CODING & BILLING AUDITS:

- Why They Happen
- How to Prevent Them
- How to Survive Them

CAC-PIAC November 2014



KEY FACT:

Podiatry has been, and continues to be, a highly audited medical specialty





The Current Audit Environment

- Affordable Care Act
- CMS Initiatives
- Most commonly audited codes



The Affordable Care Act (ACA)

- You must now self-report billing errors within 60 days of discovery or risk fines/penalties
- Lakeshore Medical Clinic case in Wisconsin
 - Whistleblower case by former billing service employee
 - Practice failed to follow-up on problems discovered in self audit



CMS Initiatives

- CMS proposes new rule to increase bounties paid to "Fraud Tipsters"
- Bounty of 15% of monies recovered (not to exceed \$10 million)
- Provider Relations Coordinator"
 - Latesha Walker RAC@cms.hhs.gov
- Publication of Medicare billing amounts



Most Commonly Audited Codes

- 11720/11721 (nail debridement)
- E/M Codes all (-25 modifier)
- 11730 (nail avulsion)
- Wound Care Codes
- 11060/11061 (I&D of abscess)
- 11050 series (paring of skin lesions) (corns/calluses)
- Orthotics Codes
- 59 Modifier
- Injection codes (Morton's neuroma, plantar fascitis)



Ongoing Confusion Over Qualified Routine Foot Care

Mycotic nail coverage rules

Covered routine foot care rules



Evaluation and Management Codes with "25" Modifiers

- Number one audit issue
- This issue was included in the Office of Inspector General (OIG) Work Plan for 2004 and 2005.
- Modifier 25 indicates that a <u>SIGNIFICANT</u>, separately identifiable E&M service was performed during the same encounter that a minor surgical procedure was performed.



Evaluation and Management Codes with "25" Modifiers

 There is not a requirement that two or more diagnosis codes be used in the billing of the services

 Very subjective as to what is considered "significant".



Partial or Total Nail Avulsions

- Documentation must describe the symptoms and complaint which establish medical necessity for the treatment.
- Nail or Nail border must be separated and removed to and under the eponychium.
- Local anesthetic (type and quantity) must be documented. If not used, provide rationale (Neuropathic patient, patient refused, medical contraindications)

Partial or Total Nail Avulsions

- Post-operative instructions and follow-up care should be documented
- If medial and lateral border are separated or removed on the same nail, only one service can be billed
- Cannot bill an I&D and avulsion or partial avulsion on the same nail



Other Audit Problems

- Failure to sign/date progress notes
- Use of medical assistants to perform nail care
- "Cloning of notes"
- DME documentation



Other Audit Problems

- Place of service codes
- Platelet therapy
- Over utilization of ultrasound
- Nursing homes standing orders
- Billing services assigning modifiers



Causes of Audits

- 1. You stand out statistically
- 2. Your patient complained
- 3. Someone else reported you
 - Former employee
 - Former spouse
 - A competitor



Preventative Measures

- Watch your coding patterns
- Good bedside manner
- Help patient understand bills
- Be fair to those around you



Current Audit Environment

- RAC audits
- 2. Evolution of Program Safeguard Contractors (PSC) to
 - Zone Program Integrity Contractors (ZPIC) to
 - "Uniform Program Integrity Contractors" (UPIC)
- 3. ADR letters/Prepayment Review
- 4. Suspension and Revocation Actions
- 5. Criminal investigations
- 6. Drastic slowdown in Medicare appeal process (sequestration)



Medicare Audit Contractors

- Medicare administrative Contractors (MAC's or carriers)
- 2. Zone Program Integrity Contractors (ZPIC's)
- 3. Recovery Audit Contractors (RAC's)
- Comprehensive Error Rate Testing Contractors (CERT)



 The 4 contractors do reviews in different ways with differing time frames

Provider confusion is the result



 RAC's do 5 times as many audits as the other contractors combined (but such audits are smaller)

Most serious audits are done by ZPIC's

CERT audits – conducted on a random basis



 1 billion claims processed by Medicare in 2012

 1.4 million claims reviewed by the 4 contractors (less than 1%)



% of Medicare Audits

Medicare Carriers	6%
• ZPIC	8%
• CERT	3%
• RAC	83%



1. RAC AUDITS

- Not random data driven audits
- Two types of computer driven audits:
 - 1. Automated review (w/o medical record)
 - 2. Complex review (w/ medical record)
- Smaller dollar amounts at issue
- Reforms implemented in April 2013:
 - Limits to number and frequency of chart requests



RAC Audits

- In fiscal years 2010-11, reviewed 2.6 million claims
 - > 1.3 million (50%) of claims were improper
 - >\$903 million recovered
 - Providers appeal only 6% of audited claims
 - ➤ Providers won 44% of appeals



RAC Audits

 OIG reports showed no one is checking the audit accuracy of RAC's

RAC's paid on basis of amount recovered

Recent stay imposed on RAC audits



2. Evolution of Zone Program Integrity Contractors (ZPIC)

- Took the place of Program Safeguard Contractors (PSC's)
- Have taken over most of the audit functions previously performed by carriers
- Often do statistical sampling and extrapolated overpayments with large dollar amounts
- Review personnel often are poorly trained as to podiatry coding and billing
- AdvanceMed, Safeguard Services



ZPIC's

Abusive investigative tactics in California

 First \$1 million O/P in podiatry imposed in late 2013



Coming Soon...

 Uniform Program Integrity Contractors (UPIC's)

 Will do fraud and abuse enforcement across Medicare and Medicaid programs (dual eligible providers)

May replace ZPIC's eventually



Coming Soon...

- Supplemental Medical Review/Specialty Contractor (SMRC)
 - Smirk?!

Will do audits of DME and Part B services



3. ADR Letters/Prepayment Review

- Often imposed without formal notice
- Creates huge administrative burden and cash flow crisis
- It is critical to quickly identify the problem and correct it
- Prepayment review will only end when denial rate goes below a certain threshold

4. Suspension and Revocation

- "Credible evidence" of fraud
- "No one at home" audits/revocations
- Billing for services to dead people
- Limited appeal rights
- Devastating career impact from a minor error

5. Criminal Investigations

 Usually involve massive numbers of charts/services

 Often involve combined Medicare (federal) and Medicaid (state) personnel

 Situations with retired FBI/police who to pose as patients with "wires" on



Criminal Investigations

Surveillance of doctors and patients

- "Before and after" photos of patients taken by FBI
- Interrogations of staff, patients



Criminal Investigations

 Involve immediate seizure of charts, computers, office records

- Possible consequences:
 - Restitution of \$
 - Jail time
 - Exclusion from Medicare/Medicaid programs
 - Loss of licensure
 - Loss of privileges



Observations

- Government auditors and investigators often do <u>NOT</u> understand podiatry or podiatry coding
- Doctors without good counsel are sitting ducks
- Fraud by podiatrists is uncommon
- Poor recordkeeping is common



"Limitations" on Medicare Auditors

- Limitations on extrapolated overpayments without first "educating" the provider or documented high rate of error
- No recoupment of overpayment until second level of appeal (QIC) is completed
- Easier process to get extended repayment plans



Despite all of the above...

- The % of doctors participating in Medicare is at an all time high: 90%
- % of doctors opting out of Medicare is less than 2%



6. Medicare Appeal Process

Level	Type of Appeal	Time <u>Limit</u>	Amount in Controversy
1 st	Redetermination	120 days	None
2 nd	Reconsideration (QIC)	180 days	\$100
3 rd	Administrative Law Judge	60 days	\$110
4 th	Medicare Appeals Council	60 days	None
5 th	Federal District Court	60 days	\$1,090

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1st Level: Redetermination

Conducted by the Medicare Carrier

 No hearing; just a "second look" by the carrier



2nd Level: Reconsideration

- Previously known as carrier fair hearing
- Carrier hearing officers replaced by Qualified Independent Contractors (QIC)
- In-person hearings not allowed
- All evidence must be submitted or may not be considered at next level of appeal

 PARSON
 BEHLE

2nd Level: Reconsideration

 Providers should not be without competent counsel at this level.

Less due process than before

QIC is bound by LCD's, NCD's, MCM



3rd Level: Administrative Law Judge

- ALJ's now come from HHS instead of SSA ("cadre judges" are history)
- Telephone and video conference hearings the norm instead of in-person
- Medicare carrier can now participate
- Bound by NCD's, but not LCD's or MCM



Moratorium of 28 months on ALJ appeal hearings per HHS

This is a disaster for providers!



Thoughts on Appeal System

- The appeals process is broken
- Class action suits pending over ALJ moratorium
- Currently a 489 day backlog to get a hearing date



Profile of a Problem Podiatrist (innocent type)

- In practice 15+ years
- Inexperienced or incompetent billing staff
- "We've always done it this way and no one has said anything"



Profile of a Problem Podiatrist (innocent type)

- Not involved in state, local or national professional organizations (isolated and uninformed)
- Both overcoding and undercoding common
- Not aware of LCD's for geographic region



* WARNING *



The mere fact that you have billed a code for many years (and have been paid) does **not** mean you are billing correctly.



Profile of a Problem Podiatrist (guilty type)

- "Aggressive" biller/upcoding
- Does not tolerate questions/concerns from staff ("my word is law")
- Willful ignorance of coding rules
- Money oriented approach to patient care, coding and billing

How to Avoid Audits, Investigations and Big Overpayments

- Implement and follow a good, <u>written</u> corporate compliance plan
- Have competent, well-trained billing staff
 OR
 Use a competent 3rd party billing service
- 3. Use all available resources to stay informed:
 - Seminars and books
 - Professional associations
 - Codingline®
 - Colleagues



Impact of EHR

Has caused decrease in quality of medical records

Not being used properly

More time consuming to do it right

Impact of EHR

- Higher risk of cloning
- Use of "medical scribes"
 - How to document use of scribes

Compliance Plan Elements

- Compliance officer
- Code of conduct
- Covers all coding, billing, fraud & abuse areas
- Encourages staff to raise concerns
- Self-auditing (single most important element)
- Recordkeeping and documentation practices
 - Superbill
 - Progress note
 - Claim form
- Forms (superbill, ABN, Medicare assignment) are these up to date?
 PARSONS

If you have not done most or all of items in previous slide...

You are not serious about coding and billing compliance



Training of Staff

- Longevity does <u>not</u> necessarily equal competence
- CPC, CCP, credentials the ideal
- Seminars, training, networking, etc....
- Do you trust this person with your financial security and professional reputation?



PICA's ADC Coverage

- Covers Medicare, Medicaid and private insurance audits and investigations
- Covers revocation or suspensions
- New \$100,000 coverage limits as of May 1st



War Stories – Strange but True

- "I feel your pain"
- "I don't need no stinking search warrant"
- Big brother is watching
- Who are those guys in orange vests hiding in the bushes?
- Everything but the kitchen sink



War Stories – Strange but True

- A stimulating conversation
- A 40-hour day
- "I see dead people"
- Photocopier medical records
- Avulsion revulsion

