

Annual
Physician Compliance
Training
2006



Office of Compliance Programs

Compliance Orientation Topics

Today's session will cover:

- OIG risk areas
- Documentation guidelines for E/M Services
- Teaching Physician Rules
- Medical Necessity
- HIPAA

Compliance Risk Areas

- Billing for items or services not rendered (or documented)
- Providing medically unnecessary services
- Upcoding
- Unbundling
- Failure to properly use modifiers (25, 26, 59, etc.)
- Consultations

Compliance Risk Areas (cont.)

- Teaching physician billing
- Misrepresenting diagnosis to justify service
- Billing for a non-covered service as covered
- Failure to maintain confidentiality of information/records
- Knowing misuse of provider ID numbers
- Billing for cardiac rehabilitation

Compliance Risk Areas (cont.)

- Inadequate resolution of overpayments
- Kick-backs / conflicts of interest
- Vendor payment and gifts
- Certification of medical necessity
- Routine waiver of co-payments and billing third-party insurance only
- Discounts and professional courtesy

Compliance Risk Areas (cont.)

- “Assumption” coding
- Alteration of documentation
- Billing for investigational devices, medications, and procedures
- Billing for services provided by unlicensed or unqualified clinical personnel
- Billing for physician services rendered by non-physicians

Compliance Risk Areas (cont.)

- Payments to VA physicians
 - Coding for E/M services
 - Use of Modifier -25
 - Use of Modifiers with CCI edits
-
- To view the 2006 OIG Work Plan, go to:
<http://oig.hhs.gov/publications/workplan.html>

Potential Penalties

- **Criminal** - Imprisonment & Fines
- **Civil** - Fines
- **Administrative** - Suspension of License, Exclusion from Medicare/Medicaid

Who assigns visit codes and what if they are inaccurate?

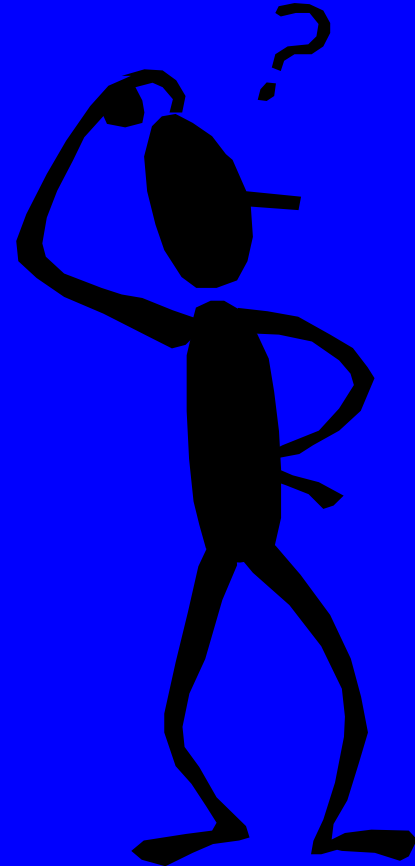
- Coding should be a TEAM EFFORT between registration staff, physicians, nurses, and coding/billing staff
- Inaccurate coding can result in any of the following:
 - Reduced revenues
 - Lost charges on procedures
 - Risk of audit or review
 - Incomplete/inaccurate physician profile
 - Possible fraud charges

Documenting E&M Services

- E&M services are the most frequently billed services to Medicare
- In 2005, Medicare allowed over \$30 billion for E&M services
- The OIG focuses on incorrectly billed & documented E&M services

Determining the E/M level

- **The Key Elements**
 - History
 - Examination
 - Medical Decision Making
- **Contributory Elements**
 - Counseling
 - Coordination of Care
 - Nature of problem
 - Time



The Three Key Components

- **History**
- **Examination**
- **Medical Decision Making (MDM)**

History

Documentation of History will include some or all of the following elements:

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past Medical, Family, and/or Social History (PFSH)

History of Present Illness (HPI)

The HPI is a chronological description of the development of the patient's presenting illness or problem from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying Factors
- Associated Signs and Symptoms

Review of Systems (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. The following systems are recognized:

- Constitutional
- Eyes
- Ears/Nose/Mouth/Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Review of Systems - ROS

- An earlier ROS does not need to be re-recorded. Instead, correlate the previous ROS by noting the date and location of the earlier ROS.
- A review of systems may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
- For a Complete ROS, you may document all positive or pertinent negative responses and then state “**all other systems reviewed and negative**”

Past, Family, & Social History - PFSH

**Past Medical
History**



**Medications
Allergies
Chronic Diseases
Prior Injuries, Hospitalizations,
Illnesses and Surgeries
Immunizations, if appropriate**

Family History



**Parents, Siblings, Etc.
Specific Diseases Related to CC
Hereditary/Congenital Diseases**

Social history



**Marital Status/Family Structure
Employment
Sexual History
Use of Drugs, Alcohol, and Tobacco
Education
Hobbies**

History - Special Exception

- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a history.
- History will be considered comprehensive
- Example: “Unable to obtain history - patient unconscious”

Documentation of History Summary

<i>History of Present Illness (HPI)</i>	<i>Review of Systems (ROS)</i>	<i>Past, Family, and/or Social History (PFSH)</i>	<i>Type of History</i>
Brief 1-3 elements	N/A	N/A	Problem-Focused
Brief 1-3 elements	Problem-Pertinent 1 system	N/A	Expanded Problem-Focused
Extended 4+ elements	Extended 2-9 systems	Pertinent 1 area	Detailed
Extended 4+ elements	Complete > 9 systems	Complete 3 areas	Comprehensive

*** Lowest level of the 3 components determines level of history**

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* Lowest level of the 3 components determines level of history

Examination

- **Body Areas**
 - Head, including the face
 - Neck
 - Chest, including breasts and axillae
 - Abdomen
 - Genitalia, groin and buttocks
 - Back, including the spine
 - *Each* extremity
- **Organ Systems**
 - Constitutional
 - Eyes
 - Ears, Nose, Mouth and Throat
 - Cardiovascular
 - Respiratory
 - Gastrointestinal
 - Genitourinary
 - Musculoskeletal
 - Skin
 - Neurologic
 - Psychiatric
 - Hematologic/Lymphatic/Immunologic

Documentation of Examination - 1995 Guidelines

- The four types of examinations are defined as follows:
 - **Problem-Focused:** affected body area or organ system
 - **Expanded Problem-Focused:** limited exam of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
 - **Detailed: extended** examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
 - **Comprehensive:** A general multi-system examination or complete examination of a single organ system.

Documentation of Examination - 1995 Guidelines

A comprehensive general multi-system exam should include findings about 8 or more of the 12 organ systems.

Medical Decision Making - MDM

Number of Diagnoses or Management Options

- Self-limited or minor problems
- Established problems - stable
- Established problems - worsening
- New problems - no work-up
- New problems - with work-up

Medical Decision Making - MDM

Amount and Complexity of Data Reviewed

- Clinical lab tests - ordered/reviewed/performed
- Radiological tests - ordered/reviewed/performed
- Medical tests - ordered/reviewed/performed
- Test results discussed with performing/interpreting physician
- Obtaining/reviewing old medical records
- Obtaining case history from another source
- Personal visualization of images or specimens

Medical Decision Making - MDM

Risk of Complication and/or Morbidity or Mortality *(Minimal / Low / Moderate / High)*

Based upon:

- Presenting problems
- Diagnostic procedures ordered or performed
- Management options

Medical Decision Making - MDM

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

☉ **Remember, two of the three elements must be met or exceeded.**

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Level of Service Based Upon time

- For encounters dominated by counseling and/or coordination of care (> 50%), **time** becomes the key element.
- If a physician elects to report the level of service based on counseling or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.

Teaching Physician Billing E/M Services

- Minimum teaching physician documentation requires a statement including ALL of the following:
 - The TP personally saw the patient
 - The TP participated in the management of the patient, and
 - the TP reviewed the resident's note, discussed the case with the resident and agrees or document corrections/changes

Teaching Physician Billing E/M Services

- Documentation examples:
 - “I saw and evaluated the patient. Discussed with resident and agree with the resident’s finding and participated as follows: _____.”
 - “I saw and evaluated the patient. I reviewed the resident’s note and participated as follows: ____.”

Teaching Physician Billing E/M Services

- Documentation example for PCE:
 - "I reviewed the history/exam/plan with the resident during / after the visit, and (document whatever you find clinically pertinent IE - HTN well controlled or schedule ultrasound).

Teaching Physician Billing E/M Services

- The teaching physician must see the patient and document the service on the same calendar date of the resident's service in order to bill for the service (next day allowed for admissions).
- Documentation by other staff, such as nurses and medical students, may not be used to support billing (except for ROS and PFSH).

Teaching Physician Billing Time-based Services

- Coding based solely on teaching physician's time
- Time spent by resident does not count
- Requires teaching physician to document time in the medical record

Teaching Physician Surgical Services

For reimbursement purposes Medicare & Medicaid require teaching physicians to participate in the care of patients.

Risk Assessment indicates this is a high risk area for the organization.

Need to strengthen process to lower risk of submitting bill in error where Teaching Physician did not participate in the service.

Teaching Physician Surgical Services

Medicaid requires:

Teaching Physician must personally furnish services

Resident furnishes service in the presence of a teaching physician.

- TP is present for the entire procedure
- TP is present for the “KEY” portions of the service

Teaching Physician Surgical Services

In order to support Teaching Physician presence and **bill** for the Teaching Physician

Document surgeries as follows:

“I was present for and participated in the entire procedure”
(excluding opening & closing)

Teaching Physician Surgical Services

OR -

“I was present and participated in the key portions of the procedure which include _____ and I was immediately available during the entire procedure.”

Medicare Medical Necessity for Diagnostic Testing

- Ordering Physician is responsible for documenting and supporting medical necessity.
- The medical necessity of each test ordered must be considered independently
- If the patient's condition is not yet determined, signs, symptoms, and complaints are appropriately reported
- “Rule-out” diagnoses are **NOT** acceptable

Medicare Medical Necessity for Diagnostic Testing

- Medicare requires ordering physician to provide diagnosis to testing entity (hospital lab, etc.)
- Certain services are covered by Medicare only for specific diagnoses or conditions.
- Medicare publishes coverage rules as Local Medical Review Policies (LMRPs).
- The Medicare Carrier's web site (gamedicare.com) provides access to the complete list of all LMRPs.

Examples of Services with Specific Diagnosis Requirements

- **Lab:** CBC, Urinalysis, Lipids, Glucose, PSA, Thyroid Panel, and others.
- **Radiology:** Chest X-rays, MRIs
- **Cardiology:** Echoes, EKGs, Vascular Studies
- **Other:** Pulmonary Function Studies, Colonoscopies

Patient Privacy/Confidentiality

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

- Please remember HIPAA rules and regulations!!

Patient Privacy/Confidentiality

Simple Things You Can Do?

- Do not leave patient information out in “plain view.”
- Log-off your computer.
- Don’t talk about patients in public areas. (Elevators, buses etc.)
- Lock your file drawers that contain patient information.
- Shred patient information that will be thrown away.
- Do not look up patient information unless it’s for TPO.

Reporting Potential Problems

When in doubt, point it out!!

Who do I go to?

- Department Compliance Liaison
- Chairman or Chief
- Compliance Department 404-778-2757
- Emory Healthcare **Trust Line** 1-888-550-8850