Compliance-MATTERS!

A Monthly Newsletter from Morehouse School of Medicine Office of Compliance

MARCH 2007

# CHECKLIST FOR COMPLIANT CODING IN YOUR PRACTICE

Change is constant in the world of coding and billing. Every medical practice should be in tune with current guidelines and ensure its adherence to those guidelines. The Office of the Inspector General (OIG) released the final OIG Compliance Program Guidelines for Individual and Small Physician Practices in 2000. While practices are not mandated to have a formal plan, they should have the confidence that they are meeting coding and billing standards and are compliant with all rules and regulations. A practice's focus on patient care can be enhanced by the adoption of a voluntary compliance program. For example, the increased accuracy of documentation that may result from a compliance program will actually assist in enhancing patient care. Review the following checklist to assess your practice's compliance with coding and billing requirements.

- Does the practice have current coding manuals?
- Do you keep reference newsletters, advisory resources, blast resources from the compliance office, and all major payers on hand? Are these accessible by employees and providers?
- Is there a system for regular audits and reviews to detect and correct billing errors, denials, reductions in payment, or other problems?
- Has your practice conducted medical record documentation and coding reviews? Do you use templates or documentation aides to assist with good documentation? Have you considered establishing a peer-review committee for addressing documentation problems?
- Is ongoing coding and compliance education provided to staff and physicians? Do you maintain records of attendance at educational programs?
- Do you have a current practice policies and procedures manual? Are employees aware of the manual and its location? Are all new employees required to read the manual?
- Does your practice have a policy for open lines of communication so that employees are able to come to the physician or a designated person for questions, suggestions, or concerns about possible areas of noncompliance?
- Are regular meetings held with physicians and staff to discuss practice management and billing issues?
- Are you compliant with HIPAA, the Anti-Kickback Act of 1986, and the Stark II regulations?

If you answered "no" to any of these questions, now is the time to update your policies and procedures! Maintaining a compliance program in your practice will help ensure adherence to coding, billing, and documentation guidelines and submission of accurate claims. The overall benefit may be increased reimbursement with decreased risk. It also encourages employees to report any misconduct.

Ref: Academy Coding Edge, November 2006

Student documentation cannot be used for billing purposes. Providers can only reference student documentation of Review of Systems and Past Family Social History. Attending physicians must link their notes to the residents' documentation in addition to attesting their involvement with the key components of the patient encounter. **Physical presence** of the attending must be evident within the documentation. The timing of attending documentation also should be clearly documented **during or after the patient visit**.

**CONFIDENTIAL DISCLOSURE LINE**
**1-888-756-1364**
**MMA/MSM COMPLIANCE LINE**

**Report suspected noncompliance in the workplace.**

**It's your responsibility to to do the right thing by being compliant!**

**COMPLIANCE EDUCATION**

Consultations:
"A straight look at how CMS rules affect your coding "
Wednesday, March 14, 2007
1 p.m. - 2 p.m.

"ABCs of 99211-99215: How to Make Sure You Code at the Right E/M Level "
Wednesday, April 4, 2007:
1 p.m.. - 2 p.m.

Provider audit review sessions
February - March 2007

**FOR MORE INFORMATION PLEASE CONTACT**

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# Q & A

When is a patient a "new patient?" How does the three-year requirement for a new patient apply to members of groups?

A. The CPT defines a new patient as one who has not received any professional services from the physician within the past three years.

For medical payment purposes, CMS interprets the term "physician" to include all physicians practicing in the same group, in the same specialty, and billing with the same billing number. If any member of a group has seen a patient and billed a visit or consultation within three years, the patient is considered "established."

Is it a HIPAA violation to take patient charts home or on vacation to complete dictation?

A. The privacy and security rules do not explicitly prohibit a provider from taking charts off site. Instead, covered entities must establish policies, procedures, and practices that reasonably ensure the integrity, confidentiality, and availability of the information. This means ensuring that:

- The chart is secure at all times (e.g. in transport, when stored off site)
- In this case, no one other than the provider has access to the chart
- Processes are in place to access the information in the event of a disaster

It is well within a covered entity's rights to impose security policies, procedures, and practices that prohibit providers from transporting patient charts off site. Such practices may pose too great a risk to the integrity, confidentiality, and availability of PHI because there are a number of increased risks when transporting data off site.

# DIAGNOSIS CODING FOR PROVIDERS

- Base the diagnosis on the highest degree of certainty at the time of the encounter. In the absence of a definitive diagnosis, report signs and/or symptoms.
- The primary diagnosis is the one that carries the highest degree of risk and is chiefly responsible for the services provided.
- Chronic conditions should be reported if the condition is addressed and treated during the encounter.
- When there is a definitive diagnosis, do not report signs/symptoms.
- Do not report a secondary diagnosis if it is inherent to the primary diagnosis.
- Never report rule out, possible, probable, or suspected conditions to a diagnosis. If there is no definitive diagnosis, code signs/symptoms. Code to the highest level of specificity. Some codes require fourth and fifth digits.