Medical Records: Compliance and Common Sense

2012 Agenda

1. Why Proper Medical Records Are Essential
2. Medical Record Format
3. Medical Records Issues
4. Surviving The Age Of Audits
5. A Look Into The Future

Why Proper Medical Records Are Essential

From a Patient Care Standpoint

1. Patients deserve no less
2. Sorry, your memory ain’t that good
3. Essential for inter and intra professional care
4. Essential for reimbursement and incentive programs

From a Legal Standpoint

You’ve heard it a million times... “not written down, not done”

1. Essential in defending your good care in alleged malpractice
2. Essential in defending your good care in Board inquiries
3. Essential in defending your medically necessary care in an audit

Medical Records Format

Whether it is paper or digital...

- Are check boxes legal?
- Are templates legal?
- Is the “all normal except” formatting legal?
- Is the use of “carry forward” technology legal?
- Is computer cognitive thinking legal?

Answer: Absolutely
**Medical Records Format**

**What is NOT legal?**

Saying you did something in a medical record that you did not do is illegal, 100% of the time.

No matter what recording system you use, +/- templates, +/- carry forwards, +/- normal with exception, the record must accurately note the care and ONLY the care you delivered to that patient.

---

**Medical Records “Issues”**

**Who Do They Belong To?**

1. No doubt, the patient...end discussion
2. Any attempts to deny or delay a patient access to their medical records goes against the Optometric Oath you swore and the first words of the Hippocratic Oath - “First of all, do no harm”

---

**Medical Records “Issues”**

**Release of Medical Records**

HIPAA clarified some issues:

- You can provide copies, not the original (only a judge can subpoena originals)
- You can provide a summary in lieu of hard copy - including summaries of tests
- You can charge for medical records, but...
- In most cases, HIPAA policy recommends the patient request be made in writing to the office Privacy Information Officer

---

**Other than that, do not push your luck. It’s not worth it!!!**

---

**Medical Records “Issues”**

**Release of Medical Records**

You can deny (best to say delay) release of medical records in very restrictive situations:

- Records are being used in preparation for a lawsuit
- Records are part of an ongoing clinical trial
- Releasing the information could be damaging to the patient or someone else (no, not you)
- The requested information is not part of your designated record set

---

**Medical Records “Issues”**

**Retention of Medical Records**

Two questions:
1. How long do I have to keep them?
2. In what format do I have to/can I keep them?
Medical Records “Issues”

Records Retention – How Long?

First, there is no absolute legal consensus on this question. I am also not an attorney. If you want a legal opinion, get one (but it will be just that…opinion)

CMS – Adults - 5yrs; Minors - 2yrs after they turn 18 or five years, whichever is longer
Texas HHSC - 5yrs from date of service or request for audit information, whichever longer
TOB – Adults 7yrs; Minors – until they reach 21 or 7yrs from last date of service, whichever is longer
COMMONLY PRESENTED LEGAL TIME FRAME - 7 years

Medical Records “Issues”

Records Retention – How Long?

Other Considerations:
- Other Payors may have specific time requirements – check your contract
- VERY IMPORTANT. Your malpractice carrier may have specific requirements – check your contract
- In the digital age, storage is easy – why not keep them indefinitely?

Medical Records “Issues”

Maintenance of Medical Records

Again, two issues:
- Storage of medical records
- Destruction of medical records

Medical Records “Issues”

Storage Of Medical Records

Very complex discussion involving legal opinions, past and current HIPAA regulations.

General statements
- Medical records, active or inactive, should be accessible only to those involved in the care of the patient
- Per HIPAA: Covered entities must implement reasonable safeguards to limit incidental and avoid prohibited uses and disclosures
- HIPAA Security measures fairly specific on this issue – would take 30 minutes to cover
- Storage off site, except in the clouds, is frowned upon (to put it lightly)

As a side note…

Most of you may not believe it but HIPAA is becoming a monster – if you are not following the current Privacy AND new Security regulations, your practice and financial foundation could be in serious jeopardy
Folks you should NEVER mess with
- IRS
- DEA
- HIPAA
- Ex-wives...
Medical Records “Issues”

**Destruction of Medical Records**

- Paper records (per HIPAA)
  "shredding, burning, pulping, or pulverizing the records so that PHI is rendered essentially unreadable, indecipherable, and otherwise cannot be reconstructed"
- Use of professional vendor is acceptable

---

**Destruction of Electronic Data**

- Once again, very complex set of HIPAA Security Standards
- In general, electronic data must be “cleared” or “purged” (not defined! Ugh...)
- Must be careful in disposal of old PCUs, notebooks, tablets, pads, phones or other storage devices that even could contain patient information

---

**The Age of Audits**

*Is this the Golden Age of audits? YES!*

So, you’re broke, you need money, your system is under scrutiny because it loses more and more money – you are presented with an investment opportunity with a historical 50:1 return on investment.

*What would you do???*

---

**The Age of Audits**

*What Has Changed?*

- First and foremost – if you hadn’t heard, the government is broke and looking for money!
- Health care reform – major emphasis on fraud, abuse and WASTE
- Change in False Claim Statute from “knows or has reason to know” to “knows or should know” (Ignorance is no longer bliss!)
- Qui Tam – The Whistleblower Act
- Recovery Audit Contractors – boo...more later

---

**General Statistics – Medicare Alone**

- Estimation of improper payment from all sources in 2010 - $48 billion
- Recovery efforts total in 2008 – just over $8 billion

Therefore...lots of low hanging fruit left!

- And Medicaid has a higher improper payment amount than Medicare!
Take home message...

Auditing is VERY good business!

The Age of Audits

What Triggers an Audit

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

None inherently wrong, but...

Normal Intraprofessional Utilization Curve - Service Items

Danger Zone

Expect a Call!!

The Age of Audits

Who Might Want to See Your Records?

1. Licensing and regulation agencies
2. Patient representatives / courts of law
3. Payors

Audits – Licensing Agencies

(In this presentation, restricted to TOB)

- Covered in 2011 PR Course
- Requests for records can be made in a Random or Focused Investigation
- Timely response is recommended
- Cannot refuse compliance based on HIPAA or any other wishful thinking

Audits - Representatives

- An agency (DARS, etc), a judge, or anyone designated by the patient to be their legal representative (usually an attorney) can request a patient’s medical record
- Always make sure you have a signed release from the patient
Audits and Payors

Everyone BUT Medicare

- The breadth of this topic is far too big for this course.
- WITHOUT A DOUBT, almost every payor has stepped up their audit/recovery game
- The bottom line is you need to familiarize yourself with the records documentation requirements and the audit procedures of every payor you do business with.

Medicare Audit System
(a system likely to be copied!)

<table>
<thead>
<tr>
<th>PREPAYMENT REVIEW</th>
<th>POSTPAYMENT REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Correct Coding Initiative (NCCI)</td>
<td>Comprehensive Error Rate Testing (CERT)</td>
</tr>
<tr>
<td>Medically Unlikely Edits (MUE)</td>
<td>Zone Program Integrity Coordinator (ZPIC)</td>
</tr>
<tr>
<td>Carrier Medical Review (MR)</td>
<td>Recovery Audit Contractors (RAC)</td>
</tr>
<tr>
<td>Medicare Review (RAC)</td>
<td>Medicare demonstration project for 2012</td>
</tr>
</tbody>
</table>

Medicare Audit - NCCI

- Promote national correct coding methodologies
- Control improper or inappropriate payment to providers
- Policies based on CPT definitions and current standards of medical and surgical coding
- Usually relates to service items that as a rule are not billed together (same visit)

Ex: 99201/11 codes, new SLO codes

Medicare Audit - MUE

1. Based on maximum units of service under most circumstances a provider would report for a single service item on a single date of service (ex. # office visits, # corneal foreign body removals, # punctal plugs)
2. Policies based on existing payment policies plus methodologies designed to identify fraud and abuse
3. Because of #2, many MUEs are NOT published

Medicare Audit - NCCI

- An automatic, prepayment edit
- Cannot override with ABN or other options for patient responsibility
- Sometimes can override by use of appropriate modifier
- No appeals process

http://www.cms.gov/NationalCorrectCodInitEd

Medicare Audit - MUE

- Sometimes can override by use of appropriate modifier:
  * -76 (Repeat service by same provider on same date of service)
  * Anatomic modifiers (RT, LT, E1 etc.)
- Can be appealed


Updates: same except R1386CP.pdf
Medicare Audit - CERT
- Designed to establish standards for and identify correct coding patterns
- “Random” sampling of claims groups to identify patterns of over or under payment
- Results used by MAC to develop payment policies
- An individual provider can be the target of a specific CERT audit (historically rare, but...)

http://www.trailblazerhealth.com/CERT/

Medicare Audit - ZPIC
- Hired by CMS to provide data mining and data analysis services for MACs (MAC4 ZPIC is Health Integrity LLC)
- Mainly focuses on fraud and abuse issues – not claim or payment “errors”
- Cases usually referred to OIG for prosecution

Medicare Audit - MR
- MAC is accountable to CMS for maintaining acceptable error rates in claims and payment processing - if they don’t, they lose their contract
- Something needed to “trigger” the MR
- Postpayment review by claims processor based on published payment directives (NCD, LCD) and information from CERT, ZPIC and RAC
- Provider can appeal

Result of audit can result in:
- **Provider Notification**
  Informational/educational but may also ask for refund if applicable. Low to moderate claims issues.
- **Postpayment Claims Review**
  Results can be statistically extrapolated as far back as five years (ouch!)
- **Prepayment Review**
  All claims subject to evaluation before payment. *Death is imminent...*

Medicare Audit - RAC
- Implemented as a three year trial by the Medicare Prescription Drug Improvement and Modernization Act of 2003
- Initial results so good (they got so much money back!) RACs were made permanent by Tax Relief and Health Care Act of 2006
- 2006 legislation mandated that RACs be assigned for all 50 states by 2010
- Initially focused on Part A but that is changing rapidly!!
RACs base their audit results on:
- State and Federal statutes
- State and Federal regulatory acts
- CMS (National Carrier Directive – NCD)
- MAC (Local Carrier Directive – LCD)
- Data from CERT, ZPIC

RAC compensation is contingency based (Yes…this is a witch hunt!!)
- Audits can be Automatic (no records review) or Complex (records review)
- Provider can appeal
- MAC4 RAC is Connolly Healthcare

CMS is implementing a demonstration project focused at states with “high abuse and improper billing practices” that allows the RAC to conduct prepayment reviews on high abuse procedures, high volume procedures, and commonly inappropriately billed procedures based on published (unlikely) billing guidelines

New for 2012
Texas is one of those states

The best defense is always a great offense!
- Keep exquisite medical records
- Know your payor rules and policies (remember they are REGIONAL!!)
- Keep updated by signing up for payor website listserves and newsletters

First, don’t panic
Second, be very careful in altering records
You can add signatures, interpretive reports, signs and/or symptoms, assessment and/or plans

BUT
Anything you alter in a medical record must be initialed and dated and definitely looks somewhat suspicious

Once again - not written down, not said or done. THE number one audit defense!
- Having said that – there is no law that says you have to document a service, only that you have to prove you provided the service (good luck without good documentation!)
- Losing is bad...on so many levels
- In MR audits, medical necessity is on your side
- USUALLY best to have legal counsel
Audit Defense Tools
- Excellent documentation
- Your verbal defense
- Your comparison to your colleagues
- How you schedule
- Remember – Medicare or any other auditor is NOT always right
NEVER waive your right to appeal and defend yourself!

FIRST AND FOREMOST
NEVER design your patient care around the fear of audit. Always do what is right for the patient, write that down, and sleep soundly.

Medicare Appeals Process
Five Levels of Appeal
- Redetermination
- Reconsideration
- Administrative Law Judge Hearing
- Medicare Appeals Court Review
- Judicial Review in District Court

But... before we go there
Do NOT appeal these...
EOMB denial code CO-16 - This means your claim is incomplete or is unprocessable due to claim error. In this case:
- Refile with correction (best idea!)
- Initiate a “reopen request” by mail, FAX, or telephone (use for changing # services, procedure codes, dates of service, place of service, or adding modifiers 25, 26, 50, 76, LT, RT, or TG)

Medicare Appeals Process
Redetermination
- Submit request (CMS Form 20027) by mail or FAX within 120 days of initial claim determination
- No monetary limit
- Performed by MAC in-house
- Response from MAC within 60 days

Medicare Appeals Process
Reconsideration
- Submit request (CMS Form 20033) within 180 days of redetermination
- Performed outside of MAC by Qualified Independent Contractor (should be peer)
- Response from QIC within 60 days
Medicare Appeals Process

Administrative Law Judge
- Written request to payor within 60 days of reconsideration result
- Must be at least $130 in question
- Response usually within 60 days

Medicare Appeals Process

Medicare Appeals Council Review
- Request by letter to CMS within 60 days of ALJ determination
- No monetary limit but in reality still must be $130 in question or you wouldn’t have made it to this level
- Variable response time

Medicare Appeals Process

Judicial Review
- Request to CMS within 60 days of MACR determination
- Conducted in US District Court
- Must have >$1300 in question
- Lengthy process at best

A Look In To The Future

Pending “ObamaCare” Ideas
- Payment Recapture Audits (“Danger Will Robinson, . . .”) Somewhat “unrestricted and unregulated” recapture of payments made “to the wrong person, for the wrong reason, or for the wrong amount” (scary!!). Estimated to produce $2 billion / minimum a year with minimal investment (all AUTOMATIC audit process)
- “Mystery Shoppers” (“Danger Will Robinson - run, run") Expansion of Whistleblower Program that involves using physicians as fake patients (oh boy!!!!)

The Medical Record of the Future

Imagine, if you will:
- Patient fills out a directed case history online or in your office including all history components through a cognitive menu system - medications are correlated to diseases
- Acuity, stereoacuity, refraction, keratometry, pupil assessment, blood pressure all performed and recorded by completely automated instruments
- External and internal photography and other imaging systems use cognitive models to delineate, measure, describe, record and enter a diagnosis for most common anomalies
- Additional finding are identified on a touch screen which are also measured, described and cognitively analyzed

Additional diagnostic testing is suggested based on history and clinical findings - when completed, interpretive reports are cognitively generated
- The assessment is populated based on cognitive analysis. In cases of unclear differential diagnosis, physician is alerted to the DDX list, the characteristics of each, and the testing recommended to finalize the diagnosis
- The treatment plan is auto-populated based on your preselected preferred practice patterns
- Prescriptions are populated and automatically sent to pharmacy identified in the information already provided by the patient - drug interactions cross checked and alerted
The Medical Record of the Future

- Requested products (ex. CLs) are ordered automatically online through constantly updated “best price” suppliers.
- Consultation letters are written and automatically emailed or FAXed to patient’s identified primary care physician or to your choice of surgical specialist.
- A patient report describing the results, conditions, and treatment plan is automatically compiled and printed.
- Your insurance claim is completed, checked against your medical record for documentation of medical necessity based on payer payment directives and forwarded to your payer clearinghouse.

And you haven’t left the room or touched a keyboard...

Does the term “Meaningful Use” now start to make sense to you?

Thank You
Have a Great 2012