

Audit Date: 5/16/2008
Auditor: Auditor A 100

All Providers

Number of Reports Audited: 48

Comments:

Records accurately coded	15	31.25%
Records over coded	22	45.83%
Records under coded	11	22.92%
Records wrong category (wc)	7	14.58%

Documentation and Coding Issues

2 Encounter(s) had the issue of: *Legibility (I)*

Some portions of this entire note includes documentation where legibility is at least questionable or extremely poor.

13 Encounter(s) had the issue of: *Documented Lower Level (I)*

The documentation substantiates a lower level of service than charged.

5 Encounter(s) had the issue of: *Documented Higher Level (I)*

The documentation substantiates a higher level of service than charged.

6 Encounter(s) had the issue of: *Assessment (I)*

The assessment is not clearly stated for this encounter. Documentation Guidelines states "The documentation for each patient encounter should include: . . . assessment, clinical impression or diagnosis . . ."

8 Encounter(s) had the issue of: *Diagnosis Variation (I)*

The documentation for this encounter reflects a diagnosis coding variation from what was listed on the HCFA 1500 or superbill.

1 Encounter(s) had the issue of: *Missed Charges (I)*

This service was not listed as a billed service on the HCFA 1500 or superbill. This represents a potential revenue loss to the practice.

3 Encounter(s) had the issue of: *Chief Complaint (I)*

The Chief Complaint for this encounter is either missing or not stated in the manner identified in the Documentation Guidelines.

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1 Encounter(s) had the issue of: *Consult Requirements (I)*

One or more of the criteria required for a Consult have not been met, or has not been documented in the patient's medical record, or is not present in the information submitted for audit.

2 Encounter(s) had the issue of: *Sick vs Preventive Health Visit (I)*

This visit was billed as a sick visit, rather than Preventive Health .

2 Encounter(s) had the issue of: *25 Modifier (I)*

Misuse of the 25 modifier.

Recommendations

The documentation was thorough, and showed medical necessity. According to Documentation Requirements, there was enough documentation to substantiate the next higher level of service; and this would have increased revenue to the practice.

If more than 50% of the face-to-face (or unit/floor time) visit is spent counseling, the code may be determined based on the entire time of the visit. Documentation must be stated as: "20/30 minute visit spent counseling the patient on _____"; or "Spent the majority of the 45 minute visit counseling the patient regarding _____".

The assessment should be clearly documented for each encounter. Since each note must "stand alone", it is imperative to accurately document the most specific diagnosis in the assessment / impression section of the note.

General Principles 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.

To reduce potential monetary loss to the practice or facility, all charges should be reviewed prior to charge entry by qualified individuals to ensure complete charge capture and coding compliance.

A chief complaint, as stated in the Documentation Guidelines is, "A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's own words." A chief complaint is required for all levels of service. If the reason for an exam is to follow chronic or existing conditions, the chief complaint should state "follow-up of Fatigue, High cholesterol . . ." etc., stating the conditon(s) being followed. "Check up" is not an appropriate chief complaint.

Diagnosis coding errors may cause claims processing delays or denials, as well as leaving the provider and/or practice open to potential false claims allegations. Accurately assigning diagnosis codes provides justification for services performed (medical necessity), and decreases resubmitting claims. CPT and

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Diagnosis (ICD9) coding should be reviewed prior to charge entry by qualified individuals, to ensure coding accuracy and compliance.

The provider should always clearly document the requesting provider, the reason for the consultation, or condition / problem to be evaluated, the necessary History, Examination and Medical Decision Making, and the evidence of written report communicating back to the requesting provider. Including statements similar to "Dr. X is requesting my consultation for the evaluation of [patient's condition]" and " Thank you for allowing me to consult on this interesting case" will clearly satisfy consultation requirements as well as clearly identify the intent of the encounter. Additionally dictating a "Consultation Report Cover Page" or developing a template for such written correspondence back to the requesting provider, to be appended to a copy of the encounter documentation, will easily satisfy the "written report" criteria. Clear concise documentation will alleviate any ambiguity regarding the status of the encounter.

Preventive Medicine Services depend largely on the age of the patient. The "comprehensive" nature of the Preventive Medicine Services codes 99381-99397 reflects age and gender-appropriate history/exam and is NOT synonymous with the "comprehensive" examination required in E&M codes 99201-99350. 99381-99387 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination. Immunizations and ancillary studies involving laboratory, radiology, other procedures, or screening tests identified with a specific CPT code are reported separately. If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine E&M service, and is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code (99201-99215) should also be reported, with modifier 25.

In order to obtain the level of service charged, additional documentation is necessary for (hx, exam, MDM).

Our recommendation of the misuse of the 25 modifier.