VitalSigns

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SUMMER 2013

Ensuring compliance with the CMS

THE INS AND OUTS OF "MEANINGFUL USE" PREPAYMENT AUDITS

In March, the CMS began conducting prepayment audits of providers who have attested to meeting the meaningful use requirements of the electronic health record (EHR) incentive programs. According to the agency, the audits are being done on a random basis, as well as on the basis of "suspicious or anomalous data." Knowing the types of information the CMS considers in a prepayment audit can help your practice prepare and ease the process, if you're selected.

GENERAL INFORMATION

Eligible professionals attesting to meaningful use to receive an incentive payment for the Medicare or Medicaid EHR incentive program may be subject to an audit. The CMS and its contractor, Figliozzi and Company, perform the audits on Medicare and dually eligible (Medicare and Medicaid) providers, while states and their contractors conduct the audits on Medicaid providers.

Providers selected for audit must present supporting documentation to validate their submitted attestation data within two weeks of the initial request. In particular, physicians must provide documentation that supports their meaningful use and clinical quality measure data. Providers selected for postpayment audits must also submit supporting documentation to validate their attestation data.

MAINTAINING DOCUMENTATION

The level of the audit review depends on a number of factors, and required documentation varies depending on the level of the audit. In general, though, you should maintain the source document (or "summary document") used when completing the attestation.

The source document should provide a summary of the data that supports the information entered during attestation. Ideally, it would be a report from your certified EHR system, but other documentation can be used under certain circumstances.

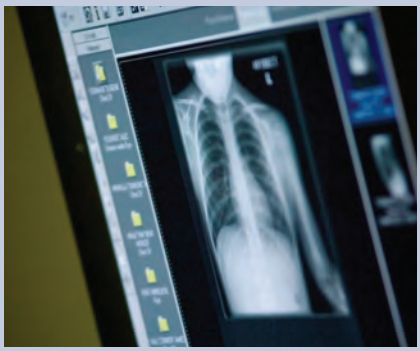
The CMS says providers should retain a report from the system to validate all clinical quality measure data entered, though, because all such data must be reported directly from the certified EHR system. And providers who use a source document other than a report from the system to attest to meaningful use data (for example, nonclinical quality measure data) should retain all documentation that demonstrates how the data was collected and computed.

The source document will be the starting point for most audits and should include, at a minimum:

- The numerators and denominators for the percentage-based measures,
- The time period the report covers, and
- Evidence to support that it was generated for that provider (for example, identified by National Provider Identifier or CMS Certification Number).

What to expect from the CMS audit process

If you're selected for a Medicare or dual eligibility audit, you'll receive an e-mail from a CMS address with the initial request letter from the auditor. The initial review process will be conducted at the audit contractor's location, using the information received in response to the initial request letter. (Note that states have separate audit processes for their Medicaid EHR Incentive Programs.)



Additional information might be required during or after this review, and an on-site review (including a demonstration of the EHR system) might follow in some cases. The auditor will use a secure communication process to assist you in sending sensitive information.

When the audit concludes, you'll receive an Audit Determination Letter that lets you know whether your practice has established meaningful use. An appeals process is available for providers found ineligible for an incentive payment.

Because some certified EHR systems can't generate reports that limit the calculation of measures to a prior time period, the CMS suggests providers download or print a copy of the report used at the time of attestation to keep for their records.

An audit could also include additional and more detailed reviews of any of the measures, including a review of medical records and patient records. You should be able to supply documentation to support each measure attested, including any exclusions claimed by the provider.

The auditor may also request additional supporting documentation for non-percentage-based meaningful use objectives, for which not all certified EHR systems track compliance. For the objective of drug-drug or drug-allergy interaction checks, for example, the CMS suggests saving one or more screenshots from the system that are dated during the EHR reporting period selected for attestation.

EXPEDITE YOUR PAYMENTS

The CMS won't release incentive payments to providers chosen for prepayment audits until they present the required documentation. So, the quicker you can provide the necessary information, the sooner you'll receive payment.

How to protect your practice from employee fraud

Employee fraud is a risk in every business, and physician practices are no exception. One survey done by the MGMA found that 83% of respondents have been affiliated with a practice that has been victimized by employee theft or embezzlement. And with an Association of Certified Fraud Examiners (ACFE) survey estimating that a typical organization loses 5% of its revenues to fraud, you could take a real hit to your bottom line.

COMMON SCHEMES

Small and midsize businesses, like medical practices, are often most

vulnerable to employee fraud. Many employee thefts involve cash receipts, such as when staff members help themselves to patient copays or deductibles and simply write them off as bad debts.

According to the MGMA survey, fraud in a medical practice may also involve:

- Cash on hand (for example, sticky fingers in the petty cash box),
- Disbursements (fraudulent invoices or forged checks),
- Expense reimbursements (fictitious or inflated claims),
- Payroll (fictitious employees, inflated hours or pay rates, or unauthorized bonuses), and
- Misuse of a practice's noncash assets (supplies, equipment or confidential information).

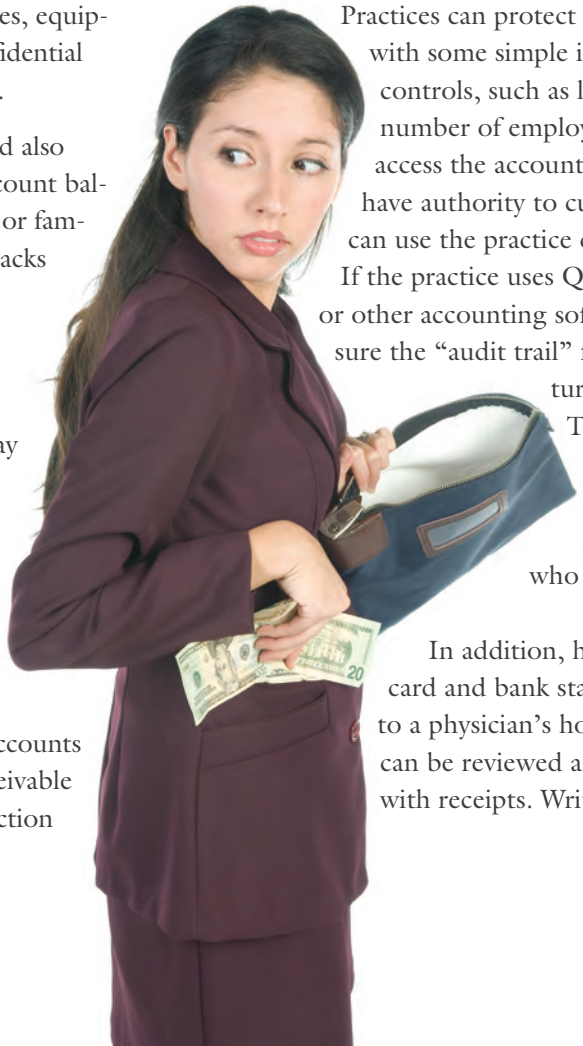
Employees could also write off the account balances of friends or family or take kickbacks from vendors.

PREVENTION

A trained financial specialist may be able to identify red flags of fraud simply by reviewing your books. He or she would look at cash flow, receipts, accounts payable and receivable balances, transaction documentation, payments to vendors, and adjustment journal entries, among other things.

A starting point is a year-to-year comparison of income and expenses. A spread of five years is even better. This comparison will help spot changes that might indicate fraud but also give the physician a five-year trend, which will aid in expense management.

Many fraud schemes can be traced back to a practice's failure to segregate accounting duties. For example, a practice might have the same employee responsible for collecting copays and deductibles, posting charges, reconciling accounts and making bank deposits.



Practices can protect themselves with some simple internal controls, such as limiting the number of employees who can access the accounting database, have authority to cut checks or can use the practice credit card. If the practice uses QuickBooks™ or other accounting software, be sure the "audit trail" function is turned on. This will record all changes made and who made them.

In addition, have credit card and bank statements sent to a physician's home so they can be reviewed and matched with receipts. Write-offs of patient accounts or adjustments to them should be approved by the practice manager and followed by a monthly review by the physician. And a doctor should sign every check and confirm that each has a legitimate invoice.

Make sure your insurance includes an employee fidelity bond. Coverage should be commensurate with your practice size.

Before bills are paid, purchase orders should be examined to verify that the correct products or services were provided, especially if the same employee authorized the purchase and approved the vendor invoice. After payment, all canceled checks should be reviewed to verify that they were deposited into a business account, rather than cashed or put into a personal account. Have a physician review all bank statements and credit card statements for unusual activity before they're turned over to accounting personnel.

Payroll demands close attention, too. Doctors who don't know how much they pay their staff members or don't review paychecks are opening the door to the possibility of inflated checks and checks to nonemployees. Also, separate the approval of payroll hours and rates from the person who prepares the payroll checks. Neither

of these persons should be able to change the general ledger or reconcile the bank accounts.

Last, make sure your insurance includes an employee fidelity bond. Coverage should be commensurate with your practice size. And, have your CPA perform an internal control review of your practice. It will be money well spent!

BAD NEWS AND GOOD NEWS

Few doctors went to medical school so they could become mired in the nitty-gritty aspects of financial management. However, ignoring the costly risks of employee fraud could mean throwing money away. Fortunately, your financial advisor can provide assistance in combating fraud in your practice. ◉

Improve productivity: Employ nonphysician providers

Efficient physician practices understand the need to have each clinician not only "practice at the top of his or her license" but also be as productive as possible. If your practice is struggling in this area, consider hiring one or more nonphysician providers (NPPs).

Physician practices — particularly those in primary care — may want to bring NPPs onboard for several purposes. For example, NPPs can provide less expensive services that are currently performed by physicians. Plus, you can delegate lower level tasks to NPPs, which may mean you don't have to recruit new doctors.

THE FUNCTION OF AN NPP

NPPs include physician assistants, nurse practitioners, nurse midwives and physical therapists. Some practices might label them as "midlevels," "physician extenders" or "supplemental providers." Whatever moniker you prefer, their training and skill sets place them along the clinical continuum between registered nurses and physicians.

When considering the pros and cons of hiring an NPP, think through the type of provider your practice needs. Also determine the role the NPP would play in the practice, the kinds of cases he or she would handle, and how patients would be allotted.

In some practices, the NPPs are the first patient contact and the physicians serve more as consultants. This can't be the case with Medicare patients, however, if the NPP is being billed to the payer as "incident to." The physician must be the first, and sometimes second, patient contact and should set up the patient's plan of care. The NPP then provides the continuity of care by following the physician's plan.

In other practices, more routine cases are handled by the NPP, while

medically complex cases are directed to the doctors. You can also use the NPP as a backup to see same-day patients when the physician's schedule is full, keeping in mind that a physician must be present in the facility if billing "incident to."

HOW IT CAN WORK IN YOUR PRACTICE

Doctors are often paired with a particular NPP. Together with a couple of nurses, they form a smoothly functioning team that's assigned to individual patients.

Other NPPs work more independently, however. Nurse practitioners and advanced practice nurses are being awarded Doctor of Nursing Practice degrees in recognition of their high level of training. Some states allow NPPs to serve as a patient's primary care provider for billing purposes; others allow them to prescribe medications.

Some speculate that the primary care practice of the future will involve a smaller group of physicians overseeing a larger team of NPPs responsible for most face-to-face patient encounters. The physicians would spend most of their time monitoring, supervising and reviewing performance data, planning quality improvements, performing diagnoses and handling the most complicated cases. Above all, NPPs must complement the work that the physicians perform.

RECRUITING AND RETAINING NPPs

To attract and keep the best NPPs:

- Offer a competitive salary and comprehensive benefits,
- Include a CME allowance,
- Pay for licensure fees, malpractice premiums and professional memberships, and
- Consider implementing a productivity incentive plan that kicks in only after a base production amount that supports salary and benefits.

Check your state's laws authorizing NPP practice and the views of the state medical board. Also determine whether the practice's malpractice insurance carrier will cover the NPP's services, and whether your payer contracts will reimburse the practice for those services.

A GOOD MOVE

Physician practices across the country are enjoying the benefits that NPPs provide every day. If your doctors are overwhelmed with too many patients and too much paperwork, consider adding one or more NPPs to your practice's roster.

The future is now

HOW TO PREPARE FOR VALUE-BASED REIMBURSEMENT

Private insurers and the government are increasingly pushing for value-based reimbursement (VBR) of providers, leading to a shift from the traditional physician compensation model toward a new focus on quality outcomes. With VBR becoming less a matter of "if" and more of "when," savvy physician practices are beginning to familiarize themselves with how it works so they can make the transition more smoothly when the time comes.

BEYOND ACOs

The Patient Protection and Affordable Care Act (PPACA) offers a number of options for providing care and paying providers, including the formation of accountable care organizations (ACOs). The CMS will reward ACOs that reduce costs while meeting performance standards on quality of care.

Provider participation in ACOs is purely voluntary but, even if you're not planning to join one, you're likely to find yourself operating in a new compensation environment in the near future. It's likely that compensation will reflect quality instead of volume, taking into account

physician performance metrics such as efficiency, coordinated care and patient satisfaction.

Indeed, by 2015, the health care act requires the CMS to begin applying a "value-based payment modifier" under the physician fee schedule. Although the modifier will initially apply only to practices with 100 or more eligible professionals (including nurses, physician assistants and other nonphysician staff), it's scheduled to apply to all physicians and groups by Jan. 1, 2017.

POTENTIAL VBR COMPENSATION MODELS

Since the passage of the health care act, several models of value-based reimbursement have emerged, including:

Pay-for-performance. Under this hybrid model, physicians are paid a negotiated payment for each service, with additional incentives based on costs, quality and patient experience.

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Shared savings. Providers work together to meet certain quality standards based on outcomes and care coordination. They then share in the savings they achieve on the targeted costs.

Bundled payments. Multiple providers share a single fixed-fee payment for, say, a single episode of care.

Comprehensive primary care initiative. This initiative, made possible by the health care act, is modeled after innovative practices developed by large employers. With this approach, practices will be given resources to better coordinate primary care for their Medicare patients.

Patient-centered medical homes. The CMS is currently testing the effects of the advanced primary care practice model — commonly known as the "patient-centered medical home" — in improving care, promoting health and reducing the cost of care provided to Medicare beneficiaries served by federally qualified health centers. In this model, a patient's health and care are coordinated through the primary care physician, and financial incentives are paid based on quality metrics.

PREPARING FOR VBR

You can take some steps *now* to position your practice for the coming models:

- Determine what each model would mean to your practice, including how it would change your financial performance.
- Rather than focusing on revenues, develop ways to increase profits by containing costs.
- Pay attention to communications from payers so you know as early as possible what they have planned regarding reimbursement.
- Evaluate your readiness for measuring and satisfying quality-related metrics.

Finally, consider exploring the potential for collaborative arrangements with other practices and hospitals.

ACT NOW

New compensation models will likely have a significant effect on your practice's finances. By planning ahead and working with your financial advisor, you'll increase the odds of maximizing revenue and minimizing disruption.