Auditing and Monitoring

An effective compliance program requires both auditing and monitoring. Auditing refers to formal reviews of coding and billing accuracy, which are usually performed by specially trained personnel or outside consultants. Monitoring, on the other hand, refers to ongoing, often informal activities performed by the organization's regular staff for early detection of problems. For example, a billing supervisor may monitor the radiology practice's rate of diagnosis-related denials for CT and MRI scans and determine that an audit is necessary if the rate rises sharply. Auditing may also be performed proactively to identify new potential risks for which monitoring systems may need to be developed.

The OIG "Compliance Program for Individual and Small Group Physician Practices" recommends a baseline audit to examine the entire process from patient intake through claim submission and payment and identify elements that may contribute to non-compliance or need to be a focus for improvement. This audit will establish a consistent methodology for selecting and examining records and this methodology will then serve as a basis for future audits.

It is essential to take steps to ensure that the program is working; it is important to measure what has occurred. This includes compliance audits and ongoing monitoring, and having a system for employees to ask questions and report concerns without retaliation for doing so. Therefore, healthcare providers should have a comprehensive review and monitoring program as a component of their compliance plan.

The OIG recommends that claims that were submitted and paid during the initial 3 months after implementation of the education and training program be examined, so as to give the healthcare entity a benchmark against which to measure future compliance effectiveness. This review should ensure that claims can be supported and defended based on the documentation in the patient medical record.

Although electronic medical records may be easier to review than paper charts, there is an entirely different set of risks with electronic documentation. For example, if the facility or practice utilizes macros or templates, it may be necessary to review their structure in addition to reviewing the documentation contained in the template.

Organizations should ask the following questions about their auditing and monitoring programs:

- Is the audit plan re-evaluated annually, and does it address the proper areas of concern, considering, for example, risk areas identified as part of the annual risk assessment, and high volume services?
- Does the audit plan include an assessment of billing systems, in addition to claims accuracy, in an effort to identify the root cause of billing errors?
- Is the role of the auditors clearly established and are coding and auditing personnel independent and qualified, with the requisite certifications?
- Do the auditors conduct unscheduled reviews and does a mechanism exist that allows the compliance department to request additional audits or monitoring should the need arise?

Electronic Signatures

An electronic signature (e-signature) is a method of authentication that employs a system and software which are protected against modification and apply administrative procedures that correspond to recognized standards and laws. Many states have published regulations on the implementation and use of electronic signatures.

HIPAA regulations require that electronic signature meet the following standards:

- User Authentication – When a document is electronically signed, the identity of the user must be authenticated. In other words, the user has a "signing password" in addition to a system login and password.
- Message Integrity – Once a document is electronically signed, it cannot be altered.
- Non-repudiation – Having electronically signed a document, the user may not reasonably challenge the authentication of that electronic signature.

CMS provides the following guidance for electronic signatures:

- Systems and software products must include protections against modification, and you should apply administrative safeguards that correspond to standards and laws.
- The individual whose name is on the alternate signature method and the provider bears the responsibility for the authenticity of the information being attested to.
- Physicians are encouraged to check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.
- Part B providers must use a qualified electronic prescribing (e-prescribing) system.
- Prescriptions for drugs incident to Durable Medical Equipment (DME) must be made via a qualified e-prescribing system.

See the Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4, as well as the Fact Sheet, "Complying with Medicare Signature Requirements" (ICN 905364):
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

Another helpful reference is the Practice Brief, "Electronic Signature, Attestation, and Authorship," from the American Health Information Management Association (AHIMA):
http://library.ahima.org/PB/ElectronicSignature#.WCiaZfkrLIU

Disclaimers

Some organizations add a disclaimer to the physician signature line that states the physician is not responsible for transcription errors or errors caused by voice recognition software, such as misspelled words or incorrect words. Regardless of the disclaimer, the physician is still responsible for the accuracy of the radiology report. The WPS Medicare document, "Guidance for Provider Signature Requirements," states that these disclaimers do not remove the provider's responsibility for the documentation, and providers should verify that the information is complete and accurate before signing.

Orders for Diagnostic Tests

Understanding when and how diagnostic imaging services are ordered is critical to ensuring compliance and appropriate reimbursement. When discussing orders and their restrictions and requirements, Medicare services should be considered separately from non-Medicare. These two categories have very different requirements and it is important to understand their differences and the associated operational and financial impact.

Commercial Payers (Precertification)

Most large commercial payers require high-cost studies such as CT, MRI, or PET to be pre-certified or pre-authorized (preapproved). It is the referring physician's responsibility to obtain this prior approval by contacting the payer and providing the medical reason for the exam. This function is typically performed by their nursing staff. Upon approval, the payer will issue an approval number which must be submitted by both the facility and the physician who interprets the exam. If the payer refuses to approve the exam, neither the facility nor the physician will be paid for it regardless of the findings.

The approval number that is provided by the payer is based upon the performance of a specific exam and is most frequently approved on a CPT® procedure code basis. If the facility and physician do not submit the exact code that was approved, the claim will usually not be paid, since it does not match the payer's approved information. Some payers will approve a range of codes instead of just one code; however, this practice is not widespread. For example, a payer might approve 74150-74170 (CT of the abdomen w/o contrast, w/contrast & w & w/o contrast) instead of just 74150 (CT of the abdomen w/o contrast).

Regardless of whether the correct code or range of codes were approved, if the incorrect exam was requested by the referring physician, no changes can be made without first contacting the referring physician's office and obtaining a new order/prior approval. Failure to do so could result in loss of reimbursement for both the facility and the physician. For commercial payers that do not require prior approval there may be some flexibility in the changing of orders; however, it is difficult to track this information on a departmental level.

Medicare

At the present time Medicare does not have a prior approval process like the commercial payers, although eventually the Medicare Appropriate Use Criteria program will require preauthorization in certain limited circumstances. (Please see the following section.)

Currently, providers must determine whether the exam will be covered by reviewing the National and Local Coverage Determinations (NCD/LCD) and issuing Advance Beneficiary Notices (ABNs) as appropriate.

Federal law [42 USC §1395u(p)] requires the ordering physician to provide diagnostic information at the time the exam is ordered. The law states that when the entity furnishing a service (in this case, the imaging facility) is required to submit diagnostic information in order to receive payment for the service, the ordering physician or practitioner "shall