Maximize Staff Skill to Minimize Payer Scrutiny

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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

• Jane Shuman: President of eyetechs
  • Consultant providing technician training

Course Objective

• Series of case studies detailing compliance issues
• Identify possible reimbursement issues under scrutiny
• Discuss the legal approach to cope with these compliance issues
• Develop a corrective action plan

Issue 1: Exam coding

• A review of charts and claims for office visits performed by an ophthalmologist revealed:
  • Code selected not supported by the medical record
  • Level of history incompatible with E/M code
  • Contradictions in EMR notes
    • History lists states “no pertinent history” yet patient takes medications for multiple chronic conditions
    • Chief complaint lists several ocular and systemic systems yet ROS states “all negative”

Addressing Documentation Concerns
• Technician Training on
  • Use of EMR
  • Interview skills and history taking
  • Scribing for physicians – creating a concise yet complete entry

Addressing Coding Concerns
• Training on
  • Scribing – creating a concise yet complete entry
  • History and exam criteria for the various exam codes

Issue 2: Identical Records

• A review of charts and claims for office visits performed by an ophthalmologist revealed:
  • Complete history and exam on every patient
  • No sense of triage
  • Duplicate notes in each entry
  • Same typos
  • Failure to update (eg, diagnosis of cataract still listed after cataract surgery, medications still listed although they were discontinued at previous visit)
**Issue 2: Identical Records**
- Practice policy regarding EMR use
  - Minimize “copy/forward”
- If problem persists, investigate
  - Staff not well trained
  - Not enough time per encounter
  - Ways to effectively streamline documentation without compromising the record

**Issue 3: Claims for services billable**
- Chart review revealed:
  - Charges for services provided in global period
    - Post-op visits billed
  - Failure to adhere to coverage guidelines
    - Diagnostic tests billed with non-covered diagnosis
  - Billing for incidental services
    - Ishihara plates, Schirmer’s test

**Issue 3: Claims for services billable**
- Review global periods and chief complaint
- Not all tests are billable
  - OCT ON and OCT Macula same day
  - Topography for cataract surgery
- Share LCDs with staff
  - Place next to equipment
  - Educate all on separately identifiable tests

**Issue 4: Inappropriate changes to the Records**
- Chart review revealed:
  - (Paper charts) Text blacked out and rewritten
  - (EMR) Records re-opened and altered after file has been completed and “locked”

**Issue 4: Inappropriate changes to the Records**
- If it wasn’t documented it wasn’t done
  - Legibility
  - Corrections
  - Addendums to EMR

**Issue 5: Wrong insurance Billed**
- Chart review revealed:
  - Patients presented for vision/wellness exam but medical insurance was billed instead
Issue 5: Wrong insurance Billed

- Proactive education
- Based on chief complaint
- Corrected claim
  - Yes or no?

Issue 6: Scribe not Identified in Chart

- Chart review revealed:
  - No unique log-in for each user
  - Scribes logged in to EMR under physician's ID
  - Log in credentials shared throughout the office

Issue 6: Scribe not Identified in Chart

- What would you do?

Conclusion

- Compliance: Billing appropriately for services rendered
- Train all appropriate staff on the finer points of
  - CC/HPI
  - Documentation
  - Scribing
  - Coding
    - E/M vs. Eye Codes
- Audit and retrain

Thank you

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More help…

For additional assistance or confidential consultation, please contact us at:

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