Legal Considerations

"The Office of the Inspector General says if you bill Medicare, your coding compliance plan should include regular auditing and monitoring. If improper payments are detected and an auditor contacts your office, your best line of defense is to have established practice standards and procedures, training, and transparency.

Even honest mistakes can trigger an audit. If your office gets on the radar of RACs, ZPICs, UPICs and other contractors commissioned by CMS, they will request the documentation that supports the claims for reimbursement that you have submitted to the Medicare program.

If it's not yours, you've got to pay it back!"

-Robert W. Liles
Managing Member of Liles Parker, PLLC, Washington D.C.

"Auditors will take a group of what they deem to be random claims, usually 15-30 patients. They will analyze the percentage of those claims they believe were overpaid, and the amount of overpayment. The percentage or error rate of that sample is used to extrapolate to the total claims over a given period that may last usually several years. For example, if the auditors believe that 12 of the 15 cases were overpaid, they will assume that 80% of all similar claims were likewise overpaid. The auditor will then calculate the total amount of 'overpayment' based on that assumption.

CMS will usually seek to recoup payments for several years based on that assumed error rate and private providers are dependent on state law in terms of how far they can go back. When you calculate the total amount of billing for those years, it is not uncommon to see a demand for reimbursement as much as $500,000 to $1 million for a single provider.

If served with an audit letter, it is imperative to call a lawyer immediately.

In the meantime, providers should be diligent in proper documentation particularly documenting the essential elements support for a given E/M code."

-Thomas L. O'Carroll
Partner in Medical Malpractice at Hinshaw & Culbertson LLP, Chicago

CMCA-E/M 041218

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Does your provider use
E/M code prompts to make decisions about an encounter?

Does your office follow
correct E/M coding guidelines?

Do you routinely
self-audit your claims?

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Does your provider use E/M code prompts to make decisions about an encounter?

Software is imperfect and auditing requires human oversight. Your EHR can help simplify the claims process, but features such as automation, copy-paste, cloning, and preselected codes are problematic.

E/M services in Part B payments have been on audit radars for a number of years because they are more likely to be paid improperly than other Part B services. In 2010, Medicare paid $32.3 billion for E/M services, representing nearly a third of all Part B payments for that year. In a report released in 2014, the OIG said $6.7 billion E/M service claims paid in 2010 were billed at levels higher or lower than warranted; 19 percent lacked documentation.[1]

Establishing an internal E/M chart audit process is the most effective way to verify claims before they go out the door.

Does your office follow correct E/M coding guidelines?

Red flags include increased denials, EHR automation features with pre-selected codes or coders with insufficient training in E/M coding guidelines.

The OIG encourages individual and small group physician practices to incorporate a compliance plan that includes internal monitoring and auditing of claims. This demonstrates a good faith effort to minimize errors and prevent improper billings before they occur.[2]

Have you received notice of a carrier audit?

Comprehensive Error Rate Testing (CERT) randomly selects Medicare Fee-for-Service claims. Government-contracted auditors use CERT data to find improper payments and recoup funds for the Medicare program.

Audit triggers include

- Repeated E/M billing problems with a carrier
- Failure to follow non-par Medicare rules
- Medical records that do not support the CPT or E/M code(s)
- Failure to routinely collect deductibles and co-pays
- Failure to perform random E/M audits on a consistent basis
- Random selection by private or government carriers
- Higher than normal distribution of E/M levels of care or a single code

[1] The annual report of the Department of Health and Human Services and Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2014 https://oig.hhs.gov/publications/docs/hcfac/FY2014-hcfac.pdf, page 48, Improper Payments for E&M Services

[2] The Seven Basic Components of a Voluntary Compliance Program, https://www.federalregister.gov/doments/2000/10/05/00-25500/oig-compliance-program-for-individual-and-small-group-physician-practices

A coding certification lays the foundation for advancement into the auditing role.

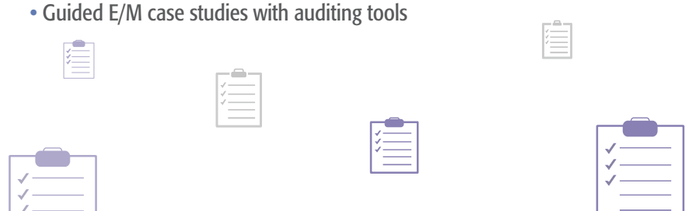
Baseline skills include familiarity with E/M coding, regulatory guidelines, carrier medical claim policies, and compliance in the medical office. Knowledge of medical terminology and anatomy and physiology is also important. Candidates for this credential should exhibit strong attention to detail, communication, and organizational skills.

CMCA E/M

The CMCA-E/M program contains everything needed to establish and maintain an E/M auditing program in an outpatient setting. Participants will learn how to analyze medical records and determine if the documentation supports CPT and medical necessity based on established coding and insurance carrier guidelines. The course workbook includes audit tools for hands-on practice using real case study exercises.

Course Outline

- Medical record compliance for the medical office
- E/M coding risk areas and compliance
- Comprehensive Error Rate Testing (CERT) and improper payment rates
- Regulatory actions and consequences for improper payments
- The role of a medical record auditor
- Local MAC guidelines for E/M auditing
- Coding and documentation for E/M services
- Review of history, exam and medical decision-making
- Difference between medical decision-making and medical necessity
- Recordkeeping, clinical documentation improvement, and physician queries
- Systematic instruction for conducting a formal chart audit
- Guided E/M case studies with auditing tools



"A clean claim should be paid in about 15 days. If a claim is denied, it could take anywhere from 30-120 days to get it paid. It takes a team to code properly and routine audits are an essential part of a healthy revenue cycle.

More of our coding positions now require auditing skills."

- Libby Purser, CHI, CMC, CMIS, CMOM, CPC, CRC
HIM Supervisor for a North TX multi-specialty provider network

Registration Information

Certified Medical Chart Auditor-E/M (CMCA-E/M)

July 26 & 27, 2018 • Program # 23407-0726 • 8:00 am to 5:00 pm

Location:
West Virginia State Medical Society
2018 Kanawha Blvd., E
Charleston, WV 25311

Register:
Online: www.pmimd.com/wvsma
Phone: (800) 259-5562
Mail: Shelby Roberts
Practice Management Institute
8242 Vicar
San Antonio, TX 78218

Registration Fee

$795 course fee includes lecture, certification manual, case study exercises, audit tools, and proctored exam.

For more information on prerequisites, course formats, and exam, visit: pmiMD.com/cmca

About | Practice Management Institute

Practice Management Institute® (PMI) has been a trusted training resource for administrative teams working in outpatient physician offices since 1983. Entry-level and skilled professionals working in medical coding, compliance, management, auditing and billing roles learn current guidelines and best practices, and earn certification in their areas of interest. Healthcare experts teach courses in both live and online formats year-round. Onsite training and consultations are available by appointment. Learn how PMI is improving the business of medicine at pmiMD.com.

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