MPC, Inc.

Summer 2018

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MEDICAL PRACTICE CONSULTANTS, INC.

CMS—Prior Audits ….What to expect in 2018!

MACs Begin Prepayment E/M Audits—TPE (Targeted Probe and Educate)

Three rounds—of prepayment probe review with education.

If continued high errors after three rounds, Novitas will refer the provider for consideration of additional action for possible extrapolation and referral to another government investigation area:

- Zone Program Integrity Contractor (ZPIC).
- Unified Program Integrity Contractor (UPIC).
- CMS contractor to support the CMS audit, oversight and anti-fraud, waste and abuse efforts.
- Recovery Auditor (RA) Previously called RAC.

Refer to: CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 2.

THINGS TO BE AWARE OF- E/M codes will be targeted.

- The OIG has noted high errors in coding of E/M codes.
- Problems identified with the use of Electronic Health Records.
- Errors identified by the OIG when EHR users copy and paste data from one entry to another.
- This can lead to clinical mistakes, over coding, and improper reimbursement.
- The OIG now classifies it as healthcare fraud.

FEDERAL AUDITS HAVE IDENTIFIED:

INSUFFICIENT DOCUMENTATION ERRORS:

- Reviewers determine that claims have insufficient documentation errors when the medical documentation submitted is inadequate to support payment for the services billed (that is, the reviewer could not conclude that some of the allowed services were actually provided, were provided at the level billed, or were medically necessary).
- Reviewers also place claims into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

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INSUFFICIENT DOCUMENTATION EXAMPLES

Incomplete progress notes (for example, unsigned, undated, insufficient detail).

Unauthenticated medical records (for example, no provider signature, no supervising signature, illegible signatures without a signature log or attestation to identify the signer, an electronic signature without the electronic record protocol or policy that documents the process for electronic signatures).

No documentation of intent to order services and procedures (for example, incomplete or missing signed order or progress note describing intent for services to be provided).

Office of Inspector General (OIG) - EXAMPLES

Some of the more common procedures that have resulted in insufficient documentation errors, description of errors, and links to the requirements are summarized below.

Cloning

- This practice involves copying and pasting previously recorded information from a prior note into a new note, and it is a problem in health care institutions that is not broadly addressed. For example, features like auto-fill and auto-prompts can facilitate and improve provider documentation, but they can also be misused. The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter. Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable. Using electronic signatures or a personal identification number may help deter some of the possible fraud, waste, and abuse that can occur with increased use of EHRs. In its 2013 work plan, the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) indicated that due to the growing problem of cloning, its staff would be paying close attention to EHR cloning.

Upcoding

- Upcoding, sometimes known as "code creep," occurs when a provider bills for a higher Current Procedural Terminology (CPT) code than the service actually furnished, resulting in higher payment. Again, auto-fill and auto-prompts can facilitate and improve documentation, coding, and billing, but if used inappropriately, these tools may suggest a higher billing code and payment than the actual services furnished warrant, resulting in an improper payment. Claims paid without the appropriate supporting documentation are improper payments, and providers must return them.

Evaluation and Management (E/M) Services

Top Three E/M CPT Code CERT errors -

- Established office visits.
- Initial hospital visits.
- Subsequent hospital visits.

High error consisted of –

- Insufficient documentation.
- No documentation.
- An correct coding of E/M services to support medical necessity & accurate billing of E/M services.

"Some of the best memories are made in flip flops."
-Kellie Elmore