Certified Professional Medical Auditor (CPMA®)
Online Exam Review
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Chapter 1

Compliance and Regulatory Control

The Basics

Auditors should be keenly aware of the compliance rules and guidelines as well as regulatory control matters. This information should always be part of the provider analysis process. Knowing these key concepts for quick and valued input into a given situation is vital to an auditor’s role in assessing deficiencies within a provider coding or billing audit.

The basic core elements of compliance relate to and are structured to adhere to regulatory control matters. The two concepts work hand in hand. Regulatory controls are more of the rules to follow and the consequences for not following them. Compliance defines how the practice will specifically adhere to the regulatory control mandates.

This section will cover compliance and regulatory control concerns, how they are governed, and what this information means for an auditor’s day-to-day job duties.

Office of Inspector General (OIG)

The mission of the Office of Inspector General (OIG) is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary of HHS and to Congress any program and management problems and recommendations to correct them. The OIG’s duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by the OIG.

The Office of Audit Services (OAS) performs audits for HHS under the jurisdiction of the OIG. These audits give a fair assessment of waste and abuse management and efficiency throughout the department of HHS. The OAS provides the needed audits of HHS’ processing, rules, and regulations in an effort to review the performance of the HHS programs and contractors utilizing their own staff or by outsourcing as OAS sees fit.

The OIG is the gate keeper of fraud and abuse within a physician medical practice. A compliance plan is a physician practice’s way of working through the OIG’s suggested compliance regulations. Section 6401 of the Patient Protection and Affordable Care Act (PPACA) requires all health care providers and facilities have a compliance plan; however a date for compliance has not been established. A compliance plan will have the basic seven elements of compliance as recommended by the OIG along with ensuring a proper disciplinary action plan. Without a disciplinary action plan, there is no true commitment to compliance as there are no internal penalties associated with deficiencies. It is not enough to merely have a compliance manual; the adaptations of the policies and procedures for compliance constructed within the manual must be implemented and maintained for true compliance. The implementation will produce a compliant environment with state and federal guidelines which could reduce any imposed fines or penalties along with improving the overall operations of a physician practice.

The fundamentals of compliance are preventing fraud and abuse. It is imperative that all staff have a clear understanding of fraud and abuse including the differences and examples of each.

The Compliance Plan must be reviewed with all employees. The defined difference boils down to intent.
Fraud: Fraud is an intentional deception made for personal gain. Fraud is a crime, and a civil law violation.

Abuse: Abuse is an act that directly or indirectly results in unnecessary reimbursement without defined intent.

According to the OIG, the fines and penalties are the same for fraud and abuse, although history has demonstrated the OIG to be more lenient in abuse cases. The OIG will be more favorable in determining fines and penalties in a practice in which a compliance plan is being actively maintained.

OIG recommends employees be educated on all matters related to compliance and the specific components of the compliance plan for the practice. Educating the staff effectively takes the compliance of the practice and rests it on the shoulders of all of the employees as it is now additionally their responsibility to be forthcoming with all potential areas of concern for fraud and abuse. Empowering the staff through this educational process will additionally reduce the practice's risk of a qui tam suit. A qui tam suit is one in which an action that will grant the plaintiff (whistleblower) a portion of the recovered penalty and gives the rest of it to the state. The Compliance Program Guidance for Individual and Small Group Physician Practices recommends new employees be trained on the compliance program as soon as possible after their start date and receive refresher training on an annual basis or as appropriate.

Improper Payments
Billing for services not provided or performed is obviously a matter of serious misconduct and there should be clear policies in place to prevent this from occurring. Many providers who have issues related to improper payments are not aware of the misconduct that caused the problem. This can occur from hiring coders/billers who are not educated or experienced in proper billing and coding guidelines.

Billing services are not exempt and should also be reviewed and audited as part of the effective compliance of a practice. Identified billing errors, just as coding/documentation errors, should be noted, reported, and have a plan of action to prevent further deficiencies in future billings. The discovery of billing errors does not mean that a physician should freeze billing of all services. At a minimum, the provider should hold billing services with noted deficiencies until the appropriate corrective action plan is implemented.

Federal Anti-Kickback
Federal Anti-Kickback Law prohibits the knowing and willful solicitation, offer, payment, or receipt of any remuneration (broadly interpreted to encompass anything of value), whether direct or indirect, in cash or in like kind, to induce or in return for referring an individual, or purchasing or arranging for an item of service for which payment may be made under the Medicare, Medicaid, or other government health program. The federal statute specifically references this in regards to government funded policies; however, commercial carriers may investigate these issues as well.

The OIG annually updates a listing of Safe Harbor provisions. A Safe Harbor provision describes various payment and business practices that, although they potentially implicate the Federal Anti-Kickback Statute, are not treated as offenses under the statute. The Safe Harbor provisions are updated by the OIG and maintained on their website at:


An auditor should be familiar with the contents of the Safe Harbor listings to ensure they can recognize a potential violation as being exempt.

False Claims
Several different statutes prohibit the submission of false claims to federally funded health plans
as well as commercial carriers. A “false” claim includes a claim that does not conform to Medicare’s (or other programs) requirements for reimbursement. Practices must have a policy to submit claims for services that were actually performed.

Often false claims are not only services billed and not provided, but they may also be services misrepresented or billed in disguise as covered services. Examples include claims billed as physician incident-to services when the physician is not in the office or services such as Vax-D (non-surgical treatment for chronic back and neck pain) that are never covered by Medicare but billed as mechanical traction, a closely related reimbursable procedure. This would represent a false claim. Honest billing errors may also be considered a false claim if the provider should have known the proper coding guidelines. For example, if CMS releases a transmittal clarifying the proper reporting of a service, it is expected providers will follow the guidance provided.

The False Claims Act includes:

- **The Civil False Claims Act:** Imposes civil monetary penalties of between $5,500 and $11,000 plus three times the value of each claim. It prohibits the knowing submission of a false or fraudulent claim for payment to the United States, the knowing use of a false record or statement to obtain payment on a false or fraudulent claim, or a conspiracy to defraud the United States by having a false or fraudulent claim allowed or paid.

- **The Criminal False Claim Act:** Prohibits knowingly and willfully making or causing to be made any false statement or representation of material fact in any claims or application for benefits under federally funded health plans as well as commercial carriers. Violations are felonies and are punishable by up to five years imprisonment and/or $25,000 in fines.

- **The 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 as claimed or for claims the provider knows or should know are false or fraudulent.

- **Other federal criminal laws:** Also may be used to prosecute the submission of false claims, including prohibitions on making false statements to the government and engaging in mail fraud. Felony convictions will result in exclusion from Medicare for a minimum of a five-year period.

**Example of How a Penalty may be Imposed**

Medicare has completed a focused audit on Dr. Joe Slack who has been found to have filed false claims for services. For this case, 45 charts were audited, and 36 claims were found to represent false claims.

Combined, these services represent an overpayment to the provider of $32,000. Dr. Joe Slack must now remit payment to Medicare for $492,000.

The math breakdown:

\[
\begin{align*}
36 \text{ claims} \times \$11,000 (\text{False Claims Act Monetary Penalty}) \text{ penalty per claim} &= \$396,000 \\
\text{Overpayment} \times \text{three times the claim amount} (\$32,000) &= \$96,000 \\
\text{Total Due Medicare} &= \$492,000 \\
\end{align*}
\]

+ 5 years in jail and/or $25,000 additional fine
A physician practice identifying areas of deficiencies related to not just the False Claims Act and the Civil Monetary Penalties Law, but all other identified areas may self disclose these findings. Self disclosure should occur within 30 days of knowing about the violation, and does not require any form of legal assistance. Payments relating to the disclosed matter should not be made until the conclusion of the OIG inquiry to allow the OIG time to verify the information disclosed. Self disclosure does NOT prevent audits by the OIG, CMS, or a carrier to find further deficiencies, so it may be construed by many to not be of a specific benefit. Self disclosure is an expectation by all governmental carriers, the OIG, and typically all carriers with whom a practice is contracted and failure to do so may be interpreted as fraud. Electing to opt out of a plan will not be of any “gain” for the provider/practice in question as this is not a “get out of jail free card.” If any of the above mentioned laws are violated, the practice should consult a health care attorney for proper guidance.

Option for Providers

Providers who find themselves in the above described scenarios must consider their options carefully. Appeals are neither handled at the state or federal level nor by the Medicare contracted carrier. Options include:

- **Self Disclosure:** Fines may be less if a practice self-disclosed its knowledge of the violation.
- **Appeal Rights:** A practice has the right to an appeal process, and may choose to request a hearing before an administration law judge (ALJ). The OIG and the respondent have the right to present evidence and make arguments to the ALJ, who issues a written decision.
- **Additional Appeal:** The ALJ’s decision may be appealed administratively and to federal court.

It is important to note that GICs, ALJs, and MACs are not bound by LCDs and CMS Program Guidance.

**OIG Work Plan**

The OIG Work Plan is released annually and identifies priority areas for OIG review/investigation, which the agency believes are HHS’ most vulnerable programs and activities, with the goal to improve HHS agency efficiency and effectiveness. The Work Plan includes projects planned in each of the department’s major entities: the CMS services; the public health agencies; and the administrations for children, families, and aging. Information is also provided on projects related to issues that cut across departmental programs, including state and local government use of federal funds, as well as the functional areas of the Office of the Secretary. Some of the projects described in the Work Plan are statutorily required, such as the audit of the department’s financial statements, which is mandated by the Government Management Reform Act.

Auditors should review the OIG Work Plan each year to determine the services that may target an audit. Take a proactive approach and incorporate the services into your audit plan to identify errors and determine corrective action. The OIG Work Plan is available on the OIG website at [http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf](http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf).

**Corporate Integrity Agreement (CIA)**

**What is a Corporate Integrity Agreement?**

It is an agreement between the OIG and a health care provider or other entity. CIA agreements are detailed and restrictive agreements imposed on providers when serious misconduct (fraudulent or abusive type action) is discovered through an audit or self-disclosure.

The government may enter into a CIA with an entity instead of seeking to exclude the entity from Medicare, Medicaid, and other federal health care programs.

The typical term of a comprehensive CIA is five years. Most CIAs require a claims review be conducted, either by an Independent Review
Organization (IRO) or in some cases by the provider with a verification review performed by the IRO. The audits are typically required to be performed annually, and the findings of this audit are reported to the compliance officer overseeing the CIA. The report provided by the IRO must include the analysis and narrative explanation with findings and supporting rationale, and the results of the Discovery Sample or Full Sample.

The claims review procedures require a Discovery Sample. A Discovery Sample is used to determine the financial error rate. The Discovery Sample is a review of 50 units to be randomly selected.

The purpose of conducting a Discovery Sample as part of the claims review is to determine the net financial error rate of the sample that is selected. If the net financial error rate equals or exceeds 5 percent, the results of the Discovery Sample are used to determine the Full Sample size. The Full Sample size is based on an estimate of the variability of the overpayment amount in the population from which the sample was drawn. The results of the Discovery Sample allow the reviewer to estimate how many sample units need to be reviewed in order to estimate the overpayment in the population within certain confidence and precision levels (e.g., generally, a 90 percent confidence and 25 percent precision level).

These samplings are performed using statistical software known as RAT-STATS. For more in-depth information about RAT-STATS visit the following OIG website:


Stark Law

The Stark Law is primarily defined as a physician self-referral law, 42 USC 1395nn. Physician self-referral is defined by the Stark Laws as: the practice of a physician referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation arrangement. The Stark Law was sponsored by Congressman Pete Stark (Calif.). Individuals such as Stark contend such arrangements may encourage over-utilization of services, in turn driving up health care costs. This law prohibits a physician from making a referral to an entity with which the physician or his or her immediate family has a financial relationship if the referral is for the furnishing of designated health services, unless the financial relationship fits into an exception set forth in the statute or impending regulations.

Stark Law has been implemented in phases over the years, and even currently continues to mature and develop with the ongoing changes in the health care community. Stark Law is often mistaken as the Federal Anti-Kickback Law as they both are similar in nature, but are separate laws and statutes.

For the most part, an auditor can quickly concur if an issue is pursuant to Stark rules merely by checking commonly performed physician types of services such as referral for physical therapy, optical stores, Ambulatory Surgical Centers (ASC), etc. However, sometimes there are services that one may not know are mandated by Stark such as the level of teaching physician presence and involvement required when billing Medicare for supervising services performed by residents. The documentation of such involvement and the retroactive application of standards for supervision and documentation must be adhered to in order to bill these services.

Services such as sleep studies, EKGs, NCVs, and Holter monitoring, or services personally performed or provided by the referring physician are, however, not targeted by the Stark Law. Referral for services provided by non-physician providers is exempt as well. The exceptions to the Stark Law covered relationships internal to a physician group include items such as those involving in-office ancillary services or certain compensation/ownership arrangements.

Stark Law is written in a legal manner of speaking and may be found by many auditors to be difficult to understand. Legal counsel familiar with the
health care law will be able to differentiate through scenarios that may or may not be considered a Stark violation. An auditor’s role would be to know the rules associated with Stark and to be able to flag areas of potential concern for the practice to thoroughly investigate, and if necessary, seek legal advice.

The Joint Commission

The Joint Commission (JC), formerly the Joint Commission on Accreditation of Health Care Organizations (better known as JCAHO), is a private sector United States-based, not-for-profit organization. The Joint Commission operates voluntary accreditation programs for hospitals and other health care organizations. The Joint Commission accredits more than 17,000 health care organizations and programs in the United States. A majority of state governments recognize Joint Commission accreditation as a condition of licensure and receiving government carrier reimbursement. Surveys (inspections) typically follow a triennial cycle. Organizations deemed to be in compliance with all or most of the applicable standards are awarded the decision of accreditation.

The current trend in the health care environment of hospital-owned physician practices makes it necessary for an auditor to know specifics of the JC rules. If a hospital-owned physician practice is set up as a “department of” the hospital, it may be subject to JC inspection during the hospital inspection. Most of the JC rules and guidelines do not relate to services that an auditor would need to substantiate such as appropriate labeling of areas within the practice, CPR/ACLS protocols, etc. However, what would be pertinent to the auditor are some documentation specifics.

JC accreditation requires that when a patient is prescribed a drug, the patient is not only given a prescription for the medication but additionally informed of the side effects of the medication of choice. It is not enough for the provider to verbally state this is provided for all patients- as the golden rule of documentation states “not documented, not done.” There must be a statement included within the documentation that specifically addresses the side effects and any patient concerns were reviewed.

JC is very stern on the utilization of abbreviations. In 2004, the JC integrated an official “do not use” list of abbreviations into the Information Management standards. Each facility or practice may develop their own specific standards of accepted abbreviations outside of the official “do not use” list. A provider using abbreviations not of the normal standard nature should be educated about this requirement and this should be appropriately noted within the findings of the audit report. Hospitals usually develop lists of abbreviations that are acceptable. Providers who see patients in the hospital must also comply with using only the approved abbreviations of the specific hospital involved when documenting services (eg, inpatient visits).

The pain scale is also noted for the documentation of any encounter through the JC. The JC requires providers to screen patients for pain. The pain scale is actually divided into an adult and pediatric scale. The pediatric scale is 0–3 and any child whose reported level is >1 has been properly noted for the medical necessity of treatment. The adult pain scale is 0–10 and any adult with a pain scale >4 is additionally properly noted for the medical necessity of treatment.

RAC Audits

CMS Recovery Audit Contractor (RAC) Program

CMS has implemented a system to identify improper payments, fraud, and abuse in the Medicare system. Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC
program permanent and required the Secretary
of HHS to expand the program to all 50 states
as of January 1, 2010. Health care providers that
might be reviewed include hospitals, physician
practices, nursing homes, home health agencies,
durable medical equipment suppliers and any
other provider or supplier that bills Medicare. As
of January 1, 2011 RACs began including audits of
Medicare Advantage and Medicaid services as part
of the Patient Protection and Affordable Care Act
(PPACA).

RACs are paid through contingency fees. The
more over-payments they uncover, the more
money they receive.

Overpayments are identified through three
types of review: automated, semi-automated, or
complex. Automated reviews identify claims that
the RAC suspects overpayments to exist due to
statistical analysis. Semi-automated require the
provider to send in medical records to verify the
service was billed correctly. Many of these audits
are for services requiring billing units. Complex
reviews are performed by RAC auditors for audits
commissioned by CMS, and medical records may
be requested from providers in order to perform
these audits. Regardless of the type of audit, these
audits are performed retrospectively and are not
prospective in nature.

Most agree RAC audits are not a matter of “if”
but more a matter of “when” a provider will be
audited. Knowing this, an auditor should be aware
of what an appropriate RAC audit request involves.
An automated review will require no additional
work on the part of the physician practice, unless
there is intent to appeal. However, the semi-
automated and complex audits require additional
records be sent for the proper review.

RAC auditors may request records from providers
for the purpose of performing the audits they have
been commissioned to perform by CMS. CMS
limits the number of records the RAC can requests
from each entity. The single entity designation is
based on the practice’s tax identification number
(TIN) and the first three positions of the ZIP code
of the physical location. Each 45 days, records may
be requested based on the entity’s size:

- less than 5 providers—10 records
- 6–24 providers—25 records
- 25–49 providers—40 records
- 50 or more providers—50 records

CMS will utilize calendar days when using the
time line for record submission. Providers have
45 days to respond to a records request. If more
time is needed to comply, physicians may request
an extension from the RAC within the 45-day
time period. The RAC may find the claim to be
an overpayment if medical records are requested
and not received within 45 days. Prior to denying
the claim for failure to submit documentation, the
RACs shall initiate one additional contact. RAC
auditors have a three-year look back period for
records review.

**RAC Audit Appeals Process**

Physicians are provided the same rights to appeal
RAC findings of overpayments as they do claim
denials by the Medicare contractor or state’s
Medicaid programs. Physicians who choose to
appeal must send a rebuttal of the findings directly
to the RAC within 15 days of receiving the RAC’s
letter identifying an overpayment. Note, however,
this does not stop the clock on the 120 day time
period during which a request for redetermination
(first level appeal) from the Medicare contractor
must be submitted. Additionally, the clock is
still running with regard to the interest accrued
when money is not refunded within 30 days of the
request. Physicians who choose to send a rebuttal
to the RAC will want to either simultaneously
file a request for redetermination to the Medicare
contractor or carefully track the status of the
rebuttal and be prepared to file the request for
redetermination within the 120-day time period,
if needed. Medicaid appeals processes will vary
from state to state as well as Medicare Advantage
appeals will vary by MCO.
Practices should attempt to prepare and have mock RAC audits in order to be best armed for superior compliance and minimal deficiencies. Careful review of CERT, OIG, previous RAC, and other carrier audits will help prepare the practice for the impending RAC audit. The worst time for a practice to prepare is the day it receives a notice of intent for a RAC audit. Preparation for a RAC audit should be complimentary to an active and effective compliance plan.

PATH Audits
Another HIPAA mandated audit process under the jurisdiction of the OIG operation is the Physicians at Teaching Hospitals (PATH) Audit. This audit process has two forms: purely government-conducted audits (PATH I), and a self-audit alternative (PATH II). This self-audit process implies through the OIG interpretation as having more lenient penalties for self disclosure of deficiencies, but does not guarantee this initiative. Billing irregularities in connection with teaching physician claims can be interpreted by the OIG as false claims violations which would carry the fines and penalties for false claims previously mentioned.

PATH II gives teaching institutions the opportunity to designate a third-party auditor of their choice to be approved by the OIG prior to any government-initiated audit. Some advantages of the PATH II process are the ability to select an institution's own auditor, with the approval of OIG, and the ability to control the audit process in a way that minimizes disruption of ordinary operation. The auditor must be an independent organization, and may not have a pre-existing relationship with the facility. There is no provision for credit of the cost of the audit against any repayment to Medicare. The cost of the self-audit must be weighed against the potential savings in repayment obligations and the waiver of confidentiality.

Conditions of Participation (CoP)
Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) are rules and guidelines set forth by CMS to ensure health care organizations meet minimum standards when providing services under the Medicare and Medicaid programs. CMS considers the health and safety standards of their requirements to be the foundation for improving not only the quality of their participant’s health care but also protecting the patient’s health and safety. These standards are expected to be the minimum and accrediting organizations should seek to exceed the Medicare standards set forth in the CoPs/CfCs.

CoPs and CfCs apply to the following health care organizations:

- Ambulatory Surgical Centers (ASCs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospitals (CAHs)
- End-Stage Renal Disease Facilities
- Federally Qualified Health Centers
- Home Health Agencies
- Hospices
- Hospitals
- Hospital Swing Beds
- Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR)
- Organ Procurement Organizations (OPOs)
- Portable X-Ray Suppliers
- Programs for All-Inclusive Care for the Elderly Organizations (PACE)
- Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
- Psychiatric Hospitals
- Religious Nonmedical Health Care Institutions
- Rural Health Clinics
- Long Term Care Facilities
- Transplant Centers

Along with requiring health and safety standards, there are additional guidelines as to the maintenance of medical records. Specifically hospitals must maintain their records for a minimum of five years and critical access hospitals must maintain theirs for six years in order to participate in the Medicare and Medicaid programs.

To be an effective auditor, you must stay up to date on the laws that pertain to health care discussed in this chapter. This allows you to take a proactive approach and develop an audit plan to identify potential risk to the practice. It is also helpful for auditors to review the findings of Comprehensive Error Rate Testing (CERT), Recovery Audit Contractors (RAC), CMS Zone Program Integrity Contractors (ZPIC), CMS Medicare Administrative Contractor (MAC), and CMS Medicaid Integrity Contractor (MIC) audits to determine services being reviewed. If performed in the practice, these services should be audited to make sure the practice is coding and billing them appropriately.
Chapter 2

The Medical Record

Frequently, it is forgotten that a medical record is a legal document and should be treated as such. Providers and office staff are expected to know the “do’s and do not’s” of proper documentation in the medical record. Although we would think staff would automatically know that pencils, white-out, and pink ink are not permitted within the medical record documentation, this knowledge should not be assumed.

The medical record must also be a communication tool to best coordinate care of the patient’s overall health. As we move in a health care setting progressing toward quality of disease management as opposed to number of services performed, the medical record should be a story book of the patient’s encounters, episodes of care, and the patient’s overall well being and health associated with the care of the given provider.

To ensure medical record documentation is accurate, the record primarily should be complete and legible. CMS defined the documentation each patient encounter should include, as appropriate:

- Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
- Assessment, clinical impression, or diagnosis
- Medical plan of care
- Date and legible identity of the observer
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient’s progress, response to, changes in treatment, and revision of diagnosis should be documented.
- Current CPT® and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Medical records can be used in professional liability cases, in courts of law, as a determination of care, and as a benchmark of the medical necessity of the services provided. Incomplete medical records may not support medical necessity or services performed by a provider. This is not only a concern for coding/billing compliance but also medicolegal concerns such as malpractice.

The medical record is owned by the physician or physician group practice and not the patient. Patients are entitled to copies of their medical records. Original charts should not be given to the patient.

Medical Record Entries

Illegible records are unacceptable. CMS, as well as other carriers, will not go to great lengths to interpret handwriting. CMS does make provisions for illegible records. If a provider is audited and the records are not legible, the provider may (according to the individual Medicare Administrative Contractor (MAC)) be allowed to dictate for clarity. Rules and guidelines are specific. Records may not be enhanced, but merely dictated. When an auditor is presented with records dictated for clarity, the handwritten note should be compared appropriately to the dictated note to verify no enhancement of the medical encounter was included. The dictation should
only be representative of a transcription of these services.

**Medical Record Corrections**

As with any record, a medical record may include an erroneous written error from time to time. These errors should be corrected for proper reporting of the patient encounter.

- Corrections in a medical record should be:
  - A single line through incorrect information
  - Initials of the person making the correction
  - Date of the correction
  - Correct information added

- Corrections should not contain:
  - White out/tape
  - Black out any area
  - Erasure marks
  - Conceal information in any way

**Medical Record Signatures**

Any form of medical documentation produced within a physician practice should be signed by the author. Regardless of the type of provider or service performed (e.g., a nurse visit or an MD providing a quick wound check), the encounter must be documented and signed.

According to CMS, “all medical record entries should be signed and dated, usually within 48–72 hours of the encounter but certainly before the claim for services is filed.” Records, orders, and reports not signed are considered invalid and may lead to a recoupment of reimbursement. An auditor should also evaluate the date of dictation vs. the date of service and compare each to the date of transcription to verify the timing of the documentation complies with the CMS expectation.

While awaiting dictation, the provider should maintain a handwritten summary/overview of the encounter to provide backup for any dictation delays. The signature should be original or electronic. Stamped signatures are not allowed. The signature authenticates the medical record is true, accurate, and complete by the provider of the services.

CMS requires the author of the note to be clearly identified on the medical record. There is no requirement as to how this must be documented. If you are auditing a dictated or EMR produced note, the provider's name is normally found at the bottom of each patient encounter. When auditing handwritten and templated documentation, the provider's name is usually on the chart but is often not legible. According to the Medicare Program Integrity Manual (100-08), 3.3.2.4 Signature Requirements; providers meet the signature and identification requirements by the following:

- Provide a legible full signature (a readable first and last name).
- Provide a legible first initial and last name.
- Write an illegible signature over a typed or printed name.
- Write an illegible signature on letterhead with information indicating the identity of the signer (Circling the name of the provider on the letterhead).
- Use an illegible signature accompanied by a signature log or attestation statement.
- Write initials over typed or printed name.
- Write initials not over typed or printed name, but accompanied by signature log or attestation.
- Unsigned handwritten note where other entries on the same page in the same handwriting are signed.

Examples of signatures that would fail the CMS signature/legibility test:

- Illegible signature without a typed or printed name
- No signature log or attestation
Unsigned typed note, with or without provider’s typed name
Unsigned handwritten note, which is the only entry on the page
“Signature on file”

Electronic signatures are recognized; however, CMS cautions providers to safeguard against potential misuse of the electronic signature. When using electronic signatures, providers are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods.

CMS understands there are exceptions to the rule. There are existing CMS policies not requiring signatures:

- Orders for clinical diagnostic tests are not required to be signed as long as a signed progress note containing the order and medical necessity are found.
- Part B drugs ordered through a qualified e-prescribing system do not require a pen and paper order.

These instances would be an exception to the above requirements.

Multiple Medical Record Entries
Some individual dates of service may have multiple medical record entries, which is acceptable according to documentation guidelines. These may include medication flow sheets, immunization forms, or history sheets. These multiple record entries are needed to meet medical legal standards and can be used to help meet medical documentation guidelines. What many practices fail to do is use these sheets appropriately within the medical record. The main documentation must direct the reader of the medical record to these specific sheets as well as the date for each entry. If there is no “linking,” the additional records cannot be used to help meet the necessary requirements.

Record Retention
According the CMS Conditions of Participation (CoP), providers and facilities such as Ambulatory Surgery Centers, Critical Access Hospitals, Skilled Nursing facilities, etc., must meet or exceed standards of accreditation. These CoPs have a requirement that medical records be kept for five years, six years for Critical Access Hospitals (CAH). The following are other recommendations by the AMA:

- If a patient is a minor, the statute of limitations for medical malpractice claims may not apply until the patient reaches the age of majority.
- Immunization records always must be kept.
- To preserve confidentiality when discarding old records, all documents should be destroyed.
- Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.

State laws vary on other specific record retention policy. On average most state policies require:

- Records be retained for six years
- Minor records must be retained until the individual reaches 18 years of age.

Policies should be compared (such as state vs. HIPAA, vs. CoP, etc.) and the policy with the most strict guidelines should be adapted.

Regulatory Forms and Consent
A patient’s chart is required to contain certain consents and authorizations. When auditing a patient’s chart, a review of the forms should also be performed. Forms that should be found in the patient’s medical record include:

- Consent for General Treatment
- Assignment of Benefits
- Medical Records Release
- Informed Consent
HIPAA Privacy Form
Advanced Beneficiary Notice (ABN)—when applicable
Financial Policy
Non-Covered Consent Form—when applicable

Each form is required when indicated based on the patient’s treatment/status.

General Consent—Regardless of treatment plan or insurance status, this consent is a formal approval from the patient to the provider authorizing treatment in the manner the provider deems appropriate. The consent should be signed by the patient or legal guardian and must be dated.

Assignment of Benefits—This form is a “permission slip” from the patient granting the practice/provider rights to file claims and accept payment from the patient’s insurance. An assignment of benefits should include permissions for the following: 1) Filing of an insurance claim to the carrier for services rendered by the practice/provider; 2) Accepting reimbursement from the carrier for services rendered and billed. Collect monies/proceeds from the patient/guarantor as necessary. If an assignment of benefits is not on file for a patient, then the practice/provider has no right to receive funds on the patient’s behalf. If the patient does not sign the assignment of benefits, the payer will send the payment for services directly to the patient and it is up to the patient to pay the provider.

Medical Records Release—There are two different forms of medical records release; 1) authorization to file insurance, and 2) distribution of medical records. Patients should authorize medical records release through the authorization to file insurance guidance. Often, insurance companies will request medical records to properly adjudicate the claim. A separate medical records release should be expected when a patient is requesting a distribution of his or her medical records. This may occur for any number of reasons. Records may be needed for another medical provider, school, attorney, etc., but in all cases they will require a medical records release. There are only three instances records can be released without the patient’s signed consent: treatment, payment, or health care operations. This will be discussed in more detail in the HIPAA section of this chapter. When a release is required, it must be signed and dated by the patient.

Informed Consent—Form of communication between a provider and patient regarding a specific medical intervention which validates the patient was completely informed regarding the procedural service and care to be provided. The consent should identify the diagnosis being treated and the procedure/service was clearly explained to the patient as well as the clinical indications of why the procedure is needed. The consent should also document the risk and benefits of having and not having the proposed treatment, alternative treatments, details of the procedure, and expected outcomes. The patient should print, sign, and date these forms. It is recommended that a witness also sign the consent. This form is not only used for informative purposes, but it is also a legally required component of the medical record. If the practice is providing the service in a facility, such as the practice’s own ASC or surgical/diagnostic suite, a separate consent should be obtained for the facility services as well.

HIPAA Privacy Form—Each patient should be given HIPAA privacy forms. These forms should explain the patient’s rights under the HIPAA legislative policy. The patient should also inform the office of how to communicate details of his or her care, for example, lab results, appointment schedules/reminders, etc. This form should be signed and dated by the patient.

Advanced Beneficiary Notice (ABN)—This form is required for any Medicare beneficiary having a procedure performed typically covered but may not be covered by the Medicare program. The ABN must indicate why the service may not be covered and the approximate cost of the service. The cost estimate must fall within Medicare’s guidelines. This form must be completed and
signed by the patient prior to services rendered. If an ABN is not properly obtained, the patient may not be held financially responsible. The services must then be appended by a modifier to inform Medicare that the ABN was properly obtained. The ABN is a standard form produced by CMS and should be the only ABN used for Medicare patients.

Non-Covered Consent Form—This form should be used as an advanced notice for non-Medicare beneficiaries to inform them of a non-covered service. The form would follow the same guidelines as the ABN, but should be a form designed by the practice and is recommended to be on the practice letterhead.

The patient would also sign and date this form. Careful research with health plans is necessary to determine if they accept these types of forms. In addition, you must see if there are “hold harmless” terms found in contracts that specifically prohibit billing any amount to the patient.

Financial Policy—A financial policy would explain to the patient the practice’s expectations for the patient’s charges/bill. This form should include all of the practice’s payment expectations and what the penalties will be if payment is not received. The patient should sign and date this form as well. These forms should be checked during an audit as appropriate.

Additional Records—There are many different records that comprise the patient’s medical chart. These may include medical records release forms, medication flow sheets, consent for treatment forms or waiver forms. However, there are no medical documentation requirements for such forms. These forms should be included within the medical record according to the policies and procedures of the identified practice.

Medicare Advanced Beneficiary Notice (ABN)

An ABN must be given each time a physician believes a service will not be covered if the physician wishes to bill the beneficiary directly for the service. ABNs are not necessary for statutorily excluded services. They are only necessary for services normally covered by Medicare but which in a particular circumstance the physician believes will not be covered for lack of medical necessity, exceeding treatment options, or other reason.

The ABN is continually updated by CMS, and an auditor should take notice of the version of the ABN utilized at the time of service. An out-of-date ABN will not be deemed as valid by CMS.

Notifiers must make a good faith effort to insert a reasonable estimate for all items or services listed in Blank (D) of the ABN form. In general, the estimate should be within $100 or 25 percent of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted.

Multiple items or services routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections.

As noted above, providers may also pre-print a menu of items or services in Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available.

GA Modifier

To properly notify Medicare an ABN has been signed appropriately by a Medicare beneficiary
you will need to attach modifier GA to the service code. For example 84443-GA informs Medicare the patient has been properly informed that the service or item may not be covered by Medicare. This can be a costly mistake in billing for any practice or provider. Identifying these errors when auditing can save a practice thousands of dollars.

When performing an audit, an auditor should make note of any services billed utilizing a GA modifier and request a copy of the ABN to support the modifier usage. If an ABN was not obtained, the service would not be billable to the patient even if it was filed to CMS with the GA modifier. Likewise, an auditor should be aware of services for which an ABN was completed, but the GA modifier was not found on the claim. Services requiring the use of an ABN should also be noted by the auditor.

When an auditor is reviewing services for which an ABN was obtained, the claim form must be reviewed for the appropriate modifier usage. Block E of the ABN requires the provider/practice to notate why the service in question may not be covered by Medicare, and this reason should support the appropriate modifier use.

The GA modifier is used when an item or service is expected to be denied as not reasonable or necessary for the patient and/or their current condition. When the modifier is used appropriately, Medicare will process the claim and if denied will apply the balance to the patient responsibility. If the GA modifier is not used, the claim will not be applied to patient responsibility.

The GX modifier is Notice of liability issued, voluntary under payer policy. Use of this modifier indicates the services delivered are excluded from Medicare coverage by statute, and the charge is being filed on the patient’s behalf. In this case, the service is filed to Medicare to obtain a denial, usually for a secondary insurance. The GX modifier should not be used on any services covered by Medicare.

GY modifier is used for items statutorily excluded from Medicare reimbursement. The use of the GY modifier will cause the claim automatic denial. Often these services are billed by the provider to obtain the Medicare denial for the secondary insurance purposes.

GZ is a modifier that reports to Medicare that the service may not meet medical necessity guidelines, and an ABN was NOT obtained from the patient. The GZ modifier will result in automatic claim denial.
Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for D. ____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. ____________ below.

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<th>D.</th>
<th>E. Reason Medicare May Not Pay</th>
<th>F. Estimated Cost</th>
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**WHAT YOU NEED TO DO NOW:**
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. ____________ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS:** Check only one box. We cannot choose a box for you.

- **□ OPTION 1.** I want the D. ____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- **□ OPTION 2.** I want the D. ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- **□ OPTION 3.** I don’t want the D. ____________ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11)   Form Approved OMB No. 0938-0566
Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996. Title I, the first rule under HIPAA, addresses portability of insurance when employees change jobs. It regulates the availability and breadth of group health plans and some limited individual health insurance policies. State law takes precedence to HIPAA policy only when the state law is more restrictive in nature.

Title II (Administrative Simplification) was designed to reduce fraud and abuse in health care and to simplify the administration of health insurance. The Administrative Simplification Rule includes:

- Electronic Transaction and Code Sets
- National Employer Identifier
- National Provider Identifier
- Privacy
- Security

HIPAA rules apply to “covered entities:”

- Health plans
- Health care clearinghouses
- Health care providers who conduct certain financial and administrative transactions electronically.

These electronic transactions are those for which standards have been adopted by the Secretary of HHS under HIPAA, such as electronic billing and fund transfers.

Business Associates Agreement—This document spells out the requirements for business associates to disclose protected health information (PHI) while representing the practice. Business associates are entities or individuals who are not a part of the covered entity’s workforce, are not covered entities themselves, but process PHI on the behalf of a covered entity.

Allowed Uses and Disclosures—HIPAA allows certain uses and disclosures without a signed authorization from the patient. This includes treatment, payment, and health care operations. The use of PHI in treatment assures for maximum continuity of care on the behalf of the patient, and the use of the PHI may be necessary in order to obtain payment for these services rendered. The uses of PHI under the pretense of health care operations may include activities such as training new workers, quality assurance (QA) and quality improvement (QI) activities, and chart audits. Covered entities may exchange protected health information as needed for these activities, with no restrictions. PHI includes medical records and insurance information. Release of information to another covered entity is allowed without restriction and without authorization. For other uses, a signed authorization is required. Even in instances such as clinical trials, a signed disclosure would be required.

A provider should always only disclose what is minimally necessary to fulfill any request. Minimum necessary is limiting the amount of PHI released regarding a patient in an effort of maintaining patient privacy. Only the minimal amount of information needed as deemed relevant should be released under HIPAA guidance.

HIPAA requires utilization of information considered PHI should have policies and procedures regarding its use by members of a practice. These policies and procedures should address specifically limited use of PHI, and using the information only as intended for job purposes in order to secure proper medical care and/or medical reimbursement. Health care workers must be able to process requests for medical records and make valid decisions regarding whether a release is supported by HIPAA policies. No records should ever be released without the patient’s authorization unless the release is for treatment, payment, or health care operations. This authorization may have been obtained specific to a request or a more generalized authorization. An example of a specific request may be a patient that is involved in clinical trials and the information
needs to be released to the appropriate research source. PHI may be released when consent for treatment and payment has been obtained, when an authorization exists that specifically addresses other uses or disclosures of the PHI and/or as permitted by public policy. Patients are given certain rights under HIPAA regarding records disclosed. A patient has the right to request copies of disclosure for up to six years. The practice must be able to produce the disclosure for this purpose. Practices should maintain a log of the disclosure of PHI so it is readily available, if requested by the patient.

Business Associates

Business Associates (BAs) are individuals or entities who are neither part of your workforce nor covered entities in their own right, but process protected health information (PHI) on behalf of a covered entity such as a private practice. The original HIPAA Privacy Rule required covered entities to establish a list of business associates and to have each business associate sign a Business Associate Agreement (BAA) in the same manner as covered entities. However, the rule required the covered entities working with these BAs to monitor the BAs’ use of PHI and to enforce protections. The covered entity would have to terminate the relationship if the covered entity learned that the BA violated the BAA.

Effective February 17, 2010, The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009 to promote the adoption and meaningful use of health information technology. With this implementation it became necessary for business associates to comply with HIPAA regulations themselves: develop policies and procedures to comply with security regulations, train their staff, periodically audit themselves for compliance, become subject to enforcement inspections, and even to some extent monitor the covered entities with which they have the BA relationship. This means not only must covered entities monitor their business associates, but business associates also have the responsibility of monitoring covered entities with which they have a BAA.

If there is a breach of PHI, covered entities and BAs must:

- Notify HHS and major media outlets if the breach involves 500 or more participants.
- Notify affected individuals in writing within 60 days of becoming aware of the breach.
- Provide in the notice to individuals at least five specific categories of information.
- Send a notice by first-class mail to each affected individual’s last known address.
- If the address available is no longer applicable, the covered entity may use an alternate method such as e-mail. If there are at least 10 individuals whose PHI has been breached and no current address is available, the notice of the breach must be posted on the covered entity’s website.

A third party auditor would need to have a BA established with a practice in order to appropriately meet the HIPAA guidelines and statues for protection of PHI. An outside auditor must have a signed BAA for all clients she audits.

Surgical Services

During the audit process, surgical services should be reviewed for any provider who performs these services. Regardless of the complexity of the procedure, each should be reviewed, from in-office minor surgical services to the complex spinal cases performed in a facility operating room (OR) setting.

An auditor should always pay close attention to the specific setting of the service. The setting could be any of the reportable places of services, but should dually match those as reported on the claim, the documentation, and the place of service code reported. A provider may neither merely deem an area of his or her office as a surgical suite nor can a provider form his or her own Ambulatory Surgical Center (ASC) or Independent Diagnostic Testing Facility (IDTF) without going through the proper channels for designation.
Any discrepancy noted regarding the place of service should be reviewed by the auditor, as different sites of service have different allowable rates associated with them. Place of service is often found on the OIG Work Plan for this reason.

The auditor’s evaluation of the surgical service should correlate to an appropriate determination of the global surgical package. The global surgical package includes the preoperative, intraoperative, and postoperative services, but may include other services such as anesthesia services (when performed by the provider of the surgical services) and wound irrigation.

The preoperative care is not the actual decision for the surgical services to be performed, as this is a separately reimbursable and reportable service. Preoperative care includes services such as an Admit H&P as required by most hospitals prior to admission for a procedure.

Routine postoperative services are inclusive and designated as part of the global surgical package. The definition of routine becomes a defining line within the global surgical package. An auditor must weigh the questions of what is routine and what is NOT routine care. An evaluation of a surgical site documented as red and puffy describes how many surgical sites appear on post evaluation. However, if the provider documented the wound was warm to touch, bright red in presentation, with oozing secretions, and noted wound dehiscence, the auditor should recognize this is not a routine encounter for surgical postoperative care. Medicare will only cover postoperative complications requiring a return to the operating room. If the complication is treated in the office, the service is considered part of the global package and separate reimbursement is not appropriate.

The presence and evaluation/treatment of a new problem, even if the problem is generated from the original problem, would not be inclusive of routine postoperative care. If a patient who had a total hip replacement is now complaining of right knee pain due to her abnormal gait from the procedure, and the provider evaluates the knee and determines it is inflamed and a cortisone injection is medically indicated, the services could be billed in addition to the surgical package with the appropriate modifiers appended. Added treatments within the global surgical package are not always inclusive as they are not routine.

The Surgical Encounter

Once the global surgical package has been evaluated, the individual aspects of the surgical intervention should be assessed and audited. Not all of the surgical components will be provided by one provider of service, but all components are part of the overall cohesive care of the patient. Services included in the global surgical package can be found in the AMA CPT* codebook.

Anesthesia Services

If the anesthesia care is performed by the provider of the surgical encounter, the services are considered bundled and inclusive of the surgical services.

An exception to covered anesthesia services by the surgeon would be Moderate (Conscious) Sedation (MCS). MCS is a drug induced depression of consciousness. The patient can respond to verbal direction by light stimulation. The patient does not lose consciousness and is not in need of artificial ventilation.

Guidelines indicate MCS includes:

- Assessment of the patient
- IV access
- Administration of sedation
- Monitoring of oxygen saturation, heart rate, and blood pressure
- Recovery

The codes are divided as services provided by the same physician who is also performing the procedure or diagnostic service and services provided by a physician other than the health care provider performing the diagnostic or therapeutic
service. Both sets of codes are further delineated based on patient age and incremental time.

MCS codes have been assigned a Status Code C by CMS, meaning they are carrier priced, and do not carry an assigned RVU. Medical Administrative Contractors (MACs) are encouraged by CMS to recognize moderate (conscious) sedation services.

Anesthesia Documentation

Anesthesia services are billed using CPT® anesthesia codes 00100–01999. There are many different forms of anesthesia services provided for surgical and non-surgical reasons. The anesthesia services codes are reported for the following types of anesthesia services:

- General
- Regional
- Monitored anesthesia care (MAC)

Anesthesia codes are selected based on the site of surgery and in some cases the type of surgery. Anesthesia services are reimbursed based on the anesthesia code and the total units billed. On the CPMA exam, 1 unit of time is equal to 15 minutes. The calculation used to determine the total units is Base Units + Time Units + Modifying Units (BTM). The units are then multiplied by the anesthesia conversion factor. The anesthesia report MUST include the anesthesia start and stop times as well as any time the anesthesia provider is not in attendance for the case. The time involved providing services such as insertion of central lines, arterial lines, and postoperative pain blocks prior to anesthesia is not included in the total anesthesia time.

Physical Status

Physical status modifiers are only appended to anesthesia codes (00100–01999). The physical status modifier identifies the patient’s health level at the time of anesthesia services. Different levels of health can vary the type, amount, and risk factors associated with anesthesia services.

These physical status modifiers are:

- **P1**: A normal, healthy patient
- **P2**: A patient with mild systemic disease
- **P3**: A patient with severe systemic disease
- **P4**: A patient with severe systemic disease with a constant threat to life
- **P5**: A moribund patient who is not expected to survive without the operation
- **P6**: A declared brain-dead patient whose organs are being removed for donor purposes

When auditing anesthesia services, a diagnosis code supporting the proper level of the patient’s health status must also be reported. This diagnosis code should be reported as the secondary diagnosis.

Medicare claims may not include physical status information as Medicare does not recognize physical status modifiers; however, the physical status must be documented by the anesthesiologist. Many third-party payers will make additional payments for patients with a physical status of P3, P4, or P5. No additional payment is made for P1, P2, and P6.

Anesthesia Modifiers

There are several HCPCS Level II modifiers an auditor may encounter for anesthesia that specifically communicate the concurrency of care and anesthesia providers involved in the case. Concurrency must be reported on claims to Medicare as well as many other payers. Concurrency indicates the level of direction or supervision by an anesthesiologist for certified registered nurse anesthetists (CRNA). Medicare will pay 100 percent of the physician fee schedule for all services performed with medical direction of four or less cases; 50 percent is paid to the anesthesiologist, and 50 percent is paid to the CRNA. If more than four cases are under the supervising anesthesiologist at any given time, then the cases must be reported by the
anesthesiologist with Modifier AD and only three units are paid. The CRNAs are not affected when medical direction is broken and more than four cases are supervised by the anesthesiologist. The CRNAs are still paid at 50 percent, while the anesthesiologist is paid for three units of service per procedure. An additional unit may be paid if the anesthesiologist was present at induction of anesthesia. CRNAs reporting anesthesia services with modifier QZ are paid at 100 percent. The following modifiers communicate this information to the carrier:

**AA:** Anesthesia performed personally by anesthesiologist  
**QK:** Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals  
**QS:** Monitored anesthesia care service  
**QX:** CRNA service, with medical direction by a physician  
**QY:** Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist  
**QZ:** CRNA service; without medical direction by a physician  

When auditing anesthesia services it is necessary to review the anesthesia record along with the reported service codes/modifiers. An auditor may request to review the surgeon’s operative report as well. The operative report will be more indicative of the surgical services performed and give better clarity to the anesthesia record.

Operative reports should include the following four sections or elements: the heading, indications of the surgery, body/detail of the procedure or surgery being performed and the findings of the surgery/procedure. The following information should be found in the operative report. Information and documentation styles can vary per provider and facility:

- Date of surgery  
- Patient name/Date of Birth  
- Pre-op diagnosis  
- Post-op diagnosis  
- Procedure performed  
- Name of primary surgeon, co-surgeon, assistant surgeon, residents as applicable  
- Name of anesthesiologist/CRNA  
- Indications for the procedures  
- Consents obtained  
- Detail of the procedure which includes:
  - Preparation of patient for surgery  
  - Surgical approach  
  - Instruments and supplies used

An anesthesiologist may perform additional services while performing the anesthesia care. These services may be reported in addition to the anesthesia services. Services such as insertion of a central line or a Swan-Ganz catheter may be reported in addition to anesthesia services. Modifier 59 may be required for some services. For example, the insertion of a central venous catheter is included with the insertion of a Swan-Ganz catheter when performed on the same vessel. If the procedures are performed on separate vessels, both can be reported. Modifier 59 is required for the central line to show that it is not bundled with the Swan-Ganz catheter placement.

If you are not familiar with anesthesia coding, it is recommended you take additional education to understand all the nuances of auditing anesthesia services.
Chapter 2 The Medical Record

- Anesthesia used
- Complications
- Condition of patient after procedure

**Date of Surgery**—Make sure to use correct date of service. Documentation should reflect the date of service and not date of dictation.

**Patient Name/Date of Birth**—Legal names must be used in the medical record and practices should avoid the use of nicknames. Verify the names on charted documentation and insurance card. Other identifiers such as patient date of birth are vital as well to identify the patient.

**Pre-op Diagnosis**—This is the diagnosis/condition of the patient before surgery. It will support the medical necessity of the procedure.

**Post-op Diagnosis**—The post-op diagnosis can be the same as the pre-op diagnosis, depending on the findings during the procedure.

**Procedure Performed**—A list of all the procedures performed. Procedures performed by the anesthesiologist can also be reported in this area. Eponyms can be used to describe procedures; however, a complete description of the procedure should also be listed to make certain there is accurate understanding of the procedure performed.

**Primary Surgeon, Co-Surgeon, Assistant Surgeons**—All surgeons should be listed on the operative report. Documentation must include the part of the procedure the co-surgeon performed. Assistant surgeons are not required to provide or dictate operative notes and document the aspects of what they assisted with in order to support medical necessity. There are no guidelines as to exactly what must be documented or how inclusive the documentation should be. However, the documentation should clearly show the services the assistant surgeon performed in order to substantiate medical necessity of his or her presence. Services provided by co-surgeons or team surgeons must have OP reports separately indicative of the services each performed.

**Indications for Procedure**—This is usually a brief statement explaining the medical necessity of the procedure and patient history. Medical necessity and the indications for a surgical service are a mirror representation of each other. The indications should directly communicate the medical necessity (eg, the need for the surgical encounter). The indications should be complete and specific and should not be minor in presentation.

**Consents Obtained**—This is a description of the procedure to be performed and risks involved in the procedure, which is signed by the patient.

**Anesthesia**—Type of anesthesia used and who performed the anesthesia care.

**Details of Procedure Performed**—This is a step-by-step report of the procedure(s) performed, including detailed information including anatomical parts of the body, sizes, and any abnormalities. Documentation should be detailed enough to re-create the procedure if necessary and to answer any questions of how the procedure was performed. Instruments used and instrument/sponge count at the end of the procedure as well as the type of supplies used (eg, sutures, packing, etc.) must be documented. In addition, documentation should include how the patient was positioned and draped for surgery.

**Complications**—Any complications occurring during the operative procedure should be described, and it should be documented if and how the complications were resolved.

**Condition of Patient after the Procedure**—The condition of the patient after completion of the procedure. Was the patient stable and comfortable or was the patient admitted to the intensive care unit?

**Additional Information**—Any information pertinent to the patient’s care should be listed (eg, blood loss, catheters, drains, etc).

**Signature**—All surgeons must read and sign the dictation of the surgical encounter after
transcription is complete. Signing the dictation is proof the physician has read and agrees with the documentation. The documentation is not authenticated until it is signed.

Surgical Procedures
Specific surgical services, even though they are comprehensive in nature, requiring the utilization of the operating room or a less complex in-office procedure, have some specific components by nature that an auditor should include in the review of the services. This section is meant as a review of important coding concepts and documentation requirements to review during an audit. This is not meant to teach you the coding proficiency needed to review the audit cases for the CPMA exam. It is recommended for CPMA examinees to review all the coding guidelines contained in the CPT®, ICD-9-CM, and HCPCS Level II codebooks. The following is an overview of the surgical services for each of the systems and audit considerations that correspond to each.

Integumentary Procedures Documentation
Lesions
- Measurement of lesion before removal—the auditor should review the documentation for the size of the lesion. The provider must document the diameter of the lesion and the margins required for a complete excision of the lesion. The code is selected based on the type of lesion (benign or malignant) and the excised diameter including the smallest margins. The measurement of the excised diameter of the lesion and its smallest margins prior to removal is used for coding rather than the size documented on the pathology report. The lesion will shrink in size after removal.
- Codes are selected based on the method of removal. Was the lesion shaved, biopsied, excised, or destroyed?
- Type of lesion—malignant or benign. It is recommended to hold the claim until the pathology confirms the type of lesion.
- Local anesthesia is included.
- Re-excisions during the global period should be reported with modifier 58.
- Simple non-layered closure is included.
- Excisions/incisions requiring intermediate or complex repair are coded separately.
- Excisions of benign and malignant lesions are inclusive to adjacent tissue transfers and rearrangements.

Lacerations
- Closures performed with sutures, staples, and tissue adhesives are reported with the repair codes (12001–13160). Closures using Steri-Strips are reported with E/M codes.
- Simple decontamination and/or debridement, exploration, and ligation of vessels is included.
- Documentation must properly define size of the wound in cm, location, and description of the complexity of the closure to determine whether the closure is simple, intermediate or complex.

Grafts
- CPT® code 15002 or 15004 is used for the initial preparation/creation of graft site by excision of open wounds, burn eschar, or scar. These codes are not reported for subsequent debridement procedures. Subsequent procedures should be billed with the appropriate skin debridement code(s) 97597, 97598, 11042–11047.
- The initial surgical preparation or creation of recipient site (CPT® code(s) 15002 or 15004) may be billed with the application of a skin substitute/skin replacement. Documentation must support both procedures were performed.
- CPT® code 15002 or 15004 is billed based on the total body surface area involved, not per wound site. CPT® code 15003 or 15005 should be used for each additional 100 sq cm or each additional 1 percent of body area of infants and children.
- Initial preparation of the wound for skin grafting (CPT® code 15002 or 15004) may be billed once at the initial skin grafting service. It is not billed per wound or per each week an existing graft is cleaned or a graft reapplied.
Application of the skin graft (CPT® codes 15100–15278) may also be billed once on the initial day of service. Each skin graft procedure has a global period of 10 to 90 days. Reapplication of graft material to the same lesion during the global period should be billed with the 58 modifier when application is consistent with FDA approved indications.

Skin graft codes (CPT® codes 15100–15278) represent total surface area grafted and cannot be billed per lesion. If the total area exceeds the size designated by the code then use the respective add-on code.

Grafts may require a modifier 58 if done in stages.

Codes are selected based on size and type of graft—autografts, tissue cultured autografts, or skin substitutes.

**Destruction**

- Documentation must support size, type of lesion, location, malignant/benign, and type of method used.
- Includes local anesthesia.

**Breast**

- Excisional breast surgery includes certain biopsy procedures.
- Bilateral procedures add modifier 50.

**Musculoskeletal Procedures Documentation**

- If a repair is performed on a major organ after exploration, code only the procedure performed. Exploration is included in the code.
- Modifier 51 is used when several orthopedic procedures are performed at the same time.
- Other procedures can often be charged in addition to spinal instrumentation when performed during the same operation.
- Applications of casts are included in the global package. You can charge for supplies, X-rays, etc., if the service is performed in the physician’s office. If the surgery is performed in a hospital or ASC, only code the professional services.
- If the physician attempts a reduction but is unable to correct the fracture successfully, you can still charge for reduction service.
- Add radiological supervision and interpretation when performed if it is not included in the code description for the procedure.
- Remember to charge for therapeutic drugs when required and supplied by the provider. Local anesthesia is included.
- Code harvesting/grafting procedures when not bundled in procedure.
- Surgical arthroscopic procedures always include a diagnostic arthroscopy of the same joint.

**Respiratory Procedures Documentation**

- If two bronchoscopy procedures are performed during the same operation, both can be charged.
- It is important to choose the code that most appropriately reflects the farthest extent of the procedure.
- Multiple endoscopic procedures may be performed through the scope during the same operative session. Add modifier 51 to all subsequent procedures, excluding add-on codes.
- Diagnostic endoscopy procedures are always included in a surgical endoscopy of the same site.

**Cardiovascular Procedures Documentation**

- If a central venous access device is removed and a new one replaced via a separate venous access site, both procedures can be reported.
- Review vascular families. See Appendix L in the CPT® codebook.
- Selective or non-selective catheter codes are selected based on vessels and order of the vessel.
- Catheter placements are coded to the farthest extent of the placement.
- Review procedures included in vascular injections.
Digestive Procedures Documentation

- Proper identification of the specific quadrant should be documented for correct diagnosis coding.
- No matter how many times a dilation procedure is used, only the successful procedure can be coded. Code where the scope ends.
- If the bleeding is a result of the endoscopic procedure, it is considered part of the primary procedure and not coded separately.
- Technique used determines the code: snare, hot forceps, brushing, etc. Report only one code when multiple polyps are removed using the same technique. If multiple polyps are removed using different techniques, report the code for each technique and append modifier 59 to the component code.
- There is no charge for Peg tub removal.
- If the removal of the appendix is incidental to another procedure, it cannot be coded separately and is part of the major procedure.

Hernias

- Documentation should include where the hernia is located and type of hernia.
- Key words to look for in the documentation are strangulated, incarcerated, reducible, initial, or recurrent.
- Age of patient must be documented.
- Mesh is included in all hernia repair codes except incisional or ventral hernias.
- Bilateral procedures are reported with modifier 50.
- Code selected based on technique-incisional or laparoscopic.

Genitourinary Procedures Documentation

- Some procedures are male and female specific.
- Diagnostic procedures are included in surgical procedures of the same site.

Male Genital System Documentation

- Circumcision codes are based on age and technique.
- Orchiectomy should be reported by bilateral/unilateral, partial/radical, and approach.
- Exploration of undescended testicles is included in surgical procedure.
- Assure appropriate use of modifier 50.

Female Genital System Documentation

- Report same procedures performed on different anatomical sites.
- Colpocentesis is part of a more major procedure; do not code it separately if bundled into another procedure.
- Some procedures are obstetrical and others non-obstetrical.
- Hysterectomy codes are reported based on approach (abdominal, vaginal, laparoscopic), what was removed (ovaries, tubes, uterus), and size of uterus.
- Procedures are performed after delivery and in the hospital.
- Unilateral or bilateral procedures-know which procedures you can report with modifier 50.
- Review services included in the OB package.
- Review services/procedures not included in the OB package.
- Type of delivery-vaginal, cesarean, VBAC.
- Appropriate units charged for billing OB services.
- How are services reported by two doctors of different specialties for OB services?
- If the OB patient has a miscarriage, you can bill for one to three visits using E/M codes.

Nervous System Procedures Documentation

- E codes are reported to identify the cause of the injury in the initial care of spinal and head injuries.
- Approach and technique determine the proper codes for brain and spine procedures.
Proper use of modifiers with skull based surgeries.
Correct location of spine procedures—cervical, thoracic, lumbar.
Modifier use for intraspinal lesions.
Nerve blocks that are included in surgical procedures.
Acute verses chronic pain for correct diagnosis codes.

**Eye/Ocular Procedures Documentation**

- Some codes are per eye and require modifier 50 if the procedure is performed on both eyes.
- Remember modifiers E1, E2, E3, and E4.
- Appropriate documentation for the use of operating microscope.
- Report cataract procedures based on the type of extraction and if an intraocular lens was inserted.
- Correct muscle for strabismus surgery.

**Auditory Procedures Documentation**

- Proper use of ICD-9-CM codes for the type of otitis media.
- Proper use of modifiers LT, RT, and 50.
- Type of anesthesia used may impact code selection.
- Appropriate documentation for the use of operating microscope.

**Surgical Modifiers**

An auditor should verify all modifiers appended to a surgical claim are supported within the documentation of the procedure. The following list is not inclusive of all surgical modifiers, but includes the most frequently used surgical modifiers and the pertinent documentation components needed.

- **Modifier 22:** This modifier indicates the surgical encounter was somehow more extensive or greater than is normally expected based on CPT® code description. The documentation of the encounter should include medical necessity to support what made the service more work on this given encounter. Only additional work/services performed above and beyond those within the code description are worthy of the modifier 22. Services that are merely utilizing a new technique or new equipment would not support the utilization of this modifier.

- **Modifier 24:** This E/M modifier would be appended to E/M services provided during the global surgical period that are not routine postoperative care and are additionally reimbursable. The documentation of this type of an encounter should include components that support why the encounter was not a routine service related to the surgical encounter.

- **Modifier 51:** The multiple procedures modifier indicates more than one stand alone procedure was performed during an operative session and the procedures were related or performed in correlation with one another. The documentation would simply need to include the details of the procedures.

- **Modifier 52:** Reduced services should be reported when all components of a billable CPT® code were not performed and the service was not fully delivered according to the description. The documentation should be inclusive of the service performed and any impending reasons why the full procedure was not performed during the surgical encounter.

- **Modifier 58:** Staged procedures are performed when a provider is planning to do a procedure in multiple sessions. The best example of staged services in separate encounters would be skin grafts when a provider performs the first graft and he or she may be unsure if another graft will be required. Another example within the same session would be a procedure that begins as a diagnostic procedure but leads to an open procedural service. The documentation does not have to specifically reflect the next procedure or the date of it, but should indicate that additional services may be forthcoming.
**Modifier 59**: Distinct procedural services modifier is used when the services provided were for separately specified reasons or sites of service. This modifier is an unbundling modifier and is used in instances when the procedures are typically inclusive of one another but for documented reasons should be reimbursed (eg, separate sessions or anatomic locations). The documentation should be inclusive for either the specified reason and/or the specific anatomical sites of service.

**Modifier 78**: This modifier is used when a provider performs a surgical service and then has to return the patient to the operating room, as an unplanned procedure or complication. A good example of this type of encounter would be a patient who presents during the postoperative period with a staph infection in the surgical site and I&D of the wound is required in the OR setting. The documentation should include what makes the surgical encounter billable as an unrelated service to the global surgical encounter.

Other surgical modifiers exist, but the ones reviewed above are the most utilized. Some modifiers are informational in nature, while others affect reimbursement. For example, modifier 78 is a payment modifier where the physician reimbursement rate is approximately 70–80 percent of the fee schedule amount. The preoperative and postoperative care is not included, because it is included in the first procedure.

**National Correct Coding Initiative (NCCI)**

Most HCPCS/CPT® codes define procedures/services that are inclusive of one another. CMS developed a system to prevent inappropriate payment of services that should not be reported together. This system is known as National Correct Coding Initiative (NCCI) and effectively replaced the CMS rebundling program in a continued effort toward a uniform payment policy method.

There are two NCCI edit tables: “Column One/Column Two Correct Coding Edit Table” and “Mutually Exclusive Edit Table.” Each edit table contains edits, pairs of HCPCS/CPT® codes that in general should not be reported together. The NCCI edits are part of the Outpatient Code Editor (OCE) that edits all outpatient claims and assigns APCs for Outpatient PPS services/Therapy NCCI edits and NCCI edits for physicians.

NCCI edits are updated on a quarterly basis and NCCI edits in the OCE are always one quarter behind the carrier NCCI edits.
### Example:

#### Column 1 / Column 2 Edits

| Column 1 | Column 2 | * = In existence prior to 1996 | Effective Date | Deletion Date | Modifier
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NCCI edits are instrumental in a governmental payer audit as they are the basis of the national standard of bundling guidelines. However, many carriers have their own bundling edits, and these guidelines will not be as pertinent. The NCCI edits or carrier edits should be referenced when performing an audit to appropriately identify bundled services. Some carriers have guidelines of defaulting to the NCCI edits as they follow Medicare rules and guidelines. The auditor should use the NCCI edits for the dates of services being reviewed. Often the CPT® codebook will make references in the parenthetical notes or the section notes of services deemed inclusive of another service and not separately billable.

### Modifiers Allowed with NCCI Edits

The following modifiers are allowed with the NCCI edits:

<table>
<thead>
<tr>
<th>Anatomical Modifiers</th>
<th>E1–E4, FA, F1–F9, LC, LD, RC, LT, RT, TA, T1–T9</th>
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<td>Other Modifiers</td>
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</table>

### Mutually Exclusive Edits (MEE)

The mutually exclusive edit table contains edits consisting of two codes (procedures) that cannot reasonably be performed together based on the code definitions or anatomic considerations.

**Example:** Abdominal hysterectomy and a vaginal hysterectomy. Each edit consists of a column 1
and column 2 code. If the two codes of an edit are billed by the same provider for the same beneficiary for the same date of service without an appropriate modifier, the column 1 code is paid.

Medically Unlikely Edits (MUE)
The CMS Medically Unlikely Edit (MUE) program was developed to reduce the paid claims error rate for Medicare claims. MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/CPT® code descriptors, CPT® coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, and unlikely clinical treatment. An MUE for a HCPCS/CPT® code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT® codes do not have an MUE.

<table>
<thead>
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<th>HCPCS/CPT® Code</th>
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Chapter 3 Ancillary and Medicine Services

All services regardless of the complexity must be documented for the service to support the medical necessity for billing of the provided service. Within this section we will review how to effectively audit the services identified within these categories.

Radiology
As in every section of the CPT® codebook, the codes are organized from the head down to the trunk, shoulders out to the fingers, and hips down to the toes.

The radiology section of the CPT® codes, 70010 through 79999, is divided into seven sections. It is suggested for an auditor to review from the body of the report and not only the heading.

Sections of Radiology
- Radiologic examination (X-rays).
- CT scans (computed tomography).
- MRI (magnetic resonance imaging) without contrast, with contrast, or without contrast followed by with contrast—scout films are not separately billable.
- MRA (magnetic resonance angiography)—study of the arterial or venous system with and without contrast—scout films are not separately billable.
- Ultrasounds—codes divided by anatomical site and in the pelvis section, obstetrical/non-obstetrical.
- Radiology Guidance—used for supervision and interpretation of procedures by fluoroscopic, CT, MRI, or stereotactic guidance.
- Mammography.
- Radiation Oncology—clinical management, treatment planning, dosimetry, treatment devices, treatment delivery, and treatment management
- Nuclear Medicine—procedures performed and listed by anatomical body site.
- Radiopharmaceuticals or drugs are reported in addition to the procedure performed.

Radiology Related Modifiers
- Technical Component—Modifier TC—reports overhead cost of performing the service which includes the technologist, equipment used, film, and film processing.
- Professional Component—Modifier 26—reports reading and interpretation of the radiologic service by the physician. This identifies the physician's portion of the service.
- Global Service—Includes both professional and technical components of the service—the combination of the technical and professional portions of a procedure. Modifiers TC and 26 are not reported when reporting the global service.

Radiology Documentation
Radiology services—whether performed in a physician office setting or in a radiologic facility—must have the defined documentation elements found within the medical documentation of the service. The required documentation is inclusive of three components:

- The specific anatomical location: If performed in a physician office setting the E/M documentation may have already included the anatomical site. Because the radiology report stands independent of the encounter, the specific anatomic site of service would need to be included.
The number of views: Determines the code reported for the service. This affects the reimbursement of the service, and must be documented within the radiology report.

The finding of the radiological encounter: Affects the diagnosis codes reported.

When reviewing a physician medical record it can be difficult to interpret if the provider performed a true reading of the film or the provider was merely referencing a previously performed radiological service. The provider will rarely include in the documentation such words as “I interpreted,” so the auditor should be evaluating the record for the components needed in order to substantiate the provider performed the services himself or herself. Supporting documentation would be an independent radiological report. There must also be an order for the radiology services performed.

Radiology services commonly have a sign or symptom as the reason for the service. The truly medically indicated reason is typically a probable diagnosis or to rule out a suspected problem. Because these events are not reported based on ICD-9-CM Guidelines for outpatient services, they would not support the medical necessity of the service, even though they adequately support the indicated need for the service.

Radiology services performed for guidance should be documented within the procedure report. The procedure should indicate the type of guidance provided (ultrasound, fluoroscopy, etc.), even if the specified form of guidance is bundled into the procedure performed. The imaging, whether film or digital, should be additionally maintained, not merely the report of the findings.

Radiation Therapy
This section encompasses the treatment and the planning for radiation therapy services. Radiation therapy is accomplished by internal radiotreatment known as brachytherapy or external beam radiotreatment known as teletherapy. Other treatments include neutron beam and proton beam delivery. Codes for these therapies are found within this section, but additionally planning sessions and simulation services are also found here.

Clinical Treatment Planning: This service is billable regardless of the radiation treatment performed for the patient. There are three coding choices for the planning event: simple, intermediate, and complex. Based on the documentation of the planning session, the auditor should be able to differentiate these levels by the following guidelines:

Simple Planning: A session that requires no interpretation of test for the appropriate planning for therapy.

Intermediate Planning: A session that requires a level of interpretation and analysis of the provider to develop a plan for the patient’s treatment. The planning is considered to be of moderate difficulty.

Complex Planning: This session requires the provider’s expertise for complex interpretation and planning for therapy. Complex planning may include CT and MR localization, special lab testing, special planning and mapping to protect the normal structures and it includes three or more areas that require treatment.

Treatment Parameters and Development
The treatment parameters are established through simulation and dosimetry. Simulation sets the radiation therapy treatment target area, and dosimetry is the calculation of how much (e.g., dose of radiation) to be delivered to the tumor. These codes vary based on the complexity of the treatment.

Simulation:

Simple: A single area that generally only requires one to two films

Intermediate: Involves three or more areas that direct to one or two treatment areas, and require two or more films of each area with or without fluoroscopy.
- Complex: Performed for three or more areas of malignancy with tangential ports and complex blocking and require additional complex verifications and testing. Additionally, simulation that requires contrast material will also meet the criteria of complex setting.

Dosimetry:
- Basic Dosimetry: May be used any time during the course of therapy when calculation of dosage is needed.

Treatment devices may need to be designed and constructed, and the treatment devices codes support these services. Based on the code choice, the documentation should include input in terms of selection and position of the blocks, and the provider’s involvement and input on the design/selection/placement of the device. These services have a professional and technical component. The construction of the device would represent the technical and the physician’s input and design are the professional component.

Treatment Management
Radiation treatment is billed in units of five fractions or treatments (not sequential) and are expected to include an overview of the patient and his or her condition. The provider’s encounter for the treatment should document that the port films were reviewed and the treatment dose/delivery/parameters were reviewed, as well as the patient’s set-up. The patient should have had at minimum one examination for medical evaluation. This is an extensive evaluation of the patient and the documentation should appropriately reflect this. The examination portion of the encounter is more focused on how the patient is responding to the treatments and the coordination of the care of the patient, as well as extensively assessing the patient’s overall health to include electrolyte and hydration management. If the documentation does not include details of five fractions/treatments and is inclusive of the evaluation service then the services would not be supported. Treatment includes normal follow-up care during the course of treatment and for three months following its completion.

Pathology/Laboratory
The Pathology/Laboratory section of the CPT® codes—80047 through 89398—are used to report services in clinical laboratory, microbiology, virology, cytology, histology, and pathology.

- Laboratory panels are inclusive of all tests listed for that panel. The tests included in the panel cannot be billed separately if all of the tests are performed. Separately reporting these services would be interpreted as unbundling and may be interpreted as fraud in an over utilization circumstance.
- Do not report two or more panel codes including any of the same constituent tests performed from the same patient collections. For example, do not code a comprehensive metabolic panel (80053) in addition to basic metabolic panel (80048) or hepatic function panel (80076).
- Documentation is required to support the medical necessity of laboratory testing, such as an ICD-9-CM code. There must be an attending/treating physician’s order for each test documented in the patient’s medical record. Tests performed without a supporting order should be deemed as non-billable.
- If the ordering physician submits an ICD-9-CM code, the laboratory must use that code unless there is a reason to question the ordering physician to change the code. The laboratory must receive and maintain the documentation to alter the claim.
- Some tests are Qualitative and others are Quantitative.
  - Qualitative tells if the substance is present or absent.
  - Quantitative tells the amount of substance present. If a drug is present (qualitative), then how much is present in the body (quantitative) is determined.
- An encounter form is not an acceptable “order” for lab services.
Medicine

The medicine section of the CPT® book contains a large variety of procedures and services. This section includes services encompassing almost every specialty. The following reviews some of these services and specific documentation requirements.

Psychiatric Services

Most psychiatric services are billed based on the amount of time spent with the patient. Time becomes a crucial requirement of psychiatric documentation. Additional documentation requirements are discussed below.

Psychiatric Diagnostic Interview

Code 90801 is the psychiatric diagnostic interview examination and is a service every psychiatric provider will likely use. This is one of the few psychiatric services that is not time-based. There are, however, some specific rules that apply to this service:

- May be provided by Physician, Clinical Psychologist (CP), or Licensed Clinical Social Workers (LCSW)
- In rare exceptions, a consultation evaluation and management (E/M) service may be billed on the same date that does not involve psychiatric treatment. Please note if the patient is covered by Medicare, a consultation E/M would not be reported. Instead, the provider would report a new or established E/M code in the office or outpatient setting and initial or subsequence hospital care codes if the patient is admitted.
- Code may be reimbursable if other family, friends, health care advisors, or other informant are seen in lieu of the patient.
- May only bill once per diagnosis onset. If there is a hiatus from illness and the patient is later re-admitted, billing may be approved. In this instance, the documentation of the encounter should not begin as, “the patient is here for a follow-up of…”
- Cannot be billed with 90802.

Psychotherapy

90804–90829 are the CPT® codes for psychotherapy. Psychotherapy services are interaction with a patient to detail why a behavior was demonstrated, not dialog of what the behavior was. Each service has two describing codes. The first code is to report the psychotherapy service. The second code states a medical E/M service was supplied in conjunction with the psychotherapy service. Codes non-inclusive of medical E/M may be billed by CPs and LCSWs per Medicare guidelines. Codes inclusive of the medical E/M service may only be billed by physicians. Psychotherapy services are time-based services and time must be documented to support the medical necessity of the services.

Documentation of the psychotherapy services should include details of the encounter, the amount of time performing the psychotherapy and the type of psychotherapy technique utilized. Psychotherapy techniques include: psychodynamic, existential, cognitive, behavioral, and transpersonal approaches.

Pharmacological Management

Code 90862 is a code specific to the psychiatric management of a patient’s medication. These services are only billable by a physician and cannot be billed by a non-physician or incident-to a physician’s service. Services include:

- Prescribing medication
- Monitoring the effect of the medication and side effect
- Adjusting the dosage
- Minimal psychotherapy services

Code M0064 is the sister code to 90862 Pharmacological Management (PM). When auditing PM services the documentation differences between these codes are the level of medication monitoring performed. In-depth review of medications and their side effects along with a mental status exam to evaluate the effectiveness of the medication is reported with
90862. If the service is straightforward medication refill for slight medication adjustment of long-term medications, then M0064 is supported.

**Ophthalmological Services**

Codes 92002–92014 describe ophthalmological codes. Ophthalmological documentation could almost be considered its own language with the different types of exams, abbreviations, and drawings used in documentation. However, it is key to remember Medicare and third-party payers do not typically employ specialty-specific auditors. All documentation should be as transparent as possible, allowing any auditor ease in identifying key elements needed to meet documentation guidelines.

Ophthalmologists and optometrists are among the few providers who have the ability to use two different code sets for patients seen in their practice. Providers can choose between ophthalmology service codes or E/M services. The best way to understand which service code set to use is to review when the ophthalmological service codes should be billed:

- **Intermediate Ophthalmology Service** should be billed for a patient with a new or existing problem complicated with a new diagnostic or management problem. Codes 92002 (new patient) and 92012 (established patient). These services require the documentation of a diagnosis, history, and medical observation of the patient condition. The exam must be documented to include external ocular and adnexal examination.

- **Comprehensive Ophthalmology Service** should be billed for a patient whose treatment includes the initiation of a diagnostic or treatment plan. Codes 92004 (new patient) and 92014 (established patient). These services also require the documentation of a history, medical observation, external and ophthalmoscopic examinations, gross visual fields, and basic sensorimotor examination.

**Cardiography**

Codes 93000–93278 describe a variety of methods used to record heart activity. The codes need to be read carefully since some of these codes describe the global procedure. Other codes describe the physician component or the technical component only.

EKG services typically contain an image tracing report. This report will usually house the physician’s interpretation of the EKG. Interpretation of the EKG must be more than a simple notation of “EKG normal.” To report the professional component, a complete report separate from the image tracing must be provided. The interpretation documentation should include the diagnosis, findings of the EKG, any clinical issues of the patient that may have relevance to the interpretation; and, if available, any comparative data such as other cardiac testing that may show relevance to the interpretation. Additionally, the report should be signed/initialed by the provider, and the E/M encounter should refer to the report for the interpretation of the testing event. As with the radiology services, it may be difficult for the auditor to clearly determine if the provider is referring to a previously performed EKG or an actual interpretation of the given date of service. By reviewing the tracing and the interpretation of the service the auditor is able to substantiate the service provided as billable. Codes 93040–93042 report one-lead to three-lead rhythm ECG. Watch for unbundling with these codes.

Cardiography and cardiovascular monitoring services codes 93000–93278 are reported by the provider based on whether the physician owns the equipment.

- If the physician owns the equipment, the code will include the test, supervision, interpretation and report.

- If the physician does not own the equipment, the code for only the professional services performed (eg, interpretation and report) is reported.
Cardiac Catheterization—Moderate sedation is included with the majority of these codes. Also, many of the codes are exempt from modifier 51. Iconology is prominent in this section.

When injection procedures are performed in conjunction with cardiac cauterization, these services include introduction of catheters, repositioning of catheters when necessary, and the recording of intracardiac and/or intravascular pressure. Evaluation and report of the cardiac catheterization is also included. Inclusion of components in cardiac catheterizations will depend on whether it is a right heart catheterization, left heart catheterization, or if the cardiac catheterization is performed for congenital heart disease. Attention to detail in the guidelines of this section is crucial.

Intravenous Infusion Services

Infusion service is a relatively small section in the CPT® manual, yet they are among the most difficult for providers, coders, and auditors to decipher.

Intravenous Infusion Codes

<table>
<thead>
<tr>
<th></th>
<th>Chemotherapy</th>
<th>Therapeutic</th>
<th>Hydration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial</td>
<td>96413</td>
<td>96365</td>
<td>96360</td>
</tr>
<tr>
<td>Each Additional Hour</td>
<td>+96415</td>
<td>+96366</td>
<td>+96361</td>
</tr>
<tr>
<td>Subsequent</td>
<td>+96417</td>
<td>+96367</td>
<td></td>
</tr>
<tr>
<td>Concurrent</td>
<td></td>
<td>+96368</td>
<td></td>
</tr>
<tr>
<td>Push Initial</td>
<td>96409</td>
<td></td>
<td>96374</td>
</tr>
<tr>
<td>Subsequent Push New</td>
<td>+96411</td>
<td>+96375</td>
<td></td>
</tr>
<tr>
<td>Subsequent Push Same</td>
<td>+96376 (Facility only—30 minutes apart)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key Factors When Auditing Infusions:

- There must be an order from the physician for infusion services.

- Typical hierarchy of infusion coding is chemotherapy, therapeutic, hydration, but should only be applied to facility based infusion services.

- Physician based services decipher the primary code as the service representing the reason for infusion and the given date of service.

- Start and stop time of infusions must be documented.

- Only one initial code per day, regardless of type of infusion, unless separate sites or sessions are medically necessary.

- An infusion of less than 15 minutes is considered a push.

- Chemotherapy infusion codes are typically associated with HCPCS J codes.

- Ensure the correct dosage and units are documented and billed.

- Items included are local anesthesia, IV start, access to indwelling IV, sub-q catheter or port, flush at conclusion, standard supplies, and preparation of chemotherapy agent. Hydration is typically included in chemotherapy and therapeutic infusions, unless it is called for additionally in the protocol.

- Two medications running through one bag/one line are reported with one infusion administration code, not two. This is typically reported as a piggy back service or IVPB (intravenous piggy back). It is appropriate to code for each drug separately.

- A port flush provided with an E/M encounter additionally is billable; however, a port flush with a nursing encounter are not both supported as separate services.

Physical Therapy Services

Physical therapy (PT) services are located within the medicine section of the CPT® book. Most PT service codes are time-based codes. Time is one of the most important factors that must be documented on the chart for every patient—for every visit. If time is not documented for a PT service, the service is NOT billed.
The time spent delivering each service described by either a timed or untimed CPT® code should be recorded in order to assure compliance with carrier policies.

The therapist should document:

- The total time or the beginning and ending time for each session defined by a timed code, and
- The total time in which the patient is involved in services defined by untimed codes and unattended codes.
- Time spent performing each individual physical therapy technique such as manual therapy, electrical stimulation, etc.
- Each component utilized for an individual technique must be documented. For example, if 20 leg presses were performed as part of manual therapy, the leg presses should be documented and “labeled” as manual therapy.

Initial Evaluation are very clear on what must be included. The medical necessity must be substantiated by including the diagnoses for the services needed and the requesting provider. Each of the additional requirements is discussed below.

Past Medical History—Should be obtained on elements that influence the Physical Therapy treatment rendered. The documentation should also include the diagnosis, information regarding the patient’s functional status prior to the onset of the condition as well as the current functional status, how long the problem has existed, and any pertinent prior physical therapy treatment information.

Examination—There are no specific guidelines as to how much examination information must be contained within the medical record, but examination documentation is a required component.

Plan of Care
Required components of a plan of care include:

- Plan of treatment including long-term goals
- Frequency and duration of treatment
- Diagnoses
- Specific modalities to be employed
- Rehab potential

Additional optional components of a plan of care include:

- Short-term goals
- Goals and duration for the current episode of care

Initial Physical Therapy Evaluation Documentation (97001)—Guidelines for the

Treatment Documentation
CMS guidelines require documentation to contain a description of the treatment provided. A description such as “therapeutic exercises” is not sufficient. Providers should note the specific exercises/services performed for the patient during the session. Not including this information in the documentation will lead to insufficient documentation.

Physical therapy services are reported with a modifier GP indicating they were provided under an outpatient physical therapy plan of care.

This chapter discusses only some of the documentation considerations for potentially audited services. It is important auditors retain a skill of research and understanding of carrier policies and guidelines, along with state and federal guidelines.
Evaluation & Management

Services Defined

Evaluation and Management (E/M) services are certainly not the only services that are audited, but since they encompass most of the services performed by any provider, regardless of specialty, it stands to reason they are the most commonly audited service.

Within the E/M section of codes there are services for different settings, including the provider’s office, the patient’s home, skilled nursing facilities (SNFs), hospitals, as well as other sites of service. It is important the auditor substantiate not only the components necessary for the appropriate level of the E/M service but that the documentation accurately reflect the site of service as well as the correct place of service (POS) on the claim form submitted for reimbursement.

This section will address some of the more commonly used E/M services. With the exception of preventive services, E/M service levels are selected based on a scoring system. Different types of E/M services are scored similarly.

E/M services are scored based on the documentation for three key components. The three key components include:

- History
- Exam
- Medical decision making

Time is considered a key component when counseling and/or coordination of care consumes greater than 50 percent of the visit. The counseling and coordination of care performed should be documented in the medical record to support the use of time as the sole factor in determining the level of visit.

E/M Components

Once the category of service is determined, the key components of history, exam, and medical decision making are scored into a category of problem focused, expanded problem focused, detailed, or comprehensive level and assigned an overall level of service in the appropriate category of patient care. An audit tool should be used by an auditor for proper scoring of each documentation element, to support the level of complexity per component, and then translating those findings to the overall level of service. A comprehensive audit tool can be used to score most E/M encounters.

We will now look at each of the components necessary for an accurately reported E/M level of service.

Time-Based Documentation

Visits should be billed on time when the visit is consumed by counseling and/or coordination of care of the patient or when the code description is based on time.

The term “counseling” can cause confusion among providers and auditors. Counseling means the physician spends a majority of the visit talking with the patient; and, due to this, is unable to fulfill all of the necessary components needed to meet documentation guidelines.

For the documentation to qualify for time-based billing, the documentation should include the amount of time spent talking with the patient, a description of what was discussed, and that the counseling dominated more than 50 percent of the visit. The actual clock time (2:15–3:45) is
not required—merely a statement of the total time spent. If time-based billing is utilized, the documentation components for the assigned levels of service do not have to be met, but the documentation should be as inclusive as possible and follow the same general format as would documentation for other dates of service.

The Three Key Components
The three key components—history, examination, and medical decision-making—must meet or exceed the requirements to qualify for each level of E/M code.

There are two sets of recognized documentation guidelines: 1995 and 1997 guidelines. Any provider may use either set regardless of specialty, practice type, place of service, or type of patient seen. The only time a provider may be “bound” to a particular set of guidelines is when the practice’s compliance plan or insurance contract mandates a specified version. The 1995 and 1997 documentation guidelines vary mainly within two components of the documentation: History of Present Illness and Exam.

History
The history component of the medical documentation should include documentation in four areas as applicable:

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, and Social History (PFSH)

The chief complaint is required for all E/M services. The remaining three areas of the history are determined by the nature of the presenting problem and the provider. History is based on the lowest category in any of these four areas.

Chief Complaint
The chief complaint is a required history component of a medical record, although it is acceptable if it is easily inferred. The documentation guidelines for the chief complaint do not change based on the E/M category, nor do the guidelines used (1995 vs. 1997).

The chief complaint is a concise statement describing the problem/condition for the patient encounter. CMS indicates the chief complaint should be documented using the patient’s own words. This guide by CMS is in an effort to encourage providers to refrain from using a diagnosis as the patient’s chief complaint as opposed to the patient’s reported complaint. A simple statement of “follow-up” or “routine visit” without further clarification of the disease processes being discussed is not sufficient for a chief complaint.

The chief complaint also helps to properly identify the medical necessity of the service as it defines the need for the patient-physician encounter on the given date of service. The chief complaint sets the tone for not only how the encounter will take place, but also the documentation needed for the services rendered. As an auditor, you may audit records with no indication of the actual disease process or complaint the patient is seen for. Without this, there is no medical necessity to report an E/M service of any level.

History of Present Illness (HPI)
The HPI expands the documented chief complaint by telling how the chief complaint has affected the patient symptomatically. The HPI can be documented in one of two ways. The 1995 & 1997 documentation guidelines allow the HPI to be documented using information on how the current chief complaint is affecting the patient symptomatically based on the following elements:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying Factors
- Associated Signs & Symptoms
The 1997 documentation guidelines give more flexibility in the documentation of the HPI. The provider can choose to document the HPI elements detailed above or the provider can list the status of three chronic or inactive conditions of the patient. The physician is required to document not only the identified chronic problem, but also include the current status of the problem.

There is no credit for an HPI that includes less than three chronic or inactive disease status reviews. If the provider documents less than three chronic or inactive diseases, the auditor should utilize the HPI elements in lieu of the status review. Three chronic or inactive disease status reviews would support an extended HPI.

HPI boils down to placing the decision for the level into one of two levels:

<table>
<thead>
<tr>
<th>HPI Elements</th>
<th>Level of HPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–3</td>
<td>Brief</td>
</tr>
<tr>
<td>4 or more</td>
<td>Extended</td>
</tr>
</tbody>
</table>

**Review of Systems (ROS)**

The ROS should be documentation of how the patient is affected systemically by his or her chief complaint on the given date of service. Sometimes, providers see the ROS as more of a compilation of history of each organ system based on the patient’s reporting.

A review by a provider of the patient’s ROS will identify how the patient’s body is systemically affected by the chief complaint on this date of service. Without a properly documented chief complaint, any systemic problems related to the chief complaint are difficult to determine.

Upon completing the work of a complete ROS, the physician must make sure that he or she properly documents the information within the patient’s medical record. Words such as unremarkable and non-contributory are not acceptable forms of ROS documentation. Physicians are required to document if the body systems reviewed are negative for systemic complaints by merely documenting negative or that the system demonstrates pertinent positive findings. It is not necessary for a physician to tell us within the ROS what the specific negative findings are; however, the documentation should list the specific pertinent positive findings.

There are many effective ways the ROS can be documented. Forms of documentation may include:

- Listing each body system with the relevant findings
- Listing all negative systems together and then stating the pertinent positive findings
- Listing all pertinent positive findings and adding a statement that “all other systems are negative”

Some CMS contract carriers may not make allowance for statements such as “all other systems reviewed and are negative,” but national guidance does permit this form of documentation. When auditing, an auditor should refer to the specific contract carrier’s medical policy.

The ROS documentation could include any or all of the following body systems: constitutional, ENT, Eyes, Cardiovascular, GI, GU, Respiratory, Neurology, Musculoskeletal, Psychiatric, Integumentary, Endocrine, and/or Hem/Lymph/Allergy/Immunology.

The ROS scoring can be simplified by adding up the documented systems and placing them into one of three levels:

<table>
<thead>
<tr>
<th>ROS Elements</th>
<th>Level of ROS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Problem Pertinent</td>
</tr>
<tr>
<td>2–9</td>
<td>Extended</td>
</tr>
<tr>
<td>10 or more</td>
<td>Complete</td>
</tr>
</tbody>
</table>

Statements within the HPI can be used for the ROS; however, the same piece of documentation cannot be used for both the HPI and the ROS. This is commonly known as “double dipping.” For example, the documentation states “The patient has shortness of breath.” If you are using this
information in the HPI as associated signs and symptoms, it cannot be additionally used as a review of systems.

**Past Family Social History (PFSH)**
The PFSH documentation will tell how the chief complaint will be affected by the patient's previous illnesses and injuries, as well as any genetic dispositions, or a social issue that may interfere with the patient's progress or course of care. Each of the histories should be reviewed and documented.

**Past History**—Documentation of the past history should tell us information pertinent to the patient’s past medical history that may have an impact on the current treatment of the patient.

**Family History**—Documentation should tell us any problems relevant to the patient’s immediate family that may have a bearing on the chief complaint and the plan of care.

**Social History**—Documentation should include information regarding the social interactions the patient may have that will affect the regimen of care.

An auditor assigns the level of PFSH based on how many of the three elements are included.

<table>
<thead>
<tr>
<th>PFSH Elements</th>
<th>Level of PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pertinent</td>
</tr>
<tr>
<td>2 of 3 elements; or</td>
<td>Complete</td>
</tr>
<tr>
<td>3 of 3 elements (depending on the category of E/M)</td>
<td></td>
</tr>
</tbody>
</table>

**Putting the History Together**
Once individual component levels of the history requirements are determined, the level of the complete history can be determined. Before scoring remember, within the history area of the documentation, the lowest documented area of either the HPI, ROS, or PFSH determines the appropriate level of service. This rule applies regardless of the patient’s status. Any patient whether new, established, consult, etc., would have the history level assigned based on the lowest documented component.


Exam
The biggest difference between the 1995 and 1997 documentation guidelines is the examination portion of the note.

1995 examinations are based on the body systems and areas. 1997 examinations are based on bullets outlined through specific system examinations.

The exam documentation should give us information about the physician’s objective findings. Exams using documentation that includes words such as unremarkable and non-contributory do not meet the necessary requirements. The areas examined by the provider must be documented, and each area should also have the findings of the exam documented as well. Documentation including words such as negative or normal meets the necessary documentation guidelines.

1995 Guidelines
Organ systems and body areas are the key points of the 1995 standards. Body areas and organ systems can be acceptable for all levels of examinations with the exception of the comprehensive level exam.

Body areas are defined as:
- Head, including face
- Neck
- Chest, including breast and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

Body systems include:
- Constitutional statement
- Eyes
- Ears, nose, throat, mouth
- Cardiovascular
- Respiratory

- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymph

There are four different levels of an examination. The levels are divided as follows:

Problem focused exam—Focuses on only the body system or body area affected by the chief complaint.

Expanded problem focused exam—Focuses on the body system/area affected by the chief complaint and a brief examination of other related systems.

Detailed exam—The affected body system/area is thoroughly examined along with other affected body systems/areas or where the patient’s presenting problem needs to have an exam that concentrates on a specified body system/area while also examining other potentially contributing systems. Some carriers also use the guidelines of five to seven body systems in lieu of two systems with one in detail. When performing an audit you should always defer to carrier specific guidelines, as carrier rules for carrier specific audits supersede national guidelines. The exam is based on national guidelines.
Comprehensive exam—Covers eight organ systems. Body areas cannot be counted as proper documentation for the comprehensive exam—only organ systems.

Level of Service

<table>
<thead>
<tr>
<th>Level of Service</th>
<th>Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>1 body area or 1 body system</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>2–7 body systems, no detail of any system required</td>
</tr>
<tr>
<td>Detailed</td>
<td>2–7 body systems with affected system in detail</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>8 or more body systems or complete single organ</td>
</tr>
</tbody>
</table>

1997 Guidelines

1997 documentation guidelines for the exam are more stringent than the requirements of the 1995 guidelines. Although not a requirement, more specialists tend to document their exams using the 1997 guidelines.

There are multiple exams to choose from the 1997 guidelines: a general multisystem exam, or other exam based on single organ systems. Examinations focus on specific organ systems and body areas. Each examination is scored based on how many bullets were examined within that organ system/body area.

The 1997 guidelines include examinations covering the following single organ systems:
- General multisystem exam
- Cardiovascular
- Ears, nose, mouth, and throat
- Eyes
- Genitourinary of female
- Genitourinary of male
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

Single organ system exams are based on the following documentation requirements:

<table>
<thead>
<tr>
<th>Level of Service</th>
<th>Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem focused exam</td>
<td>Requires one to five bullets to be documented.</td>
</tr>
<tr>
<td>Expanded problem focused</td>
<td>Requires six or more bullets to be documented.</td>
</tr>
<tr>
<td>Detailed</td>
<td>Nine (eye and psychiatric)/12 (all other single organ system exams) bullets must be properly documented and the affected area/system examined in detail—just as the name indicates.</td>
</tr>
<tr>
<td>Comprehensive exam</td>
<td>Includes documentation of all areas identified by a bullet in the shaded areas, and at least one bullet in every non-shaded area.</td>
</tr>
</tbody>
</table>

To sum it up: 1997 examinations are based on a multisystem or single organ system exam table with exam requirements identified by shaded and non-shaded bulleted areas.

Medical Decision Making

The medical decision making portion of the documentation includes information that tells the diagnoses of the patient and the planned treatment.

Diagnoses Treated

Providers need to document all diagnoses treated or being treated for the patient. Reported diagnoses should only include those treated during that visit, or affecting the management of the treatment for that visit.

Every audited chart is expected to have a minimum of one diagnosis or symptom treated with a developed plan of care. Once the diagnosis has been identified, it is audited based on its status. The status indicator options include:
- New or established diagnosis
- Improving, worsening, or stable
- Additional workup required
New problems treated are scored based on whether additional workup is planned. Established problems are scored based on whether the current diagnosis is improving, stable, or worsening, inadequately controlled or failing to change as expected.

Points are then assigned based on the number and status of each diagnosis. The points are assigned accordingly:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening) (MAX 2)</td>
<td>1</td>
</tr>
<tr>
<td>Est. Problem; stable, improved</td>
<td>1/dx</td>
</tr>
<tr>
<td>Est. Problem; worsening</td>
<td>2/dx</td>
</tr>
<tr>
<td>New Problem; no additional work-up planned (MAX 1)</td>
<td>3</td>
</tr>
<tr>
<td>New Problem; additional work-up planned ie, referred, testing</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

**Complexity of Data Reviewed or Ordered**

<table>
<thead>
<tr>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order clinical lab tests (80000)</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order tests in radiology section (70000)</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order tests in medical section (90000)</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtaining history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Decision to contact another provider about patient’s care</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simple review of report)</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

**Level of Risk**

The level of risk must be assigned to every patient’s medical record as the level of risk assigned mirrors the medical necessity of the documentation.

The Table of Risk takes the categories already reviewed within medical decision making and helps plot them according to the risk assigned. The highest level marked, within the three areas, denotes the level of risk for the patient. There are three components to the table of risk:

- The presenting problem
- Diagnostic procedure(s) ordered
- Management or treatment options assigned
## Risk of Complications and/or Mortality

<table>
<thead>
<tr>
<th>Presenting Problems</th>
<th>Diagnostic Procedure</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Min</strong></td>
<td>Lab test requiring venipuncture, chest X-ray, EKG/EEG, KOH prep or UA</td>
<td>Rest, gargles, elastic bandages, superficial dressings</td>
</tr>
<tr>
<td>One self-limited, minor problem eg, cold, insect bite, Tinea Corporis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Physiologic test not under stress, eg, PFT Non-cardiovascular image studies with contrast, superficial needle biopsies, clinical lab tests requiring arterial puncture, skin biopsies</td>
<td>OTC drugs, PT or OT, IV fluids w/o additive, Minor surgery no identified risk factors</td>
</tr>
<tr>
<td>Two or more self-limited or minor problems, 1 stable chronic illness, acute uncomplicated illness or injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mod</strong></td>
<td>Physiologic test not under stress, diagnostic endoscopy 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</td>
<td>Minor surgery with identified risk factors, elective major surgery with no identifiable risk factors, prescription drug management, therapeutic nuclear medicine, IV fluids with additives, closed treatment of fracture or dislocation w/o manipulation</td>
</tr>
<tr>
<td>One or more chronic illnesses with mild exacerbation or side effects of treatment, 2 or more stable chronic illnesses, undiagnosed new problem with uncertain prognosis, acute illness with systemic symptoms, acute uncomplicated injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>Cardiovascular imaging studies with contract with identified risk factors, cardiac electrophysiological tests, diagnostic endoscopies with identified risk factors, discography</td>
<td>Elective major surgery with identifiable risk factors, emergency major surgery, IV controlled substances, drug therapy requiring intensive monitoring for toxicity, decision not to resuscitate or de-escalate because of poor prognosis</td>
</tr>
<tr>
<td>One or more chronic illnesses with severe exacerbation, progression or side effects of treatment, acute or chronic illnesses or injuries that may pose a threat to life or bodily function, abrupt change in neurologic status</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Scoring the Medical Decision Making

Once the level of each component within medical decision making is determined, the level of medical decision making can be calculated. Within the medical decision making, one of the three components can be omitted in the scoring process, regardless of whether the patient is a new or established patient.

### Level of Medical Decision Making

Level determined with 2–3 or center level

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>1 or less</th>
<th>2</th>
<th>3</th>
<th>4 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complexity</td>
<td>1 or less</td>
<td>2</td>
<td>3</td>
<td>4 or more</td>
</tr>
<tr>
<td>Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>LEVEL</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>
Types of Services and Determining the Level of E/M

New Patient Documentation

The overall level of service is chosen differently depending on the type of E/M service being performed. All components are scored the same, but the overall levels may vary based on the category of E/M service. We will review some of the most commonly utilized E/M service types, but all E/M services may be referenced in the CPT® manual.

The documentation should identify the patient presents to this provider for a qualified new patient visit. The new patient requirements are as follows:

- The patient has not been treated by a provider of the exact same specialty within this group practice within the last three years; or
- The patient is seeing a provider with a different board specialty within the same group practice; and
- The patient has not been seen in three years.

The AMA CPT® book has placed a helpful decision tree for review of new versus established patient services. The decision tree does not cover unusual circumstances such as practice mergers and acquisitions, but does address the majority of the questions that may arise regarding the properly reported service type.

New patient services must be evaluated on all three components of an E/M service and assigned lowest of the levels supported. The following grid shows the proper assigning of each of the levels of service based on the audited E/M findings.

The grid additionally shows the amount of time required in order to support the service based on counseling and coordination of care.

<table>
<thead>
<tr>
<th>New Patients</th>
<th>History</th>
<th>Problem focused</th>
<th>Exp Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Problem focused</td>
<td>Exp Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td></td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Level</td>
<td>99201</td>
<td>99202</td>
<td>99203</td>
<td>99204</td>
<td>99205</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>10 min</td>
<td>20 min</td>
<td>30 min</td>
<td>45 min</td>
<td>60 min</td>
<td></td>
</tr>
</tbody>
</table>
Established Patient Documentation

Documentation should meet the established patient guidelines. Patients are established when they fall into the following categories:

- The patient is being treated by the reporting provider (within the past three years); or
- The patient is seeing a provider of the same exact specialty within the same group practice (within the past three years).

Once the patient is identified as an established patient, the note should continue to follow the necessary established patient guidelines. Established patients have more flexibility in documentation than do new patients as they only require two of the three key components to be documented. If a record is lacking documentation and scores low in one of the three areas, the area lacking documentation may be omitted for overall defining of the level of service.

<table>
<thead>
<tr>
<th>Established Patients</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Min</td>
</tr>
<tr>
<td>Exam</td>
<td>N/A</td>
</tr>
<tr>
<td>MDM</td>
<td>N/A</td>
</tr>
<tr>
<td>Level</td>
<td>99211</td>
</tr>
<tr>
<td>Time</td>
<td>5 min</td>
</tr>
</tbody>
</table>

99211

Code 99211 is most commonly referred to as the nurse visit code, although it may be reported by a physician. A nurse visit is an office or outpatient visit of an established patient that does not require the presence of a physician; however, the provider must be present in the medical suite. The provider delivering the nurse visit services only has to be trained, no specific credentials are required, and the physician must have confidence the provider can perform these services under supervision.

The provider-patient encounter must be face-to-face. Telephone calls cannot be billed as a nurse visit encounter, and again, this must be a medically necessary encounter. This service cannot be billed for having a patient come in and visit with the
nurse while she tries to get a medication approved through the Medicaid system—this service would not be medically necessary.

No complex key documentation components are required. Most levels of service have specific requirements for the amount of history, exam, and medical decision making that are required. However, the 99211 just requires documentation of a problem focused visit, which would be a minimal amount of history and an update on the patient’s plan of care.

**Hospital Inpatient Services**

**Initial Hospital Care**

Initial Hospital Care codes are used to report the first hospital inpatient encounter with the patient. These codes are for new or established patients and require three of the three key components.

**Initial Hospital Care**

<table>
<thead>
<tr>
<th>History</th>
<th>Detailed/Comp</th>
<th>Comprehensive</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Detailed/Comp</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward/Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Level</td>
<td>99221</td>
<td>99222</td>
<td>99223</td>
</tr>
<tr>
<td>Time</td>
<td>30 min</td>
<td>50 min</td>
<td>70 min</td>
</tr>
</tbody>
</table>

**Subsequent Hospital Care**

Subsequent hospital care codes include reviewing the medical record and reviewing results of diagnostic studies and the patient’s status, including changes since the last assessment by the physician. Subsequent hospital visits require an interval history. An interval history does not require the past medical, family, and social history.

**Subsequent Hospital Care**

<table>
<thead>
<tr>
<th>History</th>
<th>Problem Focused</th>
<th>Exp Problem Focused</th>
<th>Detailed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Problem Focused</td>
<td>Exp Problem Focused</td>
<td>Detailed</td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward/Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Level</td>
<td>99231</td>
<td>99232</td>
<td>99233</td>
</tr>
<tr>
<td>Time</td>
<td>15 min</td>
<td>25 min</td>
<td>35 min</td>
</tr>
</tbody>
</table>
Hospital Discharge Services
Hospital Discharge Services are used to report the total duration of time spent by the physician for final hospital discharge of the patient. These codes include, as appropriate, final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and prep of discharge. Time does not need to be continuous and includes prescriptions, referrals and discharge of records.

99238 is reported for hospital discharge of 30 minutes or less; 99239 is for 30 minutes or more. It is recommended that time spent be documented to appropriately charge the level of visit, especially for 99239. Codes 99238/99239 are not used for discharge from observation care or for nursing facility care discharge.

Consultation Services
Effective January 1, 2010, CMS eliminated the use of all consultation CPT®/HCPCS codes. Elimination of consultation codes is for Medicare patients only. Commercial carriers may vary on how they elect to process these services.

Even though CMS no longer reimburses for consult services the provider should continue to document consult services according to CMS’ previous rules and guidelines as they are still followed by many commercial carriers. The documentation should be inclusive of these elements in an effort to support the medical necessity of the higher reimbursable service and to show the increased work involved of a consult patient as opposed to new patient services. The documentation requirements should include:

- An initial statement of consultation, which clearly identifies who the provider is that requested the consult and the reason for the consult.
- A letter back to the requesting providers inclusive of the actual documentation of or a summary of the consult services.

These services are scored based on the following grids:

### Office or Other Outpatient Consultations

<table>
<thead>
<tr>
<th>History</th>
<th>Problem Focused</th>
<th>Exp Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Problem Focused</td>
<td>Exp Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Level</td>
<td>99241</td>
<td>99242</td>
<td>99243</td>
<td>99244</td>
<td>99245</td>
</tr>
<tr>
<td>Time</td>
<td>15 min</td>
<td>30 min</td>
<td>40 min</td>
<td>60 min</td>
<td>80 min</td>
</tr>
</tbody>
</table>

### Inpatient Consultations

<table>
<thead>
<tr>
<th>History</th>
<th>Problem Focused</th>
<th>Exp Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Problem Focused</td>
<td>Exp Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Level</td>
<td>99251</td>
<td>99252</td>
<td>99253</td>
<td>99254</td>
<td>99255</td>
</tr>
<tr>
<td>Time</td>
<td>20 min</td>
<td>40 min</td>
<td>55 min</td>
<td>80 min</td>
<td>110 min</td>
</tr>
</tbody>
</table>
**Critical Care Services**

CPT® defines critical care as “A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition.”

Critical Care Services are time-based codes and documentation of time in the patient’s medical record is crucial for reporting of these services. Time does not need to be continuous, but the individual time with the patient should be recorded and is reportable once per day.

The guidelines in CPT® list the services included in critical care which cannot be reported separately. The time spent performing the inclusive services may be counted toward the total physician time, as long as the physician personally performed the service.

Time involved in activities that do not directly contribute to the treatment of the critically ill or injured patient may not be counted toward the critical care time, even when they are performed in the critical care unit at a patient’s bedside (eg, review of literature and teaching sessions with physician residents whether conducted on hospital rounds or in other venues).

The duration of critical care services to be reported is the time the physician himself spent evaluating, providing care, and managing the critically ill or injured patient’s care. Time spent by other providers of care, regardless of credential or incident-to billing status, may not be combined with the provider’s services. That time may be spent at the immediate bedside or elsewhere on the floor or unit as long as the physician is immediately available to the patient. For any given period of time spent providing critical care services, the physician must devote his full attention to the patient and cannot provide services to any other patient during the same period of time.

The documentation should not only be inclusive of the time spent, but should also substantiate the medical necessity component for critical care services.

<table>
<thead>
<tr>
<th>Duration</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 30 minutes</td>
<td>99232 or 99233 or other appropriate E/M code</td>
</tr>
<tr>
<td>30–74 minutes</td>
<td>99291 X 1</td>
</tr>
<tr>
<td>75–104 minutes</td>
<td>99291 X 1 and 99292 X 1</td>
</tr>
<tr>
<td>105–134 minutes</td>
<td>99291 X 1 and 99292 X 2</td>
</tr>
<tr>
<td>135–164 minutes</td>
<td>99291 X 1 and 99292 X 3</td>
</tr>
<tr>
<td>165–194 minutes</td>
<td>99291 X 1 and 99292 X 4</td>
</tr>
</tbody>
</table>

**Preventive Medicine Services**

A preventive service may be predefined as a service performed on a relatively asymptomatic patient for reasons of increased preventive health compliance. Prior to 2011, CMS only covered an Initial Preventive Physical Examination (IPPE) as a source of preventive care, and most preventive services dealt with commercial carriers and Medicaid programs. Now CMS covers preventive care, but it does not recognize the typical E/M preventive service codes.

Preventive care services as found in the E/M category of care are services coded based on the patient status to the provider (new vs. established) and the age of the patient at the time of service. The documentation for these encounters should include:

- Age and gender
- Appropriate interval level history
- Examination of a comprehensive nature
- Counseling, anticipatory guidance
- Risk factor reduction interventions
- Ordering of laboratory or other diagnostic procedures
- Formulating a plan of care relevant to preventive care of the patient

A controversial point often surrounds the phrase “interval level history.” There is no guideline that
can be referenced as the definitive definition of interval history. The rule of thumb that is adhered by the majority of auditors (including carrier auditors) is no HPI elements because in theory the patient is asymptomatic on the date of service, a complete ROS as the provider should be evaluating the patient systematically to confirm the preventive nature of their status, and a complete review of all elements of the PFSH as this information is predisposing to the medical necessity of the preventive services rendered to a patient.

CMS covered preventive services include the IPPE physical, which has its own documentation guidelines, and the CMS annual preventive care services. The documentation requirements for an IPPE are listed in the CMS online manuals.

The IPPE must be performed by a physician or an NPP and documented according to the specified guidelines. This service is only reimbursable when performed during the patient’s first 12 months as a CMS beneficiary.

The CMS annual preventive care services are performed 12 months post the IPPE physical (if performed), and then the Subsequent CMS annual preventive service would be billable every 12 months. Both also have specific documentation requirements, located on the CMS website.

Prolonged Physician Services
Prolonged physician services are billable in addition to an E/M encounter. The prolonged services would be submitted when the encounter exceeds the normal time guidance for the E/M encounter and is supported by medical necessity.

The code sets are divided into categories of outpatient or inpatient and whether the prolonged service was with direct face-to-face contact with the provider of care. Providers often mistakenly think the E/M service must meet the medical necessity and documentation guidelines or exceed the time allowed for a level 5 visit (level 3 inpatient) before they can use the prolonged services codes. Prolonged services codes may be billed with any level of E/M service. For example, a provider has an established patient in the office with mildly progressing dementia (99214 based on documentation and medical necessity) requiring an extensive amount of time reviewing history and medications involving several phone calls to other providers, family members, or pharmacists. The provider spends a total of two hours (120 minutes) with the patient or performing patient related tasks. A 99214 level of service has a typical time of 25 minutes. Therefore, 25 minutes of the total time is not counted. This leaves you with 95 minutes of time you can count as prolonged services.

The codes should be audited to ensure the documentation includes the medical necessity and the time documentation to support the following guidance:

<table>
<thead>
<tr>
<th>Total time of prolonged services</th>
<th>Outpatient Prolonged Services Code(s)</th>
<th>Inpatient Prolonged Services Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 minutes</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>30–74 minutes</td>
<td>99354</td>
<td>99356</td>
</tr>
<tr>
<td>75–104 minutes</td>
<td>99354 and 99355</td>
<td>99356 and 99357</td>
</tr>
<tr>
<td>105–134 minutes</td>
<td>99354 and 99355 x2</td>
<td>99356 and 99357 x2</td>
</tr>
<tr>
<td>135–164 minutes</td>
<td>99354 and 99355 x3</td>
<td>99356 and 99357 x3</td>
</tr>
<tr>
<td>165–194 minutes</td>
<td>99354 and 99355 x4</td>
<td>99356 and 99357 x4</td>
</tr>
</tbody>
</table>

Inpatient Neonatal and Pediatric Critical Care
These codes are used for critically ill or injured neonate/pediatric patients from newborn to five years of age. The critical care service definitions are the same as for standard critical care services.
These codes are reported only once per day by a physician. The services are divided by age, initial and subsequent visits.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99468</td>
<td>Initial visit, 28 days of age or younger</td>
</tr>
<tr>
<td>99469</td>
<td>Subsequent visit, 28 days of age or younger</td>
</tr>
<tr>
<td>99471</td>
<td>Initial visit, 29 days of age through 24 months of age</td>
</tr>
<tr>
<td>99472</td>
<td>Subsequent visit, 29 days of age through 24 months of age</td>
</tr>
<tr>
<td>99475</td>
<td>Initial visit, 2 years of age through 5 years of age</td>
</tr>
<tr>
<td>99476</td>
<td>Subsequent visit, 2 years of age through 5 years of age</td>
</tr>
</tbody>
</table>

The Pediatric and Neonatal Critical Care codes include the same procedures as adult critical care codes of 99291 and 99292 but also list additional inclusive services in the guidelines of this section.

Pediatric and Neonatal services provided in the emergency room or office use codes 99291 and 99292. If services are provided in the outpatient and inpatient facilities on the same day, report only the neonate/pediatric critical care codes. Critical care services provided by a second physician of a different specialty would report their services using codes 99291 and 99292 per day.

Critical care provided to children over the age of six would be reported using the standard critical care codes of 99291–99292.

**E/M Modifiers**

There are modifiers only indicated for E/M services. These modifiers help to identify any extenuating circumstances of the encounter to the payer on the given date of service. The documentation must be found to support the use of the reported modifier.

**Modifier 24—Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period.**

This modifier is added to an evaluation and management code to specify the service was performed during a postoperative period but is unrelated to the surgical diagnosis.

**Modifier 25—Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.**

This modifier is added to an E/M code to indicate the patient's service is separate from that required for the procedure and a clearly documented encounter which either addresses issue(s) not pertaining to the procedure, or was the distinct service of defining the procedure indicated on that date of service. Different diagnoses are not required for reporting E/M services on the same day.

**Modifier 57—Decision for Surgery.**

This modifier is used when the physician makes a decision to perform major surgery the same day as the visit or the next day. Surgical packages include preoperative, surgery, and postoperative services; however, sometimes surgical decisions are made during an E/M visit that requires immediate surgical intervention.

**E/M Documentation Structures**

This section has been inclusive of describing the anatomical pieces needed in the provider’s documentation of the encounter. A provider’s documentation may take many shapes and forms, and may be constructed in a variety of forms. Some records will be handwritten while others will be generated by an EHR system, but regardless all are scored the same.

Organization of the record also varies by provider style and stereotypically on age or location of training. Common encounter structure formats may follow the SOAP or CHEDDAR formats. These formats present the elements in the following style:
SOAP
SOAP notes refer to a particular format of recording information regarding the treatment process.

S = Subjective
O = Objective
A = Assessment
P = Plan

CHEDDAR
C = Chief complaint, presenting problems, subjective statements
H = History; social and physical history of presenting problem as well as contributing information
E = Examination, including extent of body system(s) examined
D = Details of problem and complaints, etc.
D = Drugs and dosage—a list of current medications used with dosage and frequency, etc.
A = Assessment of observations, etc.
R = Return visit information

The construction of the encounter may include a procedure and/or radiological services. These services may be documented within the body of the E/M encounter as long as the “report” of these services could stand independently of the E/M encounter. The best validation of this requirement is for the auditor to review the report as an excerpt from the E/M encounter. A procedure performed within the practice is still required to include specific elements within the documentation, much like a regular procedural service. These elements include:

- Specific anatomical site
- Technique used
- Risk and benefits were reviewed with the patient

Details of the procedure to include mg/ml of any medications utilized/injected
- How the patient tolerated the procedure

Failure of properly documenting these elements for an in-office procedure could deem the procedural service as non-billable.

Incident-to Services
Incident-to services should always be carefully evaluated through an audit process. In a practice reporting incident-to services, the documentation must be considered as part of the audit process due to the recurrence of this type of encounter on the OIG work plan year after year.

Background
Incident-to services are defined as those services furnished incident to physician professional services in the physician’s office or in a patient’s home. The services are billed as Part B services to your carrier as if the physician personally provided them, and they are paid under the physician fee schedule. These services are also relevant to services supervised by certain non-physician practitioners such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists. The incident-to concept is not applicable in a hospital.

To qualify as incident-to under CMS rules and guidelines, certain criteria must be met.

- There must be an employment relationship between the physician and the auxiliary personnel providing the service.
- The provider must be on-site for direct supervision.
- New patients are not billed as incident-to.
- Established patients with new problems are not billed as incident-to.
- The services are provided in the office and are integral to the physician’s services.
Direct Personal Supervision
To be considered “direct” supervision, the physician must be present in the office suite and immediately available to provide assistance throughout the time the employee is providing the incident-to service. Having the physician available by phone does not constitute direct supervision. If it is a group practice, any physician can be the supervising physician. The CMS-1500 form allows for identification of the physician who is billing for the incident-to services and the physician who is providing the direct supervision.

Incident-to Auditing Rules
Incident-to charts should first be identified and separated from other charts being audited. A chart is identified as being an incident-to service when the provider on the CMS-1500 claim form differs from the provider on the medical record. Physicians cannot bill incident-to other physicians.

At times there may be two providers on the CMS claim form from the same group practice. There will be one provider at the bottom of the claim form and another provider within the same group in block 17 for the referring physician. This accurately reflects the provider who supervised the service on this date was not the provider who authenticated the plan of care. This style of claim reporting is a Medicare requirement. Accurate auditing of this type of chart would include auditing the visit prior to this encounter in which the provider in block 17 authenticated the plan of care.

An additional inclusion is necessary for incident-to split/shared visits. In cases in which the patient has an encounter with the supervising provider and the non-physician provider and a split/shared visit is performed, a validating statement should be included within the documentation.

The statement should include work that was performed by the supervising provider to count this service as a split/shared service. As an example, “The history and exam were reviewed with the patient by Dr. M and the following plan of care was orchestrated…” This statement shows the physician’s active involvement in the patient encounter. Incident-to requirements must be met for split/shared office visits. In other words, if the patient is a new patient, or the patient presents with a new problem, the split/shared visit must be billed under the NPP’s UPIN/PIN number. Split/shared visits in the hospital setting do not require incident-to rules. When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (eg, even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP’s UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim. Critical care cannot be billed as a split/shared visit.

As seen from this chapter, auditing E/M services can be complex. Because E/M services are the main services performed by most providers, understanding auditing of E/M services is critical to an auditor’s career.
Chapter 5

Audit Process & Communication of Findings

While performing a coding/documentation audit will satisfy the guidelines of a compliance audit as a mere paper exercise, no true gain can be had from not utilizing the audit to its full capabilities. This would include proper reporting of the audit findings to the provider, practice, and the compliance officer, but it also adds providing any education necessary to improve the provider deficiencies. This process will promote an increased awareness for the practice’s initiative toward OIG compliance.

There are different types of audits that may be performed and the type and scope of the audit will be typically based on what triggered the need for the audit.

The Purpose of the Audit

The purpose of an audit may be to provide ongoing compliance to the practice, focus of over-utilization of services, or as a general educational exercise process. The driving force of the audit should direct the auditor to the type of audit he or she will provide.

- Compliance Audits: These audits are performed strictly in an effort to evaluate the provider’s compliance with documentation rules and guidelines. These audits may be performed by an internal compliance team or outsourced to a third party auditor. These audits tend to focus only on the documentation content as it compares to the necessary rules and guidelines. There are many different compliance audits that could be performed and are performed for various reasons; the most common being pre- and postpayment audits. Audits are typically performed by the practice, a third party consultant, health plan, or government agency. A clear understanding of the types of audits is imperative.

- Prepayment (prospective) Audit: This type of audit is performed on services prior to claim submission by the practice or consultant or at the time of claim submission by the payer. These audits are typically provided for larger group practices or hospital-based practices.

- Postpayment (retrospective) Audit: A postpayment audit is the most commonly performed audit. These audits are performed on services that have already been posted, filed and paid by the payer. This audit will typically be performed for the smaller physician practice. These audits help in monitoring claims submission, trends related to denials as well as ensuring proper coding, documentation and billing.

- Risk Management Audits: This type of audit is focused on how patient care is delivered from the beginning of the encounter through the entire process as well as practice liability. This audit will focus on a variety of patient care continuity and practice liability issues such as:
  - Facilities Assessment
  - Telephone Procedures/Scheduling
  - Clinical Documentation
  - Informed Consent
  - Information Systems
  - Physician/Patient Communication
  - Continuity of Care
  - Patient Accounts and Billing Procedures
Referrals and Consults
Medications
Malpractice Claims Management and Legal Advice
Personnel Issues

Focused Audits: Focused audits appear to be associated with specific problems related to inaccurate coding and are found most commonly through the production/utilization report. The audit may focus on a particular service that is being over- or underutilized by the provider. This audit process should not always be the type of audit performed because a more across-the-board audit should be the standard audit approach. A focused audit should be performed when a provider is suspected of not appropriately using a particular service code.

Audits may be performed within a practice utilizing its own staff and this would be considered an internal audit. It is recommended each practice also have at least one external coding audit annually. Every auditor should be audited, and just as we expect the physician to use the audit as a learning process, so should the auditor.

Tools of the Trade

An auditor should be sure he or she has everything needed to provide the most detailed audit, and to support the findings. The following are tools the auditor requires and the purpose of each:

Documentation Guidelines: Having a small bound book that is easily accessible not only when auditing, but during chart review is very pertinent to an auditor. These ARE the rules and being able to point to specific information will better substantiate the auditor’s credibility. Although citing chapter and verse by memory is impressive; the best back up is the black and white copy. The auditor should be sure to maintain 1995 and 1997 Evaluation and Management Guidelines and CMS Documentation Guidelines for quick reference.

Coding Guidelines vs. Carrier Guidelines: While the instructions of this manual and testing format is built on national coding guidelines, some carriers may have policies differing from the national guidelines. So, when performing an audit, local carrier policies should be referenced. In an instance where national coding guidelines and local carrier policies (LCDs) vary, adhere to the more stringent guideline.

Audit Tool: An audit tool is essential to the trade. Many auditors have been providing these services for years, and the only audit tool they really need is in their head. However, not recording the findings on an audit tool per chart reviewed may put the auditor in a precarious situation of not being able to recall how he or she analyzed the charts while sitting in a compliance meeting or face-to-face with the provider of record.

Coding Manuals: The auditor must have access to all coding manuals for the year of the services being audited. An auditor should not only have CPT® and ICD-9-CM books at hand, but a HCPCS Level II book and any other specialty resources as well. When providing an audit in which any type of drugs or supplies are coded/billed the auditor should verify the proper mg/ml dosage in the HCPCS Level II manual compared to the amount given and billed for during the patient encounter.

Payer Policies: During the audit process, copies of PAR insurance contracts may contain vital information to help provide an accurate analysis. Contracts would prove their value when an auditor finds a large trend of denials for a particular carrier, or bundling that is not standard.

Documentation to be Audited: The information required to perform an audit of the provider’s services is the documentation of the encounter/procedure, the billing sheet (encounter form) showing what the provider intended to bill for the documented services, the CMS-1500 claim form showing what was actually billed along with modifier usage and diagnosis code(s) billed, the explanation of benefits (EOB) from the payer, and a report showing how the claim was processed by the provider.
What to Audit

For any given practice, request the specific items intended for audit. The items requested are similar from specialty to specialty, but may vary based on specialty.

A baseline audit typically includes 10–15 records per provider as recommended by the OIG. The records obtained for audit purpose should be chosen on a random approach, but should reflect the coding trends of the provider based on a utilization report of services. The records should not only include evaluation and management services (E/M), but also procedures and surgical encounters (as applicable).

Some audits may be more specifically targeted toward a specific service of a provider. This type of focused audit is utilized to assist providers in areas specifically identified as problematic areas.

Auditors should review the patient’s chart for the following information based on audit type:

<table>
<thead>
<tr>
<th>Registration Form</th>
<th>Risk Management Audit</th>
<th>Compliance Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Data Logs</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Legal Release/ Billing Forms</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Service Note</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Billing Record</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Claim Form</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>EOB per service audited</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

The audit must include the examination of the patient encounter based solely on the information provided to the auditor. Each record can only be evaluated on the information specific to the date of service being audited. For this reason, it is most important instruction is given that each encounter must be documented by the provider on an independent basis. An auditor cannot utilize information from other dates of service, other forms, or other records unless the provider specifically indicates this information has been “fused” to the documentation of this encounter. The fusing process is properly performed when the provider uses a statement such as, “The ROS and PFSH have been reviewed from the initial history form dated 11-19-2008;” however, if the initial history form was not sent as part of the audit materials, there would still be no credit allowed for this documentation.

There should be three notations of each performed audit:

- Services billed
- Documentation level of the services billed
- Medical necessity level of the services billed

It is important that every encounter be scored and reported based on documentation content as well as the medical necessity of the service.

Communication of Audit Reports

Results Retention

Once the audit is performed, the results must be presented to the provider audited. An audit, whether performed by an auditor for training or by a payer, would not serve its purpose if the results were not shared with the provider for education; however, the person with whom you review the results will be determined based on the audit request.

At times an audit may be requested by a health care attorney to maintain confidentiality on the behalf of the auditor and the provider/practice. When a health care attorney requests an audit, the results belong to the health care attorney and should be sent to/reviewed with the health care attorney only, unless further direction is given. This type of audit may be requested and performed when a provider/practice is undergoing Medicare review. As well, larger group practices and hospital-based practices typically request audits be performed through a health care attorney’s request. As an auditor, this should be
your preference, as it will eliminate the possibility of the auditor having to testify in court against the provider/practice who is being audited.

Regardless of the type or purpose of the audit the compliance officer should always maintain audit results as part of the compliance plan of the practice.

Audit Report Contents
A good audit report will include specific information allowing the provider(s) to use the information to not only reach/maintain compliance, but also enhance their coding and billing skills. The first item to communicate in the audit report is where the deficiencies have been identified. Whether the weaknesses have been identified in documentation content, billing, or regulatory control issues, the auditor must be able to effectively communicate the findings and offer strategy for future compliance.

The audit report appropriately should detail the provider changes needed in current documentation/billing for the deficiencies to be corrected. This means the audit report should specifically address problem areas along with offering recommendations for improvement. Education and training should be provided based on these results in an effort to reinforce the needed changes for compliance.

Negative findings should be provided to the provider not only in detail format, but through a summary/overview process. Many providers may not take the time to go through a full lengthy coding report, but would gain the necessary improvement and recommendations through an executive summary approach. Many recommend showing a provider a percent score or a right to wrong ratio within the audit; and, although this approach is completely substantiated, for many providers this finding will be more confrontational in approach and they will not gain as much education from the process as desired.

E/M Documentation Results
The report an auditor delivers should be a clear and concise report comparing each required documentation component, according to the E/M Guidelines. The report should not be merely defined as the history, exam, and medical decision making components, but it should delve into the specific history and medical decision making elements. At the same time, an auditor must remember the goal is to help providers achieve better documentation but not to give them system overload by expecting them to know and recite documentation guidelines for each element. A simple grid could show them the required elements compared to the needed components, as well as showing them what additional information is required to have met the components.

Billing Results
While performing any type of audit, the billing performed for the given date of service should be reviewed as well. Modifier usage should be reviewed and billing trends should be noted for the provider.

Billing trends are identified billing deficiencies the practice is demonstrating on a consistent basis. These may be repeated denials or inappropriate modifier usage. The best way to report this information to the practice is to supply the actual billing document from which the information was obtained. Commenting on their own documentation allows for automatic back up for the auditor as to the findings reported.

Trending of a Physician/Practice
Medicare Distribution Analysis
An auditor should be able to statistically analyze the coding trends of a provider and/or group practice. Providers or groups should be compared to the national average statistics for levels of service billed based on their specialty better known as the Medicare Bell Curve.

Audits should include a comparison of how the physician's levels of service compare to the expected Medicare Bell Curve (National Distribution). Variance between the actual patient levels of service and the Medicare expectations should be reviewed. By providing an aggregate analysis of the provider's services compared to
expected national levels, the auditor is able to best validate specific identification of over-coding or over-utilization of services which may put the provider at increased risk for audit. This analysis will evaluate the provider’s coding profile to show current coding patterns.

The Medicare Bell Curve statistics may appear in many different formats, but the statistical information should be the same and should be interpreted in the same manner. The following are some examples of commonly seen reporting of distribution analysis information:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
<th>Column 5</th>
<th>Column 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>Current Frequency</td>
<td>Current Practice Profile</td>
<td>National Dist. %</td>
<td>Variance:Practice vs. National</td>
<td>New Frequency if at National %</td>
</tr>
<tr>
<td>99201</td>
<td>0</td>
<td>0.00%</td>
<td>1.69%</td>
<td>-100.00%</td>
<td>4</td>
</tr>
<tr>
<td>99202</td>
<td>0</td>
<td>0.00%</td>
<td>14.81%</td>
<td>-100.00%</td>
<td>31</td>
</tr>
<tr>
<td>99203</td>
<td>154</td>
<td>73.68%</td>
<td>41.68%</td>
<td>76.78%</td>
<td>87</td>
</tr>
<tr>
<td>99204</td>
<td>55</td>
<td>26.32%</td>
<td>32.11%</td>
<td>-18.04%</td>
<td>67</td>
</tr>
<tr>
<td>99205</td>
<td>0</td>
<td>0.00%</td>
<td>9.71%</td>
<td>-100.00%</td>
<td>20</td>
</tr>
<tr>
<td>Totals</td>
<td>209</td>
<td>100.00%</td>
<td>100.00%</td>
<td></td>
<td>209</td>
</tr>
</tbody>
</table>

Figure 1) Column 1 shows the CPT® code being analyzed. Column 2 shows the number of times that specific code was billed by the provider/practice. Column 3 reports the productivity of the level of service as a percentage. Column 4 shows the national distribution of the same services. Column 5 shows the variation, in percent, between what the provider/practice is actually billing versus the National Distribution. Column 6 information shows the total number of patients that would be billed per level of service if the practice were to bill consistent with the National Distribution rate.

Figure 2) A Bell Curve Graphing—This graph is a useful visual for a practice/provider to quickly identify how it compares to the expected National averages.

Figure 3) Bar Graph Analysis—The bar graph is another reference which easily identifies to the practice/provider its averages compared to the National averages.

All three are different visual representations of the same data. The interpretation that the auditor should be reporting to the physician/practice is significant over-utilization of the 99203 level of service. Statistics
showing significant over-utilization may lead to audits by any carrier to validate if the services are being billed appropriately based on documentation and medical necessity. The auditor should also note that the provider has many levels of service that are under-billed based on this analysis.

**Finalization of the Report**

A formal report of the type of audit and findings should be compiled and presented to the practice’s Compliance Officer (CO) as well as each provider of service within the practice. The auditor should ensure the audit results are thorough yet have a brief concise explanation of the results. It is preferred that the report should be reviewed with the provider on a one-on-one basis. When audit results are delivered in a group session, providers tend to not identify that they may be the reason for the identified element of deficiency. When a one-on-one session is conducted, the provider realizes that the identified deficiency is indeed his or her problem to address.

For compliance reasons, be sure the summarization for the compliance plan includes the following information:

- Date of the audit
- Who requested the audit
- How many records were reviewed
- Which providers were audited
- A statement indicating a detailed report has been provided to each provider audited
- A statement indicating a one-on-one or group session was provided for each provider audited to review the findings
- A concise overview of the findings
- A statement regarding intended or needed follow up to be performed to adhere to the necessary compliance components
- Identification of the auditor performing the service

**Corrective Action**

Once the audit has been performed and all deficiencies have been reported and reviewed, a plan for corrective action should be implemented. The corrective action should include:

- Review with each provider regarding the findings to include appropriate actions to correct going forward.
- Review with the compliance officer to ensure he or she has an understanding of the level of compliance the audit identifies.
- Education for the provider(s) and all appropriate billing/coding/nursing staff regarding the deficiencies noted in the audit, the guidelines, and necessary requirements to meet or exceed compliance in the future.
- Develop, implement and then educate forthcoming policies relevant to the findings of the audit.
- Make restitution with any carrier for services that are not billed appropriately. Failure to reimburse a carrier for services billed inappropriately could be interpreted as fraud. This is a form of self disclosure.
- Schedule a follow-up audit to evaluate the hopeful increase in compliance.

All corrective action performed should be maintained by the practice to show its initiative toward compliance.

**Addressing the Provider**

A coding audit is essentially a review of a provider’s job performance. In many instances the auditor is faced with having to tell his or her employer what the job performance rating is. Some providers may get defensive, especially when they feel an auditor (regardless of medical training) is questioning the integrity of the medical care they provided to a patient. Most times, auditors are NOT questioning the integrity of the medical care, but many providers feel this way as soon as the auditor starts delivering the findings of the audit. Providers may feel compelled to defend their actions, and they may begin telling us the patient
history and why they are justified in the services rendered. However, what they tell the auditor was simply not found in the documentation, and the auditor is forced to remind the provider information not documented may not be counted. This is not to say that an auditor should not effectively communicate the deficiencies and needed areas of improvement to providers, but rather is a reminder to address the results with a provider in a non-threatening approach. This recommendation is not in an effort to request conformism, but as the best tactic to obtain the maximization of the benefits of an audit. No one, regardless of position, appreciates being told he or she is wrong; therefore, the best approach may be to address the positive points of the provider’s audit followed by the areas of noted deficiency. This will show that, as the score keeper of the provider’s job performance on documentation, you are acknowledging assets as well as deficiencies.

A report of the findings of the audit should be released to providers for their review and follow-up questions and educational sessions. The provider should additionally sign an acknowledgement of understanding the audit, and that deficiencies have been discussed and education provided on corrective action needed. This form should be maintained in the compliance manual, by the provider, and by the auditor.
Sample Summary Audit Report

Charts audited: 15

E/M Coding:
- E/M Level appears to be correct: 14
- E/M Level appears to under-coded: 1
- E/M Level appears to be over-coded: 0

Coding for procedures/services:
- Procedures/services are supported by the documentation: 14
- Procedures/services are not supported by the documentation: 1

Diagnosis Coding:
- Diagnoses codes are supported by the documentation: 4
- Diagnoses codes are not supported or are not reported to the highest level of specificity: 11

Key Findings & Recommendations:

1. **Further specify the patient’s diagnosis.** Submitting “unspecified” diagnoses on a consistent basis may trigger an audit. The more specific documentation can be for a diagnosis, the more specific the diagnosis code can be. For example, hypertension (401.9) can be stated as malignant (401.0), benign (401.1), easily managed by medication (401.1), etc.

2. **If Guaic cards are given to a patient to take home, they should not be reported for that date of service.** The hemoccult lab should not be charged until the cards have been returned and the lab test has been performed. Billing for the lab prior to the lab test being performed is considered billing for a service not rendered.

3. “Possible” diagnosis should not be reported; instead, report the symptoms.

   _DG: For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnosis or as “possible”, “probable”, or “rule out” (R/O) diagnosis._

   It is important to remember that probably diagnoses cannot be reported. In this instance, the symptoms should be reported.

4. **Any diagnosis that supports an ancillary service should be duplicated on the encounter form.**

   _If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred._

   Since the medical record does not go with the encounter form, the reason for ordering the tests should be noted on the encounter form. For example, a CMP was ordered for long-term medication use, V58.69 should be added to the encounter form for correct billing.
## Sample Detailed Audit Analysis

<table>
<thead>
<tr>
<th>Patient Number</th>
<th>Date of Service</th>
<th>Physician E/M Code</th>
<th>Auditor E/M Code</th>
<th>Physician ICD-9 Code</th>
<th>Auditor ICD-9 Code</th>
<th>Physician CPT Code</th>
<th>Auditor CPT Code</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>03/13/XX</td>
<td>99213</td>
<td>99213</td>
<td>477.9</td>
<td></td>
<td>465.9</td>
<td></td>
<td><strong>Allergic Rhinitis (477.9) is stated as possible and therefore should not be coded. Should code symptoms instead. Stated as “allergic rhinitis” on the encounter form.</strong></td>
</tr>
<tr>
<td>2</td>
<td>03/13/XX</td>
<td>99213</td>
<td>99213</td>
<td>729.1</td>
<td>530.11</td>
<td>729.1</td>
<td>530.81</td>
<td><strong>GERD (530.81) is not specified as esophagitis (530.11). Stated as “GERD” on the encounter form.</strong></td>
</tr>
<tr>
<td>3</td>
<td>03/13/XX</td>
<td>99214</td>
<td>99214</td>
<td>411.1</td>
<td>530.19</td>
<td>411.1</td>
<td>715.90</td>
<td><strong>Additional ICD-9s should be stated as they help contribute to the 99214. They are in the dictation but not on the encounter form.</strong></td>
</tr>
<tr>
<td>4</td>
<td>03/13/XX</td>
<td>99395</td>
<td>99395</td>
<td>V70.0</td>
<td>V70.0</td>
<td>36415</td>
<td>80061</td>
<td><strong>Excellent use of the preventive medicine codes.</strong></td>
</tr>
<tr>
<td>5</td>
<td>03/13/XX</td>
<td>99212</td>
<td>99212</td>
<td>727.00</td>
<td>727.05</td>
<td>L3908</td>
<td>L3908</td>
<td><strong>Tenosynovitis (727.00) is further specified to the left wrist (727.05). Left wrist is stated on the encounter form.</strong></td>
</tr>
<tr>
<td>6</td>
<td>03/13/XX</td>
<td>99212</td>
<td>99213</td>
<td>465.9</td>
<td>465.9</td>
<td></td>
<td></td>
<td><strong>Documentation supports a level 3 established patient visit.</strong></td>
</tr>
<tr>
<td>Patient Number</td>
<td>Date of Service</td>
<td>Physician E/M Code</td>
<td>Auditor E/M Code</td>
<td>Physician ICD-9 Code</td>
<td>Auditor ICD-9 Code</td>
<td>Physician CPT Code</td>
<td>Auditor CPT Code</td>
<td>Comments:</td>
</tr>
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</tr>
<tr>
<td>7</td>
<td>03/13/XX</td>
<td>99214</td>
<td>99214</td>
<td>401.0</td>
<td>401.9</td>
<td>36415</td>
<td>G0001</td>
<td>Hypertension (401.9) is not specified as malignant (401.0). Stated as “401.0” on the encounter form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>715.95</td>
<td>715.90</td>
<td></td>
<td></td>
<td>Osteoarthritis (715.90) is not specified to hip (715.95) in dictation or on the encounter form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>110.1</td>
<td>110.1</td>
<td></td>
<td></td>
<td>Lab was performed for long-term use of medications; this should be coded (V58.69).</td>
</tr>
<tr>
<td>8</td>
<td>03/13/XX</td>
<td>99213</td>
<td>99213</td>
<td>354.0</td>
<td>354.0</td>
<td>L3908</td>
<td>L3908</td>
<td>Agree with ICD-9 and CPT codes.</td>
</tr>
<tr>
<td>9</td>
<td>03/13/XX</td>
<td>99395</td>
<td>99395</td>
<td>V70.0</td>
<td>V70.0</td>
<td>93000</td>
<td>93000</td>
<td>Hypertension (401.9) is not specified as malignant (401.0). Stated as “401.0” on the encounter form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>401.0</td>
<td>401.9</td>
<td>81003</td>
<td></td>
<td>There is no mention of urinalysis in dictation or on the encounter form.</td>
</tr>
<tr>
<td>10</td>
<td>04/17/XX</td>
<td>99214</td>
<td>99214</td>
<td>451.2</td>
<td>451.2</td>
<td></td>
<td></td>
<td>Contusion is specified as to the ankle (924.21) in the dictation, but as to the leg (924.5) on the encounter form.</td>
</tr>
<tr>
<td>Patient Number</td>
<td>Date of Service</td>
<td>Physician E/M Code</td>
<td>Auditor E/M Code</td>
<td>Physician ICD-9 Code</td>
<td>Auditor ICD-9 Code</td>
<td>Physician CPT Code</td>
<td>Auditor CPT Code</td>
<td>Comments:</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
<td>--------------------</td>
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<td>----------------------</td>
<td>-------------------</td>
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<td>-----------------</td>
<td>-----------</td>
</tr>
<tr>
<td>11</td>
<td>04/17/XX</td>
<td>99396</td>
<td>99396</td>
<td>V70.0</td>
<td>V70.0</td>
<td>76092</td>
<td>36415</td>
<td>TSH (84443) &amp; cholesterol (82465) are stated as being done for high cholesterol (272.0). High Cholesterol is not stated as a diagnosis on the encounter form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>V76.12</td>
<td>V76.12</td>
<td>36415</td>
<td></td>
<td>Hemoccult cards were given to the patient to return, should be charged upon return.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>V76.41</td>
<td>V76.41</td>
<td>82270</td>
<td></td>
<td>There is no mention of urinalysis in dictation or on the encounter form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>272.0</td>
<td>272.0</td>
<td>84443</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>82465</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>81003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>04/17/XX</td>
<td>99214</td>
<td>99214</td>
<td>250.03</td>
<td>250.03</td>
<td>36415</td>
<td>G0001</td>
<td>Hypertension (401.9) was also treated and should be coded as it helps contribute to the level of service. It was not stated on the encounter form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>401.9</td>
<td>401.9</td>
<td>36415</td>
<td></td>
<td>36415 should be G0001 for Medicare patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>81003</td>
<td></td>
<td>Venipuncture (36415/G0001) should only be charged once per day.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>82044</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>36415</td>
<td></td>
<td>* Labs may be sent out.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>84681*</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>83036*</td>
<td></td>
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<tr>
<td>Patient Number</td>
<td>Date of Service</td>
<td>Physician E/M Code</td>
<td>Auditor E/M Code</td>
<td>Physician ICD-9 Code</td>
<td>Auditor ICD-9 Code</td>
<td>Physician CPT Code</td>
<td>Auditor CPT Code</td>
<td>Comments:</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
<td>--------------------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>-----------------</td>
<td>-----------</td>
</tr>
<tr>
<td>13</td>
<td>04/17/XX</td>
<td>99213</td>
<td>99213</td>
<td>411.1 496 427.32</td>
<td>411.1 496 V58.61</td>
<td>36415 85610</td>
<td>G0001 85610</td>
<td>36415 should be G0001 for Medicare patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>There is no mention of atrial flutter (427.32) on the encounter form or in the dictation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The ProTime (85610) was ordered for anticoagulation use (V58.61), which is on the encounter form and in the dictation and therefore should be coded.</td>
</tr>
<tr>
<td>14</td>
<td>04/17/XX</td>
<td>99396</td>
<td>99396</td>
<td>V70.0</td>
<td>V70.0</td>
<td>81003</td>
<td></td>
<td>There is no mention of a urinalysis on the encounter form or in the dictation.</td>
</tr>
<tr>
<td>15</td>
<td>04/17/XX</td>
<td>99212</td>
<td>99212</td>
<td>708.0 978.4</td>
<td>708.0</td>
<td></td>
<td></td>
<td>It is stated that the allergic reaction was to the Td immunization (978.4), this should be coded. This is stated on the encounter form.</td>
</tr>
</tbody>
</table>
Chapter 6

Tips for Taking an AAPC Certification Exam

CPMA® Exam

The CPMA® exam is a 150-question, timed exam. The exam tests knowledge of coding and documentation guidelines.

The categories include:

- Medical Record Standards and Documentation Guidelines
  - The Medical Record
  - HIPAA Privacy and Release of Medical Record Information
  - HIPAA Covered Entities
  - HIPAA Privacy Regulations
  - JCAHO Documentation Standards
  - Record Retention
  - The Advance Beneficiary Notification
  - Legal Requirements of the Medical Record
  - Analyzing the Operative Report

- Coding and Documentation Compliance Guidelines
  - The Compliance Plan
  - Fraud and Abuse
  - Civil Monetary Penalties Law
  - Federal False Claims Act
  - Stark
  - Type of Audits
  - OIG Regulations and Workplan
  - National Correct Coding Initiative
  - CMS guidelines for E/M documentation

- OIG imposed CIA (Corporate Integrity Agreements)
- Recovery Audits and other government programs

- Coding and Reimbursement Concepts
  - CPT® coding concepts
  - Modifier usage
  - Diagnosis coding and medical necessity
  - Evaluation and management Documentation Guidelines
  - Coding Guidelines versus carrier guidelines

- Scope and Statistical Sampling Methodologies
  - Audit scope
  - Statistical sampling

- Medical Record Auditing Abstraction
  - Evaluation and Management
  - Surgery
  - Physical Therapy
  - Radiology
  - Psychiatry
  - Hematology/Oncology
  - Infusion Services

- Category Risk Analysis and Communication
  - Validation of Audit Results
  - Analysis and Report of Audit Findings
  - Communicating Audit Results
  - Corrective Action
The majority of the questions are presented in multiple choice format covering auditing theory, legal and regulatory issues, NCCI, RAC audits, statistical sampling, coding concepts, and modifiers, etc. In addition, each test taker will need to audit approximately 20 health care cases.

The CPMA® examination is recommended for a certified coder or medical record auditor who has experience auditing physician services or significant coding experience and is well versed with a variety of different types of audits including but not limited to E/M services. Auditing involves compliance and regulatory issues in its day to day work, and the examinee will be tested on these concepts in addition to coding, modifiers, NCCI usage, and more.

Preparing for Your Exam
The CPMA® exam is an open book exam. The codebooks allowed during the exam include CPT® (Professional or Standard edition), HCPCS Level II, and ICD-9-CM codebooks. You must use the current year version of all codebooks. You will also be allowed to bring The CMS 1995 and 1997 Evaluation and Management Documentation Guidelines and an E/M Audit Worksheet of your choice. Please visit AAPC’s website for the list of approved codebooks.

The best strategy to prepare for the exam is reading your codebooks cover to cover and reviewing the information found in the links on the AAPC website (http://www.aapc.com/training/cpma-additional-preparation.aspx). Examinees should review all coding guidelines found within each section and subsection of the CPT® codebook, the Official Coding Guidelines in the ICD-9-CM codebook, and all coding guidelines in the HCPCS Level II codebook. This study guide should be used along with your codebooks as you prepare for the exam.

Successful examinees have well-thumbed codebooks. Become familiar with all parts of your CPT®, ICD-9-CM, and HCPCS Level II codebooks, and know how to locate the codes, guidelines, tables, and instructions within them quickly. This may be the most important tip we can give you: We recommend going through your books to mark them, tab and label them, and make notes in them for easy reference.

Anything with which you feel you might need some extra help is something we would suggest tabbing or marking. For the exam, you can write helpful notes in your books and tab them for easy reference, but you may not glue, tape, staple, or add anything to the books. You also may wish to highlight certain guidelines in your codebooks. Keep in mind, all notes in your codebooks should be relevant to work performed daily by a coder.

Examples of items to highlight or add:

ICD-9-CM codebook in the tabular list:
- Code first notes
- Use additional code notes
- Codes that are excluded from a category

Note under Fractures category (800–829) that tells you what is considered a closed and opened fracture.

CPT® codebook:
- Key words in the subsection guidelines (eg, new and established patient definition in the E/M section)
- Draw an E/M table in your CPT® if you think it will better assist you in determining E/M services.
- Key words in the Repair (Closure) guideline section defining simple, intermediate, or complex repairs.
- Guidelines for the services included with Adjacent Tissue Transfer or Rearrangement procedures.
- Key words in the Musculoskeletal System guidelines defining surgical procedures, such as closed, opened, percutaneous skeletal fixation, or manipulation.
- All parenthetical notes found in the code description or following the code.
Make note of any symbols placed before a procedure code indicating the procedure is an add-on code (+13122), modifier 51 exempt (x 31500), or includes moderate sedation (8 35471).

Make note of procedures performed percutaneously, with any type of scope (endoscope, laparoscope, etc.), or by open technique (meaning the doctor had to cut into the patient to perform the procedure).

If you need additional coding practice, AAPC’s online practice tests are excellent test simulation tools. The practice tests follow the same format as the CPMA® exam, and have been developed by AAPC’s exam content team. The practice tests are available at www.aapc.com/training/practice-exams.aspx.

**Exam Registration**

CPMA® exam registration can be completed on AAPC’s website (www.aapc.com). When your examination application has been processed, you will receive a confirmation email regarding the date and location of your exam. You may view the proctor’s name and telephone number as well as the exam location and start time on AAPC’s website under the “My AAPC” section.

Be sure to arrive to the exam on time. If the exam location is unfamiliar to you, get directions from www.googlemaps.com or www.mapquest.com. Verify the start time and examination address at least two days before your test date.

**Day of the Exam**

Try to arrive 10–15 minutes early. Take into consideration any construction, traffic, or possible inclement weather during your commute that may affect your drive time.

In addition to your codebooks, you must bring a photo ID, plenty of #2 pencils, and an eraser. Do not bring scrap paper—it is not allowed during the exam.

You will perform better when you get a good night’s sleep before the examination. We do not believe staying up all night studying for the exam is very useful. It will not matter how “prepared” you are if you fall asleep during the exam.

We recommend you eat a healthy breakfast (nothing too heavy) and bring light snacks and water to keep you energized during the exam. Peppermint or lemon candy generally keeps you alert. We request that you avoid anything loud or crunchy (eg, soda cans or potato chips) because this could be distracting for other examinees.

If you are sensitive to noise, bring earplugs to eliminate distractions during the exam.

Layer your clothing in case the room temperature fluctuates. A light jacket is always a good idea.

**During the Test**

Be comfortable but alert. Choose a good spot in the room and make sure you have enough space to work. Maintain comfortable posture in your seat, but do not “slouch.”

Listen carefully while the proctor reads the instructions. Ask questions before the examination begins if you do not understand the instructions given.

Stay relaxed and confident. Keep a good attitude. Remind yourself you are well prepared and are going to do well. If you find yourself anxious, take several slow, deep breaths to relax. It is probably best not to talk about the test to other students just before entering the room: Their anxiety can be contagious.

Scan the entire test when you are instructed to begin.

Answer the easiest, shortest questions first. Do not stay on a problem on which you are stuck, especially when time is a factor. Keep moving: This will build confidence and allow you to score points and mentally orient yourself to vocabulary,
concepts, and your studies. It also helps you make
associations with more difficult questions.

Read all the choices before choosing your answer. First, eliminate those answers you know to be
wrong, are likely to be wrong, or do not seem to fit. If you do not know an answer, skip it. Go on with
the rest of the test and come back to it later. Other parts of the test may have information that will
help you with that question. Make sure if you skip a question you do not accidentally fill in the bubble
on the grid until you go back to the question.

Remember to pace yourself. Read the entire
question and look for key words. You have an
average of 2 minutes and 15 seconds to answer
each question. Stay relaxed and do not panic.

Read each question slowly and carefully. This
may seem obvious, but it helps you avoid careless
errors. Note such words in the question as “not,”
“except,” “most,” “least” and “greatest,” or “add
together, code each.” These words are often crucial
in determining the correct answer. There are no
“trick” questions on the exam, so do not worry
about hidden words or meanings.

Remember to use the guidelines in your
codebooks. Often they will help you select the
correct answer. Also, check for any parenthetical
statements that may influence your answer.

Answer every question. If you do not know the
right answer, eliminate as many wrong answers
as possible, then select among the remaining
answers. If you do not have a clue, make your
best guess. Narrow down the answer options by
eliminating answers you know are not correct. A
guess is better than a blank response.

Don’t worry about how fast other people finish
their test; just concentrate on your own test. Be
especially careful about marking your answer
sheet. Make sure to fill in your selected bubble
on the test grid correctly. Try to avoid making
any other marking on the answer grid. Exams
are machine graded and to ensure an accurate
score, bubbles must be filled out as shown on the
example provided on your test grid. Stray marks
could be misread. If you must mark your place,
you may mark in your test booklet, but be sure to
erase any stray marks later on.

If you finish with additional time, use that time
to go back and review any questions of which you
were unsure. Use the codebooks again to confirm.

Make sure you answer all questions. Only change
an answer if you misread or misinterpreted the
question; the first answer you choose usually is
correct. Watch out for careless mistakes. Double-
check to make sure you have filled in the exam
grid properly with your first name, last name, and
ID number.

Exam Completion

Exam results are usually released within five
to seven business days after AAPC receives the
exam package back from the proctor. Results will
be accessible in the My AAPC area on AAPC’s
will be mailed within two weeks of their receipt
at the national office. Please do not call AAPC for
your test results. Exam results may not be released
over the telephone.
**Case 1**

**ANESTHESIA RECORD**

**Anesthesia**

<table>
<thead>
<tr>
<th>DATE:</th>
<th>12-2-2011</th>
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</thead>
<tbody>
<tr>
<td>OR #</td>
<td>4</td>
</tr>
<tr>
<td>FLUIDS</td>
<td>SET</td>
</tr>
<tr>
<td>ANESTHESIA TECHNIQUE:</td>
<td>REG - IV Sed - LMA</td>
</tr>
<tr>
<td>ASA PRIOR TO INDUCTION</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>INDUCTION</td>
<td>1 2</td>
</tr>
<tr>
<td>PRE-MEDICATION &amp; TIME:</td>
<td></td>
</tr>
</tbody>
</table>

**TIME OUT** PERFORMED (Correct Patient, Correct Procedure, Correct Side/Site, Correct Position, Special Anesthesia Equipment)

| O2 | 9 3 3 |
| N20 | 14 M |
| PENTANYL | 20 10 10 |

**REASONS**

- **TOTALS**
  - Regional
  - Spinal
  - Epidural
  - Other:
  - Position:
  - Prop:
  - Local:
  - IV:
  - Drug(s) Given:
  - Site:
  - Attempts x:

**MONITORS & EQUIPMENT**

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<tr>
<th>TIME</th>
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<td>BPM</td>
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</tr>
<tr>
<td>Respiration</td>
<td>140</td>
<td></td>
</tr>
<tr>
<td>SpO2</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>EKG</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>BP</td>
<td>140/90</td>
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</tr>
<tr>
<td>PIP</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>HR</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>

**SYMBOLOGY**

- O = Operation
- V = V/PP
- L = Lungs
- M = Mechanical

**VENTILATOR**

- Spontaneous
- Assisted
- Non-ventilated

**HISTORY**

- **XR**
- **ECG**
- **ETCO2**
- **TEMP**
- **SpO2**
- **PIF**
- **POST**

**REMARKS:**

- Pt td and chart reviewed. O2 + monitors in place. Meds given: Easy mask, DL x 1, VCV, ATOI. ETCO2 + BIBUS.
- Pressure Points: Vt padded
- Induction: Begin

**RECOVERY**

- Location: 200 C
- Time In:
- Time Out:
- Respiration: 17
- ETT: 12
- EMT: 10
- EMT BLS: 2
- EMT ALS: 1
- **INTUBATION**
- **Monitor**
- **Sedation**
- **Recovery**

**CPA® Online Exam Review**

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Page 70
Rationale: The anesthesia record is audited and the findings are as follows:

1. **ASA Code**: Not all carriers utilize the ASA code sets, but this carrier did. The ASA code billed was supported by the documentation recorded.

2. **Units**: The units are billed based on the ASA base units in addition to the time units. The base units are a fixed number (much like RVU’s), and the time units are converted by using 15 minutes equals 1 unit of time. The time units are documented appropriately. The case was 45 minutes which equals 3 time units and the base unit is

3. **Concurrency**: The service has appended the AA modifier. This modifier indicates that the service was performed directly by the physician. The documentation reflects that the performing and billing provider match and no incident-to billing was performed.
The documentation, time, concurrency, and medical necessity are all supported.
Case 2

Carrollton Orthopedic Center
912 Nighthawk Dr.
Thistle, NJ 05533

Patient: Georgette Bridge
DOB: 05-15-1965
Date: 09-15-2010

Pt presents today for Synvisc injection #3 into her right knee for continued complaints of chronic knee pain. She reports there was minimal improvement between #1 and #2 injections, however, she noted significant improvement with injection #2. I will review the procedure notes for any difference in injection point in order for the patient to get maximum benefit from today’s procedure.

Exam: WNWD with normal vitals and noted in the nursing note

The knee does not appear to have any redness, but does appear to have mild swelling. The pedal pulses are noted and normal. The right knee does show a decreased ROM as compared to the left knee. Guarded gait.

Impression: OA of the right knee

Procedure: The patient was advised of risks and benefits and elects to proceed. The right knee is cleaned and prepped with Betadine. 1 mg of Synvisc was injected per the point noted on diagram. The patient tolerated well.

Plan of Care: The patient should follow up in 6 months or sooner as needed. She should continue the use of Advil as needed for intermittent discomfort.

Gregory Cardalino
GC/KatieC001

D: 09-15-10
T: 09-15-10
Pt presents today for Synvisc injection #3 into her right knee for continued complaints of chronic knee pain. She reports there was minimal improvement between #1 and #2 injections, however, she noted significant improvement with injection #2. I will review the procedure notes for any difference in injection point in order for the patient to get maximum benefit from today's procedure.

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Plan of Care: The patient should follow up in 6 months or sooner as needed. She should continue the use of Advil as needed for intermittent discomfort.

Gregory Cardalino
GC/KatieC001
D: 09-15-10
T: 09-15-10
1 **Rationale:** Since this patient presented for a procedure only and no additional problems were treated the E&M service would not be billable.

2 **Procedure:** An in office procedure must have a report which could stand alone to support the service performed. The actual documentation and the guidelines are as follows:

   - Specific anatomical location—Right knee
   - Technique used—Betadine cleaning (aseptic technique)
   - Risks and Benefits—Documented as reviewed with patient
   - Details of procedure—Included
   - Medications used—Synvisc and mg use also documented
   - Outcomes—Patient tolerated well

   Procedure note is appropriately documented.

3 **Additional Information identified while auditing:**
   - Signature—Rules and guidelines met
   - Dates of Service—Consistent
   - Place of Service—Consistent
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPUS</th>
<th>CHAMPS</th>
<th>GROUP HEALTH PLAN</th>
<th>FECA BLEK LUNGO</th>
<th>OTHER</th>
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<td>(Medicare)</td>
<td>(Medicaid)</td>
<td>Sponsor's SSN</td>
<td>(Member ID)</td>
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<td>(SSN or ID)</td>
<td>(SSN)</td>
<td>(ID)</td>
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<table>
<thead>
<tr>
<th>2. PATIENT'S NAME</th>
<th>(Last Name, First Name, Middle Initial)</th>
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<tbody>
<tr>
<td>Bridge, Georgette</td>
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<table>
<thead>
<tr>
<th>5. PATIENT'S ADDRESS</th>
<th>(No, Street)</th>
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<tbody>
<tr>
<td>1414 South 8th street</td>
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<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
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<tbody>
<tr>
<td>Knoxville</td>
<td>NJ</td>
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<table>
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<th>(Include Area Code)</th>
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<tbody>
<tr>
<td>71446</td>
<td>(337) 1234567</td>
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<table>
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<table>
<thead>
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<tr>
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<td>MM DD YY</td>
<td>M</td>
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<table>
<thead>
<tr>
<th>c. EMPLOYER'S NAME OR SCHOOL NAME</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>d. INSURANCE PLAN NAME OR PROGRAM NAME</th>
</tr>
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<tbody>
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<td></td>
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</table>

**READ BACK OF THIS FORM BEFORE COMPLETING & SIGNING THIS FORM**

12. PATIENT'S AUTHORIZED PERSONS' SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to either to myself or to the party who accepts assignment below.

SIGNED | Signature on File |
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>DATE 05/10/11</td>
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</tbody>
</table>

13. INSURED'S OR AUTHORIZED PERSONS' SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED | Signature on File |
<table>
<thead>
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</table>

**14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | BILLING UNIT**

<table>
<thead>
<tr>
<th>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY (Accident) OR PREGNANCY (LMP)</th>
<th>BILLING UNIT</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM</th>
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<table>
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<th>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</th>
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<tr>
<td>17b. NPI</td>
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<table>
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<tbody>
<tr>
<td>YES</td>
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<tr>
<td>Gregory Lafferty, MD</td>
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**32. SERVICE FACILITY LOCATION INFORMATION**

Carrollton Orthopedic Center
912 Nighthawk Dr.
Tighthouse, NJ 05533

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<th>33. BILLING PROVIDER INFO &amp; PH.</th>
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**NUCC Instruction Manual available at www.nucc.org**

**VCMS-1600CS**

**APPROVED OMB 0033-0900 FORM CMS-1500 (06/05)**
Cases

Documentation and Medical necessity support the services as billed.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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CPMA® Online Exam Review

Medicare
P.O. Box 123
Knoxville, OH 44455

1a. INSURED'S I.D. NUMBER
OC5H12345217

7. INSURED'S ADDRESS (No., Street)
1414 South 8th street

15. MEDICARE MEDICAID TRICARE CHAMPVA GROUP PLAN FECA OTHER
X [Medicare] [Medicaid] [Tricare] [Champva] [Group Plan] [Feca] [Other]

8. PATIENT'S NAME (last Name, First Name, Middle Initial)
Bridge, Georgette

9. OTHER INSURED'S NAME (last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO:

b. AUTOACCIDENT? YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

11. INSURED'S POLICY GROUP OF FEECA NUMBER

12. PATIENT'S AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 05/10/11

13. INSURED'S OR AUTHORIZED PERSONS SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on file

14. DATE OF CURRENT ILLNESS (First symptom or injury) OR DATE OF F.BIRTH DATE YR OR F.PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

20. OUTSIDE LAB? YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)

1. 715.96

23. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

22. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM TO MM DD YY MM DD YY

25. FEDERAL TAX ID NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT (For govt. claims see back)

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

Carrollton Orthopedic Center
912 Nighthawk Dr.
Thistle, NJ 05533

32. SERVICЕ FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH. ()

DATE 09/15/10

a. b. c. d.
Case 3

Doctor’s Hospital
123 North 7th Street
Lovely, Arkansas 71446
Phone: 337-756-5522 Fax: 337-756-5533

OPERATIVE REPORT

PATIENT NAME: Smith, Jane
ACCOUNT #: 1667
DATE OF PROCEDURE: 5/10/11
DATE OF BIRTH: 10/15/1959

PREOPERATIVE DIAGNOSIS: Right knee: Severe degenerative joint disease severely affecting activities of daily living, no longer responsive to extensive nonsurgical intervention.

POSTOPERATIVE DIAGNOSIS: Right knee: Severe degenerative joint disease severely affecting activities of daily living, no longer responsive to extensive nonsurgical intervention.

SURGEON: Frank King, M.D.
Assist at surgery: Emily Francis, PA-C

PROCEDURE: Right, cemented, total knee arthroplasty using Biomet Vanguard components with a 60 posterior stabilized femur, 67 tibial baseplate, 10 mm posterior stabilized tibial polyethylene liner, 31 mm patellar button.

ANESTHESIA: Spinal anesthetic along with nerve block

BMI: Patient’s BMI is 45

ESTIMATED BLOOD LOSS: Minimal

TOURNIQUET TIME: 73 Minutes

COMPLICATIONS: None

DETAILS OF PROCEDURE: The patient was taken to the operative suite, placed in the supine position, and underwent spinal anesthetic along with nerve block by the anesthesia team. Prophylactic IV antibiotics were given. Pneumatic compression device placed on the nonoperative extremity. A tourniquet was placed around the proximal aspect of the operative lower extremity. The operative lower extremity was then prepped and draped in the usual sterile fashion. The limb was elevated and exsanguinated with the use of an Esmarch, and the tourniquet was inflated to 300 mmHg and maintained as such throughout the case. A longitudinal midline incision was made centered over the patella beginning proximal to the patella and extending past the tibial tubercle. This incision was taken sharply through the subcutaneous fat and down to the extensor mechanism.
With use of another knife blade and electrocauters, the subvastus approach was performed leaving a 0.5 cm cuff of tissue along the medial border of the patella, then incising down the medial border of the patella tendon.

The medial and lateral proximal tibial soft tissue structures were elevated in the usual fashion with a subperiosteal elevator. The patella was subluxed laterally, and the limb was able to be flexed. The femoral intramedullary canal was drilled. The distal femoral cutting guide was placed. Two drill holes were made, and pins were placed. The distal femur was then cut. The next femoral cutting guide was placed providing for the anterior, posterior, and chamfer cuts. This allowed good femoral trial reduction.

Attention was then directed to the tibia where, with appropriate retraction, the medial and lateral menisci were sharply removed. With the use of an extramedullary cutting guide, the proximal tibia was cut. This was sized, and the tibial trial was placed with a trial poly to allow for the best fit and allow good articulation with the femoral prosthesis.

Attention was then focused on the patella where the articular surface was measured, resected, and drilled. A trial polyethylene was applied, and the knee placed through range of motion. All of the trial components were then removed.

With the use of Pulsavac, all of the bone ends were cleaned. The cement was mixed and applied to the tibial, femoral, and patellar bone and components in that order. The components were then placed. The residual cement was removed. The leg was reduced and held in full extension until the cement was completely hardened. Any remaining cement was removed with an osteotome. The tibial trial poly was removed to allow access to any debris remaining posteriorly. The knee was then Pulsavac lavaged to remove all remaining debris.

The extensor mechanism was re-apposed with #1 Ethibond in a combination figure-of-eight and running fashion with the knee in flexion. The subcutaneous tissues were re-apposed with a 2-0 and 3-0 undyed Vicryl. The skin edges were re-apposed with subcutaneous 3-0 Prolene and Steri-Strips. A sterile Adaptic and bulky gauze dressing was applied and secured with a sterile Sof-Rol and an Ace wrap. Sof-Rol was removed from posterior knee. Ace wraps were applied from the toes to mid thigh. The tourniquet was deflated. A knee immobilizer was placed with the knee in full extension. The patient was extubated and taken to the recovery room. The patient was extubated and taken to the recovery room. The patient appeared to tolerate the procedure well without apparent complications.

Ms. Francis was used as an assist during this case. Ms. Francis prepped and opened the site and during the procedure was used to aide in retracting as well as other duties during the case. Additionally Ms. Francis closed the site and appropriately transferred the patient to the recovery staff.

Frank King, MD

Electronically Signed
FK/BolstC0001
D: 05-10-11   T: 05-11-11
PATIENT NAME: Smith, Jane
ACCOUNT #: 1667
DATE OF PROCEDURE: 5/10/11
DATE OF BIRTH: 10/15/1959

PREOPERATIVE DIAGNOSIS: Right knee: Severe degenerative joint disease severely affecting activities of daily living, no longer responsive to extensive nonsurgical intervention.

POSTOPERATIVE DIAGNOSIS: Right knee: Severe degenerative joint disease severely affecting activities of daily living, no longer responsive to extensive nonsurgical intervention.

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Frank King, MD

Electronically Signed

FK/BolstC0001

D: 05-10-11   T: 05-11-11
1 **Rationale:** Heading information: The Heading included all necessary components including the patient name, surgeon name, procedure to be performed, and additional information that was not required.

**Note:** Assist-at-surgery documented as being utilized. This alone is not enough to support the assist’s services. There must additionally be information regarding what the assist did during the procedure.

2 **Rationale:** Indications for Surgery: This documentation is appropriately identified within the pre and post diagnosis. The BMI notation is good information that additionally supports the need for the surgery as the patient is obese in presentation. However, having this statement alone would not support the use of the -22 modifier. The documentation must include a statement of how this complicated or increased the work/time of the procedure.

3 **Rationale:** Body/Details: The documentation appropriately includes the details of the procedure performed by the surgeon.

Additionally, the documentation includes what services the assist-at-surgery was used for during the procedure.

Findings: The findings of this type of procedure would be that upon internal visualization the medical necessity was met for the procedure as the diagnosis (post-diagnosis) was supported.

The provider additionally documents that the patient tolerated and did well with the procedure which also supports the outcomes of the procedure.

4 **Additional Information identified while auditing:**
   - Signature—Rules and guidelines met
   - Dates of Service—Consistent
   - Place of Service—Consistent
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<td><strong>(Last Name, First Name, Middle Initial)</strong></td>
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<td>Smith, Jane</td>
<td>M</td>
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<td>myself or to the party who accepts assignment below.</td>
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<td>Emy Francis, PA-C</td>
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<td><strong>DATE 5/10/11</strong></td>
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Medicare
P.O. Box 123
Knoxville, OH 44455

Cases

1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA ELK (UNG) OTHER
   X [Medicaid]  [Medicaid] [Sponsor’s ESN] [Member ID#]

2. PATIENT’S NAME (last Name, First Name, Middle Initial)
   Smith, Jane

5. PATIENT’S ADDRESS (No., Street)
   1414 South 9th Street

8. PATIENT’S RELATIONSHIP TO INSURED
   Self

10. IS PATIENT’S CONDITION RELATED TO:
   a. EMPLOYMENT? (Current or Previous)
      YES  NO

11. INSURED’S POLICY GROUP OR FECA NUMBER
   12345

14. DATE OF CURRENT:
   ILLNESS/First symptom) OR
   PREGNANCY (LMF)
   MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
   17a. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
   FROM MM DD YY TO MM DD YY

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.
   (Relate Items 1, 2, 3, 4 to Item 24 by Line)
   1. 719.46

24. A. DATES) OF SERVICE FROM MM DD YY TO MM DD YY
   B. Place of Service
   C. EMG
   D. PROCEDURES, SERVICES, OR SUPPLIES
   E. DIAGNOSIS
   F. CHARGES
   G. DAVOS UNITS
   H. EPSDT
   I. ID
   J. RENDERING PROVIDER ID#

   5 10 11 5 10 11 21 27447 AS 22 3078 41

25. FEDERAL TAX IDENT. SSN EIN
   1123344  X

26. PATIENT’S ACCOUNT NO.
   1667

27. ACCEPT ASSIGNMENT
   YES  NO

28. TOTAL CHARGE
   $3078.44

29. AMOUNT PAID
   $3078.44

30. BALANCE DUE
   $0

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
   Franz King, MD

32. SERVICE FACILITY LOCATION INFORMATION
   Doctor’s Hospital
   123 North 7th Street
   Knoxville, TN 74146

SIGNED
Signature on File
DATE 5/10/11
Procedure is supported appropriately by OP report.

Use of modifier -22 is not supported as the provider did not include any documentation supporting the medical necessity.
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNION CLAIM COMMITTEE 08/05

1. MEDICARE MEDICAD TRICARE CHAMPUS CHAMPVA
   (Medicaid#) (Medicaid#) (Sponsor's EDD) (Member ID)

2. PATIENT'S NAME (last Name, First Name, Middle Initial)
   Smith, Jane

5. PATIENT'S ADDRESS (No., Street)
   1414 South 9th Street

3. PATIENT'S BIRTH DATE
   10 15 59 M F

8. PATIENT RELATIONSHIP TO INSURED
   Self Spouse Child Other

CITY
   Knoxville

STATE
   TN

ZIP CODE
   71446

PHONE (Include Area Code)
   (337) 4455221

9. OTHER INSURED'S NAME (last Name, First Name, Middle Initial)
   a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH
   MM DD YY M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
    a. EMPLOYMENT? (Current or Previous)
       YES NO

b. AUTO ACCIDENT? PLACE (State)
   YES NO

c. OTHER ACCIDENT?
   YES NO

1d. RESERVED FOR LOCAL USE

12. PATIENT'S AUTHORIZED PERSONS SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File

DATE 5/10/11

14. DATE OF CURRENT ILLNESS (First symptom) OR PREGNANCY (LMP)
   MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE
   MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
   17a.
   17b. NPI

19. RESERVED FOR LOCAL USE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,2,3 or 4 to item 24b by line)
   1. 719.46
   2.
   3.
   4.

24. A. DATES OF SERVICE FROM TO
   MM DD YY MM DD YY
   1 5 10 11 5 10 11 21
   2
   3
   4
   5
   6

25. FEDERAL TAX ID NUMBER SSN EIN
   11223344

26. PATIENT'S ACCOUNT NO.
   1667

27. ACCEPT ASSIGNMENT
   YES NO
   (For govt. claims, see back)

28. TOTAL CHARGE
   3078.94

29. AMOUNT PAID
   3078.94

30. BALANCE DUE
   $ 3078.94

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
   Frank Kung, MD

32. SERVICE FACILITY LOCATION INFORMATION
   Doctor's Hospital
   123 North 7th Street
   Knoxville, TN 7446

NJCC Instruction Manual available at: www.njcc.org
WCMS-1500CS
APPROVED CMS-0398-0999 FORM CMS-1500 (08/05)
Case 4

Calming Waters Medical Clinic
1512 Waverly Court
San Jose, CA 45356
745-598-1245

Patient Name: Cynthia Gunther  
Patient Number: 88547

Date: 03-05-2011  
DOB: 08-06-1961

Encounter:

The patient presents today for evaluation of her medication usage and effectiveness with her chronic depressive disorder.

She states that she has been taking the Cymbalta as prescribed, and she has now been on this for 3 months. She also takes other medications, some prescribed by me, and are all reviewed on her medication list in the chart. The evaluation today is her status regarding use of Cymbalta. She states that she notes improvement in how she is feeling.

Therapy has been interpersonal technique and I briefly spoke with the patient. Her relationship with her grown son seems to be improving and they are having increased interactions by concentrating on growth of their relationship as opposed to so much focusing on their past relationship.

The Cymbalta appears to be working well for her, and we will give her a refill for that today and have her return in 1 month or sooner if she needs.
Calming Waters Medical Clinic
1512 Waverly Court
San Jose, CA 45356
745-598-1245

Patient Name: Cynthia Gunther  Date: 03-05-2011
Patient Number: 88547  DOB: 08-06-1961

Encounter:
1. The patient presents today for evaluation of her medication usage and effectiveness with her chronic depressive disorder.
2. She states that she has been taking the Cymbalta as prescribed, and she has now been on this for 3 months. She also takes other medications, some prescribed by me, and are all reviewed on her medication list in the chart. The evaluation today is her status regarding use of Cymbalta. She states that she notes improvement in how she is feeling.
3. Therapy has been interpersonal technique and I briefly spoke with the patient. Her relationship with her grown son seems to be improving and they are having increased interactions by concentrating on growth of their relationship as opposed to so much focusing on their past relationship.
4. The Cymbalta appears to be working well for her, and we will give her a refill for that today and have her return in 1 month or sooner if she needs.
5. (No signature)

Rationale:
1. Documentation Supports purpose of visit and diagnosis being treated.

Rationale:
2. Pharmacological Management under the 90862 is a physician level service, and the documentation states that it was performed by a physician.

Medication Evaluation: The main purpose of the encounter should be to review the patient use and effectiveness with their current medications. The documentation clearly identifies the medication and how the patient is responding.

Rationale:
3. This service must have minimal psychotherapy documented. There is no defined amount of minimal, but the documentation does include an update and pertinent information and is considered sufficient.
   With all psychotherapy services the type of psychotherapy technique used should additionally be documented. The technique is documented as being interpersonal.
4 Rationale:
- Refill of medications is documented with a follow up documented.

5 Additional Information identified while auditing:
- Signature—Rules and guidelines not met which results in an unbillable service
- Dates of Service—Consistent
- Place of Service—Consistent
1. MEDICARE MEDICAID TRICARE CHAMPVA FEDERAL HEALTH PLAN GROUP ORGANIZATION OTHER
   [Medicare] [Medicaid#] [Medicaid#] [Sponsor's SSN] [Member ID#]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   Gunther, Cynthia

5. PATIENT'S ADDRESS (No., Street)
   5515 Main Street

CITY San Jose
STATE CA
ZIP CODE 44433
PHONE (745) 9171455

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
   a. EMPLOYMENT? (Current or Previous)
      [ ] YES [X] NO
   b. AUTO ACCIDENT? PLACE (State)
      [ ] YES [ ] NO
   c. OTHER CONDITION?
      [ ] YES [ ] NO

11. INSURED'S POLICY NUMBER FOR FECA

12. PATIENT'S AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S AUTHORIZED PERSONS SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom or injury, date of injury/accident)
   MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS IN THE LAST 12 MONTHS
   GIVE FIRST DATE
   MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM
   MM DD YY TO MM DD YY

17. NAME OF REFERREING PROVIDER OR OTHER SOURCE
   17a. [ ]
   17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM
   MM DD YY TO MM DD YY

20. OUTSIDE LAB?
   YES [ ] NO [X]

22. MEDICARE SUBMISSION CODE
   [ ]

23. PRIOR AUTHORIZATION NUMBER
   [ ]

24. A. DATE(S) OF SERVICE FROM
   MM DD YY TO MM DD YY
   B. PLACE OF SERVICE
   C. CMG PROCEDURE(S), SERVICES, OR SUPPLIES
   D. DIAGNOSIS POINTER
   E. MODIFIER

   1. 03 05 11 03 05 11 11 90862 115 52 [X]

25. FEDERAL TAX I.D. NUMBER
   SSN LN 369123456 [ ]

27. ACCEPT ASSIGNMENT (Form part, claims form)
   YES [ ] NO [X]

28. TOTAL CHARGE
   $ 115 52

29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
   Michael Water, MD

30. PATIENT'S ACCOUNT NO.
   88547

33. BILLING PROVIDER INFO & PH.
   ( )

32. SERVICE FACILITY LOCATION INFORMATION
   Calming Waters Medical Clinic
   1512 2nd Ave Court
   San Jose, CA 95136

34. MEDICARE AGENCY NAME
   Calming Waters Medical Clinic
   1512 2nd Ave Court
   San Jose, CA 95136

NUCC Instruction Manual available at: www.nucc.org

WCMS-1600CS

APPROVED OMB 0938-0959 FORM CMS-1500 (08/05)
Gunther, Cynthia
5515 Main Street
San Jose, CA 95115

9. OTHER INSURED'S NAME (last name, first name, middle initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH

MM DD YY

M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

   YES   NO

b. AUTOACCIDENT? PLACE (State)

   YES   NO

c. OTHERACCIDENT?

   YES   NO

d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OF FECA NUMBER

12. PATIENT'S AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File

DATE 03-05-11

The documentation best supports the 90862 Pharmacological Management as the encounter is minimal in nature instead of brief and the encounter included minimal psychotherapy services but services are non billable due to lack of physician's signature.
Case 5

Flex-All Physical Therapy
A Division of Stanford Orthopedic Group
10515 McArthur Place
Stanfordville, OH 45203
406-817-3397

Patient #: 45034
Date: 10-07-10

Patient Name: Michael Stone
Date of Birth: 07-01-63

Referring Physician: Peter Smith, MD
Treating Physical Therapist: Paul Temple, MPT

Insurance: Medicare
Insurance approved obtained: Yes

Date of Injury/Accident: 10-05-10
Initial Visit Date: 10-07-10

Referring Diagnosis: 719.41- Right Shoulder pain

Subjective:

Chief Complaint
Right shoulder pain
Decreased ROM

Current Medications
800 mg ibuprofen daily

Symptoms
Severe pain in the right shoulder radiating to right upper back occurring 3–5 times per hour and lasting 1–3 minutes since car accident. Moderate decreased range of motion in the right shoulder since car accident.

Activities of Daily Living
Activity: Lifting 50 lbs required for work
Aggravation: Pain increases from mild to moderate after 10 lbs
Limitation: Client has to stop the activity after 20 lbs because of pain

Past History
Patient declines any past history of shoulder pain or injuries, or instances for physical therapy services.

Objective:
Tests and Measures

Gait, locomotion and balance:
Functional use of arm during gait

Muscle performance (strength, power, endurance):
No significant deficits in resisted movements

Posture
Forward head position
Rounded shoulders
Flattening of thoracic spine

Range of motion:
Shoulder complex-right-active 10-07-10

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<th>Movement</th>
<th>Position</th>
<th>Measure</th>
<th>Pain</th>
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<td>150°</td>
<td>None</td>
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Assessment

- Assessment:
  - Impaired joint mobility, motor function, muscular performance and range of motion associated with capsular restriction of the right shoulder, right shoulder adhesive capsulitis. All supporting of the referred diagnosis of shoulder pain

- Long Term Goals:
  - Client will be able to lift and carry up to 50 lbs up to 1000 feet with a 1 minute break every 500 feet 10 times a day Monday to Friday with no more than mild fatigue within 60 days

- Short Term Goals:
  - Client will be able to lift and carry up to 25 lbs up to 200 feet with a 1 minute break every 100 feet 3 times a day Monday to Friday with no more than moderate pain within 14 days
Plan

- Treatment Plan:
  - Manual therapy techniques and therapeutic exercises, right shoulder, three times a week for 4 weeks, 30 minute sessions, to increase mobility and strength to WNL as compared to left side to perform work duties
  - Homework and Self Care:
    - Initiate stretching of right shoulder for 10 minutes once a day. Gave stretching handout
  - The patient’s rehab potential is good

Physical therapy treatment today:

- Application of Cold Pack:
  - (5 minutes) Upper back, shoulders with therapy session
- Evaluation:
  - 30 minutes
- Manual Therapy Techniques
  - (20 minutes) Right shoulder, manually resisted exercises; right shoulder quadrand mobilization; scapula mobilization, myofascial release
- Therapeutic Exercises (10 minutes)
  - Right Shoulder, PROM using pulley
  - Postural correction exercises

Electronically Signed

Paul Temple, MPT
Subjective:

Chief Complaint
- Right shoulder pain
- Decreased ROM

Current Medications
- 800 mg ibuprofen daily

Symptoms
- Severe pain in the right shoulder radiating to right upper back occurring 3–5 times per hour and lasting 1–3 minutes since car accident. Moderate decreased range of motion in the right shoulder since car accident.

Activities of Daily Living
- Activity: Lifting 50 lbs required for work
- Aggravation: Pain increases from mild to moderate after 10 lbs
- Limitation: Client has to stop the activity after 20 lbs because of pain

Past History
- Patient declines any past history of shoulder pain or injuries, or instances for physical therapy services.
Objective:

Tests and Measures

Gait, locomotion and balance:
Functional use of arm during gait

Muscle performance (strength, power, endurance):
No significant deficits in resisted movements

Posture
Forward head position
Rounded shoulders
Flattening of thoracic spine

Range of motion:

Shoulder complex-right-active 10-07-10

<table>
<thead>
<tr>
<th>Movement</th>
<th>Position</th>
<th>Measure</th>
<th>Pain</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexion</td>
<td>Supine</td>
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<td>Extension</td>
<td>Prone</td>
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<td>Supine</td>
<td>45°</td>
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<td>Segmented</td>
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- Therapeutic Exercises (10 minutes)
  - Right Shoulder, PROM using pulley
  - Postural correction exercises

Electronically Signed
Paul Temple, MPT

**Rationale:** The documentation includes who the referring provider is and the diagnosis/problem to be assessed.

**Rationale:** The history for a physical therapy initial evaluation is reviewed as follows:

- **Chief Complaint**—Right shoulder pain
- **Past physical therapy**—No past physical therapy services found in history.
- **Factors affecting patient**—Symptoms documented and activities of daily living documentation contain sufficient information.
- **Functional Capacity**—
  - Prior to injury—No documentation but should be included to establish expectations of what level of functionality the patient may be able to reach again.
  - Currently—What functional level, with the injury they are currently manifesting. This will specifically define a medical need for therapy.
Rationale: The physical therapist establishes a well performed exam specific to the needs of the patient, and supports the documentation required.

Rationale: The plan of care accurately identifies the service that would be medically indicated for the patient.

- Frequency and Duration of treatment: 3 times per week for 4 weeks
- Diagnosis: The assessment clearly identifies the patient’s diagnosis and need for treatment
- Specific Modalities: Defined accurately in the treatment plan.
- Rehab potential: In the plan of care the patient’s rehab potential is documented as good.
- Goals of therapy: Long and short term goals are provided in the assessment section of documentation.

Additional Information identified while auditing:

- Signature—Rules and guidelines met
- Dates of Service—Consistent
- Place of Service—Consistent

Overall Analysis:

- Documentation components are all noted with exception of functional activities of daily living prior to incident and post incident. This documentation is vital to the medical necessity of the encounter and therefore the service is not completely supported by the documentation.
The 97001 is not documented to the fullest extent of documentation guidelines and is therefore not supported.

The total session time is not documented so all services are not supported as total time is required.
Case 6

Theater Hospital
1258 Regal Drive
Sunny, CA 12347

Performing MD: Gary Jones, MD
Ordering MD: Sheila Smith, MD

CT Brain/Head w/o contrast

Indications: Persistent headaches
Comparison: No prior studies available for comparison

Order: Verbal

Technique: Noncontrast axial images from the skull base to the vertex reviewed at soft tissue and bone window settings.

Findings: No midline shift. Normal ventricular size. No hemorrhage or mass effect. Images reviewed at bone window settings show no abnormality. The included portions of the paranasal sinuses and mastoids are unremarkable.

Impression: Negative examination

Interpreted by: Gary Jones, MD

Dictated Date: 12/12/2010
Reported sent to ordering MD: 12/12/2010

Electronically signed by
Gary Jones, MD
12-12-10
Theater Hospital
1258 Regal Drive
Sunny, CA 12347

Performing MD: Gary Jones, MD    Date: 12-12-10
Ordering MD: Sheila Smith, MD

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Impression: Negative examination

Interpreted by: Gary Jones, MD

Dictated Date: 12/12/2010

Reported sent to ordering MD: 12/12/2010

Electronically signed by
Gary Jones, MD
12-12-10

Rationale: Criteria needed and findings:

1. Ordering MD: Sheila Smith, MD
2. Order: Noted as verbal, but an auditor should request the intake of the order for verification.
3. Diagnosis: The reported diagnosis must be the symptom used to indicate the need since findings were negative.
4. Procedure: The procedure performed was appropriately identified and pertinent details included.
5. Findings: The findings were noted as negative.
Additional Information identified while auditing:

- Signature—Rules and guidelines met
- Dates of Service—Consistent
- Place of Service—Consistent
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNION COMMITTEE 08/05**

<table>
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<tbody>
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<td>3. PATIENT'S BIRTH DATE</td>
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<td>4. INSURED NAME (last name, First Name, Middle Initial)</td>
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<td>9. OTHER INSURED'S NAME (last name, First Name, Middle Initial)</td>
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<td>b. AUTO ACCIDENT?</td>
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<td>c. OTHER ACCIDENT?</td>
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**READ BACK OF THIS FORM BEFORE COMPLETING & SIGNING THIS FORM**

**SIGNED**

**DATE** 12-12-11

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<td>12. PATIENT'S AUTHORIZED PERSON'S SIGNATURE</td>
<td>I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits even to the party who accepts assignment below.</td>
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<td>13. INSURED'S OR AUTHORIZED PERSONS SIGNATURE</td>
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<td>23. PRIOR AUTHORIZATION NUMBER</td>
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<td>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</td>
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<td>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
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<td>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td>Sheila Smith, MD</td>
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<td>30. BALANCE DUE</td>
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**APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)**

NUCC Instruction Manual available at: www.nucc.org

WCMS-1500CS
The provider only billed the professional component because the place of service (hospital) owned the equipment and provider only performed the professional services.

Documentation and Medical Necessity support the service as billed.
Case 7

Dayson Infusion Center
125 West Main St. Dayson, KS 14356
404-545-1575

Patient: Kim Smith
Date: October 8, 2010

Patient #: 1115
DOB: 09-10-1950

Kim presents today for evaluation of her condition. We are currently treating Kim with Chemotherapy for her recently diagnosed left breast cancer. She was diagnosed approximately 2 weeks ago and seems to be doing well. She has had some n/v associated with the chemotherapy treatments.

ROS: She reports n/v, no fever, chills, night sweats, no trouble breathing, no tachycardia, and no bowel or bladder dysfunction.

PFSH: Remains unchanged at this time.

Exam: The patient is alert and oriented at this time; her VS are 120/80, RR12, weight 175.

Skin: Appears to have some dryness and minimal hydration depletion

Assessment: Left breast cancer

Plan: We will continue on the course with weekly infusion of Taxol 30 mg. Patient to have infusion today. Patient should have labs repeated prior to follow up visit in 2 weeks. Please see lab requisition order form.

Electronically signed

__________________________
Christopher Townsend, MD

Dictated 10-10-2010
Transcribed 10-11-2010
Transcribed SPT
Case:

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Electronically signed

____________________

Christopher Townsend, MD

Dictated 10-10-2010

Transcribed 10-11-2010

Rationale HPI: There are 4 HPI Elements identified in the documentation whether using 95 or 97 documentation guidelines.

1. Location = left breast
2. Modifying Factor = chemotherapy
3. Associated Symptom = nausea and vomiting
4. DurationTiming = diagnosed approximately 2 weeks ago.
Rationale ROS: 5 systems are found in the documentation of this encounter. Nausea and vomiting cannot be counted as a ROS because it was already used as an HPI element. However, bowel dysfunction would additionally report on the GI system and support the GI ROS. Systems include:

1. Constitutional = no fever, night sweats
2. Respiratory = no trouble breathing
3. Cardiovascular = no tachycardia
4. GI = bowel dysfunction
5. GU = bladder dysfunction

Rationale PFSH: Upon review the documentation must include the date and location of documented PFSH that was reviewed. Therefore, no credit should be allowed for this particular component.

Overall History Analysis:

- HPI = 4 elements supporting brief HPI
- ROS = 5 systems support a detailed review of systems
- PFSH = No valid documentation supporting an expanded problem focused Past, family, social history

The overall history must count all three history components regardless of the patient’s status (new/established) with the practice. The lowest documented history component would determine the overall level of history.

History level = Expanded problem focused.
Exam includes 3 body systems supporting an expanded problem focused exam under the 1995 guidelines. The systems documented include:

- Psych = alert and oriented
- Vital signs = requires 3 vital signs as noted
- Integumentary = skin exam

No system is found to be in detail so the higher level exam is not supported.

Exam = Expanded problem focused.

Medical Decision Making

Diagnosis = Left breast cancer which is an established stable problem. The documentation does not indicate this problem is worsening at this time. This is the only diagnosis and would only support 1 point in this section.

Complexity = Documentation only includes an order for lab services
Table of Risk: The block which allows for maximum coding would be drug therapy requiring intensive monitoring for toxicity. This supports a high complexity level.

The overall Medical Decision Making must now be scored. This would be done by eliminating the lowest documented component. See grid below:

Medical Decision Making = Straight Forward
**Scoring Established Patient level of service**

Entering the findings of each element will help interpret the established patient level of service.

<table>
<thead>
<tr>
<th>History</th>
<th>EPF</th>
<th>D</th>
<th>C</th>
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</table>

<table>
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<tr>
<th>Complexity of Medical Decision</th>
<th>L</th>
<th>M</th>
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</thead>
<tbody>
<tr>
<td><strong>X</strong></td>
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</tbody>
</table>

Scoring an established patient allows the auditor to drop the lowest documented element, which as shown above would be medical decision making.

*Established patient level of service = Expanded Problem Focused 99213*

Now that the documented level of service has been scored the medical necessity of the encounter must also be reviewed.

As per the above the encounter is for a patient with a chronic stable problem and would support a 99213 as well.
Additional Information identified while auditing:

- Signature—Rules and guidelines met
- Dates of Service—Consistent
- Place of Service—Consistent
- E&M with additional services—The encounter supported that a billable evaluation of the patient is appropriately documented in addition to the ancillary services provided. Therefore the 25 modifier is supported.
Dayson Infusion Center
125 West Main St.
Dayson, KS 14356
404-545-1575

Patient: Kim Smith                      Date: October 8, 2010
Patient #: 1115                           DOB: 09-10-1950
CC: Left breast cancer

Presentation: Chemotherapy services with hydration

Infusion: Patient presents with normal vitals as noted in chart and seems to be doing well at this time. We will proceed with treatment per doctor’s orders.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Start Time</th>
<th>Stop Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taxol</td>
<td>30 mg</td>
<td>845</td>
<td>1002</td>
</tr>
<tr>
<td>Normal Saline</td>
<td>1000 ml</td>
<td>845</td>
<td>1124</td>
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<tr>
<td>Benadryl</td>
<td>50 mg</td>
<td>Push</td>
<td>@ 945</td>
</tr>
<tr>
<td>Phenergan</td>
<td>100 mg</td>
<td>Push</td>
<td>@ 947</td>
</tr>
</tbody>
</table>

Patient tolerated chemo treatment well, with relatively little to report. She will return next week for additional treatments.

Electronically Signed

______________________________
Angela Smith, RN

Dictated 10-8-2010

Transcribed 10-9-2010
Dayson Infusion Center
125 West Main St.
Dayson, KS 14356
404-545-1575

Patient: Kim Smith
Date: October 8, 2010
Patient #: 1115
DOB: 09-10-1950
CC: Left breast cancer

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Patient tolerated chemo treatment well, with relatively little to report. She will return next week for additional treatments.

Electronically Signed

__________________________
Angela Smith, RN

Dictated 10-8-2010
Transcribed 10-9-2010

Rationale:

The patient’s presenting need is chemotherapy infusion and should therefore be the primary reported service.

Primary service code = 96413 for 77 minutes of chemotherapy infusion

Additional services = 96375 the push for Benadryl is an add-on service code.

J1200 is the supply code for Benadryl.
96375 is the push for Phenergan is an additional add-on service code.

J2550 is the supply code for Phenergan and is billed at 2 units.

J9265 is the supply code for Taxol and is billed at 1 unit.

Although hydration is continued for 81 minutes after the chemotherapy, there is not an order from the physician for hydration services so it cannot be reported. Normal saline is not reported because hydration is not ordered and saline used to administer other drugs is not reported separately.
# HEALTH INSURANCE CLAIM FORM

## APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

| PICA | Medicare | P.O. Box 123 | Knoxville, OH 44455 |

### 1. MEDICARE | MEDICAID | TRICARE | CHAMPA | GROUP HEALTH PLAN | FECA | OTHER |
|---------------|-----------|----------|--------|------------------|------|------|

### 2. PATIENT'S NAME (last Name, First Name, Middle Initial)

Smith, Kim

### 5. PATIENT'S ADDRESS (No., Street)

1616 Main Street

### 6. PATIENT'S RELATIONSHIP TO INSURED

Self [X] Spouse [ ] Child [ ] Other [ ]

### 8. PATIENT'S STATUS

- Single [X]
- Married [ ]
- Other [ ]
- Employed [X]
- Full-time [ ]
- Part-time [ ]
- Student [ ]
- Other [ ]

### 9. OTHER INSURED'S NAME (last Name, First Name, Middle Initial)

Smith, Kim

### 10. IS PATIENT'S CONDITION RELATED TO

- EMPLOYMENT? (Current or Previous) [X] NO [ ]
- AUTO ACCIDENT? (Place) [X] NO [ ]
- OTHER ACCIDENT? [X] NO [ ]

### 11. INSURED'S POLICY GROUP OR FECA NUMBER

12345

### 12. INSURED'S AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

### 20. OUTSIDE ABD [ ]

### 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

174.9 [X] 3 [ ]

### 22. MEDICAID RESUBMISSION CODE

### 23. PRIOR AUTHORIZATION NUMBER

123456789

### 25. PATIENT'S ACCOUNT NO.

1115 [X] YES [ ] NO [ ]

### 26. TOTAL CHARGE

28. Amount Paid

### 29. BALANCE DUE

30.00

### SIGNATURE ON FILE

Heather Wright, MD

Reserved for Local Use

### 14. DATE OF CURRENT ILLNESS (First symptom or injury) OR LESS THAN PREGNANCY (LMP)

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<tbody>
<tr>
<td>10</td>
<td>08</td>
<td>10</td>
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### 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY (Explain Unusual Circumstances)

CPTICPCS MODIFIER DIAGNOSIS POINT R

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### 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

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<tbody>
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</table>

### 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

NPI

### 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

<table>
<thead>
<tr>
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<th>DD</th>
<th>YY</th>
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<tbody>
<tr>
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<thead>
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<tbody>
<tr>
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<td>08</td>
<td>10</td>
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</table>

### 19. INSURANCE PLAN NAME OR PROGRAM NAME

ABC Hospital

### 24. A DATE(S) OF SERVICE FROM TO

<table>
<thead>
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<th>DD</th>
<th>YY</th>
</tr>
</thead>
<tbody>
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<table>
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<th>MM</th>
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</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>08</td>
<td>10</td>
</tr>
</tbody>
</table>

### 29. BILLING PROVIDER INFO & PH.

Dayson Infusion Center

125 West Main St.

Dayson, KS 44356

Cmsopor Townsend, MD
The level of service was overbilled by the provider based on documentation content and medical necessity.

- The proper infusion codes were billed.
- The proper supply codes were billed, but lacking the correct # of units for J2550 the phenegren.

| Date: 10/08/10 | Provider: Heather Wright, MD | NPI: 147258359 | J2550 | 15DB | 2 | NPI | 2928 | 1 | 306 | 1 | 455 | 2 | 15DB | 1 | 60348 | $60348 | $60348 |

Date: 10/08/10

NPPIC Instruction Manual available at: www.nucc.org

WCMS-1500CS

APPROVED ONB 0939-0099 FORM CMS-1500 (08/05)
**Detailed HPI=Status of 3 chronic illnesses with 1997 DG. Some allow for 1995 as well.**

---

### History

<table>
<thead>
<tr>
<th>History of Present Illness</th>
<th>Review of Systems</th>
<th>Past, Family &amp; Social History</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Location</td>
<td>□ Constitutional symptoms</td>
<td>□ Current medication</td>
</tr>
<tr>
<td>□ Quality</td>
<td>□ Eyes</td>
<td>□ Prior illnesses and injuries</td>
</tr>
<tr>
<td>□ Severity</td>
<td>□ Ears, nose, mouth, throat</td>
<td>□ Operations and hospitalizations</td>
</tr>
<tr>
<td>□ Duration</td>
<td>□ Cardiovascular</td>
<td>□ Age-appropriate immunizations</td>
</tr>
<tr>
<td>□ Timing</td>
<td>□ Respiratory</td>
<td>□ Allergies</td>
</tr>
<tr>
<td>□ Context</td>
<td>□ Gastrointestinal</td>
<td>□ Dietary status</td>
</tr>
<tr>
<td>□ Modifying factors</td>
<td>□ Genitourinary</td>
<td></td>
</tr>
<tr>
<td>□ Associated signs and symptoms</td>
<td>□ Integumentary</td>
<td></td>
</tr>
<tr>
<td>□ No. of chronic diseases</td>
<td>□ Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Neurological</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Psychiatric</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Endocrine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Hematologic/lymphatic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Allergic/(immunologic)</td>
<td></td>
</tr>
</tbody>
</table>

**Past, Family & Social History**

**PAST MEDICAL**

- □ Current medication
- □ Prior illnesses and injuries
- □ Operations and hospitalizations
- □ Age-appropriate immunizations
- □ Allergies
- □ Dietary status

**FAMILY**

- □ Health status or cause of death of parents, siblings, and children
- □ Hereditary or high risk diseases
- □ Diseases related to CC, HPI, ROS

**SOCIAL**

- □ Living arrangements
- □ Marital status
- □ Sexual history
- □ Occupational history
- □ Use of drugs, alcohol, or tobacco
- □ Extent of education
- □ Current employment
- □ Other

---

### General Multi-System Examination

#### Constitutional

- □ 3 of 7 (BP,pulse,respir,tmp,hgt,wgt)
- □ General Appearance

#### Eyes

- □ Conjunctivae, Lids
- □ Eyelids, irises
- □ Ophthalm exam -Optic discs, Pos Seg

#### ENT

- □ Ears, Nose
- □ Oto exam -Aud canals,Tym memhr
- □ Hearing
- □ Nasal mucosa, Septum, Turbinates
- □ ENTML: Lips, Teeth, Gums
- □ Oropharynx -oral mucosa, palates

#### Neck

- □ Neck
- □ Thyroid

#### Respiratory

- □ Respiratory effort
- □ Percussion of chest
- □ Palpation of chest
- □ Auscultation of lungs

#### Cardiovascular

- □ Palpation of heart
- □ Auscultation of heart (& sounds)
- □ Carotid arteries
- □ Abdominal aorta
- □ Femoral arteries
- □ Pedal pulses
- □ Extrem for periph edema/varicosities

#### Chest

- □ Inspect Breasts
- □ Palpation of Breasts & Axillae

#### Gastrointestinal

- □ Abd (+/- masses or tenderness)
- □ Liver, Spleen
- □ Hernia (+/-)
- □ Anus, Perineum, Rectum
- □ Stool for occult blood

#### GU/Female

- □ Female: Genitalia, Vagina
- □ Female: Urethra
- □ Bladder
- □ Cervix
- □ Uterus
- □ Adnexa/parametria

#### GU/Male

- □ Scrotal Contents
- □ Penis
- □ Digital rectal of Prostate

#### Lymphatic

- □ Lymph: Neck
- □ Lymph: Axillae
- □ Lymph: Groin
- □ Lymph: Other

#### Musculoskeletal

- □ Gait (+/-ability to exercise)
- □ Palpation Digits, Nails
- □ Head/Neck: Inspect, Palp
- □ Head/Neck: Motion (+/-pain,crepit)
- □ Head/Neck: Stability (+/- lux,sublux)
- □ Head/Neck: Muscle strength & tone
- □ Spine/Rib/Pelv: Inspect, Palp
- □ Spine/Rib/Pelv: Motion
- □ Spine/Rib/Pelv: Stability
- □ Spine/Rib/Pelv: Strength and tone
- □ R.Up Extrem: Inspect, Palp
- □ R.Up Extrem: Motion (+/- pain, crepit)
- □ R.Up Extrem: Stability (+/- lux, laxity)
- □ R.Up Extrem: Muscle strength & tone
- □ L.Up Extrem: Inspect, Palp
- □ L.Up Extrem: Motion (+/- pain, crepit)
- □ L.Up Extrem: Muscle strength & tone
- □ R.Low Extrem: Inspect, Palp
- □ R.Low Extrem: Motion (+/-pain,crepit)
- □ R.Low Extrem: Stability (+/- lux,laxity)
- □ R.Low Extrem: Muscle strength & tone
- □ L.Low Extrem: Inspect, Palp
- □ L.Low Extrem: Motion (+/-pain,crepit)
- □ L.Low Extrem: Stability (+/- lux, sublux)
- □ L.Low Extrem: Muscle strength & tone

#### Skin

- □ Skin: Inspect Skin & Subcut tissues
- □ Skin: Palpation Skin & Subcut tissues

#### Neuro

- □ Neuro: Cranial nerves (+/- deficits)
- □ Neuro: DTRs (+/- pathological reflexes)
- □ Neuro: Sensations

#### Psychiatry

- □ Psych: Judgement, Insight
- □ Psych: Orientation time, place, person
- □ Psych: Recent, Remote memory
- □ Psych: Mood, Affect (depression, anxiety)

### Exam:

1995-1=PF, limited 2-7=EPF, extended 2-7=Detailed, 8+ organ systems=Comprehensive 1997-1-5=PF, 6-11=EPF, 2x6 systems=D 2 from 9 systems=Comp.
<table>
<thead>
<tr>
<th>Number of Diagnoses/Management Options</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (Stable, improved or worsening)</td>
<td>1</td>
</tr>
<tr>
<td>Established problem (to examining MD); stable or improved</td>
<td>1</td>
</tr>
<tr>
<td>Established problem (to examining MD); worsening</td>
<td>2</td>
</tr>
<tr>
<td>New problem (to examining MD); no additional work-up planned</td>
<td>3</td>
</tr>
<tr>
<td>New problem (to examining MD); additional work-up (e.g. admit/transfer)</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount and/or Complexity of Data Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab ordered and/or reviewed (regardless of # ordered)</td>
<td>1</td>
</tr>
<tr>
<td>X-ray ordered and/or reviewed (regardless of # ordered)</td>
<td>1</td>
</tr>
<tr>
<td>Medicine section (90701-99199) ordered and/or reviewed</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old record and/or obtain hx from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summary of old records and/or obtaining hx from someone other than patient and/or discussion with other health provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing, or specimen (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE OF RISK

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One self-limited or minor problem, e.g., cold, insect bite, skin rash</td>
<td>Laboratory tests requiring venipuncture</td>
<td>• Blood gas analysis</td>
</tr>
<tr>
<td></td>
<td>One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH</td>
<td>Chest x-ray</td>
<td>• Non-cardiovascular imaging studies with contrast, e.g., barium enema</td>
</tr>
<tr>
<td></td>
<td>Acute uncomplicated illness or injury, e.g., sprain, allergic rhinitis, simple sprain</td>
<td>EKG/EEG</td>
<td>• Superficial needle biopsy</td>
</tr>
<tr>
<td></td>
<td>Acute complications: injury, e.g., head injury with brief loss of consciousness</td>
<td>Ultrasound, e.g., echocardiography</td>
<td>• Clinical laboratory tests requiring arterial puncture</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Skin biopsy</td>
</tr>
<tr>
<td>Low</td>
<td>One or more self-limited or minor problems</td>
<td>Physiologic tests under stress, e.g., polynuclear function tests</td>
<td>• Over-the-counter drugs</td>
</tr>
<tr>
<td></td>
<td>One stable chronic illness</td>
<td>Non-cardiovascular imaging studies with contrast, e.g., barium enema</td>
<td>• Minor surgery with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Diagnostic endoscopy with no identified risk factors</td>
<td>• Physical therapy</td>
</tr>
<tr>
<td></td>
<td>Two or more stable chronic illnesses</td>
<td>Deep needle or incisional biopsy</td>
<td>• Occupational therapy</td>
</tr>
<tr>
<td></td>
<td>Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>Cardiac imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization</td>
<td>• IV fluids without additives</td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms, e.g., pneumonia, sepsis, meningitis, cellulitis</td>
<td>Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>• Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>Urinalysis</td>
<td>• Minor surgery with identified risk factors</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic illnesses with moderate exacerbation, progression, or side effects of treatment</td>
<td>Physiologic tests under stress, e.g., cardiac stress test, fatal contractions stress test</td>
<td>• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Two or more stable chronic illnesses</td>
<td>Diagnostic endoscopy with contrast with identified risk factors</td>
<td>• Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors</td>
<td>• Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms, e.g., pneumonia, sepsis, meningitis, cellulitis</td>
<td>Cardiac imaging studies with contrast and no identified risk factors</td>
<td>• IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>• Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Minor surgery with identified risk factors</td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors</td>
<td>• Elective major surgery (open, percutaneous or endoscopic)</td>
</tr>
<tr>
<td></td>
<td>Two or more stable chronic illnesses</td>
<td>Diagnostic endoscopy with identified risk factors</td>
<td>• Emergency major surgery (open, percutaneous or endoscopic)</td>
</tr>
<tr>
<td></td>
<td>Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>Cardiac imaging studies with contrast and no identified risk factors</td>
<td>• Percutaneous balloon dilatation</td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms, e.g., pneumonia, sepsis, meningitis, cellulitis</td>
<td>Cardiac imaging studies with contrast and no identified risk factors</td>
<td>• Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
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### Medical Decision Making

<table>
<thead>
<tr>
<th>Number of Diagnoses or Treatment Options</th>
<th>SF</th>
<th>LOW</th>
<th>MOD</th>
<th>HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<thead>
<tr>
<th>Amount and/or Complexity of Data to be Reviewed</th>
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<th>LOW</th>
<th>MOD</th>
<th>HIGH</th>
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<tbody>
<tr>
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<td>2</td>
<td>3</td>
<td>4</td>
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<table>
<thead>
<tr>
<th>Risk of Complications, Morbidity, Mortality</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
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<table>
<thead>
<tr>
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### Chart Note
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- [ ] Handwritten
- [ ] Form
- [ ] Illegible
- [ ] Note signed
- [ ] Signature missing

### Comments

Other Services or Modalities:

Auditor’s Signature