Compliance and Chart Review in the Retina Practice

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Financial Disclosure

- Advisory Boards
- Allergan
- Genentech
- Regeneron
- Speaker Bureaus
  - Allergan
  - Genentech

Compliance

Definition of COMPLIANCE

1 a: the act or process of complying to a desire, demand, proposal, or regimen or to coercion

b: conformity in fulfilling official requirements

Source: Merriam-Webster On-line Dictionary
Medicare Program Integrity

“The primary principle of Program Integrity (PI) is to protect the Medicare Trust Fund from fraud, waste and abuse. In order to meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers.”

Source: Medicare Program Integrity Manual, Chapter 1 §1.1

Fraud

Fraud is the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

Source: Medicare Program Integrity Manual, Exhibits, §2, Definitions

Fraud

- Examples of Medicare Fraud
  - Incorrect reporting of diagnosis or procedures to maximize payment
  - Billing for services not furnished and/or supplies not provided
  - Altering claim forms to obtain a higher payment amount

Source: Medicare Program Integrity Manual, Chapter 4, §4.2.1
Waste

• To spend or use carelessly

Source: Merriam-Webster On-line Dictionary

Abuse

• Billing Medicare for services that are not covered or are not correctly coded.

Source: Medicare Program Integrity Manual, Exhibits, §1, Definitions

Abuse

• Examples of abuse
  • Billing for services that are not medically necessary
  • High utilization of specific CPT codes not consistent with standard of care
  • High frequency of visits not consistent with standard of care
Compliance Program

- Formal Compliance Program
  - Written compliance plan
- Quality Assurance Program
  - Verbal commitment of compliance

Office of Inspector General (OIG)

- OIG negotiates Corporate Integrity Agreements (CIA)
- Comprehensive CIA typically lasts 5 years
  - Settlement of Federal health care program investigation
  - In exchange, OIG agrees not to seek provider’s exclusion from participation in Medicare
  - Providers agree to obligations

Source: OIG Website

Office of Inspector General (OIG)

- Compliance
- Monitor fraud
- Compliance 101
- Compliance Program Guidance
  - Published guidelines
  - Compliance Program Guidance for Individual and Small Group Physician Practices

Source: OIG Website
Office of Inspector General (OIG)

- OIG Compliance Program for Individual and Small Group Physician Practices
- Components of an Effective Compliance Program
- Publication of the OIG’s Provider Self-Disclosure Protocol
  - Work openly and cooperatively with the OIG

OIG Work Plan

- Office of Inspector General (OIG) Work Plan
- Use of Modifiers During the Global period
  - Modifier 25
  - Modifier 59
- Place-of-Service Errors
- Ophthalmological Services

2013 OIG Work Plan

Ophthalmological Services—Questionable Billing (New)

We will review Medicare claims data to identify questionable billing for ophthalmological services during 2011. We will also review the geographic locations of providers exhibiting questionable billing for ophthalmological services in 2011. Medicare payments for Part B for physician services, which include ophthalmologists, are authorized by the Social Security Act, § 1832(a)(1), and 42 CFR § 410.20. In 2010, Medicare allowed over $6.8 billion for services provided by ophthalmologists. (OEI; 04-12-00280; expected issue date: FY 2014; work in progress)
2013 OIG Work Plan

Evaluation and Management Services
Use of Modifiers During the Global Surgery Period

We will review the appropriateness of the use of certain claims modifier codes during the global surgery period and determine whether Medicare payments for claims with modifiers used during such a period were in accordance with Medicare requirements. Prior OIG work found that improper use of modifiers during the global surgery period resulted in inappropriate payments. The global surgery payment includes a surgical service and related preoperative and postoperative E/M services provided during the global surgery period. (CMS's Medicare Claims Processing Manual, Pub. 100-04, ch. 12, § 40.1.) Guidance for the use of modifiers for global surgeries is in CMS's Medicare Claims Processing Manual, Pub. 100-04, ch. 12, § 30. (OAS; W-00-13-35607; various reviews; expected issue date: FY 2013; new start)

Modifier 25 vs. Modifier 57

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

If evaluation and management services occur on the day of surgery, the physician bills using modifier “57”, not “25”. The “57” modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, 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: Medicare Claims Processing Manual, Chapter 12, §40.2A4

Modifier 25

“Significant Evaluation and Management Service on the Day of a Procedure”

It is used to report a significantly, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed.”

Source: Medicare Claims Processing Manual, Chapter 12, § 40.2.A8
Modifier 25

NCCI also highlighted payment policy when using the modifier -25. “For minor surgical procedures (global period of 000 or 010 days), an E&M service is separately reportable on the same day as the procedure only if significant and separately identifiable. An E&M service should not be reported solely for the decision to perform the minor surgical procedure. A significant and separately identifiable E&M service is indicated with modifier -25.” If the patient is only examined to determine the need for an injection in the eye scheduled for treatment, then a visit should not be billed.

ASRS Member Alert: NCCI UPDATE - CMS to Resume Bundling Global Surgical Codes with Eye Visit Codes

Medicare Review Programs

- Comprehensive Error Rate Testing (CERT)
- Program Safeguard Contractors (PSC)
- Zone Program Integrity Contractor (ZPIC)
- Recovery Audit Contractor (RAC)
  - Paid on contingency
  - Paid percentage of funds recovered

Recovery Audit Contractors

- Region A: Performant Recovery (Diversified Collection Services)
  - CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA RI, VT
- Region B: CGI Federal, Inc.
  - IL, IN, KY, MI, MN, OH, WI
- Region C: Connolly, Inc.
  - AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico, US Virgin Islands
- Region D: HealthDataInsights, Inc.
  - AK, AZ, CA, HI, ID, IA, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, Guam, American Samoa, Northern Marianas
RAC Websites

- Region A: Performant Recovery (Diversified Collection Services)
  - http://www.dcsrac.com/
- Region B: CGI Federal, Inc.
  - http://racb.cgi.com/
- Region C: Connolly, Inc.
  - www.connollyhealthcare.com/RAC
- Region D: HealthDataInsights, Inc.
  - http://racinfo.healthdatainsights.com/

Data Analysis

- Review of submitted claims
- Specific group of providers
- Not sub-specialty specific (retina)
- “Outlier” behavior
- Retina billing patterns
- Importance of documentation

Chart Review

- Focused review
- General review
- Prospective review
  - Claims to be filed
- Retrospective review
  - Claims already filed
- Missed charges
- Overpayments
Chart Selection

- Determine sample universe
- Dictated by compliance program
- Random sampling
- RAT-STATS
  - Office of Audit Services
  - Regional Advanced Techniques Staff (RAT)
  - Random number generating program

Low Hanging Fruit

- No chief complaint
- Incomplete history
  - History of Present Illness (HPI)
  - Review of Systems
- Missing exam elements
- No interpretation and report for diagnostic tests
- Medical Decision Making (MDM)
  - Level of Risk

Coding Errors

- Coding errors
  - Wrong CPT code
  - Wrong ICD-9 code
    - ICD-10
  - Wrong HCPCS code
Common Errors

- Undercharging for services
- Missed charges
- Undercoding
- Overcharging for services
- Inadequate chart documentation
- Missing documentation
- Fragmentation
- Lack of medical necessity

Medical Necessity

- Medically Necessary Services
  - Documentation
  - Chief complaint
  - Chronic disease

Chief Complaint

**CHIEF COMPLAINT (CC)**

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s words.

The medical record should clearly reflect the chief complaint.

Source: 1997 Evaluation and Management (E/M) Guidelines
E/M vs. Eye Codes

- Evaluation and Management (E/M) Codes
  - Amount of documentation
- Eye Codes
  - Specific required elements

E/M Coding

1) History
   - HPI – History of Present Illness
   - ROS – Review of Systems
   - PFSH – Past Family and/or Social History
2) Examination
3) Medical Decision Making
   - Diagnoses – diagnoses management
   - Data – tests and additional information
   - Risk – amount of risk

History

History of Present Illness (HPI)
- Location
- Quality
- Severity
- Modifying factors
- Timing
- Context
- Duration
- Associated signs and symptoms

Source: 1997 Evaluation and Management (E/M) Guidelines
History

Review of Systems (ROS)

- Constitutional
- Eyes
- ENT, Mouth
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic
- Allergic

Source: 1997 Evaluation and Management (E/M) Guidelines

History

Past Family and/or Social History

- Allergies
- Current medications
- Illnesses, injuries
- Operations
- Hospitalizations

Source: 1997 Evaluation and Management (E/M) Guidelines

Examination

- Visual acuity (VA)
- Confrontation fields
- Ocular motility
- Conjunctiva
- External adnexa
- Iris, pupils
- Cornea
- Anterior chamber
- Lens
- IOP
- Fundus
- Mental status
- 12th element only
Medical Decision Making (MDM)

- Diagnoses – number of diagnosis
- Tests – amount of data reviewed
- Risk – severity of disease

Source: 1997 Evaluation and Management (E/M) Guidelines

E/M Coding

- 99204 New Patient Level 4 E/M Code
  - Comprehensive history
  - Comprehensive examination
  - Medical decision making of moderate complexity
  - 3 of 3 components required

Source: CPT Manual

E/M Coding

- 99205 New Patient Level 5 E/M Code
  - Comprehensive history
  - Comprehensive examination
  - Medical decision making of high complexity
  - 3 of 3 components required

Source: CPT Manual
Comprehensive Eye Codes

• Documentation
  • History
  • General medical observation
  • External Exam (Adnexa)
  • Gross Visual Fields (CVF)
  • Basic Sensorimotor Exam (Motility)
  • Ophthalmoscopic Exam (Fundus)
  • Always includes initiation of a diagnostic and treatment program

Intermediate Eye Codes

• Documentation
  • Evaluation of new or existing condition
  • Complications of new diagnostic or management problems
  • History
  • General medical observation
  • External ocular and adnexal examination

ICD-10

• ICD - 9
  • 3 to 5 digits
• ICD - 10
  • 3 to 7 digits
  • 14,000 to 68,000 codes
  • Higher specificity
  • More documentation

Source: CPT Manual, Ophthalmology, Coding Rules
**Code Structure Variability**

- Laterality
  - Right eye vs. Left eye
  - No laterality
- Combination codes
  - Diabetes Mellitus

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**Code Structure Variability**

- Age-Related Macular Degeneration (AMD)
  - No laterality
  - Nonexudative AMD
    - ICD - 9 = 362.51
    - ICD - 10 = H35.31
  - Exudative AMD
    - ICD - 9 = 362.52
    - ICD - 10 = H35.32

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**Code Structure Variability**

- Retinal detachment
  - Laterality
    - Single break
    - Multiple breaks
    - Giant tear
    - Retinal dialysis
    - Total
Code Structure Variability

- Diabetes Mellitus
- No laterality
- Severity
- Combination codes
  - Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
  - ICD - 10 = E11.321

- Diabetic retinopathy with macular edema
- ICD - 10 = E11.351

Diagnostic Tests

- Physician’s order
- Date of service
- Reliability of test
- Patient cooperation
- Findings
- Assessment
- Impact on treatment
- Physician’s signature
Case Study

- Practice received chart request from audit contractor
- Practice did not respond in timely manner
- Contractor came to practice
- Contractor received incomplete documentation
  - Missing documentation
  - Missing photos
  - Satellite offices

Case Study

- Extrapolated overpayment determination
- Sample period
  - Error rate calculated at approximately 40%
  - Reimbursement of approximately $10,000,000.00
- Received overpayment demand letter

$4,000,000.00

Case Study

- 3 year battle with Medicare audit contractor
- Redetermination
- Reconsideration
- Administrative Law Judge (ALJ)
- Medicare appeal
- Cost to practice was considerable

$2,000.00
Summary

- Treat every chart request as urgent
- Respond in a timely manner
- Supply complete and legible documentation
- Original signature requirements
- Self disclosure
- Corrective action
- Refund overpayments
- Conduct compliance training
- If it’s not written down, it wasn’t done

Questions