Preparing your Practice for an Audit
October 16th, 2014
1-2 PM EST

Thank you for joining us this afternoon!

Speakers:
• Cathleen Biga, MSN, RN, President, Chief Executive Officer, Cardiovascular Management of Illinois – Woodridge, IL
• Howard T. Walpole, Jr, MD, MBA, FACC, Vice President, Clinical Effectiveness – Northeast Georgia Health System - Gainesville, GA
### Cathleen Biga, MSN, RN: Disclosures:
- Co-chair: ACC CV Administrator Work Group
- Member: Advocacy Steering Committee
- Member: BOT Work Group on Medical and Professional Liability Insurance
- Member: CQC AUC Implementation & Evaluation
- Member: CQC FOCUS Committee
- Ownership Interest/Partnership/Principal: Cardiovascular Management of Illinois
- Consultant Fees/Honoraria: Medaxiom
- Organizational (Non-Commercial): Cardiology Advocacy Alliance
- Organizational (Non-Commercial): Medaxiom Advisory Board

### Howard T Walpole Jr, MD, MBA, FACC: Disclosures
- Member: Compensation Committee
- Member: Governance Committee
- Member: Audit Committee
- Member: Board of Trustees
- Member: Budget, Finance, and Investments Committee
- Commercial: Zoll Medical (spouse)
Preparing for Audits

Cathie Biga & Dr. Bo Walpole
cbiga@cardiacmgmt.com
bowalpole@gmail.com

The Police

Every move you make and every step you take, I’ll be watching you
Every single day and every word you say, I’ll be watching you
Every life you save in every hole and cave, they’ll be watching you
All the time you take, and every dime you make they’ll take from you.
Agenda

• What is an audit and why do I care
• Who is Watching YOU
• How do we Prepare

What is out there

Let’s define everything 😊

• MAC: Medicare Administrative Contractors
  – Integration of Part A and B
  – Reduced to 10 with further reduction to 10 in next few years

• RAC: Recovery Audit contractors
  – 2006 – 3 yr. demo project = $1.03 Billion ($96M overpayments)
  – 2010 to all States in 4 RAC jurisdictions
  – Medical necessity, DRG validation, patient status

• CERT: Comprehensive error rate testing
  – 2012 being reported with the RAC findings 😏
  – ICD; inpt. Consult levels; dual/single chamber pacemakers

• Probe audit
  • Focused – penalty driven
  • Not a good way to start your day

• Prepayment Audit
  • Payment held
  • Appeal time heading to >280 days

• ZPIC: Zone Program Integrity Contractors
  – Surprise on site visits, targeted data analysis, random audits, etc.
  – Different from RAC’s
Pre-payment

THE SERVICE PURCHASED HAVE BEEN DETERMINED NOT NECESSARY OR REASONABLE.

Therefore, no Medicare payment can be made. If it is determined the provider is liable, if you disagree with the coverage determination, you may request a formal written redetermination.

### Definitions……..

- **PEPPER reports:**
  - Report electronic reporting patterns
  - Normal component of facility’s compliance plan
  - PCI and 2 day stays for CHF and arrhythmia

- **ADR: additional data request**
  - FIRST critical “announcement”

- **Levels of Appeal**
  - 5 Levels of Appeal
The Who

- **Federal:**
  - DOJ: Department of Justice
  - OIG: Office of Inspector General
    - Inspector arm of the DOJ
  - FBI: Federal Bureau of Investigation
  - HHS: Health and Human Services
    - HEAT teams: DOJ and HHS as a "team"
      - Health Care Fraud Prevention & Enforcement Action Team
  - FTC: Federal Trade Commission
- **State:**
  - AG: Attorney General

The Why and The What...

- **Why are they coming**
  - To root out evil and eliminate fraud
  - Dedicated to combating fraud, waste, and abuse
  - Improve efficiency of Medicare and Medicaid
- **What are they looking at**
  - Physician compensation models
  - 2 midnight rule adherence
  - Patient status (in pt. vs out pt. vs observation)
  - ICD’s
  - Dual/single chamber pacemakers
  - Allocation of cardiographic reading panels
  - Medical Directorships …..payment for referrals
  - “Inappropriate” procedures (stents and pacemakers)
  - Physician/Hospital Integration
The How

- New technology now available
- Predictive modeling technology similar to tools used by credit card companies to detect fraud
- Will be used on a nationwide basis to help stop fraudulent billings from being paid
- Uses algorithms and analytical process within the claims to identify potential problems and assign “alert” and “risk scores”
- Use for either further review or other investigative or other enforcement action

Their sources

- Regulatory Investigations
- False Claims Act Lawsuits
- Audits (RACs, MACs and other Attacks)
- Tips or Complaints from Competitors
- Former or Disgruntled Employees
- Media Reports
- Complaints Obtained from Government Hotlines
- Congressional Inquiries
Is it worth it?

- Last 3 yrs. they recovered $7 for every $1 spent
  - 2013 it is now $8.10 for every $1
- In 2011 they recovered $3.03B in false claims
  - $2.4B in Federal Health Plans
  - Add Medicaid in and it is $4.3B
- The new "retirement" plan……
  - Qui Tam - $532M
  - Can receive 10-30%

What is out there.....
Sunshine Act

- Web site
  - Broke more times than functional
- Only 5 months of data
- 1/3 of all physicians NOT reported
- Payments consisted of:
  - $1.49 billion for research
  - $1.02 billion for ownership
  - $380 million for speaking and consulting
  - $302 million for royalties and licenses
  - $167 million for traveling, lodging, meals

Such an easy site to navigate…

<table>
<thead>
<tr>
<th>Physician_Last_Name</th>
<th>Total_Amount_of_Payment_USDollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVY</td>
<td>$15.10</td>
</tr>
<tr>
<td>LEVY</td>
<td>$14.30</td>
</tr>
<tr>
<td>Levy</td>
<td>$17.95</td>
</tr>
<tr>
<td>LEVY</td>
<td>$22.70</td>
</tr>
<tr>
<td>LEVY</td>
<td>$15.40</td>
</tr>
<tr>
<td>LEVY</td>
<td>$15.40</td>
</tr>
</tbody>
</table>
**Medicare release:**

By Specialty

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Number of providers</th>
<th>Average amount paid per provider:</th>
<th>Average total amount paid:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nephrology</td>
<td>2,503</td>
<td>120,144 (Work: 110,144) Expenses:</td>
<td>327,239 ($24,057)</td>
</tr>
<tr>
<td>2. Ophthalmology</td>
<td>17,667</td>
<td>97,156 (Work: 97,156) Expenses:</td>
<td>182,541 ($14,983)</td>
</tr>
<tr>
<td>4. Pulmonary disease</td>
<td>8,464</td>
<td>87,211 ($45,909) Expenses:</td>
<td>352,121 ($17,121)</td>
</tr>
<tr>
<td>5. Cardiology</td>
<td>22,241</td>
<td>82,300 (Work: 82,300) Expenses:</td>
<td>223,248 ($17,813)</td>
</tr>
<tr>
<td>6. Dermatology</td>
<td>33,907</td>
<td>72,654 ($29,624) Expenses:</td>
<td>252,745 ($20,196)</td>
</tr>
<tr>
<td>10. Cardiac surgery</td>
<td>1,532</td>
<td>43,144 (Work: 43,144) Expenses:</td>
<td>172,243 ($13,852)</td>
</tr>
</tbody>
</table>
Heightened….current awareness

• From:
• Sent: Wednesday, June 06, 2013 12:39 PM
To:
Cc:
• Subject: me thinks da Feds are coming...
• Illinois doctors near top in Medicare billing for questionable service
• Illinois ranks seventh in the number of doctors who may be excessively billing Medicare for intensive evaluation and management of patients, services that are vulnerable to fraud and abuse, according to a report by the inspector general of the U.S. Department of Health and Human Services. The inspector general identified 1,669 physicians nationwide in 2010 that consistently billed more to assess patients’ health, claiming that the services were more complex than usual. Illinois accounted for 3.5 percent of the doctors charging higher fees, but that’s lower than the 4.3 percent of Illinois physicians that bill for such services, the report said. The problem may be more severe in other states.

How doctors and hospitals have collected billions in questionable Medicare fees
You do NOT want to be on the front page

Ross Feller Casey, among the nation’s leading personal injury law firms, has a dedicated Whistleblower Litigation Department.

Medicare Fraud strike force charges 89 individuals for approximately $223 million in false billing

Florida Cardiologist Sentenced to Six Years in Prison for Fen-Phen Fraud Scheme

IN THE SUMMER OF 2010, A TROUBLING LETTER REACHED THE CHIEF ETHICS OFFICER OF THE HOSPITAL GIANT HCA, WRITTEN BY A FORMER NURSE AT ONE OF THE COMPANY’S HOSPITALS IN FLORIDA.
There seems to be a theme here....

**THEME #1:** Increased and continued Government emphasis on financial fraud and abuse, governmental waste and transparency

**THEME #2:** Increased reliance on whistleblowers, audits, corporate compliance programs, internal investigations, and self-monitoring
Someone is here to talk to you….

- Train BEFORE the event
- Usher to a quiet spot
- No small talk on the walk
- Notify legal
- Suspend the questionable practice
- Emphasize “no self help”
- Issue a “non-destruct memorandum” and immediately suspend routine destruction when a Government investigation is on the horizon

What do you have in place

- Compliance plan – that has been read
- Audit processes in place
  - AUC for procedures
  - AUC for imaging
  - Coding and documentation
  - Office and hospital
- Follow the rules: Carotid stent/TAVR/ICD
- Peer Review
- KNOW your data
NON-DESTRUCT MEMORANDUM

• It must be authored from proper authoritative source

• Be clear as to the category and type of documents to be preserved

• Provide an affirmative statement that the documents are to be maintained and preserved until further official notice

• Note that computer files (especially e-mails) regarding subject matter should be maintained or retained in an appropriate manner

• Identify appropriate contact person

Alerting Employees:

• Government has the right to contact whoever they want
• Remind staff to request identification
• Everyone has the right not to talk unless you want to
• You have the right to Counsel
• Appropriate for organization to arrange for separate (independent) counsel for employees
• Tell the truth
• Don’t guess or speculate (I don’t know or recall is okay)
• Recommend (not demand) for employee consult with counsel

Cautionary Note: While it’s entirely appropriate to alert employees that they may be contacted by investigators, care should be exercised that instructions aren’t construed as attempt to “influence, delay or prevent” testimony or to induce someone to withhold testimony/evidence (i.e., obstruction of justice)
Technology and HIPPA

- Practice had a stolen lap top
  - 3400 pt. names and data
  - Apologized
NOT ENOUGH SAYS HHS
...demonstrated "a long-term, organizational disregard for the requirements of the security rule," such as analyzing the risks associated with mobile electronic devices and taking the necessary precautions,

Smartphones, IPad, I-everything

- Technology is both a boon and bane for healthcare providers
- Facilitates us working on the run, but also affords us security headaches
- Is your phone/computer encrypted?
- Do you text?
- Do you HATE changing your password
What do you need to do...

- Inform and educate stakeholders what regulations and laws apply to them
- Encourage law-abiding behavior by all stakeholders
- Detect, as early as possible, any violations or potential violations of law
- Deal appropriately with any violations or potential violations of law

What audits are we seeing

- Coding and documentation
  - Level 4 and 5’s
- Order for EVERYTHING you bill
- Admitting order from a “qualified” physician
- Dual/Single Chamber pacemaker
- Device checks
- Short LOS
- ICD’s
DOJ and ICD's

- Resolution released in September 2012
- Very clear that it does not replace the NCD
- Did the hospital "have medical reasons" to violate Medicare rules
- Was there any adverse patient outcome
- Did the hospital have "prior" knowledge
- Statistical pattern of non-guideline implants
- Was the procedure reported to the registry
- Is there a compliance plan in place

United Healthcare – Utilization Report Card:
the very helpful – management summary

UnitedHealthcare

P.O. Box 30440
Salt Lake City, UT 84130-3040

June 1, 2014

(VIP: Variations in Practice Patterns and Opportunities for Improvement)

Health care is at a pivotal point. Significant gaps remain in health care quality, patient experience and affordability and it is incumbent on all of us to close these gaps. As an important step, the Choosing Wisely initiative sponsored by the American Board of Internal Medicine Foundation with the support of many national specialty societies has provided lists of tests and treatments they believe are of limited benefit to patients. In addition, many organizations have developed evidence-based guidelines for physicians on what the best circumstances are to utilize procedures and prescribe medications. Now many consumers and employers are encouraging payers to quantify the cost of the tests and treatments that may not be necessary or of little value in diagnosing or treating conditions under certain circumstances, and potentially not pay for them.
United Healthcare – Utilization Report Card

with you away six months over an 18-month period. We look forward to working with you during this time to support you in your improvement efforts.

We continue to improve quality care provided by our network physicians through programs such as the
United’s latest aka E&M awareness

By year (for instance of the next 18 months), the data continue to show exceptional variation from the benchmarks without improvements that bring the practice patterns) closer to the norm. UnitedHealthcare will evaluate the next stage which could impact your

• Payment of claims
• Participation in our performance-based contracting (if applicable); and
• Participation in the UnitedHealthcare Physician/Provider programs as that program evolves over time.

If you have questions, please contact the Physician Resource Center at 877-283-8098 or

Thank you.

Sincerely,

Mary Vorwaar, MD
Medstar Medical Director

Please use this information to review your billing practices to support compliance with billing standards. We may conduct an on

of medical records in the future to understand variations and ensure claim submission adheres to standard coding and billing

requirements. These standard requirements are based on common application of the Current Procedural Terminology (CPT)
coding requirements defined by the American Medical Association and the Centers for Medicare & Medicaid Services’ National
Correct Coding Initiative.
Hmm let’s compare United to CMS

- CMS bell curve for cardiology

<table>
<thead>
<tr>
<th>Code</th>
<th>Usage</th>
<th>Code</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>0.3%</td>
<td>99211</td>
<td>12.7%</td>
</tr>
<tr>
<td>99202</td>
<td>1.9%</td>
<td>99212</td>
<td>3.3%</td>
</tr>
<tr>
<td>99203</td>
<td>15.9%</td>
<td>99213</td>
<td>33.0%</td>
</tr>
<tr>
<td>99204</td>
<td>55.5%</td>
<td>99214</td>
<td>45.3%</td>
</tr>
<tr>
<td>99205</td>
<td>26.5%</td>
<td>99215</td>
<td>5.7%</td>
</tr>
</tbody>
</table>
Letter and response......

August XX, 2014

Richard Migliori, M.D.
Executive Vice President, Medical Affairs and Chief Medical Officer
UnitedHealth Group
P.O. Box 1459
Minneapolis, MN 55440-1459

Re: UHC Healthcare Management Summary Reporting Program

Dear Dr. Migliori:

The American Society of Nuclear Cardiology (ASNC) and the American College of Cardiology (ACC) are writing to express our deep concern for the letter dated June 1, 2014 regarding

Email

• The bane of our existence
• Be careful what you type – it is recoverable
• Be careful what comes in
  – Audits tend to be snail mailed but…
  – De-enrollment letters
  – Audits outlining your over utilization
  – Private payer report cards
  – Non-destruct memo’s
In the real world

1) Develop a process
2) Analyze as a team
3) Design “real life” tools
4) Implement
5) Review/revise/repeat 😊

Top 5

• Compliance plan in place
• Internal monitoring and audit plan
• Education process for all staff & providers
• Process in place for all staff in preparation for any on site visits
• Stay current
Everyone is watching

Star Tribune
Hospital prices show wild variations
(May 8, 2013)

CBS NEWS
Hospital costs can vary more than $200,000 for same procedure, government report reveals
(May 8, 2013)

BDN Maine – The Washington Post
See which hospitals have highest, lowest prices
(May 8, 2013)