



GOVERNMENT OF
NEWFOUNDLAND AND LABRADOR

Department of Health and Community Services

MCP Audit Newsletter

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TO: ALL FEE-FOR-SERVICE PHYSICIANS

The purpose of this newsletter is to provide a brief overview of the revised MCP Medical Audit process. The revisions have come about as a result of the work of a joint Department of Health and Community Services / Newfoundland and Labrador Medical Association Audit Review Committee that has recently finalized its work. Highlights of changes to the audit process include:

- 1) a commitment to pilot an "Educational Records Review" which involves the audit of services for all new physicians within the first two years of practice, as well as the audit of services for all physicians on a five year rotation;
- 2) a reduction in the time frame of comprehensive audits from five years to two years;
- 3) a reduction in the number of members on the MCC, and a redefined quorum, in an effort to bring audits to conclusion in a more timely fashion (not yet implemented);
- 4) the expansion and clarification of the Provider Claims Intervention Program (PCIP) as a positive preventative measure;
- 5) the creation of an Alternate Dispute Resolution process in an effort to encourage a co-operative climate, achieve fair and appropriate settlements, and avoid the excessive financial, psychological, and procedural costs associated with formal court proceedings;
- 6) a commitment to provide physicians who are subject to audit as a result of flags on their Provider Practice Profile with a copy of that profile;
- 7) a commitment to pursue a joint communications strategy for the purposes of physician education and the promotion of the audit process;
- 8) the institution of mandatory orientation sessions for all new physicians;

There are two main medical audit programs. One investigates potential problems with physician billing while the other investigates chronic beneficiary abuse and/or physician overservicing.

PHYSICIAN MEDICAL AUDIT PROGRAM

Physicians are entitled to payment for services which are rendered and appropriately recorded. The purpose of auditing a physician's billing is to verify that services were paid in accordance with the rates and regulations specified in the MCP Payment Schedule. A benefit of the audit process is that

billing practices which are not in accord with the rates and regulations can be changed to avoid future audit issues.

The Physician Medical Audit Program is based primarily on the documentation contained in the physician's record of service. In cases where specific elements of record/documentation requirement are specified in the Payment Schedule Preamble but do not appear in the patient's record of service, that element of service is deemed not to have been rendered and the fee component represented by that element is not payable.

In addition to the record of service, the Medical Audit Department will also consider several other audit factors which include, but are not limited to, such items as medical necessity, patterns of servicing, and information supplied by beneficiaries as well as other individuals.

The following description of the Physician Medical Audit Program covers general medical audit procedures. There may be slight deviations to these procedures at times to allow for specific peculiarities of individual audits.

AUDIT INITIATION:

Audits can be initiated based on any of the following:

- **BENEFICIARY VERIFICATION AUDITS**

This involves the random selection of claims on a regular basis and the sending of confirmation letters/questionnaires to beneficiaries for verification of recent services. Audit verification is performed using a methodology which ensures that a sample of services billed by all physicians will be verified on a continual basis.

Whenever a discrepancy exists between the service billed and the information supplied by the beneficiary, the Audit and Claims Integrity Division may request the record of service from the physician. Based upon the findings of these verification audits, an audit may proceed to an Educational Records Review.

- **COMPLAINTS OR VOLUNTARY INFORMATION**

Occasionally, the Audit and Claims Integrity Division receives complaints regarding the billings or pattern of practice of a particular physician from a number of sources (e.g. beneficiaries, other physicians, etc). These complaints are reviewed in conjunction with all available information. Records of service or other information may be requested from the Physician. After the review of this information, it may be decided to proceed to either an Educational Record Review or to the Comprehensive Stage of the physician audit.

- **PHYSICIAN PRACTICE PROFILES**

Reports are regularly compiled to present a comparative picture of service patterns of physicians. Whenever service volume significantly exceeds area or provincial averages or when practice patterns are otherwise deviant, such cases will be investigated and may result in the commencement of a physician audit. Depending on the situation, it may begin in either the Educational Records Review or Comprehensive Stage.

- **AUDITS OF TARGETED FEE CODES/PREMIUM CODES**

Such audits are initiated when certain services appear to be subject to widespread misinterpretation or incorrect billing. These audits are an important means by which Payment Schedule rules and definitions may be clarified, reviewed, and improved.

- **BENEFICIARY UTILIZATION AUDITS**

During the investigation of a beneficiary who is flagged due to high levels of utilization, issues may develop regarding the billing or documentation practices of the physician(s). These issues are analysed and may result in the commencement of a physician audit. Depending on the situation, it may begin in either the Educational Record Review or Comprehensive Stage.

EDUCATIONAL RECORDS REVIEW

An audit may enter this stage as a result of suspected misbilling or as part of a routine process designed to ensure that all physicians are audited at least once every five years. New doctors are audited within their first two years of practice.

In either case, a small sample of claims for a select number of service items is randomly selected for review. Physicians are then asked to provide copies of their records of service which pertain to or substantiate their claims.

If the records combined with any other supporting evidence gathered during the **Records Verification** stage (which can include an interview) substantiate the physician's billings, the audit is closed and the physician is notified of the findings.

It should be noted that some audits are concluded at the patient verification or early in the Educational Record Review stage where it is usually determined that services have been rendered as claimed or that minor billing errors have occurred. In these instances the audit will be concluded but minor payment adjustments may be made.

PHYSICIAN CLAIMS INTERVENTION PROGRAM (PCIP)

Overview

The Provider Claims Intervention Program (PCIP) is a mechanism designed to prevent the payment of claims which are inconsistent with the MCP Payment Schedule.

Claims for selected services are checked for compliance with MCP Medical Payment Schedule requirements prior to being paid.

Physicians entering the program are given the opportunity to meet with representatives of the Audit and Claims Integrity Division who will explain the process.

In order to be paid for the selected services, physicians must submit copies of patient records for review along with any additional information to ensure the service complies with the requirements of the MCP Medical Payment Schedule.

Following this review, the MCP Claims Management Section is directed to pay the physician the appropriate fee for each service rendered.

Entrance into the PCIP:

All physicians from whom an audit recovery is made will normally be entered into the PCIP.

Physicians whose audits have entered the comprehensive stage of the audit process will normally be subject to the PCIP.

Physicians whose documentation requirements are inconsistent with the MCP Medical Payment Schedule may at any time be entered into the PCIP (e.g. profile aberration or referrals from the MCP Claims Management Section).

Payment Advances:

While in the PCIP, physicians will be provided with payment advances. This will serve to minimize any disruption to cashflow.

Exit from the PCIP:

The PCIP is designed to be a short term measure to ensure billing patterns comply with the requirements of the MCP Medical Payment Schedule. Physicians shall remain in the program until it is determined that their billings for two successive pay periods are in keeping with these requirements.

Non-Compliance:

For cases where the physician does not conform to the billing requirements of the MCP Medical Payment Schedule within a reasonable time frame, the physician may be subject to further action as determined by the Medical Consultants Committee (e.g. continuation in the PCIP, comprehensive audit, opting out, reduction of billing by formula, legal activity, etc.).

Statistical monitoring:

Physician billings will be monitored for a period of one year following exit from the PCIP. Physicians who demonstrate patterns or practices that are not in keeping with the requirements of the MCP Medical Payment Schedule will be re-entered into the program as deemed necessary.

COMPREHENSIVE AUDIT

If the Education Records Review stage indicates **significant** discrepancies, a much larger sample will be randomly selected for verification. The size of the sample is determined by a statistical formula. The period of audit for the comprehensive stage is normally two years.

Depending on the situation, records can be obtained by two means. The physician may be required to provide photocopies of the sampled records of service. These copies can be mailed or hand delivered to the Audit and Claims Integrity Division within the time limit specified on the request.

In other cases, the Audit and Claims Integrity Division may deem it necessary to retrieve the sampled records of service on-site by a team of medical audit staff. During the course of an on-site Audit, the medical audit team retrieves and copies sampled records of service from the patient charts and depending on the situation may interview selected beneficiaries, interview the physician's staff, and perform other actions as deemed appropriate.

The records of service obtained by either method are reviewed by the Audit and Claims Integrity Division in conjunction with the Medical Consultant to Audit.

If the records combined with any other supporting evidence substantiate the physician billings, the audit is closed and the physician is notified of the findings. In cases where a small percentage of misbilling is found, a direct recovery (claims adjustment) is made and the physician is given instructions on proper billing procedures either by letter or in person.

If there is significant misbilling, the findings are extrapolated over the population of claims under audit and the physician is notified of the audit findings or the case proceeds to the Medical Consultants' Committee.

PHYSICIAN INTERVIEW

Before the information obtained in the comprehensive stage of the audit is finalized or presented to the Medical Consultants' Committee, physicians under audit may be contacted and given the opportunity to attend an interview with Audit and Claims Integrity staff. At this interview, the Medical Audit Manager and the Medical Consultant to Audit discuss the issues which were identified during the course of the audit. Physicians are offered the opportunity to respond to these issues by providing explanations and further information.

If the case is to go to the MCC the Audit and Claims Integrity Division will inform the physician of his or her right to make a written submission to be presented to the Medical Consultants' Committee for their consideration.

MEDICAL CONSULTANTS' COMMITTEE

Where significant service pattern deviations occur and substantial numbers of claims cannot be supported by record notations, or where significant discrepancies are detected, such cases may be referred for professional review by the MCP Medical Consultants' Committee.

This Committee is currently comprised of 10 members including 5 physicians nominated by the NLMA, the Medical Consultant to Audit, Medical Director and Dental Director and Medical Consultant to the Department of Health and Community Services, and a private industry chartered accountant. Its mandate is to assess and make recommendations with regard to cases of physician and beneficiary over-utilization, inappropriate billing and/or abuse.

The Committee is utilized by the Audit and Claims Integrity Division for audit cases where the Audit and Claims Integrity Division and the Medical Consultant to Audit feel that the input of this professional peer group would be beneficial. This usually occurs where there are new, complex or contentious billing issues.

NOTE: The Department is planning to reduce the number of members on this Committee, and is redefining the quorum in an effort to bring audits to conclusion in a more timely fashion.

NOTIFICATION OF RECOVERIES

The recommendations of the Audit and Claims Integrity Division are presented to the Minister of Health and Community Services. Where the Minister finds that an inappropriate pattern of practice exists or that certain services have been improperly billed or cannot otherwise be substantiated, the Audit and Claims Integrity Division may be issued a Ministerial Order instructing the Division to notify the physician of the Department's intention to undertake a recovery of funds.

Audit periods are normally two years but may vary depending upon any or all of the following factors:

- effective date of payment schedule conditions, legislative provisions or other agreements
- effective date of commencement of practice
- effective date of commencement of billing for service(s) in question; and

The actual amount to be recovered will be based upon the percentage of unsubstantiated claims within a statistically valid sample of all claims for one or more fee codes during the audit period.

Should the audit findings indicate fraudulent activity, the Audit and Claims Integrity Division consults with the Justice Department who may in turn request a police investigation.

Should the audit findings indicate practices unbecoming a physician or practices which endanger the public, Audit and Claims Integrity Division reports its findings to the Newfoundland Medical Board.

It should be noted that other penalties may also be applied in accordance with the Medical Care Insurance Act. These are as follows:

- imposing a ten percent financial penalty;
- deeming the physician to be non-participating;
- reducing the amount payable for insured services.

Alternate Dispute Resolution (ADR) Process

Alternate Dispute Resolution is an alternative for resolving issues between the Audit and Claims Integrity Division and the physician.

The intent of the Alternate Dispute Resolution is to:

- encourage a cooperative climate,
- achieve fair and appropriate settlements, and
- avoid the excessive financial, psychological, and procedural costs associated with formal court proceedings.

As outlined in the notification letter, ADR must be requested by the Physician within 30 days from the date of the notification letter.

The ADR Process has a maximum 90-day time limit from the date of notification.

As an example of how ADR could work given a specific circumstance:

A physician is audited and the findings result in a recovery that would have the effect of reducing the physician's earnings below that of a salaried physician in a similar practice (patient load / hours of operation, etc.). The salaried amount would represent the floor, below which the physician's earnings could not be reduced. Through negotiation a reasonable recovery amount could be determined.

In the event that an agreement is reached, any necessary adjustments to the recovery amount will be made accordingly. The audit will then proceed to the recovery stage as part of the ADR agreement, and the Physician will waive the right to appeal the audit findings to the Audit Review Board.

If a mutually acceptable agreement is not reached within the 90-day time limit, the conclusions and recovery amount stand and the audit will proceed to either recovery or a hearing before the Audit Review Board.

HEARING BY AUDIT REVIEW BOARD

In accordance with the Medical Care Insurance Act, upon notification of intent to proceed with a recovery, the physician in question may make written representation of his/her position and request a hearing before a Review Board. Representation may also be made in writing by the Newfoundland Medical Association.

The Review Board shall consist of three members. From a review panel consisting of up to fifteen members, one member is appointed by the Minister, one member is appointed by the physician under audit, and the third member is jointly appointed by the Minister and the physician.

The members of the Board are selected from a Review Panel of up to fifteen members who are appointed by the Lieutenant-Governor In Council. Five of these members are physicians and two of these members are dentists. They are selected from lists of nominees provided by the NLMA and the NDA respectively.

At the Hearing, the physician, witnesses (if any), and the Audit and Claims Integrity Division present oral and documentary evidence. The Committee considers all of this information and presents a written report with recommendations to the Minister.

MINISTERIAL ORDER

After considering any representations made by the physician and/or the NLMA, the report of the Review Board (if a hearing was held), the recommendations made by the Medical Consultants' Committee (if any) and the recommendations of the Audit and Claims Integrity Division, the Minister may:

- withhold from the provider all or part of the money which has been claimed
- estimate and impose on the provider a penalty of an amount not exceeding the amount of a loss sustained by the Crown together with 10% of the amount of the loss
- consider the provider to be non-participating for the purposes of the Act either permanently or for the period specified in the order
- reduce the amount payable to a participating provider for insured services by a percentage for a period specified in the order.

APPEAL TO SUPREME COURT TRIAL DIVISION

A physician aggrieved with the Ministerial Order may file notice of appeal within sixty days from the date on the Ministerial Order to a judge of the Supreme Court (Trial Division).

The judge will hear the appeal and the evidence brought forward by the physician, Crown and the Minister. After considering all factors, the judge may:

- uphold the Ministerial Order,
- amend the Ministerial Order,
- revoke the Ministerial Order, or
- make another decision as deemed appropriate.

Further appeal may be made to the Court of Appeal and the Supreme Court of Canada.

PHYSICIAN CLAIMS AUDIT PROCESS - FLOW CHART



Charts.ppt

The attached flow chart has been prepared in an attempt to present in logical sequence, the various steps and actions which are normally followed in relation to audits of physician claims.

Where exceptional circumstances apply, the procedures or investigative methods outlined in these charts may be modified to some extent.

BENEFICIARY AUDIT PROGRAM

Beneficiary Utilization Audits are those which are conducted in order to determine whether high utilization by beneficiaries may be categorized as 'legitimate illness' or program abuse. In these instances, where it is determined that a significant number of services are of questionable medical necessity, physicians may be asked to provide all claim-related information on beneficiaries for a specific period of time. Physicians may also be asked to provide comments regarding the beneficiary's use of the program. This intervention process may also include meetings with the physician and beneficiary in order to review the utilization pattern and explore alternative means of medical care.

Preliminary determination of illness or abuse will be made by the Medical Consultant to Audit or in some instances by the Medical Consultants' Committee based upon the information and comments received from physicians.

Where there is strong evidence of abuse by beneficiaries supported by information to this effect from physicians, the beneficiaries are written, informed of the problem and told of the intent to monitor future utilization. They may also be required to repay any amounts paid by MCP on their behalf for unnecessary medical services.

Where there is strong evidence of overservicing by a physician, the physician claims for services may be subjected to a Physician Medical Audit. Beneficiaries who are suspected of fraudulent use of the program are reported to police authorities for investigation.

In cases where the beneficiary does not reduce utilization levels after intervention by the Audit and Claims Integrity Division, the individual may be entered into the Beneficiary Claims Intervention Program (BCIP). Under BCIP, payments for all claims on behalf of the beneficiary are held pending a review of the physician's record of the service, the utilization levels of the patient, and any other applicable information. Claims are reviewed by the Medical Consultant to Audit, and the Medical Consultants Committee in some cases. Only those claims for medically necessary services are paid.

INFORMATION REGARDING RECORDS OF SERVICE

Record Requests

Record requests are an integral part of the audit process and in most medical audits, records form the basis for recovery through record review and the extrapolation of findings.

Record requests may be made in the following instances:

- as a result of discrepancies in information provided by beneficiaries compared with that which has been claimed

- when a physician service profile indicates that the physician billing deviates significantly from that of his or her peers
- when beneficiary utilization indicates possible program abuse
- when the physicians records, upon review, do not support the service billed necessitating a request for further records
- or other cases as deemed appropriate

With regard to sensitive patient care information, the following points should be considered:

- Photocopies of records pertaining to specific services may be requested but only that information which documents and substantiates the billing is required to be submitted. However, where beneficiary utilization is being audited, physicians may also be asked to provide voluntary comment or additional information with respect to the legitimacy of the beneficiary's medical service needs.
- All services are subject to audit. Certain services are more likely to contain sensitive information than others. Notations of sensitive information are not normally required unless they form an integral part of the documentation which substantiates the service claimed. Where such notes are not essential for service verification they may be withheld or sent directly to the Medical Consultant for his review.

In certain instances, entire patient charts will be requested in order to investigate a mode of treatment or pattern of servicing / utilization.

Where physicians fail to comply with requests for records within clearly prescribed time limits without reasonable explanation, claims from the sample selected will be deemed to be unsubstantiated.

The purpose of a request for record information is to substantiate a statistical sample of a broader base of claims which appear to have been misbilled. There are significant consequences for not providing the required information. The sample size in the Comprehensive Stage is determined from the entire base of claims by an established and proven extrapolation methodology. Therefore, any claims not submitted will have a significant impact upon the overall percentage of unsubstantiated claims, since records that have not been submitted are considered to be unsubstantiated claims.

In the case of chronic patient abuse, the legitimacy of a patient's many requests for service, usually to a large number of physicians, must be verified. While there may be no initial indication of misbilling and therefore no intent by the Audit and Claims Integrity Division to recover monies from the physician(s), a refusal to provide required claim information will lead to cancellation and recovery.

Record Copy Protection / Disposal

Record information requested for audit purposes is considered by the Audit and Claims Integrity Division to be highly confidential and is subject to strict control. It is held under secure conditions until the completion of the audit. It is not otherwise distributed, unless presented through a report to Medical Audit Management, the Medical Consultant to Audit, or the Medical Consultants' Committee.

Upon completion of audits, where billings are found to be in order or subject to minor claim adjustments (majority of cases), records are shredded by the Audit Manager.