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Coding Compliance and Risk Mitigation: Protecting Your Revenue

Nancy Clark, CPC, COC, CPB, CPMA, CPC-I, COPC, AAPC Fellow
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Objectives

- Understand how the medical claims adjudication process can lead to carrier audits
- Evaluate root causes of medical claim improper payments
- Discuss coding, billing, and regulatory updates which have significant impact on providers' revenue
- Identify opportunities for process improvements and education to support both revenue opportunities and mitigate risk of revenue loss to carrier audits

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Medical Claim Adjudication

How the Claims Adjudication Process Can Lead to Payer Audits

Claims Adjudication Process

- Medical claims are usually processed "in good faith"
- No documentation required
- Reimbursement subject to *limited* front-end edits
  - Allowed amounts
  - Inclusive codes
  - Medically necessary diagnoses

Typical Carrier Audit Process – Preliminary Round(s)

- Requests random medical records
- Compares medical records to codes billed
- Payment may be retracted or withheld from future claim payments

If Medical Records Consistently Do Not Support Codes Billed

- A more extensive review of records
  - If *patterns of noncompliance* are detected,
  - Allegations of *intent to bill/code incorrectly* may be made
- May result in prepayment review and/or
- Retrospective *extrapolation*

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Improper Payments

Summary of Improper Payments (Billions)

Claim Type	Total Payments	Projected Improper Payments	Improper Payment Rate	Percent of Overall Improper Payments
Part A (Total)	$304.8	$19.3	6.3%	59.8%

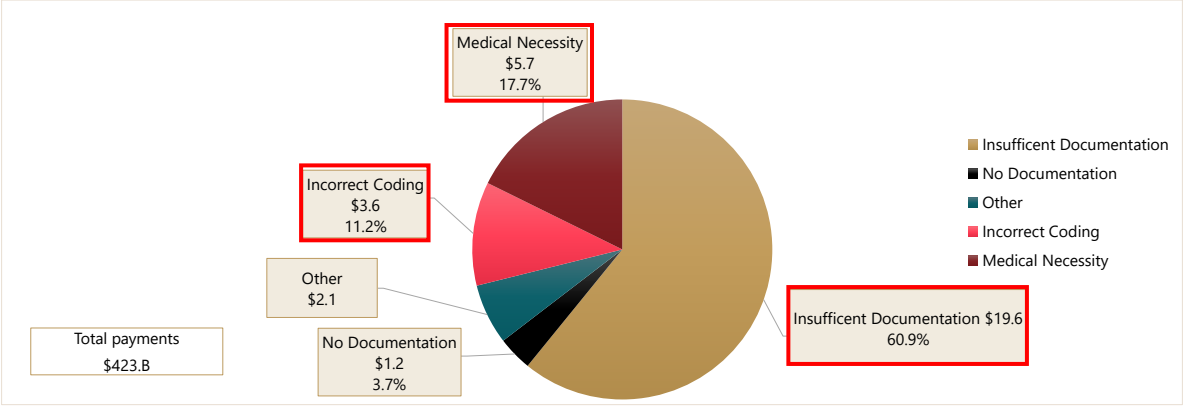
• **Excluding Hospital IPPS**
  • Home health
  • Inpatient rehab
  • OPPS
  • SNF
  • Hospice
	$183.4	$14.2	7.8%	44.1%

• **Hospital IPPS**	$121.4	$5.0	4.2%	15.7%
Part B	$109.6	$11.0	10.0%	34.1%
DMEPOS	$8.7	$1.9	22.5%	6.0%
Total	$423.0	$32.2	7.6%	100.0%

- Appendix B: Summary of Projected Improper Payments Unadjusted for A/B Rebill

Common Causes of Improper Payments[(1)(2)(3)]

FY 2023 Medicare FFS Projected Improper Payments by Category
$32.2B (7.6%) of Payments
(Dollar Amounts in Billions)



(1) May not equal 100% due to rounding
(2) Source: 2023 Medicare Fee-for-Service Supplemental Improper Payment Data Appendix B(Unadjusted for A/B rebills)
(3) Claims submitted July 1, 2021 through June 30, 2022

Top **Service Types** with **Highest Improper Payments** Part B

Service	Projected Improper Payment (Millions)	Improper Payment Rate
1. Office visits – established	$1.116	6.4%
2. Lab tests – other (non-Medicare fee schedule)	$1.041	22.9%
3. Minor procedures – other (Medicare fee schedule)	$819	15.1%
4. Other drugs	$742	6.4%
5. Specialist – other	$725	26.5%
6. Hospital visit – subsequent ("E&M")	$661	12.9%
7. Hospital visit – initial ("E&M")	$473	22.2%
7. Ambulance	$421	10.8%
8. Major procedure - other	$354	8.2%

2023 Medicare Fee-for-Service Supplemental Improper Payment Data Appendix D

Top **Root Causes** of Improper Payments
(1) **Office Visits – Established**

Root Cause Description	Error Category
1. Documentation supports lower level of E/M service than what was billed*	Incorrect Coding
2. Documentation supports higher level of E/M service than what was billed	Incorrect Coding
3. Documentation for the billed date of service (DOS) - Inadequate	Insufficient Documentation
4. Attestation for unsigned documentation - Missing	Insufficient Documentation
5. Documentation for the billed date of service- Missing	Insufficient Documentation

**Root causes frequently associated with partial improper payments are identified with an asterisk.*

Top **Root Causes** of Improper Payments
(1) **Office Visits – Established**

Root Cause Description	Focus Area / Concern
1. Documentation supports ***lower level of E/M service*** than what was billed*	• **Compliance Risk** • **Revenue Loss**
2. Documentation supports ***higher level of E/M service*** than what was billed	• **Revenue Opportunity**
3. Documentation for the **billed date** of service (DOS) - Inadequate	**Revenue Cycle Processes**
4. Attestation for **unsigned documentation** - Missing	
5. Documentation for the billed **date of service**- Missing	

**Root causes frequently associated with partial improper payments are identified with an asterisk.*

Top **Root Causes** of Improper Payments (2) **Laboratory Services**

Root Cause Description	Error Category
1. Provider's intent to order - Missing	Insufficient Documentation
2. Documentation to support medical necessity - Missing	Insufficient Documentation / Medical Necessity
3. Order - Inadequate	Insufficient Documentation
4. Risk assessment (RA) for urine drug screen - Missing	Insufficient Documentation
5. Documentation to support frequency of billing - Missing	Insufficient Documentation
6. Result of the diagnostic or laboratory test - Missing	Insufficient Documentation
7. Level of risk for urine drug screen - Missing	Insufficient Documentation
8. Order - Missing	Insufficient Documentation
9. LCD/LCA requirements, other documentation required for payment - Missing	Insufficient Documentation
10. NCD requirement(s), other documentation required for payment - Missing	Insufficient Documentation

Top Root Causes of Improper Payments (2) Laboratory Services

Root Cause Description	Focus Area / Concern
1. Provider's intent to ***order*** - Missing	•**Missing/inadequate** •**Orders** •**Results** •**Requirements** •**LCD / LCA / NCD** •**Medical necessity**
2. Documentation to support ***medical necessity*** - Missing	
3. ***Order*** - Inadequate	
4. Risk assessment (RA) for urine drug screen - Missing	
5. Documentation to support frequency of billing - Missing	
6. ***Result*** of the diagnostic or laboratory test - Missing	
7. Level of risk for urine drug screen - Missing	Insufficient Documentation
8. ***Order*** - Missing	Insufficient Documentation
9. ***LCD/LCA requirements***, other documentation required for payment - Missing	Insufficient Documentation
10. ***NCD requirement(s),*** other documentation required for payment - Missing	Insufficient Documentation

Top **Root Causes** – (3) **Minor Procedures** Improper Payments

Root Cause Description	Error Category
1. Physical/Occupational/Speech Therapy (PT/OT/ST) -Certification/Recertification – Missing	Insufficient Documentation
2. PT/OT/ST- Plan of care - Missing	Insufficient Documentation
3. Documentation does not support medical necessity for the service or item billed	Medical Necessity
4. PT/OT/ST - progress report, at least once every 10 treatment days - Missing	Insufficient Documentation
5. Units of service (UOS) incorrectly coded – Upcode*	Incorrect Coding
6. PT/OT/ST- Reason for the delayed physician certification/recertification - Missing	Insufficient Documentation
7. LCD/LCA requirements, other documentation required for payment - Inadequate	Insufficient Documentation
8. LCD/LCA requirements, other documentation required for payment - Missing	Insufficient Documentation
9. Documentation to support medical necessity - Missing	Insufficient Documentation
10. Attestation for unsigned documentation - Missing	Insufficient Documentation

**Root causes frequently associated with partial improper payments are identified with an asterisk.*

Top **Root Causes** – (3) **Minor Procedures** Improper Payments

Root Cause Description	Focus Area / Concern

1. **Physical/Occupational/Speech Therapy (PT/OT/ST)** -**Certification/Recertification** – Missing	• **Therapy**
	  • ***Physical***
	  • ***Occupational***
	  • ***Speech***
	  • **Certifications**
	  • **Plan of care**
	  • **Progress report**
	• **Units of service**
	  • **Time-based**
	• **Requirements**
	  • **LCD/LCA**
	  • **Medical necessity**
	• **Processes**
	  • **Signatures**

2. PT/OT/ST- **Plan of care** - Missing	
3. Documentation does not support medical necessity for the service or item billed	
4. **PT/OT/ST - progress report**, at least once every 10 treatment days - Missing	
5**. Units of service (UOS)** incorrectly coded – Upcode*	
6. PT/OT/ST- Reason for the delayed physician certification/recertification - Missing	
7. **LCD/LCA requirements**, other documentation required for payment - Inadequate	
8. **LCD/LCA requirements,** other documentation required for payment - Missing	
9. Documentation to support medical necessity - Missing	
10. Attestation for **unsigned documentation** - Missing	

**Root causes frequently associated with partial improper payments are identified with an asterisk.*

Top Services with **Incorrect Coding Errors**

Medicare FFS Services	Projected Improper Payments	Improper Payment Rate	Percent of Overall Improper Payments
Office visits – established	**$789 MM**	4.5%	2.5%
Hospital visit - initial	**$296 MM**	13.9%	0.9%
Hospital visit - subsequent	**$261 MM**	5.1%	0.8%
Hospital Outpatient	**$243 MM**	0.3%	0.8%
Office visits - new	**$212 MM**	6.2%	0.7%
Critical Access Hospitals	$133 MM	1.9%	.4%
Hospital visit - critical care	**$126 MM**	11.7%	.4%
Nursing home visit	**$116 MM**	5.4%	.4%
Emergency room visit	**$101 MM**	5.8%	.3%
Evaluation & Management (E&M's)	**$2.1 B**	**8 of 9**	**6.8%**

Top Audit Risks Identified by Improper Payments – Part B Summarized

E & M

- **Office Visits**
- **Hospital Visits**
- **Critical Care - Hospital**
- **Nursing Home**
- **Emergency Room**

Medical Necessity

- **Labs**
- **Minor Procedures**

Insufficient & Missing Documentation

- **Billed DOS**
- **Signature / Attestation**
- **Labs & Related Diagnostic Tests**
  - **Urine Drug Screens**
- **PT / OT / ST**
- **Minor Procedures**

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Improper Payments – Root Causes

The Same Root Causes

- Insufficient or no documentation
- Incorrect coding or billing

Can Result In Either

- Compliance Risk -
  - Overpayment or Underpayment
- Revenue Opportunity -
  - Underpayment

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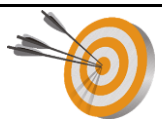
Upcoming OIG Work Plan Items

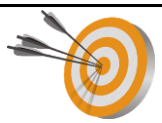
2025 Office of Inspector General (OIG) Upcoming Work Plan Items



Announced or Revised	Title	Summary	Expected Issue Date (FY)	Report Number(s)
September 2024	**Remote Patient Monitoring (RPM)**	• ⇧ 10x from CY 2019 – 2022 • ⇧ 14x for Medicare Advantage • **>** $300MM payments - CY 2022 RPM has 3 components 1. Education & device setup 2. Device supply 3. Treatment management • 43% of enrollees did not receive all 3 components	2025	OEI-02-23-00260
August 2024	**Joint Pain Management Therapies: Hyaluronic Acid Knee Injections**	• Hyaluronic acid injections • Side note: • E&M and minor procedures	2025	WA-24-0063 (W-00-24-35921)
June 2024	**Lower Extremity Peripheral Vascular Procedures**	• **>** $1.16B paid in office settings • CY 2022 & 2023 • Compliance with CMS requirements and applicable treatment guidelines	2025	W-00-24-35914

Continued...

2025 Office of Inspector General (OIG) Upcoming Work Plan Items



Announced or Revised	Title	Summary	Expected Issue Date (FY)	Report Number(s)
July 2024	**Clinical Diagnostic Laboratory Tests in 2023**	• Protecting Access to Medicare Act of 2014 (PAMA) • OIG must publicly release annual analysis of the top 25 lab tests by expenditure	2025	OEI-09-24-00350
July 2024	**Follow-up Review DMEPOS Provided During Inpatient Stays**	• Should be billed Part A • Many erroneously billed Part B • Billed DOS important	2025	WA-24-0059 (W-00-24-35919)
June 2024	**Durable Medical Equipment Fraud and Safeguards**	• **>** $7B paid annually (FFS) • Target Medicare Advantage suppliers not enrolled in Medicare FFS	2025	OEI-02-24-00310
June 2024	**Medicare Part C Supplemental Benefits**	• Payments doubled over 5 years • Federal requirements	2025	W-00-24-35917 (WA-24-0052)

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Risk Mitigation

Top Risk Areas

Improper Payments	OIG Targets
• General Compliance • Evaluation & Management (E&M) • Minor Procedures • Laboratory Services • Urine Drug Testing (UDT) • Physical, Occupational & Speech Therapy Services • Medicare Signature & Attestation	• Remote Patient Monitoring • Joint Pain Injections • Lower Extremity Peripheral Vascular Procedures • Laboratory Tests • DMEPOS – Inpatient & Medicare Advantage • Medicare Part C Supplemental Benefits

General Compliance: Principles of Medical Record Documentation

Non-compliance with Documentation Principles = Improper Payments

- Health care payers may require **reasonable documentation to ensure that a service is consistent with a patient's insurance coverage and to validate**:
  - The site of service
  - The **medical necessity** and appropriateness of the diagnostic and/or therapeutic services provided and/or
  - That services furnished have been accurately reported
- The principles of documentation listed below are applicable to all types of medical and surgical services in all settings
  - **The medical record should be complete** and legible
  - The documentation of each patient encounter should include:
    - **Reason for the encounter** and relevant history, physical examination findings and prior diagnostic test results
    - **Assessment**, clinical impression or diagnosis
    - **Plan of care**
    - **Date and legible identity** of the observer
- If not **documented, the rationale for ordering diagnostic and other ancillary services** should be easily inferred
  - Past and present diagnoses should be accessible to the treating and/or consulting physician
  - Appropriate health risk factors should be identified
  - The patient's **progress, response to and changes in treatment, and revision of diagnosis** should be documented
  - **The CPT and diagnosis codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record**

https://www.cms.gov/medicare/payment/fee-schedules/physician/evaluation-management-visits

Improper Payment Reasons

- LCD's, LCA's, NCD's
- Medical Necessity
- Insufficient & Missing Documentation
- PT / OT / ST Plan of Care
- Billed DOS Signature / Attestation
- Order & Intent to order Lab Tests
- PT / OT / ST Progress Report
- Incorrect Coding

Evaluation & Management (E&M)

Key Changes

- Removed History & Exam as Key Components
  - Utilize Medical Decision Making (MDM) or Time
  - Overhaul to MDM & Time
- Places of Service Phase-in
  - 2021:
    - Office & Other Outpatient
  - 2023:
    - Hospital / Observation
    - Consultations
    - Emergency Department
    - Home & Nursing Facilities

Compliance & Revenue Impacts

- E/M levels can ***increase or decrease*** compared to previous guidelines
- **Documentation** requirements modified
- **Guideline Changes**
  - **Telehealth**
  - **Incident-to**
  - **Split/Shared**

Proactive & Corrective Actions

- Educate
  - Physicians & Nonphysician Providers
    - Documentation Concepts
    - MDM & Time Changes
    - AMA Definitions
  - Coding and Billing Staff
    - New Codes
    - Coding Guidelines
    - Payer Requirements
- Perform Coding & Documentation Reviews
  - To mitigate compliance risk & optimize revenue earned

Minor Procedures

- Medical Necessity
  - Diagnosis linking and support
- Review applicable carrier guidelines
  - Local & National Coverage Determinations (NCD's, LCD's) & Articles (LCA's)
  - Commercial carrier clinical guidelines
  - Coverage indications and limitations, frequency and utilization criteria
- National Correct Coding Initiative (NCCI) Edits
  - Procedure-to-procedure (PTP) edits – "Bundling"
  - Medically Unlikely Edits (MUEs) – Units of Service
  - Add-on Code (AOC) Edits – Lack of primary
- Be aware of "E&M and minor procedures" on same DOS!

Laboratory Services

- Diagnostic Test Order Requirements – Treating Physician
  - Signed order or requisition listing the specific tests OR
  - Unsigned order or requisition listing the specific tests AND
    - Progress note to ***support intent to order***
- Local Coverage Determinations
  - Must be met for the CPT / HCPCS billed
  - ***Medical necessity***
- Not acceptable:
  - "Order labs," "check blood," and "repeat urine"
  - Standing orders not specific to the patient do not support medical necessity
- Submit these medical records
  - Signed progress notes or office notes
  - Signed physician order or intent to order
  - Lab results
  - Signature attestation (when applicable) or signature log for illegible signatures

- Ref: MLN909221

Urine Drug Testing (UDT)

- Presumptive UDT Panels
  - Qualitative Analysis - presence of drug/substance
  - Rapid results available
- Definitive UDT Panels
  - Quantitative analysis – "how much"
  - Individualized based on clinical history and risk assessment
  - ***Needs patient-specific supporting documentation***
- Document
  - Medical necessity
  - Patient history
  - Clinical presentation
  - Community trends
- Patient Groups
  - Symptomatic patients / multiple drug ingestion / patients with unreliable history
  - Diagnosis and treatment for substance abuse or dependence
  - Treatment for patients on chronic opioid therapy (COT)

Ref: LCD L39611

Physical, Occupational & Speech Therapy Services

- General Documentation Requirements
  - Impairments & functional limitations requiring skilled intervention
  - Prior functional level
  - ***Timed Code Treatment Minutes per modality & Total Treatment Time***
- Plan of Care (POC) Requirements
  - Diagnosis – Medical & impairment-based, specific & relevant to problem
  - Long Term Goals (LTGs)
  - Type, Amount, Frequency & Duration of Treatment
- Progress Reports
  - At least 1x every 10 treatment days
- Treatment Notes
- Certifications and Recertifications
  - Contain all required elements of POC

Medicare Signature & Attestation Requirements

Signature Requirements	Definitions

- ***Review outgoing documentation for valid signatures & submit signature attestation if necessary!***

- **Legible**
  - Full signature
  - First initial and last name
- **Illegible**
  - Signature over a typed or printed name
  - Signature where letterhead or other information on page indicates identity of the signatory
  - Signature not over a typed/printed name & not on letterhead, but submitted documentation is accompanied by a signature log or an attestation
- **Initials**
  - Over a typed or printed name
  - Not over a typed/printed name but accompanied by a signature log or an attestation statement
- **Unsigned handwritten note**
  - Where other entries on the same page in same handwriting are signed

- **Handwritten Signature**
  - A mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation
- **Signature Log**
  - Identifies author of documentation
  - Must be part of patient's medical record
  - Reviewers consider signature logs regardless of created date
- **Signature Attestation Statement**
  - For Medicare medical review purposes
  - Attestation statement must be signed & dated by author
  - Contain sufficient information to identify beneficiary[1]
- **Electronic Signature**
  - The author's e-signature, full name, credentials, date and time of e-signing

[1]CR6698

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OIG Targets

- Minor Procedures
  - Review LCD's and other coverage guidelines
    - Joint Injections (Hyaluronic Acid Knee Injections)
    - Lower Extremity Peripheral Vascular Procedures
  - E&M's and minor procedure
- Remote Patient Monitoring (RPM)
  - Bill for 3 components
- Laboratory Tests – Ongoing
  - Coverage guidelines
  - Orders, medical necessity and results
- DMEPOS
  - Inpatient Stays
- Medicare Part C (MA Plans)
  - DME supplier participation
  - Verify supplemental benefits – policies may change

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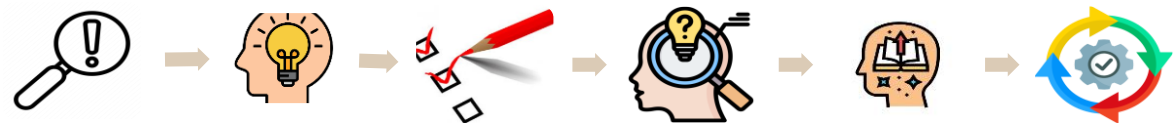
Mitigate Medical Record Documentation Deficiencies



Identify	Understand	Review	Recognize	Educate	Create & Implement
• Risk Areas	• Carrier & Coding Criteria	• Medical Record Documentation	• Deficiencies	• Providers & Staff	• Processes & Procedures

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Questions?

Nancy.Clark@eisneramper.com

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Resources

- HHS FY 2023 Agency Financial Report
- 2023 Medicare Fee-for-Service Supplemental Improper Payment Data
- Comprehensive Error Rate Testing (CERT)
- U.S. Government Accountability Office Improper Payments
- Payment Error Rate Measurement (PERM)
- Evaluation & Management Visits
- Office of Inspector General Compliance