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Sample Practice Report

Sample Doctor, MD

Auditing and Regulatory Compliance
Report of Findings

October 2019

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Audit and Regulatory Compliance
Professional Services Audit Summary
2019

PROVIDER NAME: Sample Doctor, MD

DM AUDITOR: Audit, CPC, CPMA, CPPM, CPC-I, CEMC, CEMA

AUDIT DATE: October 16, 2019

OBJECTIVE: To ensure that Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System Level II (HCPCS II), Classification of Diseases, Tenth Revision, Clinical Modification (ICD-9/10-CM) codes and related modifiers are assigned in accordance with regulatory requirements and supported by documentation in the patient's medical record.

METHODOLOGY: Each encounter was reviewed for compliance in following areas:

a. Evaluation and management (E/M) coding accuracy.
b. Charges documented in the medical record but not billed (missed charges);
c. Missing or deficient documentation (billed but not documented);
d. Accuracy of ICD-10 coding based on medical record documentation;
e. Accuracy of procedural coding (non E/M);
f. Accuracy of modifier assignment;
g. Code bundling issues;

The following tools and authoritative sources were used for the audit as applicable:

a. Centers for Medicare and Medicaid Services National Coverage Determinations;
b. Centers for Medicare and Medicaid Services Local Coverage Determinations; Cahaba
c. Commercial and other governmental payer guidelines as applicable and available;
d. Current Procedural Terminology, 2019 edition;
e. Current Procedural Terminology Assistant;
f. Centers for Medicare and Medicaid Services Evaluation and Management Guidelines, 1995 version;
g. Centers for Medicare and Medicaid Service National Correct Coding Initiative (NCCI);
h. International Classification of Diseases, Tenth Revision, Clinical Modification, FY 2019 release; and
i. Additional authoritative sources as indicated, which will be specified in conjunction with findings.

Dates of Service Reviewed: October 2018-August 2019. Specific findings for each encounter reviewed may be found in the audit spreadsheet provided.

Encounter Type	Total Codes Audited	Reported Accurately	Not Reported Accurately			Accuracy Rate
			Lower Level Supported	Higher Level Supported	No EM Supported	
E/M CODES	15	4	10	1	0	27%
			Not Supported	Alternate Code Supported	Supported but not Coded	
CPT/HCPCS CODES	12	10	2	0	1	83%

REVIEW OF FINDINGS

Evaluation and Management Documentation and Code Level Selection

Each encounter has been audited two ways. The first is by the traditional audit grid using 1995 and 1997 Documentation Guidelines. This is the "bean counting" audit. The second audit is to determine medical necessity. We look at the encounter to determine the severity of the presenting problem according to the patient and then according to the provider. Providers who document to "paint a picture" of their thought process in the assessment and plan can easily support the appropriate level of medical necessity for the visit. The reason our audits are conducted this way is to satisfy the following rule from CMS:

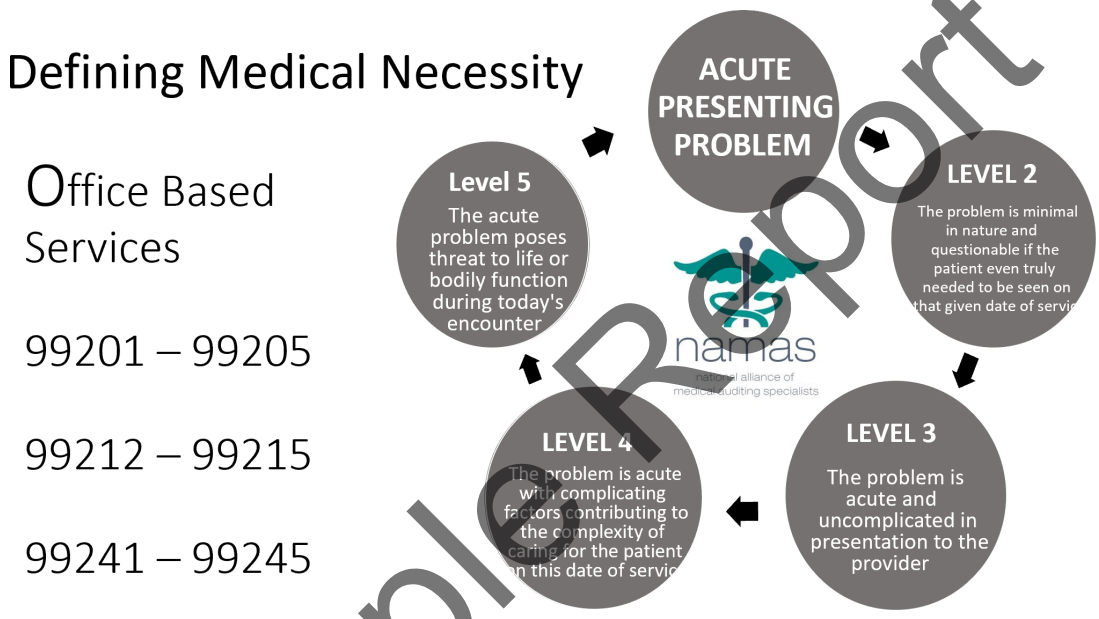
The *Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1 states*: "*Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.*"

The *Medicare Claims Processing Manual* reminds us that documentation is easily compiled with the adoption of EMR systems and therefore it cannot be the only determining factor in choosing a level of service. If it were, every patient that presents to the provider could possibly be billed at the highest level of service.

Tools for Determining Medical Necessity

Acute Problems: Office Setting
When evaluating the patient with an acute problem, we would be assessing each area of the encounter to see which level is supported based on how the documentation demonstrates the complexity of the patient.

This leveling is used the same regardless of whether the patient is new or established to the provider/practice on the given date of service. This is because the risk is associated most directly to the complexity NOT the patient status.



Chronic Problems: Office Setting
When evaluating the patient with chronic problem management, we would be assessing each area of the encounter to see which level is supported based on how the documentation demonstrates the complexity of the patient.

This leveling is used the same regardless of whether the patient is new or established to the provider/practice on the given date of service. This is because the risk is associated most directly to the complexity NOT to patient status.

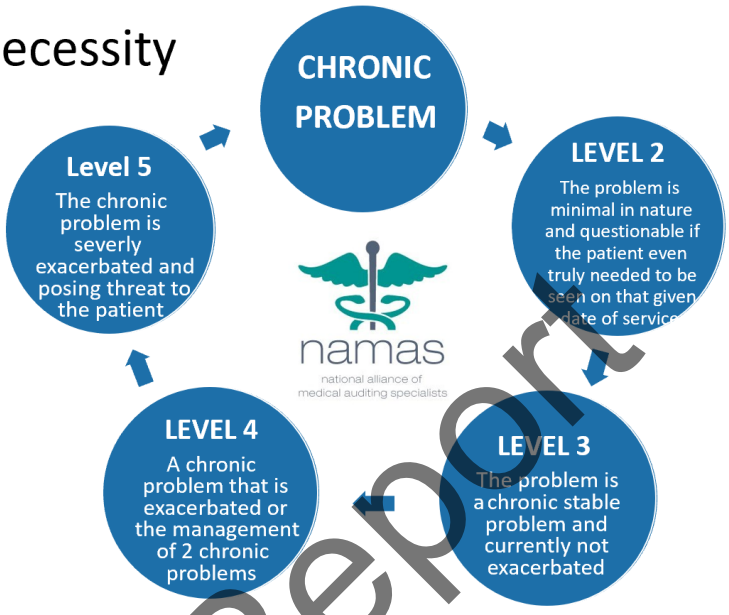
Defining Medical Necessity

Office Based Services

99201 – 99205

99212 – 99215

99241 – 99245

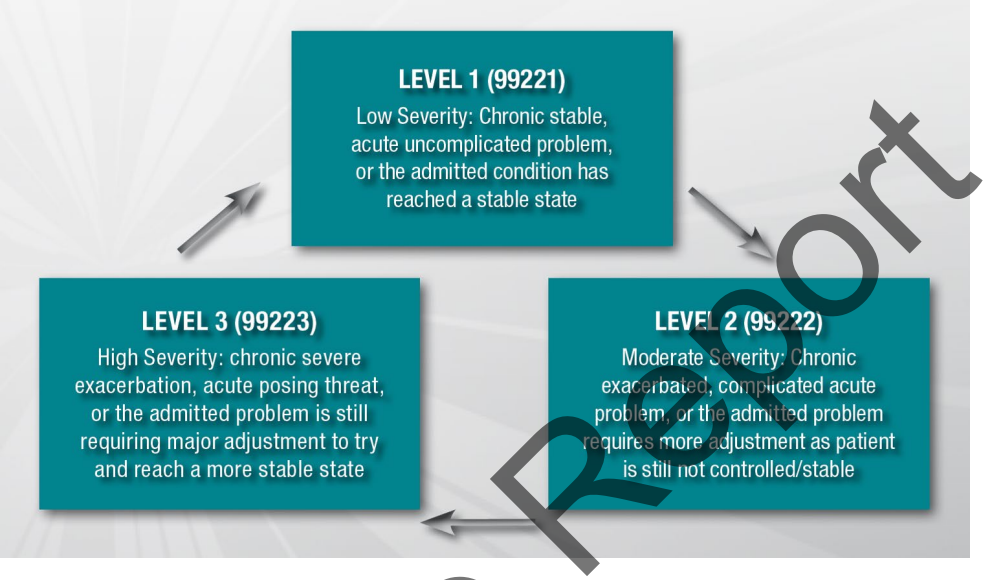


The documentation of many of the encounters reviewed supported higher levels of service than the medical necessity did. This is most likely a result of the templates being used to document the history and exam. Within the notes, the dictated documentation was usually right in line with the appropriate level of service based on medical necessity, but the ROS, PFSH, and exam typically leveled as comprehensive within the template. This style of over-documentation creates "noise" in the note and in some cases makes the auditor wonder if all of the systems were addressed at that visit. If not, the findings not addressed should be removed from the note to avoid contradictions and to make it clear what was truly addressed in the ROS, PFSH and especially the exam.

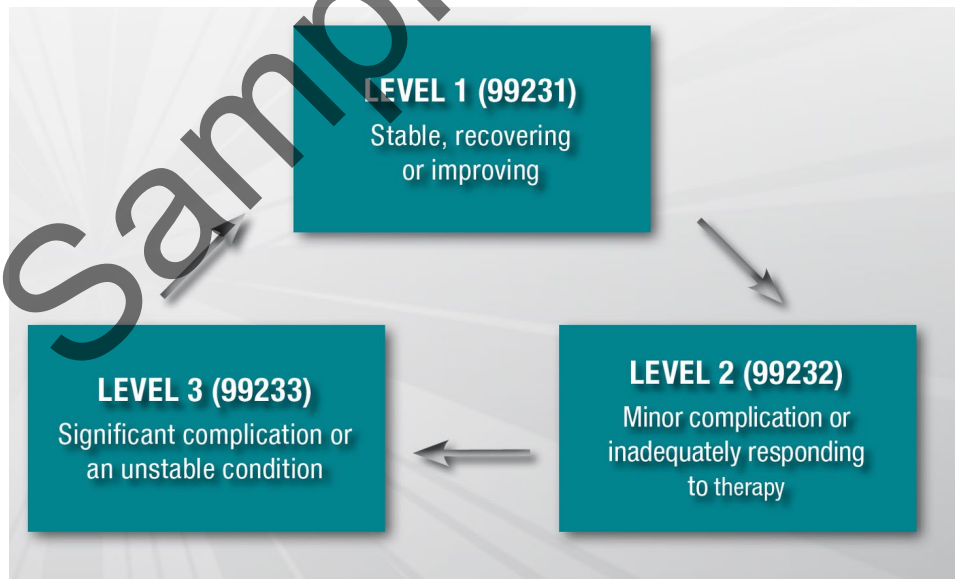
Inpatient Encounters

Inpatient encounters also follow the same medical necessity scoring technique. Their problem is evaluated on complexity as it relates to the severity of the overall condition, not necessarily as acute and chronic conditions.

Initial Inpatient Encounters



Subsequent Inpatient Encounters



Two of the three encounters reviewed supported a higher level of service than 99221 based on medical necessity, but the documentation did not also support the service. Initial visits in the inpatient setting require the documentation of a comprehensive history and comprehensive exam to support 99222 or 99223. A comprehensive history has a minimum of four HPI, 10 ROS, and ***all*** of Past, Family, and Social History. None of the encounters reviewed had family history documented. Without this element of documentation, the highest level of service that can be billed is 99221. A comprehensive exam requires the documentation of eight organ systems examined, or a complete exam of the affected organ system. All three encounters had a detailed exam documented, also only supporting 99221. For a complete neurological system exam, the following is required:

Neurological	Evaluation of higher integrative functions including: • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases, spontaneous speech) • Fund of knowledge (eg, awareness of current events, past history, vocabulary) Test the following cranial nerves: • 2nd cranial nerve (eg, visual acuity, visual fields, fundi) • 3rd, 4th and 6th cranial nerves (eg, pupils, eye movements) • 5th cranial nerve (eg, facial sensation, corneal reflexes) • 7th cranial nerve (eg, facial symmetry, strength) • 8th cranial nerve (eg, hearing with tuning fork, whispered voice and/or finger rub) • 9th cranial nerve (eg, spontaneous or reflex palate movement) • 11th cranial nerve (eg, shoulder shrug strength) • 12th cranial nerve (eg, tongue protrusion) • Examination of sensation (eg, by touch, pin, vibration, proprioception) • Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (eg, Babinski) • Test coordination (eg, finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

Much of the documentation in the inpatient setting seems to be pulled into the note from information entered by someone other than the provider. Our recommendation is that the accuracy, pertinence, and completeness is verified and updated to reflect the information considered and done by the rendering provider. Anything that is not important to the reason you are seeing the patient can be left out of your documentation. If you are uncertain how to do this, speak with your EPIC trainer/Super user.

Other E&M Findings and Recommendations

Several of the new patient encounters reviewed did not clearly indicate if a patient was a new patient to the practice or just had a new complaint. The provider needs to clearly differentiate between a new patient and established patient with a new problem in the documentation. Suggested statements would be "New patient being seen for…" or "Established patient being seen for the first time for this complaint."

In a number of the encounters reviewed, there were comments found about previous radiologic test results. It was unclear if the provider was summarizing reports, or visualizing the films and summarizing his own findings. The second option could support a higher level of medical decision making in the documentation. It is recommended the documentation be "tweaked" to more clearly indicate what is being read.

Other CPT and HCPCS II Coding

One encounter for injections of Botox included billing for two extremities, but the procedure template was not clear that more than one extremity was injected. The same encounter included guidance in the template, but the provider clearly stated in the dictation that it was not used. Other encounters reviewed for injections had templates that much better support procedure documentation. They included the following procedure documentation requirements within the template:

1. Reason for the procedure (to support medical necessity)
2. Specific anatomical site - i.e. tendon sheath, joint, which muscle, etc.
3. Technique
4. Risk and Benefits – based on comorbidities of the patient
5. Details of the procedure
6. Outcome of the procedure

The adverse findings for this encounter seem to be template related. Our recommendation is the template be updated to more easily reflect the laterality and to capture the additional documentation necessary for a procedure.

ICD-10 Documentation and Reporting

Comorbidities that are considered in the decision making process should be clearly identified in the assessment and plan. They also should be reported on the claim.

Several of the encounters reviewed appeared to have the diagnosis codes selected from the chief complaint and HPI instead of the assessment. The assessment should reflect the diagnosis the provider is treating and any associated comorbidities. These are the codes that should be reported on the claim.

Post Audit Recommendations

Based on the findings of the coding compliance audit, the following suggestions should be considered by practice leadership to continue documentation and coding improvement:

1. Medical staff education focusing on:
    a. Selection of the level of service based on documentation *and* medical necessity.
    b. Appropriate ICD-10-CM selection.

2. Administrative review of the template documentation especially ROS, exam and injection procedures

3. Follow up audit in six months to monitor for documentation and code selection improvement

4. Continuing specialty specific education for coding staff.

Provider Instruction
The provider should read and understand these comments, and address any questions or concerns this information may pose. As required by contract, these findings will be presented to the provider in an effort to properly identify deficiencies and address how they can be improved through future documentation and code selection efforts.

Disclaimer
DoctorsManagement has conducted this audit at the request of the client. All information that was reviewed was chosen by the client and released under patient confidentiality to DoctorsManagement for collective review.

It is the job of an auditor to find deficiency within a practice and make them known to the providers in an effort to improve the current level of individual and corporate compliance. The findings of this audit are therefore deemed confidential between the client and DoctorsManagement.

The findings of this audit are specific only to the records that have been reviewed for the audit. It is possible for a practice to manipulate the information that is sent for the audit, and therefore, DoctorsManagement cannot be responsible for chart findings that were not audited.

DoctorsManagement performs Coding Audits based on the guidelines set forth by the 1995 and 1997 Documentation Guidelines and those rules set forth by CMS.

This audit has been performed in a manner that meets the necessary OIG Compliance Plan Standards. DoctorsManagement recommends that the practice incorporate these findings into the Compliance Plan currently in place.

An audit is a tool to be used by a practice to increase compliance. Not properly using this audit as a tool and making changes based on the recommendations will not ensure compliance. DoctorsManagement cannot be responsible for recommendations/findings that are reported and no corrective action is taken.

CMS mandates require that any identified instances of inappropriate coding/billing that are identified by a practice (regardless of the way in which it is identified), must have restoration to the CMS system. Failure to do so may be interpreted by CMS as a false claim.