PSS EyecareMeeting

Medical Coding & Reimbursement
Including Compliant Coding

Hot Topics in Medical Care
ICD-10 (More To Come)
HIPAA Audits
How to Avoid Audits

COPE 40384 & 48335 PM

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Nteon
Practice
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FINANCIAL DISCLOSURE

President - Nteon - EyeCOR

President – Nteon Practice Consultants

Seminar Ground Rules:

- **If you have questions…Ask!**

As you go through the handouts
You will see significant changes

Updated slides available

Purpose of this seminar:

How to:

Get Paid for what you are doing!

What you need to be on top of

Case Studies & Common Coding Mistakes
NCCI Compliance
ICD-10 Expanded Codes
HIPAA
Avoid Audits (and survive)

Medical Coding and Reimbursement

Case Studies

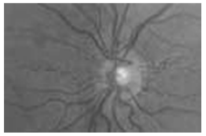
All case studies are from our users.

These were originally presented at their State Meetings

Medical Billing

Case Study

- Glaucoma Suspect



During routine Vision Plan examination, suspected glaucoma.

Be up front with the patient.

Tell them that suspect Glaucoma and will bill all visits and relevant testing for the condition to their medical plan.

Schedule Medical Exam

This example is an actual exam submitted by one of our clients.

Glaucoma Suspect - Case Study

Billed the exam as a 99213

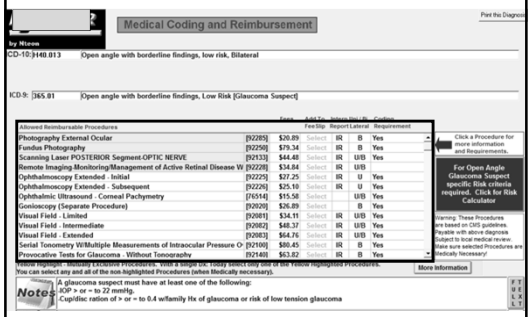
Collect all History including HPI, PFSH, ROS

Perform required Exam Elements for Level 3 exam (2 – 9 elements)

Assess Patient Risk Level

What else?

Glaucoma Suspect - Case Study



Medical Billing

H40.013 (365.01) Glaucoma Suspect - Case Study

01/02/2014	99213 E/M Level 3 Office Visit	$100.30
01/02/2014	92250 Fundus Photos	$74.29
01/03/2014	92133 Scanning Laser	$41.86
01/02/2014	92020 Gonioscopy	$25.65
01/02/2014	92083 Visual Fields - Extended	$61.11
01/02/2014	76514 Pachymetry	$14.08
01/02/2014	92100 Serial Tonometry	$75.37
	Total Insurance Billed and Reimbursed	**$392.66**

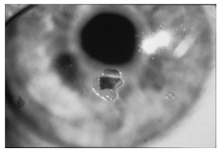
Note: This case study has been updated for new codes and fees

These are Mutually Exclusive However, performed on different days. Claim is good.

Medical Billing

Case Study

- Corneal Foreign Body



Caution!

Medical Billing

Corneal Foreign Body - Case Study

Dx: T15.01XA (930.0) Corneal Foreign Body OD – Initial Encounter
H57.11 (379.91) Eye Pain OD

Used: 99203 E/M Level 3
HPI: CC - Painful eye - OD
Pain for past 4 hours
Constant Pain
Greater with Blinking
Associated signs – Redness, tearing, photophobia
ROS: Reviewed General Health (for level 3 only 1 needed)
Exam: Acuities, IOP, pupil responses, external & internal evaluation

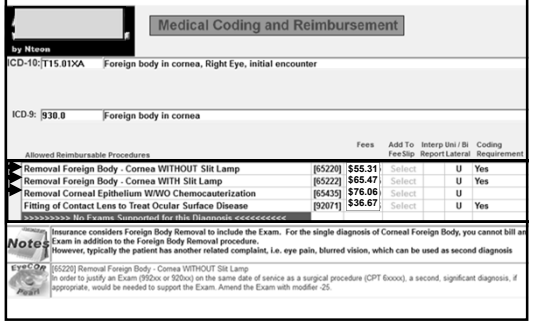
These elements fulfill HPI requirements.

Foreign Body Removal does not support an Exam.
Therefore, the exam will not be reimbursed.

Insurance considers the removal the complete exam.

A second diagnosis i.e., Eye Pain will support the exam!

Corneal Foreign Body - Case Study
What Corneal Foreign Body Supports



Case Study

T15.0xXA (930.0) Corneal Foreign Body
with H57.1x (379.91) Eye Pain diagnosis

65222 Corneal Foreign Body Removal with Slit Lamp	$65.84
65435 Removal Corneal Epithelium	$76.06
92071 Bandage Contact Lens (NEW)	$36.67
92014 Comprehensive (linked to 379.91)	$117.77

*** For either E/M exam or Ophthalmic exam must use a 25 modifier**
*** In some areas 65435 and 92071 require XU modifier**

Total Insurance Billed and Reimbursed	**$287.34**
Remember most doctors only bill Removal w/o Slit lamp	**$55.31**

Without 92014 reimbursement $117.11 less!

Note: These amounts are for CFB in only on one eye.
If bilateral all figures except exam double the procedure charges.

Diabetes Codes

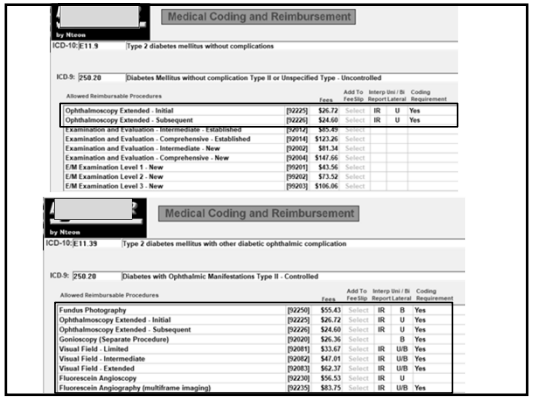
In our audits we frequently find the code:
E08/09/10/11/13.9 Diabetes without Manifestations

Frequently, the records have other DXs

Exx.9 significantly limits procedures allowed
Lost Reimbursement!

Exx.39 Diabetes With Ocular Manifestations

Provides more Allowed Reimbursable Procedures



Diabetes Codes

In a practice with 3 doctors, we calculated for just one doctor, in 1 month, they lost $4,600!

Because of the frequent use of E11.9

When E11.39 was justified due to other ocular issues

Billing

How to lose money for the wrong reasons!

I Under Bill on Purpose to Avoid Audits

Success in audits is not based on procedures billed.

Losing an audit is typically a result of multiple issues.

Billed it Because It Was Paid!

Some payers reimburse procedures even when they are not in their LCD. Then… They come after you!

Practice noticed BC paid Fundus on multiple Dx's. $190,000

During one of our audits, we found doctors routinely performing OCT "BIWP". Told them to stop. They did.
One year later were audited. Because they already stopped, returned reimbursement but, no penalty.

Outside billing company clerk found that BC paid Fundus on Cataract. When in doubt billing company changed the supporting Dx to Cataract. Later hit. Auditor did not care the billing company made the change. $155,000

Multi doctor mutipule locations practice performed Fundus, OCT, VF on every patient "BIWP". In an audit we warned the owner. She said she would continue. Then? Penatly!

Lost Reimbursement Result of Billing Problems

In our Preventative Practice Audits in addition to compliant records we perform a thorough review of Billing.

Here are some of the most common billing problems we find:

- **Diagnoses and Procedures NOT correctly transferred from Exam to Billing – Lost Reimbursement!**
- **Claims NOT correctly scrubbed – submitted then denied.**
- **EOB processing:**
  - **Denials resubmitted without change or incorrectly resubmitted**
  - **Incorrect write-offs**
  - **Patient refunds not processed. Payers will come after you!**

Each of these results in Lost Reimbursement!

Frequent Response from Billers

I Have been Billing for 15 years!

In many cases it is NOT the Billers Fault

Billing requirements change continuously.

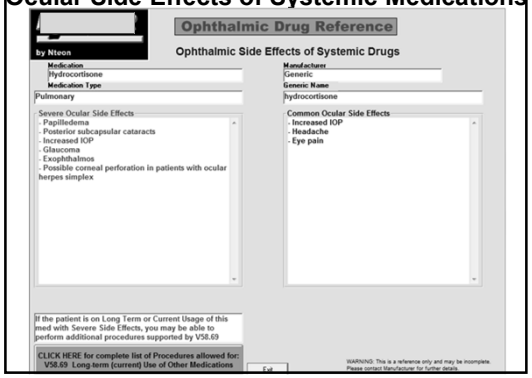
Most billers do not have the tools to keep up with changes

Payers prohibit reps from providing Coding & Billing info

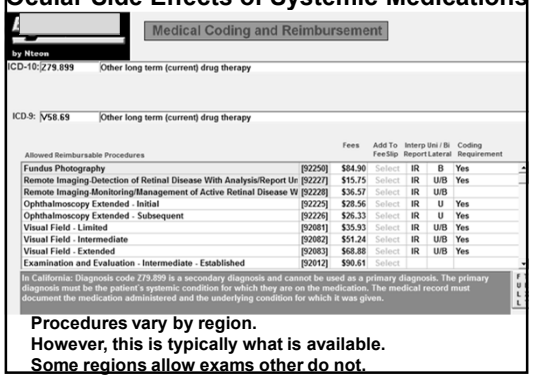
Systemic Medications

Are you recording your patients'
Systemic medications in their records?

Ocular Side Effects of Systemic Medications



Ocular Side Effects of Systemic Medications



Procedures vary by region.
However, this is typically what is available.
Some regions allow exams other do not.

Case: Patient on High Risk Medication

Z79.899 (V58.69) -Other long term (current) drug therapy

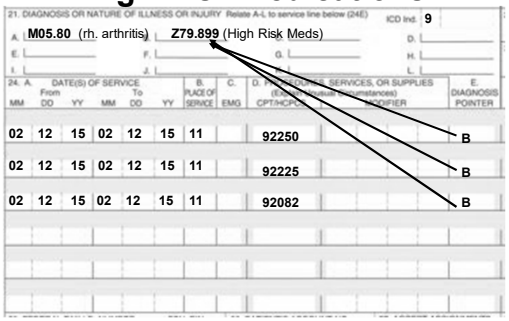
92250 Fundus Photography	**$81.81**
92083 Visual Fields Extended	**$95.36**
92014 Ophthalmic Exam Comprehensive Established	**$125.22**
Total Insurance Billed	**$302.39**

Here is a case where the only issue for this "Wellness" patient is that they are on a "High Risk" medication!

Over $300 reimbursement for an otherwise "Wellness" patient. Not that they have the High Risk side effect.

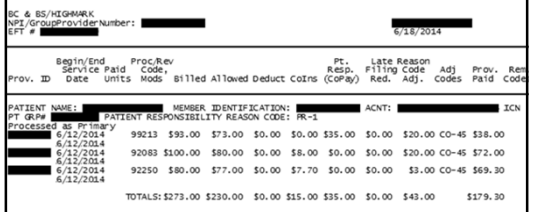
Not that they have any other diagnosis.

High Risk Medications



Note – All CPT codes point to the Z79.899 NOT Primary Dx

Z79.899 (V58.69) For you Naysayers



92xxx vs. 992xx

Ophthalmic Examination & Evaluation | **Evaluation & Management**

Which exam type should I use?

Previously Stated Did Not Matter

But with audits and reimbursement it does.

- **Many doctors use 992xx exams. Audit failures**
- **Typically for similar exam types 92xxx reimburses higher**

92xxx vs. 992xx

Ophthalmic Examination & Evaluation | **Evaluation & Management**

92002	**$77.19**	**99202**	**$71.02**
92012	**$81.13**	**99212**	**$41.26**
92004	**$142.12**	**99203**	**$102.58**
92014	**$117.77**	**99213**	**$69.13**

Mutually Exclusive Procedures

Fundus Photography
Scanning Laser (all forms… OCT, GDx, HRT)

No longer Mutually Exclusive:
External Photography (including slit lamp)
Extended Ophthalmoscopy
Visual Fields

These 2 procedures are <u>always</u> mutually exclusive from each other on the same day regardless of the diagnosis.

Mutually Exclusive Procedures

Three different scenarios

1 With a single diagnosis you can only perform one Mutually Exclusive procedure on the same day.
   You can do other Non-Mutually Exclusive on the same day.

2 You can have the patient return another day for another Mutually Exclusive procedure.
   Make sure you code the procedure date not the original exam date.

3 If you have multiple dissimilar diagnoses, you can perform multiple Mutually Exclusive procedures on the same day.
   Make sure you link the procedure to the appropriate diagnosis.
   Each diagnosis linked from a procedure must support that procedure.

Avoid using the 59 modifier. Use the XU modifier!

Back to the New SCODI Codes

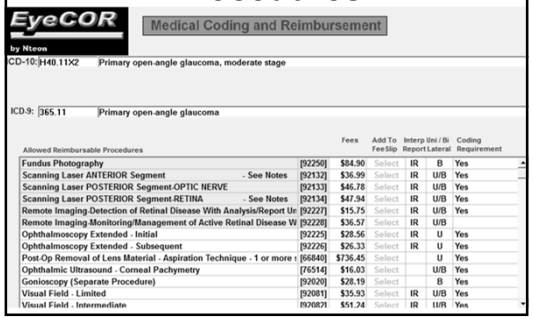
Mutually Exclusive

92132 Scanning Laser ANTERIOR segment
92133 Scanning Laser POSTERIOR – Optic Nerve
92134 Scanning Laser POSTERIOR – Retina

No regions allow 92132, 92133 and 92134 on same day even with Multiple Dissimilar diagnoses!

In a lecture a billing person said multiple Scanning lasers are paid on the same day. However, we checked the LCDs for that region. It was not there. If performing - check with the payer and your EOBs

Mutually Exclusive Procedures

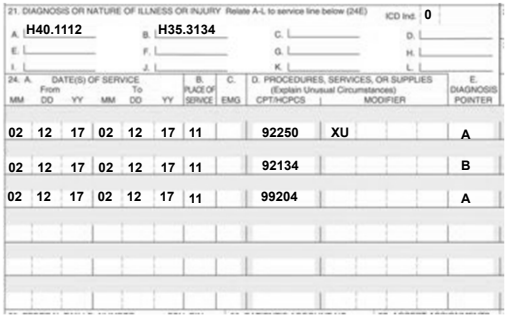

EyeCOR by Nteon — Medical Coding and Reimbursement

CD-10: H40.11X2 Primary open-angle glaucoma, moderate stage

ICD-9: 365.11 Primary open-angle glaucoma

Allowed Reimbursable Procedures		Fees	Add To Fee Slip	Interp Report	Uni / Bi Lateral	Coding Requirement
Fundus Photography	[92250]	$84.90	Select	IR	B	Yes
Scanning Laser ANTERIOR Segment - See Notes	[92132]	$36.99	Select	IR	U/B	Yes
Scanning Laser POSTERIOR Segment-OPTIC NERVE	[92133]	$46.78	Select	IR	U/B	Yes
Scanning Laser POSTERIOR Segment-RETINA - See Notes	[92134]	$47.94	Select	IR	U/B	Yes
Remote Imaging-Detection of Retinal Disease With Analysis/Report Ur	[92227]	$15.75	Select	IR	U/B	Yes
Remote Imaging-Monitoring/Management of Active Retinal Disease W	[92228]	$36.57	Select	IR	U/B	
Ophthalmoscopy Extended - Initial	[92225]	$28.56	Select	IR	U	Yes
Ophthalmoscopy Extended - Subsequent	[92226]	$26.33	Select	IR	U	Yes
Post-Op Removal of Lens Material - Aspiration Technique - 1 or more	[66840]	$736.45	Select		U	Yes
Ophthalmic Ultrasound - Corneal Pachymetry	[76514]	$16.03	Select		U/B	Yes
Gonioscopy (Separate Procedure)	[92020]	$28.19	Select		B	Yes
Visual Field - Limited	[92081]	$35.93	Select	IR	U/B	Yes
Visual Field - Intermediate	[92082]	$51.74	Select	IR	U/B	Yes

Billing Multiple Mutually Exclusive Procedures


21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. H40.1112 B. H35.3134 C. D. E. F. G. H. I. J. K. L.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER
02	12	17	02	12	17	11		92250	XU	A
02	12	17	02	12	17	11		92134		B
02	12	17	02	12	17	11		99204		A

Any questions or comments about the selection of procedures?

Interpretation and Report

We are still seeing most fail!

Reimbursement But Not Coding Tip

Interpretation and Report

Are you doing them?

80% of Optometrists and Ophthalmologists are not doing them or not properly!

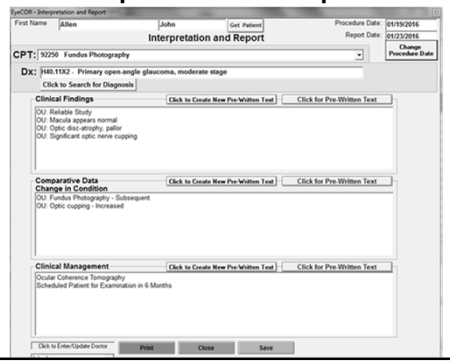
What specifically are they?

They are required and shown in all LCDs. They have specific requirements

Ophthalmic Procedures Requiring Interpretation and Report

0181T	Corneal Hysteresis Determination - By Air Impulse Stimulation
0198T	Measurement of Ocular Blood Flow By Repetitive Intraocular Pressure Sampling
2022F	Diabetes Mellitus: Dilated Retinal Eye Exam With Interpretation - Measure 117
2024F	Diabetes Mellitus: Seven Standard Field Stereoscopic Photos With Interpretation- Measure 117
5010F	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care - Measure 19
92025	Corneal Topography
92060	Sensorimotor Exam (Separate Procedure)
92081	Visual Field - Limited
92082	Visual Field - Intermediate
92083	Visual Field - Extended
92100	Serial Tonometry (Separate Procedure)
92120	Tonography - Recording Indentation Tonometer Method or Perilimbal Suction Method
92132	Scanning Computerized Ophthalmic Diagnostic Imaging ANTERIOR Segment [SCODI, HRT, OCT, RTA, GDx]
92133	Scanning Computerized Ophthalmic Diagnostic Imaging POSTERIOR Segment-Optic Nerve [SCODI, HRT, OCT, R
92134	Scanning Computerized Ophthalmic Diagnostic Imaging POSTERIOR Segment-Retina [SCODI, HRT, OCT, RTA, G
92140	Provocative Tests for Glaucoma - Without Tonography
92225	Ophthalmoscopy Extended w retinal drawing - Initial
92226	Ophthalmoscopy Extended w retinal drawing - Subsequent
92250	Fundus photography
92265	Needle Oculoelectromyography one or more extraocular muscles or eyes
92270	Electro-oculography
92275	Electroretinography
92284	Dark Adaptation examination
92285	Photography External Ocular
92286	Photography Anterior Segment Specular Microscopy
92287	Photography Anterior Segment w Fluorescein Angiography
96115	Neurobehavioral Status Exam

Interpretation and Report



Interpretation and Report

Many EHR systems claim to have a report.
However, the majority are not compliant.
They do not have all three components.

Clinical Findings
Change in Condition / Comparative Data
Clinical Management

This is an example of one of the most common systems:

SPECIAL TESTING
RETINAL PHOTOGRAPHY: CPT 92250 - Interpretation and Report: Retinal camera.
The defect exists in the macula. Defect is consistent with dry macular degeneration.
Defect is consistent with macular puckering/ERM.
Follow for trend analysis as directed and treatment as indicated in plan.

This is not an Interpretation and Report!
You must report all three Clinical Findings, Change in Condition (missing) and Clinical Management (missing)

ICD-10

It been implemented for 2 years.

Last year:
Expanded ICD-10 Codes

Elimination of Unspecified

Since 1 October 2017 More new codes
Others continually added

Avoid "Unspecified" Codes

Good:
Unspecified Condition – Many diagnoses have unspecified Conditions
H53.40 Unspecified visual field defects (Note Unspecified Condition) OK

Not good:
Unspecified Eye / Lid

Many Practice Management EHR Systems Still Have Unspecified Codes.

Make sure your system has all the correct codes. If not your billing will be in jeopardy!

Avoid "Unspecified" Codes

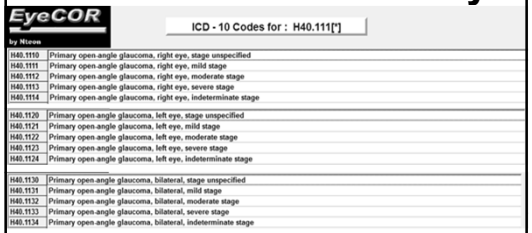
Consequences:
Many payer will deny the claim. Lost reimbursement.

But not the major problem:

From actual Insurance audit report:
"The provider is using unspecified diagnosis code for claims that represent nearly 52% of payment to the provider"

The doctor's penalty was $468,944! We have appealed the rest of the findings, but because he used "unspecified" diagnoses, he will automatically lose $253,210 – 52% of the total.

ICD-10 – POAG Severity



I have eliminated all the "Unspecified" codes
Note Severity

ICD-10 Severity

If the patient has same diagnosis Bilaterally with Different Severity

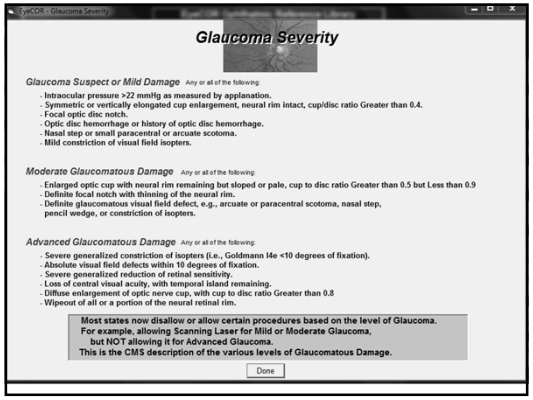
Always code worse eye:

Therefore for POAG Severe OD Moderate OS - Code: H40.1133

Example 2:
Low Tension Open-angle Glaucoma Bilaterally With different Severity

Code worse eye: Severe OD Moderate OS
Code: H40.1233 (Bilateral Severe Stage)

Severity is not subjective!



Final Word About Medical Coding and Reimbursement

You need to act to realize these reimbursement increase

EHR systems do not have this level of information

You need the right tool

It does not happen by itself

HIPAA They are out to get you!

Sign In sheet

Discussions with patients or about patients

Exam lane computers

Scheduled Examinations

New HIPAA requirements
Patient form only once in a lifetime!

Audits Before I go any further!

I want to emphasize even more!

Every lecture I talk about audits.

After these lectures doctors tell me.
But most do nothing!

Then every week we hear from doctors.

How do I everyone to realize "This is Serious"

Audits

All payers are increasing their audits!

Some are announced. Others are unannounced

Average penalty was ~~$100,000- $200,000~~
Recently $150,000 - $250,000!
Many over $1,000,000

Random

Request for documentation not fulfilled or complete
Particularly Interpretation and Reports

Billing in excess of the regional norm. This is rare!
However, not with VSP

Audits – Major Misconception

"I perform a thorough examination. I am not worried about an audit."

The following year doctor was audited – Penalized $165,000

His actual exam was through.
But exam documentation was not "compliant"

You can perform the best exam for your patient's benefit. However, if it is not "compliant" you will lose an audit!

Auditors find more Non-Compliant exam documentation with EHR systems!

Most EHR Templates do NOT include required information

We are going to cover the most common reasons

Peer Review

"We do peer review to protect us from an audit."

Common reason for practices not seeking a professional Preventative Practice audit.

Peer Reviewed Practices:

We frequently hear from practices that failed an audit.

When auditing, we find many compliance problems.

Unfortunately, most doctors who Peer Review are not fully knowledgeable in compliance!

VSP Audit

No Notice
All documentation related to

Extrapolation

$20,000 Becomes $200,000

Over 90% of Practices Audit Fail!

Before Auditors contact you, they look for "Suspect" Records

Focus on 40 – 50 records

They are looking only for a high probability of failure

They do not look at "clean" records

How Do Penalties Get So High?

Request for Records – Limited Number
– Already Targeted

Audit Performed With No Input from You

The Penalty Calculation:

Records Reviewed	– 45	(Typical 40 – 50)
Records Failed	– 41	
% of Records Failed	– 91%	(Typical)

The auditor only identified $17,500 of reimbursement

Total Reimbursement 2010 – 2015	- $127,569
Failed % of Total Reimbursement	- $116,087
Interest and Penalties	- $79,695
Total Due by Practice	- $195,782

Audit Negative Findings Top Ten List

In order of recording the exam

Audit Negative Findings Top Ten List

1

Chief Complaint

Invalid will fail an audit

IOP Check
Eye Examination (Medical Exam)
Referred by Dr. Smith

Correct:
Glaucoma
Cataracts
AMD

If it is NOT the Patient's Chief Complaint

You Cannot Bill It!

Audit Negative Findings

HPI / Chief Complaint

Here is what we find:

HPI Not recorded

HPI recorded but not printed in report

One system takes the elements and creates multiple sentences in a paragraph. Report only prints a truncated version… Non compliant!

It is so simple. The HPI with four elements!

Audit Negative Findings Top Ten List

HPI

While some exam levels do not require as much, always do four (4) elements!

Here is one frequent HPI: Eye Exam

Location, Quality, Severity, Duration, Timing, Context, Modifying Factors & Associated Signs / Symptoms

HPI Is NOT only the first complaint from the patient.
HPI can be determined throughout the exam process.

HPI can also be described by the doctor:

Bilateral Glaucoma	Increased Optic Nerve	Dx 6 months	Continuous
Location	Severity	Duration	Timing

Audit Negative Findings Top Ten List

4

Insufficient Patient History (PSFH)

920x4 Comprehensive 3 History elements (PFSH)
920x2 Intermediate 1 History element
992x3 E/M 1 History Element
992x4 + 992x5 E/M 3 History Elements (PFSH)

For comprehensive exams History must be at least one form each (Past, Family and Social)
I recommend always code all 3 PSFH!

DO NOT "Pull Forward from Previous Exam"!!!

Audit Negative Findings

Insufficient Patient History (PSFH)

! History is where we see over 90% exams fail!

First Patient History is NOT Review Of Systems

Comprehensive History at least one from each - P, F,S
I recommend always code all 3 PSFH!

Social History Alcohol or Smoking
If smoking and affirmative you must discuss and document Cessation

ODs no longer have to document Height Weight / BMI

Audit Negative Findings Top Ten List

8

Insufficient Review of Systems (ROS)

992x3 E/M 2 ROS Elements
992x4 + 992x5 E/M 10 ROS Elements
92xxx Not required but useful

ROS is easy to record and update.
I recommend always code all 14 ROS systems!

DO NOT "Pull Forward from Previous Exam"!!!

Audit Negative Findings Top Ten List

ROS

Normal Counts!

REVIEW OF SYSTEMS	REVIEW OF SYSTEMS
ALLERGY:	ALLERGY: No symptoms reported
CARDIOVASCULAR: Elevated cholesterol	CARDIOVASCULAR: Elevated cholesterol
ENDOCRINE: Diabetes Mellitus	ENDOCRINE: Diabetes Mellitus
GASTROINTESTINAL: Positive	GASTROINTESTINAL: No symptoms reported
GENITOURINARY:	GENITOURINARY: No symptoms reported
HEAD:	HEAD: No symptoms reported
HEMATOLOGIC / LYMPHATIC:	HEMATOLOGIC / LYMPHATIC: No symptoms reported
IMMUNOLOGIC:	IMMUNOLOGIC: No symptoms reported
INTEGUMENTARY:	INTEGUMENTARY: No symptoms reported
MUSCULOSKELETAL:	MUSCULOSKELETAL: No symptoms reported
NEUROLOGICAL:	NEUROLOGICAL: No symptoms reported
PSYCHIATRIC:	PSYCHIATRIC: No symptoms reported
RESPIRATORY:	RESPIRATORY: No symptoms reported
THIS COUNTS AS 3	THIS COUNTS AS 13

Audit Negative Findings

Let's combine History, Medications & ROS

For this slide "History" = combination History, Meds & ROS

Most practices have Technicians record "History"

When we perform audits, we frequently find:

"History" NOT reviewed and documented for each exam.

All three categories (History, Meds & ROS) must match.
What does this mean?

Audit Negative Findings Top Ten List

3

Cloned Records – EMR Systems

AKA: One Click Pull Forward

Because EMR systems take longer, vendors implemented this feature to speed up the process.

Payers consider this non-complaint and deny the exam

Why?

Even if your EMR contains a "All Items Reviewed" button
Records must clearly demonstrate each item reviewed

September 2012 – CMS Policy Statement against Cloning of Records

Audit Negative Findings Top Ten List

3

Cloned Records – EMR Systems

What the Auditors say:

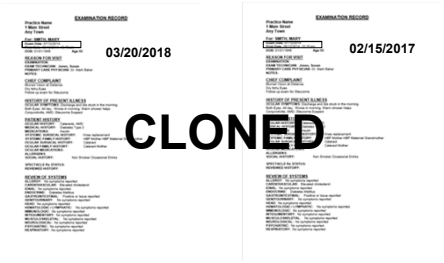
It is for the benefit of the patient. (This makes sense.)

With EHR, the insurance companies know Cloning is occurring.

How serious are the Payers? $100,000-$200,000 penalties

Best story: Auditor went to EMR vendor. Vendor told the auditor she did not know what she was talking about!

Audit Negative Findings
How easy it is for an Auditor to Fail an exam!



Audit Negative Findings Top Ten List
9

Insufficient Exam Elements

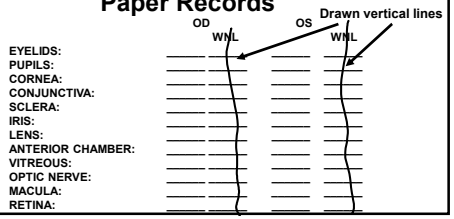
920x4 Comprehensive 10 Exam elements (8+2)
920x2 Intermediate 3 Exam elements (2 + 1)
992x3 E/M 9 Exam Elements
992x4 + 992x5 E/M 14 Exam Elements

Found many cases where elements had to be done were not documented. Therefore denied!

Many EHR systems encourage insufficient elements

Audit Negative Findings Top Ten List
9

Insufficient Exam Elements
Paper Records



Audit Negative Findings Top Ten List
9

<u>Compliantly Documented Exam Elements</u>
Paper Records

	OD	WNL	OS	WNL
EYELIDS:	____	X	____	X
PUPILS:	____	X	____	X
CORNEA:	____	X	____	X
CONJUNCTIVA:	____	X	____	X
SCLERA:	____	X	____	X
IRIS:	____	X	____	X
LENS:	____	X	____	X
ANTERIOR CHAMBER:	____	X	____	X
VITREOUS:	____	X	____	X
OPTIC NERVE:	____	X	____	X
MACULA:	____	X	____	X
RETINA:	____	X	____	X

Audit Negative Findings Top Ten List
10

Diagnosis
Inappropriate or not Supporting Exam Level

Refractive Dx for Medical Exam
Incorrect Diagnosis Code

Tip: Make sure the auditor knows the codes!!!

Audit Negative Findings Top Ten List
7

No documentation "Initiation of Diagnosis Treatment"

92xxx Ophthalmic Examination & Evaluation

Comprehensive

Initiation of Diagnostic & Treatment Plans

MUST Include at least one of the following:

- Prescription of [New] Medication, [New] Lenses or other Therapy
- Arrange special Ophthalmological, Diagnostic or Treatment Services
- Radiological services as may be indicated
- Consultation [Referral]
- Laboratory procedures

More

AUDIT ALERT –

This is the #1 reason for exams being denied during an Audit!

Audit Negative Findings Top Ten List

6

Paper Records – Illegible records

We are all in a rush! But your records must be readable!

If the Auditor cannot read the records.

Exam will be denied!

The auditor will not take your word for it!

Paper record must be compliant!

Many paper records lack required information

Audit Negative Findings Top Ten List

5

Interpretation and Reports

Remember they are required

There are 3 categories

Audit Negative Findings Top Ten List

2

Medical Decision Making

This is important since it is common with most EHR systems

Exam Compliance

Look Familiar?

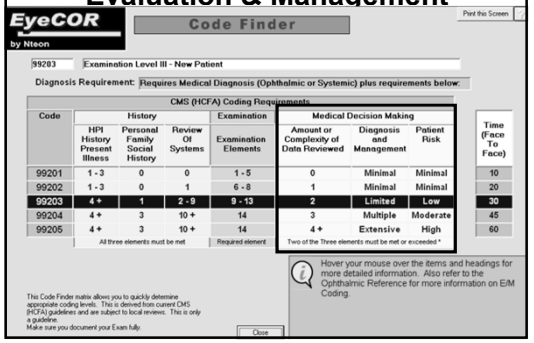
Many EHR systems have a similar matrix for verifying exam compliance With a green bar to indicate compliance in each of the areas.

CMS (HCFA) Coding Requirements

Code	History			Examination	Medical Decision Making		
	HPI History Present Illness	Personal Family Social History	Review Of Systems	Examination Elements	Amount or Complexity of Data Reviewed	Diagnosis and Management	Patient Risk
99201	1 - 3	0	0	1 - 5	0	Minimal	Minimal
99202	1 - 3	0	1	6 - 8	1	Minimal	Minimal
99203							
99204	4 +	3	10 +	14	3	Multiple	Moderate
99205	4 +	3	10 +	14	4 +	Extensive	High

Have you ever looked back at you exam to see if each of these requirements are Actually documented? We have and in almost every case they have not.

992xx Evaluation & Management



992xx E/M
Medical Decision Making

Medical Decision Making		
Amount or Complexity of Data Reviewed	Diagnosis and Management	Patient Risk
0	Minimal	Minimal
1	Minimal	Minimal
2	**Limited**	**Low**
3	Multiple	Moderate
4 +	Extensive	High
Two of the Three elements must be met or exceeded *		

We have found very few EHR systems with MDM!
Some of these only have check marks.

Medical Decision Making

Many EHR systems have one of the following for MDM

Medical Decision Making		
Amount Complexity Data Reviewed	Diagnoses and Management	Patient Risk
√	√	√

Medical Decision Making		
Amount Complexity Data Reviewed	Diagnoses and Management	Patient Risk
Mild	Mild	Moderate

These are not compliant you must document what specifically was done To achieve the levels.

992xx E/M
Medical Decision Making Not in My EHR

So what!

This is one of many practices hit because of no MDM

Solo practitioner
Used primarily 992xx for Medical
Audited by Blue Cross. Hit for $195.000 !!!!

In the audit report the auditor told the doctor to contact her vendor.

The vendor refused to acknowledge.

Remember 92xxx does NOT require MDM
992xx exams do require MDM.

All Exams (92xxx, 992xx)

Documentation AUDIT ALERT

You must document all Exam Elements and Findings carefully and completely.

Remember if audited

If you did not document it…

You did not do it!

Audits

No matter what I say too many doctors to not believe

Actual audit examples – Just a few:

State	Audit Penalty	Second Audit
California	$190,000	
California	$200,000	$545,000
California	$1,090,000	
California	$270,000	
Illinois	$210,000	
Massachusetts	$95,000	$100,000
New Mexico	$75,000	$93,000
New York	$1,850,000	
New York	$200,000	
New York	$220,000	$250,000
South Dakota	$120,000	$60,000
Texas	$156,000	

Audits

And this a recent one

An overpayment of $412,939.88 has been identified. Empire is required to recover overpayments from providers. We are requesting you remit a check within the next 30 days or contact us immediately to discuss payment arrangements.

EHR Systems and Paper Records

Many EHR systems are not compliant!

They do not contain all the required elements of an exam

Many of those with exam verification are not accurate.

Look closely at your EHR system.

If it dose not have these be careful!

Dilation

Dilation is required for 92004 and 92014!

Dilation

The AMA Professional Edition CPT manual states that 92004 and 92014 Comprehensive Eye Examinations "often includes… mydriasis" (dilation).

Many doctors interpret this as dilation is not required However, this is not the case.

To eliminate any doubt:
Every Medicare region requires dilation.

Most other payers also require dilation.

Dilation

There are some legitimate exceptions:

Patient is too young, too old
Medically contraindicated.

These are accepted exceptions to required dilation and the only reason AMA's CPT document states that
"it often includes… mydriasis."

In order to bill a comprehensive exam under these circumstances, you must specify the legitimate exception in the exam documentation.

"Patient denies" is not legitimate!

Dilation

Make sure your staff is aware of the requirement!

One of my staff contacted a local practice as a new patient. She asked about dilation.

She was told they have a "New Instrument" that replaces dilation.

Fundus photography is NOT a replacement for dilation!

Speaking of Dilation

We perform records reviews or assist a practice penalized with a negative audit.

One of the most common problems we find is not recording the dilation medication.

It is required.

Maybe This Will Make The Point

Email I sent out this past week:

I am sitting at my desk with 5 audit reports that I have received just in the last two days!

The penalties range from $220,000 to over $1,500,000.

The fact that I have 5 audit failures on my desk in just two days, is overwhelming proof that all payers have increased their audits.

In addition! Four of the five practices had received our proposal, but decided not to have our Preventative Practice audit. Now they are asking for our help and facing the huge penalty.

You need to protect you and your practice!

We know what the auditors are looking for.
We can protect your practice.

Audits

Now that I have scared you!

Here is the good news!

Each one of these are easy to correct immediately!

If you are not creating Interpretation & Reports start.
If you are not creating compliant Reports. Add

If you are Cloning. Stop immediately!

For all 10 on my list, follow the guidelines in the slides!
Those are the actual requirements.

Most Medical Insurance auditors are fair. If you demonstrate as soon as you found out and immediately changed your process, they typically find for you.

Audit

What Not to Do

This is an actual case!

- **Incomplete documentation**
- **NO Interpretation and Report**
- **No justification for procedures**

Initial Audit: $15,000 Fine, Penalties, Interest

Deal or No Deal

Round 2: $**50,000 Fine, Penalties, Interest**

Round 3: $8**0,000 Fine, Penalties, Interest**

Moral: If you know what you have done is wrong fess up and settle!

Final Word About Audits

This is Serious!

I have repeated this many times

In person and in lectures we talk to doctors about audits.

Most do nothing.

Every week we hear from some of those doctors plus more that were penalized for over $150,000!

All payers have increased their audits and penalties.

Do not be another of our statistics. Prepare.

Summary

You can and should be doing Medical!
It is a significant increase in reimbursement

Start testing and checking systemic meds your Wellness patients for ocular problems.

Do you still have "Unspecified Eye" for ICD-10 codes?

There is a significant increase in Audits

Protect you and your practice now!

For copies of updated presentation:

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