3F-Auditing Outpatient Surgical Services

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Disclaimer
• Every reasonable effort has been taken to ensure that the educational information provided in today’s presentation is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility situation.

Agenda
• Overview of Facility Outpatient Auditing
• Outpatient Chart-to-Bill Audit Review
  – Purpose
  – Key Elements
  – Forms Utilized
• Surgery
  – Auditing Tips
  – Examples
• Discussion
Facility Outpatient Auditing

• There are a number of types of audits that can be performed in the facility outpatient setting. These include:
  – Coding validation (i.e., ICD-9-CM, HCPCS, and occurrence/value/condition codes)
    • These can involve a review of a single codeset or combination of codesets on a claim to ensure they are accurate and supported by documentation.
  – Medical necessity reviews
    • These are performed to determine whether services rendered are appropriate, essential and supported by the diagnosis.

Facility Outpatient Auditing

• Types of facility outpatient audits (continued):
  – Reimbursement audits (e.g., APC, MPFS, etc.)
    • These require comparing the Explanation of Benefits (EOB) to the payment that was expected.
  – Charge capture analyses
    • These entail a review of charge encounter forms, order entry screens, ancillary system interfaces and/or staff charging practices to ensure charges are entered timely and accurately.
  – Chart-to-Bill (a.k.a. Chart-to-Charge) audits
    • These will be described in more detail on the next several slides.

Chart-to-Bill Audits - Purpose

• What is the purpose of a Chart-to-Bill audit, i.e., why would a hospital want to perform one?
  – The answer is simple – to ensure billing compliance and appropriate charge capture!
    • A Chart-to-Bill audit, also sometimes referred to as a Chart-to-Charge audit, is a review to ensure that all items (i.e., HCPCS, ICD-9-CM, payer type, provider name, etc.) reported on the UB-04, CMS-1500 and/or detail bill have been properly documented in the chart and vice-versa, and that such services do not elicit NCCI, device-to-procedure, and other payer edits.
Chart-to-Bill Audits – Key Elements

• What are some key elements that one should look out for when performing a hospital chart-to-bill audit?
  – Charges for medications/supplies or tests/services that were not ordered or that were not performed or provided
  – Charges for certain services that were performed by nurses or technicians, such as equipment monitoring, that should be included in the accommodation, surgery time, procedure or visit

Chart-to-Bill Audits – Key Elements (continued):

• Key elements of a hospital chart-to-bill audit:
  – Separate charges for tests that together comprise a panel for which there should be a single charge, i.e., unbundling
  – Duplicate charges, i.e., more than one charge for the same item or service
  – Likely to happen when same/similar services are performed by multiple departments, e.g., venipunctures, CPR, and EKGs

Chart-to-Bill Audits – Key Elements (continued):

• Key elements of a hospital chart-to-bill audit:
  – Separate charges for services and supplies that should be included in the charge for another item, e.g., NCCI edit issues
  – Charges for routine supplies and equipment such as surgical gloves, drapes, urinals, bedpans, irrigation solutions, ice bags, IV tubing, pillows, towels, gauze, oxygen masks, oxygen supplies, syringes, blood pressure cuffs, heating pads, and monitors
Chart-to-Bill Audits – Key Elements

• Key elements of a hospital chart-to-bill audit (continued):
  – Incorrect dates of service
  – Charges for tests and services that had to be repeated because they were performed incorrectly the first time, the results were lost, mislaid, or not properly documented, etc.

Chart-to-Bill Audits – Key Elements

• Key elements of a hospital chart-to-bill audit (continued):
  – Documented items and services that were not charged, but are separately billable
  – Units of service match what is charted
  – Appropriate use of modifiers
  – Rounding of timed charges is accurate when applicable

Chart-to-Bill Audits – Key Elements

• Key elements of a hospital chart-to-bill audit (continued):
  – Orders and results present for all billed services
    • Physician orders must be:
      – Legible
      – Complete, i.e., identify the patient, support the diagnosis/condition, etc.
      – Dated and timed
      – Authenticated in written or electronic form
      – Retained in the chart and available for audit purposes
Forms Utilized

- In addition to analyzing elements in the chart, a chart-to-bill audit entails a review of the UB-04 (or in some cases, the CMS-1500) and a comparison to the itemized bill.
- The UB-04 is maintained by the National Uniform Billing Committee (NUBC) and the CMS-1500, by the National Uniform Claim Committee (NUCC).

UB-04

![UB-04 Image](http://www.nubc.org/)

UB-04 – Pertinent Fields

- UB-04 Form Locators (FL 42-48)

<table>
<thead>
<tr>
<th>FL</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>UB-04 Form Locators</td>
<td>These fields can be located on the UB-04 form, and should include the code for the service that is being billed.</td>
</tr>
<tr>
<td>43</td>
<td>Procedure Code</td>
<td>This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for inpatient services, or the number of days utilized for inpatient stays.</td>
</tr>
<tr>
<td>44</td>
<td>Service Charges</td>
<td>This field is used to report units such as pharmaceutical dosage dispensed, pints of blood used, miles traveled, or the number of days utilized for inpatient stays.</td>
</tr>
<tr>
<td>45</td>
<td>Total Charges</td>
<td>This field reports the total charges—covered and non-covered—related to the current billing period.</td>
</tr>
<tr>
<td>46</td>
<td>Non-Covered Charges</td>
<td>This field indicates charges that are non-covered by the payer as related to the revenue code.</td>
</tr>
</tbody>
</table>

CMS-1500 – Pertinent Fields

- CMS-1500 Fields (selected)

  - Diagnosis or service of other type or codes
  - Place and method of service
  - Procedure or service codes
  - Rendering provider's NPI

  [Links to CMS and NCC sites]


http://nucc.org/

[Diagram of UB-04 form]
**Detail (Itemized) Bill**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Qty</th>
<th>Unit Price</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/14</td>
<td>Discharge</td>
<td>1</td>
<td>0.00</td>
<td>4.35</td>
</tr>
<tr>
<td>2/14</td>
<td>Intubation</td>
<td>1</td>
<td>0.00</td>
<td>4.35</td>
</tr>
<tr>
<td>2/14</td>
<td>None</td>
<td>1</td>
<td>0.00</td>
<td>4.35</td>
</tr>
<tr>
<td>2/14</td>
<td>None</td>
<td>1</td>
<td>0.00</td>
<td>4.35</td>
</tr>
<tr>
<td>2/14</td>
<td>None</td>
<td>1</td>
<td>0.00</td>
<td>4.35</td>
</tr>
<tr>
<td>2/14</td>
<td>None</td>
<td>1</td>
<td>0.00</td>
<td>4.35</td>
</tr>
<tr>
<td>2/14</td>
<td>None</td>
<td>1</td>
<td>0.00</td>
<td>4.35</td>
</tr>
<tr>
<td>2/14</td>
<td>None</td>
<td>1</td>
<td>0.00</td>
<td>4.35</td>
</tr>
<tr>
<td>2/14</td>
<td>None</td>
<td>1</td>
<td>0.00</td>
<td>4.35</td>
</tr>
</tbody>
</table>

**Summary of Charges**
- **Total Charges**: $13,085.00
- **Total Charges**: $13,085.00
- **Total Amount Due**: $28.67

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**Surgery – Auditing Tips**

- What should one look for when auditing for Surgical services?
  - Correct date(s) of service
  - Orders and results for services rendered

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**Surgery – Auditing Tips**

- What should one look for when auditing for Surgical services?
  - Appropriate HCPCS, ICD-9 and revenue code assignment
Surgery – Auditing Tips

• What should one look for when auditing for Surgical services?
  – Correct use of modifiers, i.e., -59 (Distinct Procedural Service), etc.
    • Be wary of modifier -59 for bypassing edits – always go back to the documentation
    • Responsibility for appending varies significantly from hospital to hospital
    • So much misuse and confusion exists that the OIG has published guidance on its use:

Surgery – Auditing Tips

• What should one look for when auditing for Surgical services? (continued)
  – Documentation for procedures, e.g., surgery, anesthesia and recovery start/stop times, etc.

Surgery – Auditing Tips

• What should one look for when auditing for Surgical services? (continued)
  – Legibility
Surgery – Auditing Tips

• What should one look for when auditing for Surgical services? (continued)
  – Proper reporting of supplies, DMEPOS items and pharmaceuticals dispensed by department, including review of Device-to-Procedure Edits and/or Procedure-to-Device Edits

Surgery – Examples

• CMS Procedure-to-Device Edits Table Example

Surgery – Auditing Tips

• When it comes to billable supplies, consider whether the items would be noted by name, size, type, use, etc., in the chart. If not, then they are routine and should not be charged separately. Implantable devices, DMEPOS and those items assigned to HCPCS C-code categories should be captured when appropriately documented.
Surgery – Auditing Tips

• Non-routine items and services may be reported separately to Medicare when they are:
  – directly identifiable items and services provided to individual patients
  – furnished under the direction of a physician because of specific medical needs
  – not reusable or represent a cost for each preparation

Surgery – Examples

• Routine Supplies Example

Surgery – Auditing Tips

• DMEPOS refers to:
  – Non-implanted prosthetic and orthotic devices (typically L-coded items with a Status Indicator of ‘A’ in Addendum B) are paid under the orthotics/prosthetics fee schedule, and should be billed to the FI/MAC under revenue code 0274 and the appropriate HCPCS code when provided for home use. DME items such as crutches (typically E-coded items with a Status Indicator of ‘Y’ or ‘E’ in Addendum B) are billed to the DME MAC, and require a separate provider number (Medicare PM A-03-035, May 2, 2003). Minimal cost take-home items without specific HCPCS coding may be reported under revenue code 0273.
Surgery – Auditing Tips

• DMEPOS (continued):
  – When a prosthetic or orthotic device is provided by hospital staff, and the HCPCS code that describes that device includes the fitting, adjustment, or other services necessary for the patient’s use of the item, an E/M visit or other HCPCS procedure code should not be reported in addition. For example, if the hospital outpatient staff provides the orthotic device described by HCPCS code L1830 (KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment), the hospital should only bill HCPCS code L1830 and should not bill a visit or procedure HCPCS code to describe the fitting and adjustment. [CMS Manual System Pub 100-04 (Transmittal 1702)]

Surgery – Auditing Tips

• Observation is often billed in conjunction with surgical services. However, observation should not be reported:
  – for routine post-operative monitoring during a normal (4-6 hours) recovery period
  – as a substitution for a medically appropriate inpatient admission
  – when not medically necessary for diagnosis or treatment
  – for routine recovery procedures and services provided prior to outpatient diagnostic testing
  – via standing orders following outpatient surgery

Surgery – Examples

• The physician orders on the next slide were written and timed prior to the procedure. Unless the patient ultimately had an adverse event, charging for observation is not warranted.
Surgery – Examples

• Order for 23-hour Observation Written in Advance of Surgery Example

Surgery – Examples

• On the next slide, we have an example of provider progress notes that are virtually unreadable. How many words you can decipher?

Surgery – Examples

• Multidisciplinary Progress Notes Example
Surgery – Examples

• On the next slide, there are time charges for surgery, recovery, general anesthesia and desflurane anesthesia gas. In the facility setting, anesthesia charges represent the supplies, equipment and gases utilized by the anesthesiologist or CRNA. What seems awry here?

Surgery – Examples

• Time Charges Detail Bill Example

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure Description</th>
<th>Units</th>
<th>Amount 1</th>
<th>Amount 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/30</td>
<td>OR LEVEL IV LAST HOUR</td>
<td>1</td>
<td>5095.00</td>
<td>5095.00</td>
</tr>
<tr>
<td>1/30</td>
<td>OR RVU TO LAST 3 VMR</td>
<td>8</td>
<td>2779.00</td>
<td>2779.00</td>
</tr>
<tr>
<td>1/30</td>
<td>PACU LEVEL II FIRST HOUR</td>
<td>1</td>
<td>834.00</td>
<td>834.00</td>
</tr>
<tr>
<td>1/30</td>
<td>PACU LEVEL II LAST HOUR</td>
<td>1</td>
<td>415.00</td>
<td>415.00</td>
</tr>
<tr>
<td>1/30</td>
<td>PACU LEVEL III FIRST HOUR</td>
<td>1</td>
<td>712.00</td>
<td>712.00</td>
</tr>
<tr>
<td>1/30</td>
<td>PACU LEVEL III Last Hour</td>
<td>1</td>
<td>712.00</td>
<td>712.00</td>
</tr>
<tr>
<td>1/30</td>
<td>SUPRA MIP LAST HR</td>
<td>1</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>1/30</td>
<td>SUPRA MIP ADD 10 M</td>
<td>7</td>
<td>25.00</td>
<td>25.00</td>
</tr>
</tbody>
</table>

Surgery – Examples

• This next slide is supposedly the documentation to support the anesthesia time charges reported on the previous detail bill example; however, it is totally illegible.
Surgery – Examples

• Illegible Anesthesia Record Example

Surgery – Examples

• Of the supplies on the next slide, how many do you think are separately billable?

Surgery – Examples

• Surgery Supplies Detail Bill Example

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Quantity</th>
<th>Unit Price</th>
<th>Total Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circuit Airs Adult</td>
<td>1</td>
<td>28.00</td>
<td>28.00</td>
</tr>
<tr>
<td>Tubing Suction</td>
<td>2</td>
<td>6.00</td>
<td>12.00</td>
</tr>
<tr>
<td>Tef Xyraphe</td>
<td>2</td>
<td>6.00</td>
<td>12.00</td>
</tr>
<tr>
<td>Bna Soot 74</td>
<td>1</td>
<td>25.00</td>
<td>25.00</td>
</tr>
<tr>
<td>IV Tubing Vinyl. JI66M</td>
<td>1</td>
<td>7.00</td>
<td>7.00</td>
</tr>
<tr>
<td>KIT IV Start</td>
<td>1</td>
<td>6.00</td>
<td>6.00</td>
</tr>
<tr>
<td>Sternumcoat 14PR</td>
<td>1</td>
<td>18.00</td>
<td>18.00</td>
</tr>
<tr>
<td>Sternumcoat 8PR</td>
<td>1</td>
<td>10.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Sst Contiplo</td>
<td>1</td>
<td>10.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Drainer Bag</td>
<td>1</td>
<td>10.00</td>
<td>10.00</td>
</tr>
<tr>
<td>SOL #MM #1000</td>
<td>2</td>
<td>6.00</td>
<td>12.00</td>
</tr>
</tbody>
</table>
Surgery – Examples

• Now we have a very complex surgery case reflected on a UB-04. The patient had bilateral breast implant rupture and cancer of her left breast with removal and implant replacement. What do you observe?

Surgery – Examples

• UB-04 Coding Example

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>-90</th>
<th>-99</th>
<th>-50</th>
</tr>
</thead>
<tbody>
<tr>
<td>38500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38792-LT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19301-LT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19371-50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19340-50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15777</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• None of the -59 modifiers reported were needed.

Surgery – Examples

• The correct codes that should have been reported per the documentation are:
  – 38500
  – 38792-LT
  – 19301-LT
  – 19371-50
  – 19340-50
  – 15777

• None of the -59 modifiers reported were needed.
Discussion

- Questions?
  - Thank you!