Summary Part I

- Motivation ~ why audit?
- Other auditors ~ RACs, OIG
- Compliance Program
- Things to consider when getting started
  - Who’s involved in the internal audit process?
  - What are you trying to find?
  - What documents are you examining?
  - How to track your findings, share results, address issues
- Tools and resources

Objectives Part II

- Concerns when auditing notes in EMR
- Auditing diagnostic tests
- Auditing surgical services
- Accurate diagnosis codes
- Other issues
  - Signatures
  - Bonus Programs
  - Issues with payments / denials
  - Follow up

Target for Scrutiny

E/M: Potentially Inappropriate Payments

“We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported.”

Source: HHS OIG FY 2013 Work Plan

Problems from Copy-Paste

- Integrity of record questioned – misrepresentation
- Confusion from nonsensical language
- Note bloat
- Difficulty identifying relevant information
- HIPAA violation where information copied from one patient record to another
- Copying prior records that contain errors
- Potential patient care issues
- Possible malpractice concerns
Living with Copy-Paste

• Minimize use
• Employ alternative approaches
  • Drop down menus
  • Pick lists
• Edit copied notations with new information
• Verify every copied notation and “click it”

EMR Concerns

We’ve always heard:

“If it wasn’t documented, it wasn’t done”

With EMR, there is concern that:

“If it was documented, doesn’t guarantee it was done”

EMR Hiccups

• 65 year old male presented for evaluation of existing condition, GLAUCOMA in both eyes for several years. The timing is described as all the time. Quality is fixed. Relief is experienced from using drops as directed. Patient described the following signs and symptoms: none currently to report.

• 66 year old male complains of blur at near in both eyes. The timing is described as all the time. Quality is unchanging. Context is reported without glasses.

Audit Considerations - Tests

• Review tests for completeness and appropriateness
• Common documentation errors
  • Missing order
  • Missing or incomplete interpretation
• Common billing errors
  • Unilateral vs bilateral
  • Bundles
  • Assigning wrong diagnosis code to service.
• Hints to improve chart documentation
  • Template for interpretation to serve as report
  • Technician instructions
  • Monitoring activities

Medicare Test Policy

42 CFR §410.32 Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

(a) Ordering diagnostic tests. All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary’s specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary.

Diagnostic Test Order

• Tests are ordered by the physician for a medically appropriate reason, generally after the eye exam
• Technicians cannot order tests
• Order may be scribed by staff on physician’s direction
  • “VF for COAG next visit per Dr. Smith”
• Standing orders pose challenges. They may be screening and not covered. When not individualized, they might not be reimbursed.
Interpretation & Report

"Carriers generally distinguish between an 'interpretation and report' of an x-ray or an EKG procedure and a 'review' of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete written report similar to that which would be prepared by a specialist in the field does not meet the conditions for separate payment of the service. This is because the review is already included in the … E/M payment."

Source: CMS MCPM Chapter 13, §100

Interpretation & Report

“For example, a notation in the medical records saying 'fx tibia' or 'EKG-normal' would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An 'interpretation and report' should address the findings, relevant clinical issues, and comparative data (when available)."

Source: CMS MCPM Chapter 13, §100

Chart Documentation

Diagnostic Test Interpretation

- Physician’s order
- Date performed
- Technician’s initials
- Reliability of the test
- Patient cooperation
- Test findings
- Assessment, diagnosis
- Impact on treatment, prognosis
- Physician’s signature

Chart Documentation

Diagnostic Test Interpretation

- Physician’s order – Why is the test desired?
- Date performed – When was it performed?
- Technician’s initials – Who did it?
- Reliability of the test – Was the test of any value?
- Patient cooperation – Was the patient at fault?
- Test findings – What are the results of the test?
- Assessment, diagnosis – What do the results mean?
- Impact on treatment, prognosis – What’s next?
- Physician’s signature – Who is the physician?

Visual Field Interpretation

- Plan: Threshold perimetry to re-evaluate POAG
- Test Date: Sept 24, 2014
- Technician: Mary Smith, COA
- 1 false positive
- Good patient cooperation
- Arcuate scotoma, OU
- POAG, shows progression since last visit
- Add another anti-glaucoma medication

Interpretation & Report

You review a visual field with a note that states "POAG". Other than the physician’s signature, there are no other notations. Is this sufficient to support an "interpretation and report"?

a) Yes
b) No
**Testing During Postop Period**

- Services not included in the global surgery package:
  - Diagnostic tests and procedures, including diagnostic radiological procedures
- Examples:
  - Testing unrelated to the prior surgery
  - Testing to evaluate an unfortunate outcome
  - Testing to prepare for another surgery
- Not covered: testing to confirm the expected outcome

Source: MCPM, Chapter 12, §40.1B

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**Testing Following Surgery**

You review a note showing a VF performed two months after cataract surgery for pre-existing COAG. Which of the following is true?

- a) Testing within the postop period is not separately reimbursed
- b) Tests are not part of the global surgery package
- c) Only the technical component of a test is billable during postop – not the interpretation
- d) Testing must be delayed until after the postop period

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**Coverage Policies Vary**

- Medicare’s policies are not universal
- Local policies differ from place to place
- Policies change from time to time
- Basis for coverage vary
- **IMPORTANT:** Monitor payers’ websites frequently

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**Noncovered Tests**

- For an indication not in the coverage policy
- Screening
- Prophylactic
- Refractive
- Investigational or experimental

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**Testing for Suspected Condition**

In your review, you note a test ordered to assess whether a suspected condition is present or not. It’s was present; the patient is normal. How should the claim have been handled?

- a) No charge the test
- b) Bill the patient for a noncovered service
- c) Berate the technician who didn’t obtain a signed ABN
- d) Bill the test to the payer using the ICD-9 for the suspected condition

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**Office Visit & Minor Procedure**

“CPT Modifier 25 – Significant Evaluation and Management Service By Same Physician On Date of Global Procedure

Pay for an evaluation and management service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable evaluation and management service that is above and beyond the pre- and post-operative work of the procedure.”

Source: MCPM, Chapter 12, §40.2.A8
Office Visit & Minor Procedure

"Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery

...where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.”

Source: MCPM, Chapter 12, §40.2A4

Nov 2012 AAO Coding Bulletin

“...A frequently asked question is: Isn’t modifier -25 associated with minor procedures in the same way that modifier -57 is associated with a decision for a major surgery? The answer is no. Modifier -25 does not indicate it is the visit to determine the need for a minor surgery.”

“If the need for the intravitreal injection has been established at an earlier visit and the patient is in the office solely to be injected, an E&M or Eye code service should not be billed.”

Modifier -25 and the OIG

- 35% of claims in 2002 with modifier 25 did not meet requirements
- Excessive use of modifier -25 garners (unwanted) attention
- OIG’s 2011 Work Plan will scrutinize it
  - Particular attention for intravitreal injections

Source: OIG Report, Nov. 2005, OE1-07-03-00470

Modifier -25

- Use modifier -25
  - Est. patient with ≥2 problems
  - OD vs. OS
  - Anterior vs. posterior seg
  - Eye vs. systemic dx
  - Multiple eye conditions

- Don’t use modifier -25
  - Decision for surgery
  - Only one reason for exam
  - Special case - new patients

Minor Surgery

Key Points

- Require sufficient chart documentation
- Subject to a global surgery package
- They have short postop periods (0, 10 days)
- Generally, includes the exam on the same day
  - Exception – exams for another reason unconnected with the minor procedure (needs modifier -25)

Modifier -25 Yes or No?

Your established patient returns with a complaint of pain and FB sensation. During your slit lamp exam, you find a FB and remove it. The rest of the exam is unremarkable. Does modifier -25 apply?

1) Yes
2) No
Modifier -25   Yes or No?

Your patient returns for a Plaquenil checkup. Today, he complains of chronic FB sensation. During your slit lamp exam, you find keratitis sicca from Sjogren’s syndrome. You perform punctal occlusion of LLL and RLL. Fundus exam is unremarkable. Does modifier -25 apply?

1) Yes  
2) No

Modifier -25   Yes or No?

Your patient returns for chalazion removal; hot compresses and medication failed. You perform the minor procedure in the lane. Does modifier -25 apply?

1) Yes  
2) No

Modifier -25   Yes or No?

Your patient returns for reevaluation of AMD. You find exudative AMD and precipitous vision loss, OS, but no change OD. You perform intravitreal injection with Avastin in the OS today. Does modifier -25 apply?

1) Yes  
2) No

Modifier -25   Yes or No?

Your patient uses artificial tears for DES but is unhappy with the treatment. She asks for an alternative. You offer a trial of punctum plugs in the lower puncta and she agrees. The rest of the exam is unremarkable. Does modifier -25 apply?

1) Yes  
2) No

Audit Considerations - Surgeries

- The chart must include the indications and medical necessity for each surgical procedure
- Know the payers’ expectations!
- Review necessary diagnostic tests to support medical necessity
- Read the body operative report, not just the header or the preoperative plan
- Appraising surgical claims involves more than reviewing the operative report

YAG Capsulotomy

CC: 4 month glaucoma check  
Hx: IOLs OU 2011  
Exam: BCVA 20/25 OU  
SLE: PCO OD>OS  
Nerve: C/D 0.5 OU  

HPI: POAG, OU x 3 yrs, C/O 
gttts sting  
Dx: 1) PCO, OD > OS  
2) POAG controlled  
Tx: YAG OD today, OS to follow
What do we know about capsulotomy?

- Indications for surgery include:
  - Subjective complaints of decreased vision and ADLs limited by decreased vision
  - BCVA acuity 20/30 or worse due to PCO
  - Patient consents to surgery

Auditor’s Notes

- Indications for surgery include:
  - Subjective complaints of decreased vision and ADLs limited by decreased vision — Not noted
  - BCVA acuity 20/30 or worse due to PCO — 20/25 OU
  - Patient consents to surgery — Not noted

NCCI

- National Correct Coding Initiative
  - Bundles
  - Mutually exclusive
  - Quarterly publication
  - Published at www.cms.gov/physicians/cciedits/

Physician’s Claim

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Auditor’s Note

Remove code 67010 Fragmentation

Diagnosis Coding – Look ahead!

- For all services, verify the diagnosis code
- Supports medical necessity
- Are you ready for ICD-10?
- Do current notes contain detail needed for ICD-10?
**Assessing Accuracy of Payments**
- Know your allowed amounts for covered services
- Were you paid appropriately?
  - Consider copays/deductibles
  - Were MPPR for tests applied
  - Did you consider the impact of sequestration (2%)?
- Review denials
  - Verify denial code - Is the denial appropriate?
  - Should you appeal or correct and resubmit?
  - Not every denial should be appealed
  - Know how to fight and when to fold!

**Physician Bonus Programs**
- If participating in PQRS and/or Meaningful Use, is the data being gathered appropriately?
- Spot check!

**Signatures**
- Through audit process, watch for signatures

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<tr>
<th>Physician</th>
<th>Patient</th>
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**Next Steps**
- Following a chart review:
  - Discuss results with physicians and appropriate staff members
  - Identify strengths and weaknesses
  - Formulate a plan for improvement
  - Make necessary refunds of overpayments
  - Plan for your follow up audit.

**More help...**
For additional assistance or confidential consultation, please contact us at:

(800) 399-6565

or

www.CorcoranCCG.com