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# Coding & Billing Quarterly

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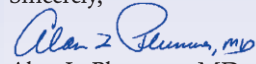
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## NOTES FROM THE EDITOR

Welcome to the third issue of the *ATS Coding & Billing Quarterly*.

Whether you have a long-standing compliance program or are a graduating Fellow going into a solo, small or large group, or academic practice, reviewing the source document of the OIG guidance on developing a compliance plan is helpful to all physicians and their coding and billing staff or outpatient billing companies.

Sincerely,



Alan L. Plummer, MD  
Editor



## DEVELOPING A COMPLIANCE PROGRAM FOR YOUR PRACTICE: THE BASICS

### INTRODUCTION

The Office of the Inspector General (OIG) has published a step-by-step approach for developing and implementing a voluntary compliance program for individual and small-group practices. Called a “guidance,” it is not a one-size-fits-all plan, but a set of guidelines. A practice can choose to incorporate some or all of its components in developing and implementing a compliance program for their medical practice.

The Centers for Medicare and Medicaid Services (CMS) developed the guidelines in 2000 in recognition of the fact that small medical practices often lack the financial resources and staff necessary to implement a full-scale, institutionally structured compliance program as exists in most hospitals where pulmonologists practice.

The purpose of voluntary compliance programs is to help practices submit clean claims and combat abusive or fraudulent submissions. Implementing a compliance program expedites proper reimbursement, minimizes billing mistakes, reduces the chances of being audited and avoids conflicts with the self-referral and anti-kickback statutes. It also helps to streamline business operations. To read the guidance in full, please visit the OIG’s Web site at <http://oig.hhs.gov/authorities/docs/physician.pdf>. This article summarizes this source document.

### FRAUD AND ABUSE

All healthcare providers have a duty to reasonably ensure that the claims submitted to Medicare and other federal healthcare programs are true and accurate. The False Claims Act, the statute under which most cases are brought against providers, prohibits physicians from submitting to the federal government a false or fraudulent claim for payment. This act only covers offenses that are knowingly committed or committed as a result of reckless disregard. It does not include mistakes, errors or negligence.

Both the OIG and CMS have noted that having an active compliance plan (not just on paper, but as an active part of practice activities) is critical to providing evidence that billing and coding are being done correctly.

## NEW G-CODES FOR THE HOME SLEEP STUDY TEST PORTABLE MONITOR

Following the approval of a National Coverage Decision addressed in the article in the last issue of *Coding and Billing Quarterly* on page 4, Medicare issued temporary “G” codes for reporting the three types of unattended home sleep monitoring devices.

Per Business Requirement 6087.2, contractors shall manually add the following HCPCS codes (G0398 through G0400) to their systems effective for dates of service on or after March 13, 2008.

### HCPCS Code Long Descriptor

<b>G0398</b>	Home sleep test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
<b>G0399</b>	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
<b>G0400</b>	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels

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## DEVELOPING A COMPLIANCE PROGRAM FOR YOUR PRACTICE: THE BASICS

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### OIG COMPLIANCE PLAN DEVELOPMENT

Before it published the guidance for individual and small-group practices, the OIG published one for third-party medical billing companies. If you use an external billing service, remember to ask to see its compliance plan to ensure that it contains current information on coding and reimbursement issues. The plan would show, for example, if a third-party company requires its staff to participate in yearly coding courses. To read the third-party guidance in full, visit <http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf>.

### BASIC PROGRAM COMPONENTS

There are seven basic components of a voluntary compliance program:

- 1) Conducting internal auditing and monitoring;
- 2) Implementing compliance and practice standards;
- 3) Designating a compliance officer or compliance contacts to monitor and enforce compliance;
- 4) Conducting appropriate training and education;
- 5) Developing appropriate responses to detected violations through investigation and disclosure;
- 6) Developing open lines of communication for staff; and
- 7) Enforcing disciplinary standards.

Reviewing these components provides an overview of the scope of a fully developed and implemented compliance plan.

#### I. Conducting Internal Auditing and Monitoring

You can perform two types of reviews—a standards and procedures review or a claims submission audit. For the former, it is recommended that an individual in the practice be charged with the responsibility of conducting periodic reviews of the practice's standards and procedures to determine if they are current and complete (see next section). If determined inadequate, the processes should be updated to reflect changes in government regulations or compendiums, such as updates to Current Procedural Terminology (CPT) and ICD-9-CM codes.

For a claims submission audit, bills and medical records should be reviewed for compliance with applicable coding, billing and documentation requirements of all major third-party payors. Claims can be reviewed either retrospectively or concurrently with the claims submission. The audits can be used to see if bills are being coded accurately, if documentation is being submitted correctly, and if the services provided are reasonable and necessary. The audit will also show if any incentives for unnecessary services exist.

A practice should judge its progress by charting either the reduction or the increase in claims paid and denied over time. As a basic guide for the minimum number of records that should be reviewed, audit five or more

medical records per federal payor (e.g., Medicare, Medicaid, Tricare, etc.), or audit five to 10 medical records per physician. At a minimum, claims that have been reimbursed by federal healthcare programs should be reviewed for accurate reporting of codes and complete documentation of the selected levels of evaluation and management (E/M) codes.

#### II. Implementing Practice Standards and Procedures

Writing standards and procedures for a practice will help reduce the prospect of erroneous claims and fraudulent activity by identifying risk areas for the practice, establishing tighter internal controls and identifying any aberrant billing practices.

Many physician practices already have policies and procedures in place regarding policy statements on patient care, personnel matters and procedures for complying with federal and state law. Practices that have not yet developed such standards should do so by writing a procedures manual and routinely updating clinical forms to ensure they facilitate clear and complete documentation. Creating a resource manual from publicly available information with relevant CMS and contractor directives may help in this process. All of this information should be routinely updated, easily accessible and continuously communicated to employees, particularly new employees.

For those just starting to develop practice standards, it is important to emphasize coding and billing, reasonable and necessary services, documentation (both medical records and CMS-1500 form completion) and improper inducements, kickbacks and self-referrals. Specifically, look for the following:

#### Coding and Billing Audit Risk Areas:

- Billing for items or services not rendered or not provided;
- Submitting claims for equipment, medical supplies and services that are not reasonable and necessary;
- Double billing, resulting in duplicate payment;
- Billing for non-covered services as if covered;
- Knowing misuse of provider identification numbers, which result in improper billing;
- Unbundling (billing for each component of the service, instead of billing or using an all-inclusive code);
- Failure to properly use coding modifiers;
- Clustering (charging one or two middle levels of service codes exclusively, under the philosophy that some will be higher and some will be lower); and
- Upcoding the level of service provided.

#### Ensure Accurate Documentation:

- The medical record is complete and legible;

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*“Physician compliance programs need not be time- or resource-intensive and can be developed in a manner that best reflects the nature of each individual practice.”*

- The documentation of each patient encounter includes the reason for the encounter; any relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression or diagnosis; plan of care; and date and legible identity of the observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services can be easily inferred by an independent reviewer or third party who has appropriate medical training;
- CPT and ICD-9-CM codes used for claims submission are supported by documentation and the medical record; and
- Appropriate health risk factors are identified. The patient’s progress, his or her response to, and any changes in treatment, and any revision in diagnosis is documented.

Proper Completion of CMS-1500 Claim Form:

- Link the diagnosis code with the reason for the visit or service;
- Use modifiers appropriately; and
- Provide Medicare with all information about a beneficiary’s other insurance coverage under the Medicare Secondary Payor (MSP) policy, if the practice is aware of a beneficiary’s additional coverage.

Risk Areas of Financial Arrangements:

- Financial arrangements with outside entities to whom the practice may refer federal healthcare program business;
- Joint ventures with entities supplying goods or services to the physician practice or its patients;
- Consulting contracts or medical directorships;
- Office and equipment leases with entities to which the physician refers; and
- Soliciting, accepting or offering any gift or gratuity of more than nominal value to or from those who may benefit from a physician practice’s referral of federal healthcare program business.

Compliance, Business and Medical Record Retention:

- The length of time that records are to be retained (federal and state statutes should be consulted);
- Medical records need to be secured against loss, destruction, unauthorized access, unauthorized reproduction, corruption or damage;
- Meet patient confidentiality of record requirements in HIPAA privacy standards; and
- Disposition of medical records in the event the practice is sold or closed.

**III. Designating a Compliance Officer/Contact(s)**

A physician practice should designate one employee to be a compliance officer or designate multiple employees to be compliance contacts. The designees should oversee the implementation and day-to-day operations of the compliance program. A practice could outsource all or part of the compliance officer’s responsibilities to a third party, such as a consultant or billing company.

**IV. Conducting Appropriate Training and Education**

A practice needs to determine who needs training, the type of training that best suits the practice’s needs and when, how often and how much education is needed. Training could mean attending in-person sessions or other meetings, distributing newsletters such as the *ATS Coding & Billing Quarterly* to staff or posting to an office bulletin board with relevant information. All of these activities can be coordinated in house or by an outside source. At minimum, the OIG recommends all individuals involved in coding and billing attend an annual training program.

Compliance training focuses on the importance of the program, the consequences of violating the standards and procedures set forth and the role of each employee in its operation. All employees should receive training on how to perform their jobs in compliance with the standards of the practice and any relevant regulations. Each employee should also understand that compliance is a condition of continued employment.

Coding and billing training should cover the following:

- Coding requirements;
- Claim development and submission processes;
- Not signing a form for a physician without the physician’s authorization;
- Proper documentation of services rendered;
- Proper billing standards and procedures and submission of accurate bills for services or items rendered to federal health care program beneficiaries; and
- The legal sanctions for submitting deliberately false or reckless billings.

**V. Developing Appropriate Responses to Detected Violations**

Upon receipt of reports or reasonable indications of suspected non-compliance, a practice should take appropriate actions. Possibilities include launching a corrective action plan, submitting a report to the government, returning any overpayments and/or submit a referral to law enforcement authorities.

It is suggested that a practice develop its own set of warning indicators as a part of its compliance program. Warning indicators might include significant changes in the number and/or types of claim rejections and/or reductions; correspondence from the carriers and

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reductions; correspondence from the carriers and insurers challenging the medical necessity or validity of claims; illogical patterns or unusual changes in the pattern of CPT, HCPCS or ICD-9-CM code utilization; and high volumes of unusual charges or payment adjustment transactions.

## VI. Developing Open Lines of Communication

A compliance program's system for meaningful and open communication can include the following:

- The requirement that employees report conduct that a reasonable person would, in good faith, believe to be erroneous or fraudulent;
- The creation of a user-friendly process for effectively reporting erroneous or fraudulent conduct;
- Provisions in the standards and procedures stating that a failure to report erroneous or fraudulent conduct is a violation of the compliance program;
- The development of a simple and readily accessible procedure to process reports of erroneous or fraudulent conduct;
- If a billing company is used, communication to and from the billing company's compliance officer/contact and other responsible staff to coordinate billing and compliance activities of the practice and the billing company, respectively; and
- The utilization of a process that maintains the anonymity of the persons involved in the reported possible erroneous or fraudulent conduct and the person reporting the concern; and that there will be no retribution for reporting conduct that a reasonable person acting in good faith would have believed to be erroneous or fraudulent.

## VII. Enforcing Disciplinary Standards through Well-Publicized Guidelines

A practice should make sure that its employees understand the consequences if they don't follow protocol. Violations of the compliance policy should result in consistent and appropriate sanctions, including the possibility of termination. That said, the program should be flexible enough to account for mitigating or aggravating circumstances.

Disciplinary actions could include oral warnings, written warnings, probation, demotion, temporary suspension, termination, restitution of damages and referral for criminal prosecution.

### WHERE DO I BEGIN?

First read the 19-page guidance, get practice ownership buy-in and begin developing a plan that your practice can support. Involve staff members who will be involved in coding and reimbursement issues early in the process. Next, start keeping records of educational courses attended by physicians and staff, as well as records of those who were unable to attend. This will be useful in identifying additional educational opportunities.

### THE BOTTOM LINE

This guide to voluntary compliance programs is intended to assist physician practices in developing and implementing internal controls and procedures that promote adherence to federal healthcare require-

ments. Physician compliance programs need not be time- or resource-intensive and can be developed in a manner that best reflects the nature of each individual practice.

By making compliance principles an active part of office culture, a physician practice can prevent/reduce erroneous or fraudulent internal conduct. Just as immunizations are given to patients to prevent illness, the implementation of a voluntary compliance program is a comparable form of preventive medicine for the business side of your practice. ■

# Q&A

In the May 2008, *cpt Assistant*, a bronchoscopy coding question and answer, was published on page 15. This was adapted from Dr. Plummer's chapter in the ACCP *Coding for Chest Medicine 2008*:

**Q. If multiple, distinct procedures are performed during a single bronchoscopy, is it appropriate to report each separately?**

**A.** It is appropriate to report multiple procedures performed during a single bronchoscopy. For example, bronchoscopy in a patient with lobar pneumonia to identify the infectious cause might include a bronchial alveolar lavage (31624), a protected brush sampling (31623), and a transbronchial lung biopsy (31628), all during the same session.

**Q. What are the HCPCS changes to J codes for albuterol and levalbuterol?**

**A.** The Healthcare Common Procedure Coding System (HCPCS 2008) includes Medicare's National Level II codes. The J codes found in the HCPCS code book are numbered J0000-J9999 for Drugs Administered Other Than Oral Method include drugs that ordinarily cannot be self-administered, chemotherapy drugs, immunosuppressive drugs, inhalation solutions, and other miscellaneous drugs and solutions. Most of the pulmonary drugs are included in the J codes including albuterol, levalbuterol, salmeterol, formoterol, etc. Changes to HCPCS J codes for albuterol and levalbuterol have been changed back to what they were last year! These changes took effect April 1, 2008. The reinstated codes are:

**J7611** Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg

**J7612** Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg

**J7613** Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg

**J7614** Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg

If you have additional questions, please contact Diane Krier-Morrow at [dkriermorr@aol.com](mailto:dkriermorr@aol.com) or (847)-677-9464.