Internal Chart Auditing:
Part 1 of 2

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Financial Disclosure

Mary Pat Johnson is a consultant for Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

Who’s watching?

• Office of Inspector General (OIG)
• Comprehensive Error Rate Testing (CERT)
• Recovery Audit Contractors (RAC)
• Zone Program Integrity Contractors (ZPIC)
• Supplemental Medical Review Contractor (SMRC)
• Medicare Part C Plans
  • Risk adjustment audits

SMRC

• Strategic Health Solutions, LLC
• Contracted by CMS as a Supplemental Medical Review Contractor (SMRC) in September 2012
• Conducting nationwide medical review as directed by CMS
• Includes Part A, Part B, and DME providers and suppliers

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/SMRC.html

SMRC – Current Projects

• Project Y3P0225 – Blepharoplasty and other related facial procedures
• Project YP0435 – Ranibizumab (Lucentis)
• Project YP0439 – Ophthalmology Services

Have You Been Flagged?

• Large practice
• Complaints
  • Patients
  • Doctors
• Frequent claims for abused services
• Frequent errors on claims
• Abnormal utilization patterns
• PRO recommendation

**Indications of Non-Compliance**

- Staff turnover
- Claims paid slowly
- Frequent problems with claims
- Problem claims unresolved
- Staff takes work home
- Poor morale
- Irregular accounting
- You are under scrutiny by Medicare or other payers

**OIG Guidance**

- Office of Inspector General (OIG), HHS
- Published “Compliance Program Guidance for Individual and Small Group Physician Practices”
- Not mandatory but advisable

- Mandatory CP is coming soon…

  Source: Federal Register Vol 65, No 194, October 5, 2000

**7 Elements of an Effective CP**

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a compliance officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication
- Enforcing disciplinary standards through well-publicized guidelines

**The Best Defense is a Good Offense**

- Be proactive
- Make compliance a priority
- Stress importance of accurate, complete documentation
- Get buy-in from management, physicians and staff
- Establish expectations and protocols
- Conduct training
- Monitor the results…...this is auditing!

**Compliance Plans**

If establishing a Quality Assurance or Compliance Program for your practice, chart audits…

- a) must be included and performed quarterly
- b) are not necessary
- c) should be included as part of program
- d) must be completed by a physician or registered nurse

**Compliance Program**

Which of the following is not an element of the “Compliance Program Guidance for Individual and Small Group Physician Practices” provided by OIG?

- a) Conducting internal monitoring and auditing
- b) Implementing compliance and practice standards
- c) Scheduling monthly compliance meetings
- d) Designating a compliance officer or contact
- e) Responding appropriately to detected offenses and developing corrective action
Compliance Program

Under a Compliance Program, employees with concerns regarding activities in the practice should...

a) have an open line of communication available to communicate their concerns
b) should report their concerns directly to OIG
c) can be terminated for causing trouble
d) do their own investigation to determine if there is really a problem before coming forward

Auditing and Monitoring

- Review standards and procedures
- Claims submission audit
  - Are bills accurately coded?
  - Is documentation complete?
  - Are services reasonable and necessary?
  - Any incentives for unnecessary services?
- Baseline audit within 3 months of initial training, and thereafter on an annual basis
  - 5-10 records per physician

Source: Federal Register Vol 65, No 194, October 5, 2000

Things to Consider

- Select your reviewers
- What approach? Post-payment or pre-payment
- Review several components
  - Medical Records
    - Exams, tests, op-notes, correspondence
  - Financial Records
  - Forms
    - Consents, waivers, registration
  - Policies and procedures
- Legal and financial arrangements

Who Are Your Reviewers?

- Create a Quality Assurance Team
  - Physicians
  - Management
  - Staff
- Potential auditors in the practice
  - Understand ophthalmology
  - Understand documentation and billing rules
  - Consider a team approach
    - Members of clinical staff (technicians, nurses)
    - Members of the billing staff

Attitude

- Extremely important
- Choose auditor carefully
  - Objective
  - Reasonable
  - Respected
  - Moderate authority
- Goal is to educate and correct, not punish or intimidate

Prospective Audit

- Review before claims are filed
- Emphasis on prevention
- Identify improper billings — correct it
- Identify inadequate chart documentation — fix it
- Less time consuming
- Less costly
Retrospective Audit

- Reviewed after claims are filed
- Emphasis on remediation
- Response to a complaint or investigation
- Identify improper billing
- Identify improper reimbursement
- Make restitution for overpayments
- Initiate remedies to prevent future errors

Refunding Overpayments

- ACA §6402(a) provided that knowingly retaining an overpayment creates liability under the False Claims Act
- Final regulations published February 11, 2016 explains that a provider has 60 days to refund under the broad definition of an “identified” overpayment


Refunding Overpayments

- Regulation states that a provider has an obligation to conduct “reasonable diligence” once the provider has credible information of a potential overpayment, and that barring exceptional circumstances, that inquiry should take no more than 6 months
- 60 day refund clock begins once the overpayment amount has been calculated
- Lookback period is within 6 years of the date the overpayment was received


True or False?

If the results of your internal compliance plan are unfavorable, it is acceptable to ignore the results and audit again in 6 months?

a) True
b) False

Source: CMS website

How Large Is The Review?

- Comprehensive review
  - Look at a little of everything
- Focused review
  - By doctor
  - By location (site)
  - By subspecialty
  - By procedure
  - By department
  - By payer

How To Select The Sample?

- Random chart sample
- Based on utilization
- What carriers are auditing
- Complicated claims
- Novel or new services
- Complaint
Office Visits
Medicare Utilization Patterns Ophthalmology (18)

<table>
<thead>
<tr>
<th>CPT</th>
<th>New Patients</th>
<th>A</th>
<th>CPT</th>
<th>Established Patients</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>Level 5 E/M</td>
<td>2%</td>
<td>99215</td>
<td>Level 5 E/M</td>
<td>1%</td>
</tr>
<tr>
<td>99204</td>
<td>Level 4 E/M</td>
<td>29%</td>
<td>99214</td>
<td>Level 4 E/M</td>
<td>54%*</td>
</tr>
<tr>
<td>99203</td>
<td>Level 3 E/M</td>
<td>62%*</td>
<td>99213</td>
<td>Level 3 E/M</td>
<td>42%*</td>
</tr>
<tr>
<td>92004</td>
<td>Comprehensive Eye</td>
<td></td>
<td>92012</td>
<td>Intermediate Eye</td>
<td>3%</td>
</tr>
<tr>
<td>99202</td>
<td>Level 2 E/M</td>
<td>6%*</td>
<td>99212</td>
<td>Level 2 E/M</td>
<td>3%</td>
</tr>
<tr>
<td>99201</td>
<td>Level 1 E/M</td>
<td>&lt;1%</td>
<td>99211</td>
<td>Level 1 E/M</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

*Combined utilization of E/M and eye codes
Source: CMS data 2015, 18 - Ophthalmology

Office Visits
Medicare Utilization Patterns Optometry (41)

<table>
<thead>
<tr>
<th>CPT</th>
<th>New Patients</th>
<th>A</th>
<th>CPT</th>
<th>Established Patients</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>Level 3 E/M</td>
<td>8%</td>
<td>99214</td>
<td>Level 4 E/M</td>
<td>8%</td>
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<tr>
<td>92004</td>
<td>Comp Eye Exam</td>
<td>54%</td>
<td>92014</td>
<td>Comp Eye Exam</td>
<td>46%</td>
</tr>
<tr>
<td>99202</td>
<td>Level 2 E/M</td>
<td>1%</td>
<td>99213</td>
<td>Level 3 E/M</td>
<td>12%</td>
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<tr>
<td>92002</td>
<td>Intermediate Eye</td>
<td>5%</td>
<td>92012</td>
<td>Intermediate Eye</td>
<td>30%</td>
</tr>
</tbody>
</table>

Source: CMS data 2015, 41 - Optometry

Resources

- CPT-4, ICD-10, HCPCS reference handbooks
- NCCI edits (i.e., bundles)
- Coverage and Payment Policies
  - Bulletins, transmittals and notices
  - Manuals including all current regulations
  - Statutes
- Fee schedules
- Checklists

Getting Started
What To Look For?

- Quality of documentation
  - Accuracy of notes
  - Appropriate forms
  - Appropriate signatures
- Accuracy of claims
- Efficiency or inefficiency of internal procedures

Subjective Findings

- Legibility
- Organization
- Quality of forms or EHR
- Registration
- Signatures
- Corrections
- Timeliness

Objective Findings

<table>
<thead>
<tr>
<th>Overbilling</th>
<th>Underbilling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upcode LOS</td>
<td>Downcode LOS</td>
</tr>
<tr>
<td>Wrong CPT (high)</td>
<td>Wrong CPT code (low)</td>
</tr>
<tr>
<td>Poor documentation</td>
<td>Missed charges</td>
</tr>
<tr>
<td>Missing entries</td>
<td>Bilateral or multiple</td>
</tr>
<tr>
<td>Duplicate billing</td>
<td>procedures</td>
</tr>
<tr>
<td>Fragmentation</td>
<td>Supplies</td>
</tr>
<tr>
<td>Not medically necessary</td>
<td></td>
</tr>
</tbody>
</table>

Objective Findings

<table>
<thead>
<tr>
<th>Coding errors</th>
<th>Other errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT code error with no financial impact</td>
<td>Date errors</td>
</tr>
<tr>
<td>Modifier omitted</td>
<td>Too frequent services</td>
</tr>
<tr>
<td>Incorrect modifier</td>
<td>Indications unclear</td>
</tr>
<tr>
<td>Diagnosis code errors</td>
<td>Wrong provider (credentialing)</td>
</tr>
<tr>
<td></td>
<td>Patient responsibility</td>
</tr>
</tbody>
</table>

Categories of Services

- Exams and consultations
- Diagnostic tests
- Surgical procedures
- Anesthesia
- Pharmaceuticals (injected)
- Post-cataract eyeglasses, CLs

Basic Requirements

- New patients
  - Registration and demographics
  - HIPAA notice
  - Assignment of benefits (signature on file)
- Established patients
  - Update registration and demographics
  - Update insurance information
Reviewing Eye Exams

- Appropriate CC and valid indication for care
- Written request for consultation (if applicable)
- Appropriate medical history
- HPI documented by physician (critical for E/M)
  - Identity of scribe noted
- Relevant exam elements documented
- Impression and plan documented
- Appropriate use of EHR
- Accurately coded (either eye code or E/M)

Reviewing Diagnostic Tests

- Indications for service
- Appropriate order
- Technicians’ notes
- Adequate interpretation
  - On date of test or later?
- Reasonable frequency for patient’s condition
  - Policy
  - Preferred Practice Patterns
- Coding accuracy

Reviewing Surgical Procedures

- Indications for surgery
- Adherence surgery billing rules
  - Minor vs. major surgery
  - Exam on day of surgery
  - Global period
  - Assistant surgeon
  - Multiple or bilateral surgery
  - NCCI edits
- Informed consent
- ABN if needed
- Coding accuracy
- Place of service

What Might You Find?

Summary of Common Mistakes

- Undercharging for services
  - Lost charges
  - Downcoding
- Coding errors
- Overcharging for services
  - Inadequate chart documentation
  - Missing documentation
  - Fragmentation

Improper Medicare FFS Payments FY 2014

- Part A & B improper payments totaling $45 billion;
  12.7% of the dollars processed by CMS
- Part C error rate 9%
- Medicaid error rate is 6.7%

Source: CCG’s Chart Reviews

Medicare FFS Improper Payments

• CY 2014
• Cataract procedures 4.1% error rate
• Ophthalmology 3.5% error rate

• Compare to:
• All procedures 12.1% error rate
• Optometry 5.6% error rate

E/M Code Inflation

E/M Coding Trends

Source: Coding Trends of Medicare E/M Services, May 2012

Your Tools

• 1997 E/M specialty guidelines published by CMS
• Eye exam coding criteria (see checklist in handout)
• Audit checklists for assessing
  • Medical history documentation
  • Office visits – E/M vs. Eye code
  • Diagnostic tests
  • Surgical services

Noting Subjective Findings

• Chart organization and completeness
• Quality and extent of documentation
• Quality of care

Noting Objective Findings

• Organize by type of error
• Easy to sort, count (Excel)
• Entire practice vs. individual doctor
• Keep detailed notes for future reference
  • Sensitive issues
  • Sensitive people
Computing the Score

- Two separate scores
  - Frequency of each error
  - Financial impact of errors

Discussing Your Findings

- Praise first
- Select your audience
- Limit your battles
- Have your facts ready
- Get back up if needed
- Stay calm
- Be prepared to offer solutions

What Next?

- Fix identified problems
  - Rebill
  - Refund overpayments
  - Train physicians and staff
  - Create or update practice policies
- Repeat chart review
  - Focus on problems previously identified
  - Look for new issues
  - Follow Compliance Program

Refund Overpayments

- Explanation:
  - Why the voluntary refund was made
  - How it was identified
  - What sampling techniques were employed
  - What steps were taken to assure that the issue leading to
    the overpayment was corrected
  - The dates the corrective action was in place
  - Specific claims involved in the inappropriate payments
  - Methodology used to arrive at the amount of the refund
  - Whether a full assessment was performed to determine
    the extent of the refund

Source: Medicare Transmittal AB-00-41, May 2000

Return of Overpayments

- Solitary vs. broad overpayments
- Refund payer claim by claim
  - Send with letter and copy of EOB
  - Check for carrier instructions
    - Full refund with corrected claim
    - Refund claim difference
- Refund patients
  - 60 days for incorrectly collected
  - 30 days for services not covered (no ABN)
  - Violation of provider agreement if refunds not timely

Compliance

- Fine line
- Daily activity
- Requires diligence
- Payoff can be substantial
With this in mind, let’s audit a few records.

**Patient #1**

**CC:** Requests CEE  
**HPI:** Reading glasses 4 yrs old, near vision blurry  
**Dx:** 1) Blepharitis  
2) Presbyopia  
**Tx:** 1) baby shampoo lid scrubs  
2) Replace readers w +2.50  
**Hx:** Comprehensive Hx  
**Exam:** CE, DFE, OU lids inflamed and red  
**Tests:** External photos  
Billed 92014 with diagnosis blepharitis to Medicare

**Exam Coverage**

What was the reason for the visit?  
Refractive error  
What do we know about Medicare coverage?  
No benefit for routine eye exam w/o a medical complaint  
Did this patient’s exam warrant a Medicare claim?  
No. Bill patient or patient’s vision plan  
What diagnosis was listed as primary?  
Blepharitis  
Was the claim supported?  
Yes, 92004 was performed  
Should other codes have been billed?  
92015-refraction

**Auditor’s Notes**

What was the reason for the visit?  
Refraction error  
What do we know about Medicare coverage?  
No benefit for routine eye exam w/o a medical complaint  
Did this patient’s exam warrant a Medicare claim?  
No. Bill patient or patient’s vision plan  
What diagnosis was listed as primary?  
Blepharitis  
Was the claim supported?  
Yes, 92004 was performed  
Should other codes have been billed?  
92015-refraction

**Auditor Score For This Entry**

92014 Billed to wrong payer; s/b patient pay  
Documentation supports the code, but this level may be challenged for blepharitis  
92015 Missed charge

**Patient #2**

**CC:** Eye injury, emergency  
**HPI:** Lid laceration 1, today 2, struck by post, headache 3 (obtained by MD)  
**Dx:** Inferior canalicular laceration, globe intact  
**Tx:** Repair in OR today  
**Hx:** Comprehensive Hx  
**Exam:** CE, DFE  
**Tests:** External photos  
Billed 99205 and 92285 to medical insurance today
Level 5 E/M Service

What do we know about this code?
• Requires comprehensive history
  • 4 elements of History of Present Illness (HPI)
  • Complete Review of Systems (ROS)
  • Past, Family, Social Histories (PFSH)
• Requires comprehensive exam (CE, DFE)
• Requires high level medical decision making
Does same day surgery affect the claim for this exam charge?

Level 5 E/M Service

What do we know about this code?
• Requires comprehensive history
  • 4 elements of HPI → No - documented only 3
  • Complete ROS → Documented
  • PFSH → Documented
• Requires CE, DFE → CE, DFE documented
• Requires high level MDM → Documented
• Documentation only supports CPT 99202 or 92004
• Does same day surgery affect the claim for this exam charge? Yes, append modifier -57 to exam claim

Auditor’s Notes

Level 5 E/M code not supported by documentation
Limited by the HPI
If using E/M codes, use 99202
CPT 92004 is a better option
Append modifier -57 since this is in pre-op portion of
global period for major surgery performed same day
External photos for chart documentation only – not
diagnostic

Audit Score For This Entry

99205 Should be billed as 92004-57
Represents an overcharge
Modifier omission
History insufficient for 99205
If using E/M code, 99202 is appropriate
92285 Omit charge. Documentation only
Verify that claim was submitted for same day surgery

Conclusion

• Compliance Program and Quality Assurance require
  periodic chart reviews
• Carefully select auditors
• Review a representative sample of charts
• Organize your resources and tools
• Keep detailed notes throughout
• Summarize with an objective score
• Use results to address errors and train staff

More help…

For additional assistance or confidential consultation,
please contact us at:
(800) 399-6565
or
www.CorcoranCCG.com