Sample Auditing Compliance Plan

(This is a <u>sample only</u>, guidelines should be based on your medical practice, MAC guidelines and compliance committee)

A. Purpose of Audits

(Name of Medical Practice) promotes adherence to a Auditing Compliance Program as a major element in the performance evaluation of all providers/NPP documentation. Providers and NPP's are bound to comply, in all official acts and duties, with all applicable laws, rules, regulations, standards of conduct, including, but not limited to laws, rules, regulations, and directives of the federal government and the state of ______, Medicare Contractor, Fiscal Agent (FI) or Carrier (Name of MAC Provider) and rules policies and procedures of (Name of Medical Practice).

B. Orientation and Training

All new physicians/NPP will receive orientation and training in documentation and auditing policies and procedures. Failure to participate in required training may result in disciplinary actions, up to and including, termination of employment. Every physician/NPP is asked to sign a statement certifying they have received, read, and understood the contents of the auditing compliance plan.

C. Education

Every physician/NPP will receive periodic training updates in auditing as they relate to the auditing process and documentation guidelines. Education will be ongoing based on regulatory changes. It will be mandatory for all providers to attend educational updates.

D. Audits/Monitoring

Name of Medical Practice auditors will conduct ongoing evaluations of compliance auditing processes involving thorough monitoring and regular reporting to the officers of (Name of Medical Practice). The (Name of Medical Practice) develop audit tools designed to address the practice's auditing compliance with CPT, HCPCS, and ICD-9-CM coding, billing, CCI and LCD's, claim development and submission, reporting, and documentation. A annual base-line audit will be performed on all providers consisting of 10 health care records per provider. The audits will inquire into compliance with specific rules and policies that have been the focus of Medicare fiscal intermediaries or carriers as evidenced by the Medicare Fraud Alerts, OIG audits, current year OIG workplans. Audits should also reflect areas of concern that are specific to (Name of Medical Practice) .The Compliance Officer/Committee shall conduct exit interviews of personnel in order to solicit information concerning potential problems and questionable practices. The audits should identify any patterns and trends in deviations identified by the audit that may indicate a systemic problem. Non-compliance with the auditing compliance plan or violations will result in sanctioning of the involved physician/NPP.

Auditors

All audits will be performed by certified coders with one or more of the following credentials; (*CPC-CPMA*, *etc*). Auditors must complete testing administered by (*Name of Medical Practice*) and maintain their credentials. Continuing education is required at a minimum of 10 hours of auditing CEU's per year. Educational expenses of a maximum of \$1000.00 per auditor will be paid by (*Name of Medical Practice*) per year. Proof of continuing education and credentials are required at anniversary hire date. (*Name of Medical Practice*)

<u>Medical Practice</u>) audits are performed (onsite/offsite/hired by another company). All auditors are required to follow the same guidelines dictated in the compliance plan for auditing purposes. Auditors employed by (<u>Name of Medical Practice</u>) will be audited by external resources to monitor their accuracy and performance. Auditors must query providers concerning any documentation questions or clarifications.

Frequency of Audits

Internal audits will be a minimum of 10 audits per provider and conducted on a (monthly/quarterly/semi-annual/annual) basis. They will be selected on (random basis, trending reports, frequency).

Audit Error Rate

Error rates will be conducted with provider audits and the following is the recommendation for follow-up audits

Error Rate	Schedule for follow-up audit
10%	Annual
20%	Eight Months
30%	Seven months
40%	Six months
50%	Five months
60-70%	Four months
80%	Three months
90%	Two months
100%	One month

Auditing Reports

Physicians will received a written report following each audit performed. The following information will be included in each report:

- a. Patient name/date of service
- b. Provider name
- c. Level billed/level documentation supports
- d. Diagnosis codes billed/diagnosis documentation supports
- e. Any coding/billing discrepancies
- f. Medical necessity
- g. Recommendations/concerns
- h. Auditor name

The provider can contact the auditor for discussion/questions concerning their audits. Reports will be sent to compliance officer and medical director for review.

E. Non-Compliant Physicians/NPP/Auditors

When disciplinary action is warranted, it should be prompt and imposed according to written standards of disciplinary action. The following action will include, without limitation, one or more of the following:

- a. Additional education/training
- b. Verbal counseling
- c. Pre-payment audits

Continuous violations will be reported to the Medical Director of (*Name of Medical Practice*) within 30 working days after receipt of an investigative report. The Medical Director shall determine the action to be taken upon the matter of Reduction, suspension, or revocation of clinical privileges.

a. Reduction, suspension, or revocation of clinical privileges

b. Suspension or termination of employment.

The Medical Director of (*Name of Medical Practice*) shall have the authority to, at any time, suspend summarily the involved provider's clinical privileges or to summarily impose consultation, concurrent review, proctoring, or other conditions or restrictions on the assigned clinical duties of the involved provider in order to reduce the substantial likelihood of documentation and auditing violations.

F. Documentation Requirements

New verses Established Patients

Providers are required to state new patient visits. Documentation should clearly state the patient is new to the practice or it is their initial visit. A new patient is someone that has not been seen within the same group practice in 3 years.

Component Requirements

These three components will be used to qualify the level of service performed. If any of above listed components is missing from the documentation, the services will not be billed.

- a. History
- b. Examination
- c. Medical Decision Making

Counseling/Coordination of Care/Time

Other components that could be used in determinations of levels charged:

- a. Counseling time spent counseling, detailed documentation of counseling (see time documentation in #4 listed below
- b. Coordination of Care documentation of time , detailed documentation of coordination of care provided and conversations with other health care providers
- c. Nature of Presenting Problem
- d. Time If time is used to report more than 50% of visit was spent on counseling, documentation must support time .
 - 1. Time
 - 2. More than 50% of the visit was spent on counseling
 - 3. Detail of counseling performed
 - 4. Condition, illness or disease counseled
 - 5. Time documentation: *I spent more than 50% of this visit or 45 minutes counseling the patient about their diabetes.*

Chief Complaint

The medical record should clearly reflect the chief complaint. The chief complaint will support the medical necessity of the services/procedures provided.

History

- a. Three chronic illness can be used for an extended HPI
- b. The History of Present Illness can be recorded by the ancillary staff or on a form completed by the patient, but the HPI must be notated it was reviewed by the provider and confirmation the information was recorded by others.
- c. Review of system and Past Medical, Family, Social History does not need to be rerecorded if obtained during a earlier encounter. However this information must substantiated and supported the physician reviewed and updated the previous information. Documentation requirement: There is no change in the patients

- Review of Systems or Past Medical, Family or Social History from their previous visit of 3 weeks ago on 03/03/2011.
- d. If the provider is unable to obtain a history, documentation should clearly reflect the patient condition or circumstances that prevented the provider from obtaining this information. Any documented unobtainable history will be counted as a complete history.
- e. Documentation of unremarkable and non-contributory are not acceptable forms of documentation and the provider will not be given credit.
- f. Documentation of normal or negative is permissible, any abnormal findings must be described.
- g. Review of Systems must meet medical necessity of the systems reviewed.
- h. "All others negative" is not acceptable with *(your FI name)*. Each system reviewed must be individually documented in the Review of Systems.
- i. If a element is used in the History of Present Illness, it cannot be used in the Review of Systems for auditing purposes.

Examination

- a. All audits are base on 95 or 97 Documentation Guidelines for Evaluation and Management (E/M) Services
- b. The extent of examination performed must meet medical necessity for the patients illness, condition or injury.
- c. Abnormal or any relevant negative findings should be documented and described. Negative or normal is sufficient documentation. Unremarkable and noncontributory are not acceptable forms of documentation.
- d. Certain acronyms are not permissible. Each organ system or body area should be described in detail. Example of unacceptable examination documentation. HEENT: Normal (no credit would be given with this documentation). Acceptable: Eyes: Equal, round and reactive to light and accommodation. Ears: TMs are clear. OP shows a lot of posterior nasal drainage, however there is no tonsillar exudate or erythema. No nasal mucosa. (documentation of 4 bullets in 97 would be given).

95 Examination

- a. The level of examination for 95 will be determined as follows:
- b. 1 body area or 1 body system Problem Focused
- c. 2-4 body areas and/or body systems Expanded Problem Focused
- d. 5-7 body areas and/or body systems Detailed
- e. 8 or more body systems Comprehensive

Medical Decision Making

- a. The provider will not get credit for a diagnosis that is not applicable to that days visit. The only exception to the rule is a diagnosis that may be a secondary issue. Example: ulcer in a patient with diabetes.
- b. Diagnoses must have relevance to the treatments provided or ordered. Must have a minimum of one diagnosis with a treatment of care.
- c. What are your MAC guidelines for ordering a test and charging for the test for complexity? Some do not allow this.
- d. Any interpretation by the attending physician should document the interpretation was done and results of the interpretation.
- e. If history is obtained from someone other than the patient, this information must be documented.
- f. Old records that are reviewed must have documentation the records were reviewed and a brief summarization of those records reviewed.
- g. Any discussions with other health care providers must be documented and a brief summarization of the conversation.

Diagnosis Codes

Diagnosis codes used for billing of services, and ordering of ancillary services must be supported in the medical record. Diseases must be documented to the highest level of specificity i.e.; Stages (ulcers, chronic kidney disease, etc), Diabetes (I, II, controlled or uncontrolled, insulin), Burns (Total Body Surface, degree of burn), Fractures (bones, tendon, muscle, nerves), Left/Right

Include information that will be important for ICD-10

G. Procedure/Surgery Documentation

Procedures performed without a Evaluation and Management component must be documented in detail with the following information:

- a. Date of surgery
- b. Patient Name and date of birth
- c. Surgeon
- d. Assistant Surgeons/Co-surgeons/Interns
- e. Anesthesiologist and type of anesthesia used
- f. Facility where services were performed
- g. Consents obtained
- h. Pre op diagnosis/Post op diagnosis
- i. Indications for the procedure
- j. IV infusions
- k. Description and details of procedure
 - 1. Anatomical location
 - 2. How the patient was draped
 - 3.Equipment used
 - 4. How patient is positioned
 - 5.Materials inserted/removed
 - 6. Tissue/organs removed
 - 7. Closure information
 - 8.Blood loss/replacement
 - 9.Wound status
 - 10. Drainage
- l. Findings
- m. Complications and how they were resolved
- n. .Diagnostic reports/pathology reports
- o. Intra-operative information
- p. Post-op condition of patient
- q. Signatures

H. Cloning Documentation

Cloning is documentation that is "cut and pasted" and the medical record is worded exactly the same or similar to previous entries or encounters. Copying information from a past encounter and passing it off as a current documentation is not permitted. Past complaints or symptoms in current documentation can lead to multitude of errors, including treatment.

I. Frequency of visits

Frequency of visits for patients that have had at least two visits per month for the previous three months will be reviewed for medical necessity.

J. Consultation visits (non-Medicare patients)

Consultations must be documented as a request **for** an <u>opinion</u> from another provider. It is the provider's responsibility to make sure a report is written to the referring provider. The report must documented. The documentation must notate the reason for the consultation, your opinion and recommendation. Documentation the patient is being "referred" does not meet the criteria for a consultation.

K. Medical Necessity

Auditors will take reasonable measures to ensure that claims for services for office encounters and all procedures performed are reasonable and necessary, given the patient's condition, are billed. Documentation will support the determinations of medical necessity when providing services.

All documentation and levels charged must meet the medical necessity and medical decision making of the level charged. If the medical decision-making is the <u>lowest</u> of the components for all three levels that require 2 out of 3 components, the medical decision-making will be the determining factor and scored accordingly. All components of History, Examination, and Medical Decision Making must meet medical necessity of obtaining information from the patient, and examination performed for the patient's symptoms, diagnosis, or illness they are presenting for. Undercoding/Overcoding of documentation will be adjusted and billed according to documentation.

L. Addendums/Late Entries

Any corrections to the medical record such as addendums or late entries are acceptable within (note days/week/months). Dates of addendums/late entries must documented. No change of documentation is permitted at any time after time listed above or if the documentation is in the process of a review outside of (*Name of Medical Practice*) during a RAC, OIG or insurance audit review.

M. Acronyms

Below are the only acceptable acronyms used for (*Name of Medical Practice*):

- a. Acceptable:
 - i. HTN Hypertension
 - ii. COPD Chronic Obstructive Pulmonary Disease
- a. Unacceptable:
 - a. HEENT in examination

N. Handwritten Notes

Handwritten notes i.e.; hospital encounters that are handwritten will be review by two separate auditors if illegible. If either auditor is unable to decipher handwritten information the documentation will be considered illegible and non-billable.

O. Modifiers

Use of modifiers will be audited according to frequency and proper use.

P. Medical Records

Paper medical records are not permitted to leave the facility. All records must be securely accessed through (*Name of Medical Practice*) EMR system with the individuals secure password. It is illegal to access any unauthorized or inappropriately access, review or view a patient's medical information without a direct need for medical diagnosis, treatment, auditing, or other lawful use. Refer to HIPAA Compliance plan for disciplinary actions.

Q. Advanced Beneficiary Notices of Noncoverage(ABN)

It is the responsibility of the providers and their staff to make sure ABN's are signed. ABN's must be presented to the patient and to the patient before a service/procedure is performed notifying the patient the service may not be covered by Medicare. The form must be completed along with an estimated cost of the services and a description of the services that may not be paid by Medicare. The description of the services/procedure should be specific and detailed. The patient must be given ample amount of time to consider their options and to make a choice. Diagnosis codes for ancillary services must be listed in the patient's medical record. Patient's should be given a copy of the ABN. Billing department must also be notified an ABN was signed by _______. (information put in the computer, sent to billing department???) ABN's cannot be signed by all patients only for those services that may not be paid by Medicare.

R. Unbundling of Services

Some services are bundled into services per CCI edits. These services will not be unbundled per the request of a provider unless documentation, or modifiers support the medical necessity. Some items such as pulse oximetry, EKG's are routinely bundled into office visits and not billed separately.

S. Global Days/Surgical Packages

Services included in global days and surgical packages cannot bill be separately.

T. Incident-to

NPP professional services can be billed as Incident-to with the following guidelines.

- a. New patients are not billed as incident-to
- b. Established patients with new problems are not billed as incident-to The supervising physicians must be present <u>in the office</u> and immediately available, when billing incident-to.

U. Scribes

Scribes can be used by physicians. The scribe must pass (<u>Name of Medical Practice</u>) testing to perform as a scribe. The scribe cannot see the patient in lieu of the physician. The record must be clear that the physician has performed all components of the service. The documentation should be clear the information was obtained by the scribe, scribes name, date and they are functioning as a scribe for the physician. A statement in the documentation should include the information obtained by the scribe has been reviewed and verified by the physician.

V. Signatures

All signatures should be original or electronic and legible. Stamped signature are not allowed. Attestation statements may be required if signature requirements are not met. All signatures must meet one of the following:

- a. Legible full-signature
- b. Illegible signature over a typed or printed name
- c. Illegible signature accompanied by signature log or attestation statement

W. Teaching Physician Guidelines

Office services provided will be determined by the combining documentation from the resident and teaching physician. The resident can document his/her services in the office and teaching physician must also document their participation of the service rendered. If documentation is incomplete or invalid, the teaching physician must document as if services were performed in a non-teaching setting.

X. Kickback/Self-Referrals

Payments for referrals or to induce referrals are considered illegal and will be closely monitored. Physicians are not permitted to make any financial arrangements with outside entities.

Y. Billing

Write-offs

Auditors will review 10 non-contractual/contractual accounts per month to verify copayments and adjustments are properly written-off.

Place of Service

Auditors will review 10 claims per month and verify Place of Service codes are appropriate for services performed in ASC or outpatient department of a hospital.

Claim Denials

Auditors will review 10 claim denials per month for medical necessity of services/procedures or supplies.

Auditors will review 10 claims denials per month for denials due to billing and coding errors. Billing Department will identify and maintain a list of claims denied due to billing and coding errors. The purpose is to identify if improper use of codes is improperly used by provider, coding or billing to help reduce non-payment of claims.

Z. External Audit Requests

External audit request must be reviewed by the Auditing Compliance Committee for review prior to submission of request of records, documentation, etc. The Auditing Compliance Committee must review the external audit request within 3 days of notification.

A committee for processing of external reviews will consist of employees in the organization to identify the requests, copying of medical records, deadlines for submission of requests and follow-up.

This Auditing Compliance Plan will be updated frequently and based on changes in the regulations by payer.

Update	Brief description of changes	Received by
01/05/2012	Describe the change to your compliance plan here	Have doctors sign off and put names here

