CPMA Exam Preparation

Chapter 1
Compliance and Regulatory Control
Compliance and Regulatory Control

• OIG – Protect HHS from themselves and providers
• Compliance
  – Currently not required by OIG
• Recommended to
  – Reduce fines and penalties
  – Increase operational efficiency
  – Increase overall compliance

Compliance plan includes:
  – 7 key compliance elements per the OIG
  – Mandatory staff education
  – Disciplinary policy and procedures
Compliance and Regulatory Control

Compliance plan should differentiate fraud and abuse.

– Fraud - Intentional deception made for personal gain
– Abuse - Act that results in unnecessary reimbursement without defined intent

The OIG does impose “self-inflicted” audits of HHS.

• Audits HHS programs and contracts
• Review for abuse and waste
• Performed by OAS
  – Internal Staff
  – Independent Resources
Compliance and Regulatory Control

Improper payments
– Identify
– Report within compliance manual
– Establish plan of action
– Suspend billing of only the identified service until plan is in place and all parties educated

Anti-kickback law prohibits:
– Knowing and willful solicitation
– Offer, payment or receipt in return for referring an individual, purchase or arrangement for an item of service
– Examples
  • Bribery
  • Kickbacks
  • Offer solicit receive payment
  • Safe harbor provisions
Compliance and Regulatory Control

False Claims Act
- Claim submitted which portrays false services
  - Never performed but billed
  - Disguised service
  - Disguised provider
- Civil False Claims Act
- Criminal False Claims Act
- Medicare/Medicaid False Claims Act

Compliance and Regulatory Control

- Provider Deficiencies
  - Self Disclosure
    - 30 days
  - Appeal Rights
    - ALJ appeal
    - Appeal of the ALJ decision
Compliance and Regulatory Control

• OIG Work Plan
  – Updated annually
  – Recurring topics
  – New inclusions
  – Auditors use of work plan

Compliance and Regulatory Control

• Corporate Integrity Agreement (CIA)
  – Agreement between OIG and healthcare provider or other entity
  – Serious misconduct
  – CIA agreement in lieu of exclusion from Medicare, Medicaid or other Federal health care program
Compliance and Regulatory Control

• Corporate Integrity agreement
  – Typical CIA agreement is five years.
  – Provide and implement audit annually
  – Reports provided to the OIG of compliance activities
  – CIA’s require an IRO perform audits
    – Annual audits
    – Results to compliance officer of the CIA

Compliance and Regulatory Control

• CIA Audit
  – Discovery sample of 50 units
  – Used to determine full sample size
  – Used to determine financial error rate
• Full Sample – Audit until the financial error rate is justified within 90% confidence and 25% precision level
• RAT-STATS
  – Recommended
  – Not a required component
Compliance and Regulatory Control

• Stark Law
  – Self Referral Law
  – Types of services
  – Physician financial relationships with hospitals
  – Professional courtesy discounts

• The Joint Commission
  – Voluntary accreditation program for hospitals
  – Many state governments recognize Joint Commission accreditation as a condition of licensure and receiving Medicaid reimbursement
  – Non profit entity

• JCAHO relevance
  – Hospital owned practice
    • Identification of areas
    • CPR
    • ACLS
  – Relevance to an auditor

• JCAHO Specific Concerns
  – Medication Management
  – Pain Scale
  – Abbreviations use
Compliance and Regulatory Control

• Recovery Audit Contractor (RAC)
• Purpose is to identify
  – Improper payments
  – Fraud
  – Abuse
• RAC’s are paid based on the amount of money they uncover for under and/or over-payments.

Compliance and Regulatory Control

• RAC audits
  – Automated Reviews
  – Records request schedule
    • less than 5 providers – 10 per group every 45 days
    • 6–24 providers – 25 per group every 45 days
    • 25–49 providers – 40 per group every 45 days
    • 50+ providers – 50 per group every 45 days
Compliance and Regulatory Control

• RAC audits
  – Appeals Process
  – 15 day letter of intent
  – Utilize CMS appeals process

Compliance and Regulatory Control

• RAC audits
  – Prepare for Audits
  – Review
    • CERT
    • Previous RAC
    • OIG
    • Internal Audits
Compliance and Regulatory Control

• PATH – Physicians at Teaching Hospitals Audit
  – Audit teaching physician services
  – 2 forms of audit
    • Path I
    • Path II

Compliance and Regulatory Control

• Conditions for Participation (COP)
  – Conditions for coverage
  – Health & Safety standards
  – Specific entities effected
  – Requirements for Medicare/Medicaid participation
  – Maintenance of Records
Chapter 2
Medical Record

Medical Record

- Medical Record
  - Legal document
    - Entries
    - Corrections
  - Owned by the provider
  - Signature requirements
  - Dictation timing
Medical Record

• The patient’s medical record will contain encounters and services rendered to the patient
  – Each face-to-face visit should include:
    • Patient’s complaints
    • Reason for visit
    • Signs
    • Symptoms
    • Past, family and social histories
    • Examination performed by the provider
    • Diagnosis
    • Plan of care

Medical Record

• Medical record entries
  – Legible
    • Dictate for clarity
    • Enhancement
  – Late entry
  – Addendums
Medical Record

• Multiple entries are acceptable
  – Main documentation must direct the reader of the medical record to these specific sheets
    • Medication flow sheets, immunization forms, history sheets, etc.
  – “Linking” important to meet necessary requirements

Medical Record

• Forms and Consents
• Patient’s chart should contain certain consents and authorizations
  – Consent for General Treatment
  – Consent to file insurance/Medicare authorization
  – Assignment of Benefits
  – Medical records release
  – Informed Consent
  – HIPAA Privacy Form
  – Advanced Beneficiary Notice (ABN)
  – Non-covered consent form
  – Financial Policy
  – Additional records
Medical Record

• Medicare ABN’s
  – Not required
    • Emergency situations
    • Statutorily excluded
• Required for billing patients
• Medicare ABN
  – Completed prior to event
  – No mass completions allowed
  – Copy to the patient
  – Valid financial responsibility
    • Within $100 or 25%
    – GA modifier

Medical Record

• Health Insurance Portability and Accountability Act (HIPAA)
• 1996
• PHI
  – Disclosures of PHI
  – Minimum necessary
• HIPAA
  – HIPAA vs. State Law
  – Business Associate Agreement
Medical Record

• National Correct Coding Initiative (NCCI)
  – Replaced CMS bundling program
  – Uniform payment policy
  – Reduction for inappropriate payments

• NCCI edits
  – Carrier audits vs. government payer audit
  – Utilization of CCI edits table
  – Refer to CPT manual
  – Common sense approach

Medical Record

• Mutually Exclusive Edits (MEE)
  – Part of the NCCI edits

• Medically Unlikely Edits (MUE)
  – Anatomically impossible
  – Published
Chapter 3
Auditing Surgical and Ancillary Services

Auditing Surgical & Ancillary Services

Place of Service (POS)
– Surgical Suite
– ASC
– OR
– Procedure Room
Auditing Surgical & Ancillary Services

Global Surgical Package
– Pre-operative services
  • Admit H&P’s
– Intra operative services
– Post operative services
  • Routine care

Auditing Surgical & Ancillary Services

Anesthesia
– Types of anesthesia
  • Performed by surgeon
    – Local
    – Monitored Anesthesia care
  • Performed by anesthesiologist
    – Types
    – Settings

• Anesthesia is billed on time
• Time begins and when time ends
Auditing Surgical & Ancillary Services

Anesthesia Services

– Physical Status
– Anesthesia Modifiers
  • Concurrency

Records to review for anesthesia services

1. Anesthesia record
2. Services billed
3. OP report by surgeon
Auditing Surgical & Ancillary Services

Four Elements of OP Reports

– Heading
– Indications of the surgery
– Body/detail of the procedure or surgery being performed
– Findings of the surgery/procedure

Auditing Surgical & Ancillary Services

OP Reports

– Information and documentation styles can vary per provider and facility
  • Date of surgery
  • Patient name
  • Pre-op diagnosis
  • Post-op diagnosis
  • Procedure performed
  • Name of primary and co-surgeon/assistant surgeon
  • Procedure Details
Auditing Surgical & Ancillary Services

OP report requirements
- Surgeon
- Co-surgeon
- Assist surgeon
- Team surgery

• Indications and Medical Necessity

Surgical Modifiers
- 22 Modifier
- 24 Modifier
- 51 Modifier
- 52 Modifier
- 58 Modifier
- 59 Modifier
- 78 Modifier
Auditing Surgical & Ancillary Services

Radiology
- Procedure must be validated by medical necessity
- Diagnosis must reflect sign, symptom, condition or injury
- Report specifics
- Reviewed vs. Interpreted
- Procedure guidance services

Auditing Surgical & Ancillary Services

Pathology/Laboratory
- Do not report two or more panel codes that include any of the same constituent test performed from the same patient collection
- Documentation is required to support the medical necessity of laboratory testing with ICD-9 code
- Laboratory must use ICD-9 code unless there is a reason to question the ordering physician
- Screening tests are performed when no specific, sign, symptom, or diagnosis is present
Auditing Surgical & Ancillary Services

Psychiatric services
– Many services are based on time spent with patient
– 90801 is the psychiatric diagnosis interview examination
  • Physician, CP, or LCSW
  • Bill once per diagnosis onset
  • Specific documentation components needed including but not limited to: Risk factors, complete mental exam, treatment plan, and specifics regarding treatment

Psychotherapy
– 2 levels of service
– Time based
– Documentation required
  • Time
  • Technique
  • Details
Auditing Surgical & Ancillary Services

Pharmacological Management

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90862</td>
<td>• Medication evaluation</td>
</tr>
<tr>
<td></td>
<td>• Brief encounter</td>
</tr>
<tr>
<td></td>
<td>• Not incident-to service</td>
</tr>
<tr>
<td></td>
<td>• Minimal psychotherapy</td>
</tr>
<tr>
<td>vs.</td>
<td></td>
</tr>
<tr>
<td>M0064</td>
<td>• Refill only</td>
</tr>
<tr>
<td></td>
<td>• Minimal encounter</td>
</tr>
<tr>
<td></td>
<td>• Not incident-to service</td>
</tr>
<tr>
<td></td>
<td>• Minimal psychotherapy</td>
</tr>
</tbody>
</table>

Ophthalmology

– Ophthalmologist can use two different sets of codes
  • Ophthalmology codes or E/M codes
– Intermediate Services (92002/92012)
  • New or existing problem complicated with a new complaint
– Comprehensive Services (92004/92014)
  • Bill for a patient whose treatment plan includes the initiation of a diagnostic or treatment plan
Auditing Surgical & Ancillary Services

Ophthalmology documentation required components

– Intermediate services
  • Diagnosis
  • History
  • Medical observation
  • Exam must document/include ocular and adnexal exam

– Comprehensive services
  • History
  • Medical observation
  • External ophthalmoscopic exam
  • Gross visual fields
  • Basic sensorimotor exam

Auditing Surgical & Ancillary Services

Infusion Services

– Must be an order from the physician
– Service patient presented for
  • Chemo, therapeutic, hydration
– Only 1 initial per day unless separate sites or sessions
– Start/stop times
– 1 bag/1 line = 1 infusion
– Flush services
Auditing Surgical & Ancillary Services

Physical Therapy

– CMS states – PT time even for untimed codes must be documented
– Total session time (start/stop)
– Time for each technique defined by a timed code
  • Procedures non-billable without time documentation
– Techniques require modality

Auditing Surgical & Ancillary Services

Physical therapy initial evaluation documentation

– Referring doctor
– History
  • Prior physical therapy
  • Functional status prior to event
  • Functional status now
– Plan of Care
  • Plan of treatment including goals
  • Frequency and duration of treatment
  • Diagnosis
  • Specific modalities to be employed
  • Rehab potential