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WEBINAR PRESENTATION

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MEET THE PRESENTER

Linda D’Spain
On the topic:
Defensive Documentation
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DEFENSIVE DOCUMENTATION

Presented by:
Linda L. D’Spain, CMPE, CMCO, CMC, CMIS, CMOM
Faculty, Practice Management Institute

Objectives:
• Understand Why Poor Documentation Needs Your Attention Now
• Overview of Some of the Most Common Mistakes Made in Medical Record Documentation
• Overview of Some of the Most Frequent and Common Billing Mistakes
• Discussion of Case Studies Illustrating Documentation Errors and the Outcomes
• Tools to Improve Documentation in Your Practice
The Best Defense is Good Documentation Offense

• What is the quality of your medical record documentation?

• Why should you prioritize the review of medical record documentation in your practice?

Begin With “Why”

Why should you prioritize the review of medical record documentation in your practice?

- Billing Compliance with State and Federal Payers
- Reflects and Creates Excellence in Medical Care
- Clear and Complete Plan of Care
- Communicates Pertinent Facts
- Credits Competent Care
- Defense Against Allegations of Malpractice
Common Documentation Mistakes

- Physicians typically approach documentation with the goal of communicating effectively with themselves
- Electronic health record templates
- Cloned medical records
- Voice dictation systems
- Hand written illegible records

Examples of Serious Documentation Mistakes

Lack of sleep and an abundance of patients can lead to some serious documentation mistakes:

- “The patient was raped in the usual sterol fashion and presented to the operating room…” (should have stated draped)
- “By the time he was admitted, his rapid heart had stopped, and he was feeling much better”
- “Examination reveals a well-developed male lying in bed with his family in no distress.”
- “Pleasant man lying comfortably in bed. Appears somewhat uncomfortable”
Examples of Serious Documentation Mistakes

- “She slipped on the ice and apparently her legs went in separate directions in early December.”
- “He had a left-toe amputation one month ago. He also had a left-knee amputation last year.”
- “The patient left the hospital feeling much better except for her original complaints.”
- “On the second day the knee was better and on the third day it had completely disappeared.”
- “This is a 981 YO female with a host of medical problems.”

Examples of Frequent and Common Billing Violations

- Billing for services that are not medically necessary.
- Up coding – Using a higher reimbursement code than the documentation supports
- Unbundling – Using two or more billing codes instead of one inclusive code where regulations require “bundling” of the procedure codes
Examples of Frequent and Common Billing Violations

• Under Coding or Clustering – Using only a few codes in the belief that it will keep you off of the “radar screen”.

• Phantom Billing – Billing for services not rendered

CHIEF CONCERN IN HEALTHCARE: BILLING COMPLIANCE AND CORRECT CODING

“Washington – New government statistics show federal healthcare fraud prosecutions on pace to rise 85% over last year due in large part to ramped-up enforcement efforts under the Obama administration.”

USA Today; 8/28/2011
Statistics on “Why Now”

The American Recovery and Reinvestment Act of 2009 (ARRA)

- The Recovery Act contains built-in measures to detect and prevent fraud, waste, inefficiency, and unnecessary spending.
- As part of the legislation, the Office of Inspector General (OIG) for the U.S. Department of State and Broadcasting Board of Governors has received $2 million of Recovery Act funds to provide oversight of the Department of State’s implementation and execution of projects funded by the Recovery Act.

The OIG Work Plan Affecting Physicians'

- Physicians and Suppliers: Compliance with Assignment Rules
- Physicians and Other Suppliers: High Cumulative Part B Payments (New)
- Physicians: Place of Service Errors
- Physicians: Incident-to-Services
- E&M Services provided during Global Surgery period & Use of Modifiers used during Global Surgical Period
- E&M: Trends in Coding of Claims
- EHR – increased frequency of medical records with identical documentation across services
Case Study in Billing and Coding

The Florida Agency for Health Care Administration
Office of the Inspector General, Bureau of Medicaid Program Integrity

“Preliminary Audit Report”

- Services billed and paid were not documented.
- Radiological film supporting services was not submitted or was not of diagnostic quality.
- Services were erroneously coded.
- Services were double billed.

Case Study in Billing and Coding

Electronic Health Record Case

Discrepancies in the Documentation

See handout
Case Study in Billing and Coding

Outcome – see handout

Tools to Improve Documentation in Your Practice

**Soap Note**
- S = Subjective
- O = Objective
- A = Assessment
- P = Plan

**Key Elements**
- History
- Exam
- Symptom / Diagnosis
- Medical Decision Making
Tools to Improve Documentation in Your Practice

Expand the SOAP note with risk reduction techniques to:

• Improve communication
• Enhance patient care
• Decrease malpractice risk

Tools to Improve Documentation in Your Practice

Expand on the SOAP note with an expandable progress note model

S = Subjective
O = Objective
O = Opinion (Replaces the A = Assessment)
O = Option
A = Advice
A = Agreed
P = Plan
Tools to Improve Documentation in Your Practice

How Can You Be Sure That Your Documentation is Satisfactory?

- Know the standard of documentation guidelines in your facility, your state and federal requirements
- Review Your notes
- Are your notes compliant with all requirements?
- Chart audits for proper coding

TOOLS TO PREPARE YOUR OFFICE FOR AN AUDIT

- Education/Training of Staff
- Communication with Providers
- Tracking denials/underpayments and analyzing
- Implementing a Compliance Program
  - 7-Step Compliance Program – Federal Register, published in 2000.*
    - Following-up and monitoring Compliance
- Responding to requests in a timely manner
- Appealing claims with appropriate knowledge and on carrier’s form when required
WHO IS HELD RESPONSIBLE FOR INCORRECT CODING AND CLAIM FILING?

• **Answer:** Everyone

  • Protect your practice, your physician and yourself by keeping up-to-date on current issues.

  • Educate, train, and share information.

  • Share your knowledge, concerns and solutions with your providers.

QUESTIONS?

• Thank you for your attendance!

• **Contact information:**
  
  Linda L. D’Spain, CMPE, CMCO, CMC, CMIS, CMOM
  
  ldspain@pmiMD.com
CERTIFIED MAIL No: __________

June 8, 2011

Provider No: __________

Florida

In Reply Refer to
PRELIMINARY AUDIT REPORT
C.I. No. __________

Dear Provider:

The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity, has completed a review of claims for Medicaid reimbursement for dates of service during the period January 1, 2006 through June 30, 2009. Based on this review, we have made a preliminary determination that you were overpaid $31,716.06 for claims that in whole or in part are not covered by Medicaid.

As cited in Sections 409.913(15), (16), and (17), Florida Statutes (F.S.), and Rule 59G-9.070, Florida Administrative Code (F.A.C.), the Agency shall apply sanctions for violations of federal and state laws, including Medicaid policy. Sanctions include, but are not limited to, fines, suspension and termination. Sanctions will be imposed in the final audit report or subsequent notifications.

As cited in Section 409.913(23), F.S., the Agency is entitled to recover all investigative, legal, and expert witness costs.

This is not a final Agency action. These findings are preliminary in nature. Upon completion of the audit, a final audit report will be issued and it will include the final identified overpayment, any sanctions applied, and the assessed costs.

This review and the determinations of overpayment were made in accordance with the provisions of Section 409.913, F.S. In determining payment pursuant to Medicaid policy, the Medicaid program utilizes descriptions, policies and the limitations and exclusions found in the Medicaid provider handbooks. In applying for Medicaid reimbursement, providers are required to follow the guidelines set forth in the applicable rules and Medicaid fee schedules, as promulgated in the
Medicaid policy handbooks, billing bulletins, and the Medicaid provider agreement. Medicaid cannot pay for services that do not meet these guidelines.

Below is a discussion of the particular guidelines related to the review of your claims, and an explanation of why these claims do not meet Medicaid requirements. The audit work papers are attached, listing the claims that are affected by this determination.

**REVIEW DETERMINATION(S)**

1. Medicaid policy specifies how medical records must be maintained. A review of your medical records revealed that some services for which you billed and received payment were not documented. Radiological film supporting some services was either not submitted or was not of diagnostic quality. Medicaid requires documentation of the services and considers payments made for services not appropriately documented as overpayment.

2. A review of your medical records revealed that some services rendered were erroneously coded on the submitted claim. The appropriate code was applied and the payment adjusted. The difference between the amount paid and the payment for the correct procedure code is considered an overpayment.

3. A review of your records indicated that some procedure codes were double billed in error. In those instances, the amount paid for the second (duplicate) procedure is considered an overpayment.

**OVERPAYMENT CALCULATION**

A random sample of 30 recipients respecting whom you submitted 575 claims was reviewed. For those claims in the sample, which have dates of service from January 1, 2006, through June 30, 2009, an overpayment of $679.00 or $1,180,849.57 per claim, was found. Since you were paid for a total (population) of 51,494 claims for that period, the point estimate of the total overpayment is 51,494 x $1,180,849.57 = $60,807,70. There is a 50 percent probability that the overpayment to you is that amount or more.

We used the following statistical formula for cluster sampling to calculate the amount due the Agency:

\[
E = \sqrt{\left[\frac{U - N}{N(N - 1)}\right] \sum (A_i - TB_i)^2}
\]

Where:
\( F = \text{number of claims in the population} = \sum_{i=1}^{U} B_i \)

\( A_i = \text{total overpayment in sample cluster} \)

\( B_i = \text{number of claims in sample cluster} \)

\( U = \text{number of clusters in the population} \)

\( N = \text{number of clusters in the random sample} \)

\( Y = \text{mean overpayment per claim} = \frac{\sum_i A_i}{\sum_i B_i} \)

\( t = t \text{ value from the Distribution of } t \text{ Table} \)

All of the claims relating to a recipient represent a cluster. The values of overpayment and number of claims for each recipient in the sample are shown on the attachment entitled “Overpayment Calculation Using Cluster Sampling.” From this statistical formula, which is generally accepted for this purpose, we have calculated that the overpayment to you is $21,716.06 with a ninety-five percent (95%) probability that it is that amount or more.

If you are currently involved in a bankruptcy, you should notify your attorney immediately and provide a copy of this letter for them. Please advise your attorney that we need the following information immediately: (1) the date of filing of the bankruptcy petition; (2) the case number; (3) the court name and the division in which the petition was filed (e.g., Northern District of Florida, Tallahassee Division); and, (4) the name, address, and telephone number of your attorney.

If you are not in bankruptcy and you concur with the overpayment, you may remit by certified check in the amount of $21,716.06, however, this will not prevent the issuance of a final audit report. The check must be payable to the Florida Agency for Health Care Administration. Questions regarding procedures for submitting payment should be directed to Medicaid Accounts Receivable, (850) 412-3901. To ensure proper credit, be certain you legibly record on your check your Medicaid provider number and the C.I. number listed on the first page of this audit report. Please mail payment to:

Medicaid Accounts Receivable - MS # 14
Agency for Health Care Administration
2727 Mahan Drive Bldg. 2, Ste. 209
Tallahassee, FL 32308

As previously noted, this is not a final Agency action. You may choose from the following options:

1) Pay the overpayment identified in this notice within 15 days of receipt of this letter and wait for the issuance of the final audit report.

2) If you wish to submit further documentation in support of the claims identified as overpayments, you must do so within 15 days of receipt of this letter. However, please be
advised that additional documentation may be deemed evidence of non-compliance with the Agency's initial request for documentation in which you were required to provide all Medicaid-related records. Sanctions for this non-compliance will be imposed. Any additional documentation received will be taken under consideration and you will be notified of the results of the audit in a final audit report.

3) If you choose not to respond, wait for the issuance of the final audit report.

A final audit report will be issued that will include the final identified overpayment, applied sanctions, and assessed costs, taking into consideration any information or documentation that you have already submitted. Any amount due will be offset by any amount already received by the Agency in this matter. The final audit report will inform you of any hearing rights that you may wish to exercise.

Documents submitted after the completion of an audit may require an affidavit or other sworn statement, in addition to the documents, as a means to authenticate the documentation. Documentation that appears to be altered, or in any other way appears not to be authentic, will not serve to reduce the overpayment. Furthermore, additional documentation must clearly identify which discrepancy, as set forth in the attached audit findings, it purports to support.

Any questions you may have about this matter should be directed to:

Investigator, Agency for Health Care Administration, Office of Inspector General, Medicaid Program Integrity, 2727 Mahan Drive, Mail Stop #6, Tallahassee, Florida 32308-5403, telephone (850) 412-4600, facsimile (850) 410-1972.

Sincerely,

[Name]

AHCA Administrator
Office of Inspector General
Medicaid Program Integrity

RC/Sm

Enclosure(s)

The Health Law Firm
1101 Douglas Avenue
Altamonte Springs, Florida 32714
ATTN: George F. Indest III, J.D., M.P.A., LL.M
## FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

**Provider:**

**Overpayment Calculation Using Cluster Sampling by Recip Name**

**Dates Of Service:** 1/1/2006 through 6/30/2009

<table>
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<th>Recip #</th>
<th>No. Claims</th>
<th>Total Dollars</th>
<th>Overpayment</th>
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<tr>
<td>1</td>
<td>1</td>
<td>$14.00</td>
<td>$0.00</td>
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<tr>
<td>2</td>
<td>27</td>
<td>$1,213.00</td>
<td>$0.00</td>
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<tr>
<td>3</td>
<td>17</td>
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<tr>
<td>4</td>
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<td>$3,841,805.00</td>
<td>$678.00</td>
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Using Overpayment per claim reflected:

- Overpayment per sample claim: $1,180,695.7
- Final estimate of the overpayment: $30,907.70
- Variance of the overpayment: $333,317,368.63
- Standard error of the overpayment: $23,500.90
- Half confidence interval: $23,091.64
- Overpayment at the 95% Confidence level: $217,950.06

Overpayment run on 2/10/2011
### EHR – CASE 1

**NOTE: 2 BULLETS - SAME DX - INCREASED LEVEL OF SERVICE!**

- **ALLERGIES**
  - Associated Signs and Symptoms: RUNNY NOSE, SNEEZING, CONGESTION, BURNING EYES
  - Context: DEViated SEPTUM, GET SINUs INFECTIONS SEVERAL TIMES A YEAR
  - Duration: CONSTANT
  - Location: SINUS/NOSE/EYES
  - Modifying Factors: HAD ALLERGY TESTING PREVIOUSLY AND DID SHOTS (FOR 6 MONTHS), TRIED CLARITIN, FLONASE, NEIL MED RINSE
  - Severity: MILD
  - Timing (Onset): YEARS
- **ALLERGIES** 7-14-11
  - Context: PT HAS BEEN DOING OK WITH SHOTS, JUST HAS SOME ITCHING
  - Modifying Factors: 6 MONTH ALLERGY CHECK UP

**Review of Systems**
- Ears: The System was normal
- Sleep: The System was normal
- Mouth/Throat: The System was normal
- Lymphatic: The System was normal
- Nose: The System was normal
- Neck: The System was normal
- Allergy/Immune System: The System was normal
- Cardiovascular: The System was normal
- Eyes: The System was normal
- Respiratory/Lung Disease: The System was normal
- Gastrointestinal: The System was normal
- General/Constitutional: The System was normal
- Endocrine: The System was normal
- Psychiatric: The System was normal
- Neurological: The System was normal
- Kidney/Urological: The System was normal
- Skin: The System was normal
- Musculoskeletal: The System was normal

**Objective**

**NOTE: EXAM SAME AS LAST VISIT. ALL SYSTEMS NORMAL EXCEPT ENLARGED TURBINATES.**

- Physical Exa:
  - Appearance: The patient was well-nourished, well-developed, alert and oriented x3.
  - Communication: The patient's voice quality was good and the patient was able to communicate readily.
  - Face and Head: The head was normal and no lesions or abrasions were seen.
  - Skin: No lesions or rashes were noticed.
  - EOMs: The extraocular movements were intact.
  - Ears and Nose: The general appearance of both the nose and ears were normal.
  - Otoscopic: The external auditory canals are clear.
  - Nasal: There was no nasal discharge. There is a moderate septal deviation to the left with turbinate hypertrophy bilaterally.
  - Lips and Teeth: The lips were free of lesions and the teeth were in a good state of repair.
  - Oral Cavity: The tonsils were of normal size and consistency. The tongue, floor of mouth, and buccal mucosa were normal.
  - Oropharynx: Inspection of the oropharynx revealed no lesions.
  - Salivary Glands: Palpation of the submandibular and parotid glands showed them to be of normal size without masses.
  - Neck: There was no lymphadenopathy palpated.
  - Cranial nerves 2-12 were intact, symmetrical without weakness.
  - Facial Strength: The facial muscles moved symmetrically without weakness.
  - Chest Inspection: The chest expanded symmetrically without restriction.

**Orders**
No orders for this visit

**Assessment**

**Diagnosis**
- 477.0 Rhinitis Allergic Due to Pollen, Established problem, stable or improved
- 492.90 Asthma Unspec., Established problem, stable or improved

**Visit Code**
- 59214 Ext Patient - Detailed Visit

**NOTE: RESPIRATORY NOT REVIEWED IN EXAM?**

**Plan**

- **Treatment Plan**
  - Instructions: Continue allergy shots
  - Check Out Message: return 6 months

- **Prescribed Medications**
  - Flonase, 50 mcg/Actuation, qty: 1, 2 sprays in each nostril daily, refill: pm, began: 7/14/2011
  - Proventil HFA, 90 mcg/Actuation, qty: 1, one to two

**NOTE: ALL SYSTEMS NORMAL?**

ALL CC, ROS & EXAM COPIED FROM LAST VISIT 4 1/2 MOS AGO. STILL THE SAME?
PMI Discussion Forum

Questions?

Post yours on PMI’s Discussion Forum:


– Click *Accept* to continue

Discussion Forum Walk Through

1) Go to [www.pmiMD.com](http://www.pmiMD.com).

2) Hover the cursor over “Practice Tools” which is the fourth button from the left on the top of the page. This will give you a dropdown menu.

3) Click on the second option listed: “Discussion Forum.”
-This will bring you to the Discussion Forum Disclaimer page. You will click, “Accept.”

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-After clicking on the “Accept” button, you will be guided to the actual discussion forum.
LOGIN OPTION 1
In order to Login to the Discussion Forum, please follow the following steps:

- In the Forum Home block located to the left, click on the “Login” option (this button will have a picture of a key next to the option).

- This will bring you to the “Forum Login” page.

Forum Login

- Enter your username and password

- You will be given the option of whether you will like to be kept logged in. This option is purely up to you.

- You will also be asked if you would like to be added to the active users list. You will want to click yes.

Forum Login