Compliance and Ethics Audits in Managed Care
With Mario Fucinari DC, CCSP®, APMP, MCS-P, CPCO
Sponsored by ChiroHealthUSA (2 Hours)

Disclaimer: The views and opinions expressed in this presentation are solely those of the author. Mario Fucinari DC do not set practice standards. We offer this only to educate and inform. The laws, rules and regulations regarding the establishment and operation of a healthcare facility vary greatly from state to state and are constantly changing. Dr. Mario Fucinari does not engage in providing legal services. If legal services are required, the services of a healthcare attorney should be attained. The information in these seminar slides is for educational purposes only and should not be construed as written policy for any federal agency.

NO RECORDING OF ANY TYPE ALLOWED

This Material is Copyright Protected

Unauthorized Audiotaping or Videotaping or Distribution of any presentation materials is illegal.

About Dr. Mario Fucinari, CCSP®, APMP, CPCO, MCS-P

- Graduate of Palmer College of Chiropractic - 1986
- Currently in Full Time Practice in Decatur, Illinois
- Certified Chiropractic Sports Physician (CCSP) – Logan College of Chiropractic
- Certified Medical Compliance Specialist Physician – (MCS-P)
- Certified Professional Compliance Officer – CPCO (AAPC)
- Diplomate Academy of Integrative Pain Management (APMP)
- Post-graduate Faculty of Palmer College of Chiropractic, NYCC, D'Youville College, Life West and Western States Chiropractic College
- National Speaker's Bureau for NCMIC, ChiroHealthUSA and Foot Levelers and many state associations
- Member Medicare Carrier Advisory Committee
- Past President of Illinois Chiropractic Society (ICS)
- Chairman, ICS Medicare Committee
- ICS Chiropractor of the Year 2012
- Member of ACA and ICS

New information posted regularly at
www.facebook.com/askmario "Like" us to get updates

Ethics and Compliance

Medicare Audits

- Required by law
- To confirm that services are covered services and are medically necessary
- Applies to Par and Non-Par doctors
- Performed by *all* carriers, including commercial carriers such as Blue Cross
- Even going "Cash" there are still HIPAA audits, Department of Professional Regulations and Board of Examiners' audits

CERT- Comprehensive Error Rate Testing (CERT) Program
The CERT contractor is currently AdvanceMed. They are a sub-contractor employed by CMS to determine error rates of providers and of the Federal government programs such as Medicare.
You must provide information upon request. This does not constitute a HIPAA violation.

Chiropractic has consistently ranked number one for errors. The reasons for our errors are ranked as follows:
Insufficient documentation (Number One!) Medically unnecessary services (maintenance care) Incorrect coding

Strategic Health Solution

- Strategic Health Solutions has been contracted to perform and provide medical review functions of Medicare and Medicaid programs.
- Strategic Health is currently performing medical review of records through the project Y4P0434 for Chiropractic Services.
- Documentation will be reviewed for compliance on such issues as medical necessity, maintenance care and signature requirements.
- CMS will direct claims adjustments and recoupment efforts.

Look up your profile at:
http://graphics.wsj.com/medicare-billing/

Altegra Health Audits

- Altegra Health is conducting a chart review for Blue Cross Blue Shield Medicare Part C claims to verify that information to be reported to Blue Cross Blue Shield and ultimately to HHS and Medicare in claims or encounter data, includes all pertinent diagnosis codes at the adequate levels of specificity.
- The review is for dates of encounter January 1, 2016 to present.

Zone Program Integrity Contractors (ZPICs)

The goal of the ZPIC is to identify cases of suspected fraud, investigate them, and take action to ensure any inappropriate Medicare payments are recouped.

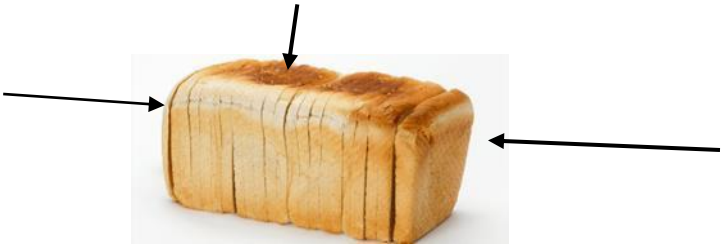
ZPIC actions to detect and deter fraud and abuse may include:

- Investigating potential fraud and abuse, including interviews and onsite visits
- Perform medical review, as appropriate
- Perform data analysis
- Identify the need for administrative actions, such as payment suspensions and prepayment, or auto-denial edits
- Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.
- ZPICs are responsible for preventing, detecting, and deterring Medicare fraud.
- ZPICS target both medical necessity for the services provided as well as coding errors
- They audit Parts A, B, C, and D claims
- Unlike RACs, ZPICS are paid on a contract basis (not percentage)

Recovery Audit Contractors (RAC)

- RACs are paid on a contingency of a percentage of the improper overpayments the collect from providers.
- RACs may review the last three years of provider claims Source:

www.aha.org/aha/issues/RAC/index.html



"The Episode of Care" Model

What Should You Do If Claim is Denied?

1. Did you send in ALL records?
2. Box 14
3. Episode of Care
4. Follow the Rules
5. Get Help!!
6. FIGHT IT!

OIG Compliance in the News

- Alleged Crimes
- Unnecessary services
- Overcharging Medicare
- Waiving Co-pays
- Waiving deductibles
- Paying for referrals
- Illegal patient recruitment

Fraudulent practices include, but are not limited to:

- Submitting claims for services never provided
- Submitting claims for medically unnecessary
- services
- Offering incentives to patients to receive
- unnecessary services
- Providing services without a valid chiropractic
- license
- Falsified patient records
- Cloning of records
- Billing for manipulation, but providing services not covered by Medicare (e.g., massage, acupuncture or trigger point therapy)

Is the Cash Practice a Reality?

Medicare Processing Manual §70.8.6 – Time Limitation for Filing Part B Reasonable Charge and Fee Schedule Claims (Rev. 170, 05-07-04)

- Medicare law prescribes specific time limits within which claims for benefits may be submitted with respect to physician and other Part B services payable on a reasonable charge or fee schedule basis
- For these services, the terms of the law require that the claim be filed no later than the end of the calendar year following the year in which the service was furnished…

"Opting out of Medicare is not an option for Doctors of Chiropractic. Note that opting out and being non-participating are not the same things. Chiropractors may decide to be participating or non-participating with regard to Medicare, but they may not opt out."
MedLearn Matters SE0479

One of the key legal issues is the extent to which the cash only practice handles services that are routinely or statutorily covered by insurance — such as manipulation in Medicare.

Financial Policies

What do you say when asked "How Much?"

According to your insurance carrier…

- Our fee is our fee
- Your Insurance Contractual Obligation
- Have you heard of ChiroHealthUSA?

Why ChiroHealthUSA?

As benefits for chiropractic care dwindle, more families are forced to choose between needed chiropractic care and other necessities. Because patients with insurance coverage have the benefit of the carrier negotiating the fees with the doctor, cash-paying patients, or those with non-covered services like Medicare beneficiaries, may have to pay MORE than insured patients. ChiroHealthUSA allows patients to use the membership concept they are already familiar with to access needed care for their immediate family.

Doctors are usually required to charge insurance companies and patients the same fees unless they are under a network contract for a lower fee. ChiroHealthUSA is a contracted network that allows doctors to set and accept discounts on their services for our members. When a patient joins ChiroHealthUSA, they are entitled to similar "in-network" discounts just like the insurance companies.

- A single $49 annual membership includes everyone in your immediate family.
- Partially insured patients who have coverage for some services and not others, like Medicare patients, may use their ChiroHealthUSA benefits to complement their existing benefits, specifically for the non-covered services.

- Patients may use their membership cards at more than 3,900 doctors in the network.

Simple. Compliant. Profitable.

ChiroHealthUSA is a provider-owned network designed with doctors in mind. Our network model allows you to offer legal, network-based discounts to cash, under-insured and "out of network" patients who are members.

Members covered by Medicare and federal programs are eligible for discounts on *non-covered services*. The network approach to discounts reduces the risks of compliance and OIG violations related to inducements, improper down-coding, dual fee schedules, and potentially inappropriate time-of-service discounts.

With ChiroHealthUSA, you can choose the level of discounts. The existence of a contract allows you to set, offer, and accept these rates from our members. Our contract eliminates the "middle man," and solves a host of legal and regulatory problems for you and your patients. ChiroHealthUSA only makes membership available to individuals, which means there is no potential for "silent PPO" activity to lower your reimbursements.

Patients pay a low annual membership fee that includes them and their legal dependents. This fee is often recovered through discounts received on their first visits. There is no cost to the clinic for this program.

www.ChiroHealthUSA.com

Fraud

Knowingly and willfully executing, or attempting to execute, a scheme or act to defraud any health care benefit program or to obtain by means of false or fraudulent pretenses, representations or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

INTENT = FRAUD = JAIL
"A reckless disregard to truth or facts"

Abuse

Abuse may, directly or indirectly, result in unnecessary costs to a health care benefit program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Despite a GOOD FAITH EFFORT if mistakes are found

Did you make a good faith effort? PROVE IT!

THE COMPLIANT OFFICE

Step One: Risk Analysis

Compliance Program Manual for the Chiropractic Office
by Mario Fucinari DC, CCSP, APMP, CPCO, MCS-P
Step-by-Step Procedures to compliance
www,Askmario.com

Compliance Program Guidelines
In 1991, the United States Sentencing Commission Federal Sentencing Guidelines were published. These guidelines were used by the United States government for the sentencing of organizations.

The Sentencing Guidelines have been used by Federal courts in determining criminal fines for corporations and organizations. The guidelines have provided the groundwork for compliance programs ever since. **A mitigating factor in this determination has been the existence of an *effective* compliance program as defined in the Sentencing Guidelines. This is known as the culpability score.** The health care industry has used the Sentencing Guidelines as a framework reference for establishing a compliance program and compliance guidance.

Federal Sentencing Guidelines
- Established in 1991
- Adopted by the OIG, FBI, DOJ
- Controls sentencing of organizations for most federal criminal violations
- Used as mitigating factor in sentencing
- Credit for "effective programs to prevent and detect violations of the law."

Culpability Score – Used as a mitigating factor to reduce fines and jail

Mitigation Factors:
- **Do you have an effective compliance manual?**
- Upper level employee "participated in, condoned, or was willfully ignorant of the offense"
- If the organization reported the offense promptly
- If the organization cooperated with the government investigators
- If the organization accepted responsibility for the violation

Patient Protection and Affordable Care Act requires that you have the establishment of a compliance program.

It has become quite clear that the adoption of the "Seven Elements of a Compliance Program" have become a **mainstay of compliance** in the corporate world and in healthcare. To protect oneself by showing a culture of ethics, it is recommended that these elements are adopted to demonstrate the ethical culture of the organization.

Seven Elements of Your Compliance Program

1. Implement written policies and procedures;
2. Designate a compliance officer;
3. Conduct comprehensive training and education;
4. Develop accessible lines of communication;
5. Conduct auditing and internal monitoring;
    a. Auditing
        - Implement risk evaluation and auditing techniques
        - Best if done by an outside entity so as not to be biased
        - Must be independent and objective
    b. Monitoring
        - Based on assessment of risk
        - Used as a management tool
        - Day-to-day activities within the office
        - Scalable to the risks and resources

6. Enforcing standards through well publicized disciplinary guidelines; and
7. Responding promptly to detected offenses and undertaking corrective actions.

Policies

"The set of basic principles and associated guidelines, formulated and enforced by the governing body of an organization, to direct and limit its actions in pursuit of long-term goals." *

Procedures

"A fixed step-by-step sequence of activities or course of action…that must be followed in the same order to correctly perform a task."

Policies and Procedures should include:

- Coding, documentation and billing policies should be documented
- All staff should be trained and aware of all policies
- Billing must accurately reflect the services provided
- All services must be medically necessary
- Medical necessity is of primary concern
- The requirements of the CPT must be met
- Documentation must support the level of service reported
- Documentation of the service must be done ASAP (24 to 48 hours) to maintain accuracy

Medicare Carrier Manual, Chapter 12, 30.6.1

The Eighth Element added is that all employees must be checked against the OIG Exclusion Database http://exclusions.oig.hhs.gov/ This is recommended to be done quarterly.

New information posted regularly at www.facebook.com/askmario "Like" us

Medicare can now ask for records from up to FIVE years ago. Are you complaint? The OIG stated that a compliance plan (different from HIPAA) is a mitigating factor against fines and/or jail time. If you have a Compliance Plan done in keeping with the OIG Recommendations, it may be your bullet-proof vest!

For a *professionally* created Compliance manual, unique to your office or chart audits contact Mario Fucinari DC, CCSP, CPCO, a **Certified Professional Compliance Officer** for further information.

Our Services include:
Office Audit
Doctor and Staff Training (Front desk, billing, compliance and therapy training)
Chart Analysis
Billing Training
One-on-One Consultations
And More!! See our list of services at www.askmario.com or e-mail at doc@askmario.com

If you have questions…
www.AskMario.com
E-mail: Doc@AskMario.com

Thank You!!