CPMA Exam Preparation

Chapter 1
Compliance and Regulatory Control

Compliance and Regulatory Control

- OIG – Protect HHS from themselves and providers
- Compliance
  - Currently not required by OIG
- Recommended to
  - Reduce fines and penalties
  - Increase operational efficiency
  - Increase overall compliance

Compliance and Regulatory Control

Compliance plan includes:

- 7 key compliance elements per the OIG
- Mandatory staff education
- Disciplinary policy and procedures

Compliance and Regulatory Control

Compliance plan should differentiate fraud and abuse.

- Fraud - Intentional deception made for personal gain
- Abuse - Act that results in unnecessary reimbursement without defined intent

Compliance and Regulatory Control

The OIG does impose “self-inflicted” audits of HHS.

- Audits HHS programs and contracts
- Review for abuse and waste
- Performed by OAS
  - Internal Staff
  - Independent Resources

Compliance and Regulatory Control

Improper payments

- Identify
- Report within compliance manual
- Establish plan of action
- Suspend billing of only the identified service until plan is in place and all parties educated

Compliance and Regulatory Control

Anti-kickback law prohibits:

- Knowing and willful solicitation
- Offer, payment or receipt in return for referring an individual, purchase or arrangement for an item of service
- Examples
  - Bribery
  - Kickbacks
  - Offer solicit receive payment
  - Safe harbor provisions

Compliance and Regulatory Control

False Claims Act

- Claim submitted which portrays false services
  - Never performed but billed
  - Disguised service
  - Disguised provider
- Civil False Claims Act
- Criminal False Claims Act
- Medicare/Medicaid False Claims Act

Compliance and Regulatory Control

- Provider Deficiencies
  - Self Disclosure
    - 30 days
  - Appeal Rights
    - ALJ appeal
    - Appeal of the ALJ decision

Compliance and Regulatory Control

- OIG Work Plan
  - Updated annually
  - Recurring topics
  - New inclusions
  - Auditors use of work plan

Compliance and Regulatory Control

- Corporate Integrity Agreement (CIA)
  - Agreement between OIG and healthcare provider or other entity
  - Serious misconduct
  - CIA agreement in lieu of exclusion from Medicare, Medicaid or other Federal health care program

Compliance and Regulatory Control

- Corporate Integrity agreement
  - Typical CIA agreement is five years.
  - Provide and implement audit annually
  - Reports provided to the OIG of compliance activities
  - CIA's require an IRO perform audits
    - Annual audits
    - Results to compliance officer of the CIA

Compliance and Regulatory Control

- CIA Audit
  - Discovery sample of 50 units
  - Used to determine full sample size
  - Used to determine financial error rate
- Full Sample – Audit until the financial error rate is justified within 90% confidence and 25% precision level
- RAT-STATS
  - Recommended
  - Not a required component

Compliance and Regulatory Control

- Stark Law
  - Self Referral Law
  - Types of services
  - Physician financial relationships with hospitals
  - Professional courtesy discounts

Compliance and Regulatory Control

- The Joint Commission
  - Voluntary accreditation program for hospitals
  - Many state governments recognize Joint Commission accreditation as a condition of licensure and receiving Medicaid reimbursement
  - Non profit entity
- JCAHO relevance
  - Hospital owned practice
    - Identification of areas
    - CPR
    - ACLS
  - Relevance to an auditor
- JCAHO Specific Concerns
  - Medication Management
  - Pain Scale
  - Abbreviations use

Compliance and Regulatory Control

- Recovery Audit Contractor (RAC)
- Purpose is to identify
  - Improper payments
  - Fraud
  - Abuse
- RAC's are paid based on the amount of money they uncover for under and/or over-payments.

Compliance and Regulatory Control

- RAC audits
  - Automated Reviews
  - Records request schedule
    - less than 5 providers – 10 per group every 45 days
    - 6–24 providers – 25 per group every 45 days
    - 25–49 providers – 40 per group every 45 days
    - 50 + providers – 50 per group every 45 days

Compliance and Regulatory Control

- RAC audits
  - Appeals Process
  - 15 day letter of intent
  - Utilize CMS appeals process

Compliance and Regulatory Control

- RAC audits
  - Prepare for Audits
  - Review
    - CERT
    - Previous RAC
    - OIG
    - Internal Audits

Compliance and Regulatory Control

- PATH – Physicians at Teaching Hospitals Audit
  - Audit teaching physician services
  - 2 forms of audit
    - Path I
    - Path II

Compliance and Regulatory Control

- Conditions for Participation (COP)
  - Conditions for coverage
  - Health & Safety standards
  - Specific entities effected
  - Requirements for Medicare/Medicaid particiation
  - Maintenance of Records

Chapter 2
Medical Record

Medical Record

- Medical Record
  - Legal document
    - Entries
    - Corrections
  - Owned by the provider
  - Signature requirements
  - Dictation timing

Medical Record

- The patient's medical record will contain encounters and services rendered to the patient
  - Each face-to-face visit should include:
    - Patient's complaints
    - Reason for visit
    - Signs
    - Symptoms
    - Past, family and social histories
    - Examination performed by the provider
    - Diagnosis
    - Plan of care

Medical Record

- Medical record entries
  - Legible
    - Dictate for clarity
    - Enhancement
  - Late entry
  - Addendums

Medical Record

- Multiple entries are acceptable
  - Main documentation must direct the reader of the medical record to these specific sheets
    - Medication flow sheets, immunization forms, history sheets, etc.
  - "Linking" important to meet necessary requirements

Medical Record

- Forms and Consents
- Patient's chart should contain certain consents and authorizations
  - Consent for General Treatment
  - Consent to file insurance/Medicare authorization
  - Assignment of Benefits
  - Medical records release
  - Informed Consent
  - HIPAA Privacy Form
  - Advanced Beneficiary Notice (ABN)
  - Non-covered consent form
  - Financial Policy
  - Additional records

Medical Record

- Medicare ABN's
  - Not required
    - Emergency situations
    - Statutorily excluded
- Required for billing patients
- Medicare ABN
  - Completed prior to event
  - No mass completions allowed
  - Copy to the patient
  - Valid financial responsibility
    - Within $100 or 25%
  - GA modifier

Medical Record

- **Health Insurance Portability and Accountability Act (HIPAA)**
- 1996
- PHI
  - Disclosures of PHI
  - Minimum necessary
- HIPAA
  - HIPAA vs. State Law
  - Business Associate Agreement

Medical Record

- National Correct Coding Initiative (NCCI)
  - Replaced CMS bundling program
  - Uniform payment policy
  - Reduction for inappropriate payments
- NCCI edits
  - Carrier audits vs. government payer audit
  - Utilization of CCI edits table
  - Refer to CPT manual
  - Common sense approach

Medical Record

- Mutually Exclusive Edits (MEE)
  - Part of the NCCI edits
- Medically Unlikely Edits (MUE)
  - Anatomically impossible
  - Published

Chapter 3
Auditing Surgical and Ancillary Services

Auditing Surgical & Ancillary Services

Place of Service (POS)

- Surgical Suite
- ASC
- OR
- Procedure Room

Auditing Surgical & Ancillary Services

Global Surgical Package

- Pre-operative services
  - Admit H&P's
- Intra operative services
- Post operative services
  - Routine care

Auditing Surgical & Ancillary Services

Anesthesia

- Types of anesthesia
  - Performed by surgeon
    - Local
    - Monitored Anesthesia care
  - Performed by anesthesiologist
    - Types
    - Settings
- Anesthesia is billed on time
- Time begins and when time ends

Auditing Surgical & Ancillary Services

Anesthesia Services

- Physical Status
- Anesthesia Modifiers
  - Concurrency

Records to review for anesthesia services

1. Anesthesia record
2. Services billed
3. OP report by surgeon

Auditing Surgical & Ancillary Services

Records to review for anesthesia services

1. Anesthesia record
2. Services billed
3. OP report by surgeon

Auditing Surgical & Ancillary Services

Four Elements of OP Reports

- Heading
- Indications of the surgery
- Body/detail of the procedure or surgery being performed
- Findings of the surgery/procedure

Auditing Surgical & Ancillary Services

OP Reports

- Information and documentation styles can vary per provider and facility
  - Date of surgery
  - Patient name
  - Pre-op diagnosis
  - Post-op diagnosis
  - Procedure performed
  - Name of primary and co-surgeon/assistant surgeon
  - Procedure Details

Auditing Surgical & Ancillary Services

OP report requirements

- Surgeon
- Co-surgeon
- Assist surgeon
- Team surgery

- Indications and Medical Necessity

Auditing Surgical & Ancillary Services

Surgical Modifiers

- 22 Modifier
- 24 Modifier
- 51 Modifier
- 52 Modifier
- 58 Modifier
- 59 Modifier
- 78 Modifier

Auditing Surgical & Ancillary Services

Radiology

- Procedure must be validated by medical necessity
- Diagnosis must reflect sign, symptom, condition or injury
- Report specifics
- Reviewed vs. Interpreted
- Procedure guidance services

Auditing Surgical & Ancillary Services

Pathology/Laboratory

- Do not report two or more panel codes that include any of the same constituent test performed from the same patient collection
- Documentation is required to support the medical necessity of laboratory testing with ICD-9 code
- Laboratory must use ICD-9 code unless there is a reason to question the ordering physician
- Screening tests are performed when no specific, sign, symptom, or diagnosis is present

Auditing Surgical & Ancillary Services

Psychiatric services

- Many services are based on time spent with patient
- 90801 is the psychiatric diagnosis interview examination
  - Physician, CP, or LCSW
  - Bill once per diagnosis onset
  - Specific documentation components needed including but not limited to: Risk factors, complete mental exam, treatment plan, and specifics regarding treatment

Auditing Surgical & Ancillary Services

Psychotherapy

- 2 levels of service
- Time based
- Documenation required
  - Time
  - Technique
  - Details

Auditing Surgical & Ancillary Services

Pharmacological Management

90862	vs.	M0064
•Medication evaluation		•Refill only
•Brief encounter		•Minimal encounter
•Not incident-to service		•Not incident-to service
•Minimal psychotherapy		•Minimal psychotherapy

Auditing Surgical & Ancillary Services

Ophthalmology

- Ophthalmologist can use two different sets of codes
  - Ophthalmology codes or E/M codes
- Intermediate Services (92002/92012)
  - New or existing problem complicated with a new complaint
- Comprehensive Services (92004/92014)
  - Bill for a patient whose treatment plan includes the initiation of a diagnostic or treatment plan

Auditing Surgical & Ancillary Services

Ophthalmology documentation required components

- Intermediate services
  - Diagnosis
  - History
  - Medical observation
  - Exam must document/include ocular and adnexal exam
- Comprehensive services
  - History
  - Medical observation
  - External ophthalmoscopic exam
  - Gross visual fields
  - Basic sensorimotor exam

Auditing Surgical & Ancillary Services

Infusion Services

- Must be an order from the physician
- Service patient presented for
  - Chemo, therapeutic, hydration
- Only 1 initial per day unless separate sites or sessions
- Start/stop times
- 1 bag/1 line = 1 infusion
- Flush services

Auditing Surgical & Ancillary Services

Physical Therapy

- CMS states – PT time even for untimed codes must be documented
- Total session time (start/stop)
- Time for each technique defined by a timed code
  - Procedures non-billable without time documentation
- Techniques require modality

Auditing Surgical & Ancillary Services

Physical therapy initial evaluation documenation

- Referring doctor
- History
  - Prior physical therapy
  - Functional status prior to event
  - Functional status now
- Plan of Care
  - Plan of treatment including goals
  - Frequency and duration of treatment
  - Diagnosis
  - Specific modalities to be employed
  - Rehab potential