Ways to Improve Medicare Compliance

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Presented by: E. Ann Rose, President, Rose & Associates

Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.

Basic Rules

• Efficient coding and billing important part of Medicare compliance
  – Basic steps can help ensure compliance and improve income
• Should be a team effort
  – Cross-training critical
  – Continuing education essential

Basic Rules

• Select CPT and ICD-10 codes from carefully designed superbill or encounter form
  – Paper or EHR
• Learn coding and billing rules applicable to your practice
  – Be aware of any differences among Medicare, Medicaid or commercial payers

Basic Rules

• Medicare Bulletins and newsletters
  – Read every newsletter or Bulletin from MAC
    • Highlight all items related to ophthalmology and your practice
    • Use route slip and circulate them to all team members and physicians
  – Check websites for newsletters if not received via regular mail

Basic Rules

• Local Coverage Determinations (LCDs)
  – Review on a regular basis
    • Check Active, Draft and Retired files on MAC website
  – These should also be circulated among team members and physicians
• Hold periodic meetings with staff to discuss compliance issues/concerns
Basic Rules

- Ask staff to relate any unusual billing activities since last meeting
  - Increase in denials
  - Requests for additional information
  - Medicare or other payer changing codes or modifiers
  - Payments greater than expected
  - Duplicate payments
- Make sure any issues are promptly corrected or addressed

Accurate Coding & Billing

- Chart documentation must support information on claims submitted to Medicare and other payers
  - Payers rely on your representation and accuracy in the claims documents
  - Claim certifies that you have earned the payment requested and complied with the billing requirements

Accurate Coding & Billing

- If data submitted incorrectly or not supported by documentation in chart
  - Could be asked for refund upon post-payment audit
- There should be an in-house “watch-dog” to make sure the claims are submitted as accurately as possible and supported by the chart notes
  - Someone should also be appointed to work any denials on a daily basis
  - Then fix what caused denial

Accurate Coding & Billing

- Medicare audits paid claims and investigates providers if fraud or abuse suspected
  - Watch for “upcoding”
    - Billing codes that reflect a more severe illness than actually existed or a more expensive treatment than was provided
  - Other issues to look for:
    - Services not actually rendered

Accurate Coding & Billing

- Make sure you use well-trained staff or certified coders when possible
- Appoint a Coding or Billing supervisor
  - Like accounting, there must be checks and balances in place to ensure accurate coding
    - This will help to enhance your compliance and minimize risk of unwanted Medicare attention
**Modifiers**

- Certain modifiers ring bells at Medicare
  - Modifier -25 is used when exam is a significantly, separately identifiable service from the procedure performed
    - If exam is only to determine need for injection in eye scheduled for treatment, visit should not be billed
  - Modifier -25 cannot be used as the "initial evaluation for surgery" like the -57 modifier
    - This is big misconception among physicians

- When procedures or services are performed on both eyes at the same session
  - Clinic must bill as follows:
    - Append the -50 modifier on one line only
    - Bill "1" unit and increase the charge
    - Can no longer bill using -RT and -LT
  - ASC still required to bill bilateral services on two lines
    - Must report with the -RT and -LT modifiers

- Implement new CCI -X modifiers instead
  - New -X modifiers created to clarify when and how services can be unbundled under CCI
    - -XE: Separate encounter: A service that is distinct because it occurred during a separate encounter
    - -XS: Separate structure: A service that is distinct because it was performed on a separate organ/structure

- Make sure you know modifier -25 is being used correctly
  - Tip: Take exam for minor surgery out of mix for a minute
    - Do you have anything left in exam?
    - If answer is no, then don’t append -25 modifier
  - Modifier -57 is to be appended the day before or day of a major surgery (90 day global)
    - Indicates initial evaluation to determine need for surgery

- Modifier -59 - Used to identify distinct procedure on same day as another procedure
  - Must be performed at different session or in different segment of eye
    - Even if “different procedure,” must still be performed in different segment or at different session
  - Modifier -59 is still on OIG radar
    - Use only when no other modifier applies
    - Use very rarely to avoid audit

- -XP: Separate Practitioner: A service that is distinct because it was performed by a different practitioner
- -XL: Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service
  - Pterygium with graft, code 65426, at same time as cataract surgery, code 66984
  - Biopsy performed on separate lesion
Diagnostic Tests

Order for Test

- Make sure test is "ordered" by treating physician
  - Can be in written form (documented)
    - Or order mailed or faxed to clinic performing test
  - If order is verbal by phone, both treating physician and clinic doing test must document telephone call in their own charts
- If not ordered, test will be disallowed in post-payment audit

Order for Test

- Order for test does not require signature by doctor ordering service
  - However, there must be documentation in progress notes that doctor intended the test be performed
    - Signature at bottom of chart of when doctor logs out of EMR authenticates order for test

Test Results

- All test results must be readily available
  - In some instances, photos and results of tests may not be in the paper chart or the EMR
    - Sometimes stored digitally
  - The medical record must document the location of the diagnostic test in this case
    - Disc C, dated 4/1/13, etc., or
    - Notation as to where test result can be found

Interpretation & Report

- There appears to be an increasing lack of compliance with Interpretation & Report requirements
- An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available)
  - Source: Medicare Claims Processing Manual, 100-4, 13-§100

Interpretation & Report

- At minimum MD should address:
  - What was seen or not seen but anticipated
    - Glaucoma
  - What findings suggest as to status of illness
    - Stable, worsening, improving
  - What impact the test results have on treatment
    - Continue present meds, surgery as indicated, see Plan, etc.
- Physician must also sign and date I&R
Revisit Medicare 101

• Coverage of an eye exam (by an ophthalmologist or optometrist) is based on the purpose of the exam, not the ultimate diagnosis of the patient’s condition

• In other words, Medicare pays for “why you saw the patient” not “what you found”

Revisit Medicare 101

• Without a complaint or reason for the visit, exam must be billed to patient as a routine office visit

• Special testing (e.g., visual fields) will be covered for the condition found even though exam is not covered

Revisit Medicare 101

• The chart should always address the question: Why is the patient here today?
  – Decreased vision while reading
  – Trouble driving at night due to glare
  – Pain in right eye, etc.

• New Patient - must be complaint or symptom (or presents with diagnosed condition from another doctor)

Revisit Medicare 101

• The chief complaint provides the basis for the nature of the patient’s presenting illness
  – This is one of the most significant issues in documenting E/M services

• Without a chief complaint, exam is considered routine and not billable
Revisit Medicare 101

- Services must be Medically Necessary, Medically Justified and Medically Reasonable – 3Ms of Medicare
- Items and services must be:
  - Consistent with the symptoms or diagnosis of the illness or injury

Revisit Medicare 101

- Necessary and consistent with generally accepted professional medical standards (not experimental or investigational)
- Not furnished primarily for the convenience of the patient or the physician
- Furnished safely and effectively to the patient

Revisit Medicare 101

- Items and services that are excluded from Medicare:
  - Services not reasonable and necessary
  - Routine check-up with no complaint or condition requiring the check-up
    - Does not include semi-annual glaucoma check-up, periodic macular degeneration check-up, etc.
  - Refractions; glasses check

Revisit Medicare 101

- Remember, Medicare payments are “interim” payments only
  - If billing errors are found, Medicare has the right to request a refund of the monies paid to you for services billed

Patient Encounter

- Make sure documentation of each patient encounter includes:
  - Date
  - Reason for encounter and relevant history, findings, and prior diagnostic test results
  - Assessment and clinical impression
  - Plan of care
  - Past and present diagnoses

Patient Encounter

- Health risk factors
- Patient’s progress, response to and changes in treatment, or patient non-compliance
- Plan of care and any medical decision making
- Patient name on each page of the chart note if still on paper claim
### Signature Requirements

**Appropriate Signatures**

- Medicare requires services be authenticated by author
  - Acceptable signatures for paper claims
    - Legible handwritten signature
    - Valid E-signature
    - Digitized signature
  - If signature not legible, name can be printed above or below entry to identify signature
    - Should be full name with credentials (MD, DO, OD)

- Medicare will accept signature log or attestation statement to be furnished with medical records requested for review
  - Best to get the medical record legibly signed at the time of service
- Acceptable EMR signatures
  - “Electronically signed by” with provider’s name
  - “Verified by” with provider’s name
  - “Reviewed by” with provider’s name

**EHR COMPLIANCE ISSUES**

**Appropriate Signatures**

- "Released by" with provider’s name
- "Signed by" with provider’s name
- "Accepted by" with provider’s name
  - Electronic signature should also include date and time of authentication
- Without correct and legible signatures in a paper chart or EMR, service could be denied as "insufficient documentation"

**Appropriate Signatures**

- “Reviewed by” with provider’s name

**EHR Documentation**

- Copy and Paste Functions
  - Can be fraud and abuse risk
    - May result in a more extensive chart note and make it appear as though a more intensive exam was performed
    - Treatment notes or patient histories may appear as though patient received treatment for a certain condition when, in effect, condition was already resolved
EHR Documentation

- Inserting standardized text into medical record
  - Usually inserted from a pre-selected list of options
  - Could automatically insert text that affects billing and may not be accurate for that patient
    - May appear as though physician reviewed or otherwise treated every condition on the list
    - Is a Risk Adjustment audit issue

EHR Documentation

- Menus
  - May limit available options for diagnoses or procedure codes
    - May only list codes that lead to the highest exam level or payment rate
- Default Settings
  - Could automatically insert text into a note when a note is opened or other action taken
    - User may be unaware of the default which could be inaccurate

EHR Documentation

- To prevent possible exposure and aid in compliance
  - If automated text function used, request that allied staff and physicians always go back and review chart notes for that visit
    - Chart note should show what was meant and extra, unwarranted words were not added
  - When using menu function, make sure EHR allows physicians to pick code he/she wants

EHR Documentation

- If the EHR has an incomplete set of options, work with your IT person or EHR vendor to get this resolved and add more codes
  - If EHR has “audit log” function, make sure it’s on
    - This allows you to see who entered what information into the medical chart, who changed the information, and when it was done
    - This function invaluable in determining what should be in chart and why and how errors were made

EHR Documentation

- EHR systems certainly not error free
  - In some respect, causes more problems as noted
  - Employees should be able to report concerns about upcoding and other EHR issues to the Compliance Officer
    - This helps identify problems and resolve compliance issues before Medicare or other payer action is required

Audits Important to Compliance
Internal Audits

- Conduct internal audits on a regular basis
  - Can be prospective (before claim billed), or
  - Retrospective (past dates of service)
    - By doctor (10 charts or 20 dates of service)
    - By procedure (e.g., complex cataract, modifier -25)
    - One date of service per month
- Ask the following questions:
  - Does service fit a Medicare-covered service?
- Is service medically reasonable and necessary?
- Is there sufficient documentation to support service was ordered and performed?
- Is service coded correctly?
- Are correct physician and practice identification numbers listed on the claim?
- Is there a CPT code that would more accurately reflect the service performed?

Internal Audits

- Local Coverage Determinations (LCDs)
- National Coverage Determinations (NCDs)
- Does the E&M service (99 code) meet the documentation and billing requirements for the level billed?
- Is the appropriate modifier used if one is required?
- Do medical records support coverage requirements
- Does the E&M service (99 code) meet the documentation and billing requirements for the level billed?
- OIG recommends practices be audited at least annually
  - Anything less may result in undue exposure and possible refund requests
  - In a very large practice choose several doctors every 6 months to make it easier to manage
    - Most important part of external is to make sure any deficiencies cited are corrected before next external audit
    - These audits are generally retrospective

Audit Follow-up

- For either an internal or external audit:
  - Identify the deficiencies cited in the audit
  - Determine staff’s internal follow-up action to prevent similar deficiencies from recurring
    - New staff should be presented with this information before billing
    - Current staff should remain aware and routinely review information

Audit Follow-up

- Hold meeting with staff, including physicians, to discuss any claims processing issues or deficiencies that can be resolved through education
  - Make sure all staff involved receives the proper training to prevent errors in the future
  - Document practice’s efforts to improve chart documentation and claims submission process
  - Don’t get complacent with audits
COMPLIANCE PLAN

Compliance Essential

- Develop a compliance plan to include these 7 components
  1. Conduct internal monitoring and auditing
  2. Implement compliance and practice standards
  3. Designate a compliance officer or contact
  4. Conduct appropriate training and education
  5. Respond appropriately to detected offenses and develop corrective action
  6. Develop open lines of communication with employees
  7. Enforce disciplinary standards through well-publicized guidelines

Compliance Essential

- Train your staff
  - Trained staff catch errors early & make corrections more effectively
  - Cross-train staff to assist with coding when needed
- Attend seminars and meetings
  - Medicare sponsored
  - ASOA annual meeting
- Bring potential problem areas to the attention of your supervisor or physician immediately

Compliance Essential

And…….remember……

Just because your competitor is doing something to get paid doesn’t mean you can or should do it!
When in doubt go to your supervisor or physician and ask for help!

Questions

Rose & Associates
1-800-720-9667
results@roseandassociates.com
www.roseandassociates.com