Documentation and Coding Compliance – Things to Consider in Audits and Reviews –

by

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Agenda

- Context
- Billing and Coding Systems (People, Review and Follow up Procedures, Controls, Tools) in the context of Compliance Program
- Internal reviews/centralized risk assessments and coding audits – pitfalls and opportunities
- Coding and billing monitoring versus auditing and escalation procedures
- Measures, metrics and trends
- IRO Claims Reviews Requirements – Worthwhile a Look
- Payor Refunds /Sampling Design
- Documentation Issues /Dos and Don'ts
- Documentation Risk Areas in Claims
- Takeaways
- Q/A
- Contact Information

Documentation and Coding Compliance in Context

- Documentation and Coding Compliance
  - Systems view.
  - Much more than just applying the correct CPT, MS-DRG, RUG, etc.
  - Focused on individual claim review and coding accuracy (pre).
  - Focused on documentation risk within the compliance program infrastructure, and controls.
  - Focused on coding with billing impact (post).
  - Focused on coding/documentation (pre) as monitoring strategy.
  - Process and transaction based issues.
  - Cost issues, budget issues.
  - Not increasing but reducing risk when implementing documentation and coding compliance strategies.
  - Problems often at the front and tail end of the review.
  - Seeing the big picture.

Billing and Coding Systems

- Billing and Coding Systems (People, Procedures, Controls, Tools) in the context of Compliance Program
  - Skilled staff, screened staff (objectivity, independence).
  - Review and follow up procedures & policies.
  - Controls.
  - Training.
  - Tools (templates, coding audit tools, web based tools, etc.)
  - EMR, billing system software.
- Stove piped approaches? Separation of duties?
- Review versus audit.
- Audit versus monitoring.
- What type of review (systems/transactions) are you doing, are you spelling out the review scope, is there a written audit plan?
  - Ad hoc, routine, focused, validation.

Centralized Risk Assessments and Internal Review

- CIA best practice: Internal reviews/centralized risk assessments.
- Coding reviews and audits are part of and overall compliance stance and oversight.
- Certain documentation expected (scoring, criticality, thresholds).
- Coding audits – pitfalls and opportunities:
  - Risk based auditing, where to spend resources.
  - Repeat work, learning nothing new. Wasteful.
  - Trends noted or not?
  - Coordination:
    - internal (operational monitoring)
    - Auditing (external/compliance)
  - Biggest pitfall: not noting/following up on trends
  - Biggest opportunity: 80/20 rule, reasonable approach and due diligence defense, resource efficient.
  - One control fix may remedy multiple root causes that will impact the claims.

Centralized Risk Assessments/Internal Review –cont'd.

- Centralized Risk Assessment on a annual basis warrants a cross-departmental discussion and coordination.
- Formalized approach with following steps:
  - (1) identify and prioritize risks,
  - (2) develop internal audit work plans related to the identified risk areas,
  - (3) implement the internal audit work plans,
  - (4) develop corrective action plans in response to the results of any internal audits performed, and
  - (5) track the implementation of the corrective action plans in order to assess the effectiveness of such plans.
- Risk identification and scoring of risk areas or issues may lead to defensible risk acceptance and focus areas for coding audits.
- Wasteful auditing and duplication of efforts needs to be avoided.

IRO Claims Reviews Requirements – Take Note

- Metrics and documentation practices in CIAs/IAs
  - Instances
    - Coding error – with financial impact
    - Medical necessity error – with financial impact
    - Inappropriate documentation error – with financial impact
  - Error rates
    - Overpayment: Financial Error Rate (i.e., FER) (dollars)
    - Count: Error Occurrence Rate (count)
    - Both aspects are important when determining magnitude and whether issues might be systemic
  - Mean Point Estimate
    - Mean overpayment in sample * frame size
- Confidence Interval
- Consider Metrics: 5% Error Rate, 95% Coding Accuracy Rate
- Auditing standards/protocol (up for a challenge?)
- Skill set (bias?)/independence.
- Review sheet with condition/criteria protocol.
- Internal controls/systems descriptions -> policies and procedures?

IRO Claims Reviews Requirements – Take Note –cont'd

- Review sheet with condition/criteria protocol – using audit templates:
  - **HICN**
  - Claim Number/ICN
  - Name
  - **Payor/Federal Healthcare Program (Medicare, Medicaid, etc)**
  - **Date Of Service**
  - **Code Submitted**
  - **Code Reimbursed**
  - **Correct Code**
  - Code Correct?
  - **Allowed Amount**
  - **Correct Allowed Amount**
  - **Difference (Over/Underpayment)**
  - Paid Date
  - Physician Order?
  - Medical Necessity?
  - Documentation Appropriate?
  - Overpayment?
- Count instances and develop Error Rate.
- Net and Gross Error Rate. Insight into what is next. Coding problem, overpayment problem?

Trending and Escalation Procedures

- Coding or billing audit strategies should have trending and escalation procedures that are best predefined.
- Avoiding ad hoc decisions.
- Auditors and monitoring/QA units benefit from a "yard stick" when to raise issue to the next level and expand the audit, or at which point reviews may switch from evaluations and judgmental samples to more stringent audit procedures and statistical Probe, Discovery and Full samples.
- Time series of small checks, judgmental problem, statistical Probe (30) or Discovery Sample (e.g. 50), Full Sample (100+).
- Escalation may trigger more focus and limiting Populations.

Auditing versus Monitoring

- Audit – formal, retrace steps and documents at the time. Independence and Objectivity important. Clear conditions and criteria needed/standards. Typically involves QA, operation external, or entity external reviewers.
- Monitoring – less formal, self-policing, but depends on what is at stake. More flexible, Quality Assurance efforts, checking for set internal controls.
- High dollar, high stakes.
- Not every review is an audit.

Documentation Assembly and Recording

- List of documents requested/reviewed to support result:
  - Medical and billing record detail, what exactly is reviewed and needs to be preserved:
    - Submitted claim
    - Paid claim/Remittance
    - Physician order/requisition form
    - Chart, Plan of Care, H&P, Evaluation
    - Medication Administration
    - Consent
    - Face to face
    - Certifications
    - Audit Logs?
    - etc
  - Sanction screening.
  - Death matching.
  - Licensure/certification.
  - Copies versus accessing electronic systems/EMR.

Payor Refunding /Sampling Design

- Larger scale coding audits may have financial impact. Documentation risk implies financial risk.
- Statistical samples
  - Required to prepare objective overpayment estimate.
  - 30+ claims; 100 claims updated OIG Self Disclosure Protocol (SDP).
- Multiple payors
  - Medicare
  - Medicaid
  - Commercial
- Strategies to address multiple payors with separate refund procedures
  - Stratification, error rate application, separate estimations, dollar or volume percentage, etc.
  - Think about it before you begin!
  - Sample overpayment handling, if there is extrapolation.

Data and Scoring – What matters?

- Error Rate.
- Error Occurrence Rate.
- Certain Instances.
- Timeline/History.
- Trends and patterns noted aside from medical documentation used for coding and billing documentation:
  - Interviews
  - Performance plans/Productivity/RVU Model
  - Similar facilities/providers
  - Time studies
  - Audit Logs in EMR
  - Investigation(s)
  - Other
- Confidence Interval.
- With coding and billing audits you gain knowledge that may impact needed next steps. Compliance looks for responsibility and diligence in what happens after the audit.

CMS Overpayment Rule and Sampling/Extrapolation

- *Repayment of Identified Overpayments. [Entity] shall repay within 60 days the Overpayment(s) identified in the Claims Review Sample, as determined by the IRO in accordance with Section … above, in accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and 42 C.F.R. § 401.301-305 (and any applicable CMS guidance) (the "CMS overpayment rule").* ***If [Entity] determines*** *that the CMS overpayment rule requires* ***that an extrapolated Overpayment be repaid****, [Entity] shall repay that amount at the* ***mean point estimate as calculated by the IRO****.*

Determination Issues

- Determination not easy but needs to be reasonable.
- Risk Profile of entity(ies) and providers under review
  - Rates and Instances
  - Comparison (internal/national/specialty)
  - Time
- When to refund/when to launch into expanded review?
- Whom to ask/consult with Legal, compliance, compliance committee, statistician, etc.
- What is the whole picture:
  - Dollar levels
  - Rates
  - Repeat occurrences
  - CAPs unsuccessful
  - Whistleblower risk
  - Hotline/complaints
  - Training history

Documentation Issues /Dos and Don'ts

- Dos
  - Have a written audit plan or documented review scope.
  - Have some guideline when to consider expanding audit/review or to raise to higher level of authority, compliance.
  - Use data and metrics to support escalation and overpayment determination.
  - Think of the type of sample you need.
  - Watch CMS Overpayment Rule (6 months +2 months=8 months).
  - Be able to demonstrate progress/improvement – hard evidence.
  - Integrate into centralized risk assessment approach.
- Don't
  - Don't fear of looking back, but be reasonable. 80/20
  - Don't overreach and miss targets and CAPs repeatedly, be realistic.
  - Don't panic. Auditing is reasonable effort.

Documentation Risk Areas in Claims

- *The following areas are areas to watch*
  - *E/M coding High Levels and changing E/M Coding Rules*
  - *Modifier 25 – Proper Use*
  - *Chronic Care Management – documentation requirements*
  - *Face to Face Documentation in Home Health/Hospice*
  - *Date and Signature*
  - *Copy/Paste*
  - *Lab billing /Provider documentation*
  - *Inpatient Rehab Facility (IRF)*
  - *Two Midnight Rule/Short Stay*
  - *Medical Necessity*
  - *Unbundling*
  - *DME/Proof of delivery*
  - *Study MLNs*

Documentation Risk Areas in Claims – E/M and Modifiers 25

- **Modifier 25 is an area of potential overuse and misuse.**
- Knowing and understanding CPT guidelines is key to the correct use of modifier 25.
- Physicians must understand the rules regarding this modifier and the documentation required to support it.
  - CPT defines this modifier as one used to indicate that the same physician performed a **significant and separately identifiable** evaluation and management (E/M) service on the same day as another procedure or service.
- Being proactive by doing routine internal audits to check for proper use of modifier 25 and ensure that necessary steps are taken if errors are found.
- Period auditing of the documentation and coding are essential to ensure continued compliance and identify weaknesses.
- Verify that billing software is not adding the modifier automatically.
- Questions to ask **before** appending modifier 25: Is modifier 25 appropriate in this case, and does the documentation support it?

Documentation Risk Areas in Claims – Chronic Care Management

- **Coding for Chronic Care Management Services was implemented in October of 2015. A high risk area to watch out for in coming months and years.**
- CPT Code 99490: Chronic care management services [require] at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  - multiple (two or more) chronic conditions expected to last at least 12 months, or until death of the patient.
  - chronic conditions place the patient at significant risk of death, acute exacerbation/decompression, or functional decline.
- Determining, documenting, tracking, and billing for the 2 or more chronic conditions.
- Comprehensive care plan established, implemented, revised, or monitored.
- Be certain that the CCM services (20 minutes of care) were provided.
- Patient's consent (written or verbal) should be on file before billing.
- This service in not for a routine in-person encounter.
- CCM CPT codes should only be billed one time per 30 day period.

Documentation Risk Areas in Claims – Face to Face

- **The Face-to Face (F2F) documentation is mandatory for a patient's home health certification.**
- The F2F Narrative should include:
  - Reason for the home health referral.
  - The skilled needs of the patient.
  - The reason the patient is homebound.
  - The date the F2F occurred.
  - The name of the certifying physician and signature.
- Obtain the correct documentation from the certifying physician, complete with required dates and signatures, that meets CMS requirements.

Documentation Risk Areas in Claims – Physician Orders

- **Invalid Physician Orders are a common but an avoidable claims documentation risk.**
- Medicare requires that the physician provides/orders services as a Condition of Payment (CoP).
  - Stamped signatures are not acceptable.
- Written orders
  - Clear and legible, with **date and signature**.
- Verbal orders
  - Accurate with **date, time and signatures**.
- Inpatient Admitting Orders.
  - Important to remember state, federal regulations as well as hospital bylaws.
- Orders for diagnostic services and tests.

Documentation Risk Areas in Claims – Copy Paste

- **Copy Paste/Over documentation errors are a concern at OIG as well as industry.**
- OIG recommended that CMS direct its contractors to review providers' audit logs. OIG pointed out, "experts in health information technology caution that EHR technology can make it easier to commit fraud." For instance, the copy-paste feature allows users to replicate information in one source and transfer the information to another source. Over- or inappropriate use of copy-paste could produce inaccurate information and facilitate fraudulent claims.
- Some EHRs provide templates that auto-populate fields by a single click; resulting in extensive documentation. OIG noted, the use of **audit logs** may reveal such data inconsistencies and "provide the most benefit in fraud detection." Accordingly, "audit logs should always be operational and be stored as long as clinical records."
- Exact same verbiage, assessments? Do they support MDM? Time/Productivity?
- Review Copy Paste patterns if allowed in EMR, and if suspected violations occur consider examining audit logs.
- OEI-01-11-00571: https://oig.hhs.gov/oei/reports/oei-01-11-00571.pdf

Takeaways

- Think about context and the big picture.
- Integrate coding and medical documentation auditing and monitoring into centralized risk assessment and internal review process, break down stove piped approaches.
- Follow risk based auditing
  - Scope and size, focus and limitation
  - Issue areas at entity and in industry
  - Write Audit Plan or Review Scope
- Have escalation procedures.
- Use metrics beyond coding accuracy
- Understand "CMS Overpayment Rule"
- Consider judgmental and statistical samples and build into escalation procedures.
- Sample sizes (30 vs 100) in statistical samples.
- 80/20 Rule.

Q/A

- Thank you! Questions?

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