

THE PHYSICIAN'S CODING COMPLIANCE ALERT™

ENSURING APPROPRIATE REIMBURSEMENT WITH MINIMIZED AUDIT RISK

Physician Coding Practices Face Intense Federal Scrutiny in 2002

By its own estimates, the government shelled out \$11.9 billion in improper Medicare benefit payments during fiscal year 2000, a finding guaranteed to spur closer attention to your paperwork. This sizable figure represents 6.8% of the total \$173.6 billion paid out to health care providers during that period, according to an audit by the Office of Inspector General (OIG) for the US Department of Health and Human Services. Excessive disbursements represent anything “from inadvertent mistakes to outright fraud and abuse,” notes the March 2001 follow-up report, *Improper Fiscal Year 2000 Medicare Fee-for-Service Payments*. At the same time, the OIG points out that the improper payment rate has been sliced by nearly one half since

error rates were first calculated in fiscal year 1996 and recommends “continued vigilance” to further cut losses.

As part of that effort, the agency has detailed two prominent new tasks pertaining to physicians and their coding habits in its annual to-do list. Among the projects outlined in the OIG General Work Plan for fiscal year 2002 is an examination of whether physicians properly coded evaluation and management (E&M) services provided in their offices. This initiative will also determine whether documentation guidelines have been well-used. Another study will investigate whether physician consultation services are billed appropriately, evaluate the financial impact of improper claims on the Medicare program, and identify the main reasons for inaccuracies in submitted claims.

“These are areas the OIG is really going to start looking at,” emphasizes Charles E. Colitre, President, Med-Management Group, Inc., in Akron, Ohio. “I think the E&M codes have always been a concern because they represent a very high percentage of total billings from physicians, particularly primary care practitioners. They are the codes used most often—and most often messed up.” Of the nearly \$12 billion spent on improper payments, \$1.7 billion can be traced to coding errors. An additional \$4.3 bil-

lion is attributed to unsupported services—services that have not been documented or are insufficiently documented. This has proved to be the largest error category in three of the last five years (see bar chart, page 6).

Dissecting the Work Plan

The OIG General Work Plan is generally issued in the fall, as the government fiscal year winds down. Colitre recommends that as part of a competent compliance plan, you make a point of retrieving and studying the document annually, an assignment that is not as daunting as it may sound. Divided into four chapters, the plan describes all matters that the OIG intends to concentrate on for the coming fiscal year. “The portion we’re really interested in involves the Centers for Medicare and Medicaid Services (CMS),” he explains. “Other areas are pretty much outside the concern of physicians’ practices.”

Within the CMS segment, first read the section devoted to physicians. One half of the 10 topics sketched out in the blueprint appeared last year as well—advance beneficiary notices, physicians at teaching hospitals, bone density screening, services and supplies incident to physicians’ services, and reassignment of benefits. “This indicates the OIG considers them continuing issues that need to be

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Our Mission: Practical Advice on Coding Compliance

We are pleased to present the inaugural issue of *The Physician's Coding Compliance Alert*, a publication devoted to providing you with information that is timely and immediately useful. While physicians often view coding compliance as a nuisance, it is essential, and if done correctly, can provide surprising benefits. Certainly, it helps to identify and correct coding problems that might otherwise slip by, spurring an audit. However, you may also find you are undercoding for services rendered your patients, an error that unnecessarily deprives you of income.

We will show you how an internal audit conducted by your practice—or by a consultant—can help pinpoint trouble. In outlining the components of an effective compliance program, the Office of Inspector General (OIG) designates internal monitoring and auditing as the first priority. While compliance programs remain voluntary, the penalties for mistakes are not! In fact, as you'll note in our cover story, the OIG will be closely examining your evaluation and management coding and consultation coding this year.

Read further, and we'll discuss how to best handle the Centers for Medicare and Medicaid's documentation guidelines. We also disclose the nine billing problems that most often get physicians into trouble.

Over time, we plan to familiarize you with other relevant government publications as well as important coding changes. Expect tips on the interpretation of CPT-4 and ICD-9-CM codes and the appropriate use of modifiers. Look for articles on—among other subjects—helpful tools and information resources, new ideas for your practice, and physicians with novel ideas to improve coding compliance. Our Advisory Board offers plenty of exciting possibilities. These authorities include four physicians—Paul Allen, Jerry Block, Robert Chugden, and Harold Kaiser—who are all too familiar with what you endure on a daily basis. Our advisory board is further enhanced by Rhonda Lynn Picou and Joseph Skeens, both coding specialists, and by Charles Colitre, a consultant whose previous experience as an agent investigating health care fraud for the Federal Bureau of Investigation affords him a unique point of view. This group, along with additional experts, will give you valuable insight into how to achieve coding compliance in a straightforward manner.

We welcome your questions and comments in addition to your ideas for future articles. For example, if you have specific coding quandaries, we can discuss them in future issues. You can check out our Web site, www.Coding-Compliance.com, which offers a forum for discussion. And of course, always feel free to contact us by phone or by E-mail.



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Documentation a Major Sticking Point for Many Physicians

More likely than not, you are expending more energy on claims submission than you ever would have expected during your medical training. Fortunately, as with medical procedures, the job is much easier when you use appropriate implements. One such tool is the Documentation Guidelines for Evaluation and Management Services disseminated by the Centers for Medicare and Medicaid Services (CMS). While these might not represent the kind of reading you'd ordinarily choose, they do set out exactly what's expected of you.

The guidelines assist physicians in providing evidence of their work on the patient's behalf. These rules also allow the government to standardize payment for services rendered. Certainly, it takes time to learn how to use the CMS's documentation guidelines, but fulfilling them helps to protect the livelihood you've worked so hard to develop.

Keep in mind that the Office of Inspector General (OIG) is not looking for every mistake you make, but rather for signs of fraud and abuse. You may not believe you fall into this category because you are not submitting false claims. However, if you are unfamiliar with the guidelines and routinely send in claims that do not meet the CMS's standards, you can develop significant problems. The agency recognizes that honest physicians do make honest mistakes. In fact, it seems that physicians make as many—and perhaps more—errors that favor the CMS. Nonetheless, if you are found to be overcoding, you can expect to have to refund payments. And if your case is judged to be more than just an innocent mistake, interest or fines can be levied against you, as well.

Check out the guidelines

Two versions of the guidelines are available; one is dated 1995, the other

1997. Either can be used. The main points are essentially the same. Each discusses the documentation of evaluation and management services, noting that history, examination, and medical decision-making are the key components to consider when deter-

example, describes one to three of eight possible elements, while an extended HPI describes four or more elements of the present illness or associated comorbidities.

While you are considering all this, remember that the highest-level ser-

A significant difference between the 1995 and 1997 guidelines is that the second set contains a far more detailed segment on documentation of examination.

—Rhonda Lynn Picou

mining the level of services provided. (Others are counseling, coordination of care, nature of presenting problem, and time.) These three areas are broken apart and addressed block by block.

For example, you might code for one of four types of history: problem focused, expanded problem focused, detailed, or comprehensive. Each requires that the patient's chief complaint be plainly stated in the medical record. Then, depending on how thorough a history is required, you would include varying amounts of information on history of present illness (HPI); a review of systems; and past, family, or social history (see table on page 4). Of course, these are also strictly defined. A brief HPI, for

vice is not actually better than a lower level, although it pays more. You may be able to see two or more level-2 patients in the time you spend with one level-4 patient. The level of service should follow the level of need.

A significant difference between the 1995 and 1997 guidelines is that the second set contains a far more detailed segment on documentation of examination. Although some consider the newer version too cumbersome to use, it's reasonable to review both and decide which one works better for you. A third form is currently undergoing testing and revision, but a release date is not yet scheduled. Either way, take the proper time to learn the set of guidelines you choose.

(Continued on page 4)

General Principles of Medical Record Documentation

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
 - Reason for the encounter, along with relevant history, physical examination findings, and prior diagnostic test results;
 - Assessment, clinical impression, or diagnosis;
 - Plan for care; and
 - Date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health-risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Source: Centers for Medicare and Medicaid Services 1995 Documentation Guidelines for Evaluation & Management Services. Available at: www.hcfa.gov/medlearn/emdoc.htm.

(Continued from page 3)

Get some help

You don't have to wade through government documents on your own. Consider hiring a consultant who can translate federal-speak and help you set up programs to meet documentation requirements. The expense can be well worth the savings in major aggravation. However, these efforts will also cost you some time, so plan to set aside whatever is needed. A consultant can explain the principles

of coding or help you and your employees set up a compliance program—but not in an hour.

Hire office staffers who are very knowledgeable in the coding area or willing to learn how to tackle it. You may have to pay them more but again, it's a well-worthwhile expense. Too often people become skillful and leave for a job offering more money or better hours, compelling you to start the hiring and training process again.

It's a costly routine, and services suffer during the lapse time, so it pays to invest in dedicated, proficient employees.

Form a relationship with your Medicare and Medicaid representatives. Access government Internet sites on a regular basis. Make sure you are getting all relevant bulletins, and review them for coding changes.

You can purchase good documentation forms or computer programs, but they will not allow you to function on autopilot. Frequently, documentation forms help in obtaining a billing level, but they do not reflect the actual medical needs of the patient. Computerized documentation is quite similar and often cues the physician to acquire information that normally would not be sought because it is not relevant or required. Some programs request so much documentation that the staff works harder when determining the level of service to bill and does not necessarily code more accurately as a result. Find out precisely how these products might help you before buying them. Once they are installed, monitor their use to make certain you're using them effectively.

Beyond this, rely on your common sense. Avoid quick fixes. Why take unnecessary chances? To view the documentation guidelines, go to www.hcfa.gov/medlearn/emdoc.htm.

Written by Rhonda Lynn Picou, in New Orleans. More information on documentation is available on our Web site (at www.Coding-Compliance.com).

Quantifying Historical Details

History of Present Illness	Review of Systems	Past, Family, and/or Social History	Type of History
Brief	Not applicable	Not applicable	Problem focused
Brief	Problem pertinent	Not applicable	Expanded problem focused
Extended	Extended	Pertinent	Detailed
Extended	Complete	Complete	Comprehensive

Source: Centers for Medicare and Medicaid Services 1995 Documentation Guidelines for Evaluation and Management Services. Available at www.hcfa.gov/medlearn/emdoc.htm.

What You Should Expect from a Capable Coding Consultant

All too frequently we hear the laments of physicians who are overwhelmed by the amount of chart documentation required to support a given level of treatment and the associated request for reimbursement. At times, their frustration is almost palpable, and it becomes a challenge to convince them that there are basic rules, the application of which should improve their ability to comply with regulatory imperatives while still continuing to deliver high-quality care. Fortunately, this information is readily available and can be mastered with the help of a qualified coding compliance specialist who possesses an understanding of the most current coding and documentation requirements.

An effective compliance program has seven basic components, according to the Office of Inspector General for the Department of Health and Human Services. You should:

- Conduct internal monitoring and auditing;
- Implement compliance and practice standards;
- Designate a compliance officer or contact;
- Conduct appropriate training and education;
- Respond appropriately to detected offenses and develop corrective action;
- Develop open lines of communication; and
- Enforce disciplinary standards through well-publicized guidelines.

At first glance, these elements can appear intimidating. However, a skilled consultant should be able to guide you through the construction of a sound program. If you are thinking of hiring a consultant, look for one who offers a chart audit, educational assistance, and follow-up services designed to keep the practice on track. A consultant should also be able to identify potential hot spots among your office procedures. For example, you may be making billing errors that could subject you to an audit (see "Risky Business," page 7).

Or, you may be handling advance beneficiary notices in a way that could be perceived as inadequate.

Find someone who is well-informed. Aside from possessing a working knowledge of the Centers for Medicare and Medicaid Service's (CMS's) Evaluation and Management Documentation Guidelines, the consultant should be someone who reviews the profusion of available governmental and trade publications, confers with other specialists, and continually attends coding seminars and workshops. All of the information acquired from these sources should enhance the knowledge that he or she has already gained from extensive field experience. An able consultant should bring this great expertise to your practice at least once a year and be able to instill in you and your staff the confidence to monitor coding and documentation activities on an ongoing basis.

For your investment in a consultant to be most fruitful, you need to embrace the coding-compliance concept and the importance of staff participation in a formalized compliance program. This would include developing standards for internal audits and inspecting charts on a regular basis. For example, such standards would designate individual employees' responsibil-

ities, the number of charts to be audited, and an auditing schedule.

Aside from participating in on-site training provided by the consultant, search out additional sources of information. Make sure you have current editions of the CPT and ICD-9-CM manuals and the Health Care Common Procedure Coding System. Subscribe to the Federal Register and CMS publications. Read newsletters and magazines devoted to coding. Those responsible for claims development should participate in locally produced coding seminars and audio conferencing, which many hospitals offer. Sponsor participation in professional coding organizations, such as the American Academy of Professional Coders or the American Health Information Management Association.

You can ensure the success of your practice's coding-compliance efforts. When committed to the viability and financial security of your endeavors, you are capable of enlisting the best efforts of employees already entrusted with the day-to-day operation of a profitable and well-run medical practice.

Written by Joseph P. Skeens, in Sarasota, Fla. More information on coding consultants is available on our Web site (at www.Coding-Compliance.com).

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examined,” Colitre says. New, along with physician E&M codes and consultations, are inpatient dialysis services, billing for residents’ services, and beneficiary access to preventive services, including annual screening mammography for women aged 40 and older and colorectal screening. Determine which of these areas apply to your practice so that you understand where the OIG will be searching for slip-ups.

“If you’re not doing bone density screening or dialysis, don’t worry about it,” counsels Colitre. “Move on to something else.” At the same time, you’ll need to at least familiarize yourself with the rest of the CMS portion. Cull any information that pertains to you, and make sure you know the rules and regulations for practicing in those areas. For example, if you are involved in hospital privileging activities, home health care, hospice care, or nursing home care, you might uncover valuable information.

Certainly, coding issues are applicable to any practice that bills for its services. While errors in E&M codes are frequent, confusion between consultation and referral codes is also very common. “The terms are used interchangeably, but they are not inter-

changeable,” Colitre observes. “You can say you’re going to refer someone for a consultation, but you need to be sure that you understand that that’s a consultation and not a referral in the

than new office visits. When you start doing the math across the United States, that can be a pretty big number.” Obviously, that situation can arouse government concern.

I think the E&M codes have always been a concern because they represent a very high percentage of total billings from physicians.

—Charles E. Colitre

true sense.” A referral, as it relates to coding, occurs when one physician sends a patient to another physician, who then treats the patient for a particular ailment. In contrast, a consultation is rendered when one physician sends a patient to another for evaluation, and the second physician returns the patient, providing findings and an opinion rather than treatment.

“What happens is that patients get sent and they get kept, and the visits are erroneously charged as a consult rather than a new office visit or referral,” explains John McDaniel, President and CEO of Physician Management Group Inc., practice management advisers in New Orleans. Consultations pay a lot more

However, many physicians inadvertently lose money by incorrectly coding for a referral rather than a consultation. This is particularly true of physicians whose practices are predominantly referral-based—general surgeons or cardiologists, for example.

Get with the Program

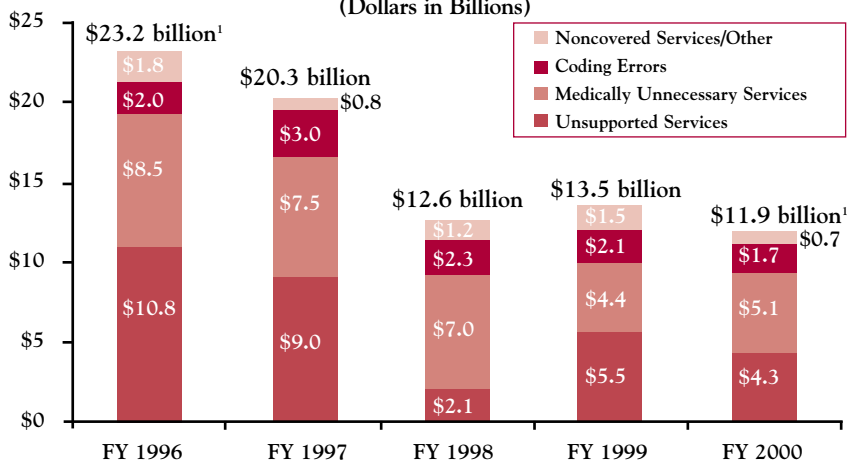
Coding and documentation errors are usually preventable, but you need compliance policies and procedures in place to check claim accuracy, and many practices do not have an efficient program, Colitre says. One avoidable mistake is using outdated coding books. Buy a new one each year. Keep in mind that codes can change during the year, so make sure you are receiving and reading bulletins from your Medicare carrier, as should everyone who is doing your coding and billing. “We generally talk about federally-funded programs, but the private payers do the same thing,” Colitre adds. “They regularly change what they will pay for, and they change the nuances of each code, too.”

You also must ensure that the codes you use are being entered correctly. “Practices should know with reasonable certainty how accurately they’re coding, just as much as they should accurately know what their financial status is,” Colitre points out. To do that, McDaniel recommends setting

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Estimated Improper Payments by Type of Error

(Dollars in Billions)



¹ Does not add to total due to rounding

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up a three-pronged compliance program. You can hire a consultant to carry it out. But if you prefer, you can do it yourself. Either way, the first step is to compare the practice's coding patterns against the CMS's national standards. If you are entering a specific code far more often than it is generally being used across the country, you may have a potential liability. Or, you may discover you are undercoding, which means you might actually have a chance to improve reimbursements.

You won't know whether your coding practices can be substantiated until you move on to the next step—the chart audit. Random charts are examined so that you can compare whether your documentation supports the code you submitted. “The guidelines for compliance programs suggest pulling a minimum of 10 charts, but we encourage pulling at least 20 to 25 to get a good sampling,” McDaniel says. “Depending on the specialty, if they do a great amount of hospital work, they may also want to go to the hospital and sample some of those charts.” Finally, take the results of the coding analysis and chart audits, sit down with those involved, and look for areas where you can improve. This should be done at least once or twice a year. If you find you are severely overcoding or undercoding, consider performing quarterly audits.

Better Than Insurance

The penalties for erroneous claims are potentially devastating, McDaniel emphasizes. “In the worst-case scenario where the government finds an aberrant pattern, you can be charged the overage, plus \$11,000 per occurrence,” he notes. Add to that the possibility of criminal punishment for those believed to have reckless disregard for the rules.

Look at compliance programs as

Risky Business

Certain billing practices inspire more audits and investigations than any other. According to the Office of Inspector General, the risk areas that most often garner attention are:

- Billing for items or services not rendered or not provided as claimed;
- Submitting claims for equipment, medical supplies, and services that are not reasonable or necessary;
- Double billing resulting in duplicate payment;
- Billing for non-covered services as if covered;
- Knowing misuse of provider identification numbers, resulting in improper billing;
- Unbundling components of service instead of using an all-inclusive code;
- Failure to properly use coding modifiers;
- Clustering, or using one or two middle levels of service codes exclusively, assuming all will average out over an extended period; and
- Upcoding the level of service provided.

Source: Office of Inspector General. OIG Compliance Program for Individual and Small Group Physician Practices. *Federal Register*. 2000;65(194):59434-59452.

insurance. “If you get audited, this demonstrates that you are trying to improve,” McDaniel says. “Thus far, when practices have been audited and found to owe money to the federal government, those with ongoing coding compliance programs have only been responsible for paying back the overpayment—not the penalties and interest.”

Aside from keeping you out of legal and financial trouble, a good compliance program can actually find you extra money. “Our experience is that about two thirds of physicians undercode,” McDaniel says. “For the majority of physicians, there may be an opportunity for coding improvement from a financial standpoint.”

Paying closer attention to your coding practices may reduce claim denials once you can better support your rationale for using certain codes. Consider, too, that better documentation in patient charts not only shores up coding choices, but also can

improve patient care. McDaniel adds that educating all employees involved in billing and encouraging communication can help streamline practice operations.

Using the OIG General Work Plan as a guide is also very helpful in this regard. “It's an excellent instrument to steer physician practices in the direction in which they ought to be doing business every year, not only with the government, but with all private payers as well,” Colitre concludes. “Those are broad concerns; if things are being done wrong for Medicare, you can be sure those practices are probably spilling over into other areas as well.”

For more information on the OIG's General Work Plan or its report on improper Medicare payments, go to www.oig.hhs.gov/wrkpln/index.htm and oig.hhs.gov/oas/reports/afma/a0002000.htm. Reported and written by Cynthia Starr, editor. More information on the OIG General Work Plan is available on our Web site (at www.Coding-Compliance.com).

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