National Nurse Practitioner Symposium: Mastering Coding & Documentation Compliance for Nurse Practitioners

Presented by Leslie Boles, BA, CCS, CPC, CPMA, CHC, CPC-I, CRC

Revu Healthcare

Co-Owner & President

About Me

Leslie Boles is Certified in Healthcare Compliance (CHC) professional and a Certified Coding Instructor. She is the Co-Owner & President of Revu Healthcare, a healthcare consulting firm. She has more than 16 years of experience in healthcare, coding, auditing and compliance in the hospital inpatient/outpatient settings, and physician coding education. Leslie has developed and implemented multiple training programs on physician coding and documentation, Medicare and Medicaid policy and compliance programs for certified coders. She is a subject matter expert in the areas of E/M, Radiology, OBGYN, General Surgery, Cardiology and Pathology coding. She prides herself in presenting very complex coding and documentation regulations in a simplified manner to physicians and clinicians. She has the credentials of CCS, CPC, CPMA, CHC, CPC-I and CRC from the American Academy of Professional Coders, American Health Information Management Association and the Health Care Compliance Association.

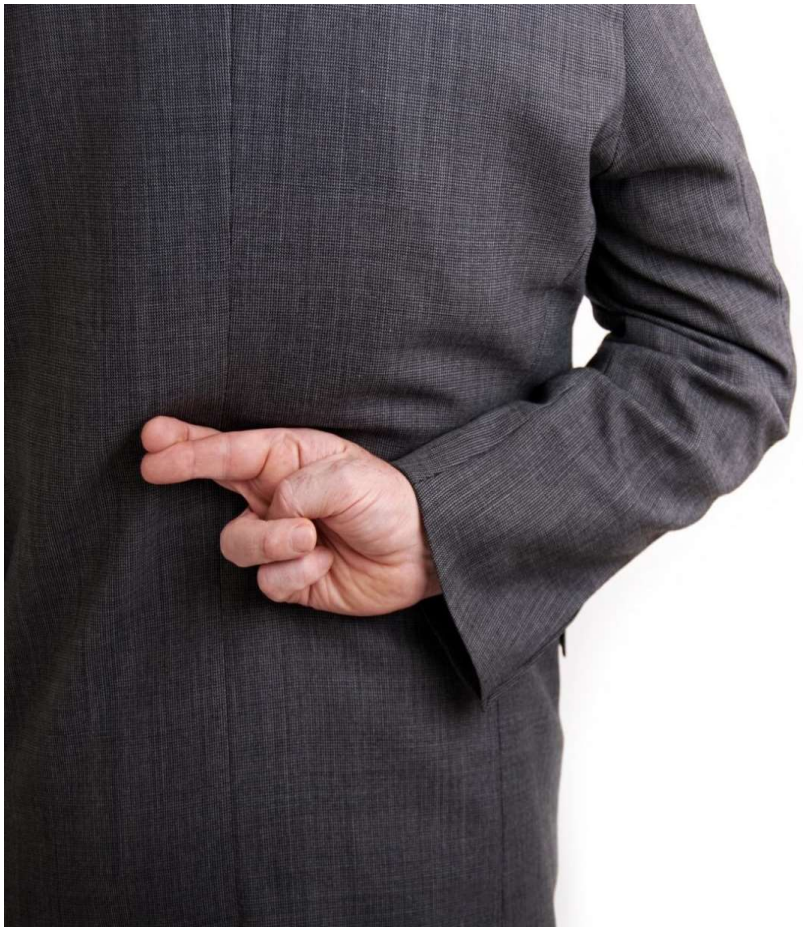
Disclosure and Learning Objectives

- Leslie Boles has no financial relationships with commercial interests to disclose

1. Discuss the intricacies of medical coding and documentation specific to nurse practitioners, including the latest updates and regulatory changes.
2. Describe how to ensure coding and documentation practices align with federal regulations, payer requirements, and ethical standards, reducing the risk of audits and penalties.
3. Identify strategies to enhance patient care through accurate and comprehensive documentation, fostering better communication among healthcare providers and improving patient outcomes.

Agenda

- False Claims Act
- Recent Enforcement Activity
- 2024 CPT Code Updates
- Evaluation & Management (E/M) CPT Updates
- ICD-10 Diagnosis Coding & Documentation
  - Social Determinants of Health (SDOH) Codes
- Modifiers
  - Modifier 25
  - Modifier 59
- Coding Compliance Program & Benefits
- Questions



False Claims Act

Prohibits the submission of false or fraudulent claims to the government

Recent Enforcement Activity

Nurse Practitioner and Medically Unnecessary Services

- Earlier in 2023, three Tennessee medical providers agreed to settle allegations of False Claims Acts violations relating to the submission of claims seeking reimbursement for autonomic nervous system testing.
- The United States and Tennessee contended that the Internal Medicine group violated the False Claims Act and the Tennessee Medicaid False Claims Act (FCA) by submitting claims for non-reimbursable and/or medically unnecessary autonomic nervous system testing during the period of January 2, 2015, through April 28, 2021. As a result of the settlement, the practice will pay $440,518.84, of which $264,050.17 is restitution.
- In addition to the practice, an NP will pay $315,000 in restitution under the terms of the settlement. Her payment will settle allegations that she violated the FCA by submitting claims for non-reimbursable and/or medically unnecessary autonomic nervous system testing.

https://www.healthicity.com/blog/overview-recent-enforcement-actions-against-nurse-practitioners-and-physician-assistants

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Recent Enforcement Activity

Nurse Practitioner Sentenced for $192M Medicare Fraud Scheme

- A Florida woman was sentenced today to 20 years in prison for her role in a scheme to defraud Medicare by submitting over $192 million in claims for genetic tests and durable medical equipment that patients did not need and telemedicine visits that never occurred.
- According to court documents and evidence presented at trial, Elizabeth Hernandez, 45, of Miami, signed thousands of orders for medically unnecessary orthotic braces and genetic testing for Medicare beneficiaries she never spoke to, examined, or treated.
- As part of the scheme, telemarketing companies would contact Medicare beneficiaries to convince them to accept orthotic braces and genetic tests and would then send pre-filled orders for these products to Hernandez, who signed them, attesting that she had examined or treated the patients. However, she had never spoken with many of the patients, and she often had others, including non-licensed individuals, sign her name to fraudulent orders. Hernandez also falsified information in the orders about beneficiaries' symptoms and injuries.

https://www.justice.gov/opa/pr/nurse-practitioner-sentenced-192m-medicare-fraud-scheme

Recent Enforcement Activity

Orthopedic Surgeon Sentenced to More Than One Year in Prison for Health Care Fraud

- Dr. Olarewaju James Oladipo, 60, of Canton, was sentenced by U.S. District Court Judge Allison D. Burroughs to 16 months in prison, followed by one year of supervised release. In December 2023, Oladipo was convicted by a federal jury of 10 counts of health care fraud.
- From approximately January 2016 through December 2019, Oladipo devised and executed a scheme to defraud health care benefit programs by falsely billing for patient visits. Specifically, Oladipo used billing codes for more complex—and thus more expensive—services that were not provided. Oladipo falsified medical records of patient visits to reflect examinations and services that were not performed. During the four-year period, Oladipo frequently billed for more than 60 patients per day and sometimes more than 100 patients per day. The result was that many, if not most, of Oladipo's patient visits on such days could have only lasted five minutes or less. However, Oladipo used billing codes that typically corresponded to visits of 15, 25, 30, or even 45 minutes.

https://www.justice.gov/usao-ma/pr/orthopedic-surgeon-sentenced-more-one-year-prison-health-care-fraud

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2024 CPT Code Updates

The annual update to the CPT code set created 349 editorial changes, including 230 additions, 49 deletions and 70 revisions. With 11,163 codes that describe the medical procedures and services available to patients, the CPT code set continues to grow and evolve with the rapid pace of innovation in medical science and health technology.

CMS extends the Direct Supervision waiver to December 31, 2024, enabling audio-visual means for incident-to services to Medicare patients. Dermatologists are urged to verify policies with commercial carriers to align with the latest updates.

Summary of Changes	
2022 Category	**2023 Change**
Hospital Observation Services (initial, subsequent and discharge codes)	Deleted; report using revised Hospital Inpatient and Observation Care Services
Office or Other Outpatient Consultations	Deleted 99241
Inpatient Consultations	Deleted 99251
Nursing Facility Services	Deleted 99318
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services	Deleted; report using revised Home or Residence Services
Domiciliary, Rest Home (e.g., Assisted Living Facility), or Home Care Plan Oversight Services	Deleted; report using Chronic Care Management Services or Principal Care Management Services

Medical Decision Making (MDM)

MDM 2020		MDM Effective January 1, 2021
Number of Diagnoses or Management Options	→	Number and Complexity of Problems Addressed at the Encounter
Amount and/or Complexity of Data to be Reviewed	→	Amount and/or Complexity of Data to be Reviewed and Analyzed
Risk of Complications and/or Morbidity or Mortality	→	Risk of Complications and/or Morbidity or Mortality of Patient Management

Minimal	Low	Moderate	High

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Time

Disclaimer: These definitions only apply when code selection is primarily based on time and not MDM.

***Total time* spent on the date of the encounter**

Face-to-face and non-face-to-face activities

- Counseling and educating the patient, family, and/or caregiver
- Communicating results to the patient/family/caregiver
- Coordinating the care of the patient when not separately reported
- Ordering prescription medications, tests, or procedures
- Performing a medically appropriate history and examination
- Preparing to see the patient such as reviewing the patient's record
- Obtaining and/or reviewing separately obtained history
- Ordering prescription medications, tests, or procedures
- Referring and communicating with other health care providers when not separately reported during the visit
- Documenting clinical information in the electronic or other health record
- Independently interpreting results when not separately reported

***The current time documentation requirements do not apply for the 2021 E/M time requirements. Use the billing practitioner's time only, not clinical or non-clinical staff time. The nature of the work must require practitioner knowledge and expertise.**

For Example: Waiting on hold for pre-cert authorization would not qualify; a peer-to-peer discussion with a physician at an insurance company would qualify.

Advancing Health Equity and Caregiver Support

Biden-Harris Administration Executive Order on Increasing Access to High Quality Care and Supporting Caregivers Health Equity

Caregiver Training Services

- Payments will be made to practitioners to train caregivers to support patients with certain diseases or illnesses in carrying out a treatment plan (e.g., dementia)

SDOH G0136

- The SDOH Risk Assessment will be part of the Annual Well Visit (AWV) with no additional costs to the Medicare patient.

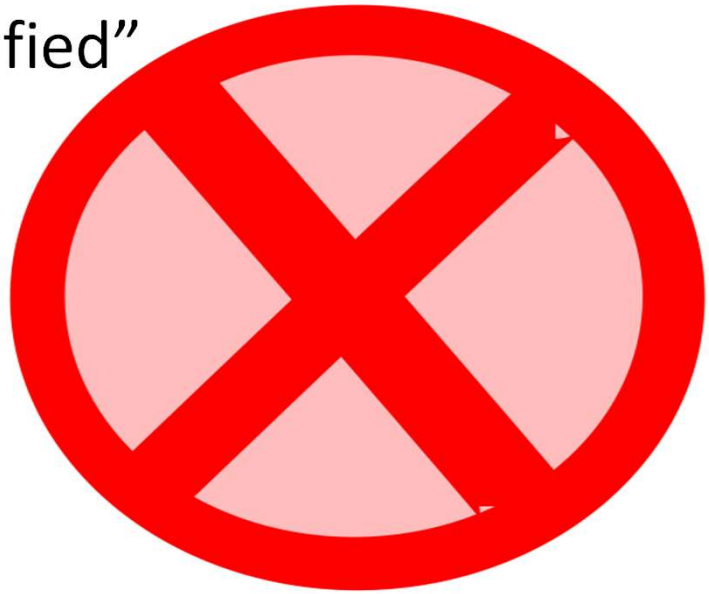
Community Health Integration (CHI) Services G0019, G0022

Principal Illness Navigation (PIN) Services G0023, G0024, G0140, and G0146)

ICD-10 diagnosis Coding and Coding specificity

ICD-10 Coding

" Getting Specific with the Unspecified"



UNSPECIFIED …….

UNKNOWN……..

RULE OUT……

OTHER……

ICD-10 Coding Reminders: Uncertain diagnosis

Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” “compatible with,” “consistent with,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

ICD-10 Coding Reminders: Signs and Symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all, codes for symptoms.

Social Determinates of Health (SDOH) CODES

ICD – 10 Code SDOH Categories:

- Z55 – Problems Related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational Exposure to risk factors
- Z59 – Problems related to housing and economic circumstances
- Z60 – Problems related to social environment
- Z62 – Problems related to upbringing

Social Determinates of Health (SDOH) CODES (cont'd)

Z56.1 Change of Job	Z56.2 Threat of Job Loss	Z56.3 Stressful Work Schedule	Z59.0 Homelessness
Z60.2 Problems Related to Living Alone	Z62.6 Inappropriate (excessive) parental pressure	Z63.0 Problems in relationship with spouse or partner	Z63.1 Problems in relationship with in-laws

ICD 10 Diagnosis Coding – SDOH Updates

NEW ICD-10 Codes as of October 1, 2023:

- **Z62.23 Child in custody of non-parental relative**
- **Z62.24 Child in custody of non-relative guardian**
- **Z62.823 Parent-step child conflict**
- **Z62.83 Non-parental relative or guardian-child conflict**
- **Z62.831 Non-parental relative-child conflict**
- **Z62.832 Non-relative guardian-child conflict**
- **Z62.833 Group home staff-child conflict**
- **Z62.892 Runaway [from current living environment]**

Modifiers

Modifiers are added to CPT codes to inform the payer that the procedure performed has been altered by a distinct factor or circumstance. Modifiers can increase or decrease reimbursement.

Modifiers are also "Flags" ☺

Modifier 25

- Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service.
- Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified NPP in the patient's medical record to support the need for Modifier -25 on the claim for these services, even though the documentation is not required to be submitted with the claim.

Append modifier 25 to an E/M service when the provider renders an E/M to the patient on the same day as another service or procedure. The medical documentation must justify performing the separate E/M service. The patient's condition may warrant the same provider performing a separate E/M service and another service or procedure on the same day

Modifier 59 AKA the unbundler

Distinct procedural service. Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

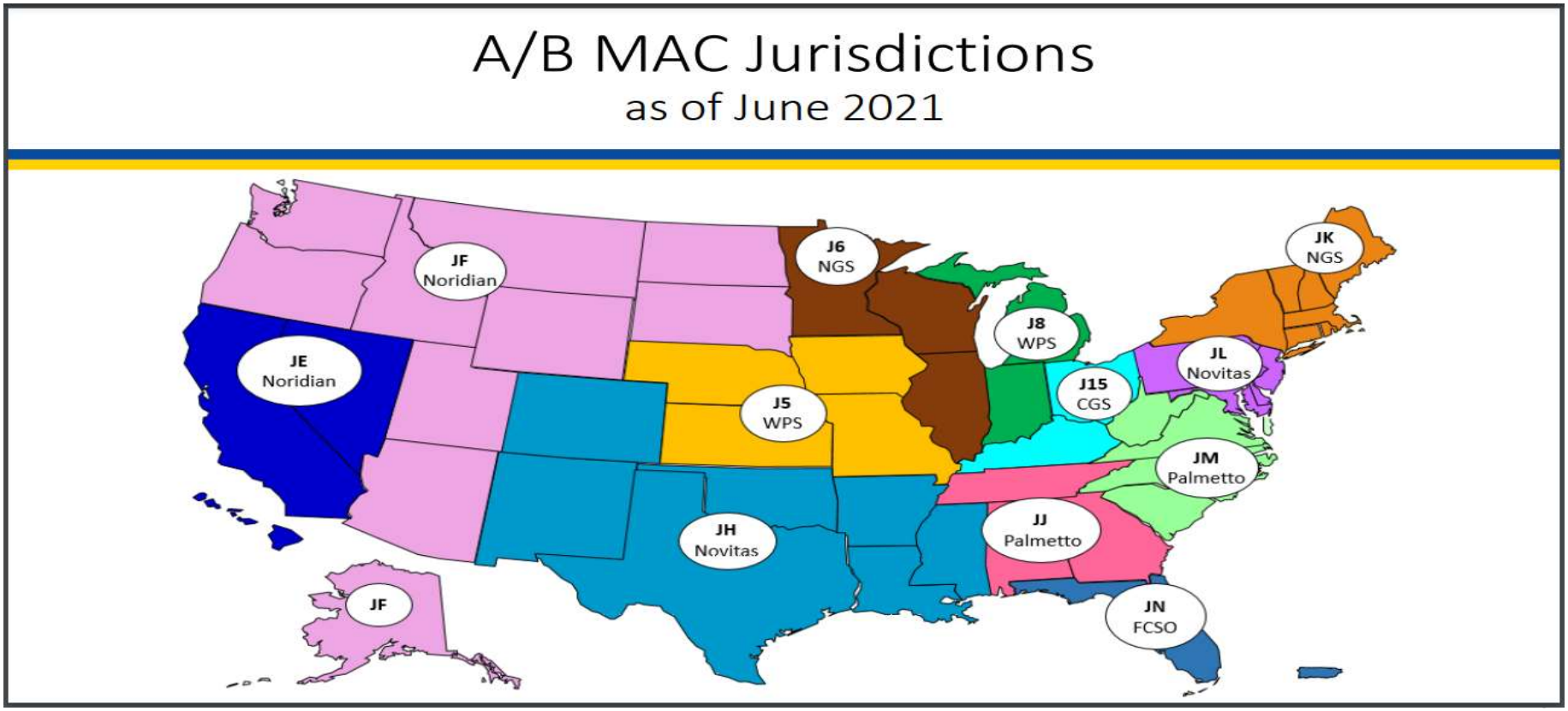
Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Modifier XE, XS, XP, XU

- **XE** – "Separate encounter, A service that is distinct because it occurred during a separate encounter" This modifier should only be used to describe separate encounters on the same date of service.
- **XS** – "Separate Structure, A service that is distinct because it was performed on a separate organ/structure"
- **XP** – "Separate Practitioner, A service that is distinct because it was performed by a different practitioner"
- **XU** – "Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service"

MEDICARE ONLY

Medicare Administrative Contractors



Benefits of an Internal Coding & Billing Compliance Program

- Ensures compliance with local and national coverage determination policies
- Ensures claims are reimbursed accurately and according to the terms of federal and commercial payor contracts
- Reduces claim denials and increase cashflow
- Prevents recurrence of coding/billing issues that can cause revenue leakage and/or compliance risk.
- Avoids leaving appropriate revenue/reimbursement on the table
- Decrease risk of reimbursement take backs/recoupments
- It may be also considered by some federal agencies when determining whether reasonable efforts were taken to avoid and detect fraud, waste and abuse

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Coding & Billing: Establish Your Coding/Billing Compliance Program Goals

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Establish Your Coding/Billing Compliance Program Goals

Identify root causes for coding/billing errors
- Utilization Review
- Claim Denials/Aging Reports

Identify external audit activity and audit focuses
- OIG Workplan Items
- Regional Medicare Administrative Contractor reviews
- Recovery Audit Contractor (RAC) reviews

Determine the frequency of reviews (**Be realistic**)
- Monthly
- Quarterly
- Annually
- Bi-Annually

Volume of cases may warrant more frequent audits and options are above are subject to change

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Establish Your Coding/Billing Compliance Program Goals

- **Prospective audits**: The prospective audit, also called a pre-payment audit, is performed prior to claim submission. Typically, the billing record (charge ticket or superbill) is obtained, along with the chart documentation and any supporting labs, medication sheets, problem lists, etc. If the documentation doesn't support the CPT®, HCPCS Level II, and ICD-10-CM codes to be billed, the coding will be corrected based on the audit findings. This type of audit may affect claim turnaround time. Communication between the provider and auditor should follow the audit immediately. A prospective audit may be random or focused.
- **Retrospective Audits**: Retrospective audits examine medical record documentation after the provider has submitted the claim to the insurance carrier and payment is received. The auditor will review the billing record (charge ticket or superbill), the Remittance Advice/Explanation of Benefits, and the medical record documentation, along with other supporting documentation. A retrospective audit could lead to refunding payment or partial payment to the insurance carrier.

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Establish Your Coding/Billing Compliance Program Goals

- **Utilization Review:** Utilization review and data mining provide insight into billing patterns and can uncover areas of risk. Utilization review provides data about how frequently certain services are billed. A utilization pattern can be found from looking at the utilization review to evaluate coding patterns. Federal contractors like to focus on frequency of improperly paid claims because, as of 2020, they can generate penalties of up to $23,331 per claim under the False Claims Act. To know whether your practice might throw up any red flags, auditors should check claims frequency against national frequency norms. Look at your 25 most frequent services and compare them to Medicare utilization data. If, for example, the national average of a code is 5.5% of all services, and you use it twice as often, prioritize a self-audit to review the service and verify that solid coding and documentation support your claims.

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Comparative Billing Reports (CBR)

The CBR program was created by The Centers for Medicare & Medicaid Services (CMS) as an educational tool for providers, intended to enhance accurate billing and/or prescribing practices and support providers' internal compliance activities. A CBR reflects a specific provider's billing and/or prescribing patterns as compared to his/her peers' patterns within a service area that may be prone to improper Medicare Part B payments. Each CBR is unique to a single provider, is disseminated only to that individual provider, and is not public ally available. Receiving a CBR is not an indication of or precursor to an audit, and it requires no response on a provider's part.

https://cbr.cbrpepper.org/home

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Comparative Billing Reports (CBR)

RELI Group
7125 Ambassador Drive, Suite 100
Windsor Mill, MD 21244

May 28, 2021

Organization Name
Address 1
Address 2
City, State, Zip

Special Edition CBR #: CBR202105
Critical Care Evaluation and Management (E&M) Services
NPI #: 1234567890
Fax #:

Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with the RELI Group to develop this Special Edition Comparative Billing Report (CBR) and to support providers with its use.

CMS routinely distributes an educational tool, known as a CBR, to the provider community in a variety of Medicare Fee-for-Service service areas. A CBR reflects a specific provider's billing and/or prescribing patterns as compared to his/her peers' patterns for the same services in his/her state or specialty, and nationwide. The CBR is intended to enhance accurate billing and/or prescribing practices and support providers' internal compliance activities. The report is not an indication of wrongdoing, and can support internal compliance review efforts, especially those related to coding and billing of code sets. Receiving a CBR is not an indication of or precursor to an audit, and it requires no response on a provider's part. Selected providers, however, may be referred for additional review and education as a part of CMS' routine CBR Program.

This CBR provides data regarding your claims submission, as compared to other providers' claims submission within your state, and in the nation. The report is offered to facilitate an analysis of your billing submissions during a timeframe that includes the PHE. Please consider the changes that took place to your billing practices during the PHE when you review the data within this report.

Periodically, CMS develops and distributes "Special Edition" CBRs, which offer more extensive education and resources to a subset of the provider community. Unlike routine CBRs, Special Edition CBRs include a series of up to four educational letters.

This second educational letter in the Special Edition CBR series is sent to selected providers based on criteria and metrics established through claim data review and research. After receiving this second Special Edition CBR you may receive up to two additional Special Edition CBR educational letters. Each Special Edition CBR educational letter will include comparison and educational data. Criteria for receiving future Special Edition CBR educational letters is as follows:

- Letter #3 will be sent to the top 5% of letter #2 recipients. If you no longer meet the defined criteria, you will not receive Special Edition CBR letter #3.
- Letter #4 will be sent to any provider who remains an outlier based on the defined criteria. If you no longer meet the defined criteria, you will not receive Special Edition CBR letter #4.

We hope that this Special Edition CBR series can help enhance your billing and/or prescribing practices and support internal compliance activities.

Please carefully review this report. You may wish to check your records against data in CMS' files and review Medicare guidelines to ensure compliance. Contact your Medicare Administrative Contractor (MAC) with

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Establish Your Coding/Billing Compliance Program Goals

- Sample size: For results to be statistically valid, choosing a sample size is critical. If the sample is too small (i.e., 10 accounts per quarter), the random variability will be not only inflated, but the likelihood of overlooking a potential issue may be increased. The recommended standard for sample sizes is to select 10 percent of the case volume.

- Error Rate or Margin of Error: According to the OIG, a minimum 95 percent accuracy rating is the best practice for a coding quality standard. This affords an acceptable 5 percent margin of error. Using local MACs error rate is a great benchmark. (**Be realistic**)

Examples:

- Performance Improvement Coding Documentation Reviews
  - Spot Check Coding Reviews: 3-5 Claims
  - Baseline Coding Reviews (New Provider): 10 claims

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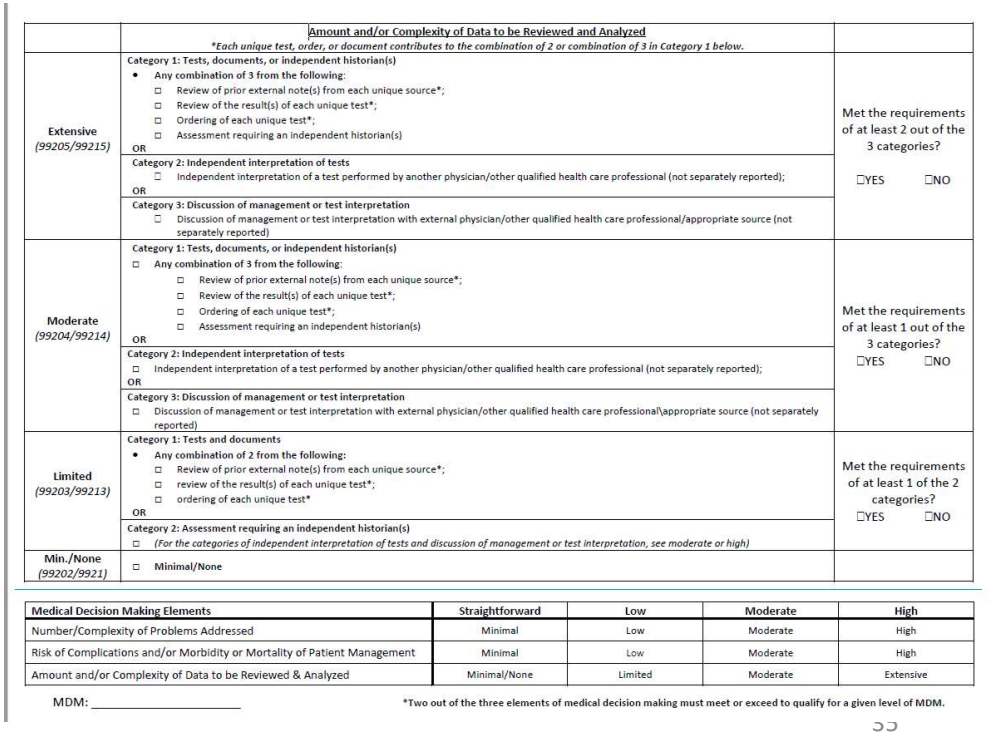
Internal Coding Tools

- Create internal coding review tools utilizing
  - ICD-10 coding guidelines
  - CMS Medicare NCDs/LCDs
  - CPT coding assistant
  - CMS E/M Auditor Checklist
    - 1995/1997 Guidelines
    - 2021 E/M Coding Guidelines



	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	
Extensive *(99205/99215)*	**Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** □ Review of prior external note(s) from each unique source*; □ Review of the result(s) of each unique test*; □ Ordering of each unique test*; □ Assessment requiring an independent historian(s) **OR** **Category 2: Independent interpretation of tests** □ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **OR** **Category 3: Discussion of management or test interpretation** □ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Met the requirements of at least 2 out of the 3 categories? □YES □NO
Moderate *(99204/99214)*	**Category 1: Tests, documents, or independent historian(s)** □ **Any combination of 3 from the following:** □ Review of prior external note(s) from each unique source*; □ Review of the result(s) of each unique test*; □ Ordering of each unique test*; □ Assessment requiring an independent historian(s) **OR** **Category 2: Independent interpretation of tests** □ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **OR** **Category 3: Discussion of management or test interpretation** □ Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	Met the requirements of at least 1 out of the 3 categories? □YES □NO
Limited *(99203/99213)*	**Category 1: Tests and documents** • **Any combination of 2 from the following:** □ Review of prior external note(s) from each unique source*; □ review of the result(s) of each unique test*; □ ordering of each unique test* **OR** **Category 2: Assessment requiring an independent historian(s)** □ *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Met the requirements of at least 1 of the 2 categories? □YES □NO
Min./None *(99202/9921)*	□ **Minimal/None**	

Medical Decision Making Elements	Straightforward	Low	Moderate	High
Number/Complexity of Problems Addressed	Minimal	Low	Moderate	High
Risk of Complications and/or Morbidity or Mortality of Patient Management	Minimal	Low	Moderate	High
Amount and/or Complexity of Data to be Reviewed & Analyzed	Minimal/None	Limited	Moderate	Extensive

MDM: _____

**Two out of the three elements of medical decision making must meet or exceed to qualify for a given level of MDM.*

Certified Coders/Auditors – Hire the Right Person

- Certified Coding Specialist (CCS): American Health Information Management (AHIMA)
  - Diagnosis Related Groups (DRGs)
    - DRG Validation Reviews
  - Facility (Technical) Coding
  - ICD-10 Diagnosis Coding
  - ICD-10 Procedure Coding
  - Consider hiring a Registered Nurse

Certified Professional Coder (CPC)

- CPT Procedural Coding
- Physician Coding
- ICD-10 Procedure Coding

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Follow Up is Important

1) Recommendations
2) Schedule Education Session
3) Re-Review High Risk Areas

Coding/Billing Compliance Education: Education is Key!

- Annual CPT and Diagnosis Coding Updates
  - ICD-10 Coding Guidelines
- Quarterly Coding Changes – OPPS/IPPS Final Rule
- Coding & Billing Policies (Federal & Commercial) – Documentation Requirements
- AMA CPT Assistant Coding Guidelines
  - HCPCS Coding (Supplies)
  - Modifier Documentation Requirements

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Coding/Billing Compliance Education: Education is Key!

- Create a coding/billing compliance education plan
  - Certified Coders
  - Medical Billers
  - Physicians/Qualified Health Care Professionals
  - Finance/Revenue Cycle Team
  - Executive Compliance Committee

Not Everything is an Audit

✓	What falls to the audit workplan?
✓	What falls to monitoring? Can you incorporate analytics/continuous monitoring?
✓	What requires working with operations to improve policies? Where can/should compliance play the role of advisor?
✓	Are there areas that could benefit from specialized training?
✓	Consider the skills and knowledge of your team and where you may need outside help (don't limit your plan and how you address risks based on the resources on your team – that could be a fatal flaw)

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Revenue Cycle

- Credit Balances/Overpayments
- Medical Necessity Reviews
- Patient Status Designation (Inpatient vs. Observation)
- Physician Order Retention
- Hospital Discharge Appeals Notices Retention
- Charge Description Master (CDM)
- Claim Edits related to coding/billing
- Patient Access Management
- Medicare Secondary Payer Questionnaire Review

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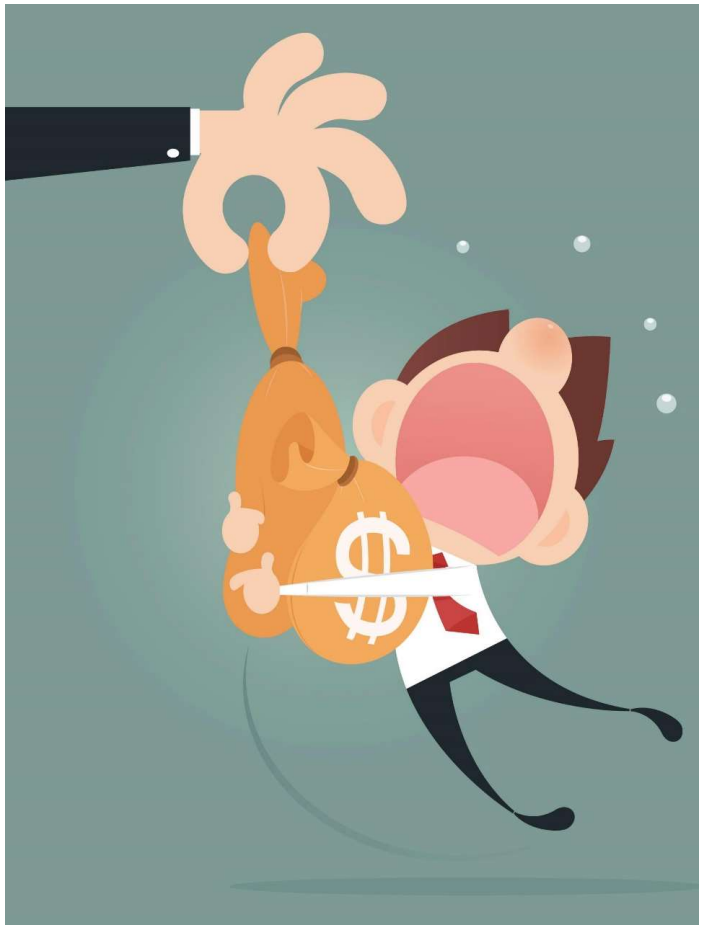

Proactive Steps: Operation "Don't Let the Money Get Away"

Data Mining: The Key to Success

Case Study Education

- Denied/Rejected Claim Root Cause Analysis

Annual Claim Edit Reviews

Charge Description Masters

- Current CPT & ICD-10 Coding Updates

Automated Processes

- Exploding Charges
- Automated Modifier Reporting
- Template Reviews
- EMR Calculators
- Artificial Intelligence/Machine Learning

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External Audit Activity: Audit Types

- Targeted Probe and Educate aka TPE
- Pre/Post Payment Reviews Coding/Documentation
- Additional Documentation Requests aka ADR – **Read Carefully**
- CMS Comparative Billing Reports – **Not an actual audit but can lead to it**
- Medical Necessity/Quality Reviews – **Livanta**
- Commercial Payor Coding/Documentation Reviews
- Special Investigation Reports – Coding/Documentation
- Recovery Audit Contractors aka RAC
  - ✓Noridian
  - ✓Performant Recovery, LLC
  - ✓HMS Federal Solutions
  - ✓Cotiviti, LLC

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Takeaways

- Identify internal and external risks that would substantiate your internal billing/coding compliance program
- Create a realistic internal audit workplan for the identified risk
- Remember not every risk identified requires an audit
- Include input form key stakeholders in your organization
- Use internal data to assist with substantiating and creating a program
- Develop an annual plan: Monthly/Bi-Monthly or Quarterly
- Hire the right individuals
- Utilize primary sources

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QUESTIONS