General Recommendations for ABC Practice
Presented by Medical Staff SOS, Inc.
April 2012

Per your request, an audit and written report of 88 encounters for the above named practice has been completed.

The following is a breakdown of the encounters audited:

This audit consisted of **88** E/M encounters. Of these, **25** encounters were over coded, **56** encounters were coded correctly and met the documentation criteria for the code(s) billed, **5** were under coded, and **2** could not be determined.

Over all, of the **88** encounters audited the following *types of codes* were reviewed:

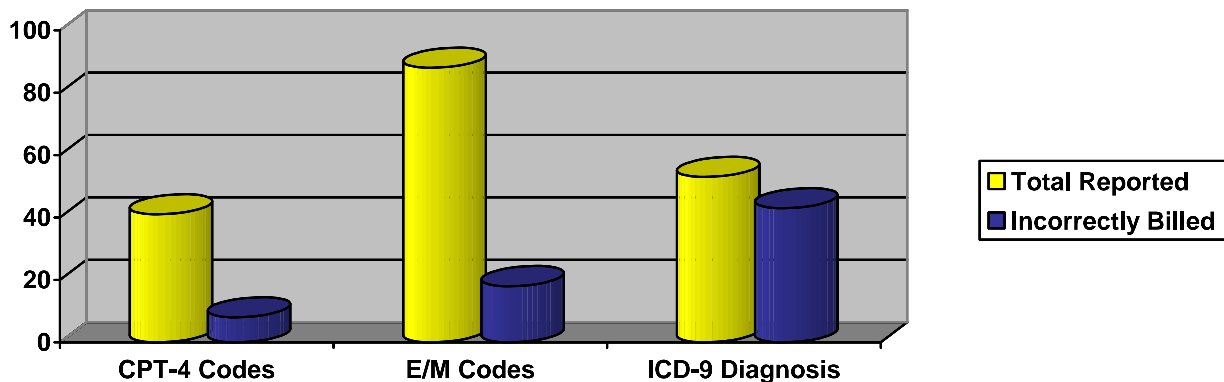
84 CPT codes
279 ICD-9-CM *diagnosis* codes

Of the **84** CPT codes audited **0** were *incorrectly billed.*

Of the **279** ICD-9-CM *diagnosis* codes audited, **247** were *incorrectly reported* due to one or more of the following reasons:

- ► Diagnosis documented did not match what was checked on fee ticket or submitted to Insurance
- ► Signs and symptoms codes were submitted along with the definitive diagnosis
- ► Conditions not discussed in the history were submitted

Reported Codes VS Incorrectly Billed Codes



The above graft has been established to show the **percentage** ratio of incorrect codes reported regarding the **88** audited:

0 % *inaccuracy* in HCPCS

0 % *inaccuracy* in CPT coding

88 % *inaccuracy* in ICD-9-CM *diagnosis* coding

During the auditing process, several areas of concern were identified. A brief description of these concerns is listed below. Medical Staff SOS, Inc. highly recommends that further education and training regarding Evaluation and Management coding be provided to the providers at ABC Practice.

These areas of concern are as follows:

1) During this chart audit, encounters were found not meeting the key components for the level of Evaluation and Management service billed. The impression should always state the diagnoses or reasons for the encounter. Predominately the HPI and ROS were deficient causing the overall history level to be lower. The examination and medical decision making often times were also lacking the necessary documentation to support the code(s) reported.

2) Some of the encounters audited had the statement "review of systems is otherwise normal" in the history. However, this statement can only be counted if a **minimum of 10 ROS** are ***separately*** documented. Most of the time only 5 - 6 ROS (sometimes fewer) were documented with this statement attached. This brought down the overall level of history for that encounter.

3) The documentation for each date of service should clearly reflect the "**reason for the visit**". The chief complaint drives the remainder of the documentation therefore the diagnosis listed in the Impression or Assessment should reflect this. If the diagnosis listed in the impression/assessment was not discussed in the history then it should not be billed. The diagnosis GERD was listed in several encounters however auditor could not give credit for it most of the time because it was not discussed in the history.

4) In order for a diagnosis to be billed it must be listed in the impression/assessment. In the majority of the encounters audited the diagnosis listed in the impression/assessment did not match the diagnosis checked on the fee ticket or what was submitted to the insurance carrier. For example: "AR, due to pollen" (477.0) was checked on the fee ticket and billed to insurance however the impression/assessment stated "AR" which involves the nonspecific code 477.9. In order to bill for "AR, due to pollen" it must be listed this way in the impression/assessment.

5) During our 3-2-12 visit, two areas of concern were brought to our attention, by the employees. The **first** being that some of the transcriptionist(s) are stamping the patient's encounter when they are finished and the chart is then submitted to the medical records department for filing. The chart is **not** being returned to the provider for review and approval before being submitted to the medical records department for filing. The **second** concern is that an employee(s) may have been instructed to change the patient's diagnosis. No staff member should ever change a diagnosis code. If there is a discrepancy found by an employee, the medical record should be returned to the provider in question and a "formal amendment" should be made. The provider should then review and approve this amendment by providing a full signature or initialing.

NOTE:

Progress notes, test results, medical records of any kind should **never** be stamped by the transcriptionist and should **always** be reviewed by the provider before being placed permanently into the patient's medical record! The **provider's full signature or initials** on progress notes, test results, etc. identifies that the **provider has *reviewed and approved*** the documentation for that particular date of service. If the provider finds the dictation to be incorrect then a "formal amendment" regarding that date of service should be added to the patient's medical record. The provider should then review and approve this amendment by providing a full signature or initialing.

6) ABC Practice should immediately put into place a "**Coding Compliance Manual**" and a "**Compliance Officer**" should be appointed.

During the auditing process, several abbreviations were encountered that are "uncommon to the typical medical practice". It became very difficult to audit these encounters due to the fact these abbreviations were developed either by the provider or by the staff member providing the transcription service and therefore could not be correctly interpreted by the auditor. When employees or providers were asked to explain the definitions of these abbreviations they were unable to do so nor were they able to produce a coding manual that could be used as a reference. It is acceptable practice for a provider to use abbreviations in their documentation but "any uncommon or made up medical abbreviations" used by the practice, should be admitted into the medical practice "**Coding Compliance Manual**". It is recommended that **ALL abbreviations** (common and uncommon) used in this practice be recorded in the Coding Compliance Manual with a ***complete explanation*** of each abbreviation.

The following are examples of "common medical abbreviations":

NAD	No Acute Distress
U/A	Urine Analysis
TM	Tympanic Membranes
B/P	Blood Pressure
WT	Weight
F/U	Follow up

The following are examples of "uncommon medical abbreviations" encountered during audit:

O/E	NYD	LEE	IX	MX	LOM
BS	OP	U/L	HSM	DRE	

For example: The initials "V/D" was written on a patient's fee ticket. The employee took these initials to mean "venereal disease", and the insurance claim was submitted as such. When in fact the documentation showed the patient had "vomiting and diarrhea". This is the type of mistake that can happen when no Coding Compliance Manual has been established. Once a diagnosis has been submitted to the insurance company for payment it is rarely, if ever, changed. This could pose a problem for the patient in the future when they try to apply for insurance (ie, cancer policy, life insurance, etc). They may be rejected or face possible rejection, due to a previous diagnosis that was submitted on the patient's insurance claim.

Medical Staff SOS, Inc.
® PHIA – Professional Healthcare Institute of America™/®HPMS – Healthcare Professional Member Services™
4010 Dupont Circle, Suite 418
Louisville, Kentucky 40207
(O) 502.473.8806 (F) 502.473.8807 (TF) 866.473.3036
www.PHIA.com

7) Recommendations were made in the past to remove all ICD-9-CM codes from the patient's fee ticket. Since then, the fee ticket has been modified by removing the diagnosis codes but the diagnostic descriptors remain. Complete removal of all diagnostic information is still encouraged. Writing the patient's diagnosis on the fee ticket encourages more specificity in reporting the correct diagnosis. A majority of the diagnoses codes encountered in this audit were unspecified. An **unspecified ICD-9-CM** code does **not** accurately describe the patient's true level of severity of illness nor does it properly demonstrate the medical necessity of the patient's E/M visit. While it is recommended the provider "write in" the patient's diagnosis rather than select a code descriptor on the fee ticket there can still be potential problems when a Coding Compliance Manual has not been established or the employee submitting the claim has **not** reviewed the documentation for the date of service in question prior to the claim being submitted.

8) Each provider's name and credentials should be admitted into the **Coding Compliance Manual** along with their full signature and written initials.

   For example:

   Matt Blake, MD (Family Practice)

   Full Signature: ____

   Written Initials: ____

   Andrea Pentwater, NP (Nurse Practitioner)

   Full Signature: ____

   Written Initials: ____

   Etc., etc., etc., until all providers names are listed in this manual. This portion of the manual **should also identify** how the provider will **sign off** on each encounter (date of service).

   Please Note:

   All providers (Physicians, NP's, PA's) and all employees involved in this medical practice, especially those involved in billing, coding, and compliance should be ***required*** to **read, initial, and date** this coding compliance manual to indicate they have reviewed and understand the policies set forth. All **new employees** should **also** be ***required*** to **read, initial, and date** the coding compliance manual to indicate they have reviewed and understand the policies set forth.