AMERICAN OSTEOPATHIC ASSOCIATION

Presents:
Documentation, OMT Coding and Auditing
February 18, 2017

Presented by: Kavin T. Williams, CPC
Disclaimer

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• Developed by the Department of Physician Services and Payor Relations, in conjunction with the General Counsels’ office.
Kavin Williams, CPC, Senior Manager of Coding and Payment
Kavin T. Williams, CPC

- Assist AOA members with coding, documentation and payor policies
- Assist AOA members with denial of payment
- Provide audit support
- Represent the AOA at national payment policy meetings
Objectives

• To provide information on documentation requirements
• To provide guidance on coding and reporting an Evaluation and Management (E/M) service and Osteopathic Manipulative Treatment (OMT)
• To provide information on how physician services are valued
• To provide information on audits, what to expect and how to respond
Documentation Golden Rules
The Golden Rules

- Must be clear and legible
- If it’s not documented, it wasn’t done
- Chief complaint and medical decision making (reviewed by most insurance auditors)
Evaluation and Management Services (E/M) Documentation
The 1995 or 1997 documentation guidelines may be used, not both.

1997 guidelines provide comprehensive single organ system examination.
The documentation of each patient encounter should include:

- Reason for the encounter (chief complaint)
- History
- Physical examination findings (diagnosis)
- Plan for care (medical decision making)
- Be sure to include the date and legible identity (signature) of the provider of service
Components of E/M Services

There are three key components for determining the level of the E/M service.

1. History
2. Examination
3. Medical Decision Making
1. History

History

- **Chief Complaint**, brief statement of why the patient is at the office, preferably in their own words
- History of present illness (HPI) what’s been going on
- Review of Systems: Body Systems Inventory
- Pertinent Past, Family and Social History (PFSH)
What does F/U mean when it is listed as the chief complaint?
You can have a physical examination of a:

- Single organ system examination involves a more extensive examination of a specific organ system
- General multi-system **examination** involves the examination of one or more organ systems or body areas
3. Medical Decision Making (MDM)

Consists of:

- The number of diagnoses or Treatment Options to be considered
- The amount and/or Complexity of data to be reviewed
- The risk of complication and/or Morbidity/Mortality, which addresses
  - Level of Risk
  - Presenting Problem(s)
  - Diagnosis Procedure(s) Ordered, and
  - Management Options Selected
PHYSICAL EXAM

Head - PERLS - Rinaes - Conjunctiva - Headache - Migraine - Cluster - TM - Canthus
Nasal - Nasal Congestion - Deviated Septum - Mono Blood - Sinuses - Nodules
Mouth - Abscess - Infection - Mass - Ulcer

Neck - Nodes - Veins - Tenderness

Lungs - Bronchitis - Pneumonia - Asthma - Excision - Nodes - CF - COPD - SC

Heart - NRP - MS - MD - Grado - HR - BP - ENF

Strider - Percussion

GI - Ulcer - Pancreatitis - Diverticulitis - Hernia - Liver - Splenic - G3 - Diabetes
Pancreas - Malena - Hemocholes - Carotidation - Diverticulum - Nausea

Blood - from - B12 - B6 - Anemia

Endo. - Thyroid - Pituitary - Adrenal - Estrogen - Testosterone - Parathyroid

Gyn. - Pap - Fehling - Menopause - Oligo - Amen - DLE - MD - Endometriosis

NEW COMPLAINT:

(30 min to now)

PLAN: 4871
E/M Service and OMT
Procedure Work Descriptors
Reporting E/M Services and OMT Procedures

• Report the appropriate E/M service code (99201-99215) based on the documentation
• Append Modifier-25 to the E/M service code
• Report the appropriate OMT procedure code (98925-98929) based on the physical examination findings
Modifiers

Append Modifier-25 to the E/M service code.
It may be necessary to indicate that on the day a procedure or service identified by the CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided, or beyond the usual preoperative and postoperative care associated with the procedure that was performed.
Modifier-25 Language Located in the CPT Guidelines for Reporting OMT

Evaluation and Management services, including a new or established patient office or other outpatient services, may be reported separately using modifier -25 if the patient’s condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the other procedure.
Description of Pre-service Work:
- Review medical history form completed by the patient & vital signs obtained by clinical staff.

Description of Intra-service Work:
- Obtain an expended problem focused history (including response to treatment at last visit and reviewing interval correspondence or medical records received).
- Perform an expended problem focused examination. Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (low complexity medical decision making).
- Discuss diagnosis and treatment options with the patient. Address the preventive health care needs of the patient.
- Reconcile medication(s). Write prescription(s). Order and arrange diagnostic testing or referral as necessary.

Description of Post-service Work:
- Complete the medical record documentation.
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medication that may occur after the visit.
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit.
- Receive and respond to any interval testing results or correspondence. Revise treatment plan(s) and communicate with patient, as necessary.
OMT Procedure Code 98927 Work Description

Description of Pre-Service Work:
The physician determines which osteopathic techniques (e.g., HVLA, Muscle energy, Counterstain, articulatory, etc.) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.

Description of Intra-Service Work:
The patient is initially in a side-lying position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: acromioclavicular joint is treated with articulatory technique; glenohumeral and costal dysfunctions are treated with muscle energy technique; cervical spine is treated with counterstain technique; thoracic and lumbar dysfunctions are treated with passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

Description of Post-Service Work:
Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.
OMT is a procedure, and although it’s distinct from other procedures, nevertheless it is a procedure and should be documented in that manner.

As such, it may be beneficial to prepare a procedure note for the OMT detailing which regions were treated, which techniques were utilized, and how the patient tolerated the treatment.

Documenting in this fashion meets the requirements for reporting any procedure that is performed and assists in an audit situation when OMT is being challenged from a documentation perspective.
How Are OMT Codes 98925-98929 Valued

The OMT codes and other CPT codes are valued based on the recommendations from The American Medical Association (AMA) Specialty Society Relative Value Scale Update Committee (RUC)
What Is The RUC

The RUC is committee comprised of 31 members, 28 voting members (16 of these 28 voting members are from specialties). The RUC is an expert panel:

• That is an independent group exercising its First Amendment Right to petition the federal government

• That evaluate the work, practice expense inputs and professional liability cross walk for new and revised CPT codes for the Medicare Physician Fee Schedule (MPFS)

• That exercise their independent judgment and are not advocates for their specialty

• The RUC activity provides the Medicare program with the ability to issue timely updates to the MPFS, at almost no cost to the government
RUC Composition 2015
American Medical Association
CPT Editorial Panel
American Osteopathic Association
Chairperson of Practice Expense Review Committee
Health Care Professionals Advisory Committee (HCPAC)
Chairperson of RUC

- Anesthesiology
- Cardiology
- Dermatology
- Emergency Medicine
- Family Medicine
- Clinical Oncology*
- General Surgery
- Geriatrics
- Infectious Disease*
- Internal Medicine
- Neurology
- Neurosurgery

- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Primary Care*
- Pediatric Surgery*
- Pediatrics
- Plastic Surgery
- Psychiatry
- Radiology
- Thoracic Surgery
- Urology
Medicare RBRVS Inputs

The resources for providing each service (RVU) is divided into three components

1. Physician Work
2. Practice Expense
3. Professional Liability Insurance
Physician Work

Divided into 3 distinct categories:

1. Pre-service period
2. Intra-service period
3. Post-service period

Physician Work determined by:

- The **time** it takes to perform the service
- The **intensity** of performing the procedure
  - The technical skill and physical effort
  - The required mental effort and judgment
  - Stress due to the potential risk to the patient
PE RVUs are divided into direct and indirect physician practice resources involved in furnishing each service:

- **Direct expense categories include:**
  - Clinical labor
  - Medical supplies
  - Medical equipment

- **Indirect expenses include:**
  - Administrative labor
  - Office expense
  - All other expenses

The RUC submits recommendations to CMS on Direct practice expense inputs for new and revised codes.

Indirect inputs are determined by CMS formula and are related to the total physician wRVU.
• In 2000, CMS implemented the resource-based professional liability insurance (PLI) relative value units

• The PLI is determined by CMS formula and is based on specialty risk adjustors and premium data
Components of the RBRVS
Percent of Total Relative Value

- Physician Work: 52%
- Practice Expense: 44%
- Professional Liability Insurance: 4%
RBRVS
Resource-Based Relative Value Scale

Calculation of code value / payment level based on RBRVS:

Work RVU
+ Practice Expense RVU
+ Malpractice RVU
= TOTAL RVU

- TOTAL RVU x $Conversion Factor = Payment

All RVUs are modified based on geographic location

*The Conversion Factor for CY 2015 = $28.356
## OMT Codes 98925-98929 RVUs

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Audits
Audits

If you are audited does it mean you have done something wrong:

A. True
B. False
What is an audit?

– A mechanism of review to determine compliance:
  • Coding
  • Documentation
  • Other payment guidelines.

– The primary payer issues:
  • appropriate coding
  • documentation
What Is An Audit?

It’s a tool used by Medicare and other payors to recover monies believed to have been lost to fraud and erroneous billings.
Why Audits Are Initiated?

- Suspicion (Billing Pattern)
- Outlier Physicians
- The Senior Patrol
- Whistleblowers
- Procedure Codes
Who Are The Auditors?

• The Office of the Inspector General (OIG)
• Medicare
• The Department of Justice (DOJ)
• The Federal Bureau of Investigation (FBI)
• Carriers
Types of Audits

- Prepayment Audits
- Post-Payment Audits
- Statistical Sampling Method
What Auditors Look For?

• Billing for services or supplies that were not provided
• Billing for non-allowable or non-covered services
• Altering claim forms to receive a higher payment amount
• Unbundling services
What Should You Do If You Get An Audit Letter?

• Determine the magnitude of the request

• Identify the requester (e.g. governmental organization or a private insurance carrier)

• Ensure your staff is aware of the significance of an audit request
How To Respond To A Request For Documentation

- Reply to the audit notice in a timely fashion
- If the guideline states respond within 30 days, that does not mean 31 days, you must follow the rules
- Gather and submit only the requested documentation
- Keep a record of and/or a copy of the information submitted
- Be cooperative
- You may want to conduct an internal audit
How to Respond to the Audit Findings

If the findings are not favorable:

- Attempt to discuss the findings with the reviewer
- If necessary request a redetermination
- If necessary request a level one appeal
Staff Contacts

Cynthia Penkala, CMM, CMPE, Director, Practice Management and Vendor Relations
(312) 202-8082 phone
(312) 202-8382 fax
cpenkala@osteopathic.org

Kavin Williams, CPC, Senior Manager of Coding and Payment
(312) 202-8194 phone
(312) 202-8494 fax
kwilliams@osteopathic.org