Ten Most Common Reasons You Will Fail an Audit

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Financial Disclosures Joe DeLoach, OD, FAAO

I Have Received Honoraria From or Served as a Consultant for:
(Partial Listing)

- Vision Source
- Alcon Laboratories
- Carl Zeiss Meditec
- Optos
- Diopsys
- Kowa
- Optovue
- AllDocs
- OfficeMate
- Marco
- TSO
- NVision
- Cleinman Partners
- Vision Trends
- Konan
- Essilor of America
- Pearle Vision / SNAPP
- Vision West
- UHCO, NOVA, RSO, UAB, Berkley, *and other optometry schools*

Over half the state optometric associations in the United States

Optometric Business Solutions, LLC – President and CEO *(no financial interest)*
Clinical Professor – University of Houston College of Optometry *(opinions do not necessarily reflect the views of the University)*

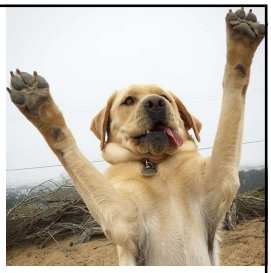
ADDITIONAL DISCLAIMERS

Policies presented or discussed in this presentation are specific to your state and predominantly based on Medicare (Jurisdiction H – Novitas Solutions - Texas Administrator) and CPT rules. Individual payer policies are unique, regional and sometimes not clearly published.

Any fees presented in this presentation are the average North Texas Medicare allowable fees. Fees presented are in no way designed to state any acceptable fee or suggest to any provider they charge certain fees

Can you join me in a feeling?

Isn't it just great to be an optometrist?



CAN I GET AN AMEN!

Can you join me in a feeling?

Is it great to be an crook?

NO!!!!

Why the focus on fraud and abuse?
Latest really bad data…

2016 Medicare fraud and abuse - $40 BILLION
2016 Medicaid fraud and abuse - $140 BILLION
2016 total fraud and abuse (RAND Study) - **$295 BILLION**

But surely optometry is not a problem….

2017 CERT study puts us at #10

We'll go over what we're doing wrong in a bit!

- "Experts"
  - Podium Experts – "I'm an expert because *(I'm on the committee; I read a lot; I'm entertaining)*"
  - Company Experts – "I'm an expert because *(Our medical director endorses this; I can make you money)*"
  - Blog Experts – "We're ALL experts ***because we say so***"
- Creative billing – **"We're getting paid!"**
- Crooks *(more on that later…)*

DO I HAVE YOUR ATTENTION YET?

The Age of Audits

Optometry has never been a big "target" – has that changed?

If you are filing claims, you are a target!
(remember - #10!)

Are audits working?

Important points…

Most common reasons you will be audited

1. **BILLING AND CODING PRACTICES**
2. **IT'S YOUR TURN**

Number 1 reason you will LOSE an audit

POOR MEDICAL RECORDS DOCUMENTATION

What Triggers an Audit

- Random
- You Stood Out
- Focused
- Whistleblowers
- You're a criminal!

What triggers a random audit?

- Randomness….duh

  "Getting a date is like fishin…you keep casting until one hits"

  Unnamed OD Colleague

- Because they can…and can do this EASILY now using Predictive Analysis

Circa 2018 and Forward

"Predictive Analysis" rules the reimbursement recapture market

Cognitive computer analysis of billing patterns to predict who should be audited

Pre-payment denial – based on "predictive analysis". Your claims look "unusual" so claim is denied and the only way to get it will be presenting a medical record that justifies what you did

Audits because you "stood out"

- ✓ Specialization
- ✓ Success (The "Ladder Principle")
- ✓ Repetition
- ✓ High utilization of single codes
- ✓ Billing codes not commonly used by the majority of ODs
- ✓ Billing codes at a higher percentage rate than the majority of ODs

None inherently wrong, but…

Focused audits – which is better one or two

Two types

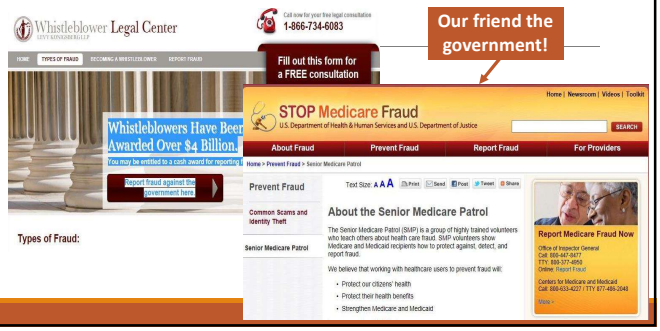
- You stood out (see previous comments)
- They're just doing their job
  - Most common issue is DM
  - Don't be fooled here..looking is looking

Jon BonJovi-ism – ♬ *livin on a prayer* ♬

Audits Due to Whistleblowing (*"Qui tam"*)

- The perfect answer….free labor *(kinda)* for the government
- Who becomes a Whistleblower
  - Opportunists – trained by the government
  - Unhappy employees
  - Unhappy patients

How about this – Everyone wants to help



And let's invite other folks to help as well, even non-trained ones…

https://www.youtube.com/watch?v=zKZuVdL-GC0

https://www.cms.gov/Outreach-and-Education/Medicare.../fraud_and_abuse.pdf

Medicare Fraud & Abuse: Prevention, Detection, and Reporting Facilitator Kit

http://www.howtoreportfraud.com/report-fraud/medicare-fraud-and-medicaid-fraud

THIS IS AN ATTORNEY FIRM – THERE ARE TONS OF THEM ONLINE

How Much Does the Government Like Whistleblowers

1. Whistleblower Protection Act
2. Even better…Congress declared June 30 as ***"National Whistleblower Appreciation Day"***

AND YOU THINK EVERYTHING IS JUST HONKY DORY AND YOU SHOULDN'T BE CONCERNED?

(because you're just an optometrist, you're just a small practice, you do what's right, you're getting paid, you haven't been audited…yet)

Last reason for an audit…

You're a crook!

Examples from crooks…

WHY SHOULD THIS CONCERN ME?

Punctal plugs on **227%** of Medicare patients
Corneal topography on **76%** of Medicare patients
Sensorimotor evaluation on **133%** of Medicare patients
Fundus photography on **86%** of Medicare patients
Anterior segment photography on **99%** of Medicare patients
1411 VEPS on 2711 Medicare patients
1901 amniotic membranes on 2711 Medicare patients

Don't think you're a crook? There's new crooks in town…Per CMS

Actions now considered as FRAUD

(amended February 2017*)

1. Upcoding claims *(in our case, Level 4/5 EM codes and overuse of Comprehensive Ophthalmologic codes 92004/14 – more later)*
2. Waving copays
3. Waving deductibles

* www.gpo.gov/fdsys/pkg/FR-2017-01-12/pdf/2016-31390.pdf

Audit Myths

Barbara Cobuzzi, MBA, CPC, CENTC, COC

The government is on a secret witch hunt

WRONG – the TRUE information is out there; CPT, ICD, CERT, MLN, provider manuals, NCD, LCD, payment policy

Only large practices are audited

WRONG – most common audit is a small, one doctor practice

It's all really complicated – they'll give me a break

WRONG – it's your legal obligation to know, not matter how complicated

Fraud and Abuse laws only apply to Medicare/Medicare

WRONG – not any more

Audit Myths

Barbara Cobuzzi, MBA, CPC, CENTC, COC

Code a lot – just write off whatever not paid

WRONG – THE OIG CONSIDERS THIS FRAUD and has instructions to the ZPICS to actively pursue this activity

I send additional information on unusual claims (so I can use the -59 modifier). I get paid so I assume I am OK

WRONG – likely would have been paid without the additional information ***(we don't even look at it)*** and the additional information will never allow you to break the rules

I'm not a participating provider in Medicare – I am immune from audits

WRONG – if ANYONE files a claim from your services, INCLUDING THE PATIENT, you are obligated to abide by ALL rules

Audit Myth

Joe DeLoach – contact auditor

Payer audits focus on the criminals so my risk is low

WRONG – only the Medicare Fraud Strike Force is looking at the criminals. Everyone else is looking at YOU!

1. The crooks are harder to convict (really?)

2. Fisherman? Little fish don't / can't fight back as hard

3. Random audits using Predictive Analysis becoming the norm

Who Conducts Audits In Our World of Optometry

In order of activity, *not severity or fairness…*

1. Medicare *(focus on fraud – typically fair, severity based on crookedness)*
2. VSP *(often not so fair and very severe – hear about California????)*
3. Aetna *(looking for anything)*
4. BCBS *(fair is a four letter word)*
5. EyeMed *(pretty fair and not too severe – unless…)*
6. On the horizon…Medicaid

So let's look at **THE** two issues

1. What are we doing to get audited *(coding practices)*
2. How can we defend against the inevitable audit *(medical records documentation)*

Specifically…Most Common Audit Issues

1. Upcoding Evaluation and Management Codes
2. Overuse of Comprehensive Ophthalmologic Code
3. Medically unnecessary diagnostic testing

Refer to coding lecture for more information…

Joe…since you said documentation of medical records was the major issue in optometry looking bad…shouldn't we talk about that?

ABSOLUTELY – let's do it!

Here they are…

Most common documentation errors that result in audit failure
(in no order of frequency or severity)

But first…most important concept to remember:

Never document to the code – document the care delivered and the code follows

NUMBER ONE
Not Following / Answering the Reason for the Visit

- Remember, in reality that is your ONLY job
- Your primary assessment ***(that means first one listed)*** must answer the Reason for the Visit
- If the Reason for the Visit is not addressed, an auditor can consider the entire examination and all associated testing not medically necessary
- Best to directly state association between diagnosis and reason for visit

NUMBER TWO
Not Using the Most Specific Diagnosis

- CPT coding guidelines dictate that you apply the MOST SPECIFIC diagnosis related to any procedure for which you bill services
- Using systemic codes instead of eye codes (except code first)
- Use of unspecified codes

NUMBER TWOa Code Substitution

Using a less specific (or different) code ***"because it pays"***

Ex 1: Payment policy does not cover glaucoma diagnosis for ERG but does for "optic atrophy" so you always use the later *(key point – suspect or confirmed)*

Ex 2: Policy pays ERG for "glaucomatous optic atrophy" but no glaucoma codes. ***Can you have glaucomatous optic atrophy and NOT have glaucoma?***

Ex 2: Using an unspecified diagnosis like "Unspecified disorder of choroid" (D31.9) to get paid for a retinal photo when the policy denies payment for "Benign neoplasm of choroid" (D31.30)

NUMBER THREE
Cloning Issues

Payers (and many state boards) frown heavily on record cloning issues. OIG directed CMS to address this issue.

So what's not legal?

- **LYING** – entering data you did not acquire or **BEFORE you acquired it**

So what are things to be careful with?

- Templates…in general, and why
- "Pre-fab" language (normative findings)
- Lack of physician documentation of work

Solutions / Recommendations

- Use templates only for wellness care
- If you use normative findings statements, make sure there is an "unless otherwise noted" statement
- BIG ISSUE! If you use normative findings statements, do not insert them in to the file before that was determined
- Use general physician attestation statements

"I have reviewed all record entries and participated directly in the patient care where required. JWD 1/1/2018"

- Use review of history attestation statements

"I have reviewed all history elements and directly made the history of present illness. JWD 1/1/2018"

NUMBER FOUR
Findings Do Not Support the Diagnosis(es)

Typical examples of money paid back…

1. Macula listed as normal but diagnosis of AMD with testing
2. New patient glaucoma suspect diagnosis with normal IOP, normal ON, no trauma and no patient direction
3. Dry eye diagnosis with all clinical findings stated as normal *(oooh….I get around that how?)*
4. Retinal periphery stated as normal and patient was not dilated – or "OPTOS performed"

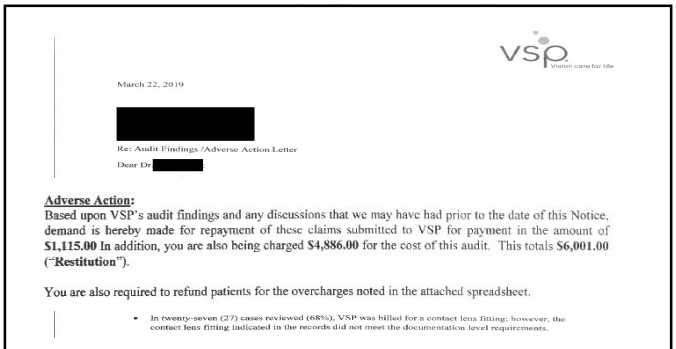
NUMBER FIVE
Conflicting Information

- Patient presents for evaluation of potential ocular complications from DM and medical history completely normal
- Patient symptoms stated as "not significant", "doesn't bother" or "no longer a problem" but diagnosis and plan centered on the issue *(often with extensive testing)*
- Evaluating for risks of medication and history does not contain the medication or condition being used to treat *(stated requirement!)*

NUMBER SIX
Not Documenting Contact Lens Evaluation

1. History must include the lenses worn, how worn, solutions used
2. Examination must document the fitting characteristics of the lenses (NOTE: Simply documenting WHAT trial lenses were used is not sufficient – need to note the fit)
3. Findings must include K's and SOR (mandate of VSP)
4. Assessment must state how the patient is doing with the lenses
5. The plan must say something - even if that is no change

Most evil - http://www.eyefinity.com



March 22, 2019

[redacted]

Re: Audit Findings /Adverse Action Letter

Dear Dr [redacted]

Adverse Action:

Based upon VSP's audit findings and any discussions that we may have had prior to the date of this Notice, demand is hereby made for repayment of these claims submitted to VSP for payment in the amount of **$1,115.00** In addition, you are also being charged **$4,886.00** for the cost of this audit. This totals **$6,001.00** ("**Restitution**").

You are also required to refund patients for the overcharges noted in the attached spreadsheet.

- In twenty-seven (27) cases reviewed (68%), VSP was billed for a contact lens fitting; however, the contact lens fitting indicated in the records did not meet the documentation level requirements.

NUMBER SEVEN
Not establishing medical necessity for level of service billed

1. For the level of office visit…or ANY office visit *(refer to coding lecture on levels of service)*
2. Biggest culprit – GLAUCOMA, based on:
   1. "Asymmetric" CD
   2. Ocular hypertension
   3. Family history
   4. "Cupping"

NUMBER EIGHT
Not Establishing Medical Necessity for Diagnostic Tests

- CPT says that for every diagnostic test…
  it must be clear to the auditor from the medical record why you performed the test
  -OR-
  The record must include a physician "order" for the test
- The second is WAY better!

Placing an order…

1. In the plan of the previous visit
2. In the reason for the visit
3. In an "order" section of the EMR
4. In the plan for today

ALL are OK…but #2 is likely the best (here's why)

Interpretation and Report

In 2019, a silly concept…but still have to do it

Include what?

- ✓ Why did I conduct this test?
- ✓ What did I find?
- ✓ How reliable were the findings?
- ✓ How am I going to use this information?

So How Do I Decide If A Test Is Going To Be Paid?

(Remember the new definition of reimbursement)

In general, this is how an audit will come down:

- ✓ Is the need for the test related to the reason for the visit?
- ✓ Is the data usable?
- ✓ Does the outcome of the test directly contribute to the care of the patient?
- ✓ Need for the test stand alone against other known data (not confirmatory)?
- ✓ Is there a more simple or less expensive alternative test?
- ✓ Was the need for the test clear (explicit or ordered)?
- ✓ Was an interpretation and report documented?
- ✓ If a payment policy exists, was if followed?

(NOTE: If there wasn't one – all the other seven still apply!)

NUMBER NINE

Not Following Preferred Practice Patterns

Only you can determine medical necessity, but if you want to be paid you have to DEFEND YOUR DECISIONS!. The rules are defended based on:

- ✓ Established standards of care *(very rare – legal issue)*
- ✓ Preferred Practice Patterns of the AAO
- ✓ Clinical Guidelines of the AOA
- ✓ PEER REVIEWED literature

NUMBER TEN

"Note Bloat"

- **Exaggerated findings related to patient symptoms**

Ex: Patient states eyes fatigue and you document extensive anterior and posterior findings with testing with every small abnormal detail noted even though does not relate to eye fatigue

- **Exaggerated testing, assessment and plan related to patient findings**

Ex: Macula findings state "few drusen" but photos, SLOs, and ERGs follow right behind *(CLINICAL TIP: Consider dark adaptation here)*

OIG directs CMS to consider this a focus issue for ZPIC investigations

Remember what CERT said?
We're #10 – and they tell us WHY

2016 Reasons for Optometry Overpayment

#1 Insufficient documentation (80%)
#2 Incorrect coding (16.7%)

80% Of denials are based on inadequate medical record documentation – some stupidity, some ignorance and a LOT of mis-information

Thank You

It's all about knowing what is expected of you!

QUESTIONS?

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