Chapter 4
E&M Services

E&M Services

- Documentation Guidelines
  - 1995
  - 1997
  - CMS
    - LCD
- Documentation Components
- History
- Exam
- Medical Decision Making (MDM)
- Time based services

E&M Services

- History
- History of the medical record documentation should include four areas:
  - Chief Complaint
  - History of Present Illness
  - Review of Systems
  - Past , Family and Social History
- Lowest documented area chooses Level of Service

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Chief Complaint

- Chief Complaint should be part of every medical record.
- Concise statement that describes the problem/condition for the patient encounter.
- Usually in the patient's own words
- Chief Complaint helps to identify the medical necessity of the service.

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History of Present Illness

- Symptoms of patient due to the Chief Complaint
- Per date of service

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HPI (History of Present Illness) : Characterize HPI by considering **EITHER** the Status of 3 chronic or inactive conditions **OR** the number of elements recorded.				O **Status of 3 Chronic Conditions**
O Location O Quality O Severity O Duration O Timing O Context O Assoc. Signs & Symptoms O Modifying Factors		O Brief (1-3)		O Extended (4 or more)
1995 HPI Guidelines				
O Location O Quality O Severity O Duration O Timing O Context O Assoc. Signs & Symptoms O Modifying Factors		O Brief (1-3)		O Extended (4 or More)
ROS (review of Systems): O Constitutional O All/Immuno O Ears, nose, mouth throat O Integumentary O Eyes O Musculo O Neuro O Hem/lymph O Cardiac/ vasc. O GU O Resp O GI O Psych O Endo	O N/A	O Pertinent to problem (1 system)	O Extended (pert & others) (2-9 systems)	O Complete (pert & all others) (10 systems)
PFSH (Past, Family, Social History): O **Past history** (the patient's past experiences with illnesses, operations, injuries and treatments) O **Family history** (a review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk) O **Social history** (an age appropriate review of past and current activities)	O N/A	O N/A	O Pertinent 1 history item	O *Complete 2-3 history areas

- Used for 95 or 97 guidelines
- Credit for minimum of 1 or maximum of 4

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- Additional HPI documentation style
  - 3 chronic or inactive problems
    - Status requirements
    - No less than 3
    - Comprehensive HPI credit

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- Review of Systems -ROS
  - Inventory of body systems obtained by questions from provider to identify how the patient is affected systematically by their problem.
  - Negative or positive
  - Mass Negative grouping
  - Unremarkable/Non-contributory
  - Laundry lists not applicable

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- **Organ Systems that qualify:**
  - **Constitutional**
  - **ENT**
  - **Eyes**
  - **Cardiovascular**
  - **GI**
  - **GU**
  - **Respiratory**
  - **Musculoskeletal**
  - **Psychiatric**
  - **Integumentary**
  - **Endocrine**
  - **Hem/Lymph**
  - **Allergy/Immunology**
  - **Neurologic**

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No Double Dipping

- If you use a symptom or system in the History of Present Illness, you cannot use it in Review of Systems

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Past Family & Social History (PFSH)

- **Past History**
  - Current medications , past surgeries , past illnesses, birth history
- **Family History**
  - Family; i.e., parents, siblings, children, aunts, uncles, grandparents, pregnancy of mother, birth mother/father
- **Social History**
  - Smoking , alcohol intake , marital status, sexual history, employment status , educational information, parents alcohol/smoking habits, childcare settings

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1. History

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the RIGHT in the table that best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the LEFT identifies the type of history. After completing this table that classifies the history, circle the type of history within the appropriate grid in section 5.

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* Complete PFSH **2 history areas:** a) established patients- office (outpatient) care, domiciliary care, home care; b) emergency department; c) subsequent nursing facility care; and d) subsequent hospital care. **3 history areas:** a) new patients-office (outpatient) care, domiciliary care, home care, b) consultations; c) initial hospital care; d) hospital observation; and e) initial nursing facility care.	PROBLEM FOCUSED 99201 99212	EXP. PROBLEM FOCUSED 99202 99213	DETAILED 99203 99214	COMPRE-HENSIVE 99204/99205 99215
	Final History requires all 3 components above met or exceeded			

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Unobtainable History

- Document why the history was unobtainable
- How to score
  - 1st view – Omit the history as scoreable component
  - 2nd view – Allow a complete history

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Second Component/Examination

- An examination based on either the 95 or 97 documentation guidelines.
- 95 examinations are based on the **body systems and areas.**
- 97 examinations are based on **bullets outlined through specific system examinations.**

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- Examination is the hands on examination may not be referred to on another date of service
- Unremarkable and non-contributory do not meet the necessary requirements
- Negative or normal meet documentation guidelines
- If abnormal – reason it is abnormal must be documented

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95 examination

- Inventory of number of organ systems documented
- Body areas should only be used as chief complaint or as organ system if possible per exam documentation
- **Body areas:**
  - Head, neck, chest, abdomen, genitalia, back, each extremity
- **Body systems:**
  - Constitutional, eyes, ears, nose, throat, mouth, cardiovascular, respiratory, GI, GU, musculoskeletal, skin, neurologic, psychiatric, lymph

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95 Exam

- 1 system = PF
- 2 systems = EPF
- 2 systems with 1 in detail = Detailed
- 8 systems = Comprehensive

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97 Examination

- Based on bullets
- Specialty specific
- More extensive documentation requirements
- No use of normal or negative wording only
- Requirement's maximum amount of detail

1997

Constitutional
- Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (may be measured and recorded by auditory staff)
- General appearance of patient *e.g. development, nutrition, body habitus, deformities, attention to grooming*

Eyes
- Inspection of conjunctivae and lids
- Examination of pupils and irises *e.g. reaction to light and accommodation, size, symmetry*
- Ophthalmoscopic examination of optic discs *e.g. size, C/D ratio, appearance* and posterior segments *e.g. vessel changes, exudates, hemorrhages*

Ear, Nose, Mouth & Throat
- External inspection of ears and nose *e.g. overall appearance, scars, lesions, masses*
- Otoscopic examination of external auditory canals and tympanic membranes
- Assessment of hearing *e.g. whispered voice, finger rub, tuning fork*
- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tonsils, tonsillar and posterior pharynx

Neck
- Examination of neck *e.g. masses, overall appearance, symmetry, tracheal position, crepitus*
- Examination of thyroid *e.g. enlargement, tenderness, mass*

Respiratory
- Assessment of respiratory effort *e.g. intercostals 3D retraction, use of accessory muscles, diaphragmatic movement*
- Percussion of chest *e.g. dullness, flatness, hyperresonance*
- Palpation of chest *e.g. tactile fremitus*
- Auscultation of lungs *e.g. breath sounds, adventitious sounds, rubs*

Cardiovascular
- Palpation of heart *e.g. location, size, thrills*
- Auscultation of heart with notation of abnormal sounds and murmurs

Examination of
- Carotid arteries *e.g. pulse, amplitude, bruits*
- Abdominal aorta *e.g. size bruits*
- Femoral arteries *e.g. pulse, amplitude, bruits*
- Pedal pulses *e.g. pulse amplitude*
- Extremities for edema and/or varicosities

Chest (breasts)
- Inspection of breasts *e.g. symmetry, nipple discharge*
- Palpation of breasts and axillae *e.g. masses or lumps, tenderness*

Gastrointestinal (abdomen)
- Examination of abdomen with notation of presence of masses or tenderness
- Examination of liver and spleen
- Examination for presence or absence of hernias
- Examination when indicated of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses
- Obtain stool sample for occult blood test when indicated

Genitourinary
- Examination of the scrotal contents *e.g. hydrocele, spermatocele, tenderness of cord, testicular mass*
- Examination of the penis
- Digital rectal examination of prostate gland *e.g. size symmetry, nodularity, tenderness*

Pelvic examination (with or without specimen collection for smears and cultures) including:
- Examination of perineal genitalia *e.g. general appearance, hair distribution, lesions* and Vagina *e.g. general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele*
- Examination of the cervix *e.g. masses, tenderness, scarring*
- Examination of the bladder *e.g. fullness, masses tenderness*
- Cervix *e.g. general appearance, lesions, discharge*
- Uterus *e.g. size, contour, position, mobility, tenderness, consistency, descent or support*
- Adnexa/parametria *e.g. masses, tenderness, organomegaly, nodularity*

Lymphatic
Palpation of lymph nodes in two or more areas:
- Neck
- Axillae
- Groin
- Other

Musculoskeletal
- Examination of gait and station
- Inspection and/or palpation of digits and nails *e.g. clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes*

Examination of joint, bone(s) and muscles of one or more of the following six areas:
1) **head and neck;**
2) **spine, ribs and pelvis,**
3) **right upper extremity**
4) **left upper extremity,**
5) **right lower extremity,**
6) **left lower extremity.**

The examination of a given area includes:
- Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions
- Assessment of range of motion with notation of any pain, crepitation or contracture
- Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- Assessment of muscle strength and tone *e.g. flaccid cog wheel, spastic* with notation of any atrophy or abnormal movements

Skin
- Inspection of skin and subcutaneous tissue *e.g. rash, lesions, ulcers*
- Palpation of skin and subcutaneous tissue *e.g. induration, subcutaneous nodules, tightening*

Neurologic
- Test cranial nerves with notation of any deficits
- Examination of deep tendon reflexes with notation of pathological reflexes *e.g. Babinski*
- Examination of sensation *e.g. touch, pin, vibration, proprioception*

Psychiatric
- Description of patient's judgement and insight
- Brief assessment of mental status including:
- Orientation to time, place, and person
- Recent and remote memory
- Mood and affect *e.g. depression, anxiety, agitation*

Problem Focused ——— One to five elements identified by a bullet
Exp. Prob. Focused ——— At least six elements identified by a bullet
Detailed ——— At least two elements identified by a bullet from each of six areas/systems
OR at least twelve elements identified by a bullet two or more areas/systems
Comprehensive ——— Performed all elements identified by a bullet and document at least two elements by a bullet from each of nine areas/systems

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CPT Type of Exam	95 Guidelines	97 Guidelines	Exam Equals
Problem Focused Exam **(PF)**	One body area or organ system	1-5 bulleted elements	
Expanded Problem Focused Exam **(EPF)**	2-7 Body Systems - No detail of any system required	6-11 bulleted elements	
Detailed Exam **(D)**	2-7 body systems w/affected system in detail	12-17 bulleted elements for 2 or more systems	
Comprehensive Exam **(C)**	8 or more body systems	Not Applicable for 1997 Guidelines	
Comprehensive Exam **(C)**	Not Applicable to 1995 Guidelines	18 or more bulleted elements for 9 or more systems.	
	Not Applicable to 1995 Guidelines	See requirements for individual single system exams	

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Medical Decision Making (MDM)

- MDM explains the complexity of the patient's problem based on the providers overall assessment
- Three areas of documentation:
  - Diagnosis
  - Complexity
  - Risk

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MDM-Diagnosis

- Must be applicable to the day's visit
- Listing an increased number of diagnoses that are not addressed or that have no direct impact on that days encounter should not be counted
- Diagnosis is either:
  - New
    - With increased work up
    - Without increased work up
  - Established
    - Stable/Improving
    - Worsening

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Number of Diagnosis or Treatment Options				
A	B	x C	=	D
Problem(s) Status	Number	Points		Result
Self-Limited or minor (stable, improved, or worsening)	Max=2	1		
Est. problem (to examiner); stable, improved		1		
Est. problem (to examiner); worsening		2		
New problem (to examiner); no add'l workup planned	Max=1	3		
New problem (to examiner); add'l workup planned		4		
		Total:		

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MDM - Complexity of Data

- "Points" for the physician work during the encounter
  - Ordering/reviewing services
  - Requesting/reviewing records

Amount and/or Complexity of Data Reviewed	
Reviewed Data	**Points**
Review and/or order of clinical lab tests	1
Review and/or order tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
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	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
Total:	

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Risk of Complications and/or Morbidity or Mortality			
Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options
Minimal	O *One self-limited or minor problem*, e.g., cold, insect bite, Tinea Corporis	O Laboratory tests requiring venipuncture O Chest x-rays O EKG / EEG O Urinalysis O Ultrasound, e.g., echo O KOH prep	O Rest O Gargles O Elastic bandages O Superficial dressings
Low	O *Two or more self-limited or minor problems* O *One stable chronic illness*, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH O *Acute uncomplicated illness or injury*, e.g., cystitis, allergic rhinitis, simple sprain	O Physiologic tests not under stress, e.g., pulmonary function tests. O Non-cardiovascular imaging studies with contrast, e.g., barium enema O Superficial needle biopsies O Clinical laboratory tests requiring arterial puncture O Skin biopsies	O Over-the-counter drugs O Minor surgery with no identified risk factors O Physical therapy O Occupational therapy O IV fluids
Moderate	O *One or more chronic illnesses with mild exacerbation*, progression, or side effects of treatment O *Two or more stable chronic illnesses* O *Undiagnosed new problem with uncertain prognosis*, e.g., lump in breast O *Acute illness with systematic symptoms*, e.g., pyelonephritis, pneumonitis, colitis, O *Acute complicated injury*, e.g., head injury with brief loss of consciousness	O Physiologic tests not under stress, e.g., cardiac stress test, fetal contraction stress test O Diagnostic endoscopies with no identified factors O Deep needle or incisional biopsy O Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram cardiac cath O Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentisis	O Minor surgery with identified risk factors O Major surgery (open, percutaneous or endoscopic) with no identified risk factors O Prescription drug management O Therapeutic nuclear medicine O IV fluids with additives O Closed treatment of fracture or dislocation without manipulation
High	O *One or more chronic illnesses with severe exacerbation*, progression, or side effects of treatment O *Acute or chronic illnesses or injuries that may pose a threat to life or bodily function*, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure O *An abrupt change in neurologic status*, e.g., seizure, TIA, weakness or sensory loss	O Cardiovascular imaging studies with contrast with identified risk factors O Cardiac electrophysiological tests O Diagnostic endoscopies with identified risk factors O Discography	O Major surgery (open, percutaneousor endoscopic with identified risk factors), O Emergency major surgery (open, percutaneous or endoscopic) O Parenteral controlled substances O Drug therapy requiring intensive monitoring for toxicity O Decision not to resuscitate or de-escalate care because of poor prognosis

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Final Result for Complexity					
A	Number of diagnosis or treatment options	1 Minimal	2 Limited	3 Multiple	4 Extensive
B	Highest risk options	Minimal	Low	Moderate	High
C	Amount and complexity of data	1 Minimal or low	2 Limited	3 Multiple	4 Extensive
Type of decision making		**Straight Forward**	**Low Complex**	**Moderate Complex**	**High Complex**

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E&M Services

5. Level of Service									
OUTPATIENT, CONSULTS (OUTPATIENT, INPATIENT & CONFIRMATORY), AND ER									
	New Office/ Consults/ ER requires 3 components within shaded area					*Established Office Requires 2 components within shaded area			
History	PF	EPF	D ER:EPF	C ER:D	C	PF	EPF	D	C
Examination	PF	EPF	D ER:EPF	C ER:D	C	PF	EPF	D	C
Complexity of Medical Decision	SF	SF ER: L	L ER:M	M	H	SF	L	M	H
Average time (minutes) (Confirmatory consults & ER have no average time)	99201-10 NEW 99241-15 OUTPT CONS 99251-20 IP CONS ER 99281	99202-20 NEW 99242-30 OUTPT CONS 99252-40 IP CONS ER 99282	99203-30 NEW 99243-40 OUTPT CONS 99253-55 IP CONS ER 99283	99204-40 NEW 99244-60 OUTPT CONS 99254-80 IP CONS ER 99284	99205-60 NEW 99245-80 OUTPT CONS 99255-110 IP CONS ER 99285	99212 10 min.	99213 15 min.	99214 25 min.	99215 40 min.
LEVEL	I	II	III	IV	V	II	III	IV	V

* Level I established visit is for when a patient sees the nurse, not the doctor.

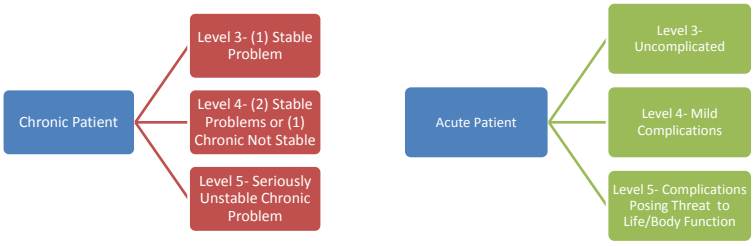
E&M Services

Medical Necessity

- Overarching determining factor
- Trumps documentation guidelines that may support an increased Level of Service
- Maximize documentation and choose level of service on medical necessity

E&M Services

Medical Necessity



E&M Services

New Patients

- 3 year rule
- Same group practice
- 3 of 3 components
  - Lesser determines level

New Patients

HISTORY	Problem Focused	Exp Problem Focused	Detailed	Comprehensive	Comprehensive
EXAM	Problem Focused	Exp Problem Focused	Detailed	Comprehensive	Comprehensive
MDM	Straightforward	Straightforward	Low	Moderate	High
LEVEL	99201	99202	99203	99204	99205
TIME	10 min	20 min	30 min	45 min	60 min

E&M Services

Established Patients

- Current treatment by provider of same group practice
- Throw out lowest documented
- May not have all 3 areas documented

Established Patients

HISTORY	Min	Problem Focused	Exp Problem Focused	Detailed	Comprehensive
EXAM	N/A	Problem Focused	Exp Problem Focused	Detailed	Comprehensive
MDM	N/A	Straightforward	Low	Moderate	High
LEVEL	99211	99212	99213	99214	99215
TIME	5 min	10 min	15 min	25 min	40 min

E&M Services

Initial Hospital Care

- **99221-99223**
- New or Established Patient
  - 3 of 3 components
- Time can be used

Initial Hospital Care

HISTORY	Detailed/Comp	Comprehensive	Comprehensive
EXAM	Detailed Comp	Comprehensive	Comprehensive
MDM	Straightforward/Low	Moderate	High
LEVEL	99221	99222	99223
TIME	30 minutes	50 minutes	70 minutes

E&M Services

Subsequent Hospital Care

- **99231-99233**
  - 2 of 3 components
- After initial admit to the hospital
- Time can be used

Subsequent Hospital Care

HISTORY	Problem Focused	Exp Problem Focused	Detailed
EXAM	Problem Focused	Exp Problem Focused	Detailed
MDM	Straightforward/Low	Moderate	High
LEVEL	99231	99232	99233
TIME	15 minutes	25 minutes	35 minutes

E&M Services

Consultation Codes

- CMS changed payment rules in 2010
- Still document according to CMS guidelines
  - Initial statement of consult
  - Letter to regular provider
  - 3 of 3 key elements
    - New or Established patients

E&M Services

Critical Care

- 99291 first 30 – 74 minutes
- +99292 each additional 30 minutes
- Documentation must support
  - Need for critical care
  - Time billed
- Vent management
- Bundled services

E&M Services

Prolonged Physician Services

- Divided codes
- With/without face-to-face
- Outpatient/Inpatient

Prolonged Services Documentation

- Amount of total time
- Medical Necessity to support

E&M Services

Preventive Services

- E&M services based on
  - New vs. Established
  - Age
- CMS services based on
  - Initial (IPPE)
  - Initial Wellness
  - Subsequent Wellness

E&M Services

Preventive Services

- CMS Specific to their guidelines
- E&M
  - Interval History
  - Complete Exam
  - Preventive Guidance plan of care

E&M Services

Neonatal/Pediatric Critical Care

- Mirrors adult critical care services
- Documentation should reflect:
  - Total time
  - Justification of time
  - Medical necessity to support the need for critical care
  - Bundled services

E&M Services

E&M Modifiers

- 24 Modifier
- 25 Modifier
- 57 Modifier
- Documentation must support and justify use

E&M Services

Documentation Structure

- SOAP Note
- Cheddar Note
- Procedure with E&M encounter

E&M Services

Incident-To

- CMS Rules
  - The physician must be present in the office suite and immediately available
  - Available by phone does not constitute direct supervision.
  - All of the above is considered Direct Personal Supervision
  - NPP provides service bills under supervising provider CMS billing information
- Incident-to supervised by non-physicians are reimbursed 85% of physician's fee schedule

E&M Services

- To qualify as "incident-to," certain criteria must be met.
  - There must be an employment relationship between the physician and the auxiliary personnel providing the service
  - New patients must be seen and examined by the supervising provider
  - Established patients with new problems must be seen and a new plan of care provided by supervising provider
  - Supervising provider must remain integral part of established patient's care

E&M Services

Incident-To Documenation

- Must include what services were provided by the supervising physician
- Should be signed by both

Chapter 5
Audit Results

Audit Results

- Compliance Audits
  - To evaluate the providers compliance with documentation rules and guidelines
  - Done internally or external auditor
  - Performed either as
    - Pre or post payment audits
- Risk Management Audits
  - Patient care from the beginning of the encounter through the entire process as well as practice liability
  - Focused audits
    - Audits on one particular service
    - Over utilization

Audit Results

- May vary by specialty
- Baseline audit 10-15 records per provider
- Use random approach
  - E&M Services
  - "Other" services

Audit Results

- Tools for an audit include
  - Documentation Guidelines
  - Audit Tool
  - Code Books
  - Payer Policy
  - Documentation to be audited

Audit Results

Communication of Audit Reports

- If results are not shared with providers, it would not serve its purpose
- Requests by healthcare attorneys
  - All information is sent/reviewed with them only
- Practice request
  - Communicate with Compliance Officer or liaison with the individual providers and practice manager

Audit Results

- Reports should be clear/concise comparing required documentation according to guidelines
- Be specific
  - Not just history is incorrect, be specific as to what is missing
- Don't overwhelm them and give them grids, information to help guide them

Audit Results

- Billing Results
  - Modifer usage, ICD-9, CPT coding
- Regulatory Control Issues
  - Show why practice/provider did not meet necessary standards and show in writing
- Trending
  - Show where they are over or under utilizing services
  - Compare to national average statistic base on specialty
  - 6-12 months of plotted statistics should be used
  - Teach providers to bill services according to medical necessity and not trending, averages or reimbursement

Audit Results

Utilization Report and Analysis

CPT® Code	Medicare Distribution	Practice LOS	Practice Distribution	Practice $ Distribution	Medicare Distribution on Practice	Distribution Difference	Medicare $ Distribution on Practice	Distribution Difference in $'s
99201	2%	0	0%	$0.00	3.82	2%	$126.22	($126.22)
99202	15%	0	0%	$0.00	31.60	15%	$1,864.45	($1,864.45)
99203	58%	154	74%	$14,938.00	121.70	-15%	$10,709.66	$4,228.34
99204	21%	55	26%	$7,535.00	44.77	-5%	$5,595.98	$1,939.03
99205	3%	0	0%	$0.00	7.13	3%	$1,140.30	($1,140.30)
Totals	100%	209	100%	$22,473.00	209.02	0%	$19,436.60	$3,036.40

Audit Results

Finalization of the Report

- Formal report given to Compliance Office of type of audits performed and findings
  - Overall results
  - Individual provider
- Recommended one-on-one with each provider
- Group education does not always identify each individual deficiencies
- Overview letter that summarizes the specific identified problems

Audit Results

- Summarization for practice compliance plan to include:
  - Date of the audit
  - Who requested the audit
  - How many records were audited
  - Which providers were audited
  - Statement that a detailed report has been provided to each provider audited
  - Statement that a one-on-one or group session was provided for each provider audited and reviewed
  - Concise overview of the findings
  - Statement regarding intended or needed follow-up to be done for necessary compliance
  - Identification of the auditor performing the service

Audit Results

- Recommended each provider sign an acknowledgement statement for the following:
  - Audit report has been reviewed and understand the needed change
  - They are responsible for coding/billing of their services
  - They will make necessary adaptions that were discussed
- Disclaimer of Service
  - Intent of audit is to merely review a sample of their documentation and only specific to the records audited.
  - Results were reviewed with provider and failure to comply to recommendations will result in insufficient practice compliance