Coding, Billing and Documentation
Where Are You in the Compliance Maze?

HEALTH CARE COMPLIANCE ASSOCIATION
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Disclaimer

A presentation can neither promise nor provide a complete review of the myriad of facts, issues, concerns and considerations that impact upon a particular topic. This presentation is general in scope, seeks to provide relevant background, and hopes to assist in the identification of pertinent issues and concerns. The information set forth in this outline is not intended to be, nor should it be construed or relied upon, as legal advice. Recipients of this information are encourage to contact their legal counsel for advice and direction on specific matters of concern to them.
Program Objectives

- Become familiar with common areas of audit exposure specific to coding and billing
- Learn insights regarding identifying coding errors and ways to avoid negative audits
- Learn practical approaches in conducting reviews and recognize areas that can be changed
- Review case examples, audit tools and suggestions for compliance improvement
Agenda

○ Compliance Risk Areas Unique to Coding and Billing
  ● Forms and Documents
  ● CPT/HCPCS Codes/Modifiers
  ● Place of Service Codes
  ● Midlevel Practitioner Services
  ● Other Considerations

○ Scenarios/Identifying Errors

○ Tools and Approaches for Improvement

○ Questions/Discussion
Spotlights in Healthcare

Escalating:
- Costs
- Expenditures
- Patient Demands/Quality of Care
- Technology Advances
- Health Insurance Premiums
- Standards and Regulatory Burdens
- Litigation
- Audits/Scrutiny
- Others
Compliance Program Guidance

- Clinical Laboratories
- Hospitals
- Home Health Agencies
- Third Party Medical Billing Companies
- Durable Medical Equipment (DME) Suppliers
- Hospices
- Medicare + Choice Organizations
- Nursing Facilities
- Individual and Small Group Physician Practices
- Ambulance Suppliers
- Pharmaceutical Manufacturers
OIG Compliance Guidance

- Potential Risk Areas
  1. Coding and billing
  2. Reasonable and necessary services
  3. Documentation
  4. Improper inducements, kickbacks and self-referrals
Claim Form – Accuracy of Information

- Uniform Health Insurance Claim Form
  - Paper claim or electronic claim
  - CMS-1500/UB-92 Claim Form

- Required use

- DATA COLLECTION

- Certification/Attestation of claim information
The Coding, Billing, Documentation and Reimbursement Process

- **Revenue Cycle**
- **TEAM APPROACH**

  - Patient Registration
  - Patient Services
  - Patient Accounts Management
  - Code Selection & Billing
  - Payor Reimbursement
The Coding, Billing, Documentation and Reimbursement Process –
A Team Approach

- **GOAL:**
  Filing an “accurate” claim

- Commitment to getting it done, the right way
“Physicians and coders work autonomously, but depend on the professional expertise of the other. In other words, it’s a two-way street. Accuracy in the physician’s clinical documentation is paramount to the accuracy of coding. Doctors rely on coders to translate the clinical information to the numerical language of codes.”

John C. Nelson, M.D.
Past AMA President
The Coding, Billing, Documentation and Reimbursement Process

- How do errors/situations crop up?

- Old business adage – What gets watched gets managed

- Take action
  - Webster-
    - “a thing done”
    - “the accomplishment of a thing usually over a period of time, in stages, or with the possibility of repetition”
    - “the most vigorous, productive, or exciting activity in a particular field, area, or group”
The Coding, Billing, Documentation and Reimbursement Process

- Complexities of:
  - The healthcare industry’s coding, billing, and payment processes, and the entire regulatory environment
  - In some cases inconsistency, lack of clarity and frequency of changes to the regulations that present enormous challenges to those working in the industry
- Overpayment estimates, underpayments, providers are not reimbursed fully for the services provided
  - Both types of errors can be problematic
Office/Facility Forms

○ Concerns identified with various office/facility forms

- Charge Ticket/Encounter Form
- New Patient Registration Form
- Medical Record Templates/Computerized Record
Forms are useful tools if:
- They are used as intended
- They are completed

- What about blank forms in charts?
- What about a multiple page form?
- Date of service recorded – is it correct, is it complete?
  - 02/07
Office/Facility Forms - Continued

- Is the form signed?
- Are credentials of person completing form used?
  - CS
  - C. Swanson
  - Cynthia Swanson, RN

- Do you have a “master list” of names, initials and signatures for all persons routinely making entries in the patient record?
Encounter Form/Charge Ticket

- **CPT/HCPCS codes** listed on encounter form/charge ticket – Are they current and accurate?

- **Code Descriptions** – Are they accurate?

  - Encounter form lists
    - **71020 – Chest xray - 1 or 2 views**
    - CPT code 71020 is defined as, Radiologic examination, chest, **two** views, frontal and lateral
Understand the Intent of Code Use

- **69210 – Removal impacted cerumen (separate procedure), one or both ears**

- 2006 Coders’ Desk Reference Procedures
  “Under direct visualization, the physician removes impacted cerumen (ear wax) using suction, a cerumen spoon or delicate forceps. If no infection is present, the ear canal may then be irrigated.”

Lay description is Copyright 2005 Ingenix, Inc.
Encounter Form/Charge Ticket - Continued

Check:

✓ Medicare Local Coverage Determination (LCD) – may reflect:
  “Simple cerumen removal provided by the office staff is not separately billable and is included in the office visit”

✓ Other payor policies
  ✓ Specific criteria and/or coverage provisions
Encounter Form/Charge Ticket - Continued

- Integumentary
  - Repair – Simple
    - 12001 – Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
      - 12002 – 2.5 cm to 7.4 cm*
      - 12004 – 7.5 cm to 12.4 cm*
      - 12005 – 12.5 cm to 19.4cm*
    - *Code description errors in the length of repairs
Patient presents today after cutting finger while doing dishes. Upon examination there is a wound laceration on right index finger. Laceration length is approximately 1.3 cm. Wound examined, cleansed with Betadine solution, Neosporin applied and wound closed with adhesive strips. Last Tetanus shot was about 13 years ago according to patient. Td ordered. Patient instructed on wound care and to call if redness, swelling or fever develops.
This service was coded with:

- 12001- Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

Correct or Incorrect?

Apply Code Guidelines
Encounter Form/Charge Ticket - Continued

Understand the Intent of Code Use

Nursing Facility (NF) Services

- Subsequent Nursing Facility Visit billed incorrectly as Comprehensive Nursing Facility Assessment service
- 99301, 99302, 99303 billed
- Should have been 99311, 99312, 99313
- These codes are deleted in 2006 and have been replaced with new codes
- Spot check to ensure the 2006 NF service codes are being correctly used
Encounter Form/Charge Ticket - Continued

- List all levels of E/M codes

Example:
Orthopedic Practice Encounter Form
- Office or Other Outpatient Consultations
  - 99243 – Office Consultation-Low
  - 99244 – Office Consultation-Moderate
  - 99245 – Office Consultation-Complex
Encounter Form/Charge Ticket - Continued

- Does the form include a place to list modifiers?
- Who is responsible to assign modifiers?
- Use of 25 modifier
- Use of 57 modifier
- Use of 59 modifier
Modifier 25
- Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
- Key is having documentation to support “Significant” and “Separately Identifiable”
- Separate reimbursement for E/M service
Encounter Form/Charge Ticket - Continued

- Modifier 57
  - Decision for Surgery – An E/M service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.
  - Key is having documentation to support “initial decision”.
  - Separate reimbursement for E/M service.
Modifier 59
Distinct Procedural Service – Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day.

- Used to report services that are not normally reported together
- Different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate injury
- Separate reimbursement for procedure or service
Encounter Form/Charge Ticket - Continued

- Does the form list the most frequent ICD-9-CM codes?
  - Include blanks for additional/other diagnosis information
  - Use of ICD-9-CM “Cheat Sheets”
  - “Good Pay” Diagnosis
Encounter Form/Charge Ticket - Continued

- **Mandated for claims submission**
  - ICD-9-CM code must be linked to CPT code
  - ICD-9-CM codes support medical necessity of services

- **Payor edits**
  - Presence of ICD-9-CM code
  - Invalid code
  - Truncated code
  - Code/age conflict
  - Code/sex conflict
  - E code as principle diagnosis
New Patient Registration Form

- Patient Demographics
- Insurance and Billing Information
- Form can include:
  - Review of Systems (ROS)
  - Past Medical History, Social History, and Family History (PFSH)
  - Other Pertinent Medical Information
New Patient Registration Form

- If a new patient registration form is used to capture history information, the form should include areas for:
  - Practitioner signature and date or alternately,
  - Practitioner notation supplementing or confirming information by others
  - Ancillary staff can assist by reviewing the form with the patient to help ensure completion
  - Initiation of Form and update/revision dates
New Patient Registration Form

- E/M Documentation Guidelines

- The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient or on behalf of the patient

  - To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others
New Patient Registration Form

Documentation Examples

- “The PFSH are all noted in the chart, in my handwriting, refer to new patient form.”

- “I have reviewed and noted the ROS and PFSH on the new patient form located in this chart.”
Medical Record Templates

- Are templates a good or bad thing?
- Templates, although helpful may trigger bad documentation habits
- Is the information recorded on the form unique to the patient?
Medical Record Templates

- Templates used to record exam component
- Slash marks, X’s, check marks - if checked, what do they mean?
- Results - positive or negative?
- Body area was checked with no documentation of finding?
- Exam is out of proportion to the nature of the visit
Medical Record Templates - Continued

- “Templates must make sense” – seems easy
- If a finding is abnormal, there must be some narrative description
- Several patients with identical exams for problems varying from simple to complex
  - Blood pressure follow up vs. abdominal pain, guarding, rigidity and fever
Evaluation and Management (E/M) Services

- CPT codes 99201 – 99499
- E/M (Visit) Services, includes:
  - Office or other Outpatient Services
  - Hospital Services
  - Consultations
  - Emergency Department Services
  - Preventive Medicine Services
  - Critical Care Services
  - Newborn Care
  - Others
Evaluation and Management (E/M) Services - Continued

- Highly utilized services by all specialties
- Pattern trending
- E/M Categories/Subcategories – codes depend on:
  - Type of service
  - Place of service
  - Patient status (new or established)
Evaluation and Management (E/M) Services - Continued

- Can be frequent errors with place of service codes especially,
  - 11 – Office
  - 22 – Outpatient Hospital
New Vs. Established Patients
CPT Definition

- **New Patient**
  - One who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

- **Established Patient**
  - One who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.
New Vs. Established Patient Documentation

- Supporting Documentation

  - “This is Nicholas’ first-time visit to the office.”
  
  - “Patient being seen for the first time to establish care.”
Encounter Dominated By Counseling/Coordination of Care - Continued

- E/M Documentation Guidelines
  - “In the case where counseling/coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital setting or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services”
Encounter Dominated By Counseling/Coordination of Care - Continued

- Documentation must
  - Reveal the total length of time of the encounter
    - Face-to-face in the office setting or
    - Floor/unit time in the hospital or nursing facility, as appropriate
  - Describe content of counseling or coordinating care
  - Suggest that more than half of time was spent counseling or coordinating care
Encounter Dominated by Counseling/Coordination of Care - Continued

- Supporting Documentation:
  - “25 minutes of 30 minute office visit spent on counseling parents regarding child’s condition, test results and treatment options........mother questioned......, it was decided to .......”
  - Code 99214 – typical time 25 minutes face-to-face with the patient and/or family
  - “Except for 5 mins.” for the exam, the 15 min. visit was spent on counseling. We discussed........”
  - Code 99213 – typical time 15 minutes face-to-face with the patient and/or family
Encounter Dominated by Counseling/Coordination of Care - Continued

- Subsequent Hospital Example:
  - “Spent 15 minutes (total visit) with patient and family discussing treatment options based on results of laboratory tests. I gave parents options of either ……., they wish to pursue………….”
  - Code 99231 - physicians typically spend 15 minutes at the bedside and on the patient’s hospital floor or unit
“I discussed at length with the patient and spouse the test results and treatment options. They have decided they would like to proceed with .....”

Rule of Thumb
- No reference to time in the record
- Cannot select E/M code based on time
Time-Based Services

- E/M Services – Counseling or Coordination of Care
- Critical Care Services
- Prolonged Services
- Psychotherapy Services
- Physical Therapy and Rehabilitation
- Physician Standby Services
- Case Management Services
- Care Plan Oversight Services

* Documentation of time in the medical record is required when performing time-based services
Consultations

- Request for opinion or advice regarding evaluation and/or management of a specific problem
  - NOT a transfer of care
  - “Referral” implies a transfer of care
- Code a new or established patient visit when a transfer of care is expected
- Consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit
Consultations – Continued

- Documentation requirements
  - **Request**: Written or verbal request for consult
  - **Render**: Consultant’s opinion and any services ordered or performed
  - **Report**: Written communication to requesting physician or other appropriate source
Consultations - Continued

○ What is the required support for a consultation?
  ● All three of the CPT E/M key components
    ○ History, Exam and Medical Decision Making
    ○ Alternatively, the level of service may be determined on the basis of time, when counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter
Consultations - Continued

Consultation Documentation Tips

- Use Form Heading depicting – “Consultation”

- Opening statement: “This is a request for consultation from Dr. __ regarding evaluation of ______”.

- History, Exam and Medical Decision Making documented

- Ending statement: “Thank you for allowing me to provide this consult”.

- Copy to _____
Consultations - Continued

Office record reflects:
DOS: 02/06.2006
Consultation

This patient was referred for evaluation of injury to left foot after being seen initially in the ER last evening. Patient fell down the last four steps at her home and injured left foot. Patient continues to have pain. X-rays done in ER did not reveal any fracture. Patient exam reveals.............. Ankle x-rays, 2 views ordered. Findings negative. Patient advised to apply alternate heat and cold to ankle area. May take Ibuprofen tablets for pain, as needed and to call if further problems develop.
X. Xwanon, MD

Consult?
Office visit?
New patient? Established Patient?
## Preventive Medicine Services

<table>
<thead>
<tr>
<th>New</th>
<th>Age</th>
<th>Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
<td>Under 1 yr.</td>
<td>99391</td>
</tr>
<tr>
<td>99382</td>
<td>1 – 4 yrs.</td>
<td>99392</td>
</tr>
<tr>
<td>99383</td>
<td>5 – 11 yrs.</td>
<td>99393</td>
</tr>
<tr>
<td>99384</td>
<td>12 – 17 yrs.</td>
<td>99394</td>
</tr>
<tr>
<td>99385</td>
<td>18 – 39 yrs.</td>
<td>99395</td>
</tr>
<tr>
<td>99386</td>
<td>40 – 64 yrs.</td>
<td>99396</td>
</tr>
<tr>
<td>99387</td>
<td>65 yrs &amp; older</td>
<td>99397</td>
</tr>
</tbody>
</table>
Preventive Medicine Services - Continued

- The “comprehensive” nature of the Preventive Medicine Service codes 99381-99397 reflects an age and gender appropriate history/exam and is NOT synonymous with the “comprehensive examination” required in E/M codes 99201 – 99350
Coding of a Problem During a Preventive Exam

- When a patient presents for preventive medicine service and a significant problem is encountered, an E/M (99201-99215) (with -25 modifier) may be billed in addition to the preventive medicine service.

- An insignificant or trivial problem / abnormality encountered during the preventive medicine service that does not require additional work and performance of key components of a problem-oriented E/M service should not be reported.
Non-Physician Practitioner Services

- Medicare Rules Specific to Split/Shared Care

- Consultations may not be billed as a shared E/M visit between a physician and a NPP.

- NPP can perform a consultation and bill under his/her own PIN number, state scope-of-practice laws permitting
Non-Physician Practitioner Services - Continued

- NPP work cannot be combined with a physician’s to bill a single, higher-level consult code as is permitted for regular, non-consult visits.

- NPP may request a consult and may also perform a consult and receive payment made at 85% of the PFS. But all the work must be performed by the NPP or all the work by the physician for 100% of the PFS. Consults are most often new patients except on occasion for a pre-operative consultation.
Non-Physician Practitioner Services - Continued

- Does not apply to critical care (a time based service) or consultation services or any other procedure codes (surgical services) or services in other places of service (i.e., SNF/NF, home care, domiciliary care)

- In the office/clinic area the incident to policy applies when an E/M service is split/shared and the patient must be an established patient
Non-Physician Practitioner Services - Continued

- Example of NPP errors identified during review:

- Billing NP services provided in the Emergency Room under the name/# of the physician

- Patient seen by NP and MD (split/shared service) and billed with consultation code
Letter Example Summarizing Scenario to the Medicare Carrier

Dear _____,
We have identified a billing error relating to how certain physician services were billed to _____, the Medicare carrier. As part of our ongoing compliance efforts, we have identified specific physician services provided by ______ for dates of service ______ that were billed under his/her Medicare performing (nonbilling) provider number _______ which is attached to ______ Medicare group number ____. We have set forth below background information, the corrective action taken and the corrections made. We have calculated a Medicare repayment in the amount of $____ based on _______. Our repayment calculation was based on dates of service _____ through ______. Enclosed is a check in the amount of $____. We regret any inconvenience this may cause, however look forward to resolution of this matter. If you have questions, please contact __________.
Other Considerations

- Is your coding/billing staff using internet listservs?

- Many use to discuss medical coding and billing questions/issues
  
  - Questions asked/situations explained
  
  - Accuracy of information/advice given?
Example:

“One of our doctors insists we are committing fraud and is telling another doctor we can’t do this. Here is the scenario........ Do you all see it the same way I do? Need second opinions. ”

ABC Clinic/contact name
Address
Phone
Example:

Q. “We want to know what to charge for Synvisc.”

A. “We bill 4.5 times the Medicare fee schedule, $__ for Synvisc and $__ for the administration. The cost of Synvisc is less than the Medicare fee schedule. We are making a great profit from private payors, especially xyz insurance.”
Other Considerations - Continued

Example:
Q. “Here is my problem with ZZZ insurance. They keep denying claims for ...... I think they are clueless and only do this to drive us crazy and put us over the edge. They need to get a life. Anyone else having problems with this issue?”

BBB Clinic/Contact Name
Address
Phone
Other Considerations - Continued

Example:
“My doctor says the injections he gives is a series of 3. He tells me to code an office visit with a modifier 25, the injection administration code (to the applicable area) and the drug code. He charges a visit each time. Is that what everyone is doing?”

TTT Clinic/Contact Name
Address
Phone
Burden of Proof

- In order for a claim for insurance benefits to be valid, medical records must contain sufficient documentation to verify the service billed.
- Medicare request for information and medical records pertaining to the submitted claim:
  - Prior to payment
  - Post payment
- Other payors may include specific review parameters outlined in their publications:
  - Use of 1997 E/M Documentation Guidelines
Proactive Approaches to Compliance

○ ACTION

○ TEAM APPROACH

○ Medical record basics as contained in the E/M Documentation Guidelines

○ Accurate coding is important whether it is reimbursed or not

○ Internal policies and procedures – spot check they are being followed
Proactive Approaches to Compliance - Continued

- At a minimum, annual review of forms

- Must have current coding and billing tools/resources

- **Routinely** route all Medicare and other payor bulletins
Proactive Approaches to Compliance - Continued

- Document and retain a record of all written and oral communication with payers if you intend to rely on that response for future direction
  - If it sounds too good to be true..................
- Internal reviews and feedback
- Communication
  - Front end and back end
- Ongoing education
Summary

How Do You Evaluate A Practice?

“Best Practice”

- Quality of Medicine
- Quality of People
- Compliance
- Productivity
- Profitability
Summary - Continued

○ **Bottom Line** –

- Code appropriately for services performed – filing an “accurate” claim
- Documentation for all services
- Receive the appropriate reimbursement for services
Live a good life and in the end, it’s not the years in life, it’s the life in years.
Abraham Lincoln