Designing, Implementing and Delivering Physician Audits

Sandy Giangreco Brown, BS, COC, CPC, CPC-I, COBGC, RHIT, CHC, PCS

Kim Huey, MJ, CPC, CPCO, COC CCS-P, PCS, CHC

HCCA Compliance Institute 2020

1

Why Are You Auditing?

PROACTIVE AS PART OF COMPLIANCE PLAN

TO INVESTIGATE A SPECIFIC ISSUE REPORTED

CONCURRENT WITH A PAYER REVIEW

TO RESPOND TO A SUBPOENA

2

Federal False Claims Act

Filing a claim that you knew or should have known was "false" – i.e., codes billed not matching documentation

No proof of specific intent to defraud is required

$10,781.40 - $21,562.80 per claim plus treble damages and paying attorneys fees for whistle blowers

HITECH makes not refunding overpayments within 60 days a false claim

3

3

Questions to Ask

Who codes the services?

Physician

Coder

EMR code generator/E&M leveler

Are there any previous audits on these services/this provider?

Known concerns or suspected concerns from a compliance perspective?

Has there been a compliance issue called in to Anonymous hotline?

4

Scoping out the Audit

Audit scope, defined as the amount of time and documents which are involved in an audit, is an important factor in all auditing. The audit scope, ultimately, establishes how deeply an audit is performed. It can range from simple to complete, including all company documents.

The Strategic CFO - https://strategiccfo.com/audit-scope/

5

Scoping out the Audit

The scope of an audit should be decided upon prior to the signing of an engagement letter or agreement to protect both the entity and the person doing the audit

Failing to clearly define the audit can result in "scope creep" which can then add on not only time but also increase the monetary cost of the audit

Working with management (or the entity requesting the audit) to clearly define the scope of the audit sets realistic expectations of what is being included in audit and what is excluded

6

- Within the scope and engagement letter/agreement to be signed, the tools and/or resources that will be used to perform the audit should be identified
- If utilizing a tool from a particular vendor, identify it by name
- Will there be calculations of revenue variances/differences?

Resources such as CPT© Professional edition for a particular year, especially if performing retrospective review, ICD-10-CM book for identified year(s), CPT© Assistant, AHA Coding Clinic, Medicare or CMS Guidance and applicable Transmittals, Fee Schedules if revenue variance is to be calculated

Tools and Resources?

7

Prospective versus Retrospective

- Prospectively performing review is “pre-bill” which is performed on claims after coding is completed but prior to being submitted to insurance payer
- Completing audits prospectively results in claims being put on hold or suspended until after review has been completed
- Retrospectively performing reviews results in review being performed after claims have been submitted for payment and subsequently paid or denied
- Time frame should be identified - more beneficial to do more real-time to provide education to providers closer to dates of service
- If issues are identified with retrospective claims, those claims should be rebilled as corrected claims

8

Proactive Compliance Audit

Will likely not be a statistically valid random sample

Time frame – may be Prospective or Retrospective

- Prospective:
  - Potential negative impact to Accounts Receivable (AR) if the accounts aren't released in a short time frame
  - Access to the records may delay the review
  - If unable to meet with provider, this could also delay the claims being billed and impact AR
- Retrospective:
  - Errors identified will need to be rebilled
  - Possible effective on physician compensation

How many encounters?

What will be the scope?

9

Scope - Proactive Compliance Audit

- OIG Work Plan
- CERT Issues
- RAC Issues
- Top ten denials for the practice
- Top ten services billed for the practice
- Specific issues brought to your attention

10

10

Time Frame?

The time frame to be reviewed will also depend on the reason for the audit

- Proactive or compliance audit – may be more helpful to choose recent claims – if the purpose is education, better to work with recent visits that the provider may remember – there may have also been changes in documentation patterns
- Audit for a specific problem will need to be for the time frame for which the problem is suspected

If retrospective, determine when provider started if audit will cover a particular time frame: quarter of the year, month or week

11

11

CIA?

Corporate Integrity Agreement

- "Forced" compliance plan when an organization had entered into a settlement for fraud allegations
- Require periodic audits to ensure that the coding/billing problems are resolved
- Requires a 95% accuracy rate by providers

12

12

Choosing the Audit Sample

This will depend on the type of audit

- If there is no specific problem being investigated – 10 encounters per provider for a proactive or compliance audit
  - "Random" sample – one days' visits, first 10 on EOB, etc.
  - Also called a "judgmental" sample – cannot be extrapolated to a larger population since it is not truly random

OIG recommends 5 per provider per federal payer per year

13

13

Choosing the Audit Sample, continued

- If investigating a specific problem, may consider a statistically valid random sample
- Probe sample followed by larger sample with a targeted confidence and precision
  - Probe usually 30, 40, or 50 items
- For self-disclosure, CMS requires that the sampling methodology be reviewed by a statistician or someone with equivalent experience

14

14

Statistically Valid Random Sample

Sampling is choosing a subset of the claims in a provider's universe of claims for the purpose of auditing them. In a random sample, units are selected at random so that the opportunity of every unit being included in the sample is the same

https://accountlearning.com/simple-random-sampling-definition-advantages-disadvantages/

- Allows a reasonable representation of the whole without the time and expense involved in reviewing each claim

https://www.randomizer.org/

https://oig.hhs.gov/compliance/rat-stats/index.asp

15

Will You Review for Medical Necessity?

"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."

- Centers for Medicare & Medicaid Services' manual system, Pub 100-4, Chapter 12, Subsection 30.6.1 A
- "Program Integrity Manual", Pub 100-08, Chapter 3, Section 3.2.3 A.

16

Have you read the back of the CMS-1500 claim form?

"I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were furnished by me, or were furnished incident to my professional services by my employee under my immediate supervision. NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws."

17

Concurrent with Payer Review

Sample will be those records requested by the payer

Review all records or just a portion?

Important that alterations not be made to records during concurrent review

18

Attorney Involvement

If review is done at the request of an attorney, he/she may determine most of the audit criteria – however, remember Attorney-Client Privilege requires:

- Attorney-client relationship and auditor/reviewing must be retained by attorney
- Attorney acting in capacity as attorney
- Communication made in confidence between the attorney and client
- For the purpose of securing legal advice.

Audit could be identified as Attorney Work Product instead

19

Attorney-Client Privilege

Attorney contracts with the auditor/consultant

Report is delivered to the attorney

Communication between the auditor and the client is at the direction of the attorney

Simply marking a report "Attorney-Client Privilege" does not make it protected nor does it function retrospectively to cover the findings which have already been reviewed and documented

20

20

Work-Product Doctrine:

- Documents tangible things – interview memos and notes
- Prepared in anticipation of litigation – temporal and intent
- By or for a party's attorney are protected against discovery unless the party seeking disclosure can demonstrate:
  - Substantial need
  - That it would produce undue hardship without discovery

21

Routine audit reports may not be protected

21

What You Need To Look At

- Documentation of Encounter
- Superbills/Encounter Forms/Charge Capture Documents
- Claim Forms
- EOBs/Remittance Advice
- Payer Policies
- Depending on service audited, may also need to review other documentation –
  - Ex: For incident-to services, you will need to review entire chart for plan of care and ongoing care by supervising physician.

22

22

Questions?

What is an error?

- Just overpayments or any deviation

Prospective or retrospective?

What will be your acceptable error rate?

- CIAs allow 5%
- In other situations, CMS has stated 7%

What will you do with the results?

- Education, follow-up auditing, penalties?

23

23

Gray Areas

Coding, especially evaluation and management coding, is full of gray areas. How will your practice interpret these?

Which components are accepted or mandatory for established patients?

Is “non-contributory” acceptable documentation?

What is a detailed examination under the 1995 CMS Documentation Guidelines?

24

24

EHR Auditing Issues

- Authentication – signatures, dates/times – who did what? (metadata?)
- Contradictions – between HPI and ROS, exam elements
- Wording or grammatical errors/anomalies
- Medically implausible documentation

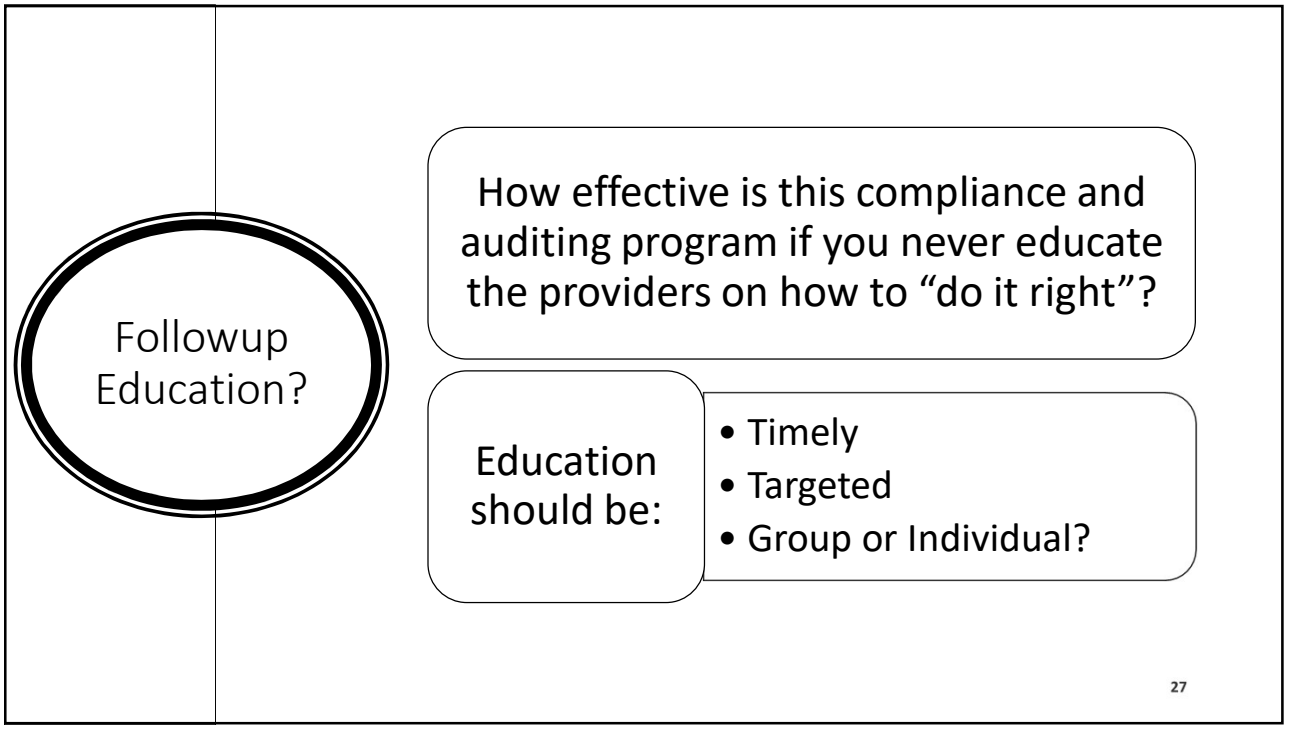
25

25

Audit Results – What do you do with them?

- If Audit was done Prospectively – claims should be billed according to findings of audit – may demonstrate need for further retrospective review
- If performed Retrospectively and claims have been submitted, corrected claims should be resubmitted for changes to codes or payments based on audit findings
- If done as part of Attorney engagement, legal counsel should determine if Self-Disclosure will need to be done and pay back will be done to payer
- Is education part of the followup?

26



27

Who are you reporting the results to?

Provider

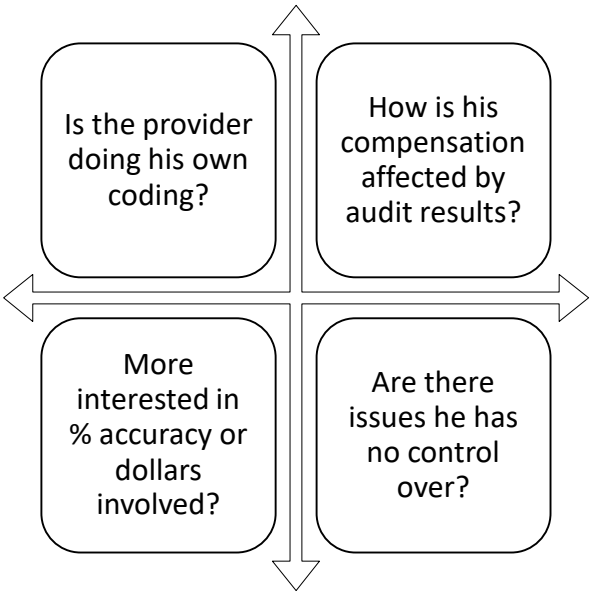
Administration

Compliance Department

Attorney

28

Provider



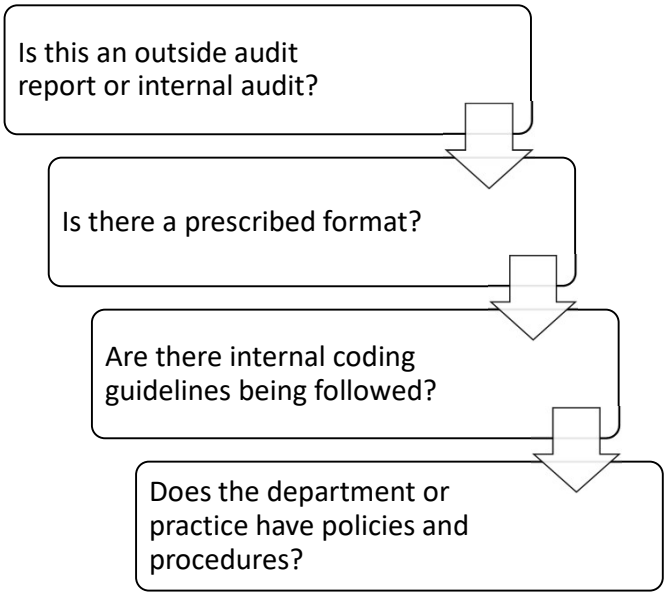
29

Administration

- Financial pressures
- Interested in undercoding and missed opportunities as well as overcoding
- Reminder to refund any overpayments

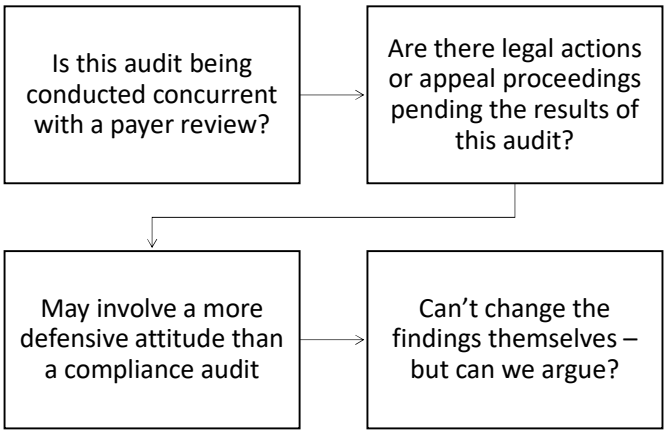
30

Compliance Department



31

Attorney



32

What's included in this audit?

- What are the objectives of the audit?
  - "Accuracy of ICD-10-CM Coding and Reporting Guidelines, CPT/HCPCS codes; modifiers, number of units reported on claim forms and remittance advices to assess if documentation in the medical record & physician orders supports the services billed."
- What is the scope?
- Judgmental sample?
- Truly randomized sample?
  - "The scope of this audit will include a review of a random sample of 10 Medicare/Medicaid encounters for each service line" OR "each provider"

33

What's excluded in this audit?

- Are there certain payers excluded in data sample?
  - Only included Government Payers – Medicare and Medicaid patients
  - Government Railroad
- Are there processes not reviewed in audit?
- "Scope Exclusions: This audit will not include testing of Advanced Beneficiary Notice (ABN) processes and controls, Pharmaceutical/drug code assignment, or claim processing by the facility."

34

When?

Time frame of results?

Do you need to include “DRAFT” in watermark with the date on report until it is finalized to begin the 60 day payback obligation?

What was your time period of your sample?

- “Time period of January 1, 2017 to December 31, 2017”

Is this a retrospective pay back audit for the past 6 years? State the dates included in the review.

35

Where was the audit performed?

This can include details such as “audit was performed remotely” OR interviews occurred while onsite then audit performed remotely OR audit was performed remotely

Location: Was this one hospital or provider clinic or multiple sites?

If multiple sites – list them out

36

How was this audit performed and how is it being reported?

- Both 1995 and 1997 Documentation Guidelines for E&M services?
- Specific MAC or commercial payer criteria used?
- Was a software utilized?
- Excel spreadsheet with results?
- Narrative report?
- Charts with graphs?

37

Why was this audit performed?

- Was this done due to a potential compliance risk that was identified?
  - How was this identified?
- Is the audit being done due to bell curve analysis identifying providers who are outliers?
- Is the audit being done as this provider bills high risk services? (e.g. prolonged care, high levels of codes)
- Is this being done due to issue on Compliance Audit Plan?
- Is this being done due to potential issue on OIG work plan?
- Is this audit being done proactively by Compliance?
- Is this audit being done post-education?
- Is this in response to payer audit – are you dealing with best practices vs. defensive audit?

38

How do the risks of the audits rank?

High

Moderate

Low

39

How does this compare?

Bell Curve Analysis may be helpful – but…

- Data available represents what was BILLED
- Medicare data available not current
- Some specialties not represented in Medicare data
- Data may be available from other sources for a fee

40

Are there any incidental findings?

Did the scope not include diagnosis coding in the review, yet errors were found?

Was there any concerning information revealed in interviews with staff that you think needs to be addressed?

41

Sample Audit Reports and Presentations

42

Sample Report - Spreadsheet

NAME OF FACILITY/PRACTICE
Quality Review of Coding and Documentation
Dr. xxxxx
DATE

Demographics						CPT®(s) and Modifiers		Feedback	E/M Components											Feedback
Case #	Patient's Name	DOB	Rendering Provider	Billing Provider	Date of Service	Provider	RGI	CPT ® Comments / Recommendations	Chief Complaint	HPI	ROS	PFSH	Hx Level	Exam 95	Dx Pts	Data Pts	Risk	MDM Level	Comments / Recommendations
		8/21/1940			6/9/2017	36905 36907 36215 37212 75710 76937 99152 J2997	36905 36907 36215 37212-**59** 75710-**59** 76937 99152 J2997	37212 attempted, unsuccessful - bill separately with modifier 59. 36215, 75710 may be billed separately when accessing and imaging the inflow artery beyond the anastomosis.	procedure only										None
		5/11/1952			1/18/2017	**99203** 36905 37212 76937 76937 99152 99153 J2997 Q9967	**99202-25** 36905 37212-59 76937 76937-59 99152 99153 J2997 Q9967 **36558**	37212 attempted, unsuccessful - bill separately with modifier 59. Tunneled dialysis catheter may be billed separately with code 36558.	clotted access	3	1	2	EPF	Det	4	1	Mod	Mod	Review of Systems documented as "All areas are negative." Complete Review of Systems is located in Nurses Notes, but the physician does not reference these.
		8/31/1969			5/5/2017	36905 76937 99152 Q9967	36905 76937 99152 Q9967	Agree with coding.	procedure only											None
		5/26/1961			3/8/2017	36905 36907 36215 **37212** 75710 76937 **76937** 99152 J2997 Q9967	36905 36907 36215 75710 76937 99152 J2997 Q9967	Transcatheter infusion for thrombolysis, 37212, and its associated ultrasound guidance, 76937 are not documented.	procedure only										None

43

Sample Report - Summary

Client Name

Issues & Recommendations Report
September 9, 2016

Audit Date Range: December 2015 – May 2016

Auditor: Kim Huey, MJ, CHC, CPC, CCS-P, PCS, CPCO, COC

All Providers

Number of Reports Audited: 81 (80 encounters – one with 2 E&M)

The following audit parameters were followed:

- **The auditor reviewed the medical record documentation, encounter form/superbill, and the final-billed CMS 1500 claim form.**
- **Under the guidelines of Medicare, Medicaid and all other federal health care programs, the auditor verified that all charges billed are for covered and billable services.**
- **The auditor verified documentation of the chief complaint.**
- **The auditor determined appropriate assignment of E/M visit level CPT codes.**
- **The auditor verified that all billed procedures are documented in the medical record either in the progress notes or via a copy of the appropriate report.**
- **The auditor verified the accuracy of CPT/HCPCS coding, modifier assignment and number of units of service for documented procedures and verified that unbundling of codes has not occurred.**
- **The auditor determined appropriate ICD-10-CM diagnosis coding and verified that the primary focus of the visit was sequenced as the first ICD-10-CM code.**
- **The auditor verified the correct place of service code reported on the CMS 1500 claim form.**

Records Accurately Coded	40	49.38%

44

Sample Report – Summary - continued

- **The auditor verified the correct place of service code reported on the CMS 1500 claim form.**

Records Accurately Coded	40	49.38%
Records Over Coded	41	50.62%
Records Wrong Category (wc)	3	3.37% (Included in Over Coded above)
Procedure Coding Accuracy		71.11%
Gross Financial Error Rate		27.79% (Based on Alabama Medicare Fee Schedule)
Diagnosis Coding Accuracy		45.3%

Please see Audit Summaries and Encounter Detail Reports for detailed information -

Documentation and Coding Issues

- Complete Review of Systems is documented by either listing at least ten systems individually or by listing the pertinent positives/negatives followed by the statement "All other systems negative." Other statements such as "14 point review of systems is negative" or "ROS: negative except for HPI" are not allowable.
- "Family History: Noncontributory" is unacceptable documentation. This statement is unclear whether the physician obtained the family history information or chose not to because it would not affect his decision-making.

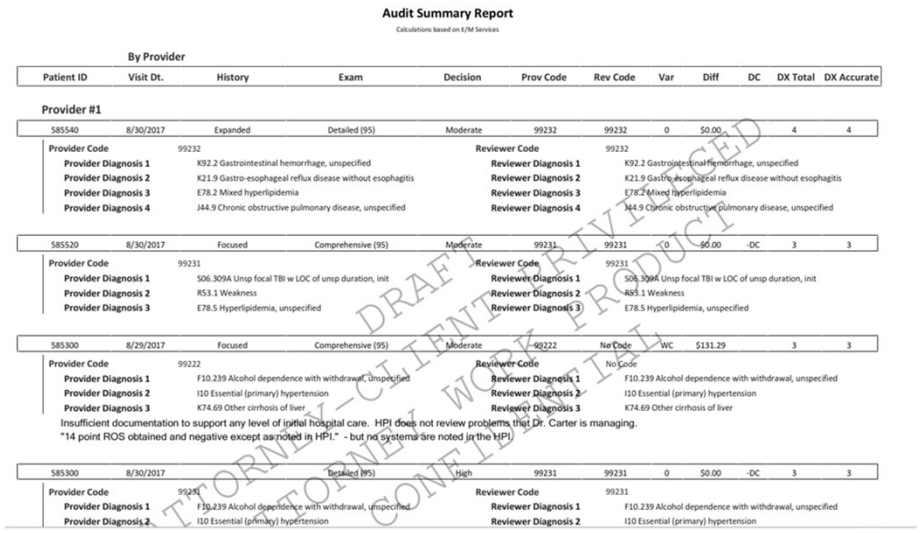
45

Sample Report – Summary - continued

- For Hospitalists, documentation requirements were met for shared visits with CRNPs and PAs; however, I was unable to determine if the employment requirement is met. The advanced practice provider must be employed in the same group practice as the physician. If this is not the case, then these encounters are not documented sufficiently by Dr. B---- and Dr. W--- to support any level of service.
- Teaching Physician errors – One encounter only included a cosignatures by the Teaching Physician and not the appropriate attestation.
- CMS Documentation Guidelines allow the status of three chronic conditions as an extended History of Present Illness; however, the documentation for some visits merely stated the chronic conditions without describing the status.
- Dr. H---- did not appropriately document interpretation of diagnostic studies such as Xrays and EKGs. Documentation for interpretation of an X-ray should be "as complete as that prepared by an expert in the field." Ideally, per the AMA, it should be on a separate piece of paper - but in all cases, it should state the structure viewed, the number of views, any comparison to previous films, and the interpretation. Likewise, documentation for EKG interpretation should include an interpretation of the tracing along with clinical correlation. Without such documentation, only the technical component may be billed.
- Dr. H---- did not document performance of procedures such as nebulizer treatment, only an order for the treatment.
- Two encounters included contradictory information entered in different sections of the electronic medical record. This may occur when the physician enters information about the patient's complaint in the History of Present Illness but then relies on a templated "Normal" Review of Systems without correcting/personalizing those entries.
- Counseling time not always appropriately documented. A visit may be coded based on total time spent face-to-face with the patient when the visit is dominated by counseling and coordination of care, but the documentation must indicate the total time, the counseling time, and the subjects discussed.
- Diagnosis coding was often incomplete – that is, diagnoses were documented that were not billed.
- Questionable diagnoses or those documented as rule out, probable, or suspected should not be billed as if definitive.
- Diagnoses were sometimes listed but not addressed in the Assessment and Plan.

46

Sample Report – Audit Summary



Audit Summary Report

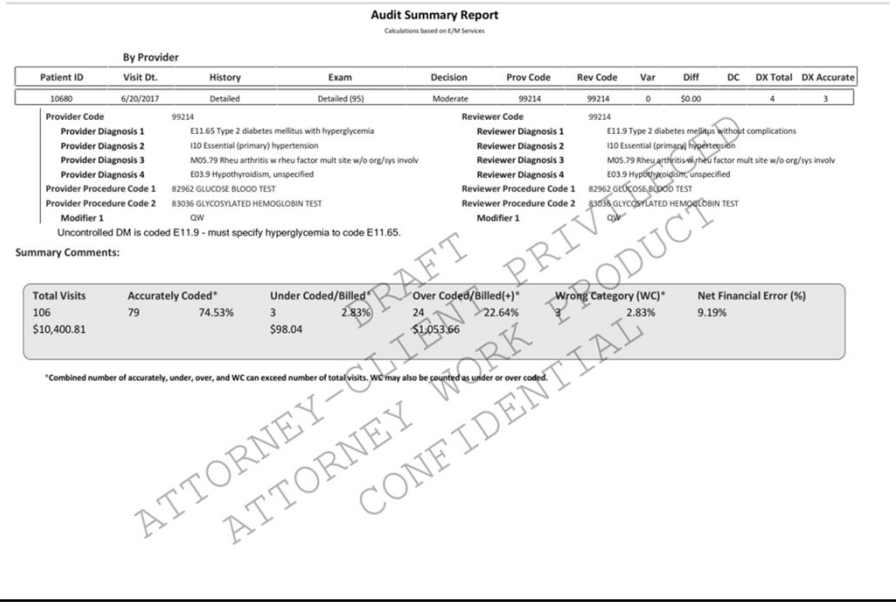
Calculations based on E/M Services

By Provider

Patient ID	Visit Dt.	History	Exam	Decision	Prov Code	Rev Code	Var	Diff	DC	DX Total	DX Accurate
Provider #1											
585540	8/30/2017	Expanded	Detailed (95)	Moderate	99232	99232	0	$0.00		4	4
Provider Code	99232				**Reviewer Code**	99232					
Provider Diagnosis 1	K92.2 Gastrointestinal hemorrhage, unspecified				**Reviewer Diagnosis 1**	K92.2 Gastrointestinal hemorrhage, unspecified					
Provider Diagnosis 2	K21.9 Gastro-esophageal reflux disease without esophagitis				**Reviewer Diagnosis 2**	K21.9 Gastro-esophageal reflux disease without esophagitis					
Provider Diagnosis 3	E78.2 Mixed hyperlipidemia				**Reviewer Diagnosis 3**	E78.2 Mixed hyperlipidemia					
Provider Diagnosis 4	J44.9 Chronic obstructive pulmonary disease, unspecified				**Reviewer Diagnosis 4**	J44.9 Chronic obstructive pulmonary disease, unspecified					
585520	8/30/2017	Focused	Comprehensive (95)	Moderate	99231	99231	-0	$0.00	-DC	3	3
Provider Code	99231				**Reviewer Code**	99231					
Provider Diagnosis 1	S06.309A Unsp focal TBI w LOC of unsp duration, init				**Reviewer Diagnosis 1**	S06.309A Unsp focal TBI w LOC of unsp duration, init					
Provider Diagnosis 2	R53.1 Weakness				**Reviewer Diagnosis 2**	R53.1 Weakness					
Provider Diagnosis 3	E78.5 Hyperlipidemia, unspecified				**Reviewer Diagnosis 3**	E78.5 Hyperlipidemia, unspecified					
585300	8/29/2017	Focused	Comprehensive (95)	Moderate	99222	No Code	WC	$131.29		3	3
Provider Code	99222				**Reviewer Code**	No Code					
Provider Diagnosis 1	F10.239 Alcohol dependence with withdrawal, unspecified				**Reviewer Diagnosis 1**	F10.239 Alcohol dependence with withdrawal, unspecified					
Provider Diagnosis 2	I10 Essential (primary) hypertension				**Reviewer Diagnosis 2**	I10 Essential (primary) hypertension					
Provider Diagnosis 3	K74.69 Other cirrhosis of liver				**Reviewer Diagnosis 3**	K74.69 Other cirrhosis of liver					
Insufficient documentation to support any level of initial hospital care. HPI does not review problems that Dr. Carter is managing. "14 point ROS obtained and negative except as noted in HPI." - but no systems are noted in the HPI.											
585300	8/30/2017		Detailed (95)	High	99231	99231	0	$0.00	-DC	3	3
Provider Code	99231				**Reviewer Code**	99231					
Provider Diagnosis 1	F10.239 Alcohol dependence with withdrawal, unspecified				**Reviewer Diagnosis 1**	F10.239 Alcohol dependence with withdrawal, unspecified					
Provider Diagnosis 2	I10 Essential (primary) hypertension				**Reviewer Diagnosis 2**	I10 Essential (primary) hypertension					

47

Sample Report – Audit Summary – final page



Audit Summary Report

Calculations based on E/M Services

By Provider

Patient ID	Visit Dt.	History	Exam	Decision	Prov Code	Rev Code	Var	Diff	DC	DX Total	DX Accurate
10680	6/20/2017	Detailed	Detailed (95)	Moderate	99214	99214	0	$0.00		4	3
Provider Code	99214				**Reviewer Code**	99214					
Provider Diagnosis 1	E11.65 Type 2 diabetes mellitus with hyperglycemia				**Reviewer Diagnosis 1**	E11.9 Type 2 diabetes mellitus without complications					
Provider Diagnosis 2	I10 Essential (primary) hypertension				**Reviewer Diagnosis 2**	I10 Essential (primary) hypertension					
Provider Diagnosis 3	M05.79 Rheu arthritis w rheu factor mult site w/o org/sys involv				**Reviewer Diagnosis 3**	M05.79 Rheu arthritis w rheu factor mult site w/o org/sys involv					
Provider Diagnosis 4	E03.9 Hypothyroidism, unspecified				**Reviewer Diagnosis 4**	E03.9 Hypothyroidism, unspecified					
Provider Procedure Code 1	82962 GLUCOSE BLOOD TEST				**Reviewer Procedure Code 1**	82962 GLUCOSE BLOOD TEST					
Provider Procedure Code 2	83036 GLYCOSYLATED HEMOGLOBIN TEST				**Reviewer Procedure Code 2**	83036 GLYCOSYLATED HEMOGLOBIN TEST					
Modifier 1	QW				**Modifier 1**	QW					
Uncontrolled DM is coded E11.9 - must specify hyperglycemia to code E11.65.											

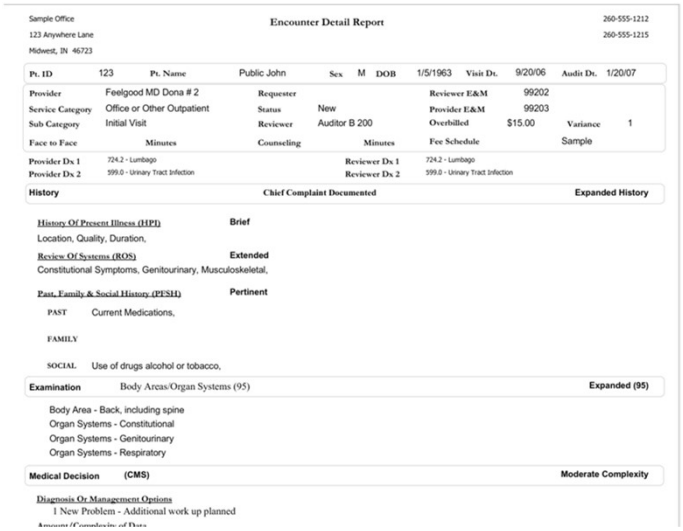
Summary Comments:

Total Visits	Accurately Coded*		Under Coded/Billed*		Over Coded/Billed(+)*		Wrong Category (WC)*		Net Financial Error (%)
106	79	74.53%	3	2.83%	24	22.64%	3	2.83%	9.19%
$10,400.81			$98.04		$1,053.66				

*Combined number of accurately, under, over, and WC can exceed number of total visits. WC may also be counted as under or over coded.

48

Sample Report – Encounter Detail Report



Sample Office
123 Anywhere Lane
Midwest, IN 46723

Encounter Detail Report

260-555-1212
260-555-1215

Pt. ID	123	**Pt. Name**	Public John	**Sex**	M	**DOB**	1/5/1963	**Visit Dt.**	9/20/06	**Audit Dt.**	1/20/07
Provider	Feelgood MD Dona # 2			**Requester**				**Reviewer E&M**	99202		
Service Category	Office or Other Outpatient			**Status**	New			**Provider E&M**	99203		
Sub Category	Initial Visit			**Reviewer**	Auditor B 200			**Overbilled**	$15.00	**Variance**	1
Face to Face		**Minutes**		**Counseling**		**Minutes**		**Fee Schedule**		Sample	
Provider Dx 1	724.2 - Lumbago							**Reviewer Dx 1**	724.2 - Lumbago		
Provider Dx 2	599.0 - Urinary Tract Infection							**Reviewer Dx 2**	599.0 - Urinary Tract Infection		

History — **Chief Complaint Documented** — **Expanded History**

History Of Present Illness (HPI) — **Brief**
Location, Quality, Duration,

Review Of Systems (ROS) — **Extended**
Constitutional Symptoms, Genitourinary, Musculoskeletal,

Past, Family & Social History (PFSH) — **Pertinent**
PAST Current Medications,
FAMILY
SOCIAL Use of drugs alcohol or tobacco,

Examination Body Areas/Organ Systems (95) — **Expanded (95)**

Body Area - Back, including spine
Organ Systems - Constitutional
Organ Systems - Genitourinary
Organ Systems - Respiratory

Medical Decision (CMS) — **Moderate Complexity**

Diagnosis Or Management Options
1 New Problem - Additional work up planned

49

Sample Report – Encounter Detail Report - continued

FAMILY
SOCIAL Use of drugs alcohol or tobacco,

Examination Body Areas/Organ Systems (95) — **Expanded (95)**

Body Area - Back, including spine
Organ Systems - Constitutional
Organ Systems - Genitourinary
Organ Systems - Respiratory

Medical Decision (CMS) — **Moderate Complexity**

Diagnosis Or Management Options
1 New Problem - Additional work up planned
Amount/Complexity of Data
- Review and/or order of clinical lab tests (CPT codes in the 80000 series)
Risk MODERATE

Presenting Problem(s)
- Acute illness with systemic symptoms
Diagnostic Procedures
- Urinalysis
Management Options
- Prescription drug management

Encounter Notes

•Legibility (I); Some portions or this entire note includes documentation where legibility is at least questionable or extremely poor.

•Legibility (R); General Prinicples of Medical Record Documentation include: "The medical record should be complete and legible." A good definition of "legibility" is that it must be legible to someone outside the practice or facility . Dictation should be considered to improve legibility and reduce potential claims issues and risk to the practice or facility for any provider with poor penmanship..

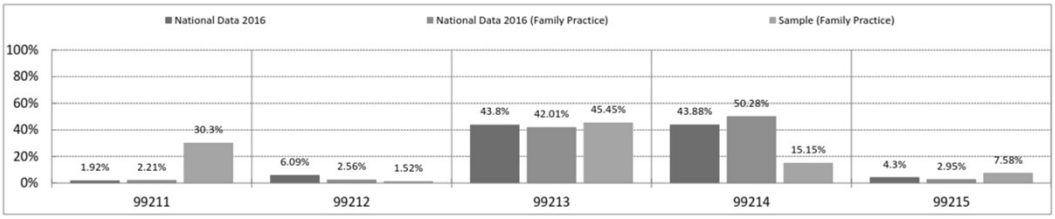
•Documented Lower Level (I); The documentation substantiates a lower level of service than charged.

50

Sample Report – Bell Curve Analysis

Sample Practice — **E & M National Bell Curve Report** — **Data Year:** 2018

Code	National Data 2016		National Data 2016 (Family Practice)		Sample (Family Practice)	
	Frequency	%	Frequency	%	Frequency	%
Follow-Up -						
99211	4,365,199	1.92%	844,764	2.21%	200	30.30%
99212	13,877,490	6.09%	978,839	2.56%	10	1.52%
99213	99,738,281	43.80%	16,068,469	42.01%	300	45.45%
99214	99,920,440	43.88%	19,230,429	50.28%	100	15.15%
99215	9,800,916	4.30%	1,126,686	2.95%	50	7.58%



51

Conclusion of Audit Results

- High level overview of what the issues were/are and how they are being addressed
- Expectations
- Action plans – Education needed, who needs it, who will provide it
- Does the client need to provide documentation of education, sign in sheet of attendees, date, copy of education provided? Was education performed during the rebuttal review of the cases?

52

Sandy Giangreco Brown, BS, RHIT, CHC, COC, CPC, CPC-I, COBGC, PCS
970-581-5144
giangrecosandy@gmail.com or sandy.giangrecobrown@claconnect.com

Kim Huey, MJ, CPC, CPCO, COC, CCS-P, PCS, CHC
205/621-0966
kim@kimthecoder.com
Facebook.com/KimtheCoder

53

53