Introduction to Provider Compliance

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Key Terms

Medicare Annual FWA Training

- The Centers of Medicare & Medicaid Services (CMS) requires Medicare providers to complete Fraud, Waste, & Abuse (FWA) & General Compliance Annual Training.

- **NOTE: As this presentation is beneficial to help understand fraud, waste, & abuse, it does NOT meet the requirements for the Fraud, Waste, & Abuse & General Compliance Annual Training for Medicare providers**

- For more information, please see:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf

Key Terms

- Fraud – Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit.

  - Many payment errors are billing mistakes & are not the result of someone such as a physician, provider, or pharmacy trying to take advantage of the Medicaid or Medicare program

  - Fraud occurs when someone intentionally falsifies information or deceives the Medicaid or Medicare program

Key Terms

- Waste – Thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of healthcare resources, including incurring costs because of inefficient or ineffective practices, systems, or controls

- Abuse – Provider practices that are inconsistent with sound fiscal, business or medical practices, & result in an unnecessary cost to health programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards

Key Terms

- Special Investigations Unit (SIU)/Program Integrity – Steps & activities included in the compliance program & plan specific to fraud, waste, & abuse

- Payment Integrity – Data mining, claims analysis, & overpayment recoveries to reduce improper payments & promote coding & billing compliance

Key Terms

- Compliance Program – Systematic procedures instituted to ensure contractual & regulatory requirements are being met

- Compliance Risk Assessment – Process of assessing a company's risk related to its compliance with contractual & regulatory requirements

- Compliance Work Plan – Prioritization of activities & resources based on the Compliance Risk Assessment findings

Fraud, Waste, & Abuse (FWA): Laws & Requirements

History of FWA

- Balanced Budget Act (BBA)
  - Amended Social Security Act (SSA) re: Healthcare Crimes
  - Must exclude from Medicare & state healthcare programs those convicted of health care offenses
  - Can impose civil monetary penalties for anyone who arranges or contracts with excluded parties
- Federal False Claims Act (FCA)
  - Liable for a civil penalty of not less than $5,500 & no more than $11,000, plus 3x amount of damages for those who submit, or cause another to submit, false claims
- Deficit Reduction Act (DRA)
  - Requires communication of policies & procedures to employees re: FCA, whistleblower rights, & fraud, waste, & abuse prevention, if receiving more than $5M in Medicaid

History of Compliance & FWA

- Seven Basic Elements of a Compliance Program as Adopted by OIG & CMS (based on Federal Sentencing Guidelines)
  - Compliance Officer & Compliance Committee
  - Effective lines of communication between the Compliance Officer, Board, Executive Management, & staff (incl. an anonymous reporting function)
  - Written policies & procedures
  - Effective training
  - Internal monitoring & auditing
  - Mechanisms for responding to detected problems
  - Disciplinary enforcement

Regulatory Changes = Heightened Federal & State Awareness

- Laws & regulations are now formalizing & emphasizing the effectiveness in prevention, detection, & resolution of fraud, waste, & abuse as well as the recovery of overpayments
- Fraud Enforcement & Recovery Act of 2009 (FERA)
- Patient Protection & Affordable Care Act (PPACA – Healthcare Reform Act)
- Per Federal regulations, providers excluded from one line of business with Beacon, will not be able to participate in any Beacon network or lines of business
- Beacon is required to check Federal exclusion lists regularly to make sure no excluded providers are in network
- CMS National Correct Coding Initiative (NCCI) Edits – Procedure to Procedure (1996) & Medically Unlikely Edits (2007)

New 8th Element of a Compliance Program

- Compliance Programs Must be Effective
  - Must show that compliance plans are more than a piece of paper
  - Must be able to show an effective program that signifies a proactive approach to the identification of fraud, waste, & abuse
  - How much fraud, waste, & abuse have you identified?
  - How much fraud, waste, & abuse have you prevented?

Current Audits & Enforcement Entities

Types of Audits

- Compliance Audit
  - Evaluates strength & thoroughness of compliance preparations
- SIU Audit
  - Evaluates strength & thoroughness of efforts to prevent, detect, & correct Fraud & Abuse
- Payment Integrity Review
  - Evaluates improper payments & coding compliance with national & state standards, such as National Correct Coding Initiative (NCCI)

Federal Level Activities – CMS

- Medicaid Integrity Program (MIP)
- Medicaid Integrity Group (MIG)
- Medicaid Integrity Contractors (MIC)
- Medicare Zone Integrity Contractors (ZPIC)
- Medicare Recovery Audit Contractors (RAC)
- Payment Suspension:
  - Switch from “pay & chase” to fraud prevention.
  - Requires provider payment suspension based on a credible allegation of fraud
  - Good cause exception must be met if payments aren’t suspended

  http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/xml/CFR-2011-title42-vol4-sec455-23.xml

Other Enforcement Entities

- U.S. Department of Health & Human Services, Office of Inspector General (OIG)
- U.S. Department of Justice (DOJ)
- Office of the State Attorney General (AG) – Medicaid Fraud Control Unit (MFCU)
- Federal Bureau of Investigation (FBI)
- Department of Insurance (DOI)

Prepare, You Will be Audited

How Do We Do This?

- Use the eight elements of an effective compliance program as a guide
- Delegate a knowledgeable point person
- Know your contractual & regulatory requirements re: fraud, waste, & abuse
  - Educate staff on how daily activities prevent, detect, & address fraud, waste, & abuse
    - https://oig.hhs.gov/compliance/101/index.asp

Establish an Environment of Awareness

- Provide clinically necessary care through services within the scope of the practitioners' licensure
- Routinely monitor treatment records for required standardized documentation elements
- Monitor & adhere to claims submission standards
- Correct identified errors
- Hold staff accountable for errors
- Cooperate with all audits, surveys, inspections, etc.
- Cooperate with efforts to recover overpayments

Establish an Environment of Awareness

- Maintain documentation of all P&Ps, activities, audits, investigations, etc.
- Verify member eligibility
- Ensure staff know how to report fraud, waste, & abuse
- Communicate internally & externally
- Set-up a suggestion box for anonymous concerns & suggestions for improvement
- Post fraud, waste, & abuse tips
- Send out weekly tips on how to prevent fraud

Conduct Self-Assessments

- Detail all compliance requirements & contract requirements

- Assess & prioritize gaps in compliance & develop action plans to remedy = document all efforts

Conduct Self-Assessments

- Ask Yourselves Assessment Questions regarding:
  - Identification of employees who lost credentials
  - Meeting standards to ensure treatment record documentation
  - Accurate billing & documenting for services rendered
  - Routine checking of member eligibility
  - Training of staff
  - Ability to anonymously report internal fraud, waste, and/or abuse concerns
  - Effectiveness of current processes

Train Staff to Recognize FWA

Common Fraud Schemes:

- Billing for “Phantom Patients”
- Billing for Services Not Provided
- Billing for More Hours than In a Day
- Using False Credentials
- Double-Billing
- Misrepresenting diagnosis, type/place of service, or who rendered service
- Billing for non-covered services
- Upcoding
- Failure to collect co-insurance or deductibles
- Inappropriate documentation
- Lack of computer integrity
- Failure to resolve overpayments
- Delays in discharge to run up bill
- Kickbacks

Train Staff to Recognize FWA

- Common Member Fraud Schemes:
  - Forgery
  - Impersonation
  - Co-Payment Evasion
  - Providing False Information
  - Sharing or theft of Medicaid benefits

Basic Documentation Requirements
“If It’s Not Documented – It Didn’t Happen”

Purposes for Documentation

- Provides evidence services were provided
- Required to record pertinent facts, findings, & observations about an individual's medical history, treatment, & outcomes
- Facilitates communication & continuity of care among counselors & other health care professionals involved in the member's care
- Facilitates accurate & timely claims review & payment
- Supports utilization review & quality of care evaluations
- Enables collection of data useful for research & education

Additional Documentation Standards

- State regulations and/or disciplinary standards may also have an impact on documentation standards

- Be sure to check your state regulations & licensing standards for any additional requirements

- CMS & AMA outlines the requirements for CPT & HCPCS codes.

Basic Documentation Needs

- All billable activities must have a start & stop time
  - Service codes used in claims for payment must match codes used in charts
- Detailed progress notes for members
- Number of units billed must match number of units in documentation
- Full signatures with credentials & dates on all documentation
- Covered vs. non-covered services
  - Services provided/documented meet service definition for code billed
  - Progress notes are legible & amendments clearly marked

Documentation – Additional Tips

- Treatment plans should be reviewed & signed by clinician & patient & should be updated when necessary
- Activity & encounter logs should not be pre-signed
- Progress notes must be written after the group/individual session
- All entries should be in blue or black ink for handwritten notes, not pencil; no white-out
- Keep records secure & collected in one location for each member

Beacon's Approach to Provider Compliance

Beacon's Approach to Provider Compliance: Prevention

- Beacon attempts to prevent paying for billing errors through the following ways:
  - Being an Industry Partner
  - Training & Education
  - Provider Support
  - Contractual Provisions
  - Provider Profiling & Credentialing
  - Ethics Hotline
  - Claims Edits
  - Prior Authorizations
  - Member Handbook

Beacon's Approach to Provider Compliance: Detection

- Audit & Detection
  - Internal/External Referral Process
  - Audits
  - Post-Processing Review of Claims
  - Data Mining & Trend Analysis
  - Special Reviews

- Investigation & Resolution
  - Investigation & Disciplinary Processes
  - Reporting Requirements

Beacon's Provider Handbook & Contract

- The provider handbook is an extension of the provider contract & includes guidelines on doing business with Beacon, including policies & procedures for individual providers, affiliates, group practices, programs, & facilities
- Together, the provider agreement, addenda, & handbook outline the requirements & procedures applicable to participating providers in the Beacon network(s)
- Except to the extent a given section or provision in the handbook is included to address a regulatory, accreditation or government program requirement or specific benefit plan requirement, in the event of a conflict between a member's benefit plan, the provider agreement & the handbook, such conflict will be resolved by giving precedence in the following order: (1) the member's benefit plan, (2) the provider contract, & (3) the handbook

Code of Conduct

- The Beacon Code of Conduct was created pursuant to State & Federal requirements

- Providers should read the code of conduct & comply with the parts that are applicable to their line of business

Beacon's Special Investigations Unit (SIU)

Beacon's SIU Provider Audits

- Referral received
- Referral reviewed & charts may be ordered
- Providers required to supply copies of the charts requested within specified timeframes
- Charts will be reviewed by Beacon's staff
- After completion of the review, results letter will be sent to the provider

Common Patient Record Errors from SIU Provider Audits

- Patient record not submitted for audit
- Evaluation does not meet the documentation requirements
- Assessment does not meet the documentation requirement
- No consent to treatment form
- No release of information
- Corrections to documentation were not completed appropriately
- Patient name/identifier is not on all pages of patient record
- No documentation on the weekends for residential services

Common Treatment Plan Errors from SIU Provider Audits

- Treatment plan is not submitted for the audit
- Treatment plan is invalid for date of service
- Treatment plan is not signed & dated by the patient, guardian, or agent
- Treatment plan is not signed & dated by the clinician
- Treatment plan does not have the required clinical elements
- Treatment plan review was not completed
- Treatment plan is illegible

Common Progress Note Errors from SIU Provider Audits

- Progress note is not submitted for the audit or is for the wrong date of service
- Progress note is illegible
- Progress note is duplicative or similar to another progress note
- Progress note references that no services were rendered
- Progress note does not have a narrative to describe services
- Progress note does not have the required clinical requirements
- Progress note does meet the service code billed on claim
- Progress note does not include the start & stop times
- Progress note is overlapping another service or patient

Beacon's SIU & Compliance Contact & Reporting Information

- Beacon's Safe to Say Compliance & Ethics Hotline

- Chief Compliance Officer: Rebecca White
  - 757-459-5167
- Report concerns to your organization’s compliance office, Beacon directly, or via Beacon’s Ethics Hotline
  - Remember: you may report anonymously & retaliation is prohibited when you report a concern in good faith
  - Reporting all instances of suspected fraud, waste, and/or abuse is an expectation & responsibility for everyone
- If available, report to your state’s Medicaid Fraud & Abuse Control Unit (MFCU)

SIU & Compliance Links

- Code of Federal Regulation:
  - TITLE 42-Public Health, Chapter IV-CMS, DHHS, SUBCHAPTER C-Medical Assistance Programs, Part 455-Program Integrity: Medicaid.
  - www.gpoaccess.gov/cfr/index.html
- Office of Inspector General (OIG):
  - www.oig.hhs.gov/fraud.asp
- *Center for Medicare & Medicaid Services (CMS):
  - www.cms.gov/MedicaidIntegrityProgram/
- National Association of Medicaid Fraud Control Units (NAMFCU):
  - www.namfcu.net/

Laws Regulating Fraud, Waste, & Abuse

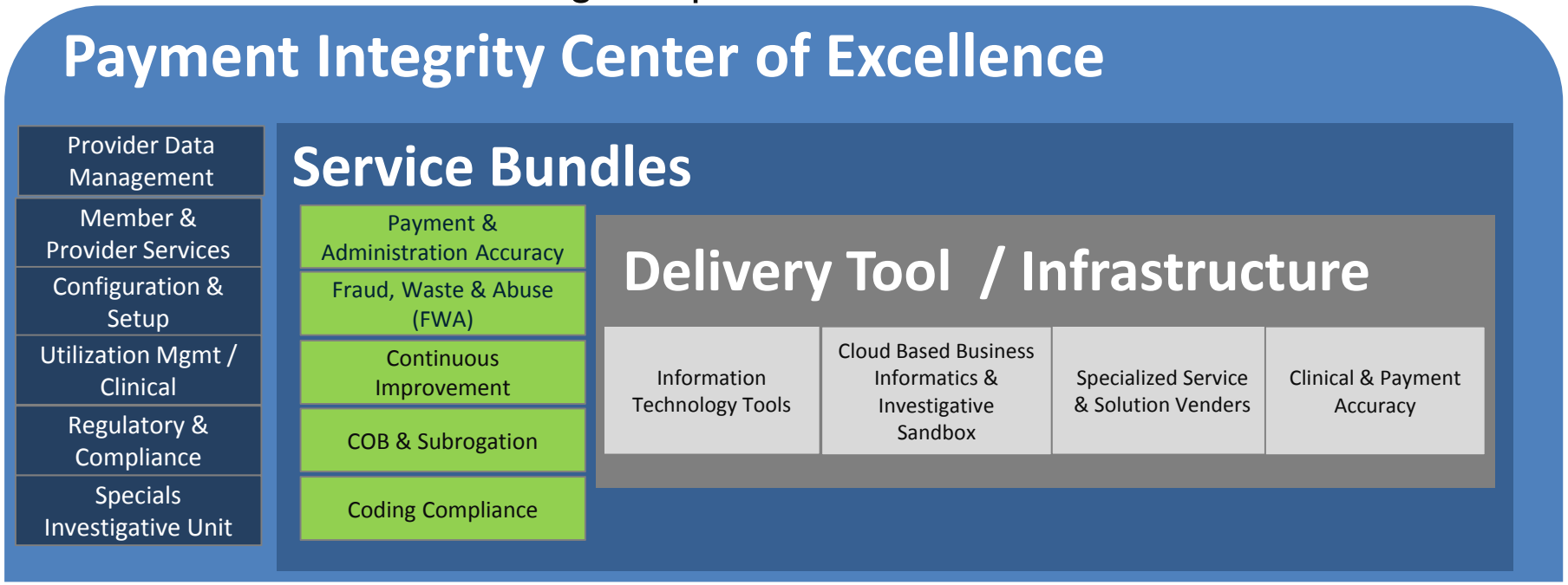
- False Claims Act (FCA), 31 U.S.C. §§ 3729-3733
- Stark Law, Social Security Act, § 1877
- Anti-Kickback Statute, 41 U.S.C
- HIPAA, 45 CFR, Title II, § 201-250
- Deficit Reduction Act (DRA), Public Law No. 109-171, § 6032
- Care Programs, 42 U.S.C. § 1128B, 1320a-7b
- False Claims Whistleblower Employee Protection Act, 31 U.S.C. § 3730(h)
- Administrative Remedies for False Claims & Statements, 31 U.S.C. Chapter 8, § 3801

Beacon's Payment Integrity

Payment Integrity Center of Excellence

Objectives of the Payment Integrity Center of Excellence:

- Improve payment integrity, compliance, cost avoidance, & awareness across the enterprise
- Develop & implement a “best in class” payment integrity operational model
- Leverage payment accuracy, clinical accuracy, & FWA data to inform areas
- Support providers & Beacon with coding compliance



Purpose of Payment Integrity Claims Reviews

- Providers have a responsibility to submit claims which are complete & accurate
- Providers must ensure that documentation fully supports their bill charges
- Beacon will identify claim lines for improper payments
- Beacon uses industry standard guidelines (CMS, AMA, other associations) to determine whether a claim is documented, coded, & billed correctly
- Beacon will review medical records where appropriate to ensure that charges are supported by documentation
- Beacon will confirm appropriate eligibility & coordination services

Scope of Payment Integrity Compliance Reviews

- Review of claims with medical record documentation for the following:
  - CPT & HCPCS coding standards & definitions
  - National & state documentation requirements
  - Professional practice guidelines & standards
  - Beacon Provider Manuals & Handbooks
- Multi-phase approach based on billing & documentation findings
- Any fraud & abuse identified through the medical record reviews will be reported

Payment Integrity Compliance Review Phases

Phase 1

- Initial sample of medical records

Phase 2

- Expanded sample of medical records

Phase 3

- Provider self-audit or on-site audits of billing errors

Examples of Documentation Findings

- Progress note missing duration or start & stop times
- Progress note are not authenticated or signed
- Medical record or progress note is illegible

Examples of Claims Billing Findings

- No progress note submitted
- Progress note references that no services were rendered
- Incorrect E&M service code billed
- Incorrect modifier billed
- Progress note does support the service
- Clinician does not have the appropriate credentials to provide service or bill code
- Progress notes are duplicative (cloned records) from other members or dates of services
- Multiple claims paid for same encounter/progress note

Payment Integrity Links

- CMS National Correct Coding Initiative (NCCI):
  - https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/
- American Medical Association (AMA) CPT Codes:
  - https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology
- MassHealth
  - http://www.mass.gov/eohhs/docs/masshealth/transletters-2017/all-218.pdf
    - Overpayments include, but are not limited to, payments to a provider:
      - For services which a provider has failed to make, maintain, or produce such records, prescriptions, & other documentary evidence as required by applicable federal & state laws & regulations & contracts

Payment Integrity Compliance Review Questions

- Questions & correspondences related to medical record requests, reviews, & findings should be directed to the following:

  Beacon Health Options, c/o Nokomis Health
  1516 West Lake Street, Suite 320
  Minneapolis, MN 55408

  Telephone: 612-284-3979
  Fax: 612-825-2344
  Email: records@nokomishealth.com

Payment Integrity Contact

- Questions related to presentation:

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Upcoming Trainings

January 16, 2018 3:00PM: *Minimum Documentation Standards*

- https://beaconhealthoptions.webex.com/beaconhealthoptions/k2/j.php?MTID=t1c07db78edbb377517068da787477fc6

February 15, 2018 10:00AM: *Documenting, Coding, and Billing E&M and Other Codes*

- https://beaconhealthoptions.webex.com/beaconhealthoptions/k2/j.php?MTID=t035f2885036fb9b6178f4d3e178ec4d0