101: The Dirty Dozen of Coding Documentation Compliance

HCCA: Clinical Practice
Compliance Conference
10/13/14

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Disclaimer

- This material is designed to offer basic information for coding and billing and is presented based on the experience, training and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the presenter does not accept any responsibility or liability with regards to errors, omissions, misuse, or misinterpretation. This presentation and handout is intended as an education guide only.

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Outline

- Introduction
- The Dirty Dozen
- Compliance Oversight & Best Practices
- Resources & Links

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Introduction

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FY 2013 Recoveries

FY 2013 HCFAC Program Report:

- $3.8B –Department of Justice (DOJ) settlements & judgments
  - $2.6B related to healthcare fraud
  - ROI = $7.90 for every $1 spent

Recovery Audit Contractors (RAC) Total Corrections:

- FY 2014:$2.2B (Oct –Jun 2014)
- FY 2013: $3.8B

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Comprehensive Error Rate Testing (CERT)

Year	Error Rate	$Billion
FY 2008	3.6%	$10.4
FY 2009	10.8%	$39.8
FY 2010	9.1%	$29.7
FY 2011	8.6%	$28.8
FY2012	**8.5%**	**$29.6**
FY 2012: $349.7 B Total Medicare Payments		

TARGET:
FY2013= 8.3%
FY2014= 8.0%
FY2015= 7.5%

Source: PaymentAccuracy.gov

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OIG Strategic Plan 2014 - 2018

U.S. Department of Health and Human Services Office of Inspector General (OIG):

Four Goals

1. Fight Fraud, Waste, and Abuse
2. Promote Quality, Safety, and Value
3. Secure the Future
4. Advance Excellence and Innovation

https://oig.hhs.gov/reports-and-publications/strategic-plan/files/OIG-Strategic-Plan-2014-2018.pdf

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2014 OIG Work Plan & E/M Services:

Reports to be published in FY2014:

1. E/M Use of Modifiers During the Global Surgical Period
2. Error Rate for Incident-To Services Performed by Nonphysicians

Repeated in FY2014 Work Plan: (Billing and Payments)

1. E/M Services Inappropriate Payments
2. Physicians Place-of-Service Coding Errors

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The Dirty Dozen
(and a few more.....)

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Documentation

- 1995 vs 1997 guidelines?
- Mix and match?
  - HPI-3 chronics/status
- Exam
  - General Multi-System Exam
  - Specialty specific?
  - Systems vs. Areas
- Check with your MAC

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Documentation

- HPI -Using check off boxes to validate HPI obtained by staff
- Reference to:
  - Previous ROS/PFSH
  - "Changes as noted on form", "unchanged"
  - "Previous examination
  - Remaining ROS – "All others negative"
- PFSH – "non-contributory", "unremarkable", negative (for what?)
- History unobtainable (why?)
- Exam – "rest of exam essentially negative"

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Documentation: Paper Templates

- Circles? Slash Marks? Straight Lines?
- Cross-outs?
- Check-offs?
- Boxes?
- Abnormals – no details
- Signature, date and LEGIBLE name of provider with credentials
- Signature Log?

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E/M Codes

- "All of my new patients are consults"
- Preventive vs. Problem
- Inpatient vs. Outpatient (Observation)
  - Hospital Status Impact for Physicians
  - MAC Prepayment Review Hospital & Physician
- Cluster coding (Presumptive Coding)*
  - Fear of the "F" word
  - Confusion

*OIG's Compliance Program for Individual and Small Group Physician Practices Published in the Federal Register, Volume 65, No. 194, Thursday, Oct. 5, 2000 Pages 59434 – 59452:

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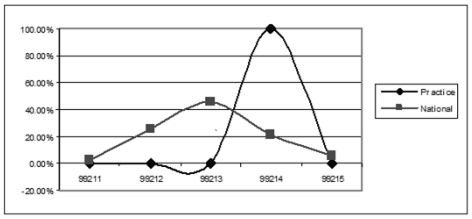
"Presumptive Coding" All Visits Level 4

- Only using one level of an E/M service in a category, will increases the risk for audit
  - The physician is using CPT 99214 **385% more often than his national compare group**, significantly increasing his risk for third-party audits.



*One physician can get the whole practice audited.

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Under-Documentation High Level Codes

Issue	Level 4 and 5 consultations/new patient office visits and level 2 and 3 admission requirements not documented.
Solution	▪ All require documentation of comprehensive **exam and** comprehensive **history**. ▪ Without it, the service billed cannot be higher than level 3 consultation/new patient visit and not higher than a level 1 initial hospital care.

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New Patient Visit Level 4 Surprise

- If 99205 (99245, 99255) = **Comprehensive** History and Exam and **High** MDM:

OP	**99201**	**99202**	**99203**	**99204**	**99205**
History	PF	EPF	D	C	**C**
Exam	PF	EPF	D	C	**C**
MDM	SF	SF	L	M	**H**

PF= Problem Focused, EPF=Expanded Problem Focused, D=Detailed, C=Comprehensive, SF=Straightforward, L=Low, M=Mod, H= High

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Initial Hospital Visit Level 2 Surprise

- If 99222 = **Comprehensive** History and Exam and **Moderate** MDM:

Hospital Admission	**99221**	**99222**	**99223**
History	D/C	C	**C**
Exam	D/C	C	**C**
MDM	SF/L	M	**H**

PF= Problem Focused, EPF=Expanded Problem Focused, D=Detailed, C=Comprehensive, SF=Straightforward, L=Low, M=Mod, H= High

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Under-Documentation Comprehensive Exam

Issue	Under-documenting comprehensive exam needed for level 4 and 5 consultations/new patient office visits and level 2 and 3 initial hospital care.
Solution	▪ '95 DG Multi-system exam: 8 or more organ systems. Cannot combine with body areas (Organ systems include **Const., Eyes, ENT, Cardio, Resp, Gastro, GU, Musc, Skin, Neuro, Psych, Hem/Lymph**) ▪ '97 DG General Multi-system exam: Perform all bullets from at least 9 systems/areas, and document at least 2 bullets from EACH of 9 systems /areas.

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Under-Documentation History: ROS

Issue	Under-documenting comprehensive history needed for level 4 and 5 consultations/new patient office visits and level 2 and 3 initial hospital care.
Solution	▪ ROS – complete review of system (at least 10) is reviewed. ▪ **"all other systems negative"** shortcut: "At least ten organ systems must be reviewed. Those systems with positive or negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such notation, at least ten systems must be individually documented".

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Under-Documentation History: PFSH

Issue	Under-documenting comprehensive history needed for level 4 and 5 consultations/new patient office visits and level 2 and 3 initial hospital care.
Solution	▪ PFSH- need 3 elements (Past, Social and **Family** History). ▪ *** Don't use the term "unremarkable" or "non-contributory", as these can be flags that you skipped family history. ▪ **Use: "Family history reviewed and negative for cardiovascular disease".**

***** There are exceptions to this rule for certain payers (Novitas)**

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MDM Documentation

- Medical Decision Making
  - No diagnosis
  - Unclear diagnosis – HA, HTN, DM
  - No status
  - Medical necessity for diagnostic tests (rule-outs ok – but not on claim form!)
  - No plan of care/follow-up treatment
  - Failure to document prescriptions prescribed or sample prescription drugs given to patient

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Medical Necessity: Overarching Criterion

Issue	Over-documentation of E/M service when the presenting problems, patient acuity or decision-making complexity supports a lower level code.
Solution	▪ "Medical necessity of a service is the **overarching criterion** for payment in addition to the individual requirements of a CPT code." ▪ " It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted." ▪ " The **volume of documentation** should not be the primary influence upon which a specific level of service is billed. ▪ Documentation should support the level of service reported."

Source: Medicare Claims Processing Manual, Pub.100-04, Chapter 12, §30.6.1.A

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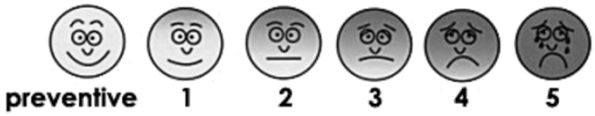
Medical Necessity: Presenting Problem

- Presenting problem- how sick is the patient?
- Review Clinical Examples CPT Appendix C
- New Patient Visits:



Source: Wong Baker Faces Pain Scale

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Time Based Codes

- **Counseling/Coordination of care**
- **Prolonged services**
- **Discharge Services**
- **Critical care**

Other Timed Non-E/M services

- Physical therapy
- Nutrition counseling
- Psychotherapy
- Surgical complications
- Infusions
- Re-programming services

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When Time is Dominant Factor

- Total time of face-to-face encounter
- More than 50%
- Sufficient documentation to describe the counseling/coordination of care discussion
  - Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reductions or discussion with another health care provider.
- Example:

" Total time spent with patient was 65 minutes of which more than half was spent discussing causes, treatment and prevention of gout. A list of foods to avoid was provided.

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Signature Requirements Change in CERT Reporting

- Strict enforcement of Signature Requirements
  - Medicare requires that services provided/ordered be authenticated by a legible identifier; and
  - Stamp signature are not acceptable***

*** Can use a stamp to provide legible identity in addition to required signature

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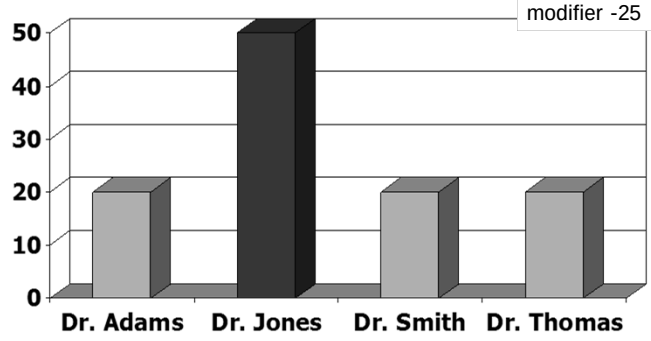
Modifier -25



October 2012: Georgia Cancer Specialist $4.1M settlement for misuse of modifier -25

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Incident-to Risk Areas

- 2013 and 2014 OIG Work Plan
  - Previous Work Plans: 2012, 2007-2009, 2004, 2003 & 2001
- Applying "incident-to" billing regulations to the institutional settings (i.e. hospitals or skilled nursing facilities);
- Billing "incident-to" for new patients, or established patients with new chief complaints; and
- Billing incident-to when services provided by unqualified staff

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Incident-to Basic Requirements

1. Physician Office
2. Employment Status
3. Direct Supervision
4. Integral Incidental
5. Prior Physician Service

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Shared Visits
Facility Setting (Hospital)

1. MD and NPP
2. Employment Status
3. Medically Necessary
4. Same Calendar Day
5. MD Document Face-to Face

Note: Physician Office: Incident-to Applies

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Scribing

- If a nurse or NPP acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note "written by X, acting as scribe for Dr. Y." Then, Dr. Y should co-sign, indicating that the note accurately reflects work and decisions made by him/her.
- Record entries made by a "scribe" should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter documentation requirement.

Source: First Coast Service Option, Part B Update Third Quarter 2006. Check your carrier for specific instructions.

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Global Days & Payment

- **CPT 22612 Lumbar Fusion**
  (Arthrodesis, posterior or posterolateral technique, single level; lumbar)
  - **"090" or 90 days.**
  - **$1,659.50 Total Medicare Payment**

Pre op	Intra op	Post op
10%	**69%**	**21%**
$ 165.95	$1,145.06	$348.50

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Critical Care Requirements

Critical Care services requirements:

1. Reasonable and medically necessary;
2. Clinical Condition;
3. Treatment Criteria; and
4. Documentation of Time

- If the services are reasonable and medically necessary but do not meet the criteria for Critical Care services, they should be coded as another appropriate E/M service (e.g., subsequent hospital care, CPT codes 99231–99233

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Critical Care Clinical Condition Criteria

The criteria for defining a critical care condition:

- High probability of sudden, clinically significant or life threatening deterioration in the patient's condition
- The condition requires the highest level of physician preparedness for urgent intervention.

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Critical Care Treatment Criteria -Full Attention

- Require a physician's direct personal supervision and management of life- and organ-supporting interventions that may require frequent manipulation by the physician
  - Without care on an urgent basis ----------likely result in sudden, clinically significant, or life-threatening deterioration in the patient's condition.
  - The physician must devote his or her full attention to the patient and therefore cannot render E/M services or other services to another patient during the same time period.

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Electronic Medical Records (EMR): Potential Problems: "Cloning"

Cloned records – OIG Work Plan 2012-2013-2014

- "Over-documentation" – not medically necessary
- Record for a beneficiary is worded exactly like or similar to the previous entries
- Medical documentation is exactly the same from beneficiary to beneficiary

  i.e. the whole history of present illness (HPI) into the note from previous visit
- Auto Population -Were services provided?
  - Conflicts with ROS and patient history and/or presenting problem

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EMR- Example: Cloning / Copy & Paste

- Full ROS every visit
- Comprehensive exam every visit
- Same HPI every visit
- Example: CC by nurse – "Nausea and vomiting for 3 days
  - Copied and pasted by nurse from prior visit every time

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EMR-Potential Problems: Authentication

- Danger to Physicians and Providers?
  - Configured by vendors
- Authentication and amendment/correction issues
  - Are users authenticated when entering data in different part of the record? (MA vs MD, NPP vs MD)
    - Name/date/time of individual entering information into electronic record
    - Failure to document review of information obtained by ancillary staff (PFSH/ROS)

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EMR- Example: Conflicting Data

- Example: CC: Patient presents today c/o chest pain
  - HPI: Pt. denies C/P, SOB…….
- Example: HPI: Patient noticed mild pain, right calf X 1 week
  - ROS: Pt. denies muscle or joint pain

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EMR- Example: Carry Over Data

- Carryover of ROS/PFSH every visit
  - Provider billed 99215 just to refill an Rx
  - Spoke to patient over the phone and billed a 99215
- Patient seen in clinic for 4 visits over a period of 5 months
  - PAP smear on every visit

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EMR- Example: MDM Diagnosis

- Listing every diagnosis that patient has ever had on every encounter
- Unrelated diagnoses
- No longer valid diagnoses
- Not significant to the reason for the encounter or presenting problems
- Not every co-morbidity was reviewed!

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Compliance Oversight & Best Practices

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Compliance Oversight?

- No compliance buy-in or vested interest
  - "I employ a certified coder"
  - "My office manager handles it"
  - "We use an EMR system"
- No plan
- Plan but not used
- Plan but not effective
- Plan overkill
- No preventive measures – internal/external

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Compliance Oversight? If Not Get Help

- Providing resources
  - Continuing education
    - For entire staff (both clinical and administrative)
  - Books, manuals, authoritative advice
- Being inflexible
  - "I'm a physician – not a coder"
  - "This is all ridiculous"
  - "This takes too much time"
  - "Too confusing"
- **We agree, but not an option – GET HELP!**

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Best Practice: Review Your Coding

- Know each physician's work RUVs, and compare to the other physicians in practice and also benchmarks by specialty (MGMA?);
- Use audits to assess the documentation for every physician in your practice;
- Document any issues identified and the training provided;
- Be certain your compliance plan adequately address E/M services and non physician practitioners and make sure to do frequent monitoring and follow up; and
- Providers should have their teams in place and procedures for dealing with the virtually inevitable interaction with the audit organizations such as the RACs and MACs.

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Resources & Links

- CMS Provider e-News
- Review Sources for Audit Concepts
- E/M
- Modifiers & Global Surgery
- Signature Requirements
- CMS Booklet for APNs & PAs

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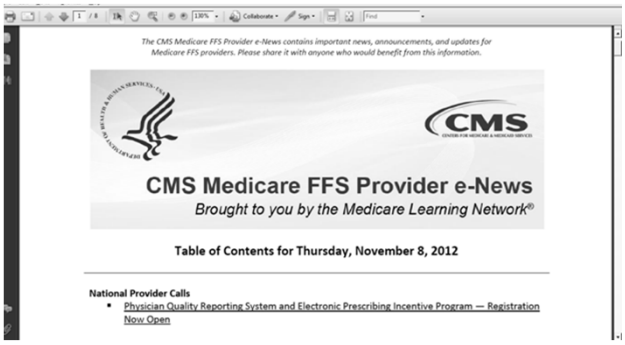
CMS Medicare FFS Provider e-News


The CMS Medicare FFS Provider e-News contains important news, announcements, and updates for Medicare FFS providers. Please share it with anyone who would benefit from this information.

CMS Medicare FFS Provider e-News

Brought to you by the Medicare Learning Network®

Table of Contents for Thursday, November 8, 2012

National Provider Calls

- Physician Quality Reporting System and Electronic Prescribing Incentive Program — Registration Now Open

Use this Link To sign up for CMS e-News:
https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819

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OIG Provider Education Resources

- Compliance Education Materials for Physicians
  http://oig.hhs.gov/compliance/101/index.asp
- Academic Medicine (August 2013): "Expanding Physician Education in Healthcare Fraud & Program Integrity" https://oig.hhs.gov/compliance/compliance-guidance/compliance-resource-material.asp
- Federal Register, Volume 65, No. 194, Oct. 5, 2000 Pages 59434 – 59452: "OIG Compliance Program for Individual and Small Group Physician Practices"
  http://oig.hhs.gov/authorities/docs/physician.pdf

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Audit Concepts Sources

- OIG Work Plan
  http://oig.hhs.gov/reports-and-publications/workplan/index.asp#current
- CMS Medicare Quarterly Provider Compliance Newsletter http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf
- CERT Reports
  https://www.cms.gov/CERT/10_CERT_Reports_and_Data.asp
- CMS Publications & Manuals
  https://www.cms.gov/manuals/downloads/clm104c12.pdf
- NCDs & LCDs

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E/M Resources

- CMS 1995 & 1997 Documentation Guidelines for E/M Services:
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html
- CMS Internet Only Manuals (IOM) Medicare Claims Processing Manual (MCPM) Publication 100-04, Ch.12:
  http://www.cms.gov/manuals/downloads/clm104c12.pdf
  (Guidelines for EM code categories etc.)
- CMS Internet Only Manuals (IOM) Medicare Benefit Policy Manual (MBPM) Publication 100-02, Ch.15: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
- OIG's Compliance Program for Individual and Small Group Physician Practices Published in the Federal Register, Volume 65, No. 194, Thursday, Oct. 5, 2000 Pages 59434 – 59452:
  http://oig.hhs.gov/authorities/docs/physician.pdf

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Modifier -25 Resources

- The Center for Medicare and Medicaid Services (CMS) Transmittal 954,CR 5025 and MLN Matter MM5025:
  "*Payment for Evaluation and Management Services Provided During Global Period of Surgery*", May 19, 2006
  https://www.cms.gov/transmittals/downloads/R954CP.pdf
- Medicare Claims Processing Manual, Chapter 12, Sections:
  - 30.5 – "Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions" and
  - 200 – "Allergy Testing and Immunotherapy"

  http://www1.cms.gov/manuals/downloads/clm104c12.pdf
- Office of Inspector General (OIG) Report:
  "Use of Modifier 25" November, 2005
  https://oig.hhs.gov/oei/reports/oei-07-03-00470.pdf
- Office of Inspector General (OIG) 2013 Work Plan:
  https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf

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Modifier -59 Resources

- The Center for Medicare and Medicaid Services (CMS):
  "*Article on Modifier -59":*
  http://www4.cms.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf
- Office of Inspector General (OIG) Report on Modifier -59:
  http://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf
- CMS MLN Matter SE0715: "Proper Use of Modifier "-59":
  http://www.cms.gov/MLNMattersArticles/downloads/SE0715.pdf
- CMS Frequently Asked Questions: *Modifier -"59"*:
  http://questions.cms.hhs.gov/app/answers/detail/a_id/3514

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Global Surgery Resources

- CMS Manual System, Pub.100-04, Medicare Claims Processing Manual, Chapter 12, 40.1.Definition of Global Surgeries Package. http://www.cms.hhs.gov/manuals/Downloads/clm104c12.pdf
- Office of Inspector General (OIG) report on modifier -25. http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf
- Transmittal 954, dated May 19, 2006 clarified when and how to use modifier -25 during the global period including how to document its use. http://www.cms.hhs.gov/transmittals/downloads/R954CP.pdf
- Medicare Carrier, NHIC, Corp Global surgical calculator http://www.medicarenhic.com/providers/billing/billing_calc_global_period.html
- Medicare Claims Processing Manual: Chapter 23 - Fee Schedule Administration and Coding Requirements http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf
- Office of Inspector General (OIG) report on evaluation and management services included in eye and ocular adnexa global surgery fees http://www.oig.hhs.gov/oas/reports/region5/50700077.pdf

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Signature Requirements

- CR6698, issued to your Medicare FI, carrier, A/B MAC, RHHI or DME MAC regarding this change may be viewed at:
  - http://www.cms.gov/Transmittals/downloads/R327PI.pdf on the CMS website (3/16/2010).
  - MM6698 Revised, April 26, 2010

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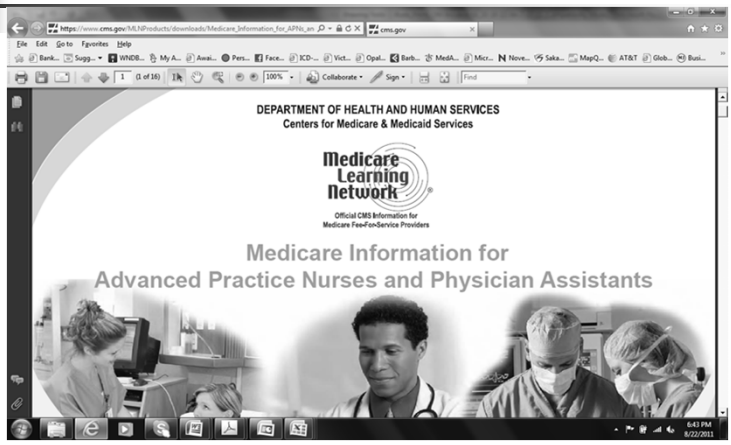
CMS Booklet for APNs & PAs



https://www.cms.gov/mlnproducts/70_apnpa.asp

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Questions?

Thank you!

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