



# Compliance-Matters!

A Monthly Newsletter from the Morehouse School of Medicine Office of Compliance  
September 2008

## CODE LEVEL IV WITHOUT FEAR

Routine medical record audits often reveal undercoding by providers. MMA audits reveal adequate documentation yet physicians under code the level of service provided. Providers frequently state “it only took a few minutes and was simple management.” Not only does this negatively impact audit scores but there is money left on the table. Documenting a 99214 for an established patient is quite simple. Providers need to include 2—7 areas/systems for the exam and 3 chronic conditions **or** a new problem without a workup along with prescription drug management.



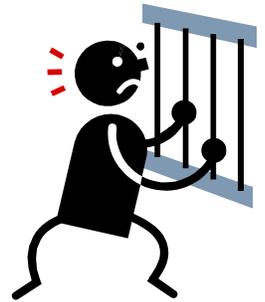
Ask the question, what is the level of acuity of my patient base? If you want to increase your revenue by \$15,000 annually, **take a moment** in your busy day to contact the Compliance Office or your billing staff consultant to assist with adequate coding and documentation.

## MSM/MMA COMPLIANCELINE

1.888.756.1364

It's your duty to report questionable practices

False Claims Act (FCA) cases are the fastest growing area of federal litigation. Under the category “healthcare fraud,” the Department of Justice obtained \$1.5 billion in settlements during fiscal year 2007 while pursuing FCA violations. Most of this amount arose out of cases involving whistleblowers.



## FALSE CLAIMS ACT VIOLATIONS

Varied acts are considered illegal under the False Claims Act. Examples of acts that are considered violations and have been litigated in court include:

- Billing for services not rendered i.e. “Annual Physical Exams” and “Healthchecks” require documented components. The reimbursement fee is based on all components of the billed CPT code.
- Upcoding i.e. billing for consults rather than new or established patients
- Misrepresenting diagnoses to justify services provided
- Performing and billing services not medically necessary i.e., labs, urinalysis, etc.
- Submitting claims for payment for services that fail to meet regulatory standards of care

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

Report suspected  
non-compliance in the  
workplace.

It's your responsibility to  
maintain a culture of  
"DO THE RIGHT THING"

### Monthly and Bi-Monthly Compliance Sessions

OB: 3rd Tuesday monthly

Pediatrics: 3rd Wednesday

Family Medicine: 4th Wednesday

Surgery: Every other month

CH/PM: TBA

Psychiatry: Every other month

DOM: 3rd Monday and Wednesday

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## PQRI BONUS CHECKS ARE IN THE MAIL ~~~PQRI IN A NUTSHELL~~~

CMS has mailed out over \$36 million in bonus payments in the past month. According to CMS, the incentive payment for 2008 will be 1.5 percent of the total allowed charges for covered services provided during a measured period. In 2008 PQRI, there are a total of 119 measures that eligible professionals can select from: 117 clinical quality measures, and two structural measures (use of Electronic Medical Records and E-prescribing). Incentive payments earned will be paid to the "Taxpayer Identification Number" under which the incentive-earning professional submitted PQRI claims. Currently, PQRI scoring is tied only to volunteer reporting. Ultimately, CMS envisions tying payment to successful performance of these measures. Regardless of the payor mix and the bonus, MMA should be proactive in preparing providers and coders for documentation of quality measures. According to CMS, there may be no cap on incentive payments for 2009.

For accurate PQRI reporting, one would need to report the proper diagnosis and appropriate CPT code for the service based on CMS documentation guidelines, and then choose a category II code for tracking purposes. Each PQRI measure has specific CPT and ICD-9 requirements. If an encounter meets these requirements, and the proper category II code is selected, a quality report /claim is submitted.

**Coding Example:** Dr. Crawford, an internist, chooses to report on PQRI measure 1, Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus. For measure 1, the patient must have one of these diagnoses; 250.00—250.93, 648.00—648.04. When Medicare sees a combination of the above codes, it will look for a PQRI report. Dr. Crawford provides a level four visit, 99214, to a patient with type II diabetes and a most recent hemoglobin A1c of 10.0 percent. On the claim, CPT 99214 will be linked to 250.02. To qualify for PQRI, Dr. Crawford then selects a category II code. According to Medicare requirements, Dr. Crawford should include 3046F (most recent HgbA1c level greater than 9.0% [DM]) on the claim to meet PQRI standards. There are category II codes for each of the measures.

**In a nutshell:** For accurate Measure 1 reporting, this example's claim should contain 99214 linked to 250.02 and 3046F. In January 2009, to assist physicians and coders complying with PQRI, the revised billing encounters will include PQRI coding for selected measures. To receive the Medicare bonus, providers will have to report on at least 80 percent of cases for three measures on the PQRI list. In collaboration with the Department chairs or designees, Dr. Sanders will coordinate the MMA PQRI measures for encounter form revisions.