Coding and Documentation to Minimize Audit Risks: Joint Replacements and other Areas of Risk

Sponsored By: Pennsylvania Orthopaedic Society
October 9, 2012
Presented By: Mary LeGrand, RN, MA, CCS-P, CPC

Objectives

- Gain insight into CMS Compliance Regulations
- Discuss “who” is auditing
- Importance of internal compliance: Risk identification and correction

What Is the Question to Ask?

Will I be audited?

OR

When will I be audited?
Where do you think your audit risks are?

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- Documentation (3)
- Human error
- Low
- Office visit levels
- For older DR’s high
- EHR
- Same day two specialty visits, preop visits

What are My Risks?

- Office of Inspector General (OIG)
- Comprehensive Error Rate Testing (CERT)
- Recovery Audit Contractors (RAC)
- Zone Program Integrity Contractors (ZPIC)
- Private Payors
Do you know the differences between OIG, CERT, RAC audits?

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If you think you are at risk, break it out by OIG, CERT, RAC:

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Comments:
- CERT
- RAC (2)

Have you received an OIG, CERT, or RAC audit?

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Orthopaedic Impact

Identify Audit Risk and Revenue Opportunity (OIG and Private Payor)

- Evaluation and Management Services: Trends in Coding of Claims
- Evaluation and Management Services Provided During Global Surgery Periods
- Evaluation and Management Services: Use of Modifiers During the Global Surgery Period (New)
- Evaluation and Management Services: Potentially Inappropriate Payments

Does your practice have EMR?

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Have you received a letter of notice from a private payor that your "E and M" or other services were variant to the peer market?

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E&M Analyzer

Evaluation and Management Services Provided During Global Surgery Periods

**Modifier 24**
Unrelated Evaluation And Management Service By The Same Physician During A Postoperative Period

Report E&M service for unrelated E&M and link modifier 24 to the appropriate E&M CPT® code.

Link 'unrelated' diagnosis (knee arthritis) to the E&M service.

Appeal inappropriate denials.

**How Did You Code This Scenario?**

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<td>99214-24</td>
<td>Knee arthritis</td>
<td>24</td>
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<td>99024</td>
<td>Hip Diagnosis</td>
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**Example:**
Physician performs and documents an E&M service on a patient seen in follow up for right knee arthritis during the global period of a hip arthroplasty. Note 99024 is recorded internally only.
Potentially Inappropriate Payments

Thou shalt not clone!

- “Identical” notes from visit to visit, from provider to provider on the 2012 OIG Work Plan
- Use caution with copy and paste
- Templates are great, but should all notes be word for word the same?
- Is medical necessity present at each visit to perform the exact same level of services?

Cloned EHR notes lead to denials, CMS contractor says

“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,” writes MAC National Government Services. “Identification of this type of documentation will lead to denial of services for lack of medical necessity and the recoupment of all overpayments made.”
OIG Focus: Physicians: Incident-To Services (New)

“We will review physician billing for “incident-to” services to determine whether payment for such services had a higher error rate than that for non-incident-to services. We will also assess CMS’s ability to monitor services billed as “incident-to.” Medicare Part pays for certain services billed by physicians that are performed by nonphysicians incident to a physician office visit.”

How are NPP’s Utilized in Your Practice?
- PA/NP/CNS?
- Speech Pathologist?
- Clinical Support Staff?

How Risky Is Our Business?

Get place of service right

- Physicians paid differently based on place of service: higher in office than facility
- Continuing issue on 2013 Work Plan
- Audit this at submission and payment

Novitas CERT: Second Quarter 2012
 Assignment of Error Categories

Based upon the review of the medical records, claims identified as containing improper payments are categorized into the appropriate error category. The five improper payment categories in the CERT program are described below.

No Documentation

Claims are placed into this category when either the provider fails to respond to repeated requests for the medical records or the provider responds that they do not have the requested documentation.

CERT Error Categories

Insufficient Documentation

Claims are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the medical reviewers could not conclude that some of the allowed services were actually provided, provided at the level billed, and/or the services were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

Medical Necessity

Claims are placed into this category when the medical reviewers receive adequate documentation from the medical records submitted and can make an informed decision that the services billed were not medically necessary based upon Medicare coverage policies.

Incorrect Coding

Claims are placed into this category when the provider or supplier submits medical documentation supporting (1) a different code than that billed, (2) that the service was performed by someone other than the billing provider or supplier, (3) that the billed service was unbundled, or (4) that a beneficiary was discharged to a site other than the one coded on a claim.

Other— duplicate payment error, non-covered or unallowable service
Are you aware of the CERT reviews in Joint Replacement Surgery? If yes, what have you changed in your practice?

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Comments:
- We have instituted a "check-off" sheet for provider to refer to when dictating on an OA patient.
- We’re working on addressing the documentation requirements.
- Yes, we follow a template for documentation for our Joint Replacement candidates.
- Better documentation.
- Set up specific guidelines specific to totals.
- Criteria must be documented and sent with surgical orders.

CERT: Total Joint Replacement

Total Joint Replacement - Understanding Documentation Requirements for Inpatient Admission

Issued: July 24, 2012

- DRG 470: Joint Replacement or Reattachment of Lower Extremity without major complications and comorbidities. This has lead to Novitas Solutions recouping overpayments totaling over $52,000,000.00. More importantly, when CMS and CERT extrapolate these errors to the universe they will account for approximately $792,000,000.00 in claims payment errors for the November 2010 report.
- The areas of concern are total knee and total hip replacements. Reviews have found that the criteria to support the joint replacement is not met, therefore the procedure is determined to be not medically necessary and the inpatient admission and stay are therefore also denied as not medically necessary.

CERT: Total Joint Replacement

Total Knee Replacement - Understanding Documentation Requirements for Inpatient Admission

- Symptoms include:
  - pain at the knee, decreased mobility,
  - decreased range of motion, swelling at the knee, and stiffness.

  Non-surgical or conservative treatment options include
  - exercise/physical therapy,
  - pain relievers and anti-inflammatory medications,
  - steroid injections, and
  - a cane or walker to assist with mobility.

When these conservative treatment options no longer provide relief to the patient, the decision to perform a total knee replacement may be made by the provider.
CERT: Total Joint Replacement

Total Knee Replacement - Understanding Documentation Requirements for Inpatient Admission

• When claims reporting a total knee replacement procedure are selected by CERT for review, the inpatient admission and stay are often denied because the procedure code is denied as not medically necessary and reasonable. The denials are based on the lack of documentation by the provider supporting the signs and symptoms experienced by the patient and the conservative treatment that was attempted and failed.

CERT: Total Knee Replacement Medical Necessity Documentation Requirements

Documentation of pain at the knee, including the level of pain and worsening of pain

• Pain that is increased with activity
• Pain that is increased with weight bearing
• Pain that interferes with activities of daily living
• Pain with passive range of motion
• Limited range of motion
• Crepitus
• Joint effusion/swelling

CERT: Total Knee Replacement Medical Necessity Documentation Requirements

An x-ray with at least two of the following findings:

• Subchondral cysts
• Subchondral sclerosis
• Periarticular osteophytes
• Joint subluxation
• Joint space narrowing
CERT: Total Knee Replacement Medical Necessity Documentation Requirements

The documentation must indicate that there were:

• continued symptoms after a trial of medication (i.e. NSAIDs) or
  the contraindication of medication due to the patient’s inability to tolerate.

• documentation of a trial of physical therapy or external joint support (i.e. use of a cane, walker, brace, etc.) greater than or equal to 12 weeks or
documentation as to why the patient was not able to tolerate physical therapy.

CERT: Total Hip Replacement Medical Necessity Documentation Requirements

As with knee replacements, the most common cause of hip deterioration is arthritis including osteoarthritis, rheumatoid arthritis, and traumatic arthritis.

CERT: Total Hip Replacement Medical Necessity Documentation Requirements

• Pain at hip
• Pain increased with activity
• Pain increased with weight bearing
• Pain that interferes with activities of daily living
• Pain with passive range of motion
• Limited range of motion
• Antalgic gait
CERT: Total Hip Replacement Medical Necessity Documentation Requirements

An x-ray with least two of the following findings:
- Subchondral cysts
- Subchondral sclerosis
- Periarticular osteophytes
- Joint subluxation
- Joint space narrowing

CERT: Total Hip Replacement Medical Necessity Documentation Requirements

The medical record documentation must indicate:
- continued symptoms after a trial of medication (i.e. NSAIDs)
- the contraindication of medication due to the patient’s inability to tolerate.
- documentation of a trial of physical therapy or external joint support greater than or equal to 12 weeks or documentation as to why the patient was not able to tolerate physical therapy.

The Hospital Receives a CERT Request—What Now?

Documentation that must be sent:
1. hospital record,
2. the physician office progress notes that support worsening symptoms not relieved with conservative treatments and confirmation that the total joint replacement surgery was discussed and agree upon by both the provider and the patient.
3. admission history and physical
4. the order for the inpatient admission.

NOTE: Upon appeal of denied claims, Novitas Solutions is often able to obtain the necessary physician progress notes to support the medical necessity for the total joint replacement, but must still deny the inpatient admission due to the absence of the admission history and physical and admission order.
CMS: MLN Matters


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CERT: Physical Therapy Plan of Care Requirements

Issued: October 04, 2012

- denial of outpatient rehabilitation therapy services due to:
  - missing physician/non-physician practitioner signature and
  - dates on the certification of the plan of care.

The financial impact:
- The recoupment: Overpayments totaling over $164.70.
- The extrapolation to the universe: approximately $19.3 million in claims payment errors for the November 2011 report.

Outpatient Rehabilitation: Written Treatment Plan

The plan of care shall contain, at minimum, the following information:
- diagnoses,
- long term treatment goals,
- type, amount, duration, and frequency of therapy services.

Other Documentation Requirements
- signature and professional identity of the person who established the plan of care
- date it was established must be documented within the plan of care.
In order to avoid an error and the denial of services, when submitting documentation for review, be sure to:

• Have established a complete initial plan of care, making certain to include your signature, your professional identification (i.e. PT, OT, etc.), and have the date the plan was established.

• Ensure that the plan of care is certified (recertified when appropriate) with a physician/non-physician practitioner signature and date.

• Clearly document when the plan of care has been modified, including how it was modified and why the previous goals could not be met.

CERT: PT and OT Services

• LCD L27513 - Physical Medicine & Rehabilitation Services, PT and OT


CERT: Diagnostic Tests- CMS Requirements to a Facility: The Orders

• Issued: October 04, 2012


Applies to: “All diagnostic x-ray tests, all diagnostic laboratory tests, and other diagnostic tests furnished to a beneficiary.”

An order can be written in the beneficiary’s record or can be a telephone order from the physician’s office to the testing facility. If a telephone order, both the treating physician and the testing facility must have documented in the beneficiary’s record the telephone call and the extent of the diagnostic tests being ordered.

Overpayment: $355.64.

Extrapolation to the universe: Approximately $22.1 million


CERT Reviews

Physician Signature Requirements for Diagnostic Testing: Issued: July 31, 2009

- Medicare has identified a recent increase in the number of CERT errors attributed to the lack of physician orders for diagnostic tests. A diagnostic test includes all diagnostic x-ray tests, all diagnostic laboratory tests, and other diagnostic tests furnished to a beneficiary.

- An ‘order’ is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (e.g., if test X is negative, then perform test Y). An order may be delivered via the following forms of communication:
  - A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility,
  - A telephone call by the treating physician/practitioner or his/her office to the testing facility;
  - An electronic mail by the treating physician/practitioner or his/her office to the testing facility;
  - If the order is communicated via telephone, both the treating physician/practitioner or his/her office, and the testing facility must document the telephone call in their respective copies of the beneficiary’s medical records.

Source: https://www.novitasolutions.com/bulletins/all/news-07312009.html

CERT Appeals

- A review must be requested within four months of the original claim determination (i.e., the date on the Medicare Remittance Notice).

- Use the MEDICARE REDETERMINATION REQUEST FORM

- Copy of claim and supporting documentation: be specific about what you want reviewed and why.

- Allow 45 days for completion of review

Close the Documentation Gaps

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**Recommendations Accepted and Agreed to by CMS**

- CERT requests: selection may be random, but if errors found will put you on a short list for further review from your Medicare Contractor ...

  Or worse!

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**RAC Reviews**

- **Automated Review:**
  - Based on clear policy on overpayment
  - Based on medically unbelievable service
  - No timely response received in response to a medical record request

- **Complex Review:**
  - Request for selected medical records
  - Notice of on-site review of records
  - GOOD CAUSE REQUIRED
    OIG findings, data analysis, comparative analysis ...

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**How Many of These Can They Look At?**

**CMS receives 1.2 billion claims/year**

or

4.5 million per day

9,579 per minute

574,000 per hour

So, they have to sort through the ones they want to look at somehow!
Sample RAC Issues: Pennsylvania

- Issue Name: Global Surgery - Pre and Post-Operative Visits
  - Issue Number: A000032009
  - Issue Description: Identification of overpayments associated to minor and major surgical services. 1) E/M services (as specifically defined in the IOM) billed the day prior to a major (90-day) or minor (0-10-day) surgical service billed without modifier 25 or 57. 2) E/M services (as specifically defined in the IOM) billed the day of a major (90-day) or minor (0-10-day) surgical service billed without modifier 25 or 57. 3) E/M services (as specifically defined in the IOM) billed 10 days following a 10-day minor surgical service or 90 days following a 90-day major surgical service and billed without modifier 24 (unrelated visit in post-op period).
  - Type of Review: Automated
  - State(s) Impacted: NY, NJ, CT, DC, DE, MD/NH, MA, ME, VT, RI
  - Provider Type: Professional Services
  - Date Posted: June 17, 2010
  - Date Revised: August 5, 2011
  - Dates of Service: Claims having a “claim paid date” which is more than 3 years prior to the ADR date will be excluded.
  - Issue References: IOM 100-04 Chapter 12, Section 40.1, 46
Recovery Audit Contractors

- Keeping us up at night
- Identify and recover overpayments
- Automated and complex reviews
- Can refer practice for OIG/Department of Justice investigation
  - RACs are still paid a percentage of what they return to the Medicare Trust Fund

Do you perform internal audits in your practices? If yes, of what services?

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Comments

- E&M (4)
  - All (2)
  - Our billing staff does internal audits of random charges and documentations
  - X-rays and injections
  - Unknown

Your To-Do List

- Look at your top billed codes.
  - Volume is a risk area
- Compare your use of modifiers with CMS.
  - Don’t just slap on a modifier
  - Beware of the coder who “knows how to get a claim paid”
- Educate everyone about the rules for these codes and modifiers.
- Conduct audits of high risk areas and for that matter, even areas that you may not consider to be high risk!
How Risky Is Our Business?

**Compare your data**

- Use of modifiers
  - Pay particular attention to use of modifiers 24, 25, 59, 58, 79
  - Compare each individual E&M profile distribution with CMS norms and practice average
- Most frequently billed codes
- E/M level of service
- Audit, Audit, Audit

Risk Identification and Reduction Steps

Use of Electronic Health Records/Electronic Medical Records

- Can the EMR/EHR protect you from an audit or reduce your risk?
- Can the use of EMR/EHR pose risk?
- Conduct E&M Audits

Don’t Delay!

- Review before you get audited!
- Deadlines are tight. Physicians without effective compliance programs run the risk of claims being denied simply because they can’t show that they crossed all the ‘T’s and dotted the ‘I’s in time.
Do you have an internal compliance plan in place?

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Review – Be Ready!

- Designate a Compliance Officer
- Stay up to date by signing up for email lists (e.g., CMS RAClistserve) and checking your RAC website.
- Designate a team member responsible for responding to RAC requests and NOTIFY your RAC with that information. Make sure ALL RAC correspondence goes to that person!
- Check your compliance policies/procedures. Have extension request and appeal template letters ready. Have response plans in place so you can respond quickly!

Recoupment Notice Received

- Log and date stamp the day request is received.
- Automated Review
  - Remittance Advice Discussion Period
- Complex Review
  - Review Results Letter
  - Discussion period
  - Demand Letter (MAC/Carrier)
You Did Call Your Attorney, Didn’t You?
- Work should have attorney client privilege
- There are implications for further review, referral to Department of Justice
- Extrapolation....
- Who is reviewing what your sending?
- Be meticulous about the package, dates of service, supporting documentation, page numbers

Review – Respond!
- Track and document all communication
- Submit clear, complete documentation for all services
- Sequentially number medical record pages
- Include:
  - Complete medical record
  - Original request letter/account listing (copy)
  - Physician query documents
  - Coding summary sheet
  - Original request letter (copy)
  - CMS 1500

Upcoming Pennsylvania Orthopaedic Society Coding Courses Presented by KZA

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