



Common Mistakes in Coding and Documentation

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Your Expert Oncology Resource

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Objective

- Understand what types of mistakes are commonly seen
- Discuss how to avoid these types of errors
- Identify potential ramifications



Common Mistakes

Missing documentation

Incorrect dates of service

Incorrect levels reported

Missing and/or late signatures

Forms or templates that are not patient specific

Billing under the incorrect physician



Physician Orders

Simulation

CT
Contrast
Treatment Device

Treatment Planning

Medical necessity
IMRT
Stereotactic
3D conformal
Treatment devices
Diodes

Verification & Imaging

Verification
simulation
IGRT
Port films

Treatment Services

Physics services
Re-evaluation CT
Additional
simulation
Additional
Planning



Missing Documentation

- Physician clinical treatment plan
 - Need specific documentation
- Medical necessity
 - IMRT
 - IGRT
 - Brachytherapy and SRS/SBRT
 - Additional CT for boost or tumor response, additional IMRT and 3D simulations



IMRT Missing Documentation

- Goals and dose constraints for IMRT
 - Required for all IMRT plans
 - Documented prior to planning
- Secondary MU check for IMRT
 - Required for all IMRT dosimetry plans
 - Separate from planning system



IMRT Requirements

CPT® Assistant, November 2009; page 3

In the second step of IMRT planning, the physician assigns specific dose requirements for the PTV (minimum dose and dose homogeneity) and dose constraints for the OAR (maximum allowable dose to these critical structures). A treatment plan that satisfies these requirements and constraints should maximize the potential for disease control as well as minimize the risk of radiation injury to normal tissue.

After the plan is complete, in a separate process, the physicist must perform basic dose calculations on each of the modulated beams. This evaluation is reported with code 77300, *Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician*. These patient-specific monitor unit computations verify through a second (independent of treatment planning computer) dose-calculation method that the computer has correctly performed the treatment planning calculations.

Missing Documentation cont'd

- Special treatment procedure, CPT® 77470
 - Must document the extra time and effort
 - As techniques or modalities become standard of care, they are no longer considered “special” by our payors.
- Special physics consults
 - Documentation by physician stating reasoning for request
 - A report from the physicist is required addressing the specific request



Special Procedures

- Procedure notes
 - For services rendered (simulations, CT, etc.)
 - For special procedures (brachytherapy, intraoperative, stereotactic radiosurgery, etc.)
- Calculation documentation for brachytherapy
 - Separate from planning system
- Respiratory motion management, CPT® 77293
 - A processes over multiple services
 - Documentation on the date in which reported
 - Add-on code to planning codes

Radiation Oncologist Participation

As stated within Novitas Solutions, Inc. LCD:

Local Coverage Determination (LCD) for Stereotactic Body Radiation Therapy (SBRT) (L30277)

Contractor Information

Contractor Name Novitas Solutions, Inc. opens in new window	Contractor Number 12101	Contractor Type MAC - Part A
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LCD Information

Document Information

LCD ID Number
L30277

LCD Title
Stereotactic Body Radiation Therapy (SBRT)

[Primary Geographic Jurisdiction opens in new window](#)
Delaware

Each SBRT case, regardless of the number of sessions, involves a specialist from the field of Radiation Oncology who manages and oversees:

- Imaging for localization
- Computer-assisted tumor localization with respiratory correlation, if required
- Treatment planning and approval of the ongoing images used for localization or tumor tracking
- Setup and accuracy verification testing
- Simulation of prescribed arcs or fixed portals
- Radiation treatment delivery
- Real-time adjustments in response to patient motion or target movement
- Evaluation of the response to treatment

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Incorrect Dates of Service

- Physician clinical treatment plan, CPT® 77261 - 77263
- Special dosimetry, CPT® 77331
- Dosimetry processes
 - Treatment plans, calculations and devices
 - IMRT calculations and device

What is the correct date???????

Weekly Services

- Weekly treatment management
 - Problems with “auto capturing” the service
 - Requirements vary between payors
 - Generally not billed on the date of the patient visit
- Physics services
 - Problems with “auto capturing” the service
 - Recommended date is the date the check is performed



Pro vs. Tech

- Differences between professional and technical
 - Same services billed on different dates
 - Should the dates be the same???



Incorrect Levels Reported

- Professional E&M's
 - New vs. established
 - Level of service documented
- Simulations
 - Initial
 - Verification
 - Electron
 - Brachytherapy



Incorrect Levels Reported cont'd

- Treatment devices
 - Can vary between Medicare providers
 - Immobilization
 - Beam Modifying
- Dosimetry services
 - Isodose plans
 - 3D simulations
 - Brachytherapy isodose plans



Missing Signatures

- Physician signatures not present on work performed
 - IMRT QA
 - Diode measurements
 - Special physics consult report
 - Simulations
 - Only first page of treatment plan
 - EMR template design



Late Signatures

- Signatures provided on a day other than when the work was performed
 - Simulations
 - Dosimetry
 - IMRT QA
 - Imaging

Results in difficulty supporting the professional work or supervision required



Inappropriate Signature Practices

- Signatures lacking time and date
 - EMR not utilized properly
 - Not present on handwritten signatures
- Illegible signatures
 - Often only a “symbol” rather than a signature
 - Missing signature log
- Missing signatures would require a separate attestation page for each service provided

As Stated by Medicare...

"All entries in the medical record must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided."

"When State law and/or hospital policy requires that entries in the medical record made by residents or non-physicians be countersigned by supervisory or attending medical staff members, then the medical staff rules and regulations must address counter-signature requirements and processes."



Signature Guidelines

Updated June 2010

Written Signatures

- Full name or first initial and last name
- Legible or accompanied by signature log
- Date and time

Electronic Signatures

- Provided via secure login and password
- Printed statement
- Name, credentials, date and time
- Medicare example:

"Electronically Signed By: John Doe, M.D. 08/01/2011 @ 06:26"



Forms and Templates

- Generic templates
 - Same content for all patients with no patient specificity
 - Same template for all procedures performed
- Incorrect information
 - Wrong patient
 - Gender specific
 - Incorrect information for the service provided
 - Inaccurate titles



Cloned Documentation Policy- National Government Services (NGS)

CLONED DOCUMENTATION COULD RESULT IN MEDICARE DENIALS FOR PAYMENT

Medicare providers today are faced with the challenges of providing quality healthcare while meeting ever increasing regulatory and compliance regulations. Many providers are investing in Electronic Health Records to increase the quality of their documentation, decrease or minimize documentation time and improve their overall record keeping capabilities. However, providers need to be aware that Electronic Medical Records can inadvertently cause some documentation pitfalls such as making the documentation appear cloned. Cloned documentation could cause payment to be denied in the event of a medical review audit of records.

Documentation is considered cloned when it is worded exactly like or similar to previous entries. It can also occur when the documentation is exactly the same from patient to patient. Individualized patient notes for each patient encounter are required. Documentation must reflect the patient condition necessitating treatment, the treatment rendered and if applicable the overall progress of the patient to demonstrate medical necessity.

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NGS Policy cont'd

An Electronic Health Record often allows the providers to utilize default options. Defaulted documentation may cause a provider to overlook significant new findings that may result in safety/quality issues. Default data may document a more extensive history and physical exam than is medically necessary and does not differentiate new findings or changes in a patient's condition. When documenting a service such as spinal manipulation therapy (SMT), it is important to document the progress of the patient. Defaulted or cloned documentation also applies to other disciplines where the documentation must demonstrate that the patient is making progress towards treatment goals, or documenting the patient's findings or changes in a patient's condition to meet for Medicare medical necessity.

Whether the documentation was the result of an Electronic Health Record, or the use of a pre-printed template, or handwritten documentation, cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. Identification of this type of documentation will lead to denial of services for lack of medical necessity and the recoupment of all overpayments made.

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Documentation Design

- Check boxes
 - Medical necessity
 - Special treatment procedure
 - Special physics consults
 - Special dosimetry services



Billing Under the Incorrect Physician

- Services performed by one physician but billed under a different
 - Ex. Physician A covers for physician B but billed under physician B
- Professional services
- Technical services can vary depending on type of facility
- Locum Physicians

Common Errors Identified

- Services billed globally when only the technical component was supported
- Lack of modifiers
- Over usage of modifiers
- Avoidance of NCCI edits
- Billing “scrubber” software not updated
- Incorrect diagnosis coding



Pro vs. Tech

- Differences between professional and technical
 - Different levels
 - Different charges
 - Different diagnosis codes
 - Professional E&M charges within 90 day global period



Potential Ramifications

- Claim denial
- Payor audit
 - Commercial payors
 - Governmental agencies
 - Medicare
 - RAC
 - OIG
 - Many more



Potential Ramifications cont'd

- Fines and penalties
- Medicare now shares information with commercial payors
- You could be on the news and become famous!!!



Why Does This Matter???????



The Obama Administration

Presidential Memorandum states:

"The Obama Administration is committed to reducing payment errors and eliminating waste, fraud, and abuse in Federal programs. On March 10, 2010, the Administration expanded the use of "Payment Recapture Audits," a process of identifying improper payments where highly skilled accounting specialists and fraud examiners use state-of-the-art tools and technology to examine payment records and uncover problems such as duplicate payments, payments for services not rendered, overpayments, and fictitious vendors."



Medicare Program Overview

Health insurance managed by the Federal government

- Medicare Administrative Contractors (MACs)
- Rules & Regulations
- Compliance
- Auditing Entities

"Collectively, the MACs and the other Medicare claims administration contractors process nearly 4.9 million Medicare claims each business day, and disburse more than \$365 billion annually in program payments." Source CMS.gov



Hot Topics

Medical Record Documentation

Provider Signatures

Simulations & IMRT

Physician Supervision



Ways to Avoid Mistakes

- Development of an internal compliance plan
- Daily code capture and documentation review
 - Codes are only exported or submitted when documentation is present and complete
 - Opportunity to correct errors prior to submission to payor
- Daily interface verification audits
 - Ensure charges exported over the interface are received on the other end



Ways to Avoid Mistakes

- Internal audits against claim forms to identify problems
 - Identifies “scrubber” issues
 - Verifies correct quantities are submitted
 - Verifies diagnosis coding
 - Identify interface concerns
 - Opportunity for staff training and corrective actions



In Conclusion

With some additional time and effort on a daily basis, all services can be captured and submitted as “clean” claims. While this may be difficult given current staffing levels, accurate coding and documentation is not an option and will require a team approach.





Questions?



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