SIGNS OF AN IMPENDING AUDIT: ARE YOU WAVING RED FLAGS?

Wound centers are likely targets for an audit. The following clinical vignettes offer providers examples of questionable situations that can arise, as well as their resolutions.

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Editor’s note: The introduction to this article was contributed by Des Bell, DPM, CWS. For information on further internal audit topics and the documentation found during an audit, see “Business Briefs” on page 6.

The “business of medicine” may sound like an oxymoron, but unless one’s bills are paid each month, even the most talented clinicians cannot provide their services. As anyone in a private or solo practice knows, being a steward of the organization’s finances is critical on several levels. Like any other business, an appreciation of the value of each dollar spent is necessary. Having a clear picture of my organization’s finances is critical on several levels. Like any other business, an appreciation of the value of each dollar spent is necessary.

My “appreciation” began when, after launching the mobile aspect of my wound practice (Wound Care on Wheels) in 2008, I came under audit by the Centers for Medicare & Medicaid Services (CMS). I wasn’t prepared for the critical eye the government would develop regarding my business and finances as I broadened my horizons in an attempt to meet the continuing needs of others in my community. Before long, I was involved in an ongoing pre-payment review that lasted more than a year, and it took its toll on me not just emotionally but physically and financially — ultimately leading to the restructuring of my organization and the discontinuation of home wound care services.

Several issues were raised by CMS regarding my practice (which I share with my wife De Anna, a nurse practitioner and fellow wound specialist) from the start of my mobile expansion, the primary concerns being why we were providing wound care in patients’ homes and the level of service provided during hospital rounds. Additionally, working as a mobile provider automatically put me outside the

“bell curve” when CMS compared my business to my colleagues and other wound care-providing organizations, meaning that I was reporting services either more or less frequently than what is statistically the norm for similar providers.

My favorite question I fielded from my case manager at the time was, “Do you perform a lot of wound care?” Imagine trying to convince CMS officials that, like them, I was the steward of an organization’s money. I wasn’t convincing enough to ward off inspection, but I was able to correct the main issue, which, according to CMS, was level of service provided to hospital patients. Upon adopting an electronic health record (EHR), I discovered that we were inadvertently under-billing for our services and not being credited for all the work we were doing. The other eye-opener came from the power of seeing our healing rates and further validation that our model was and could be successful beyond doubt.

After auditing ended, we decided the emotional stress of the experience, combined with the continued financial hardships we faced, were not worth continuing the venture. Having to wait several weeks beyond what is typically expected to receive Medicare reimbursements as our documentation went under formal review created lengthy gaps and disruptions in our payments. We decided to discontinue home visits after little more than one year. Today, we’re proof that going through any type of audit can certainly be a career-changing event. Though miserable and taxing, my auditing experience proved to be valuable in the sense that the knowledge gained made me stronger and wiser, professionally and personally. Being proactive and diligent with documentation is the best advice I can offer fellow providers, and the best way to be proactive, in my opinion, is by utilizing a reputable EHR that’s wound care-specific.

HYPOTHETICAL CLINICAL CASE FILES

PHYSICIAN SUPERVISION OF HOSPITAL-BASED OUTPATIENTS

Typical Scenario: Regional Medical Center’s busy hospital outpatient wound care department (HOPD) is open five days per week, has seven treatment rooms, and generally maintains a full schedule.

The Problem: Dr. Doeslittle, an internist/gastroenterologist and the HOPD medical director, works in the HOPD every day except Thursday mornings (when he performs endoscopy procedures) and Friday afternoons (when he does consults in his office, which is about seven miles away). Dr. Toe, a podiatrist, works in the HOPD on Thursday mornings. The HOPD nurses perform “nurse only visits” on Friday afternoons. Dr. Doeslittle still covers the hyperbaric patients on Thursday mornings and Friday afternoons, with the staff calling him for any issues.

What Should Happen? First, the HOPD program director and medical director should carefully review the hyperbaric oxygen therapy (HBOT) supervision
requirements set forth by the Centers for Medicare & Medicaid Services, the Medicare contractor that processes their claims, and Undersea and Hyperbaric Medical Society guidelines. Then, all should verify whether or not the regulations, as well as the hospital bylaws and Dr. Toe’s hospital privileges, permit Dr. Toe to supervise HBOT therapy. If “yes,” all need to ensure Dr. Toe’s Thursday morning schedule includes time for him to be in the HBOT unit at the appropriate times. If “no,” all need to staff another physician to provide the appropriate HBOT unit supervision on Thursday mornings. A physician must be scheduled to work on the HBOT unit on Friday afternoons. Supervising an HBOT unit from miles away will not meet any stakeholders’ regulations and guidelines.

**SERIAL BILLING VS. EPISODIC BILLING (BILLING FREQUENCY)**

**Typical Scenario:** Mr. Jones is receiving care in the hospital-based outpatient wound and hyperbaric department (HOPD) for a Wagner grade-III diabetic foot ulcer. During the month of April, he undergoes 17 hyperbaric oxygen therapy (HBOT) treatments as well as the application of Apligraf® and two MIST Therapy® therapy sessions.

**The Problem:** Our Lady of Serial Billing Hospital has chosen to bill its wound and HBOT charges on one monthly claim. The monthly claim for Mr. Jones lists “diabetes” as the first diagnosis code and lists “ulcer” as the secondary diagnosis code. Consequently, the Medicare contractor denies payment for the application of both Apligraf and MIST. In order for these treatments and procedures to be covered by the contractor processing the hospital’s claims, the hospital should enter the primary diagnosis in the first diagnosis position on the claim. **NOTE:** the primary diagnosis is the condition that is responsible for that particular encounter.

In some instances, the contractor’s local coverage determinations (LCDs) provide specific directions regarding the covered diagnosis. In this example, the Medicare contractor’s HBOT LCD requires the diagnosis of “diabetes” (eg, 250.8X) to be listed first on the claim and “ulcer” (eg, 707.X) to be listed as secondary. Contrarily, the contractor’s LCD for bioengineered tissue requires “ulcer” to be listed as the primary diagnosis code (eg, 707.X) with “diabetes” (eg, 250.8X) to be listed as secondary.

Why does it matter which diagnosis is listed first on the claim? The payers use the diagnosis codes to identify medical necessity for the treatment or procedure. Many LCDs have specific limitations of coverage when other diagnoses are listed as the first diagnosis. For example, if a product is only approved for use on a diabetic ulcer and the primary diagnosis code is recorded as a “vascular ulcer,” the procedure might be deemed “experimental and investigational” for that use. When the hospital submits a monthly serial bill, all services (including services from other departments) for the patient’s care for that month are submitted on the same claim. Therefore, all diagnosis codes for those services compete for the first diagnosis space and the limited number of secondary spaces on the claim. In fact, some diagnosis codes may never make it on a serial bill due to the lack of space.

**What Should Happen?** The facility should have registered the patient at each visit or treatment and should have submitted a separate bill for each visit. That could have ensured the appropriate primary and secondary diagnosis codes were on the claim in the correct order to support medical necessity for the services, the procedure, or the product. When facilities submit monthly serial bills, they often lose money due to unnecessary denials for lack of medical necessity.

**NEW VS. ESTABLISHED E/M CLINIC VISIT CODES**

**Typical Scenario:** Mr. Frail returns to the hospital-based outpatient wound department (HOPD) after an absence of two years. Previously, he received care by Dr. Vein, a vascular surgeon, for a small venous stasis ulcer and was otherwise healthy for his age. Since then, Mr. Frail has been in a car accident that resulted in paralysis. Subsequently, Mr. Frail has developed multiple stage IV pressure ulcers. He is on 15 new medications and has a four-inch-thick stack of medical records to review.

**The Problem:** During Dr. Vein’s vacation, his colleague Dr. Frustrated, a physician in the same vascular surgery group, sees the patient to care for his new pressure ulcer. Dr. Frustrated bills Medicare for a level V new-patient visit (99205). The HOPD has been incorrectly advised that its coding should always match the physician’s. Therefore, the HOPD also bills for a new-patient clinic visit (99203). When the coders for Dr. Frustrated and for the HOPD prepare the actual claims, they down-code both claims to 99215 on the grounds that the care of Mr. Frail’s new wound is actually an established visit.

**What Should Happen?** Despite 1) seeing the patient for the first time; 2) evaluating a new problem with an extensive history, physical, and medical decision making; and 3) impeccable documentation in the medical record, the vascular surgeon should have used the established-visit code (99215). This is based on the Medicare regulation that the physician can only bill for follow-up visits if the patient has received services either by the same physician or any physician of the same specialty in the same group practice (within the preceding three years). For more information, visit the Medicare Quarterly Provider Compliance Newsletter at www.cms.gov.

The HOPD should have used an established-visit code. This is based on the Medicare regulation that the HOPD can only bill for follow-up visits if the patient has a medical record number anywhere in the healthcare system during the previous three years. However, the HOPD clinic visit level should be based on its clinic visit level mapping system. It should not be based on the physician’s evaluation and management (E/M) level.

**NOTE:** If the physician and/or HOPD accidently was/were paid for a new E/M clinic visit, when they should have been paid the established-visit rate, upon an audit they may be asked to repay the Medicare program.

**DIAGNOSIS CODES THAT DON’T REFLECT DOCUMENTATION**

**Typical Scenario:** St. Elsewhere Hospital has an extremely busy, large outpatient wound care department (HOPD) located in a metropolitan area that’s also home to several other HOPDs. St. Elsewhere advertises heavily and provides regular chronic wound care education to the providers in its community. The professional staff at the HOPD takes pride in its “center of excellence” that

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exceeds in wound-bed preparation and early intervention with advanced modalities such as bioengineered tissues.

**The Problem:** To that end, St. Elsewhere routinely stocks several types of bioengineered tissues (frozen and temperature-monitored) in the supply room. If patients aren’t healed after 4–6 weeks, the physician makes the decision to use one of the bioengineered tissues during a visit. This gets tricky with patients who have, for example, a traumatic wound to the lower extremity or a pressure ulcer to the heel. If the physicians make the medical decision to use one of the bioengineered tissues, they change the patient’s diagnosis to reflect a diabetic foot ulcer or venous leg ulcer (if they state that the diagnosis is a venous leg ulcer, they add extremity compression to the treatment plan).

**What Should Happen?** St. Elsewhere staff is not allowed to change the diagnosis to a condition that does not accurately describe the patient’s condition. This is particularly problematic if a diagnosis is changed just to obtain reimbursement. Treatment options should always be discussed with the patient. If a particular treatment is normally covered by Medicare, but is not covered for a particular condition, St. Elsewhere staff should review the Advanced Beneficiary Notice of Noncoverage (ABN) with the patient. The ABN should clearly explain the costs the patient will incur (to the physician for his/her work, and to the HOPD for its work and the product) if he/she wishes to proceed with the treatment. The patient should mark his/her decision on the ABN and should sign the ABN. By doing so, staff will know if the patient wishes to proceed with the treatment.

**MODIFIERS THAT DON’T REFLECT DOCUMENTATION**

**Typical Scenario:** Nurse Jones is working in your average hospital-based outpatient wound care department (HOPD) under the direct supervision of a physician. She performs a negative pressure wound therapy (NPWT) dressing change. When these charges are entered into the billing system and they cross over to the business office, the hospital coder notes that the NPWT procedure code (97605) is linked to the 420 revenue code on the HOPD’s charge description master.

**The Problem:** The coder knows the 420 revenue code must be accompanied by a therapy modifier or it will be rejected. Therefore, the coder attaches a modifier (eg, GN, GO, or GP). The modifier communicates that either a physical therapist (PT), occupational therapist, or speech therapist performed the service. When Medicare pays this charge it will be based on its physician fee schedule, which is paid at a lower rate than the rate for an HOPD. More importantly, if audited, the chart will not reflect that this service was provided by a PT and that a PT’s plan of care will not be present in the medical record.

**What Should Happen?** The NPWT service should not have been linked to the 420 revenue code in the HOPD’s charge description master. The coder should have read the medical record to verify if a therapist performed the service before adding the therapy modifier to the code.

**SURGICAL PROCEDURES THAT AREN’T APPROPRIATELY DOCUMENTED**

**Typical Scenario:** Dr. Lightfoot is a podiatrist with a busy private practice and works in a hospital-based outpatient wound care department (HOPD). He’s often at odds with the revenue integrity department because of frequent queries related to his documentation of procedures he has done in the HOPD.

**The Problem:** His debridement documentation simply states that a “subcutaneous debridement” was performed, with no reference to the type of tissue that was removed. For heel pressure ulcers that began as stage IV, he documents muscle debridement each time because “once a stage IV, always a stage IV.” If there is tendon exposed and he curettes the surface, he documents a muscle debridement. HOPD staff members are not comfortable charging for the higher-level debridesments, but Dr. Lightfoot’s documentation is vague for any level of charge. When challenged by the revenue integrity department, Dr. Lightfoot says, “I document and charge the same procedures throughout with all different types of tissue that was debrided and removed, rather than the deepest level of the wound seen.” Coding rules apply to physicians and HOPDs. Dr. Lightfoot is personally responsible for his claims should he be audited; just like the HOPD is responsible for its claims should it be audited. The HOPD medical director and/or hospital’s chief medical officer should discuss this inadequate documentation with Dr. Lightfoot. If Dr. Lightfoot does not document a full accurate procedure report when he debrides, debridement should not be billed by the HOPD and by the physician.

**INAPPROPRIATE NUMBER OF BILLING UNITS**

**Typical Scenario:** Dave Diabetes has a 70 sq cm diabetic foot ulcer. Dr. Foot applies 75 sq cm of Dermagraft® on March 10, 2012. Because Dermagraft is available in 37.5 sq cm pieces, the HOPD orders two pieces for each application. Dr. Foot’s documentation in the medical record is thorough and correctly explains the 24 application steps.

**The Problem:** When the physician completes the charge sheet, he correctly states that he performs one unit of 15275 and two units of 15276. Unfortunately, Dr. Foot forgets that he is supposed to report the product code (Q4106) per sq cm. Instead, he marks the charge sheet with two units, because in his mind he used two pieces. As such, the coder does not abstract the medical record to see how many sq cm were used and wasted. Therefore, she bills 2 sq cm on March 10 and 2 sq cm on March 17. As a result, the hospital-based outpatient wound care department (HOPD) is reimbursed for 2 sq cm of product ($66.04 [80% of allowable]) rather than the $2,476.68 Medicare allowable for the two pieces.

**What Should Happen?** The physician should have completed the charge sheet correctly with one unit of 15275 and two units of 15265 for the application of the product to a 70 sq cm wound, and with 75 sq cm of Q4106 for the product itself.

**NOTE:** HOPDs are required to submit the Current Procedural Terminology® code for the application of the product and the Healthcare Common Procedure Coding System code for the product itself on the same date of service on the claim.