Cracking The Code

A PRACTICAL APPROACH TO CORRECT CODING & PREVENTING CARRIER AUDITS

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Dr. Rumpakis is currently President & CEO of Practice Resource Management, Inc., a firm that has been providing a full array of consulting, appraisal, and management services for healthcare professionals and industry partners for the past 30 years. He has developed some of the leading Internet-based software applications for the medical/eye care field such as CodeSAFEPLUS.com® (www.CodeSAFEPLUS.com), the industry leading cloud-based CPT & ICD Code Data and Information Service, and offers personal medical coding consultation through JustAskJohn (www.JustAskJohn.info). He is also the founder of Opt-ED® Professional Optometric Continuing Education (www.Opt-ED.com) which creates and delivers top tier continuing education around the country as well as Opt-IN® which provides optometric marketing and promotional services.

Financial Disclosures – John Rumpakis, OD, MBA

I Am A Project Based Consultant & Have Received Honoraria From:

- Alcon Laboratories
- Carl Zeiss Meditec
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- Certis Vision
- CooperVision
- Essilor of America
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Disclosures

- All fees represented within this presentation are the 2016 Medicare Maximum Allowable Reimbursements for each procedure listed as of October 13th, 2016 for this zip code.
- All information regarding policies, procedures, guidelines and definitions is current as of October 13th, 2016.
- Each viewer is responsible to be current in their own geographical jurisdiction interpretation of policies, procedures, guidelines and definitions prior to implementation within their own practice.
- The coding examples contained this presentation are examples only and each practitioner should apply these coding guidelines to what is actually recorded in the patients’ medical record before submitting any claim to a third party carrier.

Abstract & Outcomes

**ABSTRACT**

- In today's world of third party relationships between payer and provider, audits of all types are becoming increasingly more frequent and more economically impactful. Practitioners need to know how to identify the specific type of audit, and how to properly (legally) respond to protect themselves and their practices.

**OUTCOMES**

- Be able to understand the current market landscape for third party payer audits and the type of behaviors that trigger an audit.
- Be able to properly identify the type of audit for which they are being targeted.
- Be able to determine what the audit is pertaining to and the scope of the audit.
- Be able to know how to respond and the impact of how your response can affect the outcome of the audit.
- Be able to know when and what type of professionals they should have assisting in their defense.
- Be able to understand common goals of a payer and provider from the outcome of an audit.
- Be able to develop an internal compliance plan to minimize future exposure.

2017 Coding Requires 2017 Rules & Resources

- Get Your Resource Material
  - By Book
    - CPT 2017
    - ICD-10 2017
    - HCPCS Level II 2017
  - Or Get Everything Updated AUTOMATICALLY
    - Online Cloud-Based Resources
Three Resources You Are Going To Need...

John@PRMI.com
www.CodeSAFEPLUS.com
www.JustAskJohn.info

But John, I’m So Confused...
EVERYBODY’S AN EXPERT??? THERE ARE SO MANY DIFFERENT PEOPLE THAT SAY SO MANY DIFFERENT THINGS...

TRANSPARENCY
We Make It Harder Than It Really Is!

- The patient’s condition determines everything that you do.
  - History that was required understand the patient’s complaint
  - Exam that was required to properly diagnose the condition
  - Assessment of the condition(s)
  - Plan to provide the best outcome in the most efficient way that is concurrent with local standard of care
- What you do with the patient determines what you write down in the medical record.
- What you have written down determines the codes you use to describe the care required.

Bottom Line

The individual patient presentation or what you have them returning for determines everything that you do with them, and therefore determines the services performed and the subsequent coding of those services.

A Couple Of Foundational Documents That Matter

- U.S. FALSE CLAIMS ACT
- AND EACH SPECIFIC CARRIER CONTRACT YOU HAVE SIGNED
The U.S. False Claims Act

A person does not violate the False Claims Act by submitting a false claim to the government;
To violate the FCA a person must have submitted, or caused the submission of, the false claim (or made a false statement or record) with knowledge of the falsity. In § 3729(b)(1), knowledge of false information is defined as being (1) actual knowledge, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the truth or falsity of the information.

Definition Of A Claim:

It is a demand for money or property made directly to the Federal Government or to a contractor, grantee, or other recipient if the money is to be spent on the government’s behalf and if the Federal Government provides any of the money demanded or if the Federal Government will reimburse the contractor or grantee.

Provider Relationships

The Basics of Professional Ethics

Other than the doctor/patient relationship (the most important relationship), ethical behavior of providers is organized around:
- Relationships with payers
- Relationships with fellow providers
- Relationships with vendors
Relationships With Payers
- Relationships with patients is increasingly dominated by a third party – the payer
- Components of the provider/payer relationship include:
  - Accurate coding and billing
  - Accurate medical records documentation
  - Prescription authority
  - Assignment within the Medicare system

Relationship With Payers
Accurate Billing and Coding
The main issues involved in billing for rendered services include:
- Billing only for:
  - medically necessary care
  - services actually performed
- Not Billing for:
  - services with no benefit or beneficial outcome
  - services provided by improperly trained or improperly supervised care
  - services provided by a provider included in the Exclusion Statute

Special Note!
- The OIG is VERY serious about “worthless” services – patient services that provide no real diagnostic or therapeutic benefit to the patient. The last three convictions in 2014 all resulted in CRIMINAL convictions with federal prison sentences up to 10 years
“Worthless Services” – Per CMS

- is not accepted as safe and effective by the medical community
- is not supported in peer-reviewed medical literature
- is experimental or investigational
- is not medically necessary in a specific case or specific medical Dx
- is furnished at a level, duration, dosage or frequency not appropriate for a specific patient or clinical condition
- is not furnished in a manner consistent with standards of care
- is not furnished in a setting (place of service) consistent with the patient’s medical needs and condition
- is furnished in a manner for patient or provider convenience
- is a device is not approved by the FDA
- is a test or service now considered obsolete

Fundamental Principles Are IMPORTANT!

What do you do?
(hint... think evidence based medicine)

What does this patient need?
(hint... not what do you want to do)

What is in the patient’s best interest?

Medical Necessity Is...

“Services or supplies that are proper and needed for the diagnosis or treatment of the patient’s medical conditions, are provided for the diagnosis, direct care and treatment of the patient’s medical condition, meet the standards of good medical practice in the local area and aren’t mainly for the convenience of the patient or the physician.”

Source: www.Medicare.gov
So What Exactly Does That Mean?

The medical record must clearly demonstrate that the service, procedure, or test ordered & performed was absolutely necessary in order to diagnose, treat, or monitor the treatment of the patient’s condition.

E&M Medical Necessity -

Medical Necessity of E&M Services

- Section 1862(a)(1)(A) of the SSA, “Exclusions From Coverage and Medicare as Secondary Payer” does not include expenses acquired for items and services which are not deemed necessary for the diagnosis or treatment of illness or injury. This applies to all services.

- CMS IOS Publication 100-04, Chapter 12, Section 30.6.1 states:
  “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.”

Relationship With Payers

Medical Records Documentation

By contract with the payer, providers attest that the patient’s medical records are:

- Accurate
- Complete
- Show justification of medical necessity

- Have you ever read the back of your CMS - 1500 form?
  - It is a LEGAL CONTRACT assuring the necessity and truthfulness of your services.
The Contract You Sign 20x Per Day (and have never read…)

- In submitting this claim for payment from Federal Funds, I certify that:
  1. The information on this form is true, accurate and complete
  2. I have familiarized myself with all laws, regulations and program instructions available from the Medicare contractor
  3. I have provided or can provide sufficient information required to allow the government to make an informed eligibility and payment decision
  4. This claim complies with all Medicare program instructions

And The Icing On The Cake...

“My signature is to certify that the foregoing information is true and accurate. I understand that any false claims or statements or concealment of a material fact may be prosecuted under applicable Federal and Stark laws.”

Important Definitions

**FRAUD**
- When someone intentionally falsifies information or deceives Medicare.

**ABUSE**
- When health care providers or suppliers don’t follow good medical practices, resulting in unnecessary costs, improper payments, or services that aren’t medically necessary.

The Only Difference Between Fraud & Abuse is intent.

CMS Fraud Detection - Past & Present

PAST
- Providers suspected of fraudulent activity were put on prepay review, sometimes indefinitely
- CMS initiated overpayment recovery
- Law enforcement determined if an arrest is appropriate

PRESENT
- Denies individual claims
- Its contractors use prepay review as an investigative technique
- Revokes providers for improper practices
- Collaborates with law enforcement before, during and after case development
- Addresses the root cause of identified vulnerabilities

Health Care Fraud
WHERE DOES THE LEGAL OBLIGATION OF USING THE CPT & ICD SYSTEMS COME FROM? IT IS CRITICAL TO KNOW!

Who Is The OIG?
THE OFFICE OF INSPECTOR GENERAL
The OIG & Their Mission

- The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452 (as amended), is to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs.

http://oig.hhs.gov/

The OIG Work Plan

- The OIG Work Plan sets forth various projects to be addressed during the fiscal year by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General. The Work Plan includes projects planned in each of the Department’s major entities: the Centers for Medicare & Medicaid Services; the public health agencies; and the Administrations for Children, Families, and Aging.

- Information is also provided on projects related to issues that cut across departmental programs, including State and local government use of Federal funds, as well as the functional areas of the Office of the Secretary. Some of the projects described in the Work Plan are statutorily required, such as the audit of the Department’s financial statements, which is mandated by the Government Management Reform Act.

http://oig.hhs.gov/publications/workplan.asp
What Is The Current Audit Environment?

UNDERSTANDING THE CARRIER ENVIRONMENT IS CRITICAL TO EVERYTHING

The Government Recovery Is Hitting Records!

Technology Is Driving Monetary Recoveries...

...And At A Blistering Pace

Using “Big Data” analysis returned an increase from 2014 to 11.6 to 1 return on investment in 2016!
The Affordable Care Act has enabled CMS to expand efforts to prevent and fight fraud, waste and abuse. Since the Affordable Care Act, CMS has revoked 14,663 providers and suppliers’ ability to bill in the Medicare program since March 2011. These providers were removed from the program because they had felony convictions, were not operational at the address CMS had on file, or were not in compliance with CMS rules.

Update on CMS’ Anti-Fraud Efforts

Medicare Urges Seniors to Join the Fight Against Fraud

In mailboxes across the country, people with Medicare will soon see a strengthened statement of their claims for services and benefits that will help further combat potential fraud, waste and abuse. Because of actions like these and new tools under the Affordable Care Act, the number of suspected providers and suppliers thrown out of the Medicare program has more than doubled in 26 states.

In all states, the number of revocations has quadrupled since CMS put the Affordable Care Act screening and review requirements in place, as well as the implementation of practice data analysis to identify potential license discrepancies of enrolled individuals and entities. These efforts are ensuring that only qualified and legitimate providers and suppliers can provide health care products and services to Medicare beneficiaries.
Everyone Is Looking To Be Rewarded!

And It’s Not Just CMS We Need To Worry About!

What Is A “Red Flag” That Triggers An Audit?

- Using codes under review by the OIG
- Not reviewing your submitted claims against recovery audit issues
- Abusing codes
- Aberrant or inconsistent billing patterns
- Maximizing revenue without sufficient documentation
- Cloning of documentation
- Not understanding definitions of modifiers and inappropriate use of modifiers
The Top Three Issues For Audit Failure

1. Lack of medical necessity noted in record
   a) Special ophthalmic testing that falls outside of profile
2. Improper coding of office visits
   a) Using codes out of habit and not based upon patient needs
3. Improper use of modifiers -25 and -59
   a) Not understanding rules and definitions of modifiers and proper application of them to clinical circumstances

The Yates Memo...

- A recent memorandum issued by U.S. Deputy Attorney General Sally Yates to the U.S. Department of Justice outlined the government’s renewed focus on seeking accountability from individuals who engaged in wrongdoing.
  - Impact on practices – anyone, including staff, can have liability if participating in a known practice that is wrong.

Where Can I Get Information On Myself?

- www.ProPublica.org
- www.FindTheBest.com
- www.CMS.gov
Uh Oh, I Think I’m Getting Audited

• First, read your notice very carefully. What did you actually receive?
  o Heralding Notice – This alerts all providers that the payer intends to conduct audits system wide. It DOES NOT necessarily mean that you are getting audited.
  o Notice of Audit – This is an official notification that you ARE getting audited.

Determine The Scope Of The Audit

• Key Questions/Issues
• Is the audit for recovery or fraud?
• Is it an education or network-wide audit?
• Is the payer asking for specific records?
• How many records is the payer asking for?
  o There is a significant difference between asking for 20 records or 100 records. The higher the number indicates a more comprehensive review and the expectation of a higher recovery.
• Is the payer suspecting improper coding or billing issues?
• Be aware of medical necessity language

Types Of Audits

• Pre-payment Audit – Generally automated and you may never even know about it. If the payer requests documentation, they are looking at a specific issue.
• Post-payment Audit – After the claim is paid, the payer requests specific information to support the coding and claim.
• Automated Review Audit – A computer generated review performed to identify violations in standard rules or edits. The review is usually associated with a very clear and concise policy. The objective is to make sure that the claim meets all of the edits and rules for payment.
Types Of Audits

- Comprehensive Review Audit – This is a review of the entire medical record performed by a certified reviewer. The payer may apply standard criteria (i.e. CMS standards) to identify and determine medical necessity requirements or to validate that the service was provided.

- Fraud & Abuse Audit* – This is an audit that has been elevated within the carrier when there is specific suspicion of intentional violation of coding rules.

- Claim Recovery (Administrative Review) Audit – An audit that is focused on violation of coding rules, where intentional fraud is not suspected.

- Claim Focused Audit – The payer is looking at specific types of claims or services, but is not necessarily focusing on your particular practice.

- Provider Focused Audit – An audit that is focusing specifically on your practice or a specific provider within your practice with concern surrounding specific coding and billing behaviors.

*If an audit is being conducted by the SIU (Special Investigations Unit), it is because there is a very high degree of suspicion that there is intentional fraudulent behavior and the potential penalties can be much more significant.

Build Your Team

- Audits are a serious issue and should be treated accordingly.
- Find out who at the carrier is conducting the audit?
  - Learning the department within the carrier that is conducting the audit can provide you with insight on the level of seriousness.
  - Don’t go it alone
  - Build your team with individuals who can properly assist you in audit defense.
    - An OD based firm that specialized in audit defense.
    - An attorney, who can help you understand your rights and responsibilities under your provider contract.
Develop A Plan

• If the audit is for recovery or fraud
• Get your team together
• Assign someone in the office as the primary contact point for the carrier (someone familiar with medical records)
• Create a depository for all communication
• Retain an attorney and a audit expert to assist in building a defense, if possible.

Deadlines Matter

• Pay attention to all date specific deadlines that are communicated.
• General time limits to pull records is 45 days, but can vary based upon your individual contract and your states Prompt Payment Law.
• Assemble the correct information to send. Don’t fail an audit because you failed to submit the requested information
• Send copies of records, not the originals. If you can’t find a record in question, request more time.
• Never send less than what the carrier is requesting.

They Found Something, Now What?

• If an audit leads to a request for recoupment of claims payment, ask for time to review the demand letter.
• Was the demand letter received within the proper time period following the audit?
• Was proper rationale and justification provided with explanation of how they determined the recovery amount?
• Did the payer provide an explanation for each claim incorrectly paid or coded?
• Did the payer explain statistical sampling and extrapolation?
• Did the payer provide information regarding your rights of appeal and the timeframe and requirements of it?
How Can You Fight Big Data & Technology?

LET'S FIGHT BACK WITH REAL-TIME DATA & INFORMATION THAT IS SPECIFIC TO YOUR ZIP CODE & ALWAYS ACCURATE!

CodeSAFEPLUS.com
THE INDUSTRY LEADER IN CLOUD-BASED CPT & ICD DATA SERVICES

And When A More Personal Solution Is Needed...

www.JustAskJohn.info
ONE-ON-ONE PERSONAL CODING CONSULTATION SERVICES
The Key Items To Remember

- Provide only the care that is necessary for the individual patient presentation on that specific day.
- Know, understand, and adhere to the CPT definitions of the office visit codes.
- When using a modifier – understand the definition and use them judiciously
- Follow the rules that you have agreed to with your carrier. If you don’t agree with the rules, then re-evaluate your relationship with that specific carrier.

Protecting Your Practice For The Future

- Conduct internal audits on a regular basis
- Make sure that you have current rules, are using current codes, and that you are following them properly for your location
- Insure that your documentation supports the level of service being provided
- Make sure that the patient’s condition supports the procedures performed and the level of complexity billed. Scrutinize your records for statements of medical necessity.
- Compare how you practice with your peers. Usually, a physician is targeted for an audit because of being an outlier, or having unusual billing practices. Patients can also alert carriers as well.

The Best Defense Is A GREAT Offense

- Understand the use of codes under review by the OIG
- Constantly review your submitted claims against recovery audit issues
- Learn your codes and their definitions to prevent abusing them
- Avoid aberrant or inconsistent billing patterns
- Be consistent in your billing patterns and charges between all payer types. Don’t discriminate by carrier or private pay.
- Make sure your documentation is PERFECT – avoid cloning
- Learn and understand definitions of modifiers and avoid inappropriate use of modifiers in your practice
Cracking The Code

A PRACTICAL APPROACH TO CORRECT CODING & PREVENTING CARRIER AUDITS

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