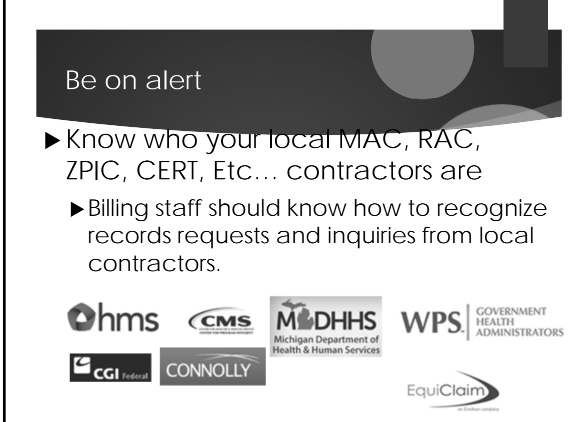
Who is coming for you?

- Medicare Administrative Contractors (MACs)
- Recovery Audit Contractors (RACs)
- Medicaid Recovery Audit Contractors (MACs)
- Comprehensive Error Rate Testing (CERT)
- Health Care Fraud Prevention & Enforcement (HEAT)
- Private Payors
- Auto Insurance



What do to

- Respond as directed ASAP!!
- Review the documentation and coding and prepare a rebuttal in the event of a negative outcome.
- Appeal downcoding with supporting documentation and justification of coding.

Know the rules

- Know the coding guidelines and policies for your payers.
- Some payers have unique rules for E&M components.
  - ROS
  - Exam
  - MDM
- Review the payer websites regularly for updates to policies.

Allergies as ROS

- "No known drug allergies or allergies in general are not considered part of the ROS. AMA/CPT publications have always indicated that these are elements of PFSH."

Allergies as ROS

- **Q 14. Can an allergy be part of the ROS rather than the past history? For example, patient has allergy to penicillin; it causes hives?**
- A 14. No, questions and responses concerning any past allergies and the resulting reactions are part of the Past, Family, and Social History (PFSH). They are not part of the Review of Systems (ROS).

WPS. GOVERNMENT HEALTH ADMINISTRATORS

WPS ROS

- **Q9. The 1995 and 1997 DGs indicate "all other systems are negative" is acceptable for a comprehensive level of the Review of Systems. Does WPS accept this?**
- A9. Yes. For a comprehensive ROS, the physician must document the review of at least 10 organ systems. The physician must document both the positive and the problem pertinent negative responses relating to the chief complaint. Indicating the individual systems leaves no room for doubt as to the number of systems reviewed, but "all other systems negative" is acceptable.

PMH as ROS

- Question: If the past medical section states a chronic or current illness (that the provider is not treating), can it be used in the Review of Systems (ROS)? If the past medical section lists several conditions and there is no mention of controlled or uncontrolled, could this be used in the ROS?
- Answer: No, per both the 1995 and 1997 Evaluation and Management (E & M) Documentation Guidelines, "a Review of Systems is an inventory of body systems obtained through a series of questions seeking to identify signs or symptoms that the patient may be experiencing or has experienced."

  A past medical history would not contain a patient's pertinent positive and/or negative responses as related to the problems identified in the patient's history of the present illness.

PFS Hx

- When a Past, Family and/or Social History documentation has the terms "Non-contributory" or "negative", these are not considered appropriate documentation.
- Documentation of PFSH must include social and/or family history information, such as alcohol consumption, smoking history, occupation, or familial hereditary conditions

-WPS

Exam	1995 E&M DG	Numerical Interpretation
Problem Focused	• a limited examination of the affected body area or organ system	• 1 Body Area or Organ System
Expanded Problem Focused	• a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).	• 2-4 Body areas or systems
Detailed	• an extended examination of the affected body area(s) and other symptomatic or related organ system(s).	• 5-7 Body areas or systems
Comprehensive	• a general multi-system examination or complete examination of a single organ system. - The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.	• 8 or more Organ systems

Examination

- The 2-4, 5-7 breakdown originated with then HCFA Medical Director, Bart McCann at the CPT Editorial Panel Advisory Committee meeting in November of 1995.
- Indicated that a new version of the DGs were to be released in 1996 that would reflect the 2-4, 5-7 to more clearly refine the exam requirements.

Examination

- Many sources changed their version of the DGs to reflect the expected update that was never made official.
- Still sources, including many of the Medicare carriers, that use the numerical breakdown to assign a level to the exam.

NHIC Examination

EXAM	Affected Body Areas (BA)	Organ Systems (OS)		1995 Guidelines			
	☐ Head/Face	☐ Constitutional	☐ Skin	1 (BA) or (OS)	2-4 (OS) and/or (BA)	5-7 (OS) and/or (BA)	8 or more (OS)
	☐ Neck	☐ Eyes	☐ Neuro				
	☐ Abdomen	☐ Ears, nose, mouth, throat	☐ Psych	(Limited exam of affected BA or OS)	(Limited exam of affected BA or OS and other symptomatic or related OS(s))	(Extended exam of affected BA(s) and other or related OS(s))	(A general multisystem exam or complete exam of a single organ system)
	☐ Chest + breast / axillae	☐ Cardiovascular	☐ Hem/Lymph/Immune				
	☐ Genital/groin/buttocks	☐ Respiratory					
	☐ Back, include spine	☐ GI					
	☐ Extremity/(ies) L / R Upper	☐ GU		PF	EPF	D	C
	L / R Lower	☐ Musculo					

CIGNA E&M Tips

- Understand the difference between "Expanded Problem-Focused (EPF)" and "Limited" examination under 1995 guidelines.
  - The difference is not the number of systems examined. Two to seven systems are required for both examinations.
  - The difference is the detail in which the examined systems are described.

Novitas 4x4 Rule

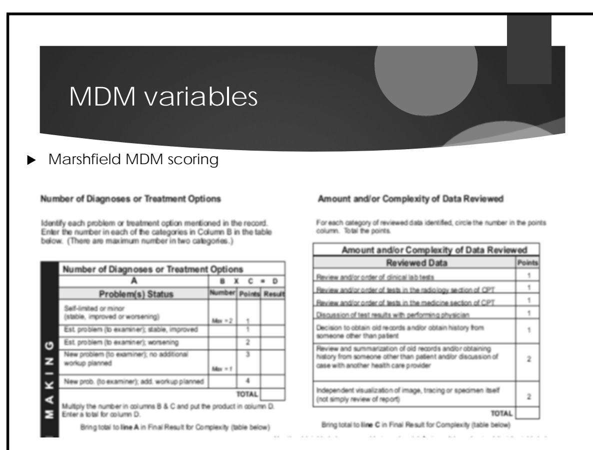
- Under the 1995 guidelines both the expanded problem focused examination and the detailed examination provide for the examination of "up to 7 systems" or 7 body areas.
- This has led to variability in reviews utilizing the '95 guidelines, and required an interpretation for proper and consistent implementation of the E/M guidelines.

Novitas 4x4 Rule

- By providing a tool (4 elements examined in 4 body areas or 4 organ systems satisfies a detailed examination) our reviewers and the physicians have a clinically derived tool to assist in implementing the E/M guidelines and decreasing one area of ambiguity.
- This is a tool that is consistent with the way medicine is practiced, as confirmed in Documentation Coding & Billing by Laxmaiah Manchikanti, M .D, and A Guide to Physical Examination by Barbara Bates, M D. And, it is a tool to reduce reviewer variability.

MDM Controversies

- Additional work-up planned
- 2 Points for interps and/or 93010
- Check box for "Old records reviewed"
- Discussion w/ another "health care provider"



MDM variables

- Marshfield MDM scoring

Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.)

Number of Diagnoses or Treatment Options			
A	B X	C =	D
Problem(s) Status	Number	Points	Result
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	Max = 1	3	
New prob. (to examiner); add. workup planned		4	
		TOTAL	

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.

Bring total to **line A** in Final Result for Complexity (table below)

Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the points column. Total the points.

Amount and/or Complexity of Data Reviewed	
Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

Bring total to **line C** in Final Result for Complexity (table below)

Marshfield Scoring- Number of Diagnoses / Treatment Options

New Problem, <u>no add'l work-up planned</u> 3 points

New Problem, <u>add'l work-up planned</u> 4 points

2 common definitions

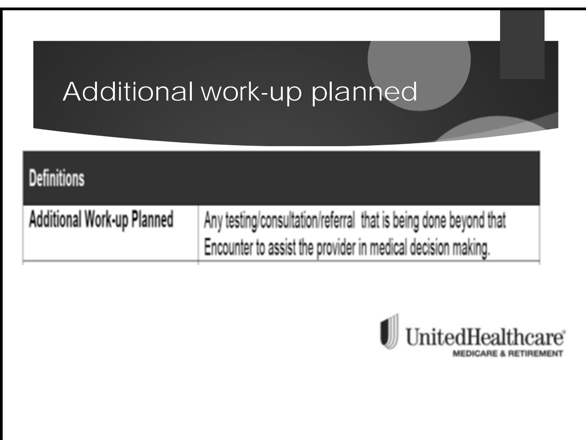
A. Additional diagnostic work-up after the current E&M service is completed.

B. Diagnostic work-up during the current E&M service.

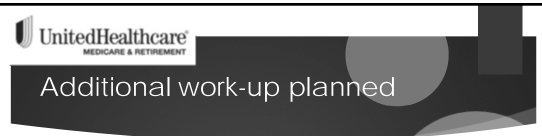
Additional work-up planned

Per Noridian:

- Q3. Please clarify if "new problem to provider, additional workup" means that the additional workup must be done beyond that encounter at that time.
- For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision making. Or, does additional work-up consist of any diagnostic testing, laboratory testing, etc. that can be performed during the visit.
- A3. There is no specific indication that "further workup needed" must be completed at a future date.



Definitions	
Additional Work-up Planned	Any testing/consultation/referral that is being done beyond that Encounter to assist the provider in medical decision making.



- An example of Additional Work-up Planned, is if the physician schedules testing him/herself or communicates directly with the patient's primary physician or representative the need for testing *which is to be done after discharge from the ED*, and the appropriate documentation has been recorded. Credit for "Additional Work-up" Planned is granted (4 points assigned).
- Credit is not given for the work up if it occurs during the ER Encounter.
- Patients admitted to the hospital under the care of a physician other than the ER physician may have testing done as part of the admitting physician's care for that patient. The ER physician will not receive credit for the Additional Work-up Planned done under the care of the admitting physician.

Novitas Add'l W/U

NOVITAS SOLUTIONS

- Is the physician doing additional workup?
- Additional workup will require the physician to review the results/make decisions on a day other than the day of the patient encounter.

Novitas Add'l W/U

NOVITAS SOLUTIONS

- What constitutes additional workup in the Amount and Complexity of Data grid for Medical Decision Making?
- Additional workup is anything done beyond that encounter at that time. For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision-making.

WPS MDM

Q6. My question centers on the number of diagnosis or management options in the MDM of the E/M service. When coding an Emergency department encounter, would all presenting problems fall under the "new problem" category (either with or without additional workup)?

WPS MDM

A6. The 1995 and the 1997 DGs have a table the provider can use in determining the level of MDM. There is no specific "new problem" category.

The number of possible diagnosis and/or the number of management options your provider considers is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician. The highest level of risk in any one category determines the overall risk.

WPS MDM

- **Q2. Define self-limited or minor problem in the medical decision making grid under minimal level of risk. At times, it is difficult to determine whether a problem is self-limited or minor or whether it is a new problem with no additional work-up planned.**

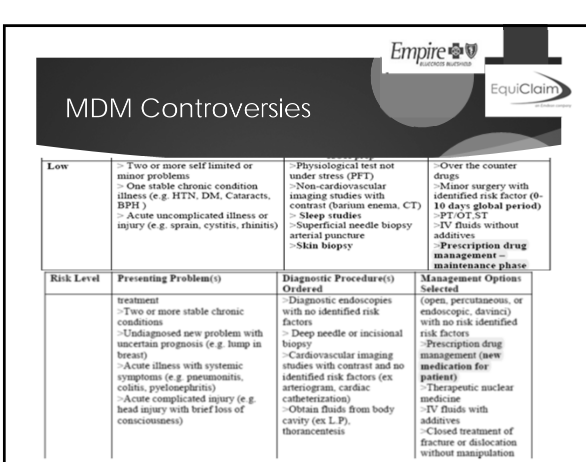
- A2. The 1995 and 1997 DGs indicate the determination of risk is complex and not readily quantifiable and includes some examples in each of the categories. <u>The DGs do not address a new problem with no additional work up planned.</u> Therefore, you can use the examples provided in the DGs to determine the level of the presenting problem.

Noridian MDM

Medical necessity cannot be quantified using a points system. Determining the medically necessary level of service (LOS) involves many factors and is not the same from patient to p patient and day to day. Medical necessity is determined through a culmination of vital factors, including, but not limited to:

- Clinical judgment
- Standards of practice
- Why the patient needs to be seen (chief complaint),
- Any acute exacerbations/onsets of medical conditions or injuries,
- The stability/acuity of the patient,
- Multiple medical co-morbidities,
- And the management of the patient for that specific DOS.

MDM Controversies



Low	> Two or more self limited or minor problems > One stable chronic condition illness (e.g. HTN, DM, Cataracts, BPH) > Acute uncomplicated illness or injury (e.g. sprain, cystitis, rhinitis)	>Physiological test not under stress (PFT) >Non-cardiovascular imaging studies with contrast (barium enema, CT) > **Sleep studies** >Superficial needle biopsy arterial puncture >**Skin biopsy**	>Over the counter drugs >Minor surgery with identified risk factor (0-**10 days global period)** >PT/OT,ST >IV fluids without additives >**Prescription drug management – maintenance phase**

Risk Level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
	treatment >Two or more stable chronic conditions >Undiagnosed new problem with uncertain prognosis (e.g. lump in breast) >Acute illness with systemic symptoms (e.g. pneumonitis, colitis, pyelonephritis) >Acute complicated injury (e.g. head injury with brief loss of consciousness)	>Diagnostic endoscopies with no identified risk factors > Deep needle or incisional biopsy >Cardiovascular imaging studies with contrast and no identified risk factors (ex arteriogram, cardiac catheterization) >Obtain fluids from body cavity (ex L.P), thorancentesis	(open, percutaneous, or endoscopic, davinci) with no risk identified risk factors >Prescription drug management (**new medication for patient)** >Therapeutic nuclear medicine >IV fluids with additives >Closed treatment of fracture or dislocation without manipulation

EMR MDM

Medical Decision Making

Discussion of test results with the performing providers: yes

Decide to obtain previous medical records: yes

Obtain history from someone other than the patient: no

Review and summarize previous medical records: yes

Discuss the patient with another provider: yes

Independent visualization of image, tracing, or specimen: yes

Auditor response

- *" These statements provide no clinical insight as to what happened in the ED or how these steps impacted the diagnosis or treatment of the patient. Documentation that is aimed to meet the guidelines for payment but is clinically irrelevant to the patient presenting problem will not increase the level assigned to that visit."*

EKG Pay vs Points

WPS GOVERNMENT HEALTH ADMINISTRATORS

- The ordering of the EKG would be part of the Medical Decision Making (MDM) under the Risk category under Diagnostic Procedures Ordered.
- The interpretation of the ordered EKG is considered part of the EKG reimbursement, and as such is not part of the Amount and/or Complexity of Data to be Reviewed category under the MDM portion of the E/M service.
- Counting both a review of the ordered EKG and billing for the interpretation and report of the same EKG is incorrect.

noridian

Independent visualization of image, tracing or specimen itself

- If I personally review a film, e.g. x-ray, electrocardiogram (EKG) in my office, will I receive 2 points on the E/M score sheet?
- Yes, you may get two points for independent visualization of an image, tracing or specimen on the E/M score sheet in the Amount and/or Complexity of Data Reviewed section under the Medical Decision Making key component.
- The medical record documentation must clearly indicate that the physician/qualified NPP personally (independently) visualized and performed the interpretation of the image; tracing or specimen and that he/she did not simply read/review a report from another physician/qualified NPP.

CC Time

- **Q5. Can I use a check box indicating 30-74 minutes instead of saying I spent 51 minutes in critical care?**
- A5. Document the total time spent each time you visit the patient. CMS IOM Publication 100-04, Chapter 12, Section 30.6.12.E states, "Critical care is a time-based service, and for each date and encounter entry, the physician's progress note(s) shall document the total time that critical care services were provided."

Automated Down coding

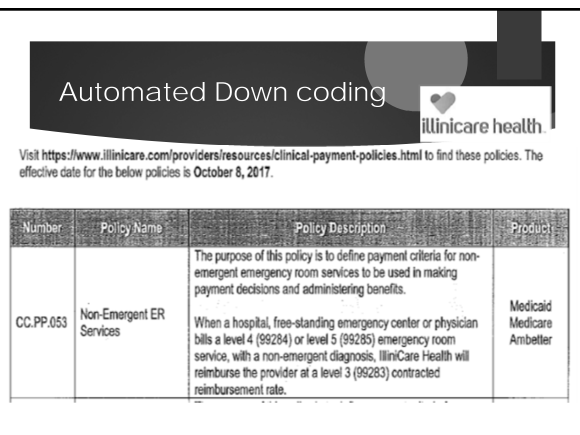
ER level of care	December 1, 2016	CPT code 99285 is used to indicate medical conditions that are of high severity, are potentially life threatening, and require the immediate attention of a physician. Services for constipation, earaches and colds, for example, should not be billed using CPT code 99285. When a hospital or physician bills a level 5 emergency room service (CPT 99285) with a designated minor diagnosis code, we will down code 99285 to a level 4 emergency room service (CPT 99284).

Aetna OfficeLink Updates | September 2016 3

Automated Down coding

In September, we communicated that when CPT code 99285 is billed with a minor diagnosis, we will recode to 99284. This policy will not be implemented. The following review program will be implemented in its place.

CPT code 99285 is used to indicate medical conditions that are of high severity, are potentially life threatening, and require the immediate attention of a physician. Services for constipation, earaches and colds, for example, should not be billed using CPT code 99285. When a hospital or physician bills a level five emergency room service (CPT 99285) with a designated minor diagnosis code, we will request documentation/medical records. If the documentation/medical records support the level five service it will be paid per Aetna Standard Guidelines. If records do not indicate a level five is warranted, the service will be recoded.



Automated Down coding

illinicare health.

Visit **https://www.illinicare.com/providers/resources/clinical-payment-policies.html** to find these policies. The effective date for the below policies is **October 8, 2017**.

Number	Policy Name	Policy Description	Product
CC.PP.053	Non-Emergent ER Services	The purpose of this policy is to define payment criteria for non-emergent emergency room services to be used in making payment decisions and administering benefits. When a hospital, free-standing emergency center or physician bills a level 4 (99284) or level 5 (99285) emergency room service, with a non-emergent diagnosis, IlliniCare Health will reimburse the provider at a level 3 (99283) contracted reimbursement rate.	Medicaid Medicare Ambetter

CENTENE Corporation

Automated Down coding

- Centene (operates in 26 states, include Medicaid MCO plans, exchange plans and Medicare/Medicaid plans)

Policy Overview

- To encourage providers to direct patients to more appropriate care settings, the health plan has adopted a payment strategy that will provide lower levels of reimbursement for services indicating lower levels of complexity or severity rendered in the emergency room.
- The purpose of this policy is to define payment criteria for emergency room services to be used in making payment decisions and administering benefits.

CENTENE Corporation

Automated Down coding

Reimbursement

- When a hospital, free-standing emergency center or physician bills a level 4 (99284) or level 5 (99285) emergency room service, with a diagnosis indicating a lower level of complexity or severity, the health plan will reimburse the provider at a level 3 (99283) reimbursement rate.

CENTENE Corporation

Automated Down coding

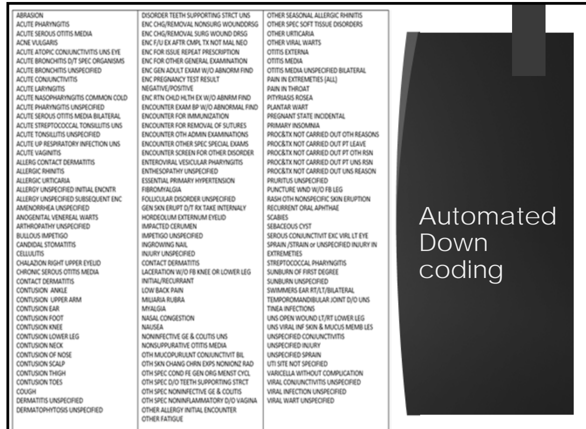
Utilization

- The health plan's claims processing system will use a coding algorithm strategy to automatically adjudicate emergency department claims based on the applicable ED claim category in accordance with the diagnosis code appearing on the claim. If the diagnosis code classification falls into a categorization indicating a lower level of complexity or severity, the claim will be reimbursed at the Level 3 emergency department reimbursement level.

Automated Down coding

Anthem Blue Cross and Blue Shield of Indiana Provider information for avoidable emergency room visits

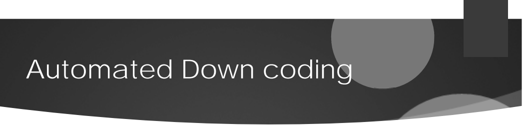
- The below clinical areas and respective codes will be reviewed if they are the emergency room discharge diagnosis. Prudent layperson language (law) was taken into consideration in development of these clinical areas. The members presenting symptoms in conjunction with prudent layperson language may allow approval of the ER visit. The program is effective for Indiana commercial local accounts on 01/01/2018.



ABRASION
ACUTE PHARYNGITIS
ACUTE SEROUS OTITIS MEDIA
ACNE VULGARIS
ACUTE ATOPIC CONJUNCTIVITIS UNS EYE
ACUTE BRONCHITIS D/T SPEC ORGANISMS
ACUTE BRONCHITIS UNSPECIFIED
ACUTE CONJUNCTIVITIS
ACUTE LARYNGITIS
ACUTE NASOPHARYNGITIS COMMON COLD
ACUTE PHARYNGITIS UNSPECIFIED
ACUTE SEROUS OTITIS MEDIA BILATERAL
ACUTE STREPTOCOCCAL TONSILLITIS UNS
ACUTE TONSILLITIS UNSPECIFIED
ACUTE UP RESPIRATORY INFECTION UNS
ACUTE VAGINITIS
ALLERG CONTACT DERMATITIS
ALLERGIC RHINITIS
ALLERGIC URTICARIA
ALLERGY UNSPECIFIED INITIAL ENCNTR
ALLERGY UNSPECIFIED SUBSEQUENT ENC
AMENORRHEA UNSPECIFIED
ANOGENITAL VENEREAL WARTS
ARTHROPATHY UNSPECIFIED
BULLOUS IMPETIGO
CANDIDAL STOMATITIS
CELLULITIS
CHALAZION RIGHT UPPER EYELID
CHRONIC SEROUS OTITIS MEDIA
CONTACT DERMATITIS
CONTUSION ANKLE
CONTUSION UPPER ARM
CONTUSION EAR
CONTUSION FOOT
CONTUSION KNEE
CONTUSION LOWER LEG
CONTUSION NECK
CONTUSION OF NOSE
CONTUSION SCALP
CONTUSION THIGH
CONTUSION TOES
COUGH
DERMATITIS UNSPECIFIED
DERMATOPHYTOSIS UNSPECIFIED

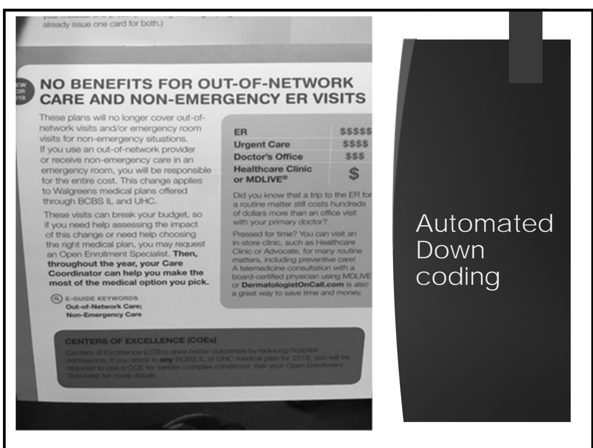
DISORDER TEETH SUPPORTING STRCT UNS
ENC CHG/REMOVAL NONSURG WOUNDDRSG
ENC CHG/REMOVAL SURG WOUND DRSG
ENC F/U EX AFTR CMPL TX NOT MAL NEO
ENC FOR ISSUE REPEAT PRESCRIPTION
ENC FOR OTHER GENERAL EXAMINATION
ENC GEN ADULT EXAM W/O ABNORM FIND
ENC PREGNANCY TEST RESULT
NEGATIVE/POSITIVE
ENC RTN CHLD HLTH EX W/O ABNRM FIND
ENCOUNTER EXAM BP W/O ABNORMAL FIND
ENCOUNTER FOR IMMUNIZATION
ENCOUNTER FOR REMOVAL OF SUTURES
ENCOUNTER OTH ADMIN EXAMINATIONS
ENCOUNTER OTHER SPEC SPECIAL EXAMS
ENCOUNTER SCREEN FOR OTHER DISORDER
ENTEROVIRAL VESICULAR PHARYNGITIS
ENTHESOPATHY UNSPECIFIED
ESSENTIAL PRIMARY HYPERTENSION
FIBROMYALGIA
FOLLICULAR DISORDER UNSPECIFIED
GEN SKN ERUPT D/T RX TAKE INTERNALY
HORDEOLUM EXTERNUM EYELID
IMPACTED CERUMEN
IMPETIGO UNSPECIFIED
INGROWING NAIL
INJURY UNSPECIFIED
CONTACT DERMATITIS
LACERATION W/O FB KNEE OR LOWER LEG
INITIAL/RECURRANT
LOW BACK PAIN
MILIARIA RUBRA
MYALGIA
NASAL CONGESTION
NAUSEA
NONINFECTIVE GE & COLITIS UNS
NONSUPPURATIVE OTITIS MEDIA
OTH MUCOPURULNT CONJUNCTIVIT BIL
OTH SKN CHANG CHRN EXPS NONIONZ RAD
OTH SPEC COND FE GEN ORG MENST CYCL
OTH SPEC D/O TEETH SUPPORTING STRCT
OTH SPEC NONINFECTIVE GE & COLITIS
OTH SPEC NONINFLAMMATORY D/O VAGINA
OTHER ALLERGY INITIAL ENCOUNTER
OTHER FATIGUE

OTHER SEASONAL ALLERGIC RHINITIS
OTHER SPEC SOFT TISSUE DISORDERS
OTHER URTICARIA
OTHER VIRAL WARTS
OTITIS EXTERNA
OTITIS MEDIA
OTITIS MEDIA UNSPECIFIED BILATERAL
PAIN IN EXTREMETIES (ALL)
PAIN IN THROAT
PITYRIASIS ROSEA
PLANTAR WART
PREGNANT STATE INCIDENTAL
PRIMARY INSOMNIA
PROC&TX NOT CARRIED OUT OTH REASONS
PROC&TX NOT CARRIED OUT PT LEAVE
PROC&TX NOT CARRIED OUT PT OTH RSN
PROC&TX NOT CARRIED OUT PT UNS RSN
PROC&TX NOT CARRIED OUT UNS REASON
PRURITUS UNSPECIFIED
PUNCTURE WND W/O FB LEG
RASH OTH NONSPECIFIC SKIN ERUPTION
RECURRENT ORAL APHTHAE
SCABIES
SEBACEOUS CYST
SEROUS CONJUNCTIVIT EXC VIRL LT EYE
SPRAIN /STRAIN or UNSPECIFIED INJURY IN EXTREMETIES
STREPTOCOCCAL PHARYNGITIS
SUNBURN OF FIRST DEGREE
SUNBURN UNSPECIFIED
SWIMMERS EAR RT/LT/BILATERAL
TEMPOROMANDIBULAR JOINT D/O UNS
TINEA INFECTIONS
UNS OPEN WOUND LT/RT LOWER LEG
UNS VIRAL INF SKIN & MUCUS MEMB LES
UNSPECIFIED CONJUNCTIVITIS
UNSPECIFIED INJURY
UNSPECIFIED SPRAIN
UTI SITE NOT SPECIFIED
VARICELLA WITHOUT COMPLICATION
VIRAL CONJUNCTIVITIS UNSPECIFIED
VIRAL INFECTION UNSPECIFIED
VIRAL WART UNSPECIFIED



Updated policies on Modifier 25 reporting and reimbursement

- Independence has updated its policies on Modifier 25 reporting and reimbursement. The following policies were posted as Notifications on May 1, 2017, and will go into effect **August 1, 2017**:
- As part of the update, a payment reduction of 50 percent will be applied to certain services when appropriately billed with Modifier 25. This applies to all professional Modifier 25 claim submissions with a date of service on or after August 1, 2017, that fall into these two scenarios:
  - When Modifier 25 is appropriately appended to an evaluation and management (E&M) service and is submitted on the same date of service, by the same professional provider or other qualified health care provider, as a minor procedure, the E&M service is reimbursed at 50 percent of the applicable fee schedule amount.



already issue one card for both.)

NO BENEFITS FOR OUT-OF-NETWORK CARE AND NON-EMERGENCY ER VISITS

These plans will no longer cover out-of-network visits and/or emergency room visits for non-emergency situations. If you use an out-of-network provider or receive non-emergency care in an emergency room, you will be responsible for the entire cost. This change applies to Walgreens medical plans offered through BCBS IL and UHC.

These visits can break your budget, so if you need help assessing the impact of this change or need help choosing the right medical plan, you may request an Open Enrollment Specialist. **Then, throughout the year, your Care Coordinator can help you make the most of the medical option you pick.**

E-GUIDE KEYWORDS
Out-of-Network Care; Non-Emergency Care

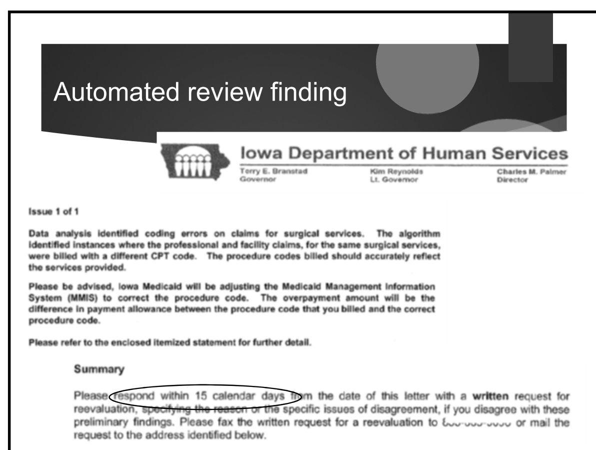
ER	$$$$$
Urgent Care	$$$$
Doctor's Office	$$$
Healthcare Clinic or MDLIVE®	$

Did you know that a trip to the ER for a routine matter still costs hundreds of dollars more than an office visit with your primary doctor?

Pressed for time? You can visit an in-store clinic, such as Healthcare Clinic or Advocate, for many routine matters, including preventive care! A telemedicine consultation with a board-certified physician using MDLIVE or **DermatologistOnCall.com** is also a great way to save time and money.

CENTERS OF EXCELLENCE (COEs)

Centers of Excellence (COEs) drive better outcomes by reducing hospital admissions. If you enroll in **any** BCBS IL or UHC medical plan for 2018, you will be required to use a COE for certain complex conditions. Ask your Open Enrollment Specialist for more details.



Automated review finding

Iowa Department of Human Services

Terry E. Branstad, Governor — Kim Reynolds, Lt. Governor — Charles M. Palmer, Director

Issue 1 of 1

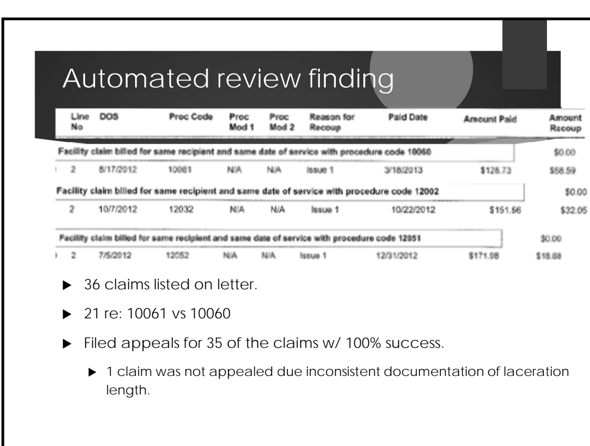
Data analysis identified coding errors on claims for surgical services. The algorithm identified instances where the professional and facility claims, for the same surgical services, were billed with a different CPT code. The procedure codes billed should accurately reflect the services provided.

Please be advised, Iowa Medicaid will be adjusting the Medicaid Management Information System (MMIS) to correct the procedure code. The overpayment amount will be the difference in payment allowance between the procedure code that you billed and the correct procedure code.

Please refer to the enclosed itemized statement for further detail.

Summary

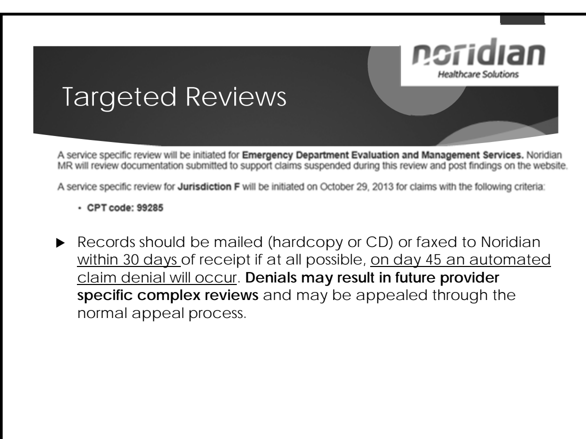
Please respond within 15 calendar days from the date of this letter with a **written** request for reevaluation, specifying the reason or the specific issues of disagreement, if you disagree with these preliminary findings. Please fax the written request for a reevaluation to [illegible] or mail the request to the address identified below.



Automated review finding

Line No	DOS	Proc Code	Proc Mod 1	Proc Mod 2	Reason for Recoup	Paid Date	Amount Paid	Amount Recoup
Facility claim billed for same recipient and same date of service with procedure code 10060								$0.00
2	8/17/2012	10061	N/A	N/A	Issue 1	3/18/2013	$128.73	$58.59
Facility claim billed for same recipient and same date of service with procedure code 12002								$0.00
2	10/7/2012	12032	N/A	N/A	Issue 1	10/22/2012	$151.56	$32.05
Facility claim billed for same recipient and same date of service with procedure code 12051								$0.00
2	7/5/2012	12052	N/A	N/A	Issue 1	12/31/2012	$171.98	$18.88

- 36 claims listed on letter.
- 21 re: 10061 vs 10060
- Filed appeals for 35 of the claims w/ 100% success.
  - 1 claim was not appealed due inconsistent documentation of laceration length.



Targeted Reviews

noridian
Healthcare Solutions

A service specific review will be initiated for **Emergency Department Evaluation and Management Services.** Noridian MR will review documentation submitted to support claims suspended during this review and post findings on the website.

A service specific review for **Jurisdiction F** will be initiated on October 29, 2013 for claims with the following criteria:

- **CPT code: 99285**

- Records should be mailed (hardcopy or CD) or faxed to Noridian within 30 days of receipt if at all possible, on day 45 an automated claim denial will occur. **Denials may result in future provider specific complex reviews** and may be appealed through the normal appeal process.

Targeted Reviews

12 **Network Bulletin:** January 2017 For more information, call 877.842.3210 or visit **UnitedHealthcareOnline.com**

UnitedHealthcare

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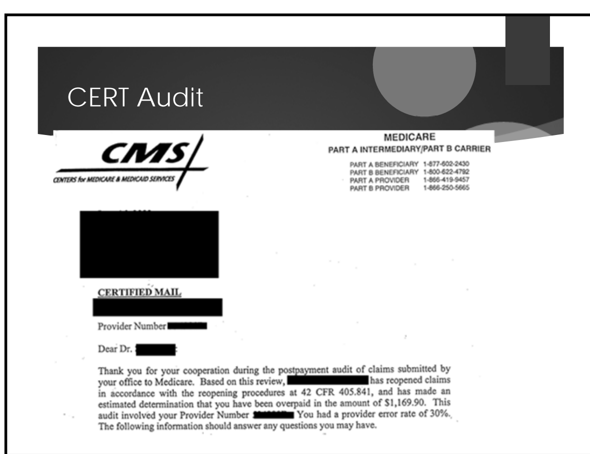
Front & Center

Evaluation and Management Reimbursement Policy for Professional Claims

As previously announced in the June and July 2016 Network Bulletins, on Sept. 1, 2016 (and Nov. 1, 2016 for Oxford), UnitedHealthcare's Evaluation and Management (E/M) Reimbursement Policy took effect to help ensure that care providers are reimbursed based on the E/M code(s) that appropriately reflect the health care services rendered. The E/M Reimbursement Policy addresses coding guidelines for all E/M codes with special sections for the ER/ED place of service.

As of Jan. 1, 2017, provider claims may be subject to review to determine whether the E/M codes submitted for reimbursement are consistent with the services rendered. Reviews may be performed pre- or post-payment and may require care providers to submit medical records. **The review will be limited to those care providers whose E/M coding practices appear to deviate significantly from those of their peers.**

Facilities are generally excluded from this program. If a facility submits charges on a professional claim (e.g., CMS 1500), that claim would fall within the scope of this program. The policy is consistent with the terms of your provider participation agreement and the Centers for Medicare & Medicaid Services coding and billing guidelines required by federal law. This policy does not represent a change to the claims submission process with UnitedHealthcare.



CERT Audit

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE
PART A INTERMEDIARY/PART B CARRIER

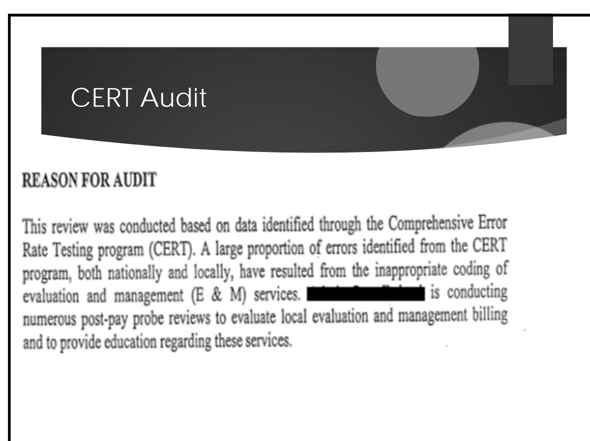
PART A BENEFICIARY 1-877-602-2430
PART B BENEFICIARY 1-800-622-4792
PART A PROVIDER 1-866-419-9457
PART B PROVIDER 1-866-250-5665

CERTIFIED MAIL

Provider Number

Dear Dr. :

Thank you for your cooperation during the postpayment audit of claims submitted by your office to Medicare. Based on this review, has reopened claims in accordance with the reopening procedures at 42 CFR 405.841, and has made an estimated determination that you have been overpaid in the amount of $1,169.90. This audit involved your Provider Number You had a provider error rate of 30%. The following information should answer any questions you may have.



CERT Audit

REASON FOR AUDIT

This review was conducted based on data identified through the Comprehensive Error Rate Testing program (CERT). A large proportion of errors identified from the CERT program, both nationally and locally, have resulted from the inappropriate coding of evaluation and management (E & M) services. is conducting numerous post-pay probe reviews to evaluate local evaluation and management billing and to provide education regarding these services.

CERT Audit

HOW THE OVERPAYMENT WAS DETERMINED

A randomly selected sample of forty claims for evaluation and management codes for emergency room care, with dates of service from January 1, 2012 through June 30, were selected for audit. The claims selected were for **CPT 99283 - 99285**[1]. The purpose

of the audit was to determine if the services billed were reasonable and necessary and met other requirements for Medicare coverage. Our medical review staff examined the submitted documentation for the selected claims.

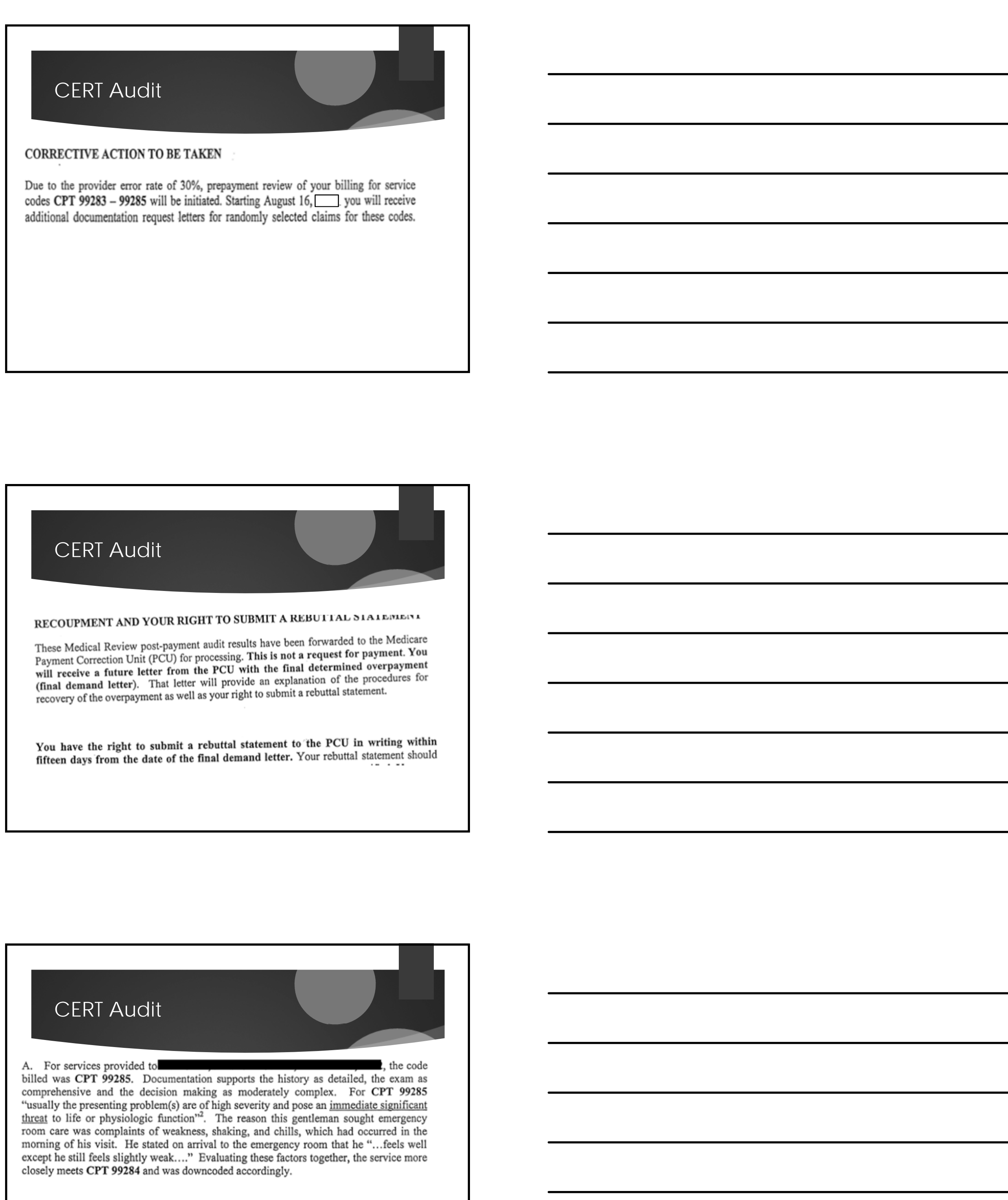
CERT Audit

MEDICAL REVIEW AUDIT DETERMINATION

You have received Medicare payment in error for an estimated overpayment of $1,169.90 for forty-four services on forty claims dated January 1, through June 30 **This is not a request for payment. The Overpayment Recovery Unit will determine the actual overpayment when all claim adjustments are considered.**

CERT Audit

A total of forty-four evaluation and management/emergency room services were examined. Sixteen services were allowed as billed. Thirteen services were downcoded from **CPT 99285** to **CPT 99284**. Six services were downcoded from **CPT 99284** to **CPT 99283**. One service was downcoded from **CPT 99284** to **CPT 99282**. Three services were downcoded from **CPT 99285** to **CPT 99283**. One service was downcoded from **CPT 99283** to **CPT 99282**.



CERT Audit

CORRECTIVE ACTION TO BE TAKEN

Due to the provider error rate of 30%, prepayment review of your billing for service codes **CPT 99283 – 99285** will be initiated. Starting August 16, [redacted] you will receive additional documentation request letters for randomly selected claims for these codes.

CERT Audit

RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT

These Medical Review post-payment audit results have been forwarded to the Medicare Payment Correction Unit (PCU) for processing. **This is not a request for payment. You will receive a future letter from the PCU with the final determined overpayment (final demand letter).** That letter will provide an explanation of the procedures for recovery of the overpayment as well as your right to submit a rebuttal statement.

You have the right to submit a rebuttal statement to the PCU in writing within fifteen days from the date of the final demand letter. Your rebuttal statement should

CERT Audit

A. For services provided to [redacted], the code billed was **CPT 99285.** Documentation supports the history as detailed, the exam as comprehensive and the decision making as moderately complex. For **CPT 99285** "usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function"[2]. The reason this gentleman sought emergency room care was complaints of weakness, shaking, and chills, which had occurred in the morning of his visit. He stated on arrival to the emergency room that he "…feels well except he still feels slightly weak…." Evaluating these factors together, the service more closely meets **CPT 99284** and was downcoded accordingly.

CERT Audit

This is an 87 year old gentleman who awoke this morning with some shaking spell. He felt like he had a shaking spell and has fever. He states after he woke up, he had this shaking spell and now feels well except he still feels slightly weak. Regarding the fever, he denies any headache, neck pain, neck stiffness, sore throat, nasal congestion, hoarseness, or stridor and the patient denies any cough, congestion, sputum, hemoptysis, or shortness of breath. The patient denies any cardiovascular chest pain, palpitations, syncope, PND, or orthopnea. GI: States that he did have "dry heaves" three or four times. He actually has no actual vomiting; however, there is no diarrhea. They did eat at O'Charley's yesterday and they both ate the same thing and no other sick contacts. No diarrhea. No abdominal pain. No urgency, frequency, dysuria, hematuria and no skin rashes and no joint swelling or inflammation.

PAST MEDICAL HISTORY: One of long-standing hypertension. Back pain and right hip surgery.

SOCIAL HISTORY The patient is does not smoke, drink or use drugs. He lives with his wife.

CERT Audit

PHYSICAL EXAMINATION Reveals a very pleasant 87 year old gentleman with temperature of 102. The blood pressure 148/64.

CNS: The patient is awake, alert and aware of surroundings. There are no focal findings. Cranial nerves II through XII grossly intact. Thyroid not palpable. Trachea midline. Moist mucous membranes . Conjunctivae of the lids without redness, swelling or edema.

CHEST: Essentially clear without wheezes, rales, or rhonchi. There is no consolidation.

CARDIOVASCULAR: S1 and S2 normal and no S3 or S4 and no murmurs, rubs or heaves.

ABDOMEN Soft and nontender and normal bowel sounds. No hepatosplenomegaly and no hernias. No aneurysms, good femoral pulses.

EXTREMITIES: Without edema, cyanosis. No calf pain and Homans is negative.

SKIN: Healthy.

PSYCHIATRIC: Oriented times 3. Appropriate.

CERT Audit

COURSE IN THE EMERGENCY DEPARTMENT: With the fever of 102, we elected to check a couple blood cultures. Those are obviously pending. The chest x-ray is reviewed by myself and this showed chronic obstructive lung disease. I did not see any acute pneumonia. I was able to find old x-rays actually from the

film library and this showed some changes in the apices. I have discussed this with the radiologist who felt that this was still chronic change without any significant pathology. Again, urine was negative. The white count was 10.8, the hemoglobin of 13.6. Comprehensive metabolic without any changes. The glucose was 111, sodium of 136.

At this stage, I really think this is probably just a viral illness without any localized finding of infection. The patient doesn't have any neck stiffness and no URI symptoms. No urinary tract symptoms. He just had a couple episodes of dry heaves. I suspect this was viral, although with an 87 year old gentleman I am a little uncomfortable with just saying this. He certainly does not have any left lower quadrant pain to suggest diverticulitis. We have elected to go ahead and just give him a gram of Rocephin and then will wait for his cultures. I suspect they will be negative. Gave him fever instructions thereafter and follow up with his doctor.

CERT Audit

- 44 charts reviewed.
  - CMS agreed with client on 16 charts
  - 20 were 1 level downcodes
  - 4 were 2 level downcodes
  - 4 denied as billed by wrong provider
- Consultant agreed with CMS on 20 of the 24 downcoded charts.

Utilization Audit

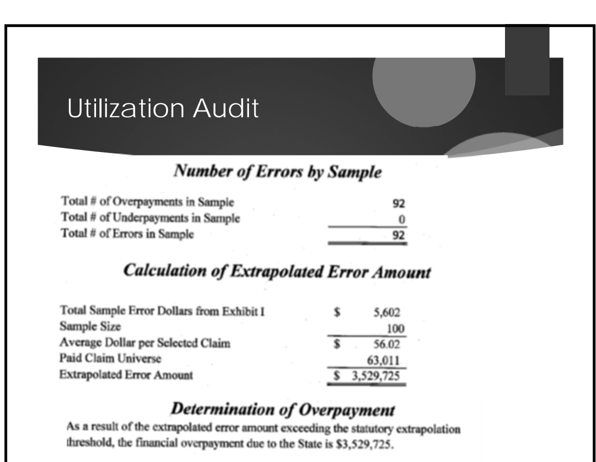
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF QUALITY ASSURANCE - AUDIT DIVISION

This letter is to provide you with thirty days' notice that the [redacted] Department of Social Services, Office of Quality Assurance (the "Department") will be performing an audit of Medical Assistance paid claims for services rendered by [redacted] during the period of 1/1/2011 through 12/31/2013.

Enclosed is the final report covering our audit of Medicaid claims paid during the period January 1, 2011 through December 31, 2013.

The final report shows that the overpayment due to the Department of Social Services is $3,529,725. Except as explained below, within 45 days from the receipt of this report, the Department will instruct HP to deduct this amount from future payments to the provider identified above.

Utilization Audit



Number of Errors by Sample

Total # of Overpayments in Sample	92
Total # of Underpayments in Sample	0
Total # of Errors in Sample	92

Calculation of Extrapolated Error Amount

Total Sample Error Dollars from Exhibit I	$ 5,602
Sample Size	100
Average Dollar per Selected Claim	$ 56.02
Paid Claim Universe	63,011
Extrapolated Error Amount	$ 3,529,725

Determination of Overpayment

As a result of the extrapolated error amount exceeding the statutory extrapolation threshold, the financial overpayment due to the State is $3,529,725.

Qui Tam / Whistleblowing

- ***qui tam pro domino rege quam pro se ipso in hac parte sequitur***, meaning "he who sues in this matter for the king as well as for himself."
- The **False Claims Act** allows people who are not affiliated with the government to file actions claiming fraud against the government

Whistleblower #1

INTRODUCTION

1. For more than ten years, the above-named Defendants have created, employed, operated and contracted with fraudulent billing systems designed to systematically overcharge federal and state health care systems, including Medicare and Medicaid.

2. The fraudulent overcharges were achieved primarily by "upcoding" medical patient interviews and examinations, e.g., regularly charging for more complicated and more expensive activities or procedures than those actually performed by physicians and other health care providers in emergency rooms and urgent care facilities.

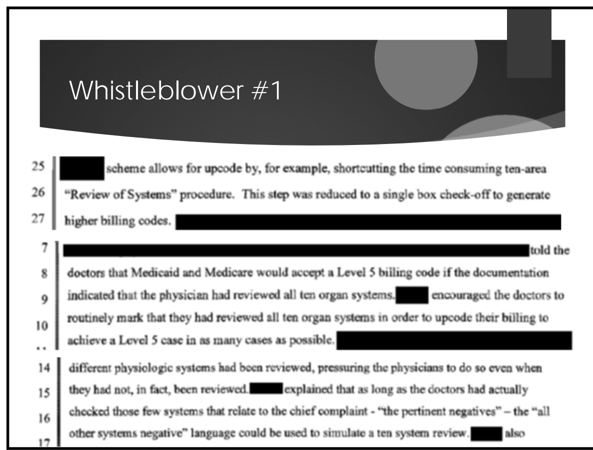
3. By creating false and misleading medical records and correspondingly upcoded billing records, and by actively falsifying medical and billing records, Defendants intended to, and did, misstate amounts due to be paid by federal and state health care systems.

4. This action is brought under the Federal False Claims Act, 31 U.S.C. §3729, et seq. and the various state false claims statutes.

Whistleblower #1

12. During the time period described in this Complaint, Relator has worked as a physician responsible for interviewing patients, investigating their ailments, and treating them. Through his work, Relator acquired direct personal knowledge of and non-public information about the Defendants' fraudulent billing of federal and state health care systems.

22. [redacted] provides forms and strategies for maximizing revenue as a result of upcoding emergency room and urgent care medical services, which are designed to rearrange and misstate basic information to make it appear complex. [redacted] originated the scheme of fraudulent conduct alleged in this case by designing a billing system – including charting templates, billing forms, order sets and later computer augmentations – that compromises patient care and physician responsibilities in order to "simplify" billing and enable more efficient upcoding and overbilling. [redacted] designs charting templates that falsely or inaccurately record interviews, observations, examination procedures, and medical diagnoses performed by physicians and other health care providers.



Whistleblower #1

25 [redacted] scheme allows for upcode by, for example, shortcutting the time consuming ten-area
26 "Review of Systems" procedure. This step was reduced to a single box check-off to generate
27 higher billing codes. [redacted]

7 [redacted] told the
8 doctors that Medicaid and Medicare would accept a Level 5 billing code if the documentation
9 indicated that the physician had reviewed all ten organ systems. [redacted] encouraged the doctors to
10 routinely mark that they had reviewed all ten organ systems in order to upcode their billing to
achieve a Level 5 case in as many cases as possible. [redacted]

14 different physiologic systems had been reviewed, pressuring the physicians to do so even when
15 they had not, in fact, been reviewed. [redacted] explained that as long as the doctors had actually
16 checked those few systems that relate to the chief complaint - "the pertinent negatives" – the "all
other systems negative" language could be used to simulate a ten system review. [redacted] also

Whistleblower #2

1. This is an action to recover damages and civil penalties on behalf of the United States of America, for violations of The False Claims Act arising from Defendants, their agents, employees, co-conspirators, or any combination thereof, knowingly presenting, or causing to be presented, false claims for payment or approval and knowingly making, using, or causing to be made or used, a false record or statement material to false or fraudulent claims for reimbursements made to the Federal Medicare and Medicaid programs.

11 [redacted] knowingly presented or caused bills to be
12 presented to Medicare and Medicaid for services claimed to be provided by Dr. [redacted]
13 which were actually performed by Physician Assistants and/or Nurse Practitioners. These

Whistleblower #2

Wherefore, qui tam plaintiff prays for the following relief:

A. Full restitution to the United States of all money damages sustained;

B. For three times the dollar amount proven to have been wrongfully sold to, paid by, or withheld from the United States;

C. For maximum civil penalties for all false records, statements, certifications and claims submitted to the United States;

D. For costs of suit, reasonable attorney's fees and the maximum relator share; and

E. For such other and further relief as the Court deems just and proper.

JURY DEMAND

Qui Tam Plaintiff hereby demands trial by jury.

Whistleblower #3

I. INTRODUCTION

1. Plaintiffs file this *qui tam* action against the Defendants for themselves and on behalf of the United States under the False Claims Act (FCA), 31 U.S.C. § 3729 *et seq*, and seek to recover damages and civil penalties from the Defendants for violations of the FCA based upon Defendants' presentment of false claims to the United States for medical services and procedures allegedly performed by Defendants in the treatment of Medicare, Medicaid, and Tricare patients.

Whistleblower #3

13. Plaintiff was employed by [redacted] She work under the title of Billing and Office Manager put her duties included coding the patient charts and preparing the claims for filing by the 3rd party billing company [redacted]

VI. Defendants' Fraudulent Conduct

24 Since at least 2013, false claims for medical services have been fraudulently and knowingly presented at the Defendants ' directions to government health care programs by [redacted] in numerous instances where (1) Nurse Practitioner (NP) and Physician Assistant (PA) services were billed under the name of and with the provider number of the attending physician who did not treat or evaluate the patients, (2) Nurse Practitioner (NP) and Physician Assistant (PA) services were billed under the name of and with the provider number of the attending physician who simply cosigned the patient chart without documenting their evaluation of the patient.

Appeal, Appeal, Appeal

- Always file at least one appeal of any findings that lower the assigned E&M code or decrease the reimbursement for services rendered.

Key Hot Spots in ED E&M

- ▶99283 vs 99284
- ▶99284 vs 99285
- ▶Medical necessity is the key.
  - ▶No longer a numbers game of counting elements.

Easy Targets for Refunds

▶ PA / NP services
- Insufficient MD documentation to support billing E&M as shared service.
- Billing MLP procedures as MD service.

▶ Teaching Physician Services
- There is not a one-size fits all attestation
- E&M, Procedures, Interpretations & Critical care all have different requirements.

Easy Targets for Refunds

▶Tissue adhesive repairs reported to Medicare as suture repair.
- Medicare requires G0168

▶Scribes in the ED
- Insufficient MD validation of scribe notes.

Q
Q
&
A
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