Surgical Chart Auditing

Presented by:
Rhonda Buckholtz, CPC, CPC-I, CPMA, CGSC, CENTC, COBGC, CPEDC

Agenda

• Introduction to the Audit Process
• Minor vs. Major Surgical Procedures
• The Global Surgical Package Concept Refresher
• Assessing the Diagnosis Code(s) for Support and Medical Necessity
• Making Sense of the Results
  – Evaluating and Rating the Surgical or Medical Document
  – Reporting the Findings
  – Interactive Auditing Session
20 Years Ago . . .

- Medical record was only seen by the physician and staff
- 1970s saw an increase in medical malpractice claims
- Defending malpractice cases depends upon the presence of clear, concise, and legible documentation

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- Strengthened existing fraud and abuse laws
- Increased civil penalties from $2,000 to $10,000 per item or service
- Established formal links between government programs and private insurers
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- Added practices to the list of those subject to penalties
  - Coding errors are now considered to be fraud if the provider acted in “reckless disregard”
  - Reckless disregard includes not being familiar with current CPT® and ICD-9-CM

What Are Payers Looking For?

- The 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.
Question . . .

• The documentation maze . . What are payers looking for?

What Is Documentation?

• A record of pertinent facts, findings, and observations about an individual’s health history including past and present illnesses, examinations, tests, treatments, and outcomes.
• Documents the care of the patient and is an important element contributing to high quality care.
What Are Payers Looking For?

- Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided.
  - Site of service
  - Medical necessity and appropriateness of services
  - Services have been accurately reported

What Are Payers Looking For?

- The nature and amount of physician work and documentation varies by type of service, place of service, and the patient’s status.
- Diagnosis code supports medical necessity.
Coding Based on Standard of Surgical Practice

- Accurately translating surgical and medical services into CPT® and ICD-9-CM codes is challenging.
- Knowledge of procedural and diagnostic rules, as well as a background in medical terminology, is needed.
- Specific knowledge of the procedure and services performed by the physician is vital in assigning the proper CPT® codes.
- In order to accurately audit the surgical medical record, the auditor must have a good understanding of surgical terminology and anatomy.

Coding Based on Standard of Surgical Practice

- The auditor must also understand the surgery coding guidelines, insurance carrier rules, Correct Coding Initiative (CCI) edits, and how to code an operative report.
- Many insurance carriers monitor a physician’s billing practices closely for possible inappropriate billing and/or unbundling. It is essential that the coding description accurately describe what actually transpired during the patient encounter.
Examples of What’s Included

• Cleansing, shaving, and prepping of skin
• Draping of patient
• Positioning the patient
• Insertion of intravenous access for medication (IV)
• Administration of sedative by the physician performing the procedure
• Local infiltration of medication – topical, or regional anesthetic administered by the physician performing the procedure
• Surgical approach, including identification of landmarks, incision, and evaluation of the surgical field
• Exploration of operative area
• Fulguration of bleeding points
• Simple debridement of traumatized tissue
• Lysis of a moderate amount of adhesions
• Isolation of neurovascular tissue or muscular, bony, or other structures limiting access to surgical field

Examples of What’s Included

• Surgical cultures
• Wound irrigation
• Insertion and removal of drains, suction devices, dressings, pumps into same site
• Surgical closure
• Application and removal of postoperative dressings including analgesic devices
• Applications of splints with musculoskeletal procedures
• Institution of patient – controlled analgesia
• Photographs, drawings, dictation, transcription to document the services provided
• Surgical supplies
AMA Surgery Guidelines

• Global Surgery Package: What’s Included?
• Often, the time, effort, and services rendered when accomplishing a procedure are bundled together to form a surgery package.
• Payment is made for a package of services and not for each individual service provided within the package.

AMA Surgery Guidelines

• The CPT® manual describes the surgery package as including:
  – Subsequent to the decision for surgery, one E/M visit on the date immediately prior to or on the date of the procedure (including history and physical).
  – Local anesthesia: defined as local infiltration, metacarpal/digital block, or topical anesthesia.
  – The operation itself.
  – Immediate post-operative care, including dictation of operative notes, talking with family and other physicians.
  – Writing orders.
  – Evaluation of patient in post-anesthesia recovery
  – Normal, TYPICAL follow-up care.
Global Surgery

Period of time following surgery which included

– A pre-defined number of days before and after surgery
– Normally 0-90 days
  • Depending on carrier
– Minor procedures (*) have 0 global days

National Correct Coding Initiative

• 1996 CMS implemented this National Policy
  – Aimed at controlling improper coding and billing practices of Part B claims
  – Many third party payers rely on CCI for implementing policy
  – CCI published quarterly
  – Reviews coding combinations and implements correct code edits
National Correct Coding Initiative

- Code combinations in 2 categories
  - Mutually exclusive
    - Denies combination that should not be separately reported based on standards of medical practice
    - If necessary to report modifier 59 should be appended
  - Modifier 59 reviewed by CMS when claims are submitted for these code pairs that are normally prohibited

Unbundling

- Similar to coding an incidental procedure
- Unbundling can result from two problems:
  1. Unintentional - results from not having a good understanding of coding.
  2. Intentional - when practitioners manipulate the coding to maximize payment.
Unbundling Prevention

- Use current code books
- Educate yourself on:
  - CPT® guidelines
  - HIPAA
  - NCCI
  - Insurance Carrier Regulations
  - When using charge tickets for coding - be specific
  - Code directly from operative note or chart note
  - Update codes annually
    - ICD-9-CM October
    - CPT® January

Unbundling Prevention

- Avoid fragmented billing
- Make sure physicians provide complete information and documentation
- Use modifiers correctly
- Use caution
Separate Procedures

• Some of the procedures or services listed in CPT® that are commonly carried out as a part of a total service or procedure are indicated by the inclusion of the term “separate procedure”
• Should not be reported in addition to the code for the total procedure or service if considered an integral component if carried out independent or considered unrelated or distinct from other procedures/services provided, may bill separately

Separate Procedures

• If separate procedure is reported use modifier 59 if not a component of the more extensive procedure
• Examples of separate procedure:
  – Different session or patient encounter
  – Different procedure or surgery
  – Different site or organ system
  – Separate incision or excision
  – Separate lesion
  – Separate injury (or area of injury in the case of extensive injuries)
Medicare Surgery Guidelines

• Minor surgical procedure
  – 0-10 global days
  – Payment includes:
    • Same day service
      – Preoperative
      – Intraoperative
      – Postoperative

Medicare Surgery Guidelines

• Major procedures:
  – Preoperative visits beginning with the day before the day of surgery.
  – Intraoperative services that are normally a usual and necessary part of a surgical procedure.
  – All additional medical or surgical services required of the physician within 90 days of the surgery because of complications which do not require additional trips to the operating room.
  – Related follow-up visits made within the 90 day postoperative period.
  – Post surgical pain management by the surgeon.
  – Any related supplies, services, procedures normally required for the particular surgery.
Surgery Auditing

Procedure Indications

What is the Surgery?

What is Diagnosis?
- Link dx to procedure
- Does dx support medical necessity for surgery?
- Can one diagnosis support multiple surgeries
- Can have multiple supporting single surgery
- Include anatomic location in diagnosis
- Indicate if uni/bilateral
- Relevant tests/results
- Anesthesia (risk considerations)
- If evaluation is performed in other P.O.S., obtain copy or at least note date and results
Clinical Indication

- Establish medical necessity
- Context for multiple procedures, repeats, staged, etc.
- Why procedure must be performed
- Goal
- Unusual circumstances
- Justify co/team surgery

Procedure Narrative

- Consent
- Anesthesia indication
- Positioning
- On-site prep
- Location of incision or scope introduction
- Location of problem
- Treatment
- Description of difficulty, unused time, etc.
- No jargon, define eponyms/abbreviations
- Specify type and placement of device, graft, prosthesis, implant, closure
How to Code from the Operative Note

- Check for the pre-operative and post-operative procedure & diagnosis
- Read entire note carefully
- Understand anatomy & terminology
- Use CPT® index as your guide
- Read all guidelines & notes that pertain to the category from which you are coding
- Code only procedures performed based on note
- Follow CPT® and ICD-9-CM coding guidelines
- Follow specific carrier guidelines

Steps In Reviewing Surgery Cases

1. Scope of Review (What will you review)
2. Dates of Service
3. Review pertinent information
4. Report Findings
5. Educate!!!
Audit Packet

• Section 1
  – Scope of work
  – Project leader
  – Project staffing

• Section 2
  – Data request
  – Schedule of events
  – Audit form options
  – Audit walk through
  – Risks
  – Reporting methodology
    • Scope
    • Objectives
    • General findings
    • Specific findings
    • Accuracy
    • Supporting documentation/calculations

Audit Packet

• Section 3
  – Training sheet
  – Follow up on claim adjustments
Project Management

- SCOPE
  - Risks
    - Make it clear up front
    - Discuss liability issues
    - Commitment vs. resistance
    - Forms of resistance
      - Interruptions
      - Silence
      - Challenge
      - Denial

Scope Conceptually
Documentation

• Limit scope for important documentation issues
  – Risk areas
• Does it impact compliance or reimbursement?
• Document audit and results

General Documentation

• Dated
• Patient Name
• Complete
• Signed Authenticated
• Time, if applicable
• Clear
• Concise
• Legible
• Illustrations
• Pen (black)

• Make entries continuous
• Logical
• Segment MD from other clinicians
• Standardize nomenclature
• Double check for right patient
• Avoid Vagueness
• Avoid Canned Notes
• Prompt entries
Coding

• Was it coded to the level of specificity required?
• Does it meet medical necessity or payor guidelines
• Have surgical package definitions and CCI been followed?

Billing

• Was it billed as coded?
• Were appropriate modifiers added?
• Timely filing met?
Reimbursement

- Review the EOB
  - Were you paid for what was submitted?
  - Were denials followed up on?
  - Did payments reflect contractual amounts?

Steps to Auditing

1. Define Focus
2. Identify claims
3. Handle Logistics
4. Record Review
5. Report/findings
6. Educate
7. Ongoing monitoring
Pre-audit

- Define focus
  - Why
  - Who
  - What
- Identify Claims
  - Payer
  - Date
  - Type
    - Patient
    - Service
    - Combination
- Handle Logistics
  - Policies/procedures
  - Onsite vs. offsite
  - Confidentiality
  - Coordinator
  - Process
  - Sample size
- OTHERS?

Intra-audit Record Review

- Documentation
- Coding
- Billing
- A/R Management
- General Consideration
  - Correct CPT® codes
  - DX/procedures
  - Surgeries
  - Incorrect CPT® codes
  - Unbundling
  - Invalid codes
  - Undercoding
  - Other issues
  - Signature requirements
Post Audit

• Report of findings
  – Oral vs. written
  – To whom
  – Disclosure
  – Corrections
  – Formal vs. Informal
• Education
  – Needs assessment
  – Coaching vs. Training vs. Lecture
  – Who/Whom
    • To training
    • Does training

– Evaluation
– Ongoing
  • Schedule
  • Prioritize
  • Redefine Focus

Audit Form Suggestions
Questions to ask:

• Software
• Flexible form
• Easy to understand
• Learning curve
• Easy of use
• Objective scoring method
• Include all issues
• Can additional content be added (flexible)
• Free to use
• Guidelines
• Training enhancement of use
Reporting Results

Chart Review Guidelines

• Tell whole story
• Don’t abbreviate
• Document where you found information to record findings
• Reference official resources
• Indicate opinion vs. fact
• Indicate which codes were wrong and how they should be changed
Data

- Audit
- Schedule
- Patient Record
- Forms
- EOB/RA

Reporting

- Format
- Include all reviewed charts
- Comprehensive analysis
- Achieve uniform level of statistical significance
- Cost considerations
- Accuracy rates
- Coding
- Billing
- Documentation
- Revenue cycle
- A/R Management
- Trends
Sample Report

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>A54</td>
<td>4/10/2010</td>
<td>1</td>
<td>99214</td>
<td>99213</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>E22</td>
<td>2/10/2010</td>
<td>1</td>
<td>99215</td>
<td>99214</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Sample Report

![Bar chart showing percentages of Over Paid EM, Under Paid EM, ICD-9 Error, and CPT Error]

52
Sample Report

Chart Review Detail

- Total charts reviewed
- Charts with coding changes
  - CPT®
  - ICD-9-CM
  - Modifier additions/changes
  - Coding Accuracy rates
  - Breakdown of code changes
  - Reasons for change
    - Have documented directives in hand
Trending

• What is Trending?
  – Statistical findings from initial review
  – Comparison of current findings from subsequent reviews
  – Analyzing to see:
    • Where improvement is made
    • Where no improvement is made
    • When new issues emerge
    • What training needs are necessary

Trending

• Why Trend?
  • Provides accountability
    – Leadership with snapshot data
      • Helps refocus future work (audits and training)
Pre-op

- HISTORY
  - Allergies
  - Reactions
  - Current Medications
  - Informed Consent

- PRE-OP EXAM
  - Operative site evaluation
  - Vitals
  - General Condition
  - Heart/lungs
  - Other Pertinent
  - Other information

Clinical Indication

- Establish medical necessity
- Context for multiple procedures, repeats, staged, etc.
- Why procedure must be performed
- Goal
- Unusual circumstances
- Justify co/team surgery
Procedure Narrative

- Consent
- Anesthesia indication
- Positioning
- On site prep
- Location of incision or scope introduction
- Location of problem
- Treatment
- Description of difficulty, unused time, etc.
- No jargon, define eponyms/abbreviations
- Specify type and placement of device, graft, prosthesis, implant, closure

Validating from an Operative Report

- Copy the note, if possible
- Title versus text
- Underline/highlight important information
- Use medical references for unfamiliar terms
- Cross out non-coding related documentation
- CPT® code underlined notes
- Check bundling issues
- Sequence
- Apply necessary modifiers
Case Examples

• Case Example 1 – Please refer to the downloadable slide packet for case information.

Case Examples

• Case example 2 – Please refer to the downloadable slide packet for case information.
Case Examples

• Surgical Case 3 – Please refer to the downloadable slide packet for case information.

Conclusion

• Remember to look at global picture
• Don’t forget regulations outside the coding arena
• Report and communicate
Case 1: Surgical Auditing

PREOPERATIVE DIAGNOSIS: Ventral incisional hernia

POSTOPERATIVE DIAGNOSIS: Ventral incisional hernia

OPERATIVE PROCEDURE: Ventral herniorrhaphy

INDICATIONS: The patient is a 68-year-old white female referred to our office with a history of upper abdominal discomfort and pain with certain types of movements due to what she describes as a large mass of her anterior abdominal wall. Upon evaluation in the office and review of her CT scan, it appeared as though she had a large ventral incisional hernia in the epigastric midline just superior to the umbilicus. Repair was recommended to her. She appears to understand the risks, rationale, expected outcome, typical postoperative course, and is willing to proceed as outlined.

PROCEDURE: The patient was placed on the operating room table in the supine position under satisfactory general endotracheal anesthesia. The skin of the abdomen was prepped and draped in the usual sterile fashion. Attention was turned to the midline hernia and an ellipse of skin was excised over the hernia, deepened down through the subcutaneous tissue. There was actually a very large fatty sac and the hernia defect was actually relatively small, being roughly 4 to 5cm in length. However there was very poor quality tissue on all sides of the defect, with very thin linea alba superior and inferior to the defect. It was decided at this point to reinforce this area of the anterior abdominal wall and therefore the rectus sheath was opened at is medial most aspect on both sides of the midline. The posterior rectus sheath was then sutured from side to side to itself to close the midline defect. This was done for roughly two-thirds of the distance from the umbilicus to the xiphoid process. Then a medium size Kugel patch was placed posterior to the rectus muscles and secured in place with suture of 0 Vicryl. At this point, the anterior rectus fascia and the rectus muscle were then closed over the Kugel patch with multiple interrupted Figure-of-Eight sutures of #1 Vicryl. The mesh was then unable to be seen as it was located within this somewhat of a “sandwich” of tissue of the anterior abdominal wall. At this point then, the subcutaneous tissue was examined. There was found to be an excess of midline skin, which was then excised. The subcutaneous tissues were then closed with multiple interrupted sutures of 0 Vicryl and the skin was closed with a continuous running subcuticular closure of 3-0 Monocryl. Dry gauze dressing was applied to the wound, secured with Cover-Roll, and a Flexitone binder was placed on the anterior abdominal wall as well. At this point, the procedure was terminated. The patient was transferred to the recovery area in stable condition. Estimated blood loss 125cc. Sponge and needle counts were correct times two.
Surgical Case 2

Sex: M  Age: 44 years

Subjective CC: Months overdue for care. Lone afib last winter treated with Cardizem.
HPI: No chest pain or SOB. Doesn't feel irreg beats. Smoking 1 1/2-2 ppd and doesn't feel he can try to quit. Recently 8 beers /day.

ROS:
Const: Denies chills, fatigue, fever and weight change. General health stated as good.
CV: Denies chest pain and palpitations.
Reap: Denies cough, dyspnea and wheezing.
GI: Denies constipation, diarrhea, dyspepsia, dysphagia, hematochezia, melena, nausea and vomiting.
GU: Urinary: denies dysuria, frequency, hematuria, incontinence, nocturia and urgency.
Musculo: Denies arthralgias and myalgia.
Skin: Denies rashes.
Neuro: Denies neurologic symptoms.
Psych: Denies symptoms other than stated above.
Current Meds:
Allergies: NKDA

PMH:
Health Maintenance:
Physical Exam-(1982)
Eye Exam - (2006)
Dental - (2005)
Childhood Illnesses:
Chickenpox, Measles, Mumps, Pertussis, Pneumonia
Medical Problems:
Atrial Fibrillation - (2008) one lone episode
Hypertension, Tobacco Abuse, Alcohol Abuse, Hypercholesterolemia, Hyperlipidemia, Tobacco Abuse,
Surgeries:
Tonsillectomy
Reviewed and updated.

FH:
Father: Deceased due to Lung Cancer.
Mother: Deceased due to Diabetes - complications.
Reviewed and updated.

SH: Highest level of education completed is 12th grade. Marital status: married. Lives with spouse. The home is not smoke free. Household pets include 3 cats and a dog. Patient is right-handed. The patient does not have an advance directive.
Personal Habits: Cigarette Use: Current Cigarette Smoker 2 Packs Daily. Alcohol: Patient has been sober for 5 months now - quit 9/3/08. Daily Caffeine: Consumes on average 3 cups of coffee per day.
Reviewed and updated Dr. Smith
Surgical Case 3

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Acute cholecystitis

POSTOPERATIVE DIAGNOSIS: Acute cholecystitis

OPERATIVE PROCEDURE: Laparoscopic cholecystectomy

ANESTHESIA: General endotracheal

INDICATIONS FOR SURGERY:
The patient is a 40-year-old woman who was admitted to the hospital today with 56 hours of right upper quadrant pain. On exam she was tender in her right upper quadrant. Gallstones were identified. White blood cell count was elevated. Liver tests were normal. I recommended admission, IV antibiotics, and a laparoscopic cholecystectomy. The procedure was reviewed with the patient and consent was provided.

PROCEDURE:

After the patient was given an adequate general endotracheal anesthetic, she was prepped and draped in the sterile fashion. An infraumbilical incision was made and the fascia was opened under direct vision. A #1 PDS purse-string stitch was placed. The infraumbilical port was inserted and pneumoperitoneum was established. An epigastric incision was made and the fascia was opened under vision. The epigastric port was placed under direct laparoscopic vision. Finally, two lateral 5mm ports were inserted. We identified the gallbladder and the gallbladder was tensely distended and the wall thickened. The gallbladder was not able to be grasped with a laparoscopic grasper. We placed a trocar in the gallbladder and we were only able to drain a small amount of very thick brown bile. The bile appeared almost hemorrhagic.

After being unable to decompress the gallbladder, we made an attempt to perform a laparoscopic cholecystectomy. We dissected out the fundus of the gallbladder and were unable to clearly identify the cystic duct. The chronic inflammation was to the point that the structures did not separate very well at all. At this point I felt that it would be unsafe to persist in an attempt in a laparoscopic cholecystectomy. We converted to open surgery.

After performing a midline upper abdominal laparotomy, the gallbladder was elevated with a Kocher clamp. We dissected the gallbladder out of the gallbladder bed bluntly. This led us down to the cystic duct and cystic artery. The cystic artery was separated and divided with clips. The cystic duct was identified and we had trouble actually seeing the cystic duct. A right angle clamp was placed on the cystic duct and the gallbladder was transected and removed. When the gallbladder was out of the way, we were able to see the cystic duct better and we performed a cholangiography. The first attempt of the cholangiogram was not successful. We elevated that area and partially transected the duct further towards the common bile duct. At this point we were able to get the cholangiogram catheter and cholangiography with C-arm was performed and this showed free flow of contrast into the duodenum with normal bile duct anatomy. There was no evidence of a common bile duct stone.
The cholangiogram catheter was removed and the short cystic duct stump was suture ligated with a 3-0 PDS suture. The gallbladder bed was examined. Hemostasis was complete. The subhepatic space was irrigated and several small stones were removed. We placed a piece of Gelfoam on the open liver bed and a J-VAC in the subhepatic space. It was brought out through the lateral port site. The fascia was closed with a #1 PDS suture in a running fashion. The subcutaneous tissue was irrigated with a pulse irrigator. The skin was closed with subcuticular 3-0 Vicryl. We closed the infraumbilical fascial incision with 0 PDS suture. The skin was also closed with 3-0 Vicryl. Steri-Strips were applied. The patient tolerated the procedure well and was brought to the recovery room in satisfactory condition.

Coded incorrectly as 47562-22