DoctorsManagement - Coding Compliance Audit Review - AUDIT FINDINGS

Client: Sample Report
DM Auditor: Auditor, CPC. CPMA, CPPM, CPC-I, CEMC, CEMA, ICD-10-CM Trainer
Audit Date: 09/25/19
Provider: Sample Doctor, MD

Findings Legent: Green- Incorrect CPT audited to a lower level, Yellow- Incorrect CPT audited to a higher level, and Blue indicates a diagnosis coding error

Patient Last Name	Patient First Name	MRN# / Account #	Date of Service	E&M Code reported	CPT/ HCPCS Code Reported	Modifier(s)	Units of service	ICD-10 Code(s) Reported	History	Exam	Medical Decision Making	DM E&M Code	DM CPT/ HCPCS Code	DM Modifier(s)	Units of service	DM ICD Code(s)	Med. Nec.(MN)	DM Audit Comments Findings/Suggestions
Patient	One	N/A	7/31/2019	99213		25	1	M17.12	Comp	Det	Low	99214			1	M25.462 M17.12	99214	Family history includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk. Most carriers have guidance that documentation of "negative" or "non-contributory" are not acceptable forms of documentation for family history. WPS has not issued specific guidance so this was not counted as wrong for this encounter, but based on the other carrier responses, this form of documentation should be avoided. It appears this patient was seen by another provider the same day as this visit. If so, the documentation should be looked at as one note and only one visit billed. The audit findings are based only on this encounter.
					20610	LT	1	M17.12					20610	LT	1	M25.462 M17.12		
					73562	LT	1	M17.12					73560	LT	1	M25.462 M17.12		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."
					J3301		8	M17.12					J3301		8	M25.462 M17.12		
Patient	Two	N/A	7/31/2019	99212		25	1	M79.644 M18.0	Comp	Det	Low	99214		25	1	M79.644	99213	Modifier 25 is supported for the documentation of the new problem. Medical necessity for the trigger finger is level three.
					20605	RT	1	M79.644					20600	F5	1	M18.0		The CMC joint is a small joint, not medium. The diagnosis for this injection is the CMC OA.
					20600	59,F7	1	M79.644					20550	F7	1	M79.644		The injection documentation did not clearly identify which right finger or the anatomical location of the finger injected. Based on the diagnosis and exam, it appears a tendon instead of a joint would have been injected. Templates are a great tool, but need to be modified to reflect the work done at the encounter.
					J1040		2	M79.644					J1040		2	M18.0 M79.644		
Patient	Three	N/A	7/31/2019	99203			1	S93.491A	Comp	Det	Low	99203			1	S93.401a	99203	The ICD-10 reported is for an "other specified" sprain. There is no specified ligament in the documentation, so we have to code the unspecified ICD-10.
Patient	Four	N/A	7/31/2019	99203		25	1	M25.561 M17.11	Comp	Det	Mod	99203			1	M17.11	99203	There is no CCI for this code pair. Modifier 25 should not be reported.
					20610	RT	1	M17.11 M25.561					20610		1	M17.11		
					73562	RT	1	M17.11 M25.561					73560		1	M17.11		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."

Sample Report

DoctorsManagement - Coding Compliance Audit Review - AUDIT FINDINGS

Client: Sample Report
DM Auditor: Auditor, CPC. CPMA, CPPM, CPC-I, CEMC, CEMA, ICD-10-CM Trainer
Audit Date: 09/25/19
Provider: Sample Doctor, MD

Findings Legent: Green- Incorrect CPT audited to a lower level, Yellow- Incorrect CPT audited to a higher level, and Blue indicates a diagnosis coding error

Patient Last Name	Patient First Name	MRN# / Account #	Date of Service	E&M Code reported	CPT/ HCPCS Code Reported	Modifier(s)	Units of service	ICD-10 Code(s) Reported	History	Exam	Medical Decision Making	DM E&M Code	DM CPT/ HCPCS Code	DM Modifier(s)	Units of service	DM ICD Code(s)	Med. Nec.(MN)	DM Audit Comments Findings/Suggestions
					J3301		8	M17.11 M25.561					J3301		8	M17.11		
Patient	Five	N/A	7/6/2019	99203		25	1	M70.62 M16.12	Comp	Det	Mod	99203			1	M70.62 M16.12 E11.9	99203	There is no CCI for this code pair. Modifier 25 should not be reported. It is documented in the procedure note that there is a risk to the patient due to the comorbidity of diabetes. This code should be appended to the E&M code.
					20610	LT	1	M16.12 M70.62					20610	LT	1	M70.62		
					73502	LT		M16.12 M70.62					73501	LT	1	M70.62 M16.12		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."
					J3301		8	M16.12 M70.62					J3301		8	M70.62		
Patient	Six	N/A	7/10/2019	99203		25	1	M50.321 M50.322 M50.323 M47.812 M19.011	Comp	Det	Mod	99203			1	M47.22 M19.011	99203	There is no CCI for this code pair. Modifier 25 should not be reported. There is an instruction under M50 to code to the most superior level, so if there was no diagnosis of spondylosis only M50.321 would be reported. The DDD is inherent in the spondylosis, so it is not reported separately for this encounter. The documentation also indicates there is radiculitis, so based on this note, M47.22 would be appropriate for the neck complaint.
					20610	RT	1	M19.011					20610	RT	1	M19.011		
					72040		1	M47.812 M50.323 M50.322 M50.321					72020		1	M47.22		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."
					73030	RT	1	M19.011					73020	RT	1	M19.011		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."
					J3301		8	M19.011					J3301		8	M19.011		

Sample Report

DoctorsManagement - Coding Compliance Audit Review - AUDIT FINDINGS

Client: Sample Report
DM Auditor: Auditor, CPC. CPMA, CPPM, CPC-I, CEMC, CEMA, ICD-10-CM Trainer
Audit Date: 09/25/19
Provider: Sample Doctor, MD

Findings Legent: Green- Incorrect CPT audited to a lower level, Yellow- Incorrect CPT audited to a higher level, and Blue indicates a diagnosis coding error

Patient Last Name	Patient First Name	MRN# / Account #	Date of Service	E&M Code reported	CPT/ HCPCS Code Reported	Modifier(s)	Units of service	ICD-10 Code(s) Reported	History	Exam	Medical Decision Making	DM E&M Code	DM CPT/ HCPCS Code	DM Modifier(s)	Units of service	DM ICD Code(s)	Med. Nec.(MN)	DM Audit Comments Findings/Suggestions
Patient	Seven	N/A	7/10/2019	99203			1	M79.645 S43.004A	Comp	Det	Low	99203			1	S61.223d S43.004d	99203	Family history includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk. Most carriers have guidance that documentation of "negative" or "non-contributory" are not acceptable forms of documentation for family history. WPS has not issued specific guidance so this was not counted as wrong for this encounter, but based on the other carrier responses, this form of documentation should be avoided. The provider documented a finger laceration. The code for the laceration should be reported instead of finger pain. Assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time. This encounter is for subsequent treatment in the healing phase so the 7th character should be "D".
					73030	RT	1	S43.004A					73020	RT	1	S43.004d		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."
Patient	Eight	N/A	7/11/2019	99213		25	1	M17.11	Comp	Det	Mod	99214		25	1	R22.4 M17.11 E11.9	99214	The medical necessity and documentation of this visit support a level four E&M. The visit was really for the lump on the knee with an undetermined source. It is documented in the procedure note that there is a risk to the patient due to the comorbidity of diabetes. This code should be appended to the E&M code.
					20610	RT	1	M17.11					20610	RT	1	M17.11		
					J1040		2	M17.11					J1040		2	M17.11		
Patient	Nine	N/A	7/17/2019	99213		25	1	M25.521 M25.511 S52.591A	Comp	Det	Mod	99214		57	1	S50.311a M25.511 S52.571a	99213	
					29075	RT	1	S52.591A					25600	RT	1	S52.571a		Fracture care was initiated at this visit and really would be more appropriate than just billing the cast application. If there is a practice policy against this, the code supplied is correct and supported.
					73030	RT	1	M25.511					73020	RT	1	M25.511		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."
					73100	RT	1	S52.591A					73100	RT	1	S52.571a		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."
					73070	RT	1	M25.521					NA					There is no report of findings for this x-ray documented.

Sample Report

DoctorsManagement - Coding Compliance Audit Review - AUDIT FINDINGS

Client: Sample Report
DM Auditor: Auditor, CPC. CPMA, CPPM, CPC-I, CEMC, CEMA, ICD-10-CM Trainer
Audit Date: 09/25/19
Provider: Sample Doctor, MD

Findings Legent: Green- Incorrect CPT audited to a lower level, Yellow- Incorrect CPT audited to a higher level, and Blue indicates a diagnosis coding error

Patient Last Name	Patient First Name	MRN# / Account #	Date of Service	E&M Code reported	CPT/ HCPCS Code Reported	Modifier(s)	Units of service	ICD-10 Code(s) Reported	History	Exam	Medical Decision Making	DM E&M Code	DM CPT/ HCPCS Code	DM Modifier(s)	Units of service	DM ICD Code(s)	Med. Nec.(MN)	DM Audit Comments Findings/Suggestions
					Q4010		1	S52.591A					Q4010		1	S52.571a		
Patient	Ten	N/A	7/6/2019	99213		25	1	M70.62	Comp	Det	Low	99214		25	1	M70.62 Z96.642	99214	Both the medical necessity and the documentation support a level four visit.
					20610	LT	1	M70.62					20610	LT	1	M70.62 Z96.642		
					73502	LT	1	M70.62					73501	LT	1	M70.62 Z96.642		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."
					J3301		8	M70.62					J3301		8	M70.62 Z96.642		
Patient	Eleven	N/A	7/13/2019	99213		25	1	S52.592A	Comp	Det	Mod	99214		25	1	S52.592a	99213	
					29075	LT	1	S52.592A					29075	LT	1	S52.592a		
					Q4010		1	S52.592A					Q4010		1	S52.592a		
Patient	Twelve	N/A	6/30/2019	99212		25	1	M65.311 M65.312	Comp	Det	Mod	99214		25	1	M65.311 M65.312 M65.341 E11.9	99214	The documentation and medical necessity support a level four visit. The provider clearly documented the concern about the comorbidity of diabetes and the effect the treatment plan could have as a result.
					20600	RT	1	M65.341					20550	FA	1	M65.312		The injection documentation did not clearly identify the anatomical location injected. Based on the diagnosis and exam, it appears a tendon instead of a joint would have been injected. Templates are a great tool, but need to be modified to reflect the work done at the encounter.
					20600	50 59	2	M65.312 M65.311					20550	F5	1	M65.311		The injection documentation did not clearly identify the anatomical location injected. Based on the diagnosis and exam, it appears a tendon instead of a joint would have been injected. Templates are a great tool, but need to be modified to reflect the work done at the encounter.
													20550	F8	1	M65.341		The injection documentation did not clearly identify which right finger or the anatomical location of the finger injected. Based on the diagnosis and exam, it appears a tendon instead of a joint would have been injected. Templates are a great tool, but need to be modified to reflect the work done at the encounter.
					J0702		2	M65.312 M65.311					J0702		2	M65.311 M65.312 M65.341		
Patient	Thirteen	N/A	6/29/2019	99213		25	1	M66.812 M66.811				NA					NA	This visit is for a known problem previously treated with cortisone injections. The work represented in the documentation does not support "the patient's condition required a significant, separately identifiable E&M service above and beyond the usual preoperative and postoperative care associated with the procedure performed." Billing an E&M with a -25 modifier is not appropriate for this visit. CPT 2017 Professional

Sample Report

DoctorsManagement - Coding Compliance Audit Review - AUDIT FINDINGS

Client: Sample Report
DM Auditor: Auditor, CPC. CPMA, CPPM, CPC-I, CEMC, CEMA, ICD-10-CM Trainer
Audit Date: 09/25/19
Provider: Sample Doctor, MD

Findings Legent: Green- Incorrect CPT audited to a lower level, Yellow- Incorrect CPT audited to a higher level, and Blue indicates a diagnosis coding error

Patient Last Name	Patient First Name	MRN# / Account #	Date of Service	E&M Code reported	CPT/ HCPCS Code Reported	Modifier(s)	Units of service	ICD-10 Code(s) Reported	History	Exam	Medical Decision Making	DM E&M Code	DM CPT/ HCPCS Code	DM Modifier(s)	Units of service	DM ICD Code(s)	Med. Nec.(MN)	DM Audit Comments Findings/Suggestions
					20610	50	1	M66.812 M66.811					20610	50	1	M66.811 M66.812		
					J3301		8	M66.812 M66.811					J3301		8	M66.811 M66.812		
Patient	Fourteen	N/A	6/22/2019	99203		25	1	M17.12 M25.562	Comp	Det	Mod	99203			1	M17.12	99203	There is no CCI for this code pair. Modifier 25 should not be reported.
					20610	LT	1	M25.562 M17.12					20610	LT	1	M17.12		
					73562	LT	1	M25.562 M17.12					73560	LT	1	M17.12		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."
					J3301		8	M25.562 M17.12					J3301		8	M17.12		
Patient	Fifteen	N/A	6/22/2019	99203			1	M79.672 M25.775	Comp	Det	Mod	99203			1	M25.772 M19.072	99203	There were findings of OA on the x-ray. This should be included in the diagnosis codes. Pain is a symptom and should not be included.
					73630	LT	1	M25.775 M79.672					73620	LT	1	M25.772 M19.072		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."
Patient	Sixteen	N/A	6/26/2019	99203			1	S92.515A	Comp	Det	Low	99203			1	S92.515d	99203	Assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time. This encounter is for subsequent treatment in the healing phase so the 7th character should be "D".
Patient	Seventeen	N/A	6/26/2019	99212		25	1	M70.62	Comp	EPF	SF	NA					NA	At his last visit, the patient was told to call for an injection if the problem didn't resolve. The reason for this visit was an anticipated procedure. The work represented in the documentation does not support "the patient's condition required a significant, separately identifiable E&M service above and beyond the usual preoperative and postoperative care associated with the procedure performed." Billing an E&M with a -25 modifier is not appropriate for this visit. CPT 2017 Professional
					20610	LT	1	M70.62					20610	LT	1	M70.62 Z96.652		
					J3301		8	M70.62					J3301		8	M70.62 Z96.652		
Patient	Eighteen	N/A	6/22/2019	99213			1	S52.591D	EPF	EPF	SF	99213			1	S52.591d	99212	The documentation supports level three, but the medical necessity of the visit is level two.

Sample Report

DoctorsManagement - Coding Compliance Audit Review - AUDIT FINDINGS

Client: Sample Report
DM Auditor: Auditor, CPC. CPMA, CPPM, CPC-I, CEMC, CEMA, ICD-10-CM Trainer
Audit Date: 09/25/19
Provider: Sample Doctor, MD

Findings Legend: Green- Incorrect CPT audited to a lower level, Yellow- Incorrect CPT audited to a higher level, and Blue indicates a diagnosis coding error

Patient Last Name	Patient First Name	MRN# / Account #	Date of Service	E&M Code reported	CPT/ HCPCS Code Reported	Modifier(s)	Units of service	ICD-10 Code(s) Reported	History	Exam	Medical Decision Making	DM E&M Code	DM CPT/ HCPCS Code	DM Modifier(s)	Units of service	DM ICD Code(s)	Med. Nec.(MN)	DM Audit Comments Findings/Suggestions
					73100	RT	1	S52.591D					73100	RT	1	S52.591d		
Patient	Nineteen	N/A	6/22/2019	99213		25	1	M17.11	Comp	Det	Mod	99214		25	1	M17.11	99214	The documentation and the medical necessity of this visit support level four.
					20610	RT	1	M17.11					20610	RT	1	M17.11		
					73560	RT	1	M17.11					73560	RT	1	M17.11		The order indicates three views were taken, but the code for 1 or 2 views was billed. This may be a mistake in the EMR. However, based on the documentation in the report, it is billed correctly because the views were not identified in the report.
					J3301		8	M17.11					J3301		8	M17.11		
Patient	Twenty	N/A	6/29/2019	99213		25	1	M16.12 M70.62	Comp	Det	Low	99214		25	1	M70.62 M16.12	99213	
					20610	LT	1	M70.62					20610	LT	1	M70.62		
					73502	LT	1	M70.62 M16.12					73501	LT	1	M70.62 M16.12		The report of an x-ray has to have the anatomical location and views identified along with the findings. This is information that has to stand alone from the order and the rest of the visit documentation. The views and/or anatomic location were not identified in this report. For example, "Four views of the left knee taken in the office today reveal..."
					J3301		8	M70.62					J3301		8	M70.62		

Sample Report

Encounter Type	Total Codes Audited	Reported Accurately	Not Reported Accurately			Accuracy Rate
			Lower Level Supported	Higher Level Supported	No EM Supported	
E/M Codes	**20**	**11**	**1**	**6**	2	**55%**
			Not Supported	Alt. Code	Supp. not Coded	
CPT/HCPCS Codes	**47**	**29**	**1**	**16**	1	**62%**