment or acts in reckless disregard or ignorance of the overpayment”

10 year look-back period!!

60 day requirements runs from the date on which the overpayment was identified

• Includes receiving information that creates an obligation to investigate
  • Ex. Results of a self-audit, anonymous compliance hotline complaint
  • Ex. Unexplainable increase in revenue
Identifying An Overpayment

• “[A] person has identified an overpayment when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment

Identifying An Overpayment

• “Reasonable diligence” is (1) proactive compliance activities and (2) reactive investigations conducted in response to credible information of a potential overpayment
  • Ex. Identification of a single overpayment requires further investigation
What If I Don’t Return A Payment Within 60 Days?

• Risk violation of False Claims Act
  • A crime
  • Could lose Medicare billing privileges
  • Triple damages
  • Also applies to claims related to other health care fraud and abuse law violations (e.g. Stark Law violations)

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Audit Issues We’ve Seen

• Incident – to violations
• Evaluation and Management Services
  • Deficiencies in components
  • Medical Necessity
• Hospice Certification of Terminal Illness
• Home Visits
• Improper and/or inaccurate coding charges
• Unnecessary tests or routine tests ordered
• Work performed by mid-level not covered per LCD

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Working Together To Attack An Audit

• Anatomy of the Appeal
  • Coding issues
    • Do the codes match the medical record?
    • Were the services medically necessary?
    • Were other criteria met (ex. supervision for “incident to” billing?)
  • Regulatory issues
    • Does auditor have authority to do what it did?
    • Did auditor conduct audit within the rules?
    • Did provider comply with the law?

Dealing With Offsets

• Medicare and Medicaid commence offsets at different times
• Cash flow can completely cease while offsets are being made
• Practice goes from “money in\money out” to “money out”
• In order to keep operating, practice requires extra money in reserve
Here Comes Trouble...

- Dr. Jones receives a records request
  - Biller/Coder
    - Notify attorney
    - Conduct “shadow audit” to identify issues that may exist
    - Examine practice’s current outstanding billing to assess cash flow in preparation of cash reserve
  - Attorney
    - Review request
    - Ensure records submitted are appropriate

Frustration Begins...

- Dr. Jones receives Preliminary Audit Report (Medicaid) or Determination (Medicare)
  - Biller/Coder
    - Scrutinize auditor’s clinical findings to determine whether “car salesman math” has been appropriately applied
    - Prepare our own audit report to enclose with rebuttal/appeal
  - Attorney
    - Evaluate whether auditor has complied with applicable law
    - Evaluate whether provider has complied with applicable law
    - Prepare initial response for timely filing
      - Early appeal filing essential to freeze Medicare offset
The Battle Continues...

• Dr. Jones receives the Final Audit Report (Medicaid) or Redetermination (Medicare)
  • Coder
    • Reassess auditor’s new analysis to determine whether the new review was accurate
    • Confirm that practice has adjusted its cash reserve as offsets likely begin
  • Attorney
    • Continue negotiations with auditor
    • Prepare Request for Reconsideration (Medicare)
    • File for formal ALJ hearing (Medicaid)

When A Lawyer Needs A Coder

• The coder keeps the attorney apprised as to accuracy of provider’s billing, coding and recordkeeping

• Thorough ongoing analysis of practice coding and related cash flow
  • Does revenue look strange this year?
  • Will provider go out of business if appeal not attempted?
  • Will the provider be successful on appeal?

• Ongoing billing and coding adjustments
  • Have the issues been addressed for the appeal process?

• Post-audit adjustments and training
  • How do we minimize the risk that this will happen again?
Our Newest Finding: HIPAA Audits

• Auditing for compliance with HIPAA’s privacy, security and breach notification rules

• Appears to be following same track as RAC program
  • Start slow, expand quickly

• Health care reform strengthened enforcement and created new obligations

• Government is enforcing HIPAA
  • We are seeing significant financial penalties being imposed
  • Now is the time to review HIPAA policies and procedures

• Did you know.......

HIPAA Protocol

• Guideline for auditors was released on June 26, 2012

• Security Rule
  • 77 performance criteria
  • Examine whether the practice:
    • Conducts risk assessments
    • Develops and implements employee training criteria
    • Evaluates existing security measures
  • “Required” vs. “Addressable”
    • If “addressable” and not implemented, must have written documentation as to why
HIPAA Protocol

- Privacy
  - 88 performance criteria
    - Notice of privacy practices?
    - Individual access to PHI?
    - Policy for uses and disclosures of PHI?

- Breach Notification Rule
  - Whether the practice has:
    - Implemented a breach risk assessment and notification procedure
    - Implemented a procedure for providing notification to the media and federal government

Epilogue: Where Are We Now?

- “The five year wait”
- “The wrong address”
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What Should You Do?

• Auditors will be looking at whether the practice has:
  • Drafted HIPAA policies and procedures
  • Implemented those policies and procedures
  • Updated those policies and procedures to reflect new changes
  • Document all compliance activities
    • One audit procedure requires the auditor to look for documentation of risk assessments that were determined not to be breaches!!

Document, Document, Document

• Medical necessity can only be proven through documentation in the medical record

  “THINK IN INK”

• Audit defenses are centered around information included in the medical record

• Proper documentation can save thousands of dollars
Document, Document, Document

- Adequate HPI flows into the exam and MDM
- Describe a patient’s risk at the end of the visit and status until the next planned visit
- Status of current chronic illnesses considered in the treatment plan
- No conflicts with HPI and ROS
- Signature requirements
- Clinical documentation improvement review

Compliance Plans

- Of significant importance in minimizing risk for audit, and in positioning your practice if an audit takes place
- Required for nursing homes Government strongly recommends all providers implement
- Having a compliance plan and not adhering to it is worse than not having one – NOT an encyclopedia
Compliance Plans

• Government looks very favorably upon compliance plans

• New overpayment refund law requires you to refund money if you should have known there was an overpayment
  • How would you know there was an overpayment? By adhering to your compliance plan

The “Culture of Compliance”

• Essential in the new world of health care
• Everyone must be a watchdog
• Everyone must do their part to create a culture of compliance
• Physicians make mistakes too
• Is everyone trained? Up-to-date on changes?
• Has everyone read and understood the compliance plan?
Questions?

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