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

Sponsored By:
Pennsylvania Orthopaedic Society
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Presented By:
Mary LeGrand, RN, MA, CCS-P, CPC
KarenZupko & Associates, Inc.

Objectives

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

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What Is the Question to Ask?

Will I be audited?

OR

When will I be audited?

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Where do you think your audit risks are?

Yes	No	Don't Know	Unanswered
			26

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

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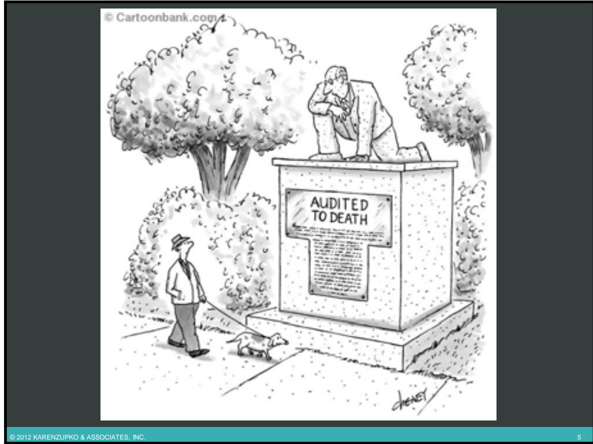

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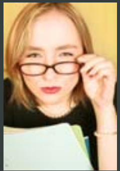
What are My Risks?



- Office of Inspector General (OIG)
- Comprehensive Error Rate Testing (CERT)
- Recovery Audit Contractors (RAC)
- Zone Program Integrity Contractors (ZPIC)
- Private Payors

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Do you know the differences between OIG, CERT, RAC audits?

Yes	No	Don't Know	Unanswered
12	12		16

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

Yes	No	Don't Know	Unanswered
	1	5	33

Comments
CERT
RAC (2)

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

Yes	No	Don't Know	Unanswered
6	16	0	15

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Orthopaedic Impact

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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

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Does your practice have EMR?

Yes	No	Don't Know	Unanswered
12	12	1	16

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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?

Yes	No	Don't Know	Unanswered
2	22	18	18

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E&M Analyzer

Source: *www.karenzupko.com/products/product_em.html*

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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?	
CPT Code/ Modifier	**Diagnosis**
99214-24	**Knee arthritis**
99024	**Hip Diagnosis**

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.

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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?

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KZA Alert

To learn more about our E&M Profile Analyzer click here.

Attend our workshops to learn more about coding and other valuable practice management information!

Who else on your team should know this?

Click "Forward" below to share this with a colleague.

Folks, pay attention to your E&M coding, because the government sure is...

CMS's Center for Public Integrity published a study last week citing physician's move to higher paying codes for office visits during the last decade. These changes cost Medicare about half of the $11 billion dollar increase in payments. 362 million claims were reviewed. In 2010, they found that the two highest codes, level 4 and 5, represented 40% of the codes billed.

EMR usage explains some of this. For example, the CPI study quotes an EMR company that promises revenue increases of $225,000 for upping the level of every visit coder. We pity the poor users of that system; they are in the spotlight! The auto-coder features KZA warned about in a cover story for AAPC are also contributory.

CMS studies show that the age and health of Medicare recipients did not precipitously decline over the decade.

Given the political issues with the Medicare budget, payment for higher level coding will receive increased scrutiny. Medicare's efforts with RAC, CERT and ZPIC have paid off in repayments. We expect more of the same. You should too.

The second story about coding appeared in JAMA a week ago and reports the results of an Accountable Care Organization pilot project. Donald Berwick, MD the former administrator for CMS in an accompanying editorial states, "The study also offers clear evidence of coding games —lawful but games nevertheless." In this case, more diagnosis codes than had been previously reported by the organization or by their peers were submitted. Berwick says, "What is needed is better care, not better coding."

Count on the fact that the same tracking software used to detect credit card fraud is being used to detect coding games. Articles on this topic appeared in the *Washington Post, Wall Street Journal* and *New York Times* not in arcane medical journals. The public is not going to remain unquestioning and ignorant about the codes or the charges on their bills.

We strongly recommend that you invest a mere $150 for our E & M Analyzer and profile your doctors. The investment is a pittance compared to legal fees, take backs, paybacks, and bad press. You can profile your physicians against other doctors in the same specialty and state for $150! This is very valuable information because the results mean you know what to pull for an audit. **More level 4 and 5 codes are not bad in and of themselves —unless of course the documentation does not support them.**

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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."

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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?

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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

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Novitas CERT: Second Quarter 2012

Analysis of Part B Comprehensive Error Rate Testing (CERT) Data - April thru June 2012 Print Bookmark

During the second quarter, 196 CERT errors (please provide link here to the errors) were assessed for all Part B contracts within J12.

Microsoft Excel Format

Adobe PDF Format

The following is a breakdown of those errors:

- 138 due to insufficient documentation (error code 21);
- 56 due to incorrect coding (error code 31);
- One due to medical necessity (error code 25); and
- One due to other errors (error code 90).

The majority of the errors for insufficient documentation were related to the following:

- Missing documentation requirements to support the need for a service based on a related Local Coverage Determination (LCD) specifically Ophthalmology Services, Physical and Occupational Therapy services, and Psychiatric Services;
- Medical Record Documentation and/or physician signature was missing or was not legible;
- Medical record lacked sufficient documentation to support the medical necessity of the procedure/service performed, specifically laboratory tests;
- Medical record did not contain a valid physician's order, documented order intent or clinical indication for the service;
- No documentation of the physical therapy certified plan of care/treatment plan;
- Documentation that did not support the Internal Classification of Disease (ICD-9) Code billed; and
- Documentation that did not adequately describe the service defined by the reported Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code.

All but 12 of the incorrect coding errors were related to Evaluation and Management (E/M) services. The E/M codes found to be incorrectly coded during this quarter ranged from new and established office and inpatient visits to emergency room and initial and subsequent nursing home visits. The reasons for the errors were due to the fact that the provider's documentation did not substantiate the level of care billed based on one or more of the key components (history, exam, medical decision making) being coded at the incorrect level.

The remaining 12 incorrect coding errors were due to the following:

- Not meeting the requirements for critical care; discharge day management, and/or physical therapy services;
- Incorrect number of units of medication/infusion services billed; and
- Incorrect code billed for laboratory services, e.g. billed procedure code 85025 (Automated CMC with automated differential), but only performed and documented 85027(Automated CBC).

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CERT Error Categories

- 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.

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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.

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Cert Error Categories

- 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.13

- 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

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf

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Are you aware of the CERT reviews in Joint Replacement Surgery? If yes, what have you changed in your practice?

Yes	No	Don't Know	Unanswered
16	6	0	18

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

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CERT: Total Joint Replacement

Total Joint Replacement - Understanding Documentation Requirements for Inpatient Admission

https://www.novitas-solutions.com/bulletins/all/news-07242012.html

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 $52,000.00. 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.

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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.

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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.

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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

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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

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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.

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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.

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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

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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

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CERT: Total Hip Replacement Medical Necessity Documentation Requirements

The medical record documentation must indicate :

- 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 greater than or equal to 12 weeks or documentation as to why the patient was not able to tolerate physical therapy.

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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.

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CMS: *MLN Matters*

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1236.pdf

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CERT: Physical Therapy Plan of Care Requirements

Issued: October 04, 2012

https://www.novitas-solutions.com/bulletins/all/news-10042012.html

- 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.

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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.

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The Practice Receives a CERT Request—What Now?

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.

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CERT: PT and OT Services

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

Source: https://www.novitas-solutions.com/policy/mac-ab/l27513-r7.html

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

- **Issued: October 04, 2012**

https://www.novitas-solutions.com/bulletins/all/news-10042012-1.html

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

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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; and
  - 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.novitas-solutions.com/bulletins/all/news-07312009.html

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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

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Close the Documentation Gaps

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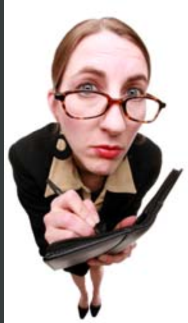
Recommendations Accepted and Agreed to by CMS



- 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 a 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!

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CMS Recovery Audit Program

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Fee-for-Service Recovery Audit Program
August 2012

Recovery Audit National Program

	FY 2010 Oct 2009- Sept 2010	FY 2011 Oct 2010- Sept 2011	FY 2012 1st Qtr Oct 2011- Dec 2011	FY 2012 2nd Qtr Jan 2012- Mar 2012	FY 2012 3rd Qtr Apr 2012- June 2012	Total National Program
Overpayments Collected	$75.4M	$797.4M	$397.8M	$588.4M	$657.2M	$2.5B
Underpay-ments Returned	$16.9M	$141.9M	$24.9M	$61.5M	$44.1M	$289.3M
Total Corrections	$92.3M	$939.3M	$422.7M	$649.9M	$701.3M	$2.8B

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/National-Program-Corrections-FY-2012-3rd-Qtr.pdf

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Sample RAC Issues: Pennsylvania

A000012011	Failure to Correctly Bill Codes on the Medically Unlikely Edit List for Practitioner Services	Automated	Professional Services	12/7/2011
A000462009	Duplicate Claims - Part B	Automated	Professional Services	6/17/2010
A000092009	Global Billing of Radiology or Diagnostic Tests in the Facility Setting	Automated	Professional Services	6/17/2010
A000032009	Global Surgery - Pre and Post-Operative Visits	Automated	Professional Services	6/17/2010
A000022009	National Correct Coding Initiative (CCI) - Part B Professional Services	Automated	Professional Services	8/1/2011
A000012009	Add-On Codes Paid without a Paid Required Primary Procedure	Automated	Professional Services	6/17/2010
A009002010	Place of Service Coding for Physician Services	Semi-Automated	Professional Services	12/7/2010
A001362010	Bilateral In Nature Procedures	Automated	Professional Services	2/10/2011
A001312010	Incorrect Bilateral Billing for Codes with Bilateral Indicator 3	Automated	Professional Services	2/18/2011
A000072009	New Patient Visits	Automated	Physician (Carrier) / Outpatient Hospital	6/17/2010

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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) surgical service without modifiers 57 or 25. 2) E/M services (as specifically defined in the IOM) billed the day of a major (90-day) or minor (0- or 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, PA, 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, 40

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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

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

Yes	No	Don't Know	Unanswered
18	5	18	1

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

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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!

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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

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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

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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.

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Do you have an internal compliance plan in place?

Yes	No	Don't Know	Unanswered
17	6		19

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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!

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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)

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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

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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

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Upcoming Pennsylvania Orthopaedic Society Coding Courses Presented by KZA

Date	Location
March 22, 2013	Crown Plaza Philadelphia Valley Forge
Wednesday, March 27, 2013	Wyndham Downtown (Pittsburgh)

Visit www.karenzupko.com or call (312) 642-5616 for more details!

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Upcoming AAOS Sponsored Courses Presented by KZA

Date	Location	Hotel
Costa Mesa, CA	Oct 26-27	Westin South Coast Plaza
Chicago, IL	Nov 16-17	Chicago, IL
Dallas, TX	January, 25-26	Westin Galleria Dallas
Orlando, FL	Feb 15-16	Hilton Orlando Lake Buena Vista
Las Vegas, NV	March 8-9	Encore at Wynn Las Vegas

Visit www.karenzupko.com or call (312) 642-5616 for more details!

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