DOCTORS®
MANAGEMENT
Leave the business of medicine to us

Sample Clinic

Sample, MD

Auditing and Regulatory Compliance
Report of Findings

January 2021

DoctorsManagement
10401 Kingston Pike
Knoxville, Tennessee 37922
Tel: 800-635-4040 Fax: 865-531-0722
www.drsmgmt.com

Audit and Regulatory Compliance
Professional Services Audit Summary
2021

PROVIDER NAME: Sample, MD, FACS
DM AUDITOR: Senior Consulting Team Member, CPC, CEMA, CPMA
AUDIT DATE: 1/20/2021

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;
h. Validation of ancillary services (if applicable);
i. Potential electronic medical record issues (e.g., templates that may be causing documentation deficiencies).

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

a. Centers for Medicare and Medicaid Services National & Local Coverage Determinations;
b. Commercial and other governmental payer guidelines as applicable and available;
c. AMA CPT Guidance to include AMA CPT Assistant;
d. Documentation Guidelines to include, as appropriate: 1995, 1997, and/or 2021
e. National Correct Coding Initiative (NCCI) Bundling Edits;
f. International Classification of Diseases, Tenth Revision, Clinical Modification; and
g. Additional authoritative published guidance, which are specified in conjunction with findings.

Dates of Service Reviewed: January 2021. Specific findings for each encounter reviewed are 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	10	9	1	0	0	90%

COMPARISON TO 2020 REVIEW FINDINGS

February 2020 Results: 40% accuracy rate for review of 10 E/M encounters
July 2020 Results: 90% accuracy rate for review of 10 E/M encounters
January 2021 Results: 70% accuracy rate for review of 10 E/M encounters

There was substantial improvement seen across the span of multiple audit reviews performed across 2020 and into 2021. While the initial February 2020 audit did show multiple variances regarding the selection of E/M services based on supporting documentation and medical necessity, the second audit performed in July 2020 showed only one variance regarding the lack of exam documentation for one patient. There were multiple variances noted within the 2021 review one of which is COVID related, one administrative error, and one under-coded encounter as noted on the attached spreadsheet claim line detail report. Below are specific findings as noted in the detail report along with corrective action for compliance performance.

REVIEW OF FINDINGS

Evaluation and Management Documentation and Code Level Selection

Each encounter has been audited utilizing the AMA E&M 2021 Documentation Guidelines for all office-based services. This audit did not include any services outside of the office place of service that would require the use of any other E&M Guidelines. Medical necessity is still the overarching factor as noted below in the *CMS 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.*"

Selection of E/M Service Based on Supporting Documentation and Medical Necessity

One (1) encounter reviewed with a 2021 DOS had a variance between the billed and reported level of service. The provider billed a level 3, but the encounter was found to support a level 4. Utilizing the new 2021 MDM criteria, 2 of the 3 MDM components are required to support the level of service reported. While within your specialty is noted that often the data portion of MDM does not contribute to higher levels of service, the complexity of the presenting problem in combination with the management options and considerations made during the patient encounter often contribute to higher levels of service. That is the case in the noted encounter.

Consider the following reference card that can be used when working to allocate the work of the encounter into the appropriate MDM allocations:

Elements of MDM:	Straightforward/Minimal Complexity Encounter	
	MDM Level Two New Patient: 99202 Est. Patient: 99212	Level of Service: Total Minutes Required
Nature of Presenting Problem(s) Data Reviewed/Analyzed	Self–Limited OR Minor Minimal **OR** None	New Patient 99202: 15-29 minutes Established Patient 99212: 10-19 Minutes
Patient Management Risk	**Examples Could Include** (e.g. rest, gargle, elastic bandages)	Prolonged services not applicable If total time on date of encounter meets above ranges, codes are supported on time w/qualifying time statement
Elements of MDM:	**Low Complexity Encounter**	
	MDM Level Three New Patient: 99203 Est. Patient: 99213	Level of Service: Minutes Required
Nature of Presenting Problem(s)	1 Chronic; **OR** 1 Acute Uncomplicated 2+ self-limited or minor problems	New ...nt: 99203: 30-4...tes
Data Reviewed/Analyzed	(2 of the following: Review external notes, Review Unique* Test, Order Unique* Test): ... Independent Historian	Established Patien...213: 20-29 Minutes
Patient Management Risk	**Examples Could Include:** (e.g. OTC meds, physical therapy, minor procedure w/o risk factors)	**Prolonged Services NOT Applicable** ...al time on date of encounter meets above ranges, ...re supported on time w/ qualifying time statement
Elements of MDM:	**Mod... Complexity E...unter**	
	MDM Level ... New Patient: 99204 Est...ient: ...4	Level of Service: Total Minutes Required
Nature of Presenting Problem(s)	2+ Chro... **OR** 1 Chronic E...sted, **OR** 1 Acut...mplicated...1 undiagnose...w problem ...certain prog; ... acute illness ...ystemic sx	New Patient 99204: 45-59 Minutes
Data Reviewed/Analyzed	Any 3 from the ...Review exter...notes, ...Unique...st, Order Unique...Independent Histo... Independent Review & Interpretation of ...R Discussion w/another Provider	Established Patient 99214: 30-39 Minutes
Pa...t Man...ment Risk	Ex...les Could Include: (e...PX meds, ...or procedure /w risk, major ...cedure w/o risk, SDOH limiting care)	Prolonged Services NOT Applicable If total time on date of encounter meets above ranges, codes are supported on time w/ qualifying time statement
Element... of MDM:	**High Complexity Encounter**	
	MDM Level Five New Patient: 99205 Est. Patient: 99215	Level of Service: Total Minutes Required
Nature of Presenting Problem(s)	1 Chronic Severe Exacerbated, **OR** 1 Acute/ Chronic w/Threat to life/loss of bodily function	New Patient 99205: 60-74 Minutes 60-74 Minutes
Data Reviewed/Analyzed	**REQUIRES 2 OF 3 Options:** Review external notes, Review Unique* Test, Order Unique* Test, Independent Historian); **OR** Independent Interpretation of Test; **OR** Discussion w/another Provider	Established Patient 99215: 40-54 Minutes
Patient Management Risk	**Examples Could Include:** (e.g. high-risk medication, major surgery w/ risk factors, emergency surgery, DNR due to poor prognosis, decision regarding hospitalization)	**Prolonged Services Add-on Codes Allowed per each additional 15 min:** **Listed minutes below are the minimums* New Patient (99205, +G2212 **OR** 99205, +99417) Medicare (+G2212 x1): 89 min • CPT (+99417 x1): 75 min Establish Patient (99215, +G2212 **OR** 99215, +99417) Medicare (+G2212 x1): 69 min • CPT (+99417 x1): 55 min

Other Variances Noted:
Missing Documentation: The audit noted an encounter in which it appears the documentation of the encounter was not completed. This does not appear to be a normal occurrence for this provider and has been noted as an administrative error. However, the provider is reminded that in such instances, the carrier may request reimbursements for any billed service with incomplete documentation. Furthermore, this would also be a medical liability consideration that should be addressed. A "Late Entry" is when documentation is created anytime beyond 24-48 hours of the encounter occurrence and would be appropriate in such instances. A compliant late entry in such an example would include appropriate documentation of the encounter, to the best of the providers recall, and a date (time is encouraged by CMS) and signature on date in which the entry occurred. There is no fine or penalty for late entries, but any over utilization of such documentation techniques could trigger further carrier audit and review.

COVID Related Care: During the pandemic, managing the ever-changing landscape of coding and billing has been quite the battle. During this review, we noted an encounter in which the provider saw an asymptomatic, non-exposed patient for travel related COVID screening. Such encounters do not meet the definition of a medically necessary interaction with the provider. This encounter cannot be supported as a reimbursable encounter for this reason. Recommendation for such encounters are as a cash pay service.

Post Audit Recommendations

Based on the expectations of 90-95% accuracy, the current proficiency rating is noted as deficient. While the finding of this coding compliance audit note variances that were not related to documentation and coding by the provider, they are still compliance deficiencies which necessitate improvement. In an effort toward mitigating further compliance risks in these areas the following action plan is recommended:

1. Post initial provider training to include a purposeful and interactive review of 2021 E/M Documentation Guidelines in conjunction with encounters audited, we recommend a re-audit evaluation for objective performance improvement in 6-8 weeks. This time will allow any required template or workflow process improvement and implementation as well as encounter volumes to populate a new sample pool. Subsequent sample size should include no less than 10 encounters.
2. Proficient scoring by the provider of noted deficiencies will show improved compliance for successful audit review.
3. Deficient scoring upon re-review should adhere to the organizations Audit Escalation Policy, and DM has samples available upon request by the Client.

PROVIDER INSTRUCTIONS

Acknowledgement of Audit Findings

Sample Organization, contracted with DoctorsManagement consulting firm using NAMAS, a division of DoctorsManagement, to perform an audit. The purpose of this audit was to review each individual provider's documentation on a one-on-one basis, specifically identifying weakness based on required documentation guidelines.

Coding Forums have been held to reviewing the specific findings of the audit, included within this report to include corrective measures required. The provider of record has been advised of their opportunity to discuss any of the findings with the Senior Consultant Trainer from DoctorsManagement during the feedback session.

Furthermore, the provider has been made aware that ongoing auditing of their documentation content and coding will be performed on a consistent basis to maintain a high level of compliance for CLIENT.

The undersigned provider is acknowledging and agreeing to the above statements, full understanding of this report, and affirms their commitment to **Sample Organization**, to make the noted changes to their documentation, coding, and billing to ensure the highest level of accuracy for compliance purposes. The undersigned provider also acknowledges that while their status is under the umbrella of **Sample Organization,** ultimately each provider is responsible for their own documentation and coding. **Sample Organization** will continue to provide audits, make resources available to each provider, and perform ongoing educational sessions, but ultimately the content of the documentation and the coding produced by each provider is their own responsibility.

The provider noted below agrees with the above acknowledgment, and a copy of this form will be maintained within **Sample Organization's** Compliance Plan.

The provider should read and understand the comments and educational feedback and address any questions or concerns this information may pose. The findings are 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.

Providers Printed Name	Providers Signature	Date

DISCLAIMER

DoctorsManagement to Sample Organization and The Provider of Record

DoctorsManagement has conducted this audit at the request of the client. All information that was reviewed was a sample selected and provided by the client and released under secure HIPAA compliant data exchange to DoctorsManagement for collective review.

It is the job of an auditor to find deficiency within an organization 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, 1997, and 2021 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 organization maintain these findings within 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 have been identified through the audit review (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.