

The Fraud and Abuse Environment for Anesthesiologists

Jointly Sponsored By:

- Anesthesia Business Consultants, LLC
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Department of Anesthesiology
- The Center for Continuing Education
Tulane University Health Services Center

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Target Audience: Anesthesiologists

Statement of Need: Anesthesia is no longer just the clinical work of anesthetizing patients for surgery. In the changing healthcare environment, anesthesiologists need to be knowledgeable about the business and system issues in their practices as they develop strategies to maximize effectiveness and efficiency in practice management without compromising patient care and safety.

The Fraud and Abuse Environment for Anesthesiologists

The goal of this activity is to improve patient care by increasing learner competence in the practice management of anesthesia services within a quality environment.

Learner Objective

At the conclusion of this activity, the participant should be better able to document services correctly.

Predicted Practice Outcome

As a result of this activity, the participant should be better able to conduct a review of the practice compliance plan and the internal educational/monitoring methodologies.

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Accreditation

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Anesthesia Business Consultants, LLC and Tulane University Health Sciences Center. Tulane University Health Sciences Center is accredited by the ACCME to provide continuing medical education for physicians.

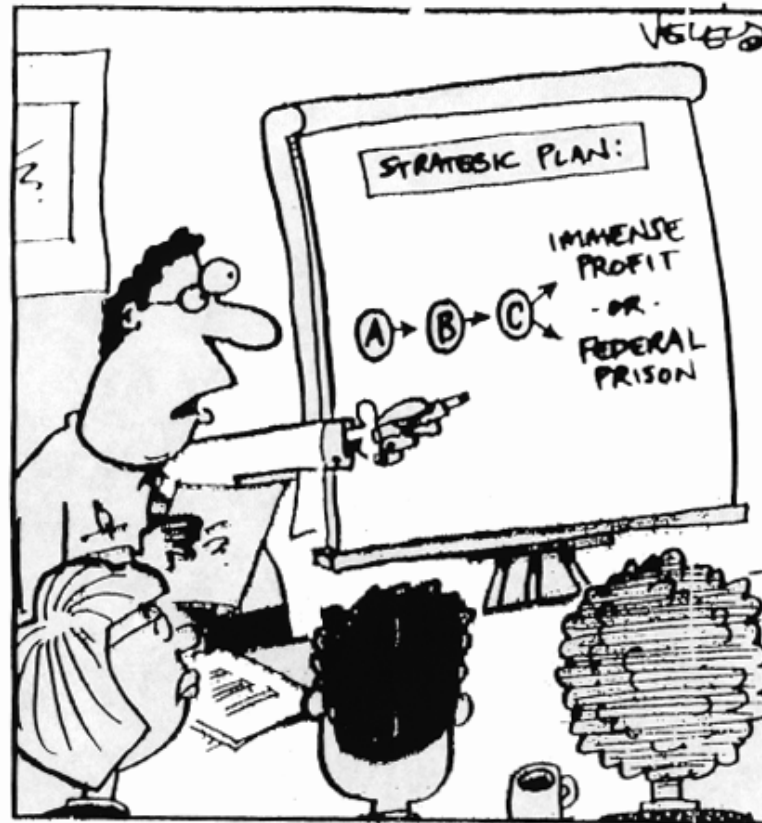
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"Stay with me now, people, because in step C, things get a bit delicate."

Compliance Landscape

- Health Care Reform:
 - Mandatory compliance programs- Recent enrollment regulations deferred compliance requirements for future rule making!
 - False Claims- mandatory refund obligations
- EHR Risks
- Audit risks
- The New OIG Roadmap for Physicians – Released November 5, 2010- renewed focus on physicians understanding their responsibility to submit accurate claims.

The Future of Audits

- Increased auditing of health care providers by all payors
 - Medicare
 - Recovery Audit Contractors (“RACs”)
 - Program Safeguard Contractors (“PSCs”)/
Zone Program Integrity Contractors (“ZPICs”)
 - Medicaid
 - Medicaid Integrity Contractors (“MICs”)
 - RACs- new
 - Private Payors
 - Third party recovery vendors
 - Internal audit and fraud and abuse units

Audit Landscape

Recovery Audit Contractors (“RACs”)

- RACs are companies contracted by CMS, tasked to identify and correct Medicare improper payments.
- RACs are compensated on a contingency fee basis based on the principal amount collected from and/or returned to the provider or supplier.
 - Although the RACs are responsible for correcting all types of improper payments, during the demonstration program:
 - RACs identified and collected \$992.7 million in overpayments (96%)
 - RACs ordered repayment of \$37.8 million in underpayments (4%)
 - Part B, Part A, Part C and Medicaid- NEW!

MEDICARE

RAC Vendors

- www.cms.hhs.gov/RAC
 - Region A – Northeast States
 - Diversified Collection Services, Inc., of Livermore, CA
 - www.dcsrac.com
 - Region B – Midwestern States
 - CGI Technologies and Solutions, Inc. of Fairfax, VA
 - <http://racb.cgi.com>
 - Region C – Southeast States
 - Connolly Consulting Associates, Inc. of Wilton, CT
 - www.connollyhealthcare.com/RAC
 - Region D – Western States
 - HealthDataInsights, Inc. of Las Vegas, NV
 - <http://racinfo.healthdatainsights.com>

Audit Landscape

PSC/ZPIC Audits

- PSCs are responsible to perform benefit integrity functions, including:
 - Fraud and abuse investigation and detection
 - Overpayment identification
 - Case resolution (*e.g.*, coordination of overpayment recovery; referral to law enforcement)
- PSCs are authorized to:
 - Conduct prepayment reviews
 - Recommend suspensions of payment
 - Conduct post-payment audits and extrapolate the amounts of alleged overpayments identified
- Unlike RACs, PSCs are not compensated on a contingency-fee basis
- Statistics
- Data analysis driven- significant audit activity around country

NATIONAL MEDICAID AUDIT PROGRAM

- Medicaid Integrity Program- Audit MICs (Medicaid Integrity Contractors) are entities with which CMS has contracted to perform audits of Medicaid providers
- Unlike RACs, MICs are not compensated on a contingency fee basis
- ***Objectives of Audit MICs*** – to ensure that paid claims are:
 - For services provided and properly documented;
 - For services billed using appropriate procedure codes;
 - For covered services; and
 - In accordance with Federal and State laws, regulations and policies
- Data analysis driven
- State law appeals process

Compliance Environment

False Claims

- Presentation of “false ... or fraudulent claim.”
- Treble (3x) damages plus \$5,000 to \$10,000 forfeiture for each false “claim” presented for a payment.
- False Claims Act permits the United States to intervene and take over “qui tam” lawsuits by private whistleblowers
- No proof of specific intent to defraud is required.
 - 31 USC § 3729(b)
- Knowing or knowingly means that a person with respect to information:
 - **Has actual knowledge**
 - **Acts in reckless disregard of the truth or falsity of the information; or**
 - **Acts in deliberate ignorance of its truth or falsity**

Environment-Return of Overpayments and Health Care Reform

- Mandatory return and reporting of overpayments within 60 days after the date on which the overpayment is identified or the date any corresponding cost report is due along with a written explanation for the overpayment. Retention of an overpayment beyond the 60 day deadline is deemed an "obligation" under the civil False Claims Act (FCA) thereby subjecting the provider or supplier to treble damage and civil penalty liability.
- PPACA- Section 6402(a).

Environment-Compliance and Health Care Reform

- Mandatory compliance programs
 - Section 6401(a)(7) of the Patient Protection and Affordable Care Act ("PPACA" or the "health care reform bill") included provisions mandating compliance programs as part of the Medicare enrollment process.
 - According to the health care reform bill, providers or suppliers within particular industries or categories, as yet unspecified, must have a compliance program in place as a condition of enrollment. Regulations will be issued which will specify the required elements of compliance, timelines and other details regarding implementation.
 - September 23, 2010 Issuance of Proposed Approach and Solicitation of Comments
 - February 2011 Provider enrollment regulations deferred compliance mandates to future rule making
 - What can physicians expect?

OIG-A Roadmap for New Physicians

- November 5, 2010 release
- Tool for training
- Addresses
 - Relationships with payers
 - Relationships with other physicians and providers
 - Relationships with vendors

Documentation is Critical

- Documentation issues predominate in audits and other cases
- OIG notes: “one of the most important physician practice compliance issues”- OIG states:
- The record should be complete and legible;
- Each encounter should include the reason, relevant history, exam findings, prior test results, assessment, clinical impression or diagnosis, plan of care, date and identity of observer
- Electronic Record Documentation Issues/Issues in Audits
 - Template issues
 - Populating issues
 - Signatures

Compliance

- A PHYSICIAN IS LEGALLY RESPONSIBLE FOR THE ACCURACY OF CLAIMS SUBMITTED UNDER HIS OR HER BILLING NUMBER
 - Medical necessity
 - Documentation issues
 - Regulatory requirements for levels
 - Personal performance
 - Medical direction
- A PHYSICIAN IS RESPONSIBLE FOR KNOWING MEDICARE POLICIES

Anesthesia Time

- Anesthesia time issues
 - Rounding
 - Documentation to support start and stop times
 - Others
- **Anesthesia Start Time-**
 - Time starts when anesthesiologists/CRNA begins to prepare patient for anesthesia care
 - Start should not occur due to placement of invasive monitoring line or other separately payable procedure prior to induction – note that time used for blocks that are the primary anesthetic is okay-
 - Transportation of patient without any other preparatory activities should not begin anesthesia time
 - Document unusual circumstances resulting in greater than usual disparities between time for anesthesia services and duration of surgical procedure (e.g. difficult intubation)
 - Actual **not** rounded minutes are required
 - Documentation must be present to support start time selected- would expect to see documented vital signs on the anesthesia record within approximately 5 minutes of start time to support time selected and would like to see a notation to corroborate time selected. For example, “In OR”, “IV sedation”, “Induction started”

Anesthesia Time

- Discontinuous time – documentation should be clear on the record and multiple start and stop times should be clearly documented. Time must be continuous within the time periods around the interruption.
- Activities included in the base unit cannot be counted- For example, pre-anesthesia exam and evaluation activities, monitoring services.
- **Anesthesia End Time**
 - Time ends when the anesthesiologist or CRNA is no longer in personal attendance, i.e., when the patient may be safely placed under post-op supervision.
 - A patient is safely placed under post-op supervision after transports to PACU, stabilizes patient and gives report

Anesthesia Time

- **Anesthesia End Time**

- Documentation should be present to support end time. For example: “PACU report given/anesthesia out”
- Expect to see clear documentation of anesthesia involvement in PACU when anesthesia presence is required for longer than approximately 7 minutes. Document note on PACU record with signature/initials.
- Actual **not** rounded minutes to be documented
- Reliefs/transfers – document applicable times- For example, Dr. A relieving Dr. B at 9:45.

Personally Performed Cases

- **Personal Performance**

- Anesthesiologist or CRNA performs entire case alone.
- Anesthesiologist and CRNA are involved in a single case and the services of each are medically necessary- must have extensive documentation of medical necessity to support such cases-
- Continuous presence is required- no leaving the room
- Transfers of care must be documented including relief times- E.g. Dr. A in for Dr. C at 11:33.
- Note: Anesthesiologist/CRNA cannot perform any other activity that would prevent responsibility for personal performance.

Medical Direction

- Medical direction documentation:
 - The physician alone inclusively documents in the patient's medical record that the conditions set forth in paragraph (a)(1) have been satisfied, specifically documenting that he or she performed the pre-anesthetic exam and evaluation, provided the indicated post-anesthesia care, and was present during the most demanding procedures, including induction and emergence where applicable.

Medical Direction

- Per 42 CFR §415.110, medical direction requires that for each patient the anesthesiologist fulfill the following seven (7) specific responsibilities:
 - Performs the pre-anesthetic exam and evaluation
 - Prescribes the anesthesia plan
 - Participates in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence
 - Ensures that any procedures in the plan that he/she does not perform are performed by a qualifying individual
 - Monitors the course of anesthesia at frequent intervals
 - Remains physically present and available for immediate diagnosis and treatment of emergencies
 - Provides indicated post-anesthesia care

Documentation

- Groups should focus on enhancement of medical direction documentation:
 - Discussion of various methods
 - Individual attestations
 - Global attestations
 - Handwritten entries
 - Time line initialing
 - Know your audience

Compliance: Medical Necessity is Key

- All services billed **must be** reasonable and necessary
- Who determines medical necessity?
- LCD and NCP provisions
- Medical necessity and anesthesia

Invasive Monitoring Lines/Other Procedures

- **Invasive Monitoring Lines**

- Medicare and certain other payors allow separate payment for invasive monitoring lines if they are reasonable and medically necessary
 - Note: ASA/CPT position- should not start anesthesia time based on placement of line prior to induction of primary anesthetic –
- The provider is responsible for documenting the insertion of invasive monitoring lines/other procedures
 - Should have some type of procedure note documentation with a signature or initials of placing provider– These services are not just a part of anesthesia for billing purposes and thus such services should have a clear note showing performance and other applicable information.
 - Discussion of use of procedure forms-

Acute Pain

- The anesthesiologist/CRNA should document the surgeon's request for the services
- A claim for separate payment should only be made when the procedures are done for post-operative pain management and not primarily for anesthetic use. The American Society of Anesthesiologists takes the position that a provider may bill for a regional anesthetic technique as a separate service from the anesthetic in the case if the regional technique is employed primarily for post-op analgesia and if (a) the anesthesia for the surgical procedure was not dependent upon the efficacy of the regional technique; and (b) the time spent on the block is not reported in the anesthesia time when placed before anesthesia induction or after anesthesia emergence. - Last amended October 20, 2010--
- Recommend that documentation should be present in a procedure note specifically noting that such placement was not used for the primary anesthetic in the surgical case.
 - *Documentation discussion- Separate placement note-*