Compliance Corner

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Anesthesia Practices Should Prepare for More Audit Activity

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The administrative burden and financial pressure on physicians and other healthcare providers, as a result of increased scrutiny of claims and audit activity by third party payors, is not expected to end anytime soon. Many physician practices around the country are already feeling the impact in the form of pre-payment audits and edits, voluminous record requests, and post-payment audit review activity.

By way of background, over one billion claims are submitted to Medicare each year. This means that Medicare processes over four million claims per work day (over 9,000 claims per minute). Because of this volume, Medicare contractors process most claims without investigation or even reviewing any clinical records. As a result, the Medicare Trust Funds are vulnerable to the submission of false and fraudulent claims as well the submission of claims failing to meet certain documentation and other requirements. Because of this vulnerability, the Department of Justice, the Department of Health and Human Services and the Centers for Medicare

and Medicaid Services ("CMS") have taken steps to combat activities perceived to constitute Medicare fraud and to seek out overpayments paid to healthcare providers.

As we have previously reported, CMS' Medicare Recovery Audit Contractor Program ("RAC") is already underway in all 50 states. The main objective of the Medicare RAC Program is to identify and recoup overpayments to health care providers. The RAC contactors are compensated on a contingency fee basis for monies that they restore to the Medicare Trust Funds. In Addition, CMS recently issued final regulations governing the implementation of a Medicaid RAC Program. These regulations require each state to implement a Medicaid RAC Program by January 1, 2012. Accordingly, practices may soon be recipients of record requests initiated by their respective state Medicaid RAC contractor in addition to requests from the Medicare RAC contractor. Although there are differences in the Medicare and Medicaid RAC Programs (e.g., appeals process), the main objective (i.e., to identify and recoup overpayments) for all practical purposes is the same.

Not only are the CMS RAC audit programs in motion, but Medicare Administrative Contractors ("MACs") (or Medicare Carriers and Intermediaries) conduct their own audits, and Zone Program Integrity Auditors ("ZPICs") (or Program Safeguard Contractors ("PSCs")) are conducting nationwide benefit integrity audits. Similarly, Medicaid HMOs are busy with audit activities. In addition to these government audits, many private payors appear to be following in line with the government's latest audit initiatives by contracting with outside vendors to conduct claims reviews and audits.

During the audit process, physicians are held to certain standards including, but not limited to:

- Having legal responsibility for all claims submitted under their billing numbers;
- Having legal responsibility for knowing Medicare policies regarding the services and procedures they perform, including policies on documentation. Pursuant to federal regulations, a physician will be deemed to have knowledge of a Medicare coverage policy if the Medicare Affiliated Contractor ("MAC") (i.e., Medicare Carrier or Intermediary) provides actual notice to the physician regarding coverage; if CMS has provided notices related to the subject service (e.g., Manual issuances, bulletins or other written guides); and/or if a National Coverage Decision has been adopted with respect to the service.[5]; and
- Being subject to medical necessity and documentation requirements (including for anesthesia services). The Social Security Act confers to patients entitlements to a range of medical services defined by broad categories. The Social Security Act also describes exclusions from coverage, most notably including payment for expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Generally speaking, a service may be covered if it is reasonable and necessary under Section 1862 (a) (1) (A) of the Social Security Act.

Given the highly-regulated health care environment and the ever-increasing audit landscape, it is extremely important for anesthesia and pain management practices to focus on compliance activities including deploying substantial effort towards improving medical record documentation. Although many physicians appear to believe that their documentation is sufficient to withstand audit scrutiny, the practical reality is that auditors traditionally take a very technical and conservative approach to documentation often times denying legitimately provided services based on reasons such as "lack of documentation to support services". With this in mind, we offer the following straightforward tips for consideration:

1. Focus Considerable Effort on Documentation Improvement:

The most prevalent types of denials raised in the various audit processes include documentation deficiencies. For those practices deploying a medical direction practice model, a key issue should be to ensure appropriate documentation of compliance with the medical direction requirements. As a refresher, according to 42 C.F.R. § 415.110 (b):

> The physician alone inclusively documents in the patient's medical record that the conditions set forth… 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.

Although CMS has not provided specific national instruction regarding the manner in which this documentation must be accomplished, there are many ways that medical direction can be documented (e.g., individual attestation statements with a comment section; a combination of attestation statements and time line initialing; handwritten notations with no formal attestations, etc.). Whichever form of documentation is used by an anesthesia practice, the bottom line is that documentation should be present to clearly establish

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[5] 42 C.F.R. § 411.06 and Medicare Claims Processing Manual (CMS Pub. 100-04), Chapter 30, § 40.1.
[6] 42 C.F.R. § 415.110.

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that the anesthesiologist fulfilled his/her regulatory obligations with respect to all of the following responsibilities:

- The anesthesiologist performed the pre-anesthetic exam and evaluation;
- The anesthesiologist prescribes an anesthesia plan;
- The anesthesiologist participates in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence;
- The anesthesiologist ensures that any procedures in the plan that he or she does not perform are performed by a qualifying individual;
- The anesthesiologist monitors the course of the anesthesia at frequent intervals;
- The anesthesiologist remains physically present and available for the immediate diagnosis and treatment of emergencies; and
- The anesthesiologist provides post-anesthesia care, as indicated.[6]

To the extent that an anesthesia practice is utilizing an electronic medical record, it is imperative to carefully review records to ensure that the appropriate documentation is captured and clearly displayed when printed to hard-copy form.

With regard to medical necessity, each note should establish the medical necessity for the service provided. Specifically, according to the OIG:

- 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 the observer. Records should take into account any applicable National Coverage Decision or Local Coverage decision requirements; and
- If not documented, the rationale for ordering a test or service should be easily inferred and past and present diagnoses should be accessible.

By way of example, with respect to pain management physicians, documentation of visits should include the patient's diagnosis; the patient's pain history; a description of prior treatments and the patient's response to each treatment; the rationale for the encounter; documentation of the location and intensity of pain; any other information required by a Medicare Local Coverage Decision; and any other information that will help establish the medical necessity for the service or procedure performed. Moreover, anesthesiologists must be mindful that medical necessity does apply to anesthesia services. It is particularly important to document the medical necessity for the anesthesiologists' involvement in certain types of cases including, but not limited to, the provision of monitored anesthesia care; the provision of anesthesia services by qualified anesthesia providers in colonoscopy cases and other procedures where the surgeon may have handled the anesthetic for the procedure in the past; and the provision of anesthesia services by qualified anesthesia providers in chronic pain management cases. Merely relying upon hospital protocol or that the surgeon requested anesthesia involvement is not sufficient to establish medical necessity when challenged.

2. Obtain and Review Payor Policies and Guidelines:

Whether dealing with contract requirements which typically require the anesthesia practice to follow the payor's guidelines and policies (which may be unilaterally changed and revised from time to time) or Medicare requirements, it is important that every physician in the practice understands the requirements applicable to the services being submitted for payment. In order to make sure the

practice is obtaining necessary billing and documentation rules and guidelines, the practice should designate an individual who is responsible for (1) determining which third party payors have published policies and guidelines (this can be accomplished by making telephone calls; researching websites; reviewing contracts; communicating with billing personnel or billing company representatives); (2) creating a list of the payors (with applicable websites) that have policies and guidelines and keeping the list updated; and (3) obtaining the available information. The Medicare Contractors all have websites and many have email services that are easy to register with to receive updates.

Once the practice is obtaining necessary billing and documentation information, the information must be appropriately disseminated to the physicians. As the policies may contain requirements regarding documentation and frequency limitations in addition to coding issues, the physicians and providers in the practice should be included in the distribution. Many physicians believe that they do not need to review the materials as long as their billing company/administrative staff is aware of the policies. Physicians must understand that they are personally responsible for services billed under their numbers. Moreover, that the payor policies often contain information necessary for the physician such as specific documentation elements that must be contained in the record to support billing of a service. In addition to the potential audit and overpayment exposure that exists for failing to comply with payor policies and guidelines, physicians should be aware that certain patterns can lead to the physician being de-participated from a payor program.

3. Engage In Educational Activities:

Anesthesia practices should make compliance education a component in regularly scheduled board or other corporate meetings. For example, when a new policy is published by Medicare that impacts the practice (e.g., a policy on anesthesia for endoscopy cases, etc.), the policy should be discussed at the meeting to ensure that everyone has received the information and understands the information. If there are no new policies to discuss, the allotted time for education can be used to provide refresher education on other issues. For example, the definition of anesthesia time could be discussed to ensure everyone is tracking and documenting time appropriately.

We recommend that the practice document these educational efforts. This can be accomplished by drafting simple meeting minutes that reflect that compliance education on a particular topic took place.

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