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PART 4: MONITORING, AUDITING, AND ENFORCEMENT OF A COMPLIANCE PROGRAM

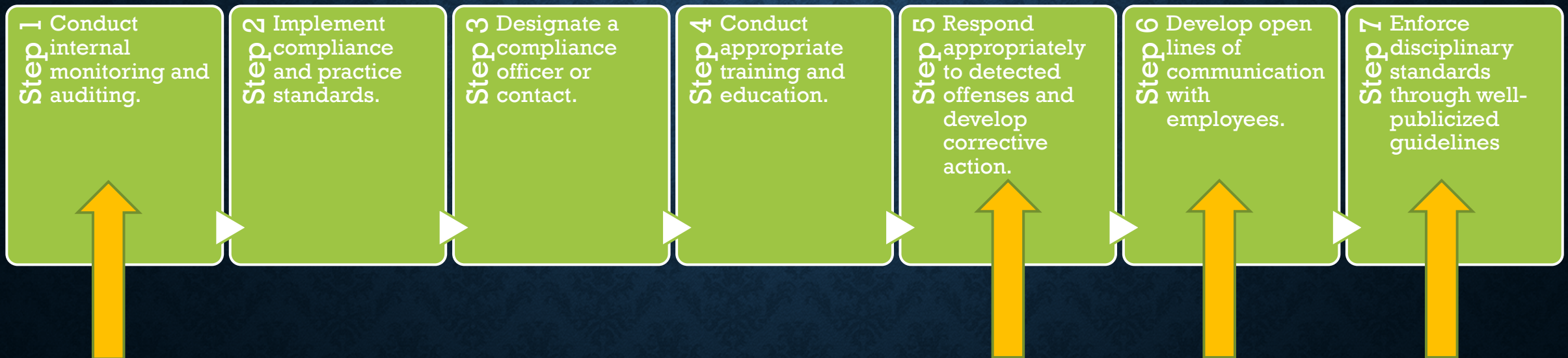


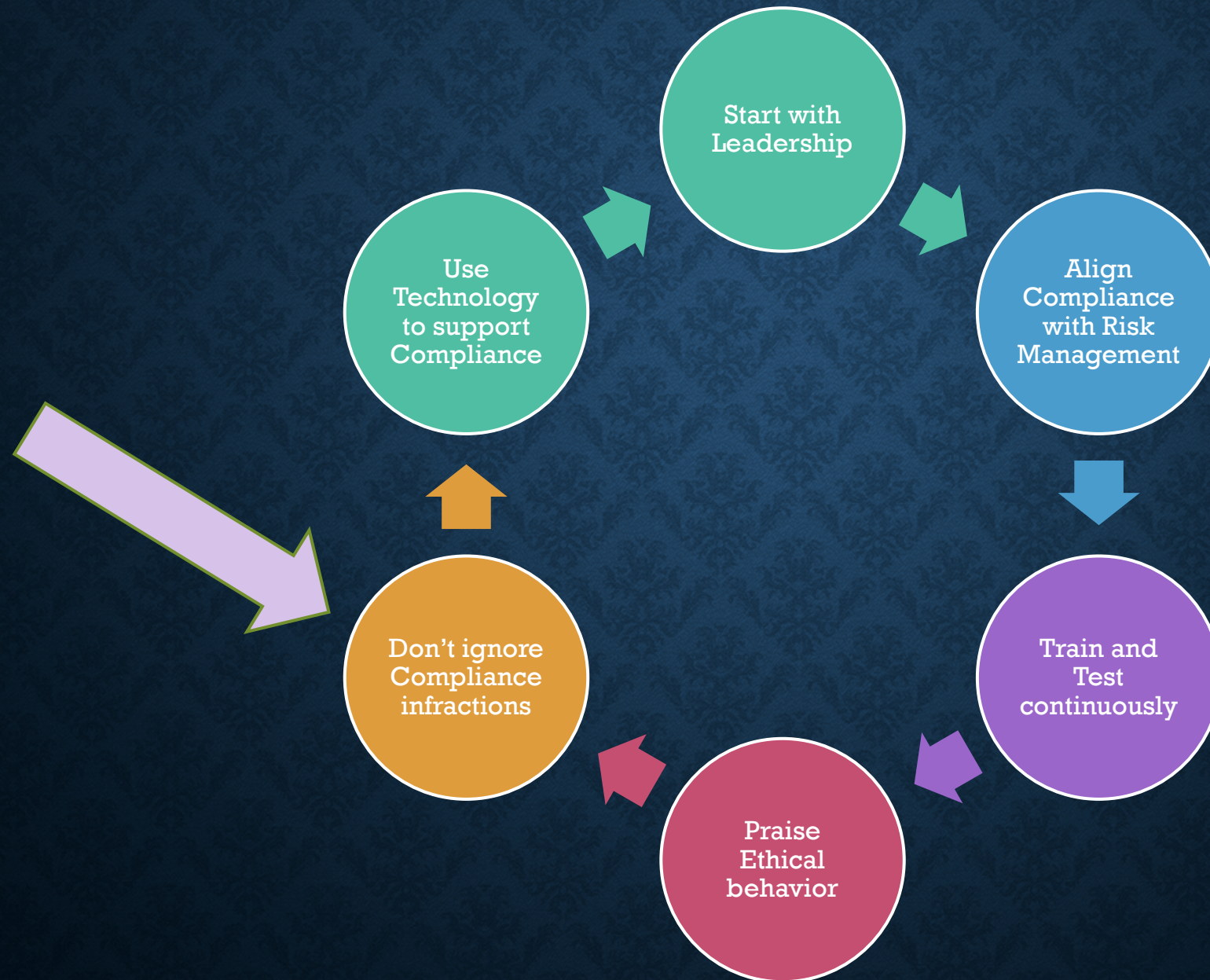
TODAY'S TOPICS

- Revisit elements of a compliance plan
- Review Auditing and Monitoring
 - Get to know Audit methods
 - Discussion of potential KPI's for tracking compliance
 - Baseline Audits
- Review Enforcement
 - Infraction response and corrective action
 - Open lines of communication
 - Disciplinary standards

WHAT IS A COMPLIANCE PLAN?

- Steps that a provider, organization or practice establishes to ensure adherence to federal and state regulations. Office of Inspector General (OIG) developed voluntary compliance program guidance in an effort to help organizations with their compliance programs. This resource assists in setting the foundation for an effective program.
- Make sure that Auditing is a major part of the compliance plan.







AUDITING AND MONITORING

FROM YOUR WRITTEN COMPLIANCE PROGRAM

- Example of possible elements in your Auditing and Monitoring section of your written program:
- Ongoing auditing and monitoring is an essential part of any effective compliance program. Auditing and monitoring activities shall be conducted on an ongoing basis under the advisement of the Compliance Officer.
- Auditing and monitoring activities will be designed to address compliance with laws governing CPT®, HCPCS, and ICD-10-CM coding.
- Focus will be placed on compliance with specific rules and policies that have been identified by Medicare, the OIG, or fiscal intermediary, as high-risk areas.
- Overpayments identified shall be promptly refunded to the applicable payer with appropriate documentation and an explanation of the reason for the refund.

An ongoing evaluation process is important to a successful compliance program.

This ongoing evaluation includes not only whether the procedures are in fact current and accurate, but also whether the compliance program is working, *i.e.*, whether individuals are properly carrying out their responsibilities and claims are submitted appropriately. Therefore, an audit is an excellent way to ascertain what, if any, problem areas exist and focus on the risk areas that are associated with those problems.



There are two types of reviews that can be performed as part of this evaluation:

**(1) A standards and
procedures review.**

**(2) A claims
submission audit.**

GET TO KNOW CLAIM AUDIT METHODS

- Prospective Audit
 - RCM team can set up a “buddy system” to review documentation and claims prior to submission (second set of eyes or rigorous automated function with a smaller data set for validating the automated process)
 - This practice allows for areas of inconsistency to be identified before the claim reaches the payer.
- Retrospective Audit
 - RCM team and compliance committees can do a post-payment audit where you can review documentation, coding and billing after claims have been submitted.
 - This would require making corrections after claims have been submitted and either rejected, denied or paid.

Each organization needs to determine which method or combination of methods works best for the environment.

However, efficiency should not trump compliance!

PRE AND POST PAYMENT AUDITS

- Random Samples
 - There are many ways to identify the claims/services from which to draw the random sample of claims to be audited.
 - One methodology is to choose a random sample of claims/services from either all the claims/services a practice has received reimbursement for or all claims/services from a particular payor.
 - Another method is to identify risk areas or potential billing vulnerabilities. The codes associated with these risk areas may become the universe of claims/ services from which to select the sample.
 - The OIG recommends that the practice evaluate claims/ services selected to determine if the codes billed and reimbursed were accurately ordered (authorized), performed, and reasonable and necessary for the treatment of the patient.

EXAMPLES OF OTHER AUDIT AREAS

- Session Notes
 - Audit for demographic information such as session start and end time, client name, provider name, etc.
 - Provider signature and time stamp on signature
 - Audit clinical content of notes
- Client Files
 - Verify that files are complete – use a checklist
 - Confirm that consents and other applicable documents such as assignment of benefits are signed annually
- HR/Provider Files
 - Verify that current credentials are on file
 - What trainings or qualifications expire – such as CPR or First Aid
 - What trainings need to be done annually – such as HIPAA
- Policies and Procedures
 - Review payer handbooks to look for any changes to policy requirements

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POTENTIAL KPI'S FOR TRACKING COMPLIANCE



The OIG recommended that a baseline, or “snapshot,” be used to enable a practice to judge over time its progress in reducing or eliminating potential areas of vulnerability. This practice, known as “benchmarking,” allows a practice to chart its compliance efforts by showing a reduction or increase in the number of claims paid and denied.



When audit results reveal areas needing additional information or education of employees and physicians, the physician practice will need to analyze whether these areas should be incorporated into the training and educational system.

BASELINE AUDIT

- A baseline audit examines the claim development and submission process, from patient intake through claim submission and payment, and identifies elements within this process that may contribute to non-compliance.
 - This audit will establish a consistent methodology for selecting and examining records, and this methodology will then serve as a basis for future audits.
- The OIG recommends that claims/services submitted and paid during the initial 3 months after implementation of the education program be examined, to give the practice a benchmark against which to measure future compliance effectiveness.
- Following the baseline audit, a general recommendation is that periodic audits be conducted to ensure that the compliance program is being followed.
 - A randomly selected number of records could be reviewed. Although there is no set formula to how many medical records should be reviewed, a basic guide is five or more medical records per Federal payor (i.e., Medicaid), or five to ten medical records per provider.



ENFORCEMENT

FROM YOUR WRITTEN COMPLIANCE PROGRAM

- Example of possible elements in your Enforcement section of your written program:
- Document and maintain a record of every complaint received involving a potential violation of any law or regulation related to healthcare fraud and abuse.
 - Including the following:
 - Date received
 - Who or how the report was received
 - Details indicating a timely investigation and response
 - Summary of the action taken and the date the action was taken
- Agency's code of conduct applies to all employees and will be enforced regardless of employee's position.
- Disciplinary action up to and including termination from employment may result if an employee fails to comply with the policies set forth by Agency.

EXAMPLES OF EMPLOYEE INFRACTIONS

- Staff signing in for a training that they did not actually attend
- Provider adding on and billing for additional time in a session that did not actually occur
- Billing for a session that the client did not show up for
- “Upcoding”
 - Billing for a BCBA when the session was provided by a Behavior Technician
- Writing and “back” dating notes past the deadline for session documentation
- Billing for direct therapy while a client is napping

INFRACTION RESPONSES AND CORRECTIVE ACTION

- One of the most important components of a successful compliance audit protocol is an appropriate response when the practice identifies a problem. This action should be taken as soon as possible.
- The action a practice takes should depend on the situation. The response can be as straight forward as generating a repayment with appropriate explanation to Medicaid or the appropriate payor from which the overpayment was received. In others, the practice may want to consult with a coding/billing expert to determine the next best course of action. There is no boilerplate solution.
- It is a good practice to create a system to address how you will respond to and report potential problems. In addition, preserving information relating to identification of the problem is as important as preserving information that tracks the provider's reaction to, and solution for, the issue.

DEVELOPING OPEN LINES OF COMMUNICATION

In order to prevent problems from occurring and to have a frank discussion of why the problem happened in the first place, practices need to have open lines of communication.



OIG defines meaningful and open communication as:

The requirement that employees report conduct that a reasonable person would, in good faith, believe to be erroneous or fraudulent

The creation of a user-friendly process for effectively reporting erroneous or fraudulent conduct

Provision in the written program that failure to report this conduct is a violation of the compliance program

ENFORCING DISCIPLINARY STANDARDS THROUGH WELL-PUBLICIZED GUIDELINES

- The last step that a practice may wish to take is to incorporate measures into its practice to ensure that practice employees understand the consequences if they behave in a non-compliant manner.
- An effective practice compliance program includes procedures for enforcing and disciplining individuals who violate the practice's compliance or other practice standards.
- Enforcement and disciplinary provisions are necessary to add credibility and integrity to a compliance program.



RESOURCES

- **ABA Coding Coalition:** <https://abacodes.org/>
- **Autism Law Summit:** <https://www.autismlawsummit.com/>
- **Association for Professional Behavior Analysts:** <https://www.apbahome.net/>
- **ABA Therapy Billing and Insurance Services** (blogs and webinars:
<https://www.ababilling.net/>
- **Council for Autism Service Providers:** <https://casproviders.org/>