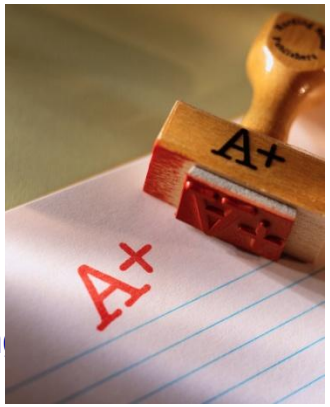
Auditing Medical Chart Documentation

Greater Pittsburgh Chapter
AAPC Meeting

February 15, 2011

Why Are Audits Performed?

- **Federal Regulation**
  - OIG – Office of the Inspector General insists on the importance of accurate E&M coding and documentation
  - OIG recommends medical record reviews by a third party annually
  - An annual coding review should be part of every physician group compliance plan
  - Ensure compliance with applicable laws and regulations which are increasingly changing
  - ***To prepare the physician practice for the impending government health plan audit***
- **Required by the Health Plan**
  - HEDIS: performance measures in managed care
- **Research**
  - Treatment strategies, geographic consideration
- **Quality Improvement**
  - Identify deficiencies and development improvement plan
  - Ensure billing accurately reflects the documentation and identify codin
- **Identify areas of revenue opportunities**



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Office of Inspector General

- Responsible to protect the integrity of the Department of Health and Human Services as well as beneficiaries of these programs

- Duties are carried out through a nationwide network of audits, investigations and inspections
  - Investigate:
    - Medicare and Medicaid fraud – including *allegations* of fraud

- Coordinate duties with Department of Justice and other law enforcement authorities

2011 OIG Workplan - Providers

Hospice Utilization in Nursing Facilities
Services Provided to Hospice Beneficiaries Residing in Nursing Facilities
Place-of-Service Errors
Ambulatory Surgical Center Payment System
Coding of Evaluation and Management Services
Payments for Evaluation and Management Services
Evaluation and Management Services During Global Surgery Periods
Medicare Payments for Part B Imaging Services
Billing of Portable X-Ray Suppliers
Services Performed by Clinical Social Workers
Partial Hospitalization Program Services
Outpatient Physical Therapy Services Provided by Independent Therapists
Questionable Billing for Medicare Outpatient Therapy Services
Appropriateness of Medicare Payments for Polysomnography
Medicare Payments for Sleep Testing
Excessive Payments for Diagnostic Tests
Laboratory Test Unbundling by Clinical Laboratories

Medicare Part B Payments for Glycated Hemoglobin A1C Tests
Trends in Laboratory Utilization
Lab Test Payments: Comparison of Medicare with Other Public Payers
Geographic Areas With a High Density of Independent Diagnostic Testing Facilities
Independent Diagnostic Testing Facilities' Compliance With Medicare Standards
Comprehensive Outpatient Rehabilitation Facilities
Medicare Providers' Compliance With Assignment Rules
Medicare Payments for Claims Deemed Not Reasonable and Necessary
Medicare Billings With Modifier GY
Payments for Services Ordered or Referred by Excluded Providers
Payments for ESRD Beneficiaries Entitled to Medicare Under Special Provisions
Error-Prone Providers: Medicare Part A and Part B
Comprehensive Error Rate Testing Program: FY 2010 Error Rate Oversight
Medicare Services Billed With Dates of Service After Beneficiaries' Dates of Death

Medicare Claims Review Programs

- *"The overall goal of CMS' claim review programs is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers"*
  - Since 1996
  - to prevent improper payments ***before*** a claim is processed and also, to identify and recoup improper payments ***after*** the claim is processed.

https://www.cms.gov/MLNProducts/downloads/MCRP_Booklet.pdf

Prepayment Reviews – NCCI Edits

- Based on coding conventions defined in CPT and HCPCS Manuals

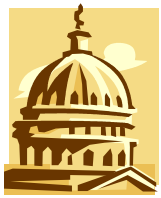
- Test every pair of codes reported for the same date of service for the same beneficiary by the same provider against the NCCI edit tables.
  - *If a pair of codes hits against an NCCI edit, the column two code of the edit pair is denied unless it is submitted with an NCCI associated modifier and the edit allows such modifiers.*
    - may not be billed to Medicare beneficiaries
    - provider cannot utilize an “ABN form to seek payment from a Medicare beneficiary

Prepayment Reviews – Medically Unlikely Edits (MUE)

- Established units of service edits
  - maximum units of service under most circumstances that a provider would report for a code for a single beneficiary on a single date of service
- Based on anatomic considerations
- A claim line denial due to an MUE may be appealed

Postpayment Reviews - RAC (Recovery Audit Contractors) Audits

- National RAC program in place effective January 1, 2010
- Result of successful demonstration in which RAC's identified Medicare overpayments and underpayments to healthcare providers and suppliers.
  - **$900 million** in overpayments being returned to Medicare Trust Fund between 2005 and 2008
  - **$38 million** in underpayments returned to healthcare providers
- RAC Auditors have their own software that assists in identifying areas to audit
- May also use "automated" review based on statistics
  - Can only be performed when there is certainty that claims represent an overpayment
    - NCD, LCD, etc.
    - Based on medically unbelievable service
    - Occur when no timely response is received in response to MR request letter



Postpayment Review - CERT (Comprehensive Error Rate Testing)

- Produce a National Medicare FFS error rate
  - Paid claims error rate
  - Provider compliance error rate
- Small percentage of providers
  - Still subject to
    - potential post-pay payment denials
    - payment adjustments
    - other administrative or legal actions
- Normal appeals rights and processes do apply.
- The CERT program cannot be considered a measure of fraud

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Penalty for False Claims

- ***The Medicare/Medicaid Civil Monetary Penalties Law*** provides for the imposition of civil monetary penalties up to $10,000 per false service claimed, PLUS assessments equal to three times the amount claimed, for services that the provider knows or should know were not provided.
- ***The Civil False Claims Act*** imposes civil monetary penalties of between $5,000 – $10,000 PLUS 3 times the value of each claim.
- ***The Criminal False Claim Act*** prohibits knowingly and willfully making or causing to be made any false statement in any claim. Violations are felonies and are punishable by up to 5 years in jail and/or $25,000 in fines.
- ***Other federal criminal laws*** also may be used to prosecute the submission of false claims. Felony convictions will result in exclusion from Medicare for a minimum of 5 years.

Top Documentation Errors for Professional Services

- Consistently billing the same level of service
- Misinterpreted abbreviations
- Not listing a chief complaint for each visit
- Billing service(s) included in global period
- Inappropriate or no modifier used
- No documentation for services billed
- No signature on documentation
- Unbundling of procedural services
- Billing consult vs. new patient visit
- Billing invalid codes due to encounter form not being updated

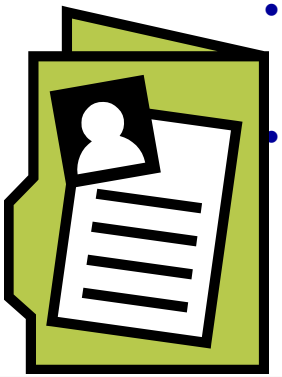
Purpose of THE AUDIT

The purpose of an audit should be determined prior to performing the review. The purpose will determine the documentation that is requested from the physician or physician group as well as the deliverable.

Types of Audits

COMPLIANCE AUDIT

- Evaluate the providers compliance with documentation rules and guidelines
- Focuses on documentation content and adherence to rules and guidelines
- May be performed internally or by a third party auditor
  - Prospective/Prepayment Audit: performed prior to claim submission; larger practices or hospital based practices
  - Concurrent Audit: performed as service is performed; provides immediate education
  - Retrospective/Postpayment Audit: most commonly performed; performed after claim has been filed; smaller physician practices

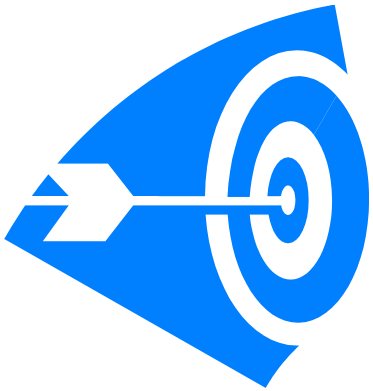


Types of Audits

RISK MANAGEMENT AUDIT

- **Evaluates how patient care is delivered**
- **Request will include all chart documentation: history forms, referral forms, HIPAA documents, etc.**

Types of Audits



FOCUSED AUDIT

- **Identified <u>after</u> the baseline audit**
- **Targeted/Problematic areas**
  - Claims paid for selected services (Focus on 99214, 99233)
  - Claims paid on selected payers (Medicare and Medicaid)
  - Identified Risk areas (Consultations, New Patients)

Beginning the Audit

Begin with a BASELINE AUDIT:

- 20 – 25 records per provider
- Randomly chosen – reflecting the coding trends of the provider based on utilization
- Should include office procedures and surgical procedures when appropriate
- Measure progress and allows practice to tracks its compliance efforts

Audit Documentation to be Requested

Documentation	Compliance Audit	Risk Management Audit
Patient Information Form		X
Medical Information Logs (history forms, medication logs, problem lists, etc.)	X	X
Legal Release/Billing Forms (assignment of benefits, HIPAA, ABN, etc.)		X
Progress Note	X	X
Encounter Form	X	X
Billing Record	X	X
Claim Form	X	X
Health Plan explanation of benefits – identifies denial issues	X	X

Auditing the Records

- ***The auditor*:**
  - **Must audit based solely on the information provided – <u>never assume</u>**
  - **Must audit specific to the date of service being audited**
    - **Cannot utilize information from other dates of service or other records UNLESS clearly identified where to find the information**
      - **The progress note must state, "The PFSH has been reviewed and is unchanged from the initial history form dated 11/6/2010" <u>AND</u> the initial history form must be included in the audit documentation**

Auditing Evaluation and Management Services

New Patient vs. Established Patient

A patient is considered **NEW** when he/she has not has professional face-to-face services from the physician or from a physician of the same specialty *in the group* within **3 previous years.**

Coding and Documentation Guidelines

"Carriers and A/B Medicare Administration Contractors (MACs) are to continue reviews using both the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services (whichever is more advantageous to the physician)."

https://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp

Components

KEY COMPONENTS

- **History**
- **Exam**
- **Medical Decision Making**

CONTRIBUTORY COMPONENTS

- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time

History Component

- **History of Present Illness (HPI)**
- **Review of Systems (ROS)**
- **Past Medical, Family, Social History (PFSH)**

History

Chief Complaint

- **Why is the patient being seen?**
- **Chief complaint is a required history component and must be able to stand independently from other portions of the medical record**
- **Expressed in the patient's own words**
- **Brief and concise**
- **Some providers indicate history elements here**

TIP: *1.* **Not acceptable**

- "Labs"
- "Follow Up"
- "Post Op"
- "No complaints"
- "If the patient has to have BW today, he had a chicken sandwich for lunch"

History

HPI – Elements

- **CPT recognizes 8 elements (1995 & 1997)**

Location	**Severity**
Quality	**Timing**
Duration	**Modifying Factors**
Context	**Associated Signs/Symptoms**

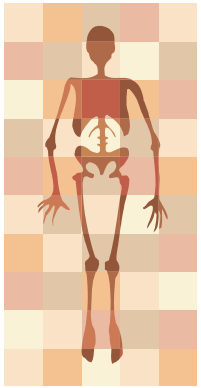
OR

- Status of Chronic Conditions (1997 only)
- Further explains the CC; how the CC affects the patient symptomatically
- Expressed in patient's own words
- **Information must be obtained and documented by the provider**

History
ROS

- **Verbal between the patient and physician; in the patient's own words**

Constitutional
Eyes
Ears, Nose, Mouth Throat
Cardiovascular
Respiratory
Gastrointestinal
Genitourinary



Musculoskeletal
Integumentary
Neurological
Psychiatric
Endocrine
Hematologic/Lymphatic
Allergic/Immunologic
ALL OTHERS NEGATIVE

TIP: *1. COMPLETE ROS – 10 organ systems reviewed and documented OR Systems Related to CC AND statement, "All Others Negative"*
2. Can use intake/health history form – indication must be made that physician reviewed/updated
3. "Unremarkable" and "Non-contributory" not acceptable
4. No double dipping – cannot use same symptom as ROS and HPI

History

PFSH

- **Past History of Patient**
  - **Illnesses, Operations, Medications, Allergies, Dietary Status**
- **Family History**
  - **Review of medical events, hereditary diseases that may place the patient at risk**
- **Social History**
  - **Age appropriate review of activities: employment, use of drugs, alcohol, tobacco, sexual history**

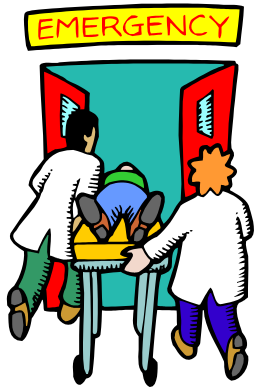
TIPS: *1. May be obtained by support staff*
2. Can use intake/health history form – indicate on current progress note that physician reviewed/updated
3. No credit for "non-contributory"
4. Watch for unnecessary documentation here – only what supports medical necessity is relevant

Past, Family, Social History

- **TWO LEVELS**:
  - **Pertinent PFSH:** At least ONE specific item from ANY of the three components of PFSH must be documented.
  - **Complete PFSH**: A review of two or all three of the PFSH components are required depending on the category of E/M service
    - *At least ONE item from TWO out of three PFSH components must be documented for a Complete PFSH for an established patient or ER visit.*
    - *At least ONE specific item from THREE of the three components of PFSH must be documented for a Complete PFSH for new patients, observation services, initial hospital services and consults and comprehensive nursing care facility assessments.*

Unobtainable History

- **Not obtainable due to:**
  - Trauma, Mental Status, Mentally Handicapped or Comatose



- **Chart should indicate specific reason why history is unobtainable**

- **Two Auditing/Scoring Possibilities**:
  - Omit History and score visit solely based on Exam and Medical Decision Making. The provider is not penalized or credited based on lack of documentation
  - Give credit for complete history. This gives provider potentially more credit than provider may be due
  - Should be documented in practice compliance plan

History
RESULT

- **Problem Focused**
- **Expanded Problem Focused**
- **Detailed**
- **Comprehensive**

History

Elements

1. History

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the *RIGHT* in the table, which best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the *LEFT*, identifies the type of history.

After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 5.

HISTORY				
HPI: Status of chronic conditions: ☐ 1 condition ☐ 2 conditions ☐ 3 conditions OR:		☐ Status of 1-2 chronic conditions		☐ Status of chronic conditions
HPI (history of present illness) elements: ☐ Location ☐ Severity ☐ Timing ☐ Modifying factors ☐ Quality ☐ Duration ☐ Context ☐ Associated signs and symptoms		☐ Brief (1-3)		☐ Extended (4 or more)
ROS (review of systems): ☐ Constitutional (wt loss, etc) ☐ Eyes ☐ Ears, nose, mouth, throat ☐ Card/Vasc ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Integumentary (skin, breast) ☐ Neuro ☐ Psych ☐ Endo ☐ Hem/lymph ☐ All/Immuno ☐ All others negative	☐ None	☐ Pertinent to problem (1 system)	☐ Extended (2-9 systems)	☐ *Complete
PFSH (past medical, family, social history) areas: ☐ Past history (the patient's past experiences with illnesses, operations, injuries and treatments) ☐ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) ☐ Social history (an age appropriate review of past and current activities)		☐ None	☐ Pertinent (1 history area)	☐ **Complete (2 or 3 history areas)
	PROBLEM FOCUSED	EXPANDED PROBL FOCUSED	DETAILED	COMPREHENSIVE

*Complete ROS: 10 or more systems, or some systems with statement "all others negative".

**Complete PFSH: 2 history areas: a) Established patients - office (outpatient) care; b) Emergency department.

3 history areas: a) New patients - office (outpatient) care, domiciliary care, home care; b) Consultations; c) Initial hospital care; d) Hospital observation; e) Initial Nursing Facility Care.

NOTE: For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Please refer to procedure code descriptions.

Exam

- **Hands On**
- **Provider Present**

Organ Systems (1997)

Constitutional
Eyes
Ears, Nose, Mouth, Throat
Cardiovascular
Respiratory
Gastrointestinal
Genitourinary
Musculoskeletal
Skin
Neurological
Psychiatric
Hematological/Lymphatic/Immunologic

OR

Body Areas and Body Systems (1995)

Head, including face
Chest, including breasts/axillae
Abdomen
Neck
Back, including spine
Genitalia, groin, buttocks
Each extremity

TIPS: *1. State specific abnormal and relevant negative findings*
2. "Normal" and "Negative" meets necessary documentation requirements

Exam
RESULT

- **Problem Focused**
- **Expanded Problem Focused**
- **Detailed**
- **Comprehensive**

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Exam Elements

2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination.
Circle the type of examination within the appropriate grid in Section 5.

Limited to affected body area or organ system (one body area or system related to problem)	PROBLEM FOCUSED EXAM
Affected body area or organ system and other symptomatic or related organ system(s) (additional systems up to total of 7)	EXPANDED PROBLEM FOCUSED EXAM
Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 or more depth than above)	DETAILED EXAM
General multi-system exam (8 or more systems) or complete exam of a single organ system (complete single exam not defined in these instructions)	COMPREHENSIVE EXAM

EXAM					
Body areas: ☐ Head, including face ☐ Chest, including breasts and axillae ☐ Abdomen ☐ Neck ☐ Back, including spine ☐ Genitalia, groin, buttocks ☐ Each extremity Organ systems: ☐ Constitutional (e.g., vitals, gen app) ☐ Eyes ☐ Ears, nose, mouth, throat ☐ Cardiovascular ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Skin ☐ Neuro ☐ Psych ☐ Hem/lymph/imm	☐ 1 body area or system	☐ Up to 7 systems	☐ Up to 7 systems	☐ 8 or more systems
	PROBLEM FOCUSED	EXP PROB. FOCUSED	DETAILED	COMPRE-HENSIVE

Medical Decision Making

Measured by:

- **Number of Diagnosis or Treatment Options**
- **Amount and/or Complexity of Data Reviewed**
- **Level of Risk**

MDM – Number of Diagnosis or Treatment Options

Section A Number of Diagnoses or Management Options			
Self-limited or minor (stable, improved or worsening) **Max=2**		x1	
Est. problem (to examiner); stable, improved		x1	
Est. problem (to examiner); worsening or failing to respond		x2	
New problem (to examiner); no additional workup planned **Max = 1**		x3	
New problem (to examiner); additional workup planned		x4	
Total			

MDM – Number of Diagnosis or Treatment Options

For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

- For a presenting problem with **an established diagnosis** the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.

- For a presenting problem **without an established diagnosis**, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible", "probable", or "rule out" (R/O) diagnosis.

- The **initiation of, or changes in, treatment should be documented.** Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.

- If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.

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MDM – Amount and/or Complexity of Data to be Reviewed

Section B Amount and/or Complexity of Data to be Reviewed				
Review and/or order of clinical lab tests	**Max = 1**		x1	
Review and/or order of tests in radiology section of CPT	**Max = 1**		x1	
Review and/or order tests in medicine section of CPT	**Max = 1**		x1	
Discussion of test results with performing physician (unexpected results)			x1	
Decision to obtain old records and/or history from someone other than patient			x1	
Review and summarization of old records and/or obtaining history and/or discussion of case with another health care provider			x2	
Independent visualization of image, tracing or specimen itself (not just review of report)			x2	
Total				

MDM – Risk of Complications

Section C Table of Risk			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Options Selected**
Minimal	•One self-limited or minor problem, e.g., cold, insect bite, tinea corporis.	•Laboratory tests requiring venipuncture •Chest x-rays •EKG/EEG •Urinalysis •Ultrasound •KOH prep	•Rest •Gargles •Elastic bandages •Superficial dressing
Low	•Two or more self-limited or minor problems •One stable chronic illness •Acute uncomplicated illness or injury	•Physiologic tests not under stress •Non-cardiovascular imaging studies with contrast •Superficial needle biopsies •Clinical laboratory tests requiring arterial puncture •Skin biopsies	•OTC drugs •Minor surgery without identified risk factors •IV fluids w/o additives •Physical therapy •Occupational therapy
Moderate	•One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment •Two or more stable chronic illnesses •Undiagnosed new problem with uncertain prognosis •Acute illness with systemic symptoms •Acute complicated injury	•Physiologic tests under stress •Diagnostic endoscopies with no identified risk factors •Deep needle or incisional biopsy •Cardiovascular imaging studies with contrast and no identified risk factors •Obtain fluid from body cavity	•Minor surgery with identified risk factors •Elective major surgery with no identified risk factors •Prescription drug management •Therapeutic nuclear medicine •IV fluids with additives •Closed treatment or fracture or dislocation without manipulation
High	•One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment •Acute or chronic illnesses or injuries that pose a threat to life or bodily function •An abrupt change in neurologic status	•Cardiovascular imaging studies with contrast with identified risk factors •Cardiac electrophysiological tests •Diagnostic endoscopies with identified risk factors •Discography	•Elective major surgery with identified risk factors •Emergency major surgery •Parenteral controlled substances •Drug therapy requiring intensive monitoring for toxicity •Decision not to resuscitate or to de-escalate care because of poor prognosis
The highest level of risk in any one category on this table determines the level of risk.			

Level of Medical Decision Making

Result

- Straight Forward
- Low Complexity
- Moderate Complexity
- High Complexity

MDM – Final Selection

Levels of MDM (2 out of 3 decides complexity)	Straight Forward	Low	Moderate	High
Number of Diagnoses or Management Options	1	2	3	4
Amount & Complexity of Data	1	2	3	4
Risk of Complications	Minimal	Low	Moderate	High

Medical Necessity

Per CMS Guidelines:

*"**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."*

https://www.cms.gov/transmittals/downloads/r178cp.pdf

Office/Outpatient E/M

	New Office / Consults / ER Requires 3 components within shaded area					Established Office Requires 2 components within shaded area				
History	PF ER: PF	EPF ER: EPF	D ER: EPF	C ER: D	C ER: C	*Minimal problem*	PF	EPF	D	C
Examination	PF ER: PF	EPF ER: EPF	D ER: EPF	C ER: D	C ER: C	*that may not require presence of*	PF	EPF	D	C
Complexity of medical decision	SF ER: SF	SF ER: L	L ER: M	M ER: M	H ER: H	*physician*	SF	L	M	H
Average time (minutes) ER has no average time	10 New (99201) 15 Outpt cons (99241) 20 Inpat cons (99251) ER (99281)	20 New (99202) 30 Outpt cons (99242) 40 Inpat cons (99252) ER (99282)	30 New (99203) 40 Outpt cons (99243) 55 Inpat cons (99253) ER (99283)	45 New (99204) 60 Outpt cons (99244) 80 Inpat cons (99254) ER (99284)	60 New (99205) 80 Outpt cons (99245) 110 Inpat cons (99255) ER (99285)		5 (99211)	10 (99212)	15 (99213)	25 (99214)	40 (99215)
Level	I	II	III	IV	V		I	II	III	IV	V

Inpatient E/M

- **Initial Visits (99221-99223)**
  - **First inpatient encounter by the admitting physician**
  - **Only 1 initial visit per hospital stay**
  - **Includes**
    - **Care associated with admission**
    - **All work performed by the physician in all admit from office/nursing home, etc.)**
  - **Must have 3 of 3 Key Components**
    - **History**
    - **Exam**
    - **Medical Decision Making**

Inpatient E/M

- **Subsequent Visits (99231-99233)**
  - **Medicare allows only one hospital visit per day for the same patient**
  - **Payment is considered for more than one when physicians of different specialties bill with different diagnosis codes**
  - **Requires 2 of 3 Key Components**
    - **History**
    - **Exam**
    - **Medical Decision Making**

Inpatient E/M

Hospital Care	Initial Hospital/Observation Requires 3 components within shaded area			Subsequent Hospital Requires 2 components within shaded area		
History	D/C	C	C	PF interval	EPF interval	D interval
Examination	D/C	C	C	PF	EPF	D
Complexity of medical decision	SF/L	M	H	SF/L	M	H
Average time (minutes) (Observation care has no average time)	30 Init hosp (99221) Observ care 99218)	50 Init hosp (99222) Observ care (99219)	70 Init hosp (99223) Observ care (99220)	15 Subsequent (99231)	25 Subsequent (99232)	35 Subsequent (99233)
Level	I	II	III	I	II	III

Discharge Day Services

- **Used to report the total duration of time spent by physician discharging a patient**
  - **Final Exam**
  - **Discussion of hospital stay**
    - **(even if time spent is not continuous)**
  - **Instructions for care to all caregivers**
  - **Preparation of discharge record**
  - **Prescriptions**
  - **Referral Forms**

- **99238 – 30 minutes or less**
- **99239 – > 30 minutes – time MUST be documented**

Observation Care

PATIENT ADMITTED TO OBSERVATION STATUS & DISCHARGED FROM OBSERVATION ON A SUBSEQUENT CALENDAR DATE	**PATIENT IN OBSERVATION STATUS OTHER THAN THE INITIAL OBSERVATION OR DISCHARGE DATE** **(Effective Jan. 1, 2011)**	**OBSERVATION DISCHARGE** **Only Use when patient was discharged from observation "status" on different calendar date from observation admission and the patient was discharged home. (Always use in conjunction with 99218-99220).**	**PATIENT ADMITTED & DISCHARGED FROM OBSERVATION ON SAME CALENDAR DAY**
99218-Initial Observation Care, per day, D/D/SF or LOW	**99224** – Subsequent Observation Care, per day: PF/PF/SF or LOW	**99217**- Observation care discharge day management	**99234**- Observation or inpatient hospital care, D/D/SF or LOW
99219-Initial Observation Care, per day, C/C/MODERATE	**99225** – Subsequent Observation Care, per day: EPF/EPF/MODERATE		**99235**- Observation or inpatient hospital care, C/C/MODERATE
99220-Initial Observation Care, per day, C/C/HIGH	**99226** – Subsequent Observation Care, per day: D/D/HIGH		**99236-** Observation or inpatient hospital care, C/C/HIGH

Observation Care

- Only the **physician who admitted** and was responsible for the patient during his/her stay in observation may **bill observation codes**.

- If the provider is asked to see a patient while he/she is assigned to observation and that **provider is not the admitting provider,** the **outpatient visit or outpatient consultation codes should be used.** (Outpatient New 99201-99205, Outpatient Established 99211-99215, Outpatient Consult 99241-99245).

- There must be a **medical observation record** for the patient which contains dated and timed physician's admitting orders on the patient's care in observation, nursing notes and progress notes prepared by the doctor which the patient was in observation status. This record must be prepared **IN ADDITION TO** any emergency department or outpatient clinic department record. The physician order should reflect "Outpatient Observation" vs "Inpatient Admission".

- Observation services are **not considered routine service** prior to or **after** a diagnostic or outpatient therapeutic procedure.

Critical Care Codes

- Use when time is spent on the unit or floor directly contributing to the treatment of the critically ill or injured patient.
  - 99291: 30-74 minutes
  - 99292: each additional 30 minutes
- Time must be documented, even when not continuous
- For any documented time, full attention must be devoted to the patient

Critical Care Documentation

Critical Care Services must:

- **Be medically necessary and reasonable**

Documentation must include:

- **The critical illness causing impairment of vital organ systems**
- **The high-complexity intervention**
- **How much time the attending physician spent in direct critical care of the patient**

Critical Care - Time

- Time <u>includes</u>:
  - Direct patient care
  - Time spent on unit or nursing station
  - Discussing patient with nurse/consultant
  - Writing progress notes and reviewing imaging studies/labs
  - Bundles procedures:
    - ventilator management
    - reading a chest x-ray
    - blood gas
    - Venipuncture
    - gastric intubation
    - temporary pacing
    - vascular access procedures
    - cardiac output interpretation
  - Documented discussions with family members only when the patient cannot participate and the discussion is necessary for treatment decisions

- Time <u>does not include</u>:
  - Time spent on billable procedures
  - Time teaching residents on rounds
  - Linking to resident note
  - Routine daily updates to family when not necessary for care of patient

Coding E/M based solely on TIME

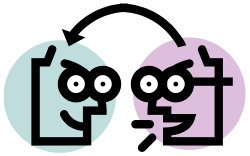
In the case where counseling and/or coordination of care **dominates (more than 50%)** of the physician/patient and/or family encounter (**face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility**), time is considered the key or controlling factor to qualify for a particular level of E/M services.

TIP: If coding is based on time - there are NO SPECIFIC DOCUMENTATION REQUIRMENTS FOR HISTORY, PHYSICIAL EXAM *AND* MEDICAL DECISION MAKING. HOWEVER, pertinent information about these elements should be documented and MDM must be supported.

"Incident to" Services

- Incident-to services are those services commonly furnished in a **physician's office** that are "incident to" the professional services of a physician.
  - Physician must personally perform an initial service for each new condition, make an initial diagnosis, and establish a treatment plan.
  - Physician must personally perform subsequent services at a frequency that reflects his/her active participation in and management of the course of the treatment for each medical condition.
  - Services must be performed under a physician's **direct personal supervision**:
  - Present in the office suite and immediately available to provide assistance and direction throughout the time the ancillary staff or NPP is performing the "incident to" services.
  - NPP may see a **new patient or treat a new problem** AND bill under his/her respective number if the collaboration/general supervision rules are met and the services are within the scope of practice of the NPP. *Payment will be made by Medicare at 85% of the physician fee schedule.*

Split or Shared Visits



- Split/Shared visits are those professional services furnished in an **inpatient/outpatient/emergency room setting.**

  – May be billed by NPP if scope of licensure, collaboration, and **general supervision** criteria are met.

  – Split/shared visits for initial and subsequent visits in the inpatient/ outpatient/ ED setting may be performed and billed by either the physician or NPP.
    - Physician and NPP must be from the same group practice
    - Physician must provided some face-to-face portion of the E/M visit; simply reviewing and/or signing the patient's chart **is not** sufficient to qualify for a shared service.
    - Both the NPP's and the physician professional services must be clearly documented on the patient's chart.
    - Both the NPP and the physician must see the patient on the same calendar day

  – Split/Shared Visits **cannot be billed** for: Critical care visits, consults, skilled nursing facility services, home care or domiciliary care visits or procedures

Non E/M Coding and Documentation

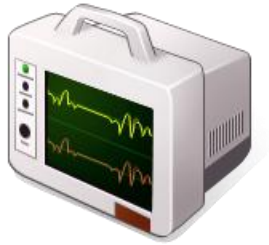
Injections, "J" Codes, Immunizations/Vaccines, Trigger Point Injections

- **Injections (subcutaneous):**
  - 2 codes
    - "J" code or actual medication code
    - Administration Code: 96372 (can only be reported under direct supervision of physician)
- **Injections (allergy)**
    - 95115, 95117 (does not include provision of extract)
- **Immunizations/Vaccines**
  - 2 codes
    - Actual immunization/vaccine
    - Administration Code: dependent on physician supervision

- CPT codes 20552-20553 describe single or multiple **trigger points** by the number of muscle groups involved
- CPT codes 20600-20610 describe aspiration/injection of joint size **(arthrocentesis)**
- The diagnosis of trigger points/arthrocentesis does not have a specific ICD-9 code, but you should code by specific muscle group or joint
- Documentation should state clearly and explain the evaluation leading up to this therapeutic option, as well as identification of the affected muscle(s)/joints

Documentation for Radiology Services Performed in the Practice

- Both CPT rules and Medicare billing/payment rules address the need for:
  - **A separate written report**
    - Medicare states the report should *mirror a "specialist in the field"*



- Ensure documentation includes:
  - Specific views (e.g. PA/lateral, standing), anatomic location of X-ray
  - Diagnosis
  - Reason for radiology service
  - Professional interpretation (include findings, limitations of exam, impression or conclusion, recommendations for follow-up.

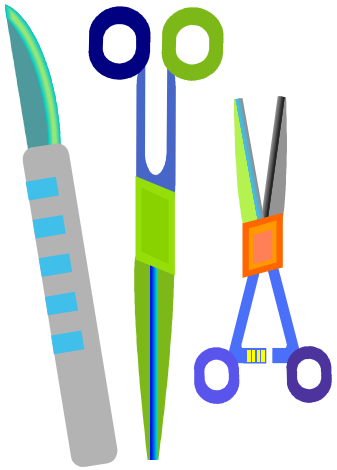
Auditing Surgical Services

Operative Notes

Operative note

- **Describes the procedure performed, diagnosis, names of surgeons, type of anesthesia, patient name and date of surgery. Most contain pre/post operative diagnoses.**

- **Includes four sections: Heading, Indications of the surgery, Body – detail of the procedure or surgery and the Findings.**



Operative Notes – Detail

- **Should contain the following**
  - Date of surgery
  - Patient Name
  - Pre-op diagnosis
  - Post-op diagnosis
  - Procedure performed
  - Name of primary and co-surgeon/assistance surgeon
  - Indications for the procedures
  - Consents obtained
  - Detail of the procedure which includes:
    - Preparation of patient for surgery
    - Surgical approach
    - Instruments and supplies used
    - Anesthesia used
  - Complications
  - Condition of the patient after the procedure
  - Provider signature (s)
- **Co-surgeon should have his/her own note**

Coding the Operative Note

- Read through report to confirm the procedure was performed
- Do not code from “Procedures Performed” – use as a guideline
- Make sure all appropriate diagnosis codes have been identified and are reported
- Verify surgical approach, complications, patient position, special equipment and unusual details
- Appropriate use of modifiers
- Know surgical guidelines by payer

Procedures Performed in the Office

- **Should have “mini”-procedure note documenting:**
  - **Site (left/right)**
  - **Technique (aseptic, sterile)**
  - **Risks/Benefits**
  - **Details of procedure**
  - **Outcomes**

Auditing Diagnosis Codes

Diagnosis Code Guidelines

- An ICD-9 code describes the **diagnosis, symptom, complaint, condition, or problem**, indicating why the service was performed must be selected.
- The medical record must **justify** the diagnosis.
- **Code** the **primary diagnosis first**, followed by the secondary, then tertiary, etc.
- The diagnosis reported **must match** the **physician documentation** in the medical record.
- Diagnosis codes for chronic conditions should not be used unless managed during the visit.
- “Rule outs”, “suspected” may be present in the medical chart documentation; *they cannot be used as a billing diagnosis* – this supports medical necessity.

Auditing CPT Code Modifier(s)

Use of Modifiers

- **Modifier usage helps**:
  - Add more information regarding the **anatomical site** of the procedure
  - Eliminate the appearance of **duplicate billing**
  - Add additional information about the service being provided when the **procedure code definition** is **not specific enough**
  - Eliminate the appearance of **unbundling**

TIP: *1.Can act as a red flag in post-payment audits because they generally make an additional representation about how the service was performed or the circumstances in which the service was performed. Watch overutilization of same modifier, i.e., -25, -59 or -22.*

PROVIDER SIGNATURE

Legibility

"II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible."

Physician Signature Requirements

With the implementation of RAC audits

- All medical records must be signed to support the service rendered
  - all medical records must be signed by the performing provider
  - include a "legible identifier" for all services provided/ordered
    - According to the Medicare medical review documentation standards, the legible identifier must be in the form of a hand written or electronic signature
  - Signature stamps are not acceptable

TIP(S):

1. *Watch for timely signatures!*
   - *Follow hospital guidelines for hospital records; follow policy and procedure in compliance plan for non-hospital records*
2. *"Dictated, but not read", "The provider indicated on this note is not responsible for transcription errors" – **NOT ACCEPTABLE***

THE AUDIT REPORT

The Audit Report

- The final results should be delivered and reviewed with the provider(s). The provider should be educated with regard to any inaccuracies or documentation issues.
- If the practice has a Compliance Officer, the results should be reviewed with him/her as well.
- If a healthcare attorney requests the audit, the results belong to the attorney.

Audit Report Contents

The ***FINAL REPORT*** should contain:

- A **summary memo** identifying the following:
  - Date of Audit
  - Who requested the audit
  - How many records were reviewed
  - Which providers were audited
  - A statement indicating a detailed report was prepared for each provider
  - A statement indicating a face-to-face or one group meeting was conducted/planning to be conducted to review the results
  - A brief overview of the findings
  - A recommendation for regular follow-up and re-audting
  - Identification of auditor

Audit Report Contents – con't.

The ***FINAL REPORT*** should contain:

- **Detailed reporting** of each record, including the History, Exam and Medical Decision scoring. The results should indicate what the provider coded and what the auditor coded. An explanation or recommendation with regard to the providers inaccuracies is a must for educational purposes. For example, "The history component would have met the criteria for a level IV if an additional HPI element was documented."
- **Trending/Bell Curve Reports** should be included as well. The CPT code utilization report must be obtained from the practice. It is recommended the data from the previous twelve months should be obtained. This information should be compared to the national provider average for the particular specialty.
- **Potential Revenue Gain/Loss** based on the practice fee schedule and sample audited can be provided.
- A summary of the **Explanation of Benefits Review** should identify any potential issues with billing or the healthplan.
- **Educational Materials** which specifically address the provider inaccuracies should be included as well.

Audit Report Contents

TEST OFFICE

Audit Summary Report

All Providers Audit Dt. Range 11/9/2009 To 11/9/2010

PatID	Visit Dt	Stat	First Name	Last Name	History	Exam	Declaion	Reviewer	Mod	DC	IT	Provider	Mod	Var	Diff
00129	11/9/10	Est.	Mary	Lamb	Expanded	Expanded (97)	Moderate	99213				99214		1	$0.00

Provider Dx 1	784.0 Headache	Reviewer Dx 1	784.0 Headache
Provider Dx 2	787.01 Nausea with vomiting	Reviewer Dx 2	787.01 Nausea with vomiting
Provider Dx 3	401.9 Hypertension NOS	Reviewer Dx 3	
Provider Proc 1		Reviewer Proc 1	81002 Urinalysis nonauto w/o scope

The documentation does not support a level IV established patient visit. Documentation guidelines state 2/3 key components must be documented as follows: History - DETAILED, Exam - DETAILED and Medical Decision Making - MODERATE. An additional HPI element or exam element would have met this criteria.

•CPT Code/CPT Code Modifier Inaccuracy (I); The CPT Code(s) or CPT Code Modifier(s) reported do not accurately reflect the documentation in the medical record. A urinalysis was documented, but not billed.

•Diagnosis Code Incorrect/Not Specific (I); The diagnosis code(s) reported do not reflect the medical record documentation as accurately as possible. Hypertension was not documented as managed for this visit.

Now What?

The Audit has been completed and reviewed, now what?

- **Ensure the practice compliance plan addresses these details**
- **EDUCATE, EDUCATE, EDUCATE!**
- **Based on compliance plan; re-audit as necessary. For example, if the compliance plan states the accuracy rate must be 85% or better, those providers who fall short of that benchmark should be re-audited every 3 months.**
- **Audit on an annual basis.**
- **Utilize a third party auditor.**
- **Keep detailed documentation of audit results and action plans.**

Medical Chart Auditing should be considered an investment, not an expense.

Audit Tools

- https://www.highmarkmedicareservices.com/em/pdf/scoresheets/8985.pdf
- http://emuniversity.com/FreeContent.html
- http://www.e-medtools.com/EandM_Coding_Tool_v1.pdf (online fillable)

Additional Resources

- **Evaluation and Management Guidelines:** http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

- **ICD9CM Coding Guidelines:** http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf

- **OIG 2011 Workplan:** **http://www.oig.hhs.gov/publications/workplan/2011/**