Developing Effective Audit Tools and Reports

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presented by
Lynn Pascoe, CHCA, CPC, CPC-I, CEMC, CPCO, PCS, CCP

Disclaimer

- Every reasonable effort has been taken to ensure that the educational information provided in today's presentation is accurate and useful.
- Applying best practice solutions and achieving results will vary in each hospital/facility situation.

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Audit Standards

- Performed Routinely – quarterly, semi-annual, annual
- Based on:
  - federal documentation guidelines
  - carrier guidelines
  - payer standards
  - other applicable regulations

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Why Audit?

- Improve coding accuracy
- Improve billing accuracy
- Improve documentation completeness
- Internal compliance program requirement
- Verify compliance with coding, billing, reimbursement and documentation requirements

Why Audit?

- POS issues?
- Identify areas of lost revenue or revenue that is **at risk!**
  - Civil monetary penalties (CMP) - ≥ $10,000 per violation per each item service
  - Initiate corrective actions

Why Audit?

- EMR changes
  - Compare to previous years prior to EMR implementation
  - EHRs don't focus on NPP
  - Overuse of macros
- Identify problem areas in over and undercoding E/Ms
- Focus on gray areas of E/M
  - Most MDs E/M coding is inaccurate per CMS (~75%)

Why Audit?

- Medical necessity supported every service rendered and claims submitted
- Physician productivity
- Support both required and voluntary education – providers and staff
- Improve revenue stream
- Achieve "quality" measures

Why Audit?

- Work collaboratively with physicians and staff to ensure they understand coding errors/vulnerabilities
- Denial review
- Meaningful use
- Correct modifier usage

Why Audit?

PEACE OF MIND!!

Who is looking and auditing our claims?

Here's some history

Improper payment Elimination and Recovery Act

- Identify programs that may be **susceptible to** significant improper payments
- Estimate the amount of improper payments in those programs
- Share the estimates with Congress
- Report publicly the estimate and actions the Agency is taking to reduce improper payments

Improper Payment

- Payments that should not have been made or payments made in an incorrect amount (including overpayments & underpayments)
  - –Payment to an ineligible recipient
  - –Payment for an ineligible service
  - –Any duplicate payment
  - –Payment for services not received
  - –Payment for an incorrect amount

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Improper Payments

- Identified through review of the medical record
- Items or services that do not meet Medicare's coverage and medical necessity criteria
- Payment for items that are incorrectly coded
- Payment for services where the supporting documentation submitted does not support the ordered service.

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Improper Payment Measurement History

- Office of Inspector General (OIG) Error Rate Measurement 1996-2002:

–OIG drew a sample of 6,000 claims

–OIG asked the Durable Medical Equipment Regional Carriers (DMERC), Carriers, Fiscal Intermediaries (FI), and Quality Improvement Organizations (QIO) to review the claims against all coverage, coding, and payment rules

- OIG calculated a single National Claims Payment Error Rate

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Improper Payment Measurement History

- CMS took over improper payment measurement
  - Transition began in 2001
  - First reported an improper payment rate in November of 2003
- Current sample size is 50,000 claims
- Multiple improper payment rates computed:
  - Nationally
  - By Contractor
  - By Service
  - By Provider Type

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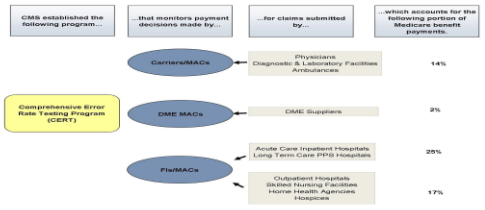
CERT PROGRAM



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CERT Program

- CERT program calculates the Medicare FFS program improper payment rate.
- Considers any claim that was paid when it should have been denied or paid at another amount (including both overpayments and underpayments) to be an improper payment.
- Claims are selected on a semi-monthly basis
- The final CERT sample is comprised of claims that were either paid or denied by the MACs

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CERT Program

- To meet this objective, a random sample of Medicare FFS claims is reviewed by an independent medical review contractor (herein, CERT contractor) to determine if they were paid properly under Medicare coverage, coding, and billing rules.
- If these criteria are not met, the claim is counted as either a total or partial improper payment, depending on the category of error at issue.

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CERT Error Types

1. No documentation
2. Insufficient documentation
3. Medical Necessity Errors
4. Incorrect Coding Errors:
5. (1) a different code than that billed, (2) that the service was performed by someone other than the billing provider or supplier, (3) that the billed service was unbundled,
6. Others

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National Improper Payment Rates by Year (Dollars in Billions) 2012

		Overpayments		Underpayments		Overpayments + Underpayments	
	Total	Improper	Improper	Improper	Improper	Improper	Improper
Fiscal	Dollars	Payment	Payment	Payment	Payment	Payment	Payment
Year	Paid	Amount	Rate	Amount	Rate	Amount	Rate
1996	$168.1	$23.5	14.0%	$0.3	0.2%	$23.8	14.2%
1997	$177.9	$20.6	11.6%	$0.3	0.2%	$20.9	11.8%
1998	$177.0	$13.8	7.8%	$1.2	0.6%	$14.9	8.4%
1999	$168.9	$14.0	8.3%	$0.5	0.3%	$14.5	8.6%
2000	$174.6	$14.1	8.1%	$2.3	1.3%	$16.4	9.4%
2001	$191.3	$14.4	7.5%	$2.4	1.3%	$16.8	8.8%
2002	$212.8	$15.2	7.1%	$1.9	0.9%	$17.1	8.0%
2003	$199.1	$20.5	10.3%	$0.9	0.5%	$12.7	6.4%
2004	$213.5	$20.8	9.7%	$0.9	0.4%	$21.7	10.1%
2005	$234.1	$11.2	4.8%	$0.9	0.4%	$12.1	5.2%
2006	$246.8	$9.8	4.0%	$1.0	0.4%	$10.8	4.4%
2007	$276.2	$9.8	3.6%	$1.0	0.4%	$10.8	3.9%
2008	$288.2	$9.5	3.3%	$0.9	0.3%	$10.4	3.6%
2009[a]	$285.1	$34.2	12.0%	$1.2	0.4%	$35.4	12.4%
2010	$326.4	$33.2	10.2%	$1.1	0.3%	$34.3	10.5%
2011	$336.6	$28.0	8.4%	$0.8	0.2%	$28.8	8.6%
2012	$349.7	$28.5	8.2%	$1.1	0.3%	$29.6	8.5%

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ZPIC (Zone Program Integrity Contractors)

- Primary goal to investigate instances of suspected fraud, waste, and abuse.
- Investigate early
- Take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid.

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ZPIC

- Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
- Conducting investigations in accordance with the priorities established by CPI's Fraud Prevention System;
- Performing medical review, as appropriate;

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ZPICS

- They also identify any improper payments that are to be recouped by the MAC.
- Actions:
  - Investigate potential fraud and abuse for CMS administrative action or referral to law enforcement;
- Conduct investigations in accordance with the priorities established by CPI's Fraud Prevention System

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ZPICS

- Perform medical reviews, as appropriate;
- Perform data analysis in coordination with CPI's Fraud Prevention System;
- Identify administrative action needs such as payment suspensions and prepayment or auto-denial edits
- Refer cases to law enforcement for consideration and initiation of civil or criminal prosecution.

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ZPICs

- ZPICs may also, as appropriate:
  - –Request medical records and documentation;
  - –Conduct an interview;
  - –Conduct an onsite visit;

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RAC

RAC detect and correct past improper payments so that CMS can implement actions that will prevent future improper payments:

- **Providers** can avoid submitting claims that do not comply with Medicare rules
- **CMS** can lower its error rate
- **Taxpayers** and future Medicare beneficiaries are protected.

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OIG

- May 2012, "Coding Trends of Medicare Evaluation and Management Service" report
- Must read
- Excerpts next 3 slides

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OIG

Excerpts from their May, 2012 report

- "2001 and 2010, Medicare payments for Part B goods and services increased by 43 percent, from $77 billion to $110 billion.
- During this same time, Medicare payments for evaluation and management (E/M) services increased by **48 percent**, from $22.7 billion to $**33.5 billion**.
- 2001 to 2010, physicians increased their billing of **higher level E/M** codes in all types of E/M services".

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What We (OIG) Found

"From 2001 to 2010, physicians increased their billing of higher level E/M codes in all types of E/M services. Among these physicians, we identified approximately 1,700 who consistently billed higher level E/M codes in 2010.

Although these physicians differed from others in their billing of E/M codes, they practiced in nearly all States and represented similar specialties.

The physicians who consistently billed higher level E/M codes also treated beneficiaries of similar ages and with similar diagnoses as those treated by other physicians.

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What We (OIG) Found

"E/M services have been vulnerable to fraud and abuse."

"In 2009, two health care entities paid over $10 million to settle allegations that they fraudulently billed Medicare for E/M services as a result of our efforts."

"CMS also found that certain types of E/M services had the most improper payments of all Medicare Part B service types in 2008."

"This report is the first in a series of evaluations of E/M services".

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OIG

- "Subsequent evaluations will determine the appropriateness of Medicare payments for E/M services and the extent of documentation vulnerabilities in E/M services".

https://oig.hhs.gov/oei/reports/oei-04-10-00180.asp

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Let's consider our audits

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General Considerations E/M Service Documentation?

- History:
  - –Chief complaint
  - –HPI
  - –ROS
  - –*PFSH*
- Physical Examination:
  - 7 body areas and/or
  - 11 organ systems
  - (combination)
- MDM Components:
  - Risk, Amt of Data, NPP, etc.

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Medical Necessity - NPP

- Parts of audit relate to Med Nec.
- History:
  - –CC, HPI, ROS, PFSH
  - –Was NPP cloned from visit to visit
  - –Forms/Template used – Propagate
  - –PMH referred back to previous visit?

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Physical Examination

Examination	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
1995	1 Body Area or Organ System	Limited Exam 2-4 Body Areas or Organ Systems	Extended Exam 5-7 Body Areas or Organ Systems	8 Organ Systems or a Comprehensive Single Organ System Exam
1997	Any 1-5 Bullets	Any 6+ Bullets	General: 2 bullets from 6 or more organ systems/body areas or 12 bullets from 2 or more organ systems/body areas Eye/Psych: 9+ bullets All Others: 12+ bullets	General: Perform all, document 2 bullets from 9 Organ Systems/body areas All Others: Perform all, document all elements in each bolded box and 1 element in each un-bolded box

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95 P/E documentation requirement

- Problem focused – limited exam of affected body area or organ system
- Expanded Problem focused – limited exam of affected body area or organ system and other symptomatic or related organ system(s) (2-4) or (5-7) or (2-7)? **(All vary by MAC)**
- Detailed – extended exam of the affected body area(s) and other symptomatic or related organ system(s) **(5-7) OR (2-7) OR (4 X 4) (All vary by MAC) and individual opinion**
- Comprehensive – general multi-system exam or complete exam of a single organ system, including findings about 8 or more of the 12 organ systems

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Medical Decision Making (MDM)

- MOST SUBJECTIVE
- Marshfield Clinic
- Does our MAC use Marshfield clinic or their own variation of it?
- Maybe something altogether different

  NPP??? OR Only #s
- What does RTC mean in terms of severity?
- What is the sense or tone or feel of the severity for NPP?

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Marshfield Clinic Approach to MDM

From a presentation given by Dr. Stephen R. Levinson, author of "Practical E/M Documentation and Coding Solutions", he states:

- Changes the table of risk (*violates RVUs*)
- Non-compliantly blends a non-compliant level of risk with diagnoses and type of visit
- – Ignores # of treatment options
- – Distorts # of diagnoses (by inserting a max #)
- – If 1 new problem = "multiple diagnoses," how many diagnoses are "limited" or "minimal"?
- – For initial visits, this approach significantly over values relatively minor illnesses
- – For established visits, this approach significantly undervalues relatively moderate/severe illnesses

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Marshfield Clinic Approach to MDM (con't)

From a presentation given by Dr. Stephen R. Levinson, author of "Practical E/M Documentation and Coding Solutions":

- Nearly every problem can be presented as a "new problem"
  - Overvalues a mild new problem
  - Undervalues a worsening established problem (e.g., metastatic cancer with symptoms)
    - Ignores consideration of treatment options
- Puts limits on number of diagnoses in several of the categories
- Frequently leads to different results than CPT principles
- Fails to consider # of treatment options
- Fails to consider medical necessity!

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Other Considerations

- Payers interpretation of current CMS and 3rd party payer guidelines
- Carriers policies
- OIG work plan for each fiscal year
- What are credible resources?
  - Specialty groups forms and advice (good/bad?)

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Other considerations

- Organization have coding/documentation "*standards*" manual – all trained
- Audit Results - Do providers and staff get trained at least annually, updated at least semi-annually
- What style of communication back works best with your group?

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EHR Specific Issues

- Cloning, cloning, cloning

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EHR Specific Issues

- CC: recorded by non-MD – often inconclusive or incorrect
- Doesn't speak to NPP
- New complaint often overlooked
- MD shortcuts often due to poor quality typing
  - Difficult to read/understand kind of like illegibility????

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EHR Specific Issues

- Vendor Preloaded macros or templates
  - Like manual chart – propagating
  - Did they ask the question and obtain and answer to ROS, P/E elements?
- Semi-auto responses: PFSH – "see previous visit, unchanged previous visit
  - What happened today?

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EHR Specific Issues

- Copy/paste whole sections of Hx, P/E, MDM (A/P) from previous notes
- Diagnosis codes – same for every visit

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Typical Approach to Audit

- Review documentation and compare to codes assigned
- Determine if we have an overcode or undercode situation
- NPP/Risk MDM may not be considered in whole if numbers are achieved
- Is level 5 really a level 5?

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Best Practices Audit Process & Tool

- Code Decision:
  - Bottom up coder/auditor
  - Weight NPP to determine appropriate documentation, codes and care levels
  - Based on NPP is service over or under coded?
  - Driven by MD judgment based on A/P and NPP
  - Not a numbers game

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Best Practices Audit Process & Tool

- Documentation:
  - –Review documentation against code assigned
  - –Is documentation sufficient or insufficient based on NPP?
  - –Was there upcharting? Is it warranted by NPP?
  - –Physician's judgment rules

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Audit tools

Consideration for E/M audit tool

- 2011 -- 16 Jurisdictions/MACs
  - –Individual audit tools
    - •Marshfield clinic?
    - •AMA CPT guidelines
    - •Combinations of 95/97
    - •All of the above

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Consideration for E/M audit tool

- Design our own
- For Sale by owner:
  - Variations in E/M Audit Tools
    - Some may take short cuts
- Is it free to use?
- Goals of audit
- Practice convert to EMR within past 12 mo.
- Reports

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Consideration for E/M audit tool

- Gives **reliable**, **accurate** results
- Easy for MDs and staff to learn and utilize in work
- Coding and documentation tools can be developed from all of these audit tools

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Consideration for E/M audit tool

- Applicable to my specialty
- Does it ensure consistency?
- Is there space for comments?
- Does it improve objectivity?
- Most important –does it improve communications between auditor and staff?

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Audit Tool Example

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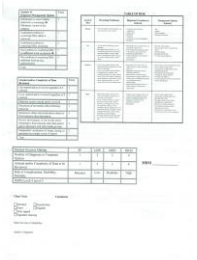
MDM

- 

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AAPC's Audit Form

Chart #: _____

E/M Audit Form

Patient Name: _____ Date of service: ___/___/___ Provider: _____ MR #: _____

Place of Service: _____ Service Type: _____ Insurance Carrier: _____

Code (s) selected: _____ Code(s) audited: _____ ☐Over ☐Under ☐Correct ☐Miscoded

History

History of Present Illness

- ☐ Location
- ☐ Quality
- ☐ Severity
- ☐ Duration
- ☐ Timing
- ☐ Context
- ☐ Modifying factors
- ☐ Associated signs and symptoms
- ☐ No. of chronic diseases

Review of Systems

- ☐ Constitutional symptoms
- ☐ Eyes
- ☐ Ears, nose, mouth, throat
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Gastrointestinal
- ☐ Genitourinary
- ☐ Integumentary
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Psychiatric
- ☐ Endocrine
- ☐ Hematologic/Lymphatic
- ☐ Allergic/immunologic

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, & 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
- ☐ Level of education
- ☐ Current employment ☐ Other

PF=Brief HPI -

EPF=Brief HPI, ROS (Pertinent-1)~

Detailed- Extended HPI (4+) + ROS (2) +5 PFSH (1)

Comprehensive- Extended HPI + ROS (10 + systems) PFSH-2 Established, 3 New Patient

☐ PFSH-Form reviewed, no change ☐ PFSH-form reviewed, updated ☐ PFSH- form new

**Extended HPI-Status of 3 chronic illnesses with 1997 DG. Some allow for 1995 as well.

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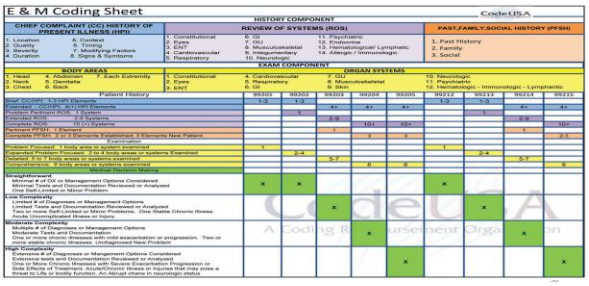
Free E/M audit form-Code USA



E & M Coding Sheet — CodeUSA

HISTORY COMPONENT

CHIEF COMPLAINT (CC) HISTORY OF PRESENT ILLNESS (HPI)

1. Location
2. Quality
3. Severity
4. Duration
5. Context
6. Associated
7. Modifying Factors
8. Signs & Symptoms

REVIEW OF SYSTEMS (ROS)

1. Constitutional
2. Eyes
3. ENT
4. Cardiovascular
5. Respiratory
6. GI
7. GU
8. Musculoskeletal
9. Integumentary
10. Neurologic
11. Psychiatric
12. Endocrine
13. Hematological/ Lymphatic
14. Allergic / Immunologic

PAST,FAMILY,SOCIAL HISTORY (PFSH)

1. Past History
2. Family
3. Social

EXAM COMPONENT

BODY AREAS

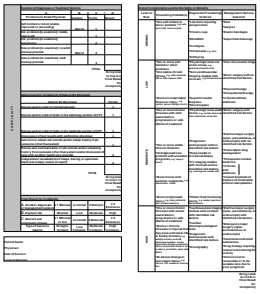
1. Head
2. Neck
3. Chest
4. Abdomen
5. Genitalia
6. Back
7. Each Extremity

ORGAN SYSTEMS

1. Constitutional
2. Eyes
3. ENT
4. Cardiovascular
5. Respiratory
6. GI
7. GU
8. Musculoskeletal
9. Skin
10. Neurologic
11. Psychiatric
12. Hematologic - Immunologic - Lymphatic

Patient History	99201	99202	99203	99204	99205	99212	99213	99214	99215
Brief CC/HPI: 1-3 HPI Elements	1-3	1-3				1-3	1-3	4+	4+
Extended CC/HPI: 4+ HPI Elements			4+	4+	4+				
Problem Pertinent ROS: 1 System		1					1		
Expanded ROS: 2-9 Systems			2-9					2-9	
Complete ROS: 10 (+) Systems				10+	10+				10+
Pertinent PFSH: 1 Element			1					1	
Complete PFSH: 2 or 3 Elements Established; 3 Elements New Patient				3	3				2-3
Examination									
Problem Focused: 1 body area or system examined	1					1			
Expanded Problem Focused: 2 to 4 body areas or systems Examined		2-4					2-4		
Detailed: 5 to 7 body areas or systems examined			5-7					5-7	
Comprehensive: 8 body areas or systems examined				8	8				8
Medical Decision Making									
Straightforward Minimal # of DX or Management Options Considered Minimal, If Any, Documentation Needed, Reviewed or Analyzed One Self-Limited or Minor Problem	x	x				x			
Low Complexity Limited # of Diagnoses or Management Options Limited Tests and Documentation Reviewed or Analyzed One or two chronic illnesses with mild exacerbation, One Stable Chronic Illness. Acute Uncomplicated Illness or Injury			x				x		
Moderate Complexity Multiple Diagnoses or Management Options Moderate Tests and Documentation One or more chronic illnesses with mild exacerbation or progression. Two or more stable chronic illnesses. Undiagnosed New Problem				x				x	
High Complexity Extensive # of Diagnoses or Management Options Considered Extensive tests and Documentation Reviewed or Analyzed One or More Chronic Illnesses with Severe Exacerbation Progression or Severe Side Effects of Treatment. Acute or Chronic Illness that is a threat to Life or bodily function. An Abrupt chane in neurologic status					x				x

Free Audit Tool



HIGHMARK. West Virginia

E/M DOCUMENTATION AUDITORS' WORKSHEET
1997 Guidelines

Member Last Name or Identifying Number

Provider Name

Date of Service

Procedure Code(s) Reported

HCC_____

Auditor Agree
Auditor Disagree

Code Assigned by Auditor

Record Audited by: Date

History

E/M Audit Form

Chart #: _____

Patient Name: _____ Date of service: ___ / ___ / ___ Provider: _____ MR #: _____

Place of Service: _____ Service Type: _____ Insurance Carrier: _____

Code (s) selected: _____ Code(s) audited: _____ Done Denied Correct Miscoded

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

PFSH Form reviewed, no change PFSH form reviewed, updated PFSH form new

**Extended HPI=Status of 3 chronic illnesses with 1997 DG. Some allow for 1998 as well.

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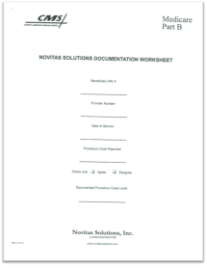
Novitas Audit Form



CMS

Medicare Part B

NOVITAS SOLUTIONS DOCUMENTATION WORKSHEET

Beneficiary HICN

Provider Number

Date of Service

Protective Code Reviewer

Check one: Agree Disagree

Documented Procedure Code Level

Novitas Solutions, Inc.

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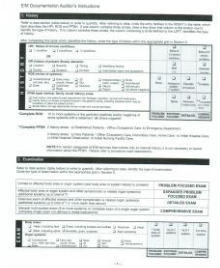
Novitas



E/M Documentation Auditor's Instructions

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Trailblazers

- 3 MEDICAL DECISION-MAKING (continued)

Determine total points for each diagnosis or problem and associated management options using Tables A.1 and A.2. Use the larger of the two "Totals" for Section D. Final Assignment of Medical Decision Making Type.

Table A.1 Number of Diagnoses

A "problem" is defined as definitive diagnosis or, for undiagnosed problems, a related group of presenting symptoms and/or clinical findings.		Points
Each new or established problem for which the diagnosis and/or treatment plan is evident with or without diagnostic confirmation		1
Each new or established problem for which the diagnosis and/or treatment plan is not evident:	2 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record; requiring diagnostic evaluation or confirmation	2
	3 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record; requiring diagnostic evaluation or confirmation	3
	4 or more plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record; requiring diagnostic evaluation or confirmation	4
Total Points		

Table A.2 Management Options

Important Note:	These tables are not all inclusive. The entries are examples of commonly prescribed treatments and the point values are illustrative of their intended quantifications. Many other treatments exist and should be counted when documented.	Points
Do not count as treatment option's notations such as: Continue "same" therapy or "no change" in therapy (including drug management) if specified therapy is not described (record does not document what the current therapy is nor that the physician reviewed it)		0
Drug management, per problem. Includes "same" therapy or "no change" in therapy if specified therapy is described (i.e., record documents what the current therapy is and that the physician reviewed it). Prescription of current medications are not required, however, the record must reflect conscious decision-making to make no dose changes in order to count for coding purposes	≤2 new or current medications per problem	1
	>2 new or current medications per problem	2
Open or percutaneous therapeutic cardiac, surgical or radiological procedure; minor or major		1
Physical, occupational or speech therapy or other manipulation		1
Closed treatment for fracture or dislocation		1
IV fluid or fluid component replacement, or establish IV access when record is clear that such involved physician decision-making and was not standard facility "protocol"		1
Complex insulin prescription (OC or combo of SC/IH), hyperalimentation, insulin drip or other complex IV admix prescription		2
Conservative measures such as rest, ice/heat, specific diet, etc.		1
Radiation therapy		1
Joint, body cavity, soft tissue, etc injection/aspiration		1
Patient education regarding self or home care		1
Decision to admit to hospital		1
Discuss case with other physician		1
Other		1
	Total Points	

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Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.) Do not categorize the problem(s) if the encounter is dominated by counseling/coordinating of care, and duration of time is not specified. In that case, enter 3 in the total box.

MAKING

Number of Diagnoses 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 additional workup planned	Max = 1		3	
	New prob. (to examiner); add. workup planned			4	
				TOTAL	

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.

Bring total to **line A** in Final Result for Complexity (table below).

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Reports

- Educate to the problems with effective solutions
- Be certain to cover areas of dispute
- Medical necessity should be included

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Audit Report Example

Audit #	MD	PT INIT	DOS	INS	CPT Assigned by MD	DX Assigned by MD	Mod. Assigned by MD	CPT Auditor	Dx Auditor	Mod.	Agree/ Disagree Y/N	Refun dY/N	Comments
1		C, K	6/13/12	AmeriGroup	99213	034.0, 382.9, 684	GE	99213	034.0, 382.9, 684	GE	Y	N	Teaching attestation excellent for primary care exception purposes. Does not indicate TP performed key components, so you must default to 99213-GE. Could have been 99214.
					87880	034.0, 382.9, 684	N/A	87880	034.0, 382.9, 684	N/A	Y	N	Agree
2		C, S	6/5/12	AmeriGroup	99213	300.4, 311	GE	99213	300.4, 311	GE	Y	N	TP supervision attestation is excellent for primary care exception. Does not indicate TP performed key components, so must default to 99213. Could have been 99214 based on amt of work documented and performed
					85027	300.4, 311	N/A	85027	300.4, 311	N/A	Y	N	Agree
3		F, D	6/13/12	UHC	99203	879.5, 305.1	GE	99203	879.5, 305.1	GE	Y	N	Agree. Patient presenting as follow-up to ER visit. New patient
4		L, J	6/22/12	Medical Mutual of Ohio	99203	V70.0	N/A	99202	V70.0	GE	N	Y	Over coded 1 level d/t SF MDM. No T/P attestation statement.

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Audit Report Example

Patient ID	Provider initials	Date of service	Procedure codes from superbill	Procedure codes from patient account	Procedures documented in medical record	Procedures provided but not billed	Allowed charges for all procedures	Date and amount paid by insurance	Lost revenue	Need explanation of benefits?	Notes
1	BAN	5/8/2008	99213	None	Office visit	99213	$ 85	None	$ 85	No	Charge never entered
2	JAL	5/8/2008	Not found	None	New patient visit, quick strep test	99203 87880	$ 128	None	$ 128	No	Lost superbill
3	BAN	5/8/2008	99396 82270 90718	Same	Same, plus vaccine administration	90471	$ 168	$143 on 5/28/2008	$ 25	No	Service provided but not billed
4	BAN	5/8/2008	99214 17000	Same	Same	None	$ 210	$125 on 5/24/2008	$ 85	Yes	Two problems addressed, two diagnoses. No modifier 25 on E/M. Never resubmitted
5	DNA	5/8/2008	99214	Same	Same	None	$ 125	None	$ 125	Yes	Ineligible provider
6	BAN	5/8/2008	99213	Same	Same, plus wet mount and KOH prep	87210 87220	$ 85	$57 on 5/24/2008	$ 28	No	Services provided but not billed

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Audit Score Card

			E/M Audit/Documentation Results												
Physician	Records Reviewed	Total # E/Ms audited	# E/Ms Overcoded	Over Coding Error%	# E/Ms Undercoded	Under Coding Error%	# Missing Documentation (FF E/M)	% Missing Documentation (FF E/M)	Insuff T/P statement	% Insuff T/P statement	Composite Score	Composite Target	Goal	Reaudit Target
MD Name	18	18	1	6%	6	33%	0	0%	4	22%	61%	%	90%	
MD Name	21	20	2	10%	0	0%	3	15%	1	5%	90%	%	90%	
MD Name	19	19	1	5%	4	21%	4	21%	N/A	N/A	74%	%	90%	
MD Name	20	21	2	10%	3	14%	5	24%	4	19%	76%	%	90%	
MD Name	24	23	2	9%	8	35%	1	4%	2	9%	56%	%	90%	
MD Name	17	14	7	50%	1	7%	0	0%	N/A	N/A	43%	%	90%	
MD Name	20	20	4	20%	8	40%	0	0%	4	20%	40%	%	90%	
MD Name	12	14	1	7%	6	43%	2	14%	N/A	N/A	50%	%	90%	
MD Name	25	0	0	N/A	0	N/A	1	N/A	N/A	N/A	N/A	%	90%	
MD Name	20	20	2	10%	5	25%	1	5%	1	5%	65%	%	90%	

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Surgery Audit

	CPT Procedure Audit Results							
Physician	Records Reviewed	Total # CPTs audited	Incorrect/Missed CPT Code	CPT Error %	# Missing Documentation (FF CPT)	% Missing Documentation (FF CPT)	Composite Score	Goal
MD Name	18	16	0	0%	0	0%	100%	90%
MD Name	21	15	13	87%	0	0%	13%	90%
MD Name	19	16	6	38%	0	0%	62%	90%
MD Name	20	21	17	81%	0	0%	19%	90%
MD Name	24	12	2	17%	1	8%	83%	90%
MD Name	17	8	2	25%	0	0%	75%	90%
MD Name	20	22	1	5%	0	0%	95%	90%
MD Name	12	0	0	N/A	0	N/A	N/A	90%
MD Name	25	34	9	26%	0	0%	74%	90%
MD Name	20	28	27	96%	0	24%	4%	90%
MD Name	23	20	1	5%	1	5%	95%	90%
MD Name	15	27	0	0%	5	19%	100%	90%
MD Name	22	23	5	22%	1	4%	78%	90%
MD Name	16	10	0	0%	0	0%	100%	90%
MD Name	21	15	15	100%	0	0%	0%	90%
MD Name	22	20	3	15%	1	5%	85%	90%
MD Name	19	21	1	5%	1	5%	95%	90%

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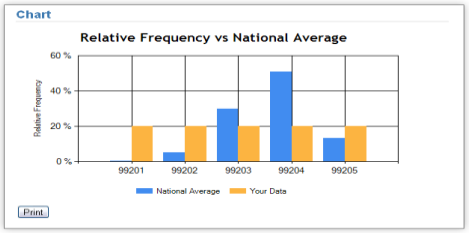
Do your audit results look like this?
Code Frequency vs. National Averages



Benchmarking

New Patient Office Visits –

99201 New Patient - Focused *
99202 New Patient - Expanded * 99203
New Patient - Detailed *
99204 New Patient - Comprehensive *
99205 New Patient - Complex *

Office Visits – Established -

99211 Est Patient - Minimal *
99212 Est Patient - Focused *
99213 Est Patient - Expanded *
99214 Est Patient - Detailed *
99215 Est Patient - Comprehensive *

- No of Svcs. (12 Month Period)
- No of Svcs. (12 Month Period)

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Example Executive Summary

MEMORANDUM

To:
From:
Date May 6, 2013
Re:

This report contains the findings and recommendations from the recently completed documentation review of services performed by residents and attendings in the _____.

EXECUTIVE SUMMARY

_____was tasked with reviewing the Part B documentation and coding performed in the teaching clinic for _____. This review is an expanded review resulting from the findings dated February 17, 2013. The focus of this review is to confirm the accuracy of the service level, diagnosis coding and conformity with the Centers for Medicare and Medicaid Services regulations and guidance.

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Example Exec Summary

A review of a random sample of encounters to assess the quality of medical record documentation and the coding processes was performed. The review was based on claims for services rendered between December 1, 2012 and December 31, 2012. The encounters selected primarily represented Medicare/Medicaid claims and all services were reviewed under the Medicare requirements for Physicians in Teaching Settings. A total of 150 encounters were examined for this review.

- Residents completing less than six months experience in an approved GME Residency Program.
- List CMS or other authoritative body used in audit. Medicare Claims Processing Manual, Part3, Section 15016, Section C.3 indicates: *Under the primary care exception residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least six month of a GME approved residency program.*
- Cite regs: The teaching physician may not supervise more than four residents at any given time. The schedule is compliant *on paper*. CMS regulations permit residents with less than six months of training in the group of four with the understanding that there must be physical involvement by the teaching physician.
- Give status of audit in bullets: Visit type and patient status - New patient visits are consistently documented as established. This appears to be an EMR issue which should be addressed.
- Overall the documentation provides a clear indication of the encounter to include medical necessity and outcomes. Opportunities for improvement exist in the following areas:

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Audit Conclusion

- What are the issues
- Make certain notate positive as well as negative findings on audit reports
- Trend the data – benchmark against specialty providers
- Educate, educate, educate

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Audit Conclusion

- Over codes or force fails – return $$ within 60 days, if possible
- Look at practice policies and processes
- Refile claims as needed
- Ongoing monitoring – especially based on audit score: again policy in place

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Resources

- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1204.pdf
- Medicare Fee-for-Service national error rate can be found at www.cms.gov/cert.
- Novitas: www.novitassolutions.com
- www.cms.gov/cert
- **RAC**@cms.hhs.gov
- http://www.aafp.org/fpm/2009/0300/p15.html#fpm20090300p15-bt3
- Practical E/M: Documentation and Coding Solutions for Quality Patient Care, Stephen Levinson, MD 2006, AMA Press; isbn #1-57947-746-1
- Susan E. Garrison, President, AHCAE, 2007 E/M Audit tool: seg@magnmusconfidential.com
- https://oig.hhs.gov/oei/reports/oei-04-10-00180.asp

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Thank You!

Lynn Pascoe, CHCA, CPC, CEMC, CPC-I, CPCO, PCS, CCP

Innovative Medical Practices, LLP

Office: 410-859-5757

Mobile: 443-822-0519

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