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On the topic:
Gray Areas in Coding, Billing and Auditing
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Gray Areas for Coding, Billing and Auditing

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The Mind of an Auditor

Overall Documentation

• Organization
• Legibility
• Consistency
• Evidence of Training
• Cloned notes and phrases
• Use the same verbiage as Medicare
Before you Begin the Audit

- If you conduct a 1,000 record audit you had better plan to track these elements up-front, not after the fact. This would require either a spreadsheet or database audit tracker.
- Upcoded notes.
- Downcoded notes.
- Cloned notes.
- Missing Hx Elements.
- Missing Exam Elements.
- MDM incorrect.
- “Could Have Been’s.”

Our Slant Today

- Auditing is as much art as it is science. In other words, some issues are quantitative and will vary very little among auditors and carriers. There are numerous “gray areas” where this is significant debate, disagreement and confusion.
- This presentation is the result of over 25 years experience in coding and billing, over 10,000 audits, and hundreds of Seminars and Webinars.
- This presentation is not an introduction to auditing but designed to elicit debate and discussion within your auditing group and providers. Have you decided how to score the “gray areas.” Who decides?
- Let’s discuss the gray areas.
1. The 50% (Auditing) rule

- This is an Ritecode Concept. You won’t hear this anywhere else.
- For many of my audits I prefer to list a percentage of audit risk versus correct or incorrect.
- Some consultants teach everything is Black and White. I don’t.
- If I believe there is 50% or greater probability that an auditor will rule against you then I will audit it as incorrect.
- That means you can find “Suzie” in Idaho, a certified coder with 20 years experience, and she will not agree with me. I can find 5 and you can find 5. Those are coin flipping odds. Are you willing to assume that risk?
- There is a wide difference in the skill level and clinical experience of documentation auditors.
- All auditors are not created equal.
- Lots of vague and interpreted rules (see grey areas).

2. Documentation Consistency and Small Errors

- If the patient is on Aricept© (Donepezil) then there should be consistency in the medical record:
  - ROS: Psychiatric should note this.
  - Exam: A & O X 3 should note this.
  - MDM: Relevance should be noted.
- Never check ROS: All Normal when the patient is on Lasix, Boniva and Effexor.
- This is not specifically a CPT or Medicare guideline. It helps to avoid the impression of cloning; it shows continuity, and an attention to details. Essentially this is my interpretation.
- Some auditors may not enforce, require, or discuss this.
3. What Exactly is a Red Flag?

- Some call them *outliers*.
- Do you *want* to be an outlier?
- If it’s justified, you *want* to be an outlier
- More diagnostic procedures.
- More higher level codes.
- A lot more revenue.
- What do you *need* to make all this happen?
- What is a concise, correct answer for skewing higher?

4. Chief complaint

- Chief complaint locked in or not?
- Technically it does.
- Everyone hates this rule.
- Best advice is to train the front-office staff to discover any potential problems or complaints.
- Always list any chronic problem that can impact the health condition.
- Map the CC to a condition or disease not a test or lab.
5. Cloned notes

• Cloned notes / Illegible notes.
• Number one EMR error.
• Very subjective.
• 24% of all records.

6. Professional-Courtesy Waivers

• This is one of the top gray areas that is not a coding issue but 100% a legal (and management) issue.
• This issue is so controversial and a “gray area,” that even healthcare lawyers will issue a disclaimer concerning this very common practice!
• The issue is that it’s illegal to waive co-insurance and deductible amounts so waiving the entire fee is another story.
7. Rarely-Paid Codes

- Is this a red-flag or good billing practice? Medicare will not pay on these codes, however, in any given city, maybe 1-3 carriers will pay. Do you bill the patient if the carrier does not pay?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99058</td>
<td>Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service</td>
</tr>
<tr>
<td>99060</td>
<td>Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service</td>
</tr>
</tbody>
</table>

8. Well visit reported with a sick visit on the same Day of Service

- There are both Medicare and E & M preventive care codes.
- The gray area is when a Provider feels that he/she has also performed a “sick visit” exam, because the patient either has a chronic problems or brought up a “presenting problem” during the encounter.
- These are valid issues and opinions vary on the requirements to bill an additional E & M service.
- Every clinic should establish a coding and billing policy on this issue. It must be properly explained to the Providers. Key: what did you do differently? Check AMA CPT archives articles and all relevant Medicare bulletins for guidance.
9. Incident-to Services

- Reporting 99211 for non-Provider encounters.
- Recommend at least one exam element.
- Incident-to services. Can it be a tech or a nurse? Does it matter?

10 Undercoding/Downcoding

- Is undercoding illegal or considered fraudulent?
- It’s mostly financial.
- It’s a legal issue.
- Nobody agrees on this. Ultimately it’s a clinic policy.
11. E & M: 2 of 3 Rule/3 of 3 Rule

- For a **new patient**, to report a given level, all three key components, hx, exam, and MDM must be at the highest level. Missing 10 ROS on a comprehensive encounter (99204/5) is fatal.
- For an **existing patient**, either hx, or the exam, may be at a lower level, and the level is determined by MDM and the other key component.
- Remember that MDM always determines the level and can never be the lower of the three (hx, exam and MDM).
- I have seen some clinics either skip or document a minimal hx or exam for a level IV or V visit. While I must audit these as “correct” I do not recommend this unless there is a very good reason for it (patient is going to the ER or unconscious).

12. ROS: “Ten Systems Were Reviewed”

For the ROS do not document: “ten systems were reviewed.” This is not allowed per Medicare guidelines. Copied from Medicare 1997 exam guidelines:

- "A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems."

DG (Comprehensive):

- “At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.”
13/14/15: Review of Systems

13. ROS: Drawing a line through ROS
   • This is not allowed ever for the exam. But would it be allowed for the ROS?
   • I say no.
   • Others might argue that the patient can fill out the ROS.

14. Using allergies for ROS
   Allergies is both an ROS element and part of PFSH. If the ROS is not specifically listed, I often borrow it. However, you should not count it for both. Some auditors might not allow this if allergies is clearly listed in the “PFSH” section.

15. ROS - Non-contributory
   I recommend not using the word "non-contributory." Use instead negative or positive.

16. A+OX3 and Mood and Effect in History Section
   • This does not apply to all specialties or primary care. But it is a good concept to consider.
   • A+OX3 and Mood are exam elements.
   • I won’t allow these if in the history section. Some EMRS list it as a History element.
   • History includes ROS of psychological. So the same information could be listed in both sections.
   • Sometimes it’s simply the last element before exam but not clearly delineated.
   • The error disallows all 99204 and 99205 encounters based on the three of three rule for a comprehensive exam.
17. EXAM: Comprehensive For Every Visit

- Not every exam element, or 18+ elements necessary for every visit or condition.
- When all audited records indicate a comprehensive history and exam that is not necessarily a good thing but an indication of cloning.

18. Counseling and Coordination of Care, Time

- Must include both total time and then either counseling time or a specific percent.
- Must be over 50% of total time.
- Must be unique as a counseling note. Use the phrase “I counseled the patient on...” Don’t use the term “discussed.”
- Always something unique to the patient and this individual encounter (Date of Service) in your notes.
- Include specifics on what was discussed, the reason and topic of counseling.
- History and exam should be minimal; do not include counseling with every progress note; do not document comprehensive exam notes with counseling.
- MDM is no longer a factor. State time and counseling was used to determine the level of the visit.
19. Level 5 Encounters

- Level 5 Encounters should follow the CPT MDM: The Table of Risk.
- Not everyone agrees what is a potentially serious or organ-threatening condition.
- Not every oncology or heart-surgery patient is a level 5.

20. No LCD from your carrier

- What do you do (or use) if there is not an LCD for a procedure from your local Medicare carrier?
- Some consultants say ignore others and refer to the CPT definition.
- I argue that “any LCD is better than no LCD.”
21. Injury location and activity

- Why report an injury location and reason if this is not required per Medicare?
- It provides important data for research.
- Good coding practice.
- I do not count off if the injury and location codes are not documented but do mention that it’s considered accurate coding to include it.

22. Medical Decision Making (MDM)

- Single most important element in determining the level of an E&M office visit.
- The sicker the patient and the more chronic illnesses, generally, the higher the MDM. Think 3 chronic illnesses = moderate MDM.
- **Time is not a factor** (Except for counseling encounter).
- Three Tables in CPT. 1) Number of diseases 2) Data analyzed 3) Table of Risk. Medicare has more detailed guidelines.
- The MDM **scoring system** was not developed by Medicare or in the original guidelines but widely used by Medicare intermediaries and auditors. Not every carrier follows the MDM “scoring system.” It is the best we have. It does not take into account Medical Necessity. Recommend peer reviews.
Medical Decision Making Tables

<table>
<thead>
<tr>
<th>(A) Number of Diagnoses/Management Options.</th>
<th>B) Amount and/or Complexity of Data to be Reviewed.</th>
<th>(C) Table of Risk of Significant Complications, Morbidity and/or Mortality</th>
</tr>
</thead>
</table>

- Only two of the three components need to be at a given level. Sometimes you will see these listed as Tables 1, 2 and 3.

- The Table of Risk is further divided into three tables/columns. An example is in your CPT manual.

23. Self-limited diagnosis

- What is a self-limited diagnosis?
- It is one that could get better without treatment.
- Lots of disagreement.
- Recommend the clinic Providers creating a list.
- Is the condition self-limited diagnosis (max. 2 points) or chronic (up to 4 points)
  - Common cold
  - Cough
  - Earache
  - Conjunctivitis
  - Strep?
24. MDM: Problem List

- Do you accept a Problem List in the History section as supporting MDM or considered an assessment?
  - I don’t.
  - They are fundamentally different.

25. Diagnosis List (only) as Impression

- A simple list of diagnoses and codes is not sufficient for the assessment/ impression (no status codes: stable, worsening, or improving).
  - Is it newly diagnosed?
  - Tell me something about the condition.
26. Medical Necessity

- Medical Necessity for Office Visits.
- Different than for procedures.
- This is an entire presentation.
- Recommend providers discussing list of “Level-5 worthy” conditions.
- Encounters could be down-coded based on medical necessity.
- There is no scoring system; it’s all subjective.
- Clinical.

27. Foreign Body definition

- Coding definition of a foreign body versus the clinical one.
- It is not something put into the body such as a stent, wire or suture.
- Not something the body creates such as conjunctival concretions (lithiasis).
- It includes: glass, wood, stone, metal.
- Do not report the removal of something put into the body as a foreign body removal.
28. Modifier 25

- CPT manual states it must be “separate and distinct.”
- However, CPT also states that it may be linked to the “same ICD-10 code!” However, I personally recommend two, separate diagnoses to avoid confusion.
- Most often used for small surgical procedures:
  - Small sutures
  - Removal of a foreign body
  - Biopsies
- Do not report if the procedure is the only reason the patient is seeing the doctor.
- Does “red eye” with a subsequent foreign body found support a removal code plus an E & M code?

29. Mod -59: Distinct Procedural Service

- Use this modifier to indicate a procedure or service that was distinct or independent from other services performed on the same day. This code is now being replaced with the more specific XE modifiers.
- Mod-59 is appropriate for procedures or services that are not normally reported together, but are appropriate under the circumstances. CPT™ states that mod-59 may represent a different session or patient encounter, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same date by the same physician.
30. MOD-58 versus MOD-78

Mod-58: Staged or Related Procedure
- This is officially a: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period. While often referred to as the “staged procedure code” this modifier is used three ways:
  1. For a surgery planned in stages—a actual staged procedure
  2. To report a more extensive procedure performed during the postoperative period of a less extensive procedure.
  3. To report a therapy given after a diagnostic surgical procedure
- Real World: This modifier is often confused with MOD-78, return to the operating room.

Mod -78: Return to the Operating Room for a Related Procedure during the Postoperative Period
- Mod -78 reports related procedures performed in the operating room within the assigned postoperative period of a surgical operation. This modifier is often utilized when the patient develops a complication which requires a return trip to the operating room for intervention.

31. Interpretation and Report: The Three C's

- Interpretation and Report guidelines. (The Three C’s first appeared in EyeWorld and other Eyecare-related publications.)
- There are three main components.
  1. Clinical Findings
  2. Comparative Data.
- Do not list simply “normal.” Recommend separate from office visit documentation.
- This is not an official Medicare requirement. But recommended.
32: Carrier-Specific Rules

- Which concepts or areas are nearly universal and which fall into the category of carrier-specific rules?
- This impacts a “pure coder”, the billing department, and is a major source of frustration and confusion for Providers.
- A rejection by the Clearinghouse versus a Denial by the Carrier.
  - Global Days
  - NCCI edits
  - Bilateral Surgery Modifier
  - Modifier use and application
- Every clinic should have a manual, spreadsheet or database with their carrier-specific rules.

Summary

- Learn the basics. This should be at least 4-8 hours of training for both Providers and staff.
- Set up an auditing prep meeting.
- Discuss all the gray areas. Include the Providers and management.
- Discuss what you wish to count.
- Perform the audit (3-30 encounters per provider).
- Review the results.
- Provide training.
- Repeat as needed.
Gray Areas for Coding, Billing and Auditing Questions?

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