Ongoing Compliance - Coding, Billing and Documentation

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SEIM JOHNSON

SOLUTIONS WITH VISION

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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 encouraged to contact their legal counsel for advice and direction on specific matters of concern to them.

Agenda

- **Ongoing Compliance Management**
  - Areas of Focus
  - Recent Developments
    - ***Effectiveness***
- **Assessment and Monitoring**
  - Risk Areas/Considerations
- **Tools/Resources/Best Practice**
- **Other Issues/Discussion**

Ongoing Compliance Program Efforts

- **Background - Goal/Purpose of Compliance**
  - Proactive approach
  - Assistance to practitioners/staff with operations, compliance of Medicare regulations, medical record documentation and applicable reporting for services furnished to patients
  - Appropriate revenue capture
  - Minimize compliance risks
  - Best practice

Compliance – Areas of Focus

- **Monitoring Coding/Billing Compliance**
- **Components of Coding/Billing Compliance**
  - Detection
  - Correction
  - Prevention
  - Verification
  - Comparison

Compliance – Areas of Focus (continued)

- **Detection**
  - Potential coding/billing compliance problems
  - Ongoing monitoring
    - Accuracy and completeness
    - Sampling
      - Pre bill
      - Post bill
      - Random
      - Statistical
      - Legal
        - » Attorney-client privilege

Compliance – Areas of Focus (continued)

- **Correction**
  - Prepayment review findings
  - Postpayment review findings
  - Repayment obligations?
- **Prevention**
  - Training, education, system changes, edits, internal policies/procedures

Compliance – Areas of Focus (continued)

- **Verification**
  - Audit trail of all compliance actions
  - Compliance database
    - Identification of patterns/trends
- **Comparison**
  - Coding/reporting patterns/trends over time
  - External norms
  - Benchmarks

Billing and Related Claim Form

- **Uniform Health Insurance Claim Form**
  - Paper Claim
  - **Electronic Claim**
  - **Claim Certification/Attestation**
- ***CMS-1500 New claim form, version 02/12***
  - Effective 2014
  - Accommodate new ICD-10-CM codes
  - Qualifiers to identify ordering, referring, and supervising providers
- **CMS-1450 – UB-04**

Claim Accuracy

- **Claim**
  - CMS-1500/UB-04
    - Paper or Electronic Equivalent
    - Certification/Attestation
- **Data Fields**
  - Data Mining
- **Information Accuracy**
  - First Time Submission
- **Minimize Risks/Proactive Steps**

Claim Form

- **Accuracy of claim information is key**
  - False Claims Act
- **Claim information captured by payers**
  - **<u>Data capture/data mining</u>**
    - Patient demographic and insurance information
    - Billing information, reporting patterns and trends
- **Overall goal - filing an accurate claim the first time**

Claim – UB-04

- **The submitter of this form understands that misrepresentation or falsification of essential information as requested by this form, may serve as the basis for civil monetary penalties and assessments and may upon conviction include fines and/or imprisonment under Federal and/or State law(s).**
- **Submission of claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts.**

Claim - Signature of Physician or Supplier

CMS-1500/Electronic Equivalent

Block 31 - "I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations."

Medical Necessity of Service

- **Medicare Claims Processing Manual, Chapter 12, §30.6 E/M Service Codes – General (Codes 99201-99499)**
  - "**Medical necessity of a service is the overarching criteria 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. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record."
  - Medical necessity determinations are left to the decision of the physician, based on the physician's knowledge, skill, experience and expertise.

Type of Provider Error

- Inpatient Hospital
- Physician
- Home Health Agency
- Outpatient Hospital
- Skilled Nursing Facility
- Laboratory
- Diagnostic Testing Facility
- Rural Health Clinic (RHC)
- Others

Most Common Errors

- **Insufficient or No Documentation**
- **Lack of Medical Necessity**
- **Incorrect Coding**
- **Unallowable Service**
- **Others**

Office of Inspector General (OIG) Compliance Guidance

- **02-23-1998 Compliance Program Guidance for Hospitals**
  - 01-31-2005 Supplemental Compliance Program Guidance for Hospitals
- **10-05-2000 Compliance Program Guidance for Individual and Small Group Physician Practices**
- **And Others**

Office of Inspector General (OIG) Compliance Guidance (continued)

Potential Risk Areas

1. Coding and billing
2. Reasonable and necessary services
3. Documentation
4. Improper inducements, kickbacks and self-referrals

Heightened Compliance Efforts

- **Health Reform – Compliance Provisions**
- **Repayment Deadlines**
  - Identified Errors
- **Medicare and Medicaid**
  - Increase of edits
  - Increase of audits
- **Whistleblowers**
  - Members, employees
  - Incentives

Heightened Compliance Efforts (continued)

Contractors and Enforcement Agencies

- **Recovery Audit Contractors (RAC)**
- **Zone Program Integrity Contractors (ZPIC)**
- **Medicare Administrative Contractors (MAC)**
- **Medicaid Integrity Contractors (MIC)**
- **Qualified Independent Contractors (QIC)**
- **Office of Inspector General (OIG)**
- **Department of Justice (DOJ)**

Compliance – Areas of Focus

In the Beginning…..

Provider Enrollment Process – Critical Area of the Medicare Program

- **Enhanced Emphasis on Provider Enrollment Activities**
  - Accurate form completion
  - Keeping your enrollment information up-to-date
- **Mandatory Revalidation**

Risk Areas

OIG 2017 Work Plan

- **Hospitals**
- Home Health Services
- Nursing Facilities
- Hospices
- **Other Providers and Suppliers**
- Medical Equipment and Supplies
- Part B Payments for Prescription Drugs
- Part A and Part B Contractor Operations

Risk Areas (continued)

- **Hospitals**
  - Hyperbaric Oxygen Therapy Services
  - Case Review of Inpatient Rehabilitation Hospital Patients Not Suited for Intensive Therapy
  - Intensity-Modulated Radiation Therapy (IMRT)
  - Outpatient Outlier Payments for Short Stay Claims
  - Comparison of Provider-Based and Free-Standing Clinics
  - Use of Outpatient and Inpatient Stays Under Medicare's Two-Midnight Rule
  - Others

Risk Areas (continued)

- **Other Providers and Suppliers**
  - Clinical Diagnostic Laboratory Tests
  - Transitional Care Management (TCM) Services
  - Chronic Care Management (CCM) Services
  - Ambulance Services
  - Ambulatory Surgical Centers-Quality Oversight
  - Payments for Medicare Services, Supplies and DMEPOS

Risk Areas (continued)

- **Other Providers and Suppliers**
  - Physician Home Visits
  - Prolonged Services
  - Chiropractic Services
  - Physical Therapists
  - Portable X-ray Equipment
  - Sleep Disorder Clinics
  - Drug Waste of Single Use Vials
  - Inflation-Based Rebates in Medicare Part B
  - Others

Updates to OIG Work Plan

- **The OIG's Work Planning Process**
  - Dynamic and ongoing adjustments are made to meet priorities and respond to emerging issues
  - **Effective June 15, 2017 OIG began updating its Work Plan website monthly**
  - Areas needing the most attention
  - Additionally,
    - Investigating Fraud, Waste and Abuse
    - Facilitating Compliance in the Health Care Industry
    - Excluding Bad Actors from Participation in Federal Health Care Programs

Other Considerations - Risk Areas

E/M Services

- **Highly utilized services by all physician specialties**
- **Continuation of pattern trending**
- **E/M Categories/Subcategories – codes depend on:**
  - Type of service
  - Place of service
  - Patient status (new or established)

Other Risk Areas (continued)

- **Medicare Guidelines**
  - Advanced Practice Nurses
    - Certified Registered Nurse Anesthetists (CRNAs)
    - **Nurse Practitioners (NPs)**
    - Certified Nurse-Midwives (CNW)
  - **Physician Assistants (PAs)**
  - Other NPPs

NP and PA Medicare Billing Options

- **Three options for billing NP and PA Services:**
  - Medicare's "Incident to" rules
  - Medicare's Split/Shared E/M visit rule
  - Billing under NP or PA name/number

NP and PA Services

- **NP and PA compliance concerns:**
  - Billing NP or PA services provided in the Emergency Department (ED) under the physician name/NPI number when service provided by NP only or PA only
  - Patient seen for consultation or new patient office visit by NP or PA and MD (as a split/shared service) and billed under physician name/NPI number
  - Billing E/M service as “incident to” in the office setting with no physician supervision

Risk Areas (continued)

- **Supervision of Diagnostic Test Services**
  - If state law permits, NP or PA may **order, interpret and personally perform** diagnostic test services; however, NPs and PAs are not permitted by CMS to supervise Medicare diagnostic test services

EHR Documentation

- **Challenges with EHR**
  - Invalid autopopulation of data fields
  - Manufactured documentation to enhance expected reimbursement
  - Other undesirable outcomes
  - Preserving documentation integrity
  - Compliance issues surrounding EHR

EHR Documentation (continued)

- **Impact on coding and documentation audit process**
  - EMR Templates
  - Cloning
  - Cut and Paste and Copy Forward Features

EHR Documentation (continued)

Audit/Review Challenges

- -Who documented what?
- -Cut/copy/paste features
- -Cloning
- -Macros
- -Templates
- -Signatures/authentication
- -Access to record/controls

Other Billing Challenges

- **Modifiers**
  - Who assigns?
  - Is record reviewed prior to using modifier 25, modifier 59?
- **Place of Service (POS) Codes**
  - 11-Office vs. 19-Off Campus Outpatient Hospital/22-On Campus-Outpatient Hospital
- **Units of Service**
  - Are correct units of service used
    - Medications - J codes
- **Time based services**
  - Does documentation support time billed?

Other Billing Challenges (continued)

- **Teaching physician rules**
- **New patient vs. established patients**
- **Radiology services**
  - Supervision of diagnostic tests
  - Professional and technical components
  - Documentation regarding the number of views
- **Medical necessity**
  - Does documentation/diagnosis(es) support the medical necessity of service?
- **Others**

Medicare Signature Guidelines for Medical Review

- **Pub 100-08 Medicare Program Integrity Manual, Transmittal 327, Change Request 6698**
- **Effective Date: March 1, 2010, Implementation Date: April 16, 2010**
- **MLN Matters MM6698 Revised**
- **Clarification to providers regarding how Medicare claims review contractors review claims and medical record documentation submitted by providers**

Signature Guidelines for Medical Review (continued)

What should you do?

- **Review information to help ensure you are in compliance**
- **Communicate any needed changes with practitiponers and applicable staff**
- **Incorporate guideline information into your internal policies and procedures**

Part B Medical Review Top Denial Reason Codes

- **Denial Reason Codes for All Benefit Types**

Reason Description
Documentation requested for this date of service was not received or was incomplete
Documentation lacks the necessary provider order
Payer deems the information submitted does not support medical necessity of services billed
Information submitted deemed illegible
Documentation received lacks the necessary radiology report
Information submitted contains an invalid/illegible provider signature
These changes are non-covered services; documentation supports Maintenance Therapy
Information received lacks the necessary patient medical record

Avoiding Claim Denials

- **Respond to requests within timeframes for requested information**
  - Key staff to handle inquiries
- **All documentation should be submitted for each date of service requested**
- **Ensure that all applicable documentation is submitted**
- **Ensure that documentation is signed**

Use of Advanced Beneficiary Notice (ABN)

- **Use of *new* ABN Form – effective 06/21/2017**
- **Capture otherwise lost revenue**
  - Improve cash flow
  - Improve write-offs
  - Recoup potential or real lost revenue
- **Avoid potential problems with CMS or OIG**

Metrics to Determine Success

- **Monitor your internal data**
  - Patterns, trends, E/M level distributions, high volume procedures, facility and physician procedure coding and other
  - Measure denials related to coding, claim edits, quality coding by practitioner and coding staff, hold accounts, and other
- **Identify areas to streamline processes**
- **Standardization of policies/procedures with consistent application of coding and regulatory guidelines**

Compliance Strategies

- **Team effort and communication**
- **Written internal policies and procedures**
  - Are internal policies being followed and enforced?
  - Are internal policies annually reviewed and updated?
- **Ongoing Education**
  - Staying current with the rules

Compliance Strategies (continued)

- **Conducting internal and external reviews**
  - Selecting risk areas for review
    - Who decides?
  - Methods of communication
    - How are results communicated with staff?
    - Is communication effective?
  - Are identified problems corrected and spot checked to ensure correction?

Considerations

- **Assess your compliance plan**
  - Do you annually review your compliance plan and update accordingly?
  - Is your plan ongoing and are you following your plan?
    - Internal documentation of compliance efforts
  - Is your compliance plan effective?
    - Feedback
- **OIG/HCCA Guide – Published March 27, 2017**
  - *Measuring Compliance Program Effectiveness: A Resource Guide*

Summary

- **Bottom Line**
  - Be proactive
  - Goal - accurate claim submission
  - Goal - minimize risks
  - Goal - proper documentation to support services billed
  - Challenge incorrect reimbursement

Summary (continued)

- Use resources/references
- Use internal reporting tools/data mining
- Internal policies and procedures
- **Document/retain internal records of ongoing compliance efforts**

Summary (continued)

- **Teamwork**
- **Communications**
- **Education**
- **Best practice**
  - Quality of People
  - Quality of Medicine
  - Compliance – Doing the Right Thing
  - Productivity
  - Profitability

Questions/Additional Discussion