Hospice Insights: The Law and Beyond

Episode 35: The Audit Series: The Second Guessing of Billed Hospice Physician Visits

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Speaker	Statement
Meg Pekarske	Hello, welcome to "Hospice Insights: The Law and Beyond," where we connect you to what matters in the ever-changing world of hospice and palliative care. Welcome to Hospice Insights, the Audit Series: "The Second Guessing of Billed Hospice Physician Visits." Today I'm joined by Bryan Nowicki and Erin Burns to discuss the recent denial of physician visits and audits. Over the last several months, a number of auditors have begun questioning the medical necessity of billed physician visits claiming that the physician services were solely administrative in nature. We break down the criteria auditors appear to be using, what this means for hospices and how hospices can avoid such denials. I hope you enjoy this conversation. All right, welcome Erin and Bryan.
Bryan Nowicki	Yes.
Meg Pekarske	Bryan. I was, you just look so young today. So you look youthful.
Bryan Nowicki	Oh how nice.
Meg Pekarske	Exactly.
Bryan Nowicki	We can turn that around.
Meg Pekarske	Exactly. You know me and my compliments. So okay. So, so Erin, let's jump right in here and this is sort of hot off the press in terms of we're seeing this and to set the stage here. We'll break this down a bit, but hospices can bill on their Part A claims, physician visits and they get separately reimbursed for those. They are covered under the cap and I think historically we've seen that auditors look to see if there's a visit note that

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	corresponds to the date of that billed physician visit. But they're not really getting into perhaps applying what would be the Part B E&M code requirements to it. And so it's just like is there visit note, yes, no and then if yes then it's sort of paid. Now putting aside if they say that the patient is ineligible for service, they don't want to pay the physician visit, but maybe that's for another day. But so that's up until very recently that's what we saw. So tell us what's the latest and greatest and why are we doing a podcast on this.
Erin Burns	Yeah so thanks Meg. Happy to be here today with you and Bryan. So the most recent physician visit denials that we have been seeing which like you said typically in the past they were just denied physician visits based on clinical denials and not really going into any detail as to why. Other than that they would deny a physician visit. Now we're seeing a couple different types of physician visits denials. The most basic physician visit denials that we're seeing are still the same saying because these clinical services are denied, we're denying the physician visit. But they--
Meg Pekarske	Just to pause there. That's like we don't believe you had this six-month prognosis, so you shouldn't have billed for hospice services and therefore these physician visits were on your claim form so those are denied too?
Erin Burns	Correct. That's actually what they're getting at.
Meg Pekarske	Okay.
Erin Burns	None of what we're seeing is the auditors instead of just saying we're denying this patient clinically so we're denying your physician visits, they're saying we're denying this physician visit because it was administrative in nature. Sometimes they leave it just at that and other times they say there's a physician face-to-face visit on this day and you separately billed for a physician visit. We're denying that because that's administrative. A little bit more detail is being provided and it's not just your boilerplate clinical denial language. We're also seeing in specifically with a UPIC audit that we're involved for a client, a pretty robust review of a specific physician visit note to basically say this physician visit based on the note did not meet the E&M code or evaluation and management CPT code requirements. The auditor went through kind of the three different criteria that were required for this level of coding and said it didn't meet it. We've only seen that once so far but it kind of gives you an insight into what the auditors are looking at. Either way, it shows that they're looking more kind of taking a closer look at

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	these physician visits than they were in the past.
Meg Pekarske	Yeah so let's talk about the first one which I mean I think everyone is in agreement that the face-to-face encounter in and of itself is not a billable service. It's very clear in rule commentary and elsewhere that that is an administrative service. However, if there is a billable service like I'm doing this face-to-face encounter and the person's like I've been having severe back pain, I'm throwing up as a result, like whatever, you know, and then you assess them and you do a treatment plan. All that stuff. That's okay, like if it meets the criteria for separating billing. And so that's why I think these are frustrating denials because they're not saying okay yes, an administrative service happened but then there was a billable service. Then I think that, you know, some of the things we've been seeing are making sure you're documenting separately those two different things if there is both an administrative and billable service because I think it's low-hanging fruit if they see, you know, one note covering both. Again, I would still argue about it, but I just think part of this is how do you stay out of the realm of these denials. So I guess what's your thought on that Erin?
Erin Burns	Yeah I agree with that. And in terms of arguing against some of these denials for the clients that do have a good practice in place where if during an administrative visit there seems to be a care component that starts or there is a component to the visit that kind of would be separately billable, to begin a separate visit note and call it something else. Like a progress note versus the face-to-face visit. But if you have just the face-to-face visit, making sure that the documentation in the face-to-face note is clear as to kind of differentiating the parts so that we can still make the argument that there was a care component, valid, and the billing was valid for that.
Meg Pekarske	Yeah and I think as you said best practice is to create the separate note and I think that's probably makes the most sense. And I think that's the practice of many, many people to do that and that note should look very separate. Not only is it a separate document but it's not a copy and paste of the original.
Erin Burns	Sure.
Meg Pekarske	It's sort of its own thing because if it's a separate document but is just a copy and paste of the encounter findings, that's not going to be all that helpful either.
Erin Burns	That's not going to be helpful and it may even create more problems than you want.

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Meg Pekarske	That is true because you know copying and pasting is a very frustrating issue. So let's talk about sort of the more detailed review because again just saying administrative in nature I think is silliness because it's like yeah, I documented a separate clinical service here and the biggest development and this is a UPIC who handles a lot of the country. This is why we wanted to do the podcast on this because this is the first time in whatever 10 years we're seeing this, is they're essentially saying okay are you meeting the E&M code requirements for this code that you billed. And obviously it's a whole separate conversation to talk about all these new evaluation and management code revisions which we're not going to get into that today. I think this goes to do you have a coder involved in coding your claims or all the staff. But they're essentially, it's almost like a Part B audit. You know the OIG did that audit of Part B billing. I mean they have nothing to do with hospice but essentially pulling evaluation management codes saying hey are these patients eligible for what you billed and there was a very, very high error rate. So they're sort of doing that same thing here. I guess tell me a little bit more of the details like are these decisions detailed, who's doing it, is a physician reviewing the physicians?
Erin Burns	Yeah.
Meg Pekarske	Tell me what you're seeing.
Erin Burns	Yeah so in this particular case it was a physician that did the review of the physician visit note. So this again is kind of a unique situation but the UPIC had a physician review and it was called the physician review note. So they were kind of summarizing their review of the clinicals in the same time as they were looking at the C&M code. So the code here that they looked at was 99336 which is probably a pretty standard code for hospices. It's just an E&M visit for an established patient in their home. For that to be the appropriate code, it requires two of three components to be met. So a detailed interval history, a detailed exam, and/or medical decision-making of a moderate complexity. So what the physician reviewer did here was go through each of those three components based on what they could see in the note. So they basically said that this visit didn't rise to that level because it didn't meet really any of these three components let alone two of three. They said it lacked detailed interval history, and didn't support the need for hospices generally. They thought the exam was limited and general and the patient's problems didn't rise to the level of moderate severity. The time spent with the patient wasn't documented. So for those three reasons they're saying this visit wasn't, shouldn't have been

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	paid and shouldn't have been billed separately.
Meg Pekarske	Right.
Erin Burns	It's different than the other kind of more general audit decisions that we're seeing where they just say administrative in nature.
Meg Pekarske	Well and this client in particular they have an outside coding company that codes their claims. So we feel like we're in a very good position and I think many hospices may not actually work with a coder and so I think we're very confident that this meets the coding requirements.
Bryan Nowicki	And Meg I think what we're seeing here with this new kind of examination of physician notes is consistent with something that you and I have been predicting for some years now and that's the increase scrutiny over how physician hospice physicians practice and how they document. We have seen more and more criticisms of the narratives in the certifications and Meg you and I have educated hospice physicians and trained them about documentation practices in context. You know, knowing that are they really documenting something with an eye that some other physician or coder or nurse down the road is going to be looking over their shoulder looking at their work. So I think this is another step on this increased scrutiny of physicians and I think we can just expect this to continue and therefore making sure your physicians are aware of this increased scrutiny, have the skills they need to document. And I'm not saying physicians need to be coders. Those are two different skill sets which makes me question whether this auditor physician was really the right kind of person to determine whether the code elements were met. I would think a certified professional coder would be the best expert for that and that's how we intend to push back against these as well. But it requires some more training education for physicians or at least an awareness of what they're doing. Adding to your audit response team, it may be a coder at this point is another person you want to have handy to reach out to as these kinds of denials continue.
Meg Pekarske	Well and I think too, it's a really good point about just the scrutiny of hospice physicians in particular but I do think some people will say well I'm going to slough this off, this isn't that much money. And there are some hospices who do fewer physician billable visits but in an earlier episode we talked about extrapolation. Right, you start adding up these $150 visits and those are now getting extrapolated too and I mean these numbers can really add up and also because claim denials are considered education, like you're doing something wrong and now you need to go fix it.

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	So I think obviously in this whole audit series we'll be talking about how you defend these. I think it is important to push back on these in addition to some proactive strategies like you said Bryan. Even if it's not I have a full-time coder on staff. I mean how are you giving your physicians training, how are you auditing a sample of their billed visit or on the prebilling basis to just make sure they're understanding the codes right. Because I think that OIG report from a lot of years ago error rate was like well over 80 percent and I mean there's sort of an art to some of this too and now we have a lot of changes to physician billing and E&M codes. Some of it I think is going to impact hospices immediately but nonetheless I think it's an area that for those compliance folks listening adding to your list and understanding are you paying any attention to this. If not, you probably do want to do that and be able to show that you're doing some education, some prebilling audits on this and then think about how you integrate a coder into this. But we'll provide an update. Hopefully, we'll be able to get these kicked very early on in the process so we can give an update to folks. But I guess any closing thoughts, comments.
Bryan Nowicki	Well just something you mentioned about extrapolation. In that prior episode where we described the successes we've had with extrapolation but one example of that keeps me grounded in terms of how significant are these denials if you are involved in extrapolation. I think in one of those audits we came down to one claim that was denied because of an insufficient narrative and through extrapolation that one narrative could potentially cost the hospice I don't know if it was $2 million or $3 million just the way they extrapolate that. We ended up winning on that case so that didn't come about. But if you see how these things can exponentially increase one physician visit or multiple physician visits at a relatively modest sum, it can really add up. So that's why I pay particular, we as a team pay particular attention to any kind of denial because we don't want these things to spin out of control.
Erin Burns	And I would just add, too, kind of what Bryan was stating earlier when we were talking about documentation, I feel like we hound people on documentation and to make sure that their documentation is quality, basically every day. This is just another example of why documentation needs to be good and detailed and to kind of use the example of the extrapolated denial as a teaching moment for physicians who may not want to spend a lot of time on their documentation for whatever reason. But it can really add up. Just reeducating people on billable versus not billable, creating policies and procedures that make it so that there's kind of a distinction as we were talking earlier between the billable part of a visit and the administrative part, just so that you can see on the front end of these denials and not have to be reactive.

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Meg Pekarske	Yeah well, and I think the final thing as you said, I think there's a bench to not pay this stuff when they're determining the patient is ineligible. I mean usually this is just like an add-on right and it's maybe, you know, in counter to our arguments we've historically made is even if someone, you're saying they're not eligible for hospice, this medically necessary physician service should still be paid because essentially it's a Part B service that by function of law must be included on our Part A claim. So now they're sort of like oh okay I'll use these Part B guidelines now, but I think it's still very intertwined with the patient isn't medically appropriate for hospice. So I don't know that we're necessarily seeing like oh yeah totally eligible for hospice but I'm not going to pay for these one off physician services.
Erin Burns	We have seen that so it does happen.
Meg Pekarske	But I mean one of the criteria you earlier said with this 99336 thing was that the detailed interval history supporting the need for hospice services. There clearly is like this well did he really even need to be seeing this patient but I think point well taken though is that it's sort of like we're running a Part A and a Part B service and some respect; again some people don't do much physician billing. And everything we said still applies to nurse practitioners. We're just going to put that as a focus because you can only bill for nurse practitioner services if they're the patient's attending physician and whatnot. So but the same goes true to the extent an NP is an attending and doing a billable visit. They should be following the same practices physicians do. But anyway while I appreciate you taking the time from fighting the good fight here to deliver the latest and greatest because that's what we're trying to do with this audit series is provide sort of quick and very timely information to people about what's crossing our desks. So thanks Erin and I would call you "Andrew" again, Bryan even though, you know, your beard isn't gray anymore, it's dark brown like it was.
Bryan Nowicki	I'll take it as a compliment.
Meg Pekarske	It is, it is. So you're an optimist too, just like I am.
Bryan Nowicki	Right.
Meg Pekarske	You see the best in people Bryan. So thank you.
Bryan Nowicki	I try. Thanks Meg.
Meg Pekarske	Well that's it for today's episode of "Hospice Insights: The Law and Beyond." Thank you for joining the conversation. To subscribe to our podcasts, visit our website at huschblackwell.com or sign up wherever you

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