



Compliance-Matters!

A Quarterly Newsletter from the Morehouse School of Medicine Office of Compliance and Internal Audit
April 2009

Why Do Audits?

During these challenging financial times and decreasing Medicaid and Medicare funds, the government is targeting healthcare for fraud in an effort to recoup monies that may be inappropriately paid to healthcare providers. The Centers for Medicare and Medicaid have contracted with Medicare Audit Contractors (MACs) to routinely audit providers. Many institutions are putting into place special teams to respond to these audits.



One major component of the Compliance Program of Morehouse School of Medicine and Morehouse Medical Associates is auditing. The Compliance team audits for the following reasons:

- To ensure Compliance with Federal regulations and Institutional policies and guidelines
- To help enforce coding guidelines
- To identify problem areas
- To identify potential risks
- To reveal hidden errors
- To correct deficiencies

This month's article focuses on auditing medical records. Revenue and compliance are the objectives of auditing so auditors examine coding practices for lost revenue and appropriate payment compensation. Improper use of codes and inappropriate billings and patterns address Compliance issues. A medical record audit targets the following:

- Services not billed or reported
- Undocumented services
- Denied or downcoded services
- ICD9 codes not justified with documentation
- Current patient data
- Physician signature and Resident supervision
- Signed consent forms/ABN/Insurance forms



There are three types of audits: Prospective, Retrospective and Focused. Prospective audits occur prior to claim submission. The auditor reviews the superbill with documentation. The consequence of this type of audit is that it slows down claims submission. However, mistakes can be rectified prior to submission. Retrospective audits occur after billing. Auditors review the superbill, documentation and payments. Oftentimes, retrospective audits could lead to refunds. Any such outcomes must be addressed and handled timely. Focused audits can occur pre-payment or post-payment. These audits generally are done to review medical necessity, excessive services or questionable patterns in billing.

Internal auditing may reveal system errors or the need for additional training. It is vital that once audits are completed, results must be summarized, analyzed and communicated to the appropriate team members in a timely manner. In addition, if refunds or overpayments have occurred, this must be corrected. The MSM/MMA compliance team will be initiating the audit process following a shadowing and training period. During the interim, billing coders should aggressively audit their providers on a random basis. The following tools should be utilized when auditing: E/M guidelines, CPT, ICD-9-CM, HCPCS level II books, payor guidelines, payment policies, coding supplemental and AHA Coding Clinic references.

**MMA/MSM COMPLIANCE
LINE**

1-888-756-1364

“DO THE RIGHT THING”

**Corporate Compliance
& Ethics Week**

May 26 - 29, 2009

Join Compliance for break-
fast and lunch sessions

TBA

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**FOR MORE INFORMATION,
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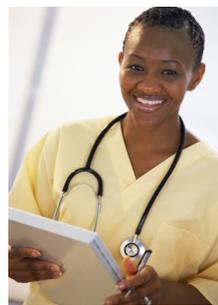
Don't use "here for a refill" or "needs refill"

A chief complaint (CC) is always noted in the medical record. Though the CC is stated per the patient and oftentimes recorded by the triage nurse, providers should always probe deeper and re-document the chief complaint. When patients present to the office "for a medication refill," providers should make sure that documentation includes the condition for which the medication refill is being considered. If documentation isn't clear, such a chief complaint may generate a denial or question medical necessity. Generally, such patients' conditions are more involved requiring exams and medical decision making.

Put a stop to stamped signatures once and for all

Hospitals cannot accept stamped physician signatures under any circumstances. A recent publication, *MLN Matters article SE0829*, states that "stamped signatures are not acceptable on any medical record." Medicare will accept handwritten, electronic signatures, or facsimiles of original written or electronic signatures. If a signature stamp is used, it must be supported by a dated and signed signature and used for legibility purposes only.

Billing for Evaluation and Management codes



The level of a selected CPT code is determined by the documentation of the three components, *History, Exam, Medical decision making*. The medical decision making should drive your code selection. If you have a detailed MDM (99214), you must meet or exceed that level for the history or exam. If your MDM is a level 4 and your exam based on medical necessity is a level 3, your visit will be downcoded to a level 3. You must meet or exceed the level selected according to the documentation based on medical necessity.

CIGNA bulletin boosts importance of good physician documentation

A recent bulletin from the Centers for Medicare and Medicaid Services (CMS) carrier Cigna should add an extra impetus for reluctant physicians unwilling to document to a higher degree of specificity. Documentation of the three elements of E/M – patient history, physician medical decision making, and the exam itself – is separate and distinct from documentation of medical necessity, according to the bulletin. In other words, carriers will deny physician payments for services such as initial and subsequent inpatient visits, if the services aren't supported by good documentation demonstrating the medical necessity of those visits.

Honeypots - a sweet tool used to monitor snooping staff

It doesn't matter whether a staff member peeks at the medical record of Usher, Tiger Woods, Barack Obama, or your next-door neighbor - inappropriate access to medical information is a HIPAA violation.

The seriousness of this problem has led some institutions and other HIPAA covered entities to enhance their investigations. Instead of simply monitoring system access logs, they're using "Honeypots" as bait to catch snooping staff members. Honeypots are fictitious medical records that information technology staff monitors to determine whether anyone is accessing them. Don't snoop!