Medicare 201: Practitioner

Importance of Auditing

13 August 2014

EY Fraud Investigation and Dispute Services
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Agenda

- Importance of Auditing
- National and Local Coding Edits
  - Modifiers, Unbundling and Global Period
- Chart Audit
  - Documentation Required to Support the Diagnosis and Treatment Codes
  - Random Sampling using RAT STATS
  - CMS Definition of Error Rate
  - Evaluation and Management Basics
- After the audit
Importance of Auditing OIG 2014 Report

- Improper Payments for Evaluation and Management Services Cost Billions in 2010

  - Medicare paid $32.3 billion for E&M services in 2010
  - Nearly 30% of Part B payments
  - Most improper payment results are errors in coding
  - Medicare inappropriately paid $6.7 billion for E&M services
  - 42% of claims were incorrectly coded
  - 19% lacking documentation
  - 26% were upcoded
Importance of Auditing
OIG Work Plan 2014

► **Evaluation and management services – Inappropriate payments**
  - Reviewing multiple E&M services associated with the same providers and beneficiaries
  - **NEW** - Interested in consecutive patient E&M visits
  - Identified an increased frequency of medical records with identical documentation
Importance of Auditing

► Center for Public Integrity Sept 2012
  ► “coding levels may be accelerating in part because of the increased use of electronic health records…”

► Sebelius-Holder Letter Sept 24, 2012
  ► “False documentation of patient care is not just bad patient care; it’s illegal. The indications include potential ‘cloning’ of records in order to inflate what providers get paid.”
What are auditors looking for?

► Authentication- signatures, dates/times, *supporting metadata*.
► Who did what? Increased use of physician extenders makes identification of service provider critical
► Contradictory information
► Medically implausible or unlikely documentation
► Cloned documentation
► Medically necessary services
What is cloned documentation?

► Medical record documentation should be patient specific.
► Documentation is considered cloned when each entry in the medical record is worded exactly alike or is substantially similar to previous entries.
► Cloning often found in the form of pre-written, template type notes.
► It would not be expected that every patient had the exact same problem, symptoms (or lack of), normal values.
National and Local Edits

► National Correct Coding Initiative (NCCI) established to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims
  ► Comprehensive/Component Edits
  ► Medically Unlikely Edits
  ► Mutually Exclusive Edits
  ► Unbundling
  ► Global Period

► Local Coverage Determinations
  ► Medical Necessity
National and Local Edits

Comprehensive/Component Edits

Identifies code pairs that CMS have determined should not be billed together because one service inherently includes the other (bundled service)

- The code describing a broader and inclusive set of services is identified as being "comprehensive." While the code describing a more discrete service that is actually a subcomponent of the broader service is described with the term "component."

- Since the component code represents a portion of the service described by the comprehensive code it is therefore bundled and may not be reported separately.

- When two bundled procedures are submitted for the same patient during the same session, Medicare payers will ordinarily pay you only for the higher-valued between the two.
National and Local Edits

► **Comprehensive/Component Edits**
  - 43239  Upper gastrointestinal endoscopy with biopsy of stomach
  - Vs
  - 43235 for Upper gastrointestinal endoscopy and 43600 for biopsy of stomach
Medically Unlikely Edits (MUEs)

► To prevent payment for an inappropriate number or quantity of a service

► For example, CPT code 44950 (Appendectomy) may be reported with a maximum of one unit of service since there is only one appendix. If units of service in excess of one are reported, the MUE prevents payment
Mutually Exclusive Edits

Two procedures that for clinical reasons, can not be performed at the same patient encounter because the two procedures are *mutually exclusive* based on anatomic, temporal or gender

- Column 1/Column 2 edits
  - If you code Column 1 code you can not also code a Column 2 code
  - Adding modifier 59 can bypass the edit on most codes
Correct Usage of Modifiers a Key Audit Area

Modifier 59 – Distinct Procedural Services

- Used to identify procedures that are not normally reported together, but are appropriate under the circumstances
- Can lead to “unbundling”
- Documentation must support different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion or separate injury.

Example

- 30905 Control of nasal hemorrhage, simple
- 30903 Control of nasal hemorrhage, complex
  - Modifier -59 would be appropriate if these services occurred at different times of the day.
National and Local Edits

Local Coverage Determinations

► An LCD is a decision by a Medicare administrative contractor (MAC), fiscal intermediary or carrier whether to cover a particular item or service on a MAC-wide, intermediary wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the item or service is reasonable and necessary).
National and Local Edits

LCD for Routine Foot Care: Documentation Requirements

1. All documentation must be maintained and available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information.
3. The submitted medical record should support the use of the selected ICD-9 and CPT/HCPCS code(s).
4. Routine foot care services performed more often than every 60 days will be denied.
5. Physical findings and services must be specific and precise (e.g., left great toe OR right foot, 4th digit).
6. There must be adequate documentation to demonstrate the need for routine foot care services as outlined in this determination.
The Error Rate shall be the percentage of net Overpayments identified in the sample. The net Overpayments shall be calculated by subtracting all underpayments identified in the sample from all gross Overpayments identified in the sample.

The Error Rate is calculated by dividing the net Overpayment identified in the sample by the total dollar amount associated with the Paid Claims in the sample.
Documentation Elements Required to Support the Diagnosis and Treatment Codes

► A medical record that is complete and legible
► Patient encounter information, including the reason for the encounter, relevant history and physical exam findings, results of diagnostic tests, the clinical impression or diagnosis, the plan of care, and the date and identity of the provider
► Documentation for ordering diagnostic and other ancillary services
► Past, present, and revised patient diagnoses
► Appropriate health risk factors
► The patient’s progress, along with responses to and changes in treatment
Data Criteria

► Select time frame for audit
  ► Monthly
  ► Quarterly
  ► Annual

► Select target of audit
  ► Coders/Physicians
  ► Locations (radiology, cath lab or a building site)
  ► HIM coding or charge master description (CDM) coding

► Select sampling methodology
  ► RAT STATs
## Determine Data Items for Review

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Patient Identifier</th>
<th>Diagnoses</th>
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</thead>
<tbody>
<tr>
<td>CPT/HCPCS codes</td>
<td>Modifiers</td>
<td>Units</td>
</tr>
<tr>
<td>Coders</td>
<td>Providers</td>
<td>Location</td>
</tr>
<tr>
<td>DRG/APCs</td>
<td>Paid vs Paid Amount</td>
<td>Documentation</td>
</tr>
<tr>
<td>Data Entry</td>
<td>Denials</td>
<td>Incident to</td>
</tr>
</tbody>
</table>
Random Sampling using RAT STATS

- Free statistical software package available from the OIG
- Providers can download to any computer
- Simple and easy to use
- Generates a random sample
- Statistical tool for the OIG’s Office of Audit Services
RAT STATS Results

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<thead>
<tr>
<th>Date: 5/29/2014</th>
<th>Time: 15:28</th>
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<tr>
<td>Audit: TEST</td>
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<td>Order</td>
<td>Value</td>
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<td>668</td>
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<td>25</td>
<td>506</td>
</tr>
</tbody>
</table>
Evaluation and Management Visits

There are three key elements:

► **History**
  ► Chief Complaint
  ► History of Present Illness
  ► Review of Systems
  ► Past, Social and Family History

► **Exam**
  ► Organ systems reviewed

► **Medical Decision Making**
  ► Number of Diagnoses
  ► Amount of Data Reviewed
  ► Level of Risk
Evaluation and Management
Case example

► This is a new patient.
► 10 year old boy fell off his bike yesterday and injured his elbow, hip and knee. He was seen in the ER and is here now for follow up.
► The mother filled out the office paper work.
► The physician reviewed the X-ray films and called the radiologist to discuss.
► The boy was discharged and prescribed Tylenol.
### Evaluation and Management History Requirements

**New Office Visit - History**

<table>
<thead>
<tr>
<th>History of Present Illness</th>
<th>Brief</th>
<th>Brief</th>
<th>Extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of Systems</td>
<td>None</td>
<td>Pertinent to problem</td>
<td>Extended</td>
</tr>
<tr>
<td>Past Medical, Family and Social History</td>
<td>None</td>
<td>Pertinent</td>
<td>Complete</td>
</tr>
</tbody>
</table>

**Problem Focused**

- Expanded Problem Focused
- Detailed
- Comprehensive
## Evaluation and Management Exam Requirements

| Organ Systems       | 1 system | Up to 7 systems | Up to 7 systems | 8 or more systems
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td></td>
<td>Expanded</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Problem Focused</td>
<td>Detailed</td>
<td></td>
</tr>
</tbody>
</table>

Constitutional, Ears/Nose/Mouth/Throat, Eyes, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Skin, Neurological, Psychological and Hemo/Lymphatics/Immunilogical
### Evaluation and Management Medical Decision Making

<table>
<thead>
<tr>
<th>New Office Visit - Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Second Circle from the Left</strong></td>
</tr>
<tr>
<td>Number of Diagnoses or Treatment Options</td>
</tr>
<tr>
<td>Highest Risk</td>
</tr>
<tr>
<td>Amount and Complexity of Data</td>
</tr>
<tr>
<td>Straight Forward</td>
</tr>
</tbody>
</table>
Evaluation and Management
Putting it all together

<table>
<thead>
<tr>
<th>New Office Visit</th>
<th>Must Meet or Exceed 3 Components</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
<td>Problem Focused</td>
</tr>
<tr>
<td><strong>Exam</strong></td>
<td>Problem Focused</td>
</tr>
<tr>
<td><strong>Medical Decision Making</strong></td>
<td>Straight Forward</td>
</tr>
<tr>
<td><strong>Level</strong></td>
<td>I</td>
</tr>
</tbody>
</table>
Example of CMS Error Rate

<table>
<thead>
<tr>
<th>Past Methodology</th>
<th>Current Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit did not include a dollar value</td>
<td>Audit includes a dollar value</td>
</tr>
<tr>
<td>A True random sampling was cumbersome</td>
<td>RAT STATS tool is readily available and easy to use</td>
</tr>
<tr>
<td>Number of charts were the denominator</td>
<td>Total dollars allowed for selected charts is the denominator</td>
</tr>
</tbody>
</table>
Example of CMS Error Rate

- The audit included 10 randomly selected Level 3 E&M visits
- Eight were coded correctly
- Two supported documentation for Level 2 E&M visits
- 20% error rate?

<table>
<thead>
<tr>
<th>Allowed Amount Billed</th>
<th>Allowed Amount Audited</th>
<th>Net Overpayment</th>
<th>Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 1,203.30</td>
<td>$ 1,129.04</td>
<td>$ 166.40</td>
<td>6%</td>
</tr>
</tbody>
</table>
Example of CMS Error Rate

► The audit included 10 randomly selected Level 3 E&M visits
► Seven supported documentation for Level 3 E&M visits
► Two supported documentation for Level 2 E&M visits
► One supported documentation for a Level 4 E&M visit
► 30% error rate?

<table>
<thead>
<tr>
<th>Allowed Amount Billed</th>
<th>Allowed Amount Audited</th>
<th>Net Overpayment</th>
<th>Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,203.30</td>
<td>$1,192.24</td>
<td>$11.06</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>
After the audit

► Develop an action plan to remediate any negative findings
  ► Make vs buy decisions on education and training
► Follow-up as needed to ensure understanding and continued compliance
► Maintain documentation of the audit and remediation plan and any additional follow-up
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