

Top 10 Audit Findings from a Compliance Perspective

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Compliance Structure for Auditing and Monitoring per the Office of Inspector General

- ▶ Perform proactive reviews in coding, contracts and quality of care
- ▶ Create an audit plan and re-evaluate it regularly (OIG Work Plan)
- ▶ Identify your organization's risk areas. Use your networking with compliance resources to get ideas and see what others are doing.
- ▶ Don't only focus on the money – also evaluate what caused the problem
- ▶ Create corrective action plans to fix the problem
- ▶ Use a valid sample size to provide confidence in the results without causing a burden to staff

CMS Provider Compliance Resource
http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp
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Evaluation and Management for Office and Other Outpatient Services

- ▶ 3 key elements of the E/M visit
 1. History
 - History of Present Illness (HPI)
 - Review of Systems (ROS)
 - Past Medical, Family, Social History (PFSH)
 2. Exam
 3. Medical Decision Making (MDM)
- ▶ If any of the elements are not able to be obtained or preformed, the provider should document the reason why.

History of Present Illness (HPI)

- ▶ The HPI is a chronological description of the patient's present illness from the first sign and/or symptom to the present.
- ▶ The HPI should describe any of the following elements:
 - Location-Where?, unilateral or bilateral,
 - Quality-What kind? Aching, burning, radiating
 - Severity-How bad? Scale of 1 to 10, nonverbal signals of discomfort
 - Duration-How long? Length of time of the symptom
 - Timing-How often? Constant or it comes and goes
 - Context-What's happening? Circumstances or factors that surround the event
 - Modifying Factors-What changes it? Better with heat, took OTC pain reliever
 - Associated Signs & Symptoms-What else? Symptoms that accompany the presenting problem. (should not include Review of Symptoms)
- ▶ A comprehensive HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

Review of Systems

- ▶ ROS is the inventory of body systems obtained by clinical staff or the provider by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced.
- ▶ A comprehensive ROS is a minimum of 10+ systems that have been reviewed. Pertinent positives and negatives are identified for each system that has been reviewed.
- ▶ The provider may use an ROS or PFSH from a previous encounter. The provider must notate the date of the earlier ROS or PFSH and review all elements of the previous encounter notating any changes or elements not reviewed.
- ▶ The provider must document any specific and pertinent abnormal and relevant negative findings of the affected or symptomatic body area(s) or organ system(s). A notation of "abnormal" without elaboration is insufficient documentation.

Past Medical, Family, Social History

- ▶ A past medical history would not contain a patient's pertinent positive and/or negative response as related to the problems identified in the patient's history of the present illness.
- ▶ Must be referenced as reviewed in the progress note. When responding to a request for documentation from Medicare or other entity, you would need to supply documentation to support the service billed, including any previously recorded information. You will need to know where the previous information is stored.
- ▶ Examples of Social History:
 - Tobacco Use, and/or Alcohol Use
 - Adopted, Lives with Mom and Dad
 - Has had any "sick contacts"
 - Divorced, Married, Single

Examination

An examination may involve several organ systems or a single organ system. The exam performed is based upon clinical judgment, the patient's history, and nature of the presenting problem.

- ▶ Problem Focused : limited exam of the affected body area or system related to the problem
- ▶ Extended Problem Focused : limited exam of 2-7 systems or 6 bullets related to the affected body area of the presenting problem.
- ▶ Detailed: Extended exam of 2-7 systems or 12 bullets of the affected body area(s) or system(s) and any other symptomatic or related body areas or systems.
- ▶ Comprehensive: A general multi-system examination of 8 or more systems OR complete examination of a single organ system and other symptomatic or related body areas or organ systems

Documenting Medical Decision Making

- ▶ MDM refers to the complexity of establishing a diagnosis and/or selecting a management option (CPT Book 2010)
 - MDM comprises of 3 elements
 - The number of diagnosis or management options
 - The amount or complexity of data to be reviewed
 - The risk of complications and/or morbidity or mortality
 - How to document the 3 elements of MDM
 - An assessment
 - A clinical impression or diagnosis
 - Management plans and/or further evaluation or workup

Documenting Medical Decision Making

- ▶ What to document
 - For a problem with an established diagnosis, the documentation should indicate the status:
 - Improved, well controlled, resolving or resolved
 - Inadequately controlled, worsening or failing to change as expected
 - Document all changes in the patients condition
 - For a problem without an established diagnosis, the assessment or clinical impression may list the differential diagnosis:
 - Possible, probably or rule out
 - Sign, symptom which support the medical necessity for additional work-up in order determine definitive diagnosis.
 - List any underlying conditions that may impact the patient's complaints

Documenting Medical Decision Making

- Include the following to support higher MDM
 - Any complications or underlying conditions that could complicate the patient's condition
 - Decisions to keep patient on same medications, even if no changes were made
 - Any discussion of testing with the performing provider
 - Any discussion of the case with another physician
 - Any additional workup needed
- Avoid Documenting:
 - The patients entire problem list
 - Conditions that are not pertinent to the encounter
 - An assessment and plan that contradicts the History and/or Exam

Documenting Medical Decision Making

- ▶ Key Points
 - The MDM should reflect the History and Exam components of the encounter
 - The conditions listed in the Assessment should have been addressed in the History and/or Exam
 - The Assessment and Plan should be consistent with the History and Exam and support Medical Necessity of the amount of services provided.

New Patient 99203

- ▶ **History:** CC
 - ▶ 4+ HPI
 - ▶ 2-9 ROS
 - ▶ 1-2 PFSH
- ▶ **Exam:** 2-7 Body Systems (Detailed)
- ▶ **Medical Decision Making:** Low Complexity
- ▶ **Clinical Examples:**
 1. Initial office visit for a 50 y/o female with dyspepsia and nausea.
 2. Initial office visit for a 22 y/o female with irregular menses.
 3. Initial office visit for a 14 y/o male with unilateral anterior knee pain.

Established Patient Visit 99213

- ▶ **History:** CC
- ▶ 1-3 HPI
- ▶ 1 ROS
- ▶ No PFSH
- ▶ **Exam:** 2-7 Body Systems (Extended Problem Focused)
- ▶ **Medical Decision Making:** Low Complexity
- ▶ **Clinical Examples:**
 1. Quarterly follow-up office visit for a 45 y/o male, established patient, with stable chronic asthma, on steroid and bronchodilator therapy.
 2. Office visit for a 56 y/o male, established patient, with stable exertional angina who complains of new onset of calf pain while walking.

Office visit for 50 y/o female with IDDM and stable CAD for monitoring.

Quick Reference Guide

<u>New Patients</u>	<u>Established Patients</u>
99201 History = CC, 1-3 HPI, No ROS, No PFSH Exam = 1 body system/area or 1-5 bullets MDM = Straightforward	99211 Nurse's Visit (with direct supervision)
99202 History = CC, 1-3 HPI, 1 ROS, No PFSH Exam = 2-7 body system/areas or 6+ bullets MDM = Straightforward	99212 History = CC, 1-3 HPI, No ROS, No PFSH Exam = 1 body system/area or 1-5 bullets MDM = Straightforward
99203 History = CC, 4+ HPI*, 2-9 ROS, 1-2 PFSH Exam = 2-7 body systems/area or 12+ bullets MDM = Low Complexity	99213 History = CC, 1-3 HPI, 1 ROS, No PFSH Exam = 2-7 body system/areas or 6+ bullets MDM = Low Complexity
99204 History = CC, 4+ HPI*, 10+ ROS, 3 PFSH Exam = 8+ body systems/areas or 18 bullets MDM = Moderate Complexity	99214 History = CC, 4+ HPI*, 2-9 ROS, 1 PFSH Exam = 2-7 body systems/area or 12+ bullets MDM = Moderate Complexity
99205 History = CC, 4+ HPI*, 10+ ROS, 3 PFSH Exam = 8+ body systems/areas or 18 bullets MDM = High Complexity	99215 History = CC, 4+ HPI*, 10+ ROS, 3 PFSH Exam = 8+ body systems/areas or 18 bullets MDM = High Complexity

Top 10 Audit Findings from a Compliance Perspective

1. No authentication of notes - signature stamps not acceptable.
2. Missing documentation - billed before the documentation is completed
3. Inappropriate use of Electronic Health Record (EHR)
4. Documentation by ancillary staff and not the provider (Scribing, HPI)
5. Lacking Documentation of History Components
6. Lacking Documentation to bill based on time (no exam)
7. Inappropriate use of Modifiers - 24, 25 and 59
8. Preventive Medicine services vs. Evaluation and Management services
9. Incident-to vs. Split Shared Visits
10. Diagnosis Coding errors

#1 Documentation Authentication

- ▶ Federal Signature requirements found in the CMS Transmittal 327/6698 3-16-10
 - All services provided/ordered via the Medicare program must be authenticated by the author (i.e. the provider)
 - No stamped signatures. The method of authentication "shall be hand written or an electronic signature"
 - For non-EHR submit a Signature Log when sending documentation to auditors. This lists the typed or printed name of the provider with the associated initials or illegible signature.
 - Signature requirements do not change with the use of templates, checklists, and/or electronic medical records. The documentation must show a legible identifier of the provider.
 - CMS Internet-Only Manual (IOM) Publication 100-08, Chapter 3, Section 3.4.1.1.D

#2 Missing Documentation

- ▶ Documentation for services provided at another facility or location and billed by office not available in patients medical record.
- ▶ Billing documents or charge entry slips should be kept separate from the legal medical record and do not take the place of documentation of the visit.
- ▶ Claim is sent before the note is completed. It is not unreasonable for the provider to document at a later date but should not exceed 30 days.

#3 Inappropriate use of the Electronic Health Record

- ▶ **Cloning** – *Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.*
- ▶ *Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made. OIG 2011 Work Plan for Physicians*
- ▶ **Copy Forward** – Documentation that has been copied from a previous visit and used again to document the current visit. *2008 AHIMA Copy Functionality Toolkit*
- ▶ **Plagiarism** – Documentation that has been copied from another author and used as part of the providers own encounter with the patient, without appropriate identification of the author.

#4 Documentation by ancillary staff and not the provider

- ▶ In the office setting, the physician's staff member may independently record the Past, Family and Social History (PFSH) and the Review of Systems (ROS), and may act as the physician's "scribe," simply documenting the physician's words and activities during the visit. WPS Medicare Guidelines for the Use of Scribes in Medical Record Documentation
- ▶ Should state the name of the person "written by ____, acting as a scribe for Dr. X."
- ▶ Physician co-signs the note indicating the note is an accurate record of both his/her words and actions during that visit.
- ▶ EHR audit trail to identify who has logged in and documented in the medical record.
- ▶ Nurse logs in and documents patient's chief complaint, vitals, PFSH and ROS. Physician logs into the same note and documents History of Present Illness (HPI), Exam and Medical Decision Making (MDM). The provider must notate his/her review of the information. Additions to the file or confirming notations substantiate the provider's review and sign the note.
- ▶ HPI - **The billing provider must perform the History of Present Illness (HPI).** The ancillary staff cannot collect this information and enter it into the medical record with the provider only signing or acknowledging they read the notation.

#5 Lacking documentation of History Components

- ▶ History is composed of 3 elements
 - History of Present Illness (HPI)
 - Review of Systems (ROS)
 - Past Medical, Family, and Social History
- ▶ Chief Complaint is different than the HPI documented by the provider
- ▶ History portion of the visit was not documented or reviewed. This may be deliberate when only 2-of-3 components of the E/M are required, however this is not recommended. Provide Interval History.

#6 Lacking Documentation to bill based on time

- ▶ Counseling/coordination of care (C/CoC) is face-to-face time with the patient.
- ▶ Time can be used as the dominating factor for E/M level assignment when C/CoC constitutes >50% of the total face-to-face time.
- ▶ Does not include pre/post visit work in the time recorded.
- ▶ If no examination is conducted, a reason why exam was not obtained must be documented.
- ▶ To bill based on time must document:
 - Total time spent with patient face-to-face
 - Total time spent in C/CoC to document that at least >50% of the visit was spent in C/CoC
 - What was discussed (description/nature/content of the C/CoC)
- ▶ The CPT nomenclature defines *counseling*, as it relates to E/M coding, as a discussion with the patient and/or family or other caregiver concerning one or more of the following areas: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment) options; instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; and patient and family education.

#7 Inappropriate use of Modifier 24

- ▶ Modifier -24 allows E/M services to bypass system edits during a global period. It indicates that the E/M service is not related to the surgery.
- Definition: Modifier -24 is to be appended to the E/M code when an E/M service unrelated to the original surgery, by the same physician (who did the original surgery), was done during a post-operative period
- For initial documentation "proof":
 - Documentation supports E/M visits submitted with modifier 24 are unrelated to the post-operative care of the procedure. ICD-9 codes that clearly indicate the reason for the encounter was unrelated to surgical postoperative care may provide sufficient documentation. *WPS Global Surgery Modifier Fact Sheet*

#7 Inappropriate use of Modifier 25

- ▶ Modifier 25 indicates the patient's condition on the day of the procedure required a significant, separately identifiable E/M service beyond the usual preoperative and post-operative care associated with the procedure or service performed
- Definition: Modifier -25 is to be appended to E/M codes when significant, separately identifiable E/M services are rendered by the same physician on the same day of a procedure or other service
 - "Significant" denotes an increased amount of additional work over/above that typically done for the patient receiving the performed procedure/service
 - "Separately identifiable" denotes a third party, upon review of the documentation, can differentiate the additional E/M work done from that of the procedure/service
 - Medicare considers the "same physician" to also be another provider within the same group practice with the same medical specialty designation

#7 Inappropriate use of Modifier 59

- ▶ May be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same date.
- ▶ Represented by a different session or patient encounter, different procedure or surgery, different site, separate session, or separate injury (or area of injury)
- Definition: Distinct Procedural Service
- Last resort modifier and should not be used to bypass an edit. Verify no other modifier is appropriate. Documentation must support the:**
- ▶ Different session or patient encounter
- ▶ Different procedure or surgery
- ▶ Different site or organ system
- ▶ Separate incision or excision
- ▶ A separate lesion
- ▶ A separate injury
- ▶ An additional payment maybe received for professional and primary services furnished on the same day at different times. These services should be billed using revenue code 052x and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon.

#8 Preventive Medicine services vs. E/M services

- ▶ Preventive Medicine is a comprehensive evaluation based on an age appropriate : history, exam, counseling/anticipatory guidance/risk factor reduction, interventions, and the ordering of lab/diagnostic procedures. (i.e. Well Child Check, Well Women Exam, Sports Physical)
- ▶ Evaluation and Management Services is a evaluation based on the patients presenting complaints and includes a problem-oriented history, examination and medical decision making
- ▶ The chief complaint would be a good way to determine the appropriate procedure code.
- ▶ Annual Wellness Exam – New benefit effective January 1, 2011 for Medicare beneficiaries. The goal is health promotion, disease detection and to foster the coordination of the screening and preventive services. This is not a "yearly physical" examination and does not take the place of the preventive medicine visit.
- ▶ Rural Health Clinics (TOB 71X) will be paid based on the all-inclusive rate. However, for TOBs 71X the AWV does not qualify for separate payment with another encounter.

#9 Incident-to vs. Split Shared Visits

- "A Split/Shared E/M visit is defined ... as a medically necessary [visit] ... where the physician & a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same pt. on the same date. A substantive portion ... involves all or some portion of the history, exam or MDM key components of an E/M service ..."
- Split/Shared must include a face-to-face visit with the physician.
- The services would be billed by the physician.
- The following statement is insufficient:
 - "I have personally seen/examined the patient, and reviewed the NPP's notes and agree" Signed MD

#9 Incident-to vs. Split Shared Visits

- ▶ Incident-to billing is when a service is provided in an office setting by someone other than the physician.
- ▶ Clinics or centers which are not physician- directed must have an arrangement with a physician which provides for the supervision and guidance of physician assistants and nurse practitioners. The arrangement must be consistent with State law and provide for at least one onsite supervisory visit by the physician every two weeks (except in extraordinary circumstances). The physician must be a doctor of medicine or osteopathy. See the State Operations Manual for examples of extraordinary circumstances.
- ▶ In the case of a physician-directed clinic or center, the general supervision of physician assistants and nurse practitioners must be performed by one or more of the clinic or center's staff physicians.

#9 Incident-to vs. Split Shared Visits

- ▶ Services performed by Nonphysician practitioners listed in §30.1 are covered as RHC or FQHC services. They are covered if:
 - Furnished by an employee of the RHC or FQHC or an individual who receives compensation from an RHC or FQHC;
 - Furnished under the general (or direct, if required by State law) medical supervision of a physician (see §70.6);
 - Furnished in accordance with clinic or center policies and any physician medical orders for the care and treatment of a patient;
 - Of a type which the nurse practitioner, physician assistant, or certified nurse midwife who furnished the service is legally permitted to perform by the State in which the service is rendered; and
 - Of a type which would be covered under Medicare if furnished by a physician.

- ▶ The RHC and FQHC benefits are defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 (<http://www.cms.hhs.gov/manuals/Downloads/bp102c13.pdf>.)

#10 Diagnosis Coding Errors

- ▶ **Primary Diagnosis**- The reason for the encounter. The definitive diagnosis.
 - Should not be the sign or symptom if a diagnosis is confirmed. (i.e. Strep throat vs. sore throat)
 - Do not code suspected or probable conditions.
- ▶ **Secondary Diagnosis** – Coexisting conditions that were diagnosed or evaluated and affected the patient's treatment during the visit.
 - Do not report conditions that are not addressed in the Medical History, Review of Systems or Exam
 - Inappropriate sequencing of diagnosis because of instructional notes in the ICD-9 coding book.
- ▶ **Acute vs. Chronic vs. History-of**
 - Cerebrovascular Accident, CVA, Stroke: Code 436, Acute, but ill-defined, cerebrovascular disease, should not be used when the documentation states stroke or CVA. The correct code is 434.91 unless this is not a current event and the patient has no residuals, should be coded as a history-of V12.54.
 - Neoplasm/Cancer: When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of an existing primary malignancy, a code from category V10, Personal history of malignant neoplasm should be used to indicate the former site of the malignancy
 - Diabetes Mellitus: Careful consideration must be given to code category 250, Diabetes Mellitus, to ensure that the selection of the fourth and fifth digits accurately describe the patient's condition.
 - DVT: In general, initial episode of care would indicate the acute phase, while "subsequent episode of care" would indicate the chronic phase. If the DVT is an old condition, no longer under treatment (neither acute nor chronic phase) the "history of" code, V12.51 personal history of venous thrombosis and embolism, should be reported.

CERT Review by CMS

- Comprehensive Error Rate Testing (CERT) error findings for incorrect coding of E/M services continue to be an area of concern for WPS Medicare. Services billed at the level other than what is documented in the medical record account for over 75% of our CERT errors for these services.
- Based on these findings, we encourage all providers who bill these services to review their billing and documentation practices or perform a self-audit. If you utilize a billing service, we strongly recommend sharing this information to assist with the preparation and submission of your Medicare claims.
- WPS Medicare provides many opportunities to increase your knowledge of E/M documentation and coding guidelines. Visit our Education web page to find information on upcoming seminars, teleconferences, and online resources to assist you in proper billing and documentation of these services.
- <http://www.wpsmedicare.com/j5macpartb/training/>
- http://www.cms.gov/CERT/01_overview.asp

Federal Auditing Initiatives

- ▶ RAC's – Recovery Audit Contractors hired by CMS to detect and recover past improper payments. Claims based approach and will request additional documentation when necessary. <http://www.cms.gov/RAC>
- ▶ QIC's – Qualified Independent Contractor hired by CMS to provide independent review of appealed claims http://www.cms.gov/OrgMedFFSAppeals/03_ReconsiderationbyaQualifiedIndependentContractor.asp
- ▶ QIO's – Conducts quality of care projects and "peer reviews" for quality of care issues. <http://www.cms.gov/QualityImprovementOrgs/>
- ▶ ZPIC's – Zone Program Integrity Contractors works with the Medicare Administrative Contractors (MAC's) to investigate fraud leads and build fraud cases. http://www.csc.com/advancedmed/ds/11859/56878-zpic_zone_2
- ▶ MIC's – Medicaid Integrity Contractors used by the state to provide post payment audits and recover overpayments. <http://www.cms.gov/MedicaidIntegrityProgram/>

Resources

- ▶ WPS Medicare E/M webpage http://www.wpsmedicare.com/j5macpartb/resources/provider_types/evalandmngmnt.shtml
- ▶ Annual Wellness Visit <http://www.cms.gov/transmittals/downloads/R134BP.pdf>
- ▶ OIG webpage <http://oig.hhs.gov/>
- ▶ American Health Information Management Association <http://ahima.org>

Resources

- ▶ *The ABCs of Providing the Initial Preventive Physical Examination* Quick Reference Chart provides Medicare Fee-For-Service providers a list of the elements of the IPPE, as well as coverage and coding information. To view the chart, please visit: http://www.cms.gov/MLNProducts/downloads/MPS_ORI_IPPE001a.pdf.
- ▶ *The ABCs of Providing the Annual Wellness Visit* Quick Reference Chart provides Medicare Fee-For-Service providers a list of the elements of the AWV, as well as coverage and coding information. To view the chart, please visit: http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf.
- ▶ *The Medicare Preventive Services* Quick Reference Chart provides Medicare Fee-For-Service providers coverage, coding, and payment information on the variety of preventive services covered by Medicare. To view the chart, please visit: http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.
