Getting Started with OIG Compliance
Kathy Mills Chang, MCS-P CCPC

Do You Feel Like This?

Does Your Business Deserve the Same Focus Your Patients Do?

Or This?

How This Training Will Protect You!

• Stay within the lines
• Eliminate confusion
• Medicare is not to be trifled with
• Correct financial inconsistencies
• Risk Management and Risk Avoidance
Reduce Your Risk
• Scrutiny and accountability in healthcare are up
• Affordable Care Act and other state-level documentation and compliance rulings make it more critical than ever to decrease your practice risks.

Learn the Basics to Reduce Your Risk
• Many DCs don’t know what they don’t know, when it comes to compliance in healthcare today!
• OIG Compliance is that rule book that many don’t know they must follow

Who is the OIG?
• Office of Inspector General's (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.

Government’s Healthcare Oversight
• HHS OIG is the largest inspector general's office in the Federal Government, with approximately 1,600 dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs.
• A majority of OIG's resources goes toward the oversight of Medicare and Medicaid — programs that represent a significant part of the Federal budget and that affect this country’s most vulnerable citizens.

OIG Strategic Plan 2014-2018
The OIG has a clear an narrow focus for success:
• Goal One: Fight Fraud, Waste, and Abuse
• Goal Two: Promote Quality, Safety, and Value
• Goal Three: Secure the Future
• Goal Four: Advance Excellence and Innovation

Goal One: Fight Fraud, Waste, and Abuse
• Critical to OIG’s mission is fighting fraud, waste, and abuse. We will continue to employ a multi-faceted approach of prevention, detection, and deterrence.
  • Identify, investigate, and take action when needed
  • Hold wrongdoers accountable and maximize recovery of public funds
  • Prevent and deter fraud, waste, and abuse
Work Plan Focus #1 - Identify Biggest Issues

**Billing and Payments.** We will compile the results of prior OIG audits, evaluations, and investigations of chiropractic services paid by Medicare to identify trends in payment, compliance, and fraud vulnerabilities and offer recommendations to improve detected vulnerabilities.

**Context**—Prior OIG work identified inappropriate payments for chiropractic services that were medically unnecessary, were not documented in accordance with Medicare requirements, or were fraudulent.

Work Plan Focus #2 - Proactive Reviews

**Billing and Payments.** We will review Medicare Part B payments for chiropractic services to determine whether such payments were claimed in accordance with Medicare requirements.

**Context**—Prior OIG work identified inappropriate payments for chiropractic services furnished during calendar year (CY) 2006. Subsequent OIG work (CY 2013) also identified unallowable.

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3 issued aimed at chiropractic the last several years...the impact has been significant

**Work Plan Focus #1 - Identify Biggest Issues**

Medicare does not pay for items or services that are "not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member." (Social Security Act, § 1862(a)(1)(A).)

This planned portfolio document will offer new recommendations to improve Medicare chiropractic vulnerabilities detected in prior OIG work. (OAS; OIG-12-14-03; expected issue date: FY 2014; work in progress)

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**Work Plan Focus #2 - Proactive Reviews**

Part B pays only for a chiropractor’s manual manipulation of the spine to correct a subluxation if there is a neuro-musculoskeletal condition for which such manipulation is appropriate treatment. (42 CFR § 410.21(b)). Chiropractic maintenance therapy is not considered to be medically reasonable or necessary and is therefore not payable. (CMS’s Medicare Benefit Policy Manual, Pub. No. 100-02, ch. 15, § 30.5(B).

Medicare will not pay for items or services that are “not reasonable and necessary.” (Social Security Act, § 1862(a)(1)(A)) (OAS; W-00-12-35606; W-00-13-35606; various reviews; expected issue date: FY 2014; work in progress)
Work Plan Focus #3-Identify and Address Trends

Billing and Payments. We will determine the extent of questionable billing for chiropractic services. We will also identify trends suggestive of maintenance therapy billing.

Context—Previous OIG work has demonstrated a history of vulnerabilities relative to inappropriate payments for chiropractic services, including recent work that identified a chiropractor with a 93-percent claim error rate and inappropriate Medicare payments of about $700,000.

Although chiropractors may submit claims for any number of services, Medicare reimburses claims only for manual manipulations or treatment of subluxations of the spine that provides "a reasonable expectation of recovery or improvement of function." Moreover, Medicare does not reimburse for chiropractic maintenance therapy. (CMS’s Medicare Benefit Policy Manual, Pub. No. 100 02, ch. 15, § 30.58.) (OEI-01-14-00200; expected issue date: FY 2015, work in progress)

OIG Compliance vs. HIPAA Compliance

• OIG Compliance relates to fraud and abuse
• Documentation, coding, billing and patient financial inconsistencies
• Medical necessity and erroneous payment demands
• Federal programs with extension through Office of Audit Services

• HIPAA requires covered entities to have contingency plans that establish policies and procedures regarding protected health information
• HIPAA also administered by HHS
• Office of Civil Rights

To Be In Compliance You Need BOTH!

Under the Magnifying Glass

EXECUTIVE SUMMARY: CMS SHOULD USE TARGETED TACTICS TO CURB QUESTIONABLE AND INAPPROPRIATE PAYMENTS FOR CHIROPRACTIC SERVICES
OEI-01-14-00200

WHY WE DID THIS STUDY
Chiropractic services have the highest rate of improper payments among Part B services, according to the Centers for Medicare & Medicaid Services’ (CMS’s) Comprehensive Error Rate Testing program. Medicare covers chiropractic services to improve function, which it refers to as “active treatment,” but does not cover “maintenance therapy,” which is when further clinical improvement cannot be reasonably expected from ongoing treatment. Past OIG work has found that between 49 and 47 percent of all paid chiropractic claims were for maintenance therapy. In addition, Medicare fraud cases suggest that vulnerabilities exist relative to other Medicare services for beneficiaries receiving chiropractic services, such as physical therapy.
Improper Payment Rate for Chiropractic Services
Chiropractic services have had the highest rate of improper payments among Part B services over the last several years, according to the Centers for Medicare & Medicaid Services' (CMS) Comprehensive Error Rate Testing (CERT) program. In fact, from 2010 to 2014, the improper payment rate for chiropractic services increased from 49.9 to 54.1 percent while the overall improper payment rate for Part B services remained between 9.9 and 12.9 percent (see Table 1).

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount of Projected Improper Payments for Chiropractic Services</th>
<th>Rate of Improper Payments for Chiropractic Services</th>
<th>Rate of Improper Payments for All Part B Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$23,697,082</td>
<td>49.9%</td>
<td>12.9%</td>
</tr>
<tr>
<td>2011</td>
<td>$323,058,123</td>
<td>44.1%</td>
<td>10.3%</td>
</tr>
<tr>
<td>2012</td>
<td>$277,750,037</td>
<td>47.4%</td>
<td>9.9%</td>
</tr>
<tr>
<td>2013</td>
<td>$273,488,430</td>
<td>51.7%</td>
<td>10.5%</td>
</tr>
<tr>
<td>2014</td>
<td>$303,816,558</td>
<td>54.1%</td>
<td>12.1%</td>
</tr>
</tbody>
</table>

Source: CMS, Supplementary Appendix for the Medicare Fee-for-Service Improper Payments Reports for 2010-2014.

Some Raw Data

**BACKGROUND**

**Medicare Coverage of Chiropractic Services**

In 2013, Medicare paid $302 million for chiropractic services provided by 45,490 chiropractors to almost 2 million beneficiaries.1 Chiropractors treat patients for problems of the musculoskeletal and nervous systems, such as headaches or pain in the back, neck, or joints.2 However, Medicare limits coverage of chiropractic services to manual manipulation treatments to treat subluxation of the spine, which is the dislocation of one or more spinal bones.3 Medicare covers chiropractic services to improve function, which it refers to as “active treatment.”4-5 Medicare does not cover “maintenance therapy,” which is when further clinical improvement cannot be reasonably expected from ongoing treatment.6

Eagle Eye for Maintenance Care

**Treatment Suggestive of Maintenance Therapy.** A high average number of claims per beneficiary per chiropractor suggests billing for services that were not active treatment. Previous OIG work has found that as more services are provided to a beneficiary, it becomes more likely that services are medically unnecessary or maintenance treatment.
98942 Issues

Potentially Upcoded Claims: A high average “physician work relative value unit” for a chiropractor’s claims suggests billing for services at a higher level than warranted.29 Only about 10 percent of all paid chiropractic services are for the highest CPT code, 98942. Previous OIG work found that almost half of chiropractic services with CPT code 98942 were upcoded.30

Compliance

They Do the Math

Unlikely Number of Services per Day. A high number of hours of services provided by a chiropractor on 1 day suggests billing for services of diminished quality and/or for services that were not rendered.

We calculated these measures for each chiropractor and analyzed the distribution of chiropractors for each measure. For the first three measures, we used a statistical technique called the Tukey method to identify chiropractors who were outliers compared to other chiropractors. For these three measures, we considered a chiropractor’s payments to be unusually high, or questionable, if they were greater than the 75th percentile plus 1.5 times the interquartile range.21 For the fourth measure, we established a threshold of 16 hours per day based on our knowledge, experience, and discussions with experts.

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Covered DX Codes

Table 5: Chiropractors Who Received 81 Percent of the Payments for Days With 16 Hours or More of Chiropractic Services

<table>
<thead>
<tr>
<th>Location</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Medicare paid a chiropractor $302,729 for 115 days of providing 16 hours or more of chiropractic services. On these dates, this chiropractor was paid for an average of 89 chiropractic services per day.</td>
</tr>
<tr>
<td>Illinois</td>
<td>Medicare paid a chiropractor $302,729 for 115 days of providing 16 hours or more of chiropractic services. On these dates, this chiropractor was paid for an average of 89 chiropractic services per day.</td>
</tr>
</tbody>
</table>

Source: OIG analysis of data from 2013 Part B claims for chiropractic services paid for by Medicare.

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Recommendation #1

Establish a more reliable control for identifying active treatment

Given that half of the questionable payments that we identified in 2013 were for treatment suggestive of maintenance therapy, CMS should devise a more reliable method for detecting it. As a first step, CMS could examine the date of initiation of treatment for a particular diagnosis reported on a chiropractic claim. Doing so would enable CMS to determine the length of a beneficiary’s chiropractic treatment and identify treatments likely to be maintenance therapy. CMS could also consider including this information in the National Claims History file so that it is available to Medicare contractors for pre- and post-payment review.

Compliance

Recommendation #2

Develop and use measures to identify questionable payments for chiropractic services

CMS could use these measures in a variety of ways. For example, it could use measures as part of its Fraud Prevention System to identify chiropractors for investigatory followup. It also could use measures to help its contractors identify and review potentially upcoded claims. In addition, it could use measures to identify and examine same-day services (such as therapy services) provided to beneficiaries, especially in high-frequency areas. Lastly, it could use measures to identify chiropractors who warrant pre- or post-payment review of services as called for in MACRA.
Let's Review

Table B1: Threshold and Summary Data for Each Measure of Questionable Payment in 2013

<table>
<thead>
<tr>
<th>Measure of Questionable Payment</th>
<th>Threshold for Chiropractor To Be Considered an Outlier</th>
<th>Summary Statistics for All Chiropractors With Paid Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>Minimum</td>
</tr>
<tr>
<td>Treatment Suggestive of Maintenance Therapy</td>
<td>Was paid for an average of 20 services per beneficiary</td>
<td>Average of 3 services per beneficiary</td>
</tr>
<tr>
<td>Potential Sharing of Beneficiaries</td>
<td>12.5% of a chiropractor’s beneficiaries had paid claims from another chiropractor</td>
<td>12% of beneficiaries</td>
</tr>
<tr>
<td>Potentially Upcoded Claims</td>
<td>Was paid for an average of 0.85 work relative value units (RVU) per service</td>
<td>Average of 0.83 work RVU</td>
</tr>
<tr>
<td>Unlikely Number of Services per Day</td>
<td>Was paid for 16 or more hours in 1 day</td>
<td>0.57 hours in 1 day</td>
</tr>
</tbody>
</table>

Source: OIG analysis of data from 2013 Part B claims for chiropractic services paid by Medicare.

Findings

In 2013, $76 million of the Medicare payments for chiropractic services were questionable.

Of the $502 million that Medicare paid in 2013 for chiropractic services, $76.1 million was for claims that were questionable based on our four measures of questionable payment. Payments for these claims represent 15 percent of the Medicare payments for chiropractic services in 2013.

Treatment suggestive of maintenance therapy was the driver of questionable payments.

In total, 16 percent of chiropractors (7,191) paid by Medicare in 2013 received questionable payments for chiropractic services. Almost half of these payments were for claims suggestive of maintenance therapy, which we identified through high average numbers of claims per beneficiary per chiropractor. Medicare does not cover maintenance therapy. Table 3 provides detail on our measures that identified questionable payments.

AT Modifier Doesn’t Work for the OIG

Lastly, the use of the AT modifier to ensure that payments are made only for active treatment is not effective. Every claim that we identified as being suggestive of maintenance therapy included the AT modifier, raising questions about its effectiveness as a control to ensure that Medicare pays only for active treatment. Prior OIG work found that CMS’s requirement to use the AT modifier to indicate active treatment merely resulted in an increase in the use of the AT modifier, rather than in reduced payments for maintenance therapy. Moreover, in 2013, 96 percent of all claims for chiropractic services that were submitted to Medicare included the AT modifier.
Why Is Documentation So Important?

• Ensures quality patient care
• Meets licensure requirements to protect the public
• Guards against malpractice action
• Secures appropriate reimbursement
• Because...if it wasn’t written down, it didn’t happen!

Know your Audience

• Another health care provider
• Your board
• A malpractice attorney
• Third party payer’s medical necessity auditor

Risk #1

Is All Care Medically Necessary?

Clinically Appropriate Care
• Enhances life
• Relieves symptoms
• Wellness care
• Supportive care
• Maintenance care

Medically Necessary Care
• Yields a significant improvement in clinical findings and patient functionality

How is Care Defined?

FINANCIAL RESPONSIBILITY OF CHIROPRACTIC CARE

PATIENT RELATIONSHIP OVER TIME

COURSE OF TREATMENT
The Foundational Visit of the Episode

Risk #2
Error Rate Information

• Insufficient documentation is a known issue in the chiropractic profession
• Failure to provide any documentation to auditors represents nearly 50% of the poor scores

Are You an Outlier?

• Statistics tell us that the improper coding of full-spine treatment can cause you to appear to be an outlier
• You therefore can be subject to more scrutiny, red flags, and even an audit

Episodes of Care

Medicare Documentation Guidelines

Initial Visit
• History
• Description of Present Illness
• Physical Exam
• Diagnosis
• Treatment Plan
• Date of initial treatment

Subsequent Visits
• History
• Review of chief complaint
• Physical Exam
• Document daily treatment
• Progress related to treatment goals/plan

Risk #3

Don’t Stick Out Like a Sore Thumb!
What Dr. Diep Didn’t Know That He Didn’t Know!

- The $708,000 recoupment finding to Medicare:
  - Ignorance of the rules
  - Upcoding charges
  - Billing Medicare inappropriately
  - Poor documentation
  - No Policies and SOP
  - Ignored help when notified of OIG concerns

Size Matters

- Dr. Diep was in the top 5 in the entire country for volume of CMT codes billed. Top 5!!!
- He billed an outrageous percentage of 98942, all 5 spinal regions!

So? I’m a Full Spine Adjuster!

- Medical necessity definition dictates that you must prioritize each area of complaint
- Every visit:
  - S + O (P + ART) for every region treated
  - 2 DX codes for each region
  - Treatment plan for each/short and long term goals

Why It LOOKS Fishy…

98942-Appearance of Evil

- The Medicare claim data that we reviewed showed that all of the chiropractic services provided by ACS were billed with the AT modifier. Further, almost all (99 percent) of the services were billed with CPT code 98942, which had the highest physician fee schedule amount among the other CPT codes covered by Medicare for chiropractic services.
Put on Your Auditor Hat

- What is expected/typical
  - 98940: 40-60%
  - 98941: 40-60%
  - 98942: 1-10%
- How would your office look?
- Run Your Ratios!

The History

Presented with bilateral lower back pain and tightness. Patient states that she strained her lower back while deadlifting the gym yesterday. There is no leg pain, numbness, tingling, burning or weakness. Lower back feels very tight and weak. Her pain level today is 6 out of 10 with 10 being the worst.

The Examination

Cervical Orthopedic Tests:
- Palpation
- Range of Motion
- Flexion
- Extension
- Side Flexion
- Axial Load
- Rotation
- Dominant

Thoracic-Lumbar Orthopedic Tests:
- Palpation
- Range of Motion
- Flexion
- Extension
- Side Flexion
- Axial Load
- Rotation
- Dominant

The Charges
### Subjective?? NOT!

- Subjective: The patient said that overall she is feeling the same since her last visit.

### Objective?? Really?

- Objective: I received the recent testing and diagnostic results with the patient, 30 minutes ago.
- Multiple subluxations were identified, hypomobility and end point tenderness were found and adjusted at the following areas: right C2, left C4, right T2, T3, right T10, right L3 and left pelvis. An extremely subluxation was discovered and adjusted in the right leg and left leg.
- Palpation of the muscles revealed, spasm in the following areas: right cervical dorsal area, right upper thoracic area, left upper thoracic area, right lower thoracic area, left upper lumbar area, right lower lumbar area and left lower lumbar area.
- The posture evaluation revealed the following: a head tilt to the left, right hip flexion, high left shoulder and rotation of the trunk to the left.
- Active trigger points were discovered in the cervical musculature, suboccipital, suboccipital, lumbar paraspinal, gluteus medius and minimus and iliopsoas regions.
- Prolonged stress reactions in the lumbar region, then active paraspinal and hip flexion. Many of the patients have created in your tissues to make even the smallest movement. A trigger point exploits when over-stimulated. The postural imbalance often causes pain in the flank area. The resulting oxygen starvation and accumulation of waste products of metabolism irritates the trigger point. The trigger point responds to this emergency by sending out pain signals.

### Assessment?? Guarded?

- Assessment: The patient’s prognosis is guarded and uncertain at this time. There was no change after the adjustment. This means that there is a 60% chance of a need for long-term treatment. It also means that there is a 60% to 80% chance of long-term residuals of Natalie’s primary presenting musculoskeletal, orthopedic and neurological complaints.

### Subjective

- Subjective: The patient sought treatment today complaining of discomfort and or paresthesia in the cervical-dorsal and lumbosacral regions. The patient complained of headaches.

### Objective

- Objective: Multiple subluxations were adjusted and noted with spasm, hypomobility and end point tenderness in the cervical-dorsal, lumbar and sacroiliac regions.
- Active Release Technique - FAP identified including post isometric muscle relaxation technique and physician assisted muscle stretching technique is utilized for the involved body parts to release fibrosis formation in the joints and muscle groups, to promote overall ranges of motion, and reduce pain level.
- Suggested MRI study to rule out vertebral artery insufficiency. Patient will discuss option with her MD's. Cold laser therapy was applied to both rotator cuff, cervical region, and lumbosacral region while doing specific movement to increase blood flow, reduce inflammation and pain, and increase range of motion, joint stability and coordination of the involved areas. Percussion Therapy was used on the lumbosacral and adductor regions to increase the functional performance and range of motion and decrease inflammation and muscle spasm in the involved area.
- Assessment: The patient reported feeling better after the treatment.

### Plan

- Plan: We will continue to treat the patient as per the examination findings and continue the existing treatment plan. It is recommended that the patient return for treatment on Wednesday.
The Guideline and Expectation

*The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patients condition and provide a reasonable expectation of recovery or improvement of...."
Maintenance

CMS defines Maintenance Therapy as: "Chiropractic maintenance therapy is not considered to be medically reasonable or necessary under the Medicare program, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy."

Episodes of Care

- Wellness
- Prevent disease
- Promote health
- Prolong/enhance the quality of life
- Supportive
- Maintain or prevent deterioration of a chronic condition

Understand the Rules

- Diep ONLY billed AT modifier, never ever moving a patient to maintenance care.
- Even in the details of the rebuttal from his attorney, he also argued that he "never delivered care that was not AT Modifier worthy".

Expect Payment from 3rd Party

GA

Modifier
What’s Wrong with this Picture?

B. Patient Name: [Redacted]  C. Identification Number: [Redacted]

Advance Beneﬁciary Notice of Noncoverage (ABN)

NOTE: if Medicare doesn’t pay for D. _________ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider believe you need. We expect Medicare may not pay for the D. _________ below.

D. E. Reason Medicare May Not Pay: F. Estimated Cost

Exams
Therapy
Maintenance Treatment
Splint Decompression
Massage Therapy
Support, Biofreeze, Ice Pack, TENS, etc.

not a covered service
not a covered service
not a covered service
not a covered service
not a covered service
not a covered service

$10-50 range
$10-100 range
$10-200 range
$30-350 range
$30-500 range
$30-500 range

WHAT YOU NEED TO DO NOW:

Compliance

Voluntary Use = “MAY I?”

When May I Issue an ABN?

Voluntary ABN Uses

Medicare does not require ABNs for statutorily excluded care or for services Medicare never covers. However, in these situations, you may issue an ABN voluntarily. Refer to the “What Clause Reporting Methods Do I Use?” section at the end of this booklet for information on claim modiﬁers associated with voluntary ABN use.

A Warning the Should be Heeded

What We Found

Of the 100 sampled chiropractic services, 7 services were allowable in accordance with Medicare requirements. The remaining 93 services were not allowable. 70 were medically unnecessary. 11 were incorrectly coded. 8 were unbilled, and 5 were insufﬁciently documented. As a result, Deep Chiropractic received $3,108 in allowable Medicare payments.

Another Recent Decision

Unallowable Medicare Payments

As a result, [Redacted] received $3,347 in unallowable Medicare payments for the 92 chiropractic services that did not meet Medicare requirements. On the basis of our sample results, we estimate that at least $330,625 of the Medicare payments for chiropractic services was unallowable for Medicare reimbursement.

OIG Report Facts

• The OIG is not “out to get us all”
• There is enough “low hanging fruit” to take care of the federal budget deficit
• Be aware of the speciﬁc errors pointed out in the reports like this

ABN for Voluntary Use

You should only provide ABNs to beneﬁciaries when you are not sure whether to get services and accept ﬁnancial responsibility for the services, and that Medicare will not pay. The ABN serves as proof that the beneﬁciary knows you will not accept the Medicare payment. The ABN also serves as an optional (voluntary) beneﬁciary notice to provide care and services covered by Medicare. Medicare does not require you to issue an ABN in order to bill a beneﬁciary for an item or service that is not a Medicare beneﬁt and never covered.

• When you issue the ABN as a voluntary, the beneﬁciary does not check an option box or sign and date the notice.

Compliance
What Should You Do Now?

Install the 7 Steps of the OIG Compliance Program

Why Implement a compliance program?
Integrate policies and procedures into the physician's practice that are necessary to promote adherence to federal and state laws and statutes and regulations applicable to the delivery of healthcare services

Policies and Procedures to Address THESE Risks

Improved Compliance Brings Opportunities

A “Program” is not a “Manual”
Is it Mandatory?

• Obviously is a concern
• Part of the sentencing guidelines
• Affordable Care Act: Mandatory Compliance Plans Coming Soon
• CMS has NOT finalized the requirements
• CMS will advance specific proposals at some point in the future

Step One: Set Up Your Manual

1. Implement Policies and Procedures
2. Compliance Officer or Contact

OIG Compliance Policy Table of Contents

Section One: Code of Conduct
(Here is where you will have a sample of your office’s code of conduct and signed copies of all the codes of conduct signed by your team members.)

Section Two: Billing and Coding Policies
(Here is where you will list policies for how to handle third-party payers. These include your policies relating to patient information, the schedule, fee level, charges, and information that pertains to your third-party payer contracts in billing, such as a billing company or an electronic claims submission intermediary.)

Section Three: Financial Policies
(Here is where you will list policies about the financial aspects of your practice, such as policies on your collection of repayments and deductibility, payment arrangements, special financial policies that patients pay, special agreements you offer for certain groups, etc., pertinent to your financial policies.)

Section Four: General Compliance Policies
(Here is where you will list any written compliance policies that are not specifically related to billing, coding, or Patient Financial Matters, for example, general policy about documentation, samples of your paperwork and other such policies will fit into the “catch-all” category.)

Section Five: Official Guidance and Legal Opinions Followed
(Here is where you will list any compliance opinions, fact sheets, correspondence from third-party payers about billing preferences, and other guidance resources that you can use to set your compliance policy.)

Section Six: Internal Audit Findings and Information
(Here is where you will list audit findings from your own internal routine monitoring. These reports and findings should include any amounts or issues that have been identified in third-party program and appropriate re-audit actions.)

Step Two: Compliance Officer or Contact

Review the 7 Steps of the OIG Compliance Program
Step 3 - Employ Comprehensive Education and Training

Step 4 - Enforce Disciplinary Standards

Step 5 - Respond Swiftly to Detected Offenses

Step 6 - Internal Audits and Monitoring

Step 7 - Open Lines of Communication

Step 1 - Implement Policies and Procedures
Why You Need Both

• Policy: This is how and why we do things here
• Procedure: Standard Operating Procedure (SOP)—It’s how we implement the policy we’ve decided upon.

Know and Apply These Two Important Concepts

• A clear knowledge of both policy and procedure ensures a proper compliance program.
• Every issue may not need both
• Less is not more in this instance!
• It’s a journey, not a destination.

Build As You Go

• The most efficient way to accomplish this daunting task is to build both manuals as you go.
• As you work through each area of focus or lesson, appropriate SOP and Policy will be developed and implemented.

Implement Policies and Procedures

• Assess what policy and procedure exists
• Make an action list of the most important policies first
• Documentation, Medicare, Financial, and Coding policies take precedent
• KMCU clients have sample policy for each lesson

Opening Checklist - Front Desk

1. Arrival and Prepare for Opening
   a. Ready to begin work – Mon, Wed, Fri – 7:30 a.m. and 1:30 p.m.
   b. Turn on all inside lights (except bathrooms)
   c. Check patient’s face and room with pick-up stack, etc.
   d. Turn off Alarm
   e. Flip back any newspapers
   f. Write any messages in the phone book
   g. Make any appointment changes from the answering machine in the appointment book
   h. Return any calls that need to be returned
   i. Put Travel Charts, Fee Slips and Account Cards together for each patient scheduled for the shift
   j. Fee Slips, Account Card, Travel Card
   k. On Fee Slip and Account Card inside Travel Chart (perpendicular)
   l. Place an AMR in each Medicare Chart, behind the Daily Treatment Notes, perpendicular
   m. Place sorted Charts/Charts on Dr. Wait List Desk by 7:45 am / 1:40 pm
   n. Turn on the copier (Switch on left side of copier as you face it)
   o. Count money in purple money envelope
   p. Copy appointment book schedule for shift and give one to each staff member
   q. Sign In Sheet date stamped, on clipboard with pen
   r. Count total scheduled appointments and initial new patients scheduled for the day and note in pencil on the bottom of the appointment book (two shifts only)
   s. Turn on the intercom TV’s
Step 2 - Compliance Officer or Contact

Daily, Weekly, Monthly, Annual and As Needed Duties

• Let’s Review---
  • Daily: Ongoing monitoring
  • Weekly: Team meeting training; review recommended concerns
  • Monthly: Compliance meeting with doctor; spot check 1-4 notes per provider; random EOB review
  • Annually: Complete audit of 5-10 charts per provider; complete coding audit; review all provider contracts; review existing policy and procedure; annual compliance meeting with the team; renew the practice’s Code of Conduct; confirm key team members have completed annual training; conduct formal compliance training with the entire team

As Needed Duties

• Initial compliance training for new team members, within 10 to 90 days of employment
• Ongoing, and remedial training based on audit findings or spot check findings
• Ongoing case work for compliance incidents

Step 3 - Employ Comprehensive Education and Training
Employ Comprehensive Education and Training

- Always document every training with a training log signed and added to the compliance manual.
- Every webinar, free or otherwise should be included, if appropriate.
- All outside seminars should be documented.
- CO should lay out a training plan early in the year according to the calendar.

Step 4- Enforce Disciplinary Standards

Enforce Disciplinary Standards

- Lay out a sliding scale of discipline to be enforced.
- Range from verbal warning and retraining up to referral to law enforcement.

Other Items to Include in Sanction Policy

- Negligence
- Incompetence
- Disorderly conduct
- Fraud or falsification on employment application
- Unsuitability to job requirements
- Insubordination
- Violation of applicable statutory requirements
Chronicel Record of Compliance Incident # 2013-01-1

1/12/13: Patient Mary Smith called and spoke to Mary Jones, very concerned and upset that we were overbilling her insurance. She stated that the EOB from BC/BS for date of service 11/14/12 showed billing the CMHC at $46, 97011 at $60, and 97012 at $30. She felt sure that she did not receive therapy on that date, as she remembered it as her birthday and she was just in and out quickly. Because her co-insurance is 30% of allowed charges, she felt she was overcharged on her recent statement. She said she will need to return to the office until this is resolved. (Notes copied from the notes section of our software, in Mary’s account.)

1/14/13: In my investigation of this alleged compliance incident, I reviewed the daily notes and the posted charges from 11/14/12. The notes reflect documentation for CMHC provided to the cervical spine, but no additional therapy. The billing and allowed charges reflect charges for CMHC 97011, and 97012, although no notes are present to indicate that the service was rendered. I met with Dr. Brown about this, showed him the notes and he requested that I double check the therapy log book in the therapy lab. There is an entry for Mary Smith on the date in question, after meeting with Dr. Brown, we concluded that the service was likely performed.

1/16/13: Met with Sally, the front desk staff who posts charges. We reviewed the charge entry for that day, as well as the scanned copy of the billing logs from 11/14/12. The billing log for Mary Smith indicates that the only service rendered that day. However, the charge entry was posted as all three services. Sally admitted that she uses macros, and the failure in the software that allows her to import the services from the prior visit so that the entry looks less time. She cannot remember exactly whether she did this on Mary Smith that day, but did state that she has caught herself making that error other times. I asked her about how the End of Day Balancing Sheet could balance if she deleted all of the charges made from the computer. When we looked at the routing slip, we found that she incorrectly placed the total of all three charges in the lower left corner total on the routing slip. However, only one service was marked as completed. We discovered that this was a human error. When asked how often this happens, she admitted that it could slip through on busy days. I copied the routing slip, the End of Day Balancing Sheet and have included them in this record as evidence of the human error.

Brief summary of Investigative Findings: The charges were not performed and we incorrectly billed for them. Use of macros at the front desk likely caused this error. We were overpaid by BC/BS by $42.

Brief summary of Incident resolution: Removal of Sally, Expire #10 so BC/BS, Dr. Brown will check. Many no sweeping action taken.

Date of complaint resolution: 1/23/13

Received by: [Signature]

Approved by: [Signature]
Step 6 - Internal Audits and Monitoring

- Consider an outside entity to conduct a baseline audit on your behalf
- Use error rates to determine what is next
- Coding audits conducted by KMCU as part of PPP or within PhD program

Why Bother to Self-Audit?

- Self-audit can improve standards of documentation considerably and increase doctor and team member’s knowledge and confidence
- Self-auditing is used as a continuous improvement incentive for all clinical staff
- Self-audit can deliver an improvement in practice at no extra cost

4 Kinds of Audits

- Full Chart Documentation Audits
- E/M Coding Audits
- Coding Audits
- Explanation of Benefits (EOB) Review Audits

Post Audit Necessities

- **Make refunds, if appropriate:** Your self-audits may reveal that incorrect codes have been submitted or that certain bills should not have been submitted at all.
- **Take disciplinary action, if necessary:** If a team member refuses to adapt his or her coding and documentation patterns to ensure compliance with applicable regulations, disciplinary action may be warranted.
- **Change the focus of the audits:** Issues and problem areas identified in a self-audit may help determine the scope of the next round of auditing.

Take Action!

- **Revise policies and procedures:** Distribute copies of the updates that came as a result of the audit.
- **Provide additional training in specific areas:** For their education and to improve their coding and documentation, providers receive individual feedback as needed. For example, a physician with a pattern of under-coding may be asked to review the appropriate CPT or ICD-9 codes, as well as the documentation guidelines, to strengthen his or her coding skills.

Step 7 - Open Lines of Communication

Communication requirements can be satisfied utilizing various formats or a combination of formats. There must be a clear and concise procedure for the reporting of fraudulent or erroneous practices. The site of the practice and budgetary considerations will define the components of the communication policy.

- **Open Door Policy:** Practitioners may institute a policy stating the providers and the Compliance Officer or contact are available to all personnel to discuss a possible non-compliant situation or answer any questions regarding compliance issues, without fear of retribution.
- **Drop-Box Policy:** Practitioners may institute a “drop-box” for placement of anonymous reporting of all non-compliant conduct or behavior. The drop-box should be located strategically within the clinical site to encourage usage by personnel and patients.
- **Compliance Bulletin Board:** Bulletin boards for compliance-related issues are utilized to consistently remind patients and personnel of compliance-related topics or to disseminate new compliance information. Personnel and patients should have continual access to the compliance bulletin board. Information posted will have to be regularly reviewed to ensure current data is being provided.
- **Hotline or E-mail:** Practitioners may implement a compliance hotline or compliance e-mail capability to encourage anonymous reporting directly to the Compliance Officer or compliance contact. The hotline can be an 800 number or separate telephone number established for personnel and patients to verbally report compliance complaints. An e-mail address can be established to receive electronically generated complaints of alleged noncompliant or fraudulent behavior or conduct. These systems should not identify the person making contact, record the telephone number or any other data that could result in a breach of informant confidentiality. Practitioners can also contract with an outside source to provide these services.
Need help?
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