Set the Record Straight

OXFORD

August 2016

Common HIM Errors Related to Nursing Facility Services

By: Melody Czapski, Oxford HIM Auditor

I recently attended the "A Day with Medicare" seminar. One of the more interesting and educational sessions was on Skilled (SNF) and non-skilled Nursing Facility (NF) services. The Medicare contractor did not just reiterate the regulatory guidelines, but focused on the most common errors found in recent CERT (Comprehensive Error Rate Testing) results. Below is a summary of the problem areas.

CERT Errors

- ◊ Insufficient documentation
- ◊ Incorrect coding
- ◊ Medically unnecessary service or treatment
- ◊ Services billed were not rendered
- ◊ Improper documentation
- ◊ Legible identity of the provider
- ◊ Incorrect place of service

Examples:

1. Claim billed by the physician for initial visit does not match the documentation and signature of the individual who authored the note.

a. As a reminder, CMS does not allow Incident-to and Shared/split visits with Nursing Facility (both SNF and NF) E/M services.

2. Medically Necessary Visits, both Initial and Subsequent, were not supported.

a. The NPP visit prior to Physician's initial visit was not medically necessary. Documentation did not support a significant illness or injury requiring an evaluation prior to the Physician's initial visit. There are instances where a NPP visit prior to the physician's initial that would support medical necessity, but these would be exceptions not the norm.

b. When performing a federally mandated Subsequent NF visit, in most instances the patient is stable, orders in place and no new complications. The level was not supported, or over-coded.

3. An E/M visit required by state law or other administrative purposes is not separately payable.

a. In this instance, a modifier –GY would be appended to the SNF E/M visit and the patient would be responsible for the charge.

4. Incorrect Place of Service

a. A designated office in the nursing facility (NF) would be billed with POS 11

In This Issue:

Health Catalyst: 80% of Hospitals Unprepared for Medicare Patient-Reported Outcomes

The small percentage of hospitals already tapping into the CMS PROs are tracking chronic care management, surgical interventions, mental health and cancer treatments. And there is evidence more healthcare entities will get in the game soon.

By: Bernie Monegain | August 2, 2016 | Healthcare IT News

Fewer than one-fifth of U.S. hospitals indicate they regularly review the patient-reported measures to guide medical care, according to a new survey from Health Catalyst. That's despite Medicare forging ahead with its plan to incorporate patient-reported outcomes – PROs – in its new payment system.

The Centers for Medicare and Medicaid Services, in fact, has already begun to calculate how much healthcare providers should be paid using the patient's own views of their health as a yardstick. It means that providers whose patients report significant improvements in health could be paid more than those whose patients report problems.

PROs were first incorporated into a new CMS program designed to lower the cost of knee and hip replacements. And the measures are bound to become more prevalent as a key piece of the proposed Merit-based Incentive Payment System that aims to restructure how Medicare pays for medical services.

"Patient-reported outcomes are critical to enabling healthcare's evolution from focusing on the volume of services delivered to the value created for patients," Health Catalyst senior vice president Paul Horstmeier said in a statement. "Their use promises seismic changes not only in the way providers are paid, but how they measure success, how patients choose their doctors, and most importantly how clinical outcomes are improved."

Health Catalyst conducted its online survey of 100 clinical and administrative executives in health systems of all sizes across the country and the research revealed that just 18 percent always use PROs to guide clinical care. But the analytics and data

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(office). A designated office in the skilled nursing facility (SNF) would be billed with POS 31 (SNF). Remember, even if the patient is transported from the SNF to a physician office by the SNF, the physician's office would still bill with POS 31.

Initial Comprehensive Assessment (99304 – 99306):

SNF: Place of Service 31

Must be completed by a MD/DO. Cannot be delegated to another provided, for example a Non-Physician Practitioner (NPP).

Cannot be performed as a split/shared service between the physician and NPP.

NF: Place of Service 32

Can be performed by the Physician or NPP. The NPP cannot be employed by the facility. The NPP is under a collaboration arrangement* with the Physician. The Physician or NPP who performed the Initial care would submit service under his/her provider number.

**Collaboration is not a split/shared service. Collaborative partnerships are agreements and actions made by consenting organizations to share resources to accomplish a mutual goal. Collaborative partnerships rely on participation by at least two parties who agree to share resources, such as finances, knowledge, and people. (Ref: wikipedia.org)*

Subsequent Comprehensive Assessment (99307 – 99310):

1. Used for both medically necessary and federally mandated visits (every 30 days for the first 90, every 60 days thereafter).

a. When performing a federally mandated visit, usually the patient is stable, orders already in place, no new acute episodes, versus physicians or NPP who are called in for complications, in which you could support a higher level E/M.

2. Alternate visits may be performed by the NPP.

3. The physician does not have to counter-sign the documentation. The services can be billed under the NPP provider number.

Discharge Services (99315 – 99310):

1. Time based, usually includes a final exam but not required and is billed on the date of the actual face-to-face encounter.

There are occasionally instances where the patient may stay after the physician performs the discharge assessment (e.g., 99316). In these situations, if a medically necessary visit is required, after the discharge service, the physician can bill for a subsequent NF visit. Keep in mind that this is not the norm, and the documentation must support the visit. For example, if a patient awaiting discharge suddenly develops a significant condition, and the physician delays the discharge to perform a subsequent visit (e.g., 99307), both visits would be appropriate.

Reference:

Seminar, WPS, Government Health Administration, "A Day with Medicare," 8.23.2016

Health Catalyst Article

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warehousing vendor also found that hospitals are preparing for the change. Nearly three-fourths – 72 percent – of survey takers indicated plans to use patient-reported outcomes within one to three years.

That said, survey respondents indicated time and money as chief barriers to deploying PROs. Other barriers included fitting PROs into clinicians workflow.

Among the 18 percent of participants who said their organizations are currently using PROs, 59 percent apply them to chronic care tracking and 58 percent to surgical interventions, while 27 percent use them for mental health purposes, and 22 percent for patients undergoing cancer treatments.

Hospitals and clinicians use PROs to gauge patient's quality of life, considering symptoms and cognitive, physical and social functioning.

"The question is no longer whether someone will survive, but how their life will be after treatment," added Caleb Stowell, MD, vice president of Standardization and Business Development for the International Consortium for Health Outcomes Measurement.

Reference:

http://www.healthcareitnews.com/news/health-catalyst-80-percent-hospitals-unprepared-medicare-patient-reported-outcomes

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Consultant Spotlight

Henock A., CDI Consultant, MD, MPH, CCDS, CCS

As an International Medical Graduate with over twelve years of clinical/surgical experience, Henock started working as Clinical Documentation Specialist in Orange County hospitals in California and eventually landed with Oxford HIM in August of 2015. He also holds an MPH from The Johns Hopkins University as well as CCS and CCDS certification.

Currently Henock works as a Contract HIM CDI Consultant for Keck Hospital of USC in Los Angeles. He appreciates working with his recruiter Victor Sanchez, who is the reason he joined Oxford. He is happy with his time with Oxford HIM thus far and looks forward to what the future has to offer.

In his spare time, Henock enjoys watching movies, especially cartoons and animated features.

Employee of the Month

Cameron Moya, CDI Recruiter

Born in Riverside, California, Oxford CDI Recruiter Cameron Moya grew up in Rancho Cucamonga, a suburb of Los Angeles where the show "Workaholics" and the movie "Friday after Next" are set.

Cameron attended Arizona State University, where he graduated with a B.S. in Political Science at the top of his class — literally, he was in the last row of the graduation picture. During his time at ASU, Cameron played rugby and participated in the Snowdevils, a snowboarding club.

After conquering the extreme temperature of the desert he moved to Hawai'i for a much needed cooler climate. Then, realizing that relaxing on the beach his entire life was not an acceptable career plan, Cameron moved back to California. This is when he joined Oxford HIM and was pleased to find a work environment that fit his desire for an active and productive lifestyle.

Says Cameron, "All of my coworkers are great and we love to see each other out side of work." He is excited to help Oxford HIM grow in the CDI staffing market.

News & Events

Are you going to AHIMA this fall?

Join us for a chat at booth #617!

AHIMA 2016

Baltimore, MD, October 15–19, 2016

New Oxford HIM PTO Benefit

Oxford HIM now offers full-time consultants the opportunity to take paid time off! The new PTO benefit comes in addition to holiday pay, 401(k) and medical insurance packages, paid travel and other benefits we provide.

If you have any questions, please contact your recruiter or email HIM@oxfordcorp.com.

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Refer a Colleague to Oxford HIM

Increase your cash flow by referring other HIM professionals to Oxford HIM!

You can earn **$500** for every qualified contract or direct hire candidate. The bonus will be paid to you after the referred contract employee has worked 120 hours or the direct hire employee has completed 90 days.

Please ask your recruiter for more details, or email referrals to lauren_pease@oxfordcorp.com.

Hot Jobs

- Onsite CDI Specialist—West Coast
- Onsite CDI Manager—West Coast
- Remote Inpatient Coder—Multiple Locations
- Remote Outpatient Coder—Multiple Locations
- Remote Profee Coder

Email Lauren_Pease@oxfordcorp.com today to learn more about these opportunities or refer a friend!

Who Knows?

How do new codes become part of the ICD-10 classification system?

Send your answers to:
Lauren_Pease@oxfordcorp.com

All correct answers will be put into a raffle for a chance to win a $25.00 Visa gift card.

Last Edition's 'Who Knows' Winner

And the winner is …

Jacquie B.!

Answer: Rx means "to take," from the Latin word "Recipe."