<u>University of California
Compliance & Audit Symposium</u>

<u>Billing and Coding Roundtable: Advanced Topics</u>

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Goals

1. What's on your mind?
   - An opportunity for attendees to provide topics orally or in writing (will be discussed during the 4th section of the session)

2. Top billing & coding challenges for Academic Medical Centers

3. The compliance dimension to the challenges

4. Hypotheticals and interactive discussion
   - Note: these will be presented live

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Themes

- Complex billing and coding challenges are sometimes just as much about operational challenges as they are about "the rules"

- The rules and an error rate tell one thing
  - the root cause tells another thing!

- Many of the top challenges for billing and coding are more about operational flow than confusion over rule

- Need to go below the surface

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5 Top Billing & Coding Challenges

1. Deference to Electronic Medical Record (EMR) systems

   - An EMR should not be relied on solely to manage coding risks
     - There still needs to be a human element with oversight!

   - Challenge: EMRs often electronically replicate the same coding selection process that occurred on paper before EMR
     - There is a risk that EMRs will make mistakes happen faster

   - Templates (or "smart text") that are being used in the EMR present the same coding risks as pre-designed paper forms

   - Note: I want to reinforce that EMRs are a good thing, but to keep them "good" humans need to understand them!

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5 Top Billing & Coding Challenges

2. Relying heavily on physicians to choose codes in the EMR or on paper encounter forms

   - There is nothing inherently wrong with a physician choosing a code, but as rules become more complex and change frequently, are they the right person?

   - How is an organization's incentive structured designed that could add risk to physician's choosing codes

   - The coming challenge: ICD-10 – how will the doctors react if they are choosing diagnosis codes?

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5 Top Billing & Coding Challenges

3. Growing trend to use natural language processing software to "read" text and assign codes, particularly in radiology.

   - Expect this trend to continue throughout the country

   - These approaches are in early stages of development

   - Many organizations are doing 100% monitoring of natural language software

   - Know if and where you may be using it

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5 Top Billing & Coding Challenges

4. Lack of communication between the billing offices for the hospital and medical group

   - In many instances the "answer" on the code is the same for the physician as for the hospital (except in hospital outpatient E/Ms!)

   - There is increased scrutiny by MACs, RACs, ZPICs on whether the physician claim and the hospital claim match

   - The coming challenge: Medicare pre-payment review which puts all the risk of the physician professional fees on an additional document request of the hospital record

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5 General Observations

5. Pushing coding decisions and charge capture as close to ordering and scheduling as possible

   - This creates compliance risk if the test performed is not the same as test scheduled or ordered

   - Compliance risk also exists if the test is cancelled or never occurs

   - Some EMR designs have this approach as the default – know when this is occurring

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- Compliance Billing & Coding Challenges

- What compliance efforts can be undertaken to address challenges?

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Compliance Billing & Coding Challenges

1. Campus strategy for facility E/M codes should be examined to ensure there is a policy and clinic approaches are consistent with the policy.

- The professional E/M is not the same as the facility E/M

- Outpatient clinics that use the physician's professional E/M code level to drive the facility E/M code level should have facility charges reviewed

- CMS has stated that the facility E/M must "reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes." (Claims Processing Manual, Ch. 4, Sec. 160).

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Compliance Billing & Coding Challenges

- More on facility E/M...

- In the Federal Register for Nov 27, 2007 at page 66,805, CMS has set out 11 expectations for factoring into the facility E/M method:

- (1) The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code.

- (2) The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources.

- (3) The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits.

- (4) The coding guidelines should meet the HIPAA requirements.

- (5) The coding guidelines should only require documentation that is clinically necessary for patient care.

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Compliance Billing & Coding Challenges

- More on facility E/M...(continued)

- (6) The coding guidelines should not facilitate upcoding or gaming.

- (7) The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.

- (8) The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.

- (9) The coding guidelines should not change with great frequency.

- (10) The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.

- (11) The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

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Compliance Billing & Coding Challenges

2. Service areas that charge at point of order should be reviewed.

   - This is an evolving environment which may change over time at organizations. For organizations that utilize EMR (or as a campus comes onto an EMR), there should be tracking of which clinical areas capture charges based on orders.

     - Discuss this with the EMR transition team

     - If there is an EMR update, be involved in the planning team to understand where updates and modifications may produce this

     - Most common area seen across the country: Lab

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Compliance Billing & Coding Challenges

3. Service areas that have auto-populate and/or copy and paste functionality turned on in the EMR should be reviewed based on an evaluation of the safeguards and oversight which may or may not be in place to monitor these functionalities

4. The first year of EMR conversion (or an upgrade) should have samples pulled equally from each quarter during the year to assess risk based on coding shifts and to assess risks which may have occurred for adjusted functionalities in the EMR.

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- Hypotheticals & Roundtable

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Discussion Scenario 1

- <u>Facts</u>: An audit of drug billing is conducted in a hospital outpatient clinic.

- <u>Finding 1</u>: There is no order for the drug.

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Discussion Scenario 1

- <u>Facts</u>: An audit of drug billing is conducted in a hospital outpatient clinic.

- <u>Finding 2</u>: There is a verbal order for a drug but it is not signed by the physician.

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Discussion Scenario 1

- <u>Facts</u>: An audit of drug billing is conducted in a hospital outpatient clinic.

- <u>Finding 3</u>: There is no record of administration of the drug.

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Discussion Scenario 1

- <u>Facts</u>: An audit of drug billing is conducted in a hospital outpatient clinic.

- <u>Finding 4</u>: The number of units billed is not the number of units administered.

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Discussion Scenario 2

- <u>Facts</u>: Doctor X orders 14 day course of drug infusion on an outpatient basis. The patient goes to an infusion clinic daily for 14 days of treatment and during this time is supervised by Doctors Y and Z. Doctor X sees the patient once a week for an evaluation but is not in the clinic to supervise the patient's daily infusion.

- <u>Question 1</u>: Who gets to bill the professional fees for supervising the patient's infusion? (assume a physician office setting)

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Discussion Scenario 2

- <u>Facts</u>: Doctor X orders 14 day course of drug infusion on an outpatient basis. The patient goes to an infusion clinic daily for 14 days of treatment and during this time is supervised by Doctors Y and Z. Doctor X sees the patient once a week for an evaluation but is not in the clinic to supervise the patient's daily infusion.

- <u>Question 2</u>: Who gets to bill the professional fees for supervising the patient's infusion? (assume a hospital outpatient setting)

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Discussion Scenario 2

- <u>Facts</u>: Doctor X orders 14 day course of drug infusion on an outpatient basis. The patient goes to an infusion clinic daily for 14 days of treatment and during this time is supervised by Doctors Y and Z. Doctor X sees the patient once a week for an evaluation but is not in the clinic to supervise the patient's daily infusion.

- <u>Question 3</u>: An audit identifies that all 14 days were billed under Dr. X's name. What are the implications? (assume a physician office setting)

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Discussion Scenario 2

- <u>Facts</u>: Doctor X orders 14 day course of drug infusion on an outpatient basis. The patient goes to an infusion clinic daily for 14 days of treatment and during this time is supervised by Doctors Y and Z. Doctor X sees the patient once a week for an evaluation but is not in the clinic to supervise the patient's daily infusion.

- <u>Question 4</u>: An audit identifies that each infusion was billed under the Doctor who supervised on that day, but the audit reveals that on Days 4, 8 and 12 there was no physician on-site – only RNs. What are the implications? (assume a physician office setting)

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Discussion Scenario 2

- <u>Facts</u>: Doctor X orders 14 day course of drug infusion on an outpatient basis. The patient goes to an infusion clinic daily for 14 days of treatment and during this time is supervised by Doctors Y and Z. Doctor X sees the patient once a week for an evaluation but is not in the clinic to supervise the patient's daily infusion.

- <u>Question 5</u>: (assume a hospital outpatient clinic setting) An audit identifies that on Days 4, 8 & 12 there was no physician in the infusion clinic – only RNs. What are the implications?

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Discussion Scenario 3

- <u>Facts</u>: An audit is done of physician professional fee billing in a hospital outpatient clinic for procedure X.

- <u>Finding 1</u>: Procedure X was performed by a nurse practitioner 8 out of 10 times.

- <u>Question</u>: What are the first questions to ask?

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Discussion Scenario 3

- <u>Facts</u>: An audit is done of physician professional fee billing in a hospital outpatient clinic for procedure X.

- <u>Finding 2</u>: Procedure X was performed by a nurse practitioner 8 out of 10 times. The physician was on-site 7 of the 8 times.

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Discussion Scenario 3

- <u>Facts</u>: An audit is done of physician professional fee billing in a hospital outpatient clinic for procedure X.

- <u>Finding 3</u>: Procedure X was performed by a nurse practitioner 8 out of 10 times. The physician was on-site 1 of the 8 times.

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Discussion Scenario 3

- <u>Facts</u>: An audit is done of physician professional fee billing in a hospital outpatient clinic for procedure X.

- <u>Finding 4</u>: Procedure X was performed by a nurse practitioner 8 out of 10 times. The physician was on-site 1 of the 8 times.

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Discussion Scenario 3

- <u>Facts</u>: An audit is done of physician professional fee billing in a hospital outpatient clinic for procedure X.

- <u>Finding 5</u>: Procedure X was performed by a nurse practitioner 8 out of 10 times. The physician was on-site for 1 of the 8 times. It appears both the physician and the NP billed for the service.

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- Questions/Discussion

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