HCCA HEALTH CARE COMPLIANCE ASSOCIATION

Compliance TODAY

July 2017

A PUBLICATION OF THE HEALTH CARE COMPLIANCE ASSOCIATION

WWW.HCCA-INFO.ORG

Watching out for America's health

an interview with Mike Joyce

Vice President, Chief Auditor
& Compliance Officer
Blue Cross Blue Shield Association
Chicago

See page 16

Contents

July 2017

FEATURES

COLUMNS

DEPARTMENTS

Compliance Today is printed with 100% soy-based, water-soluable inks on recycled paper, which includes includes 10% post-consumer waste. The remaining fiber comes from responsibly managed forests. The energy used to produce the paper is Green-e® certified renewable energy. Certifications for the paper include Forest Stewardship Council (FSC), Sustainable Forestry Initiative (SFI), and Programme for the Endorsement of Forest Certification (PEFC).

by Deborah Hill, MBA, CMPE, CPC, CHC

Rolling the dice: Gambling with improper documentation and billing practices

» Some internal processes may enhance revenue but increase risk.
» Various documentation elements can expose your practice to compliance risk.
» The documentation process imposes limits on use of support staff.
» Coding outliers in your organization can be identified.
» Baseline and regular random reviews are critical to maintaining compliance.

Deborah Hill *(dhill@cokergroup.com) is a Senior Manager at the Coker Group in Alpharetta, GA.*

In the electronic age of medical records and patient portals intended to improve connectivity between patients and providers while improving clinical outcomes, the promise of increased (or at least sustained) provider productivity has gone by the wayside in many practices across the nation. Physicians and providers increasingly are frustrated by the growing time demands needed to meet additional documentation requirements. In an effort to maintain previous productivity thresholds and associated revenue as well as to decelerate provider frustration, creative measures to adopt electronic medical records (EMRs) and utilize practice resources have evolved. Additionally, questionable provider behaviors and shortcuts were implemented to save providers time in their daily routine. As expected, a common byproduct of such tactics is an increased compliance risk. Some practices are virtually rolling the dice and gambling that these schemes will escape increased external audit scrutiny. The answers to some key questions can identify multiple areas that may need further investigation to eliminate risky behaviors from the daily workflow.

Hill

Internal processes designed to increase revenue and patient through-put may also expose the practice to unnecessary risk because of improper billing practices. Additionally, each specialty has its set of unique issues and remedies. The following areas have undergone scrutiny for years, and they continue to be problematic on a nationwide scale, even with annual focus and constant awareness efforts.

To guard against the risk of non-compliance, review this list of common practice processes that may have been initiated to increase efficiency and provide greater patient access. Ask yourself these questions and consider any responses that may need to be carefully examined to ensure compliance:

- Are non-physician providers (NPP) employed in the practice?

- Are they practicing within their scope of practice for your state?
  - Are their services billed independently or under the supervision of a physician?
  - Is there a clear understanding of the incident-to and split/shared service requirements?
  - Are all NPPs enrolled with Medicare and Medicaid?
- Are locum tenens employed in the practice?
  - Are they employed to add patient capacity?
- Are the requirements and limitations for billing these services understood clearly?
- Are support staff (e.g., medical assistants and scribes) used to initiate and capture information during the patient encounter?
  - Do the physicians/providers understand what they are expected to document themselves? For example, the physician/NPP is expected to develop and document the history of present illness (HPI), complete the physical exam, and determine the assessment and plan (A&P).
  - Are the documentation limitations of support staff understood? For example, a scribe can only document what is verbalized or witnessed during the patient encounter. He/she cannot complete any of this information independently.

Who can document?

The use of support staff, such as medical assistants (MA) and scribes, to help a provider become more efficient and productive is a growing and clearly understandable practice in many medical specialties to offset the time required to use an EMR and to ensure quality metrics are achieved. This assistance generally results in a more complete medical record and allows the provider to spend more time face to face with the patient. Nevertheless, there are specific limitations to services and documentation an MA or scribe is authorized to provide, and delegating these physician/NPP responsibilities to the support staff is inappropriate and non-compliant.

> The information gathered by ancillary staff...may be used as preliminary information, but needs to be confirmed and completed by the physician.

Per the Centers for Medicare & Medicaid Services (CMS), only the physician or NPP who is conducting the evaluation and management (E&M) visit can perform the HPI and chief complaint (CC). This is physician work and cannot be relegated to ancillary staff.

Noridian Healthcare Solutions (Noridian) reminds providers that E&M codes are valued as including all elements of work to be performed by the physician or NPP when "physician" criteria are met. Although ancillary staff may question the patient regarding the CC, that does not meet criteria for documentation of the HPI. The information gathered by ancillary staff (i.e., Registered Nurse, Licensed Practical Nurse, MA) may be used as preliminary information, but needs to be confirmed and completed by the physician. The ancillary staff may write down the HPI as the physician dictates and performs it. The physician reviews the information as documented, recorded, or scribed and writes a notation that he/she reviewed it for accuracy and did perform it, adding to it if necessary, and signing his/her name.

Reviewing information obtained by ancillary staff and writing a declarative sentence does not suffice for the HPI. An example of unacceptable HPI documentation would be, "I have reviewed the HPI and agree with above."

A scribe's core responsibility is to capture accurate and detailed documentation (e.g., handwritten, electronic, or otherwise) of the encounter in a timely manner. Scribes are not permitted to make independent decisions or translations while capturing or entering information into the health record or EHR beyond what is directed by the provider. The general duties of a scribe may vary and can include:

- Assisting the provider in navigating the EHR;
- Responding to various messages as directed by the provider;
- Locating information for review (e.g., previous notes, reports, test results, and laboratory results);
- Entering information into the EHR as directed by the provider; and
- Researching information requested by the provider.

The role of a scribe is dependent upon the provider practice and setting. It is possible for a provider to select a clinical assistant (i.e., non-licensed clinical staff) who has performed clinical duties and worked with the provider to perform scribe services. It is not recommended, however, to allow an individual to fill the role of scribe and clinical assistant simultaneously during the same encounter. This practice raises legal and other issues regarding job role and responsibilities.[1]

What is the reason for the visit?

The next area of significant risk is in the documentation itself and how that translates into billable charges. Not only does this expose the practice to unnecessary risk, but it also inflates the accounts receivable with charges that may never be paid based on common coding policies.

For groups and practices that incentivize the more productive physicians/providers in the practice based on some work relative value unit (wRVU) model, careful consideration of charges/wRVUs billed compared to payments/wRVUs paid should be considered. Many physicians have learned how to play the game of submitting charges for services that they will receive wRVU credit for, but that will never be paid (e.g., unbundling, multiple procedure payment reductions, E&M with procedure codes, billing for assist at surgery).

According to the results of audits completed under the Comprehensive Error Rate Testing (CERT) program in 2013:

> E&M services for Office Visits Established, Hospital Initial, and Hospital Subsequent were identified as the top three CERT errors in E&M service categories. High errors consisted of insufficient documentation, no documentation, and incorrect coding of E&M services to support medical necessity and accurate billing of E&M services.[2]

When an outsider looks at your medical records, the medical reason(s) for the visit should be crystal clear within the first line or two of the encounter documentation. If it is not, medical necessity is not established, and this exposes the practice to non-compliance risk.

Answering the questions

Consider this next list of questions. How you would answer them if a Recovery Audit Contractor (RAC) showed up at your front desk to audit your charts?

Does the physician/NPP share their login with any other member of the staff so that documentation can be initiated in the provider's name?

The author of any documentation in a patient medical record must be readily identifiable and distinguishable. Physicians/providers that share EMR login information with support staff in order to give a false impression of the author of the documentation are engaging in non-compliant behavior.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a handwritten or electronic signature. Stamped signatures are not acceptable.[3]

Are documentation templates used in your practice to ensure complete documentation?

- Are these pre-populated to ensure high levels of HPI and physical exam (PE)?
- Is documentation from previous dates of service copied into current encounters?
- Are frequently used blocks of documentation cloned from note to note?

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author.

In 2012, cloned documentation was already on the radar of the independent contractors engaged by the Medicare Administrative Contractor (MAC). They clearly recognized that these steps were taken to increase provider efficiency, but it didn't change the fact that the cloned notes were misrepresentations of the visit.

As reported by *Medscape*, "Cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient."[4]

Does your EMR automatically calculate the level of service that can be billed?

- Does the EMR require a procedure/ICD-10 match when diagnostics are ordered?
- Does it give hints about elements that could be added to support a higher level of service?
- Does the physician/NPP have to validate the level of service to be billed?

Are the physicians/NPPs required to complete documentation within a certain timeframe?

- Are claims dropped before the documentation is finalized and signed by the provider?
- Are physicians/NPPs held accountable for timely completion of documentation?

Are diagnosis codes from previous visits pre-populated into the current encounter?

- Is documentation reviewed by coding or billing staff prior to claim submission?
- Do they have the authority to change levels of service and diagnosis codes or diagnosis priority?

Are diagnostic services provided in the practice (i.e., lab, pathology, radiology, EKG, etc.)?

- If an internal physician provides professional diagnostic interpretation, are the documentation requirements for billing those services understood clearly? Does the documentation meet those requirements?

For example, the radiology over-read report serves as an official interpretation and legal record of the episode of care, and therefore, it should be documented according to the American College of Radiology (ACR) documentation guidelines and should include the same components traditionally found in a radiologist's report.[5]

In primary care practices, are preventive services provided to Medicare patients?

- Are these billed with the appropriate preventive service codes (G0403, G0438, G0439, etc.) or as high-level E&M codes?

In primary care practices, are E&M services routinely billed on the same date of service as preventive services?

- Is the concept of "significant and separately identifiable E&M service" understood by staff and providers?
- Are Advanced Beneficiary Notices (ABNs) used to notify Medicare patients about potential out-of-pocket expense for services that may not be medically necessary?

In surgical practices and other specialty practices, are high-level PE templates used to enable a higher level of service to be billed?

In surgical practices and other specialty practices, are E&M services routinely billed on the same date of service as minor surgical procedures?

- Is "significant and separately identifiable E&M service" understood by staff and providers?

The problem with this guideline is the definition of "significant and separately identifiable" is based on the subjective opinion of the provider and anyone reviewing the record. As a warning, Modifier 25 continues to be on the watch list for CMS, payers, and the OIG, because of the frequency it is billed and the frequency an audit recovers funds because the E&M visit was not substantiated by the documentation.

In surgical practices and other specialty practices, are multiple procedures billed on the same date of service?

In an article in *Physicians Practice*, Betsy Nicoletti explains the use of Modifier 25:

> The National Correct Coding Initiative (NCCI) manual states 'The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. …If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is 'new' to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure.
>
> And the CMS manual states that 'The initial evaluation is always included in the allowance for a minor surgical procedure.'[6]

This list is just a sample of the questions that should be considered, and they likely will lead to a hundred more. These items are under scrutiny because they are commonplace in a 2017 medical practice and many administrators, physicians, billing directors, etc., will bend the rules and stretch the limits of what is "acceptable" to increase revenue, which is the essence of fraud and abuse.

What are the potential consequences for incidences of fraud and abuse?

As you can see from the figure from CMS (see Figure 1), there are significant occurrences of "bending the rules," which is considered abuse and defined as "practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program." The bottom segment of the figure includes intentional deceptions, such as fraud, which is defined as "knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a Federal health care payment for which no entitlement would otherwise exist."

An easy way to compare your physician/providers billing patterns for E&M services is to plot their activity on a national bell curve for their specialty. This information is published every year and is also available by request from CMS. Examples of questionable coding patterns are shown in Figures 2 and 3.

In Figure 2, this particular physician is billing almost 70% of new patient visits at a level IV and 40% of the established patient visits at level IV as well. Compared to the national bell curve, the physician is over coding and is probably already on the radar because of the variance from peers of the space specialty. Comparing this information to a baseline record review would give a clearer view of the whole picture. If this physician is using templates that show comprehensive HPI and PE but has low medical decision making (MDM), this indicates the medical necessity may not support such a high-level exam. Also, if the physician is allowing ancillary staff to do all the workup and not documenting those services appropriately, that workup would be reduced as well. The next step is to use the bell curve information to see what effect changes to the coding pattern would have on the practice.

Looking at the impact on wRVU totals in Figure 3, the variance of this physician's coding pattern to the national bell curve is pretty startling. This would clearly indicate that the records should be reviewed.

Conclusion

Based on the information presented, it is clear that ignoring this information could lead to disaster. A baseline assessment and review of

Figure 1: Types of Improper Payments[7]

* The types of improper payments in Figure 1 are examples for educational purposes. Providers who engage in incorrect coding, ordering excessive diagnostic tests, upcoding, or billing for services or supplies not provided may be subject to administrative, civil, or criminal liability.

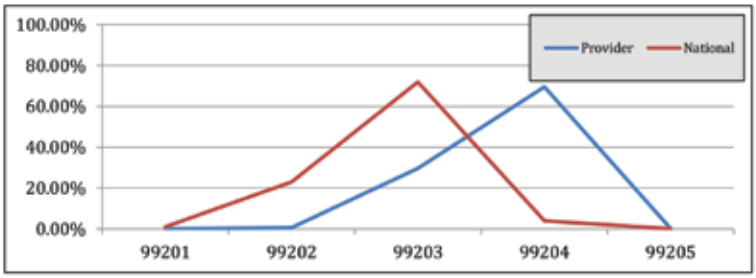
the internal processes, staff functions, EMR setup and issues, and documentation and coding review of the physicians and providers should be scheduled on a regular basis. Additionally, a frank discussion with the Billing department to understand the denials and adjustments related to improper coding would help identify areas that need immediate attention. An ongoing education program for the staff and providers related to compliance and the repercussions of non-compliance is also a stark reminder of what happens when the rules are broken. On the other hand, if you are sure your practice is documenting, coding, and billing in a compliant manner, carry on. I guess it just depends on how lucky you feel, so go ahead and roll the dice.

1. AHIMA: "Using Medical Scribes in a Physician Practice" Available at http://bit.ly/2qAHvrY
2. CMS fact sheet: "Complying With Medical Record Documentation Requirements" Available at http://go.cms.gov/2roIaMi
3. CMS: Medicare Program Integrity Manual, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions. 3.3.2.4 Signature Requirements. Available at http://go.cms.gov/2smCoIA
4. Robert Lowes: "Cloned EHR Notes Jeopardize Medicare Payment" *Medscape*; September 25, 2012. Available at http://wb.md/2rEYda0.
5. American College of Radiology: ACR Practice Parameter for Communication of Diagnostic Imaging Findings, Resolution 11 (Revised 2014). Available at http://bit.ly/2smW1A5
6. Betsy Nicoletti"Use of Modifier 25 Explained" *Physicians Practice*, September 4, 2013, http://bit.ly/2rkDl4L.
7. CMS: Medicare Learning Network: Medicare Fraud & Abuse: Prevention, Detection, and Reporting. ICN 00627, October 2016. Available at http://go.cms.gov/2rksSWV.

Figure 2: Questionable Coding Pattern 1

Total New Patient Visits = 1,391

	% of visits	
	Provider	Nat'l Disp.
99201	0.07%	1.04%
99202	0.65%	23.02%
99203	29.62%	71.88%
99204	69.52%	3.98%
99205	0.14%	0.08%
Total	100.00%	100.00%



Total Estab Patient Visits = 7,171

	% of visits	
	Provider	Nat'l Disp.
99211	0.00%	0.90%
99212	1.65%	29.84%
99213	57.68%	65.55%
99214	40.18%	3.66%
99215	0.50%	0.05%
Total	100.00%	100.00%

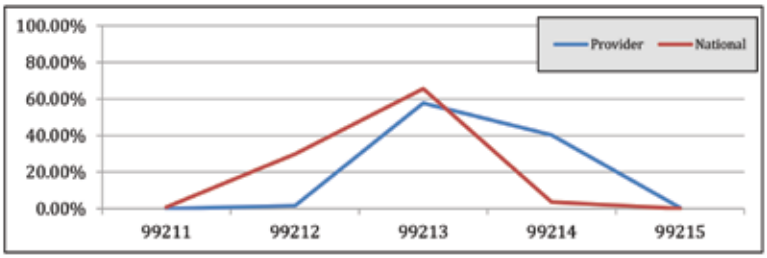
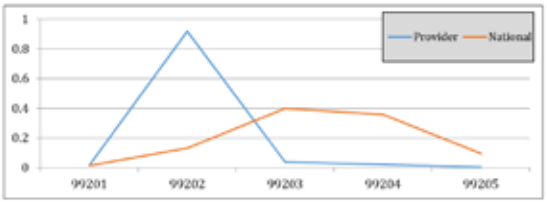


Figure 3: Questionable Coding Pattern 2

Total New Patient Visits = 1,283

		% of visits		wRVU Impact		Difference Per Code
	wRVU	Provider	Nat'l Disp.	Provider	Nat'l Disp.	
99201	0.48	0.07%	1.04%	0.44	6.40	5.96
99202	0.93	0.65%	23.02%	7.72	274.67	266.95
99203	1.42	29.62%	71.88%	539.62	1309.55	769.94
99204	2.43	69.52%	3.98%	2167.37	124.08	-2043.28
99205	3.17	0.14%	0.08%	5.85	3.25	-2.59
Total		100.00%	100.00%	2720.99	1717.97	-1003.03



Total Estab Patient Visits = 6,136

		% of visits		wRVU Impact		Difference Per Code
	wRVU	Provider	Nat'l Disp.	Provider	Nat'l Disp.	
99211	0.18	0.00%	0.90%	0.00	9.94	9.94
99212	0.48	1.65%	29.84%	48.47	878.87	830.41
99213	0.97	57.68%	65.55%	3432.87	3901.48	468.61
99214	1.50	40.18%	3.66%	3697.77	336.87	-3360.91
99215	2.11	0.50%	0.05%	65.00	6.47	-58.52
Total		100.00%	100.00%	7244.11	5133.64	-2110.47