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Innovating your auditing and monitoring program

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As we all know, monitoring and auditing is one essential element of every effective compliance program. However, we have seen over the years that monitoring and auditing does not receive nearly the amount of dedication of resources and attention that it may deserve.

Yes, we may spend months planning and executing on our periodic risk assessment process and do an outstanding job of gathering input from both operational areas and risk assurance functions about emerging areas of risk, the likelihood of each risk occurring, and the derivative business impacts if/when they do. But do we carefully assess and monitor the effectiveness of the activities we then create to mitigate and measure those risks considered both high likelihood and impact and which we also view as being measurable through an auditing or monitoring activity? Unfortunately, we have seen that in many programs, the activities created may not always examine each risk in a holistic or comprehensive manner.

As for revenue cycle–related risks specifically, auditors have traditionally employed largely standardized methods to evaluate compliance with applicable documentation, coding, coverage, and reimbursement rules. Some of the common tactical approaches may include items like reviewing and evaluating the following:

1. Documentation for 5–10 encounters for each provider annually,
2. Evaluation and management service bell curve reports,
3. Program for Evaluating Payment Patterns Electronic Reports,
4. Comparative billing reports, and
5. Program integrity contractor additional documentation requests and associated findings.

While there is nothing inherently "wrong" with any of those methods, there are many questions that activities of that nature leave unanswered, such as:

1. Was the patient seen by a qualified provider?
2. Did the provider who signed the documentation take part in the encounter?
3. Is the information in the medical record a correct reflection of the encounter?
4. When was the documentation created and by whom?
5. Is the encounter documentation unique and specific to this patient visit?

The purpose of this article is to present some battle-tested ideas for you to consider and which may shed light on

whether each of your scheduled and ad hoc audits are well-designed to measure and mitigate all the compliance risks that may be present. We will try to achieve this through the discussion of some scenarios that may sound familiar to you.

Scenario #1

Over a period of several weeks, many anonymous reports are received on the compliance hotline about certain activities at a large hospital-based rehab service department. Complaints are wide ranging and varied, but there were two common themes included in the complaints. One was a fear of retaliation for bringing the concerns forward, and the second theme expressed somewhat ambiguous concerns about the accuracy of billing for certain rehab services.

Anonymous reporting mechanisms are essential to ensuring open lines of communication. However, these anonymous reports can often make it difficult for those of us working in the compliance community to craft a meaningful response plan to examine the validity of the reported concern. With this compliance team's ability to gather more specific information about the billing issues hampered by the anonymous nature of the reports and coupled with the retaliation concerns, compliance decided to review a 30-record probe sample of encounters to evaluate the billing issue.

The sample was not statistically valid, but it was stratified across rehab disciplines to include speech, occupational, and physical therapies, and as many licensed therapists as possible. Documentation for almost all the encounters included within the sample appeared supportive of the services coded and billed. With an error rate from the first sample being within an acceptable range, is that the end of the story?

During the period of the probe sample review, compliance tried to communicate with the anonymous reporters to obtain more information. In response, select team members indicated they were willing to meet with compliance provided that their identities were protected to the degree possible. After conducting a round of confidential interviews with team members, it became clear that the concerns about improper billing really arose from how physical therapy assistants (PTAs) were scheduled in certain of the outpatient rehab clinic units. Specific issues raised included:

- PTAs were practicing without adequate supervision.
- Progress notes not being written or signed timely.
- Supervising physical therapists (PTs) were not actively taking part in the ongoing care of the patients after the creation of the plan of care.

Compliance then worked in conjunction with revenue cycle and the operational leaders to develop a randomized and stratified sample. One clinic where allegedly PTAs often staffed the clinic with no physical on-site presence by a PT was sampled separately to examine whether the PTAs had been adequately supervised. A blended sample was developed and reviewed from claims from other outpatient clinics to evaluate whether the Medicare conditions of payment associated with periodic progress notes and ongoing and active PT participation were met. In that sample, all encounters within a progress note period for each sampled patient were evaluated.

The second round of sampling reflected an unacceptably high error rate. Attention was then, of course, turned to mitigating prospective risks by adjusting PT and PTA schedules, supplying education to all team members about expectations, and implementing a prebill quality assurance review to confirm that applicable payer requirements were met before claims were submitted. Outside subject matter experts and legal counsel were relied on to develop a work plan to address the retrospective overpayment concerns and to facilitate discussions among the enterprise and the Medicare administrative contractor entity to resolve the overpayment liability.