MEDICAL SOCIETY OF NEW JERSEY

EMR DOCUMENTATION, RECORD RETENTION & AUTHENTICITY WORKSHOP

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EMR: The Legal Landscape

Navigating Health Reform Legislation
Opportunities and Managing Risk

PPACA: Patient Protection and Affordable Care Act

- Health Reform Legislation Overview
  -- Goals:
  -- Improve the quality of patient care
  -- Cost savings

  - Incentives for physicians who demonstrate cost – effective and high quality patient care
  - Penalties to providers who do not
  - Effective 2015

Paying for Health Reform

- Medical payment modifications

  -- Primary care physicians – eligible for 10% bonus

  -- Extension of bonus to physicians reporting quality measures

  -- Value based payment modifier for physicians demonstrating cost effective and high quality performance; penalties to those who do not

Fraud and Abuse Enforcement

Significant focus by OIG and DOJ on Criminal and Civil Violations to Recapture Funds and Impose Monetary Sanctions

EMR, PPACA and HITECH

- HITECH and PPACA include funding incentives for EMR

HITECH – Encourages use of EMR;

- Patient care delivery
- Payment systems tied in
- Incentive programs

Medicare: $44,000 available per eligible provider

Medicaid: $63,000 per eligible provider

- Applications submitted by individual provider
- Not by employers or practices
- Funding may be reassigned

EMR, PPACA and HITECH

HITECH and PPACA

-- Reimbursement tied in to EMR implementation

-- 2015 deadline for implementation of EMR

-- Requirements:

Enrolled in PECOS

Must use Certified EHR system

Attestation of Meaningful Use

-- Allows for tracking quality of care measurements, cost savings and enforcement

Meaningful Use

- Final Rules (7/13/2010)

  -- Core elements and additional menu tasks delineated

  -- Must meet the Core Elements and some of the Menu Elements

  -- Attestation of meaningful use of certified system for 90 days for 2011 funds

EMR – Recordkeeping requirements

EMR – Allows for better documentation

- ✓Lower rate of medication errors
- ✓Decrease in law suits

EMR Record Retention

- Federal and State Mandates

Federal

-- Medicare ~ Six (6) years

-- Medicare managed care ~ Ten (10 years)

State

-- Seven (7) years from the date of last entry

Risk Management and Litigation Issues

- EMR

  -- Integrity of Records
  - Changes and Alterations
  - Safeguarding data

  -- Authentication

  -- Scanned Documents
  - Must be identical to original, CMS required verification
  - Audit program to ensure compliance
  - Legibility requirement

Risk Management and Litigation Issues

- Litigation issues
  - -- E-discovery
    - Secure records
    - Hard drive requests
    - Costly process
    - Discovery of Alterations

      Systems should provide tracking information which is discoverable

Risk Management and Litigation Issues

- Spoliation of Evidence

  -- Intentional or negligent withholding, hiding, altering or destruction of evidence to a legal proceeding

  -- Penalties to parties and impact on case

  - Preclusion of evidence, dismissal of claims, adverse inference

Risk Management and Litigation Issues

- Risk Management

  -- Ensure compliance with recordkeeping requirements and document compliance; education of providers on compliance

  -- Presuit claims ~ secure records and review for documentation issues; secure hard drive data if necessary

  -- Ensure EMR systems are not subject to information alterations or destruction of data

False Claims Act 31 U.S.C. §3279

- Provides for penalties & damages for presenting false or fraudulent claims
- Intended to recover funds for the gov't
- In addition to the basic "false claims" prohibitions, also encompasses:

1. Anti-Kick Back Statute ("AKS")

   42 U.S.C. §1320a-7b
2. Prohibition against Self-Referrals ("Stark laws")

Civil Fraud Claims

- Civil portion of the FCA does NOT REQUIRE a specific intent to defraud the gov't
- Thus the absence of intent is not a defense
- Rather, the simple existence, and knowledge of, the error or mistake is enough to impose liability and impose penalties
- 10 year Statute of Limitations

Civil Fraud Claims

- “Knowledge” of a false claim is broad
  - -- actual knowledge
  - -- deliberate indifference
  - -- reckless disregard

- FERA and PPACA amendments have broadened definitions of “false claims” and given the Federal & State gov’ts more tools and discretion to go after violators

Liability can be imposed for:

1. submitting a false claim
2. making a false statement (in support of a claim for reimbursement)
3. wrongful retention of/ not returning monies received improperly (a “reverse false claim”)

Coding and Billing

- Fraud & Abuse laws apply whenever the Federal gov't covers items or services rendered to Medicare and Medicaid beneficiaries
- CMS recognizes that most payment errors occur as the result of simple billing and/ or coding mistakes
- Not necessarily because of an intent to defraud

Penalties

- Include:
  1. Civil Monetary Penalties ("CMPs")

     -- imposed by Civil Monetary Penalties Law ("CMPL") §1128A of the Social Security Act

  2. Exclusion from participation in the Federal & State programs

     -- mandatory (where criminal conduct)

     -- permissive (discretion of OIG)

Civil Monetary Penalties

- Can range from $10,000 to $50,000 per violation
  -- $50,000 for false statements
  (in support of a claim or in response to
  an investigation)
  -- $15,000 per day for delaying or hindering
  an investigation
  -- $10,000 for failing to report overpayment or
  ordering/ prescribing while excluded from
  program
- Can include treble damages

Factors considered in assessing penalties

- Measure of culpability
- Degree of fraudulent conduct
- Whether "fraud" or "innocent billing error"
- Whether any actual harm to patients

** The OIG's stepped up efforts to identify and penalize fraudulent conduct can result in claims against physicians who have mistakenly failed to devote adequate resources, staff & training to ensure proper billing and coding practices, notwithstanding the absence of any intent to defraud

NOW THAT WE HAVE YOUR ATTENTION …

HOW DO YOU AVOID GETTING YOURSELF & YOUR PRACTICES INTO THIS SORT OF TROUBLE?

Glad you asked …

Important considerations

- Recognize that coding has evolved from a simple clerical data entry function to a complex system of rules & regulations that must be overseen by properly trained professionals ("Compliance officers")
- Recognize that the OIG relies upon the healthcare industry to self-police itself
- Review (and adopt as much as possible of) the OIG's compliance program guidelines

OIG Compliance programs

- Modeled after the United States Federal Sentencing Guidelines
- Based upon the principle that healthcare providers self- monitor their compliance with proper coding & billing practices, by identifying and monitoring their practices for high risk areas of potential fraud and abuse
- Further based upon principle that healthcare providers will self-report and self-correct errors & mistakes

Elements of OIG's Compliance Program

1. designate a Compliance Officer or Committee
2. create and maintain policies & procedures, including a compliance code of conduct
3. conduct internal auditing to assess risks and avoid fraudulent billing practices
4. maintain open & confidential means of reporting compliance concerns

5. training & education of staff to ensure adherence to federal program requirements
6. create method to detect & correct errors
7. enforce disciplinary action against violators of program

** A successful compliance program will:

-- minimize the risk of being subject to an enforcement action; and

-- mitigate the damages/ reduce penalties assessed if there is a violation

Designating a Compliance Officer and Committee

- Officer should have a strong understanding of all coding & billing principles
- Full time or assigned responsibility as part of existing position, or more than one

  (depends on size of practice)
- Should have direct access to physicians/ providers of services
- Should have regularly scheduled meetings to discuss compliance activities
- Should keep minutes of meetings (to show proof of compliance program if questioned)

Policies & Procedures

- Ensure continuing education & training
- Disciplinary plan for unethical behavior
- Method of reporting concerns (without fear of adverse consequences)
- Procedure for making repayments
- Procedure for responding to investigations
- Record retention policy (for both medical & business records)

Code of Conduct

- Should be a clear statement of your practice's basic principles
- Should establish the authority & responsibility of the Compliance Officer
- Should set forth the basic operation of the practice's compliance plan
- Should cover day-to-day compliance activities

Internal Auditing

- Primary goal is to identify your practice's most likely areas of risk, by:

  -- analyzing practice's top reimbursable services
  -- reviewing history of denied claims
  -- reviewing claims that have resulted in overpayments

Types of internal reviews

1. Standards & Procedure review

   -- make sure are current and up to date

   -- ensure using current CPT codes and delete use of out dated codes (CPT manual is published annually for Jan 1 effective date)

2. Claims Submission audit

   -- ensure claims coded correctly, that documentation complete and services rendered were reasonable & necessary

Open & Confidential Reporting

- Establish an “open door” policy
- Encourage good faith reporting (and that failure to do so is itself a violation)
- Establish a consistent process for reviewing any reported concerns
- If using a third party billing entity, ensure means for communication between that entity and your compliance officer

Training & Education

- Provide consistent training and education to all staff, not only compliance officer

** will not only improve accuracy of coding & billing, but can also improve your practice's revenue stream and cash flow

Detecting & Correcting Errors

- Most billing errors are “coding errors”; not any intentional effort to defraud
- Most processing errors are the result of outdated software or billing systems
- Most documentation errors are the result not adequately documenting the patient encounter and behavior taken
- When an error is detected, must take swift & decisive action to rectify & prevent going forward

Disciplinary Measures

- Program in place to ensure all violations handled in a consistent manner
- Yet should be flexible enough to allow for mitigating (or aggravating …) factors
- After rectifying an error, your practice should review the chain of events resulting in the error to prevent a reoccurrence

For any questions, concerns or requests for additional information or advice, please feel free to reach out to us

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