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How to Perform a Successful Chart Audit

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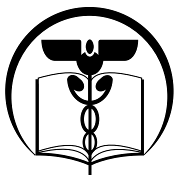

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How to Perform a Successful Chart Audit

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How to Perform a Successful Chart Audit

Introduction

Chart auditing is similar to coding, but differs in that the coder actually is analyzing the medical record based on the documentation. Chart auditing is a broad topic, ranging from the basic patient encounter to determine the level of service reported (along with correct diagnosis codes, ancillary services, and modifier usage), to an extensive review of the entire chart to examine thoroughly all aspects of the medical record.

Insurance carrier interpretation of evaluation and management (E/M) guidelines, modifier usage, and service bundling may vary; therefore, the auditor should review carrier and/or contractor policy requirements and have them available when auditing the medical record. For example, if you are auditing physical therapy services for Medicare patients, the medical policy for physical therapy should be referenced for specific guidelines. For E/M services, the 1995 and 1997 Evaluation and Management Documentation Guidelines should be referenced.

This session will cover:

1. Medical Necessity
2. E/M Service Audits
3. Surgical Audits
4. The Audit Process
5. Audit Steps
6. Designing an audit report with corrective action
7. Hands-on E/M and Surgical Cases to audit

What Is Medical Necessity and Why Does It Matter?

Services rendered to patients should be necessary to affect a cure or a change in the condition for which the patient is being seen.

The term "medical necessity" is difficult to define, and there are almost as many definitions as there are payors. Most definitions incorporate the principle of providing services that are "reasonable and necessary" or "appropriate" in light of clinical standards of practice. The lack of objectivity in these terms often leads to widely-varying interpretations by physicians and payors that, in turn, can result in the care provided not meeting the definition. The decision whether the services were medically necessary typically is made by a payor reviewer who never sees the patient.

Medicare defines "medical necessity" as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. CMS has the power under the Social Security Act to determine on a case-by-case basis if the method of treating a patient is reasonable and necessary. For all payors and insurance plans, even if a service is reasonable and necessary, coverage may be limited if the service is provided more frequently than allowed under a national coverage policy, a local medical policy, or a clinically accepted standard of practice.

Claims for services that are not medically necessary will be denied—but not getting paid for these claims isn't the only risk. If Medicare or other payors determine that services were medically unnecessary after payment has been made, they treat it as an overpayment and demand that the money be refunded, with interest. Moreover, if a pattern of such claims can be shown— and the physician knows or should know that the services are not medically necessary—the physician may face large monetary penalties, exclusion from Medicare program, and criminal prosecution.

ICD-9-CM codes form a crucial partnership with CPT® procedural codes by supporting the medical necessity of the CPT® procedure or service performed. Diagnosis codes identify the medical necessity of services provided by describing the circumstances of the patient's condition.

Most payors use claim "edits," or automatic denial/review commands within their computer software, to review claims. These edits ensure that payment is made for specific procedure codes when provided for a patient with a specific diagnosis code or predetermined range of ICD-9-CM codes. Neither the CPT® codes nor the ICD-9-CM codes can stand-alone.

Apply the following principles to diagnosis coding to demonstrate medical necessity:

1. List the principal diagnosis, condition, problem, or other reason for the medical service or procedure.
2. Assign the code to the highest level of specificity.
3. For office and/or outpatient services, never use a "rule-out" statement (a suspected but not confirmed diagnosis); a clerical error could permanently tag a patient with a condition that does not exist. If no definitive diagnosis is yet determined, code symptoms and/or signs instead of using rule-out statements.

4. Be specific in describing the patient's condition, illness, or disease.
5. Distinguish between acute and chronic conditions, when appropriate.
6. Identify the acute condition of an emergency situation (e.g., coma, loss of consciousness, or hemorrhage).
7. Identify chronic complaints, or secondary diagnoses, only when treatment is provided or when they affect the overall management of the patient's care.
8. Identify how injuries occur.

These facts must be substantiated by the patient's medical record, and that record must be available to payors upon request.

When reporting a patient encounter, codes should be selected that best represent the services furnished during the visit. The common codes used to support and identify these services are the diagnosis (ICD-9-CM) codes and the procedure (CPT®) codes from the American Medical Association (AMA) CPT® manual.

Medical Necessity and CMS

Medicare conducts an in-depth analysis of medical necessity for office visits, hospital visits, nursing home visits, and procedures and services provided by physicians. The Centers for Medicare and Medicaid Services (CMS) developed a program to determine national, contractor specific, provider compliance error rates, paid claims error rates, and claims processing error rates. The program is known as the Comprehensive Error Rate Testing (CERT) program.

Based on data gathered in 2009, CMS has determined that 4 percent of all claims reported were not medically necessity.

Medical necessity of a service must be reviewed when selecting the level of E/M code, even if two of three key components for the established patient are met.

For example, if the physician documented a detailed history and examination for a diagnosis of rhinitis—even if this is a new problem and the physician writes a prescription—it would not be medically necessary to report a 99214 for this service because the medical necessity based on the presenting problem and management of the problem would be of low complexity.

For surgical and other procedures, as well, the diagnosis must meet support medical necessity for the service(s) rendered.

***CMS Internet Only Manual (IOM)* 100-04, *Medicare Claims Processing Manual*, Chapter 12, section 30.6.1 states:** "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 evaluation and management service when a lower level of service is warranted. The amount 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. The service should be documented during, or as soon as possible after it is provided in order to maintain an accurate medical record."

The Comprehensive Error Rate Testing Program also identifies "undercoding" when the service supports a higher level of service based on documentation and medical necessity. When auditing these services, CMS will recode the claims and reimburse at the appropriate level. These situations also are considered coding errors.

Table 1: Summary of Error Rates by Category (Improper Medicare Fee-For-Service Payments Report, November 2009)

Type Of Error	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
	Net	Net	Net	Net	Net	Net	Net	Net	Gross	Gross	Gross	Gross	Gross	Gross
No Documentation Errors	1.9%	2.1%	0.4%	0.6%	1.2%	0.8%	0.5%	5.4%	3.1%	0.7%	0.6%	0.6%	0.2%	0.1%
Insufficient Documentation Errors	4.5%	2.9%	0.8%	2.6%	1.3%	1.9%	1.3%	2.5%	4.1%	1.1%	0.6%	0.4%	0.6%	1.9%
Medically Unnecessary Errors	5.1%	4.2%	3.9%	2.6%	2.9%	2.7%	3.6%	1.1%	1.6%	1.6%	1.4%	1.3%	1.4%	4.0%
Incorrect Coding Errors	1.2%	1.7%	1.3%	1.3%	1.0%	1.1%	0.9%	0.7%	1.2%	1.5%	1.6%	1.5%	1.3%	1.6%
Other Errors	1.1%	0.5%	0.7%	0.9%	0.4%	-0.2%	0.0%	0.1%	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%
Improper Payments	13.8%	11.4%	7.1%	8.0%	6.8%	6.3%	6.3%	9.8%	10.1%	5.2%	4.4%	3.9%	3.6%	7.8%
Correct Payments	86.2%	88.6%	92.9%	92.0%	93.2%	93.7%	93.7%	90.2%	89.9%	94.8%	95.6%	96.1%	96.4%	92.2%

When selecting E/M service levels, provider must make certain that even if the documentation supports a level 4 or level 5 visit, the service level is medically necessary based on the presenting problem and the management of the patient. It is not enough to document a detailed or comprehensive history and examination without supporting medical necessity. Medical necessity is determined with documentation in the assessment and plan.

To support medical necessity, the assessment and plan must define clearly the following:

1. all diagnoses the provider is managing during the visit,
2. for an established diagnosis; whether the patient's condition is stable, improved, worsening, etc,
3. when diagnostic tests are ordered; the rationale for ordering the tests are either documented or easily inferred., and
4. management of the patient is documented clearly, (i.e., prescription drugs, over the counter medication, surgery, etc.)

The documented assessment and plan must support the service level reported based on medical necessity. An appropriate history and exam also must be documented.

The Purpose of Auditing and Monitoring

A chart audit is an examination of medical records to determine what procedure(s) or service(s) is performed. From this, the auditor determines if the documentation is compliant, if the claim is correctly coded, and if all charges are captured. Chart audits may measure:

- adherence to clinical protocols
- patient adherence with medication regimens
- provider compliance with coding and documentation requirements for E/M services, office procedures, modifier usage, diagnosis code supporting medical necessity, and/or surgical procedures

You can conduct a chart audit on virtually *any* aspect of medicine and medical care: Chart audits even can review the prevalence of symptoms and disease. The important point is that the data you are reviewing should be accurate and must be available in the chart.

Note also that a chart audit will involve reviewing data that may be deemed confidential; therefore, it is necessary to consult the appropriate institutional guidelines prior to reviewing any medical record.

Auditing is the process of examining the medical record, verifying information, and gathering baseline information to identify risk areas. *Monitoring* is the ongoing process of reviewing coding practices and the adequacy of the documentation and code selection. Monitoring should be conducted on a regularly-scheduled basis and should include such activities as auditing, reviewing utilization patterns, reviewing computerized reports, and reimbursement. A monitoring system usually is put in place based on findings from the baseline audit.

The Medical Record

The medical record serves many purposes, and is essential to the proper functioning of the medical practice. A medical record can be a paper chart, or in electronic format using an Electronic Health Record (EHR). The medical record details information that is pertinent to patient care, including:

- Demographic and insurance information
- Progress notes
- Laboratory reports
- X-ray reports
- Ancillary procedures, services, and tests
- Diagnostic studies
- Operative Notes (if applicable)
- Medication information
- Immunizations
- Old medical records

The purpose of the medical record is to document services provided to the patient, to verify the legitimacy of billable services, and to serve as a legal document describing the course of the patient's treatment. Practitioners, including physicians and non-physician practitioners, face the challenge of submitting correct coding information based on the documentation in the medical record. Periodic audits—whether internal or external—are vital to ensure that the documentation will meet the standards and requirements of the individual carrier to avoid repayment and, in the case of government payors, additional fines and penalties.

Reporting the highest level and correct type of service provided ensures that no fraudulent activity has occurred, and that all charges are captured, billed, and reimbursed. A coding audit, along with ongoing monitoring and education, will assist the organization in meeting the goal of compliance. Careful planning and implementation of the audit process is worth the time and effort invested.

Why Perform the Audit?

1. In addition to identifying potential risks to the organization, an audit helps ensure compliance to organization policies and procedures, payor regulations, and coding guidelines. An audit should not be undertaken without the full support of the organization (including medical directors, board of directors, and other administrative entities). It is beneficial to uncover potential problems *before* the organization is surprised by a request from a payor, CMS contractor, Recovery Audit Contractor (RAC), or the Office of Inspector General (OIG).
2. The audit also helps to identify problem areas so the organization can make corrections before further damage occurs. A great deal of information can be gathered when the documentation is compared to the charge ticket/superbill and the actual claim. A medical audit can reveal errors hidden in the medical record, such as: services not provided, services billed under the wrong provider, services not ordered by the licensed professional, wrong procedures and diagnoses reported, and other coding and billing errors.

Developing a clear plan of action makes sense, so that a practice can be prepared for an eventual audit by an insurance carrier or CMS. The operative phrase is "eventual audit." Many carriers, including Medicare, have been gearing up compliance teams nationwide to enable frequent and random on-site and off-site audits of hospitals and medical practices. Many factors that trigger an audit by a federal health care program or insurance carrier are based on specific criteria, such as:

- Consistently using one level of E/M service or routinely using higher levels
- Ordering excessive tests
- Billing Medicare or another government program for care not provided
- Unbundling of procedures
- Waiving coinsurance and deductibles in absence of financial hardship
- Changing codes to get paid
- Coding based only on reimbursement and not medically necessary services
- Practitioner's profile (utilization pattern) does not meet the standards of the industry

You must understand how to perform a compliance audit as a "preventive" measure.

3. Audits also may identify missed charges that could be reported, and encourage the review and correction of denials and under-documented services (such as services that could be reported at a higher E/M level with more detailed documentation).

Internal vs. External Audit

Many practices today use a combination of internal and external audits to maintain compliance; however, hiring a full-time internal auditor is sometimes cost prohibitive for the solo or small group practice. Another problem is finding an auditor with the necessary training and expertise in auditing medical records for coding and compliance (In the future, when the Electronic Health Record is the standard in every medical practice, the role of the coding professional may change from coding claims to reviewing patient encounters for correct coding and documentation—which essentially is the "Audit function").

One advantage of conducting an **external** audit is that it provides an objective approach in determining whether problems exist, and provides a framework for developing a remedy for isolated issues. When a practice hires an external auditor, the auditor typically will conduct a "baseline" audit—which is a sampling of various levels of E/M services, along with office or surgical procedures—to measure the coding compliance for each practitioner. External audits are performed quarterly, biannually, or annually, depending on the results of the baseline audit.

An **internal** audit may be conducted periodically by the coding staff trained in auditing medical records, or by a practitioner trained to audit for coding and compliance. At a minimum, the internal audit should be conducted annually (and more often if problem areas have been identified).

The decision to perform the audits internally or externally is determined by each individual practice. One advantage of an external audit is that the practice may realize more objectivity than with an employed auditor, in some cases.

Type of Audits

- Pre-payment (prior to submitting the claim)
- Retrospective (after the claim is submitted and paid)
- Focused Review (review of a significant number of chart notes)

A pre-payment audit is performed prior to submitting the claim to the insurance carrier. Typically the billing record (charge ticket or superbill) is obtained, along with the chart documentation and any supporting labs, medication sheets, problem lists, etc. This type of audit may affect claim turn-around time. Communication between the provider and auditor should follow the audit immediately.

A retrospective audit is performed after the provider has submitted the claim to the insurance carrier and payment

is received. The auditor will review the billing record (charge ticket or superbill), the Remittance Advice/Explanation of Benefits, and the medical record documentation, along with other supporting documentation. A retrospective audit could lead to refunding payment or partial payment to the insurance carrier. This is the most common audit method and charts can be selected based on utilization or frequency of the service provided. A cost might be involved when using an external auditor, for attorney fees when hired under "Attorney Client Privilege."

After the audit is complete, the auditor will report findings identifying:

- the error and accuracy rate(s) for each procedure or service performed
- a list of each record in the sample
- a comparison between reported and documented services
- whether the provider's documentation supports the service that was billed, and
- if the service was medically necessary based on the carrier's policy.

Focused Medical Review

Section 1 842(a)(2)(B) of the Social Security Act requires carriers to apply safeguards against unnecessary utilization of services furnished by providers. This is accomplished by conducting prepayment and post-payment reviews to identify inappropriate, medically unnecessary, or excessive services and take action where a questionable pattern of practice is found. This identification effort is termed Medical Review (MR).

In 1993, Medicare carriers implemented a new program for medical review. This program is called Focused Medical Review (FMR). FMR is the targeting and concentration of more in-depth medical review efforts of claims for items, services, or providers that present the greatest risk of inappropriate program payment.

The objectives of FMR are to maximize program protection, to avoid provider hassle, and to conduct the most cost effective method of accomplishing MR.

Contractors develop components of their FMR program (i.e., local MR policy, internal guidelines, and local screens) by identifying aberrances and areas subject to potential abuse or overutilization. They are responsible for targeting specific aberrances, and the individual providers of service are responsible for excessive atypical billings. This will help to eliminate the use of generic MR screens that affect the entire physician population.

Physician education and policy development are the major components resulting from FMR. A physician whose aberrant pattern cannot be explained logically may be placed on prepayment claim monitoring if the physician fails to take corrective action.

Medical Directors work closely with the Carrier Advisory Committee in the development of Medicare policy.

A focused review can be conducted by a contractor, carrier, or independent audit reviewer. A focused chart review is performed after identification of a specific problem related to inaccurate coding, based on documentation. Typically, this is requested by a carrier that submitted claims that were challenged. The questionable claims are selected and reviewed against documentation in the medical record. The result is a report that either supports or challenges the carrier's findings. Usually, a focus review consists of twenty or more medical records per provider.

How often you audit depends on the practice and the errors found during the "baseline" audit. The baseline audit is the first audit performed to identify problem areas.

Again: An audit should be performed to maintain compliance at a *minimum* of once per year—if not more often.

Top Billing and Coding Errors

1. Duplicate claim submitted

Description: Claims submitted are exact duplicates of previous claims submitted. Claims often are denied as duplicates because:

- The claim was previously processed (i.e., no payment made, allowed amount applied to deductible on the initial claim). The provider re-files the claim to "correct" it. The second claim submitted is considered a duplicate because the initial claim was processed correctly.
- The provider automatically re-files the claim to seek payment if the initial claim has not been paid within 30 days.

2. Non-covered services

Description: Billing for services not covered under the Medicare program or by other insurance carriers.

- Medicare defines many, "exclusions" such as: personal comfort items; self-administered drugs and biologicals (i.e., pills and other medications not administered by injection); cosmetic surgery (unless done to repair an accidental injury or improvement of a malformed body member); eye exams for the purpose of prescribing, fitting or changing eye-

glasses or contact lenses in the absence of disease or injury to the eye; routine immunizations; routine physicals; lab tests and X-rays performed for screening purposes; hearing aids; routine dental (care, treatment, filling, removal or replacement of teeth); custodial care, services furnished or paid by government institutions; services resulting from acts of war; and, charges to Medicare for services furnished by a physician to immediate relatives or members of the same household.

- Stay up-to-date on current exclusion policies by checking with your Medicare carrier and/or its website for changes. Most contractors will post changes to policies and their effective date.

3. Lack of medical necessity established
Description: The payor deems the services billed are not medically necessary.

- The claim will be denied because the payor does not deem the procedure for this diagnosis to be a "medical necessity." Check the particular carrier or contractor for the list of covered diagnoses for a particular service.

4. Inappropriate bundling of services
Description: This indicates a lack of awareness of the National Correct Coding Initiative (CCI) edits that govern appropriateness of tests being performed together on the same date of service. Alternately, it may indicate a lack of understanding of the appropriate code status of a specific CPT® code. For example, payment for "B" status code services always is bundled into payment for other services; whereas with "C" status codes, the local carrier determines bundling and the appropriateness of the procedure and subsequent reimbursement.

- Access the CCI Edits on the Medicare website (www.cms.hhs.gov/NationalCorrectCodInitEd/) to review which codes may be billed together on the same date of service, as well as the appropriate modifiers to use in those situations.
- Familiarize yourself with the payment status code of the CPT® procedure codes you report.

5. Beneficiary eligibility
Description: You submit a claim for processing and the beneficiary/patient does not have eligibility. Claims often are denied for eligibility because:

- The beneficiary number is invalid on the claim
- The beneficiary is not eligible to receive benefits
- The beneficiary's claims must be filed to another insurance plan

6. Incorrect carrier
Description: The claim was submitted to the incorrect payor/contractor for payment.

It's important to screen patients and be aware of the types of services provided prior to submitting a claim to the carrier. Check the patient's insurance card and verify the Health Insurance Claim (HIC) number on the card. Patients with traditional Medicare coverage will have HICs of nine digits followed, by an alphanumeric suffix.

7. Medicare is the secondary payor
Description: The care of a Medicare patient may be covered by another payor through coordination of benefits. Medicare may be the secondary payor in our offices when the Medicare patient is: 65 years or older, employed full- or part-time by an employer who has 20 or more full- or part-time employees, and covered under the Employer's Group Health Plan (EGHP); or covered under the EGHP of an actively employed, full- or part-time spouse whose employer has 20 or more employees.

- Liability and auto/no-fault liability: Section 953 of the Omnibus Budget Reconciliation Act of 1980 was amended by the Deficit Reduction Act of 1994. It precludes Medicare payment for items or services to the extent that payment has been made or reasonably can be expected.
- Where the primary claim should be filed under auto, medical, Personal Injury Protection (PIP), no-fault, worker's compensation, or any liability insurance plan or policy including self-insurance plans.
- Workers' compensation: Medicare will be the secondary payor for work-related illnesses or injuries covered under a workers' compensation plan.
- Veteran's Affairs (VA): VA records are set-up by information received by the Social Security Administration. Veterans who are entitled to Medicare may choose which program will be responsible for payment of services covered by both programs.

8. Incorrect Diagnosis
Description: Services were denied because the diagnosis listed as primary was not a covered diagnosis for the procedures performed.

- Having a covered diagnosis does not mean you automatically can perform any procedure for which the covered diagnosis exists. The medical record must substantiate the service. For example, consider

routine anterior segment photography for a patient who presents with allergic conjunctivitis. Despite having a "covered diagnosis" for taking the photo, there most likely is insufficient medical necessity to take an annual photo of the allergic eye.

9. The claim is missing a modifier or has an incomplete or invalid modifier
Description: The modifier necessary to process the claim correctly is missing, incomplete, or invalid for the specific procedure and diagnosis indicated on the claim form.

- Know how to apply CPT® modifiers for the specific condition or situation. CPT® modifiers are defined in their entirety in Appendix A of the CPT® manual.
- Misuse and abuse of modifiers—particularly modifiers 22, 25, and 59—is under OIG scrutiny and can result in significant penalties.

Coding for physician services and materials is seemingly complex, but keeping current with published policies and guidelines that are obtainable easily should help ensure a high degree of success within your practice.

Top Evaluation and Management Coding Errors

1. **Upcoding**
   Documentation in the chart does not support the level of service
2. **Downcoding**
   Documentation in the chart supports a higher level of service
3. **Chief complaint or reason for the visit is missing from the note**
4. **Assessment is not documented clearly**
   Providers cannot use rule out, probable, or suspected conditions for a diagnosis; however, providers should document suspected conditions to get credit for the medical necessity for the service, while also documenting signs and/or symptoms.
5. **Documentation is not initialed or signed**
6. **Tests ordered are not listed in the documentation, but are billed on the encounter form/superbill**
   When tests are ordered, document in the medical record for the date of service the tests were ordered.
7. **A clear assessment and plan is not documented clearly**
8. **Diagnosis is not a referenced correctly**
9. **Documentation is missing**
10. **Lost dictation**
11. **Superbill/encounter form and/or charge (fee) ticket are not available**
12. **Superbill/encounter is incomplete or incorrect**
13. **Documentation is illegible**

When auditing medical records, the auditor should review the documentation for coding errors the government and other payors have identified as problematic.

Auditing Evaluation and Management Services

The CPT® system for reporting office visits, consultations, hospital visits, emergency department visits, and all the other "visit" services provided by physicians was revised in 1992 to correlate with the payment system instituted by the federal government for Medicare claims. In the past, the reporting of the physician's professional encounters was subjective, undefined, and easily manipulated for better description. With the new method of payment, the entire structure of an encounter had to meet measurable standards.

In 1992, all narratives and components changed, thereby forcing the measurement of service intensity into the selection process. Intensity of service is measured as graduated levels of service, but not given names equivalent to the terminology used in the past (e.g. brief, intermediate). Within each level, CPT® lists specific components to measure service intensity.

Which E/M Guidelines Should You Use?

The Center for Medicare & Medicaid Services, local contractors, and commercial carriers have all supported the use of *either* the 1995 or 1997 E/M documentation guidelines. When auditing medical records, carriers will review both sets of guidelines and give the provider credit for using either set.

When reviewing your physician's records, it is recommended that you encourage your providers to use the 1997 guidelines, so that when the final determination is made by the insurance carrier, your provider will not have difficulty defending the service provided; however, when you audit the medical record, you might want to use both sets of guidelines. If the practitioner meets the definition of compliance with the 1995 guidelines, it is compliant unless your organization has a specific policy that the 1997 guidelines should be used.

An issue to consider when using the 1995 guidelines is that there is no quantifiable number of body area(s) or organ system requirements.

Auditing the Surgical Medical Record

- Insurers monitor physicians' 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.

Accurately translating surgical and medical services into CPT® and ICD-9-CM codes is challenging. To audit the surgical medical record accurately, the auditor must have a good understanding of surgical terminology and anatomy. The auditor also must understand the surgery coding guidelines, insurance carrier rules, CCI edits, and how to code an operative report.

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. The CPT® manual describes the surgery package as including:

1. 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)
2. local anesthesia: defined as local infiltration, metacarpal/ digital block, or topical anesthesia
3. the operation itself
4. immediate post-operative care, including dictation of operative notes, talking with family and other physicians
5. writing orders
6. evaluation of patient in post-anesthesia recovery
7. normal, uncomplicated follow-up care

The following are some examples of what might be included in a surgical procedure:

- 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
- 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

Medicare Surgical Guidelines

Minor Surgical Procedures

A minor procedure is defined by Medicare as a service that has 0 or 10 day postoperative period. Payment for minor procedures includes same-day services (either preoperative or postoperative care), intraoperative care, and care within the defined global period.

Major Surgical Procedures

The major surgical procedure is defined as having a one-day preoperative period and a 90-day postoperative period. Payment for a major medical procedure includes all related preoperative care, postoperative care, and intraoperative services. The global fee includes the following services:

- Preoperative visits beginning with the day before the day of surgery
- Intraoperative services that are 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 due to complications that 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

Correct Coding Initiative (CCI)

In 1996, CMS implemented a nationals policy aimed at controlling improper or incorrect practices in the filing of Medicare Part B claims. A comprehensive review of CPT® code descriptors, CPT® coding instructions, national and local coding edits, and Medicare billing history was followed by a comment period by specialty societies and the AMA. After input from these groups and CMS' review of their comments, the code combinations became "correct coding edits." The CCI replaced a variety of rebundling programs that were being used by local carriers. Many third-party payors and other insurance carriers now rely on the CCI when initiating policy for surgical procedural coding.

The CCI constantly reviews code combinations and makes recommendations for addition and deletion of combinations from the correct coding edit list. After input is solicited and evaluated from specialty societies and the AMA, the edits are updated quarterly. The absence of a combination from the edit tables does not imply coverage. All changes are controlled and approved by CMS. Local carriers may not add or delete code combinations.

The code combinations fall into two categories and are listed on two tables: Correct Coding (often referred to as rebundling) and Mutually Exclusive. **Correct coding edits** are established to deny component procedures that should not be reported separately with more comprehensive procedures. **Mutually exclusive edits** are established to deny one of a combination that would not or could not be performed at the same time on the basis of CPT® code description or standard medical practices.

In those instances where it is proper and necessary to report a code combination performed on the same day that is normally prohibited by CCI, the CPT® modifier 59 *Distinct procedural service* should be applied.

Unbundling

Unbundling occurs when multiple procedures are billed separately when the services are covered by a single comprehensive code. Never divide the components of a procedure when one code covers all the components. Procedures should be recorded with the CPT® and or HCPCS level II code(s) that most comprehensively describe the services performed by the practitioner.

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.

Medicare closely monitors physician billing practices for possible abuse or fraudulent billing. Private payors also watch for unbundling.

Unbundling Prevention Tips

1. Use current CPT®, ICD-9-CM, and HCPCS Level II code books, as well as the current rules, regulations, and provider manuals for Medicare and for private payors with whom you have a contractual arrangement.
2. Educate yourself on CPT® guidelines, as well as the rules and regulations of your payors. The Health Care Insurance and Portability and Accountability Act (HIPAA) does not excuse lack of knowledge for incorrect coding.
3. When using an encounter form/superbill/charge ticket, specify the exact CPT® code and description. Always have an area on the encounter form to add procedure and diagnosis codes.
4. Code directly from the chart note or operative note.
5. Update codes annually. Remember: Guidelines and codes are added, deleted and revised each year.
6. Avoid fragmented billing. Use your encounter form as key to correct coding. You might add an "SP" next to the separate procedures (discussed below) on your encounter form.
7. Make sure physicians provide the person coding the encounter with complete documentation and concise information. Consult the physician if documentation is not adequate or if documentation will not support the code selected.
8. Use correct modifiers to clarify or append circumstances that can arise within the global package.
9. Coders must exercise caution when reporting integral procedures. Medicare and Medicaid closely monitor physicians' billing practice for possible abuse or fraudulent billing. Private payors also have the mechanisms in place to scrutinize claims.

Performing the Chart Audit

The medical record serves a variety of purposes, and is essential to the proper functioning of your practice—especially in today's complicated regulatory health care environment. The medical record should contain detailed information pertinent to the care of the patient, document the performance of billable services, and serve as a legal document that describes a course of treatment. Periodic audits, whether internal or external, ensure that the record adequately serves these purposes and meets with federal and state regulations.

Auditing your charts can be a valuable learning experience. Four of the most important reasons to audit your medical records are:

1. To assess the completeness of the medical record
2. To determine the accuracy of the physician's documentation whether is be an E/M service, radiology report, surgical report, etc.
3. To identify under-documented services
4. To uncover lost revenue

An auditor (internal or external) examines the documentation to determine whether it adequately substantiates the service billed, and identifies medical necessity. If you do not check the quality of your charts on an ongoing basis, you may be unaware of incorrect or inappropriate documentation and coding practices, and areas of noncompliance with government and private payor guidelines.

There are five parts to auditing a medical record:

1. Performance of the audit
2. Reporting
3. Meeting and discussing results with the practitioner
4. Identifying any repayment or submitting missed charges
5. Ongoing periodic auditing and monitoring to identify problem areas and areas that have improved

A medical record chart audit has no value unless all steps are performed.

Audit Objectives

Prior to performing a chart audit, identify specific goals. You can divide chart audit objectives into two main categories: 1.) revenue, and 2.) compliance with correct coding policies.

Revenue

An audit's revenue objectives involve examining coding practices for lost revenue due to the improper use of codes. This process also may reveal inappropriate billing to gain higher reimbursement (which is an open invitation to a payor audit). When considering revenue, look at:

- underbilled services
- overbilled services-frequency or upcoding
- undocumented services
- denied services
- downcoded services
- services not billed or missed charges

Services Not Billed or Reported

Compare the medical record to the billing to identify services that are documented in the medical record, but are not coded. This often is caused by ineffective communication between the provider and the billing staff, or lack of knowledge on the part of the coders.

Overbilled and/or Underbilled Services

As with non-billed services, the search for overbilled or underbilled services begins with comparing the chart documentation to the billed codes. All services, including E/M services, ancillary procedures or services, and surgical procedures should be documented with sufficient detail to allow coders to select the proper CPT®, HCPCS Level II, and ICD-9-CM codes.

Undocumented Services

A good audit (review) will identify instances where codes are billed without proper supporting documentation. When a private payor, Medicare, or Medicaid requests written proof of billed charges, the provider must be able to substantiate the service. Some examples of commonly-misplaced information are laboratory test results, X-ray reports, problem lists, and medication lists. You must be able to defend documentation to support medical necessity and be prepared to defend the documentation upon carrier/contractor appeal, or in a court of law.

Under-documented Services

These are services that support a higher E/M service level or other services, but the documentation does have enough detail to report the service at the appropriate level, or to report any additional ancillary or office procedures.

Denied or Downcoded Services

Downcoded services are services the payor determines should be paid at a lower level of service. Analyze those services that are denied or downcoded by payors to discover the cause. This information comes from comparing the billed services to the Explanation of benefits (EOB) or Remittance Advice (RA) portion of the payor statement.

Evaluating for Compliance

The second set of audit objectives involves evaluating the documentation for compliance with Medicare, Medicaid, and/or private payor standards. Not only are compliance issues important to the overall good management of patients, they are also important for expedient and accurate reimbursement.

When looking at compliance issues, consider:

- Current patient data or patient demographic form
- Superbill/charge ticket/encounter form
- Physician signatures
- Signed patient consent forms
- Medicare limitation of liability waiver-Advanced Beneficiary Notification
- CMS 1500 or UB-04 claim forms
- Individual Carrier Policies if applicable
- Correct reporting of CPT®, ICD-9-CM, and HCPCS coding
- Utilization patterns

Current Patient Data

The patient information sheet will identify the patient demographics, as well as updated and complete insurance information.

- date of birth
- address
- nearest living relative
- complete insurance information including copy of the card in the chart

The patient information should be updated regularly. Request that the patient with insurance sign the assignment of benefits form to ensure direct payment of insurance benefits to the provider. Update this record yearly.

Physician Signatures

A thorough audit will verify that all services and procedures provided to a patient are signed or initialed by the provider. The signature of the provider acknowledges that he/she has performed or supervised the service or procedure.

An unsigned entry in a medical record may be viewed by an insurance payor as nonperformance of that service. Some areas of the country do not currently require an original signature or the initials of the provider of the service. Some carriers will allow electronic signatures, initials, and full signature. It is a good idea to check with each local carrier in your area to determine the requirement. However, CMS along with most major carriers have now disallowed the use of rubber stamps (CR # 6698 and PIM 100-08 6698.3 and MM 6698).

Chart entries that are not in the physician's handwriting should be countersigned by the attending physician. This includes medical services performed by:

- Nurses
- Medical assistants
- Physician assistants
- Nurse practitioners
- Other staff

Signed Consent Forms

The medical record of each patient that undergoes a procedure involving significant risk should contain a written consent form. Always obtain consent before conducting an invasive procedure. The consent should state that the patient has been informed about the procedure, its risks and benefits, and any alternatives. It should also indicate that the patient understood the issues discussed and has given consent to treatment. This information may be kept in a separate section or accompany the documentation of the procedure.

Insurance Forms

An auditor should check claim forms—whether submitted electronically or by hard copy—to see that they are completed correctly. Include all pertinent dates, and diagnostic and procedural coding information necessary for payors to generate reimbursement. If claims are submitted electronically, the medical billing system is a tool to generate the insurance claim that was submitted.

Superbill/Charge Ticket

These forms are used to record the patient billing information. This may include the procedure and/or the diagnosis code. Not all physicians use superbills, especially when using the Electronic Medical Record. Reference this form identifies the intended coding of the practitioner and helps to identify data entry errors.

Beginning the Audit Process

A well thought-out plan is essential to carrying out a chart audit that will yield useable data. The first questions to consider are:

- What is the focus of the audit (e.g., new patient visits, consultation, office, hospital, etc.)?
- Are you performing a prospective or retrospective audit?
- What is the number of charts you are going to review?
- Is there a measure for the focus such as utilization patterns?
- Has the provider been audited before where data is available?
  - If "yes," then a benchmark or standard exists;
  - If "no," then a standard for comparison may not exist.
- What type of audit tool will you use?
  - Electronic
  - paper

Chart auditing is an iterative process: Do not be discouraged if the answers to some of the questions above change several times before being finalized. It is always a good idea to inform the medical records manager or compliance officer when you are conducting a chart audit. The records manager can help locate the appropriate charts, arrange an ideal time to review charts, and can assist with issues related to confidentiality.

How to Conduct a Chart Audit Step by Step

Before beginning the audit process you must do your homework. You must analyze and determine what type of records to audit; how many (sample size), and how you will summarize and present results. Review the following issues to consider:

1. Select type of services to review, which might include:
   a. Office or Hospital
   b. New versus established patients
   c. Consultation
   d. Nursing home visits
   e. Surgical procedures
2. Identify measures (levels of services)
3. Identify patient population based on insurance carrier
4. Determine sample size (typically 10-20 charts)
5. Create or obtain audit tool (s) paper or electronic
6. Collect data (Perform the audit)
7. Summarize results
8. Analyze and apply results
9. Meet with the practitioner to discuss results and offer solutions for improvement
10. Refund overpayments and submit claims for missed charges if applicable

The Steps

Although the chart audit process is not always necessarily linear, this list represents the general steps involved.

Step 1: Identify Audit Objectives

An audit helps facilitate the maintenance of an accurate and complete assessment of the organization's coding and reimbursement practices. The audit helps ensure compliance with external regulations and internal policies by accurately reporting correct coding to insurance carriers. Potential risk areas and areas for improvement that have an impact on the financial and clinical aspect of the practice may be identified. The audit is also conducted to ensure the documentation in the medical record supports the CPT®, HCPCS Level II, and ICD-9-CM code(s) assigned.

Practitioners must have an opportunity to get involved and support the coding and/or billing teams. Physicians routinely should assign the code(s) for all services, and the coding and billing team is best utilized to keep track of the rules for the practitioners, and to make sure they have the appropriate tools to code and document accurately. Documentation is crucial to code selection, and physicians must have help to cope with the overwhelming demands of paperwork that they may believe adds little value to patient care. Physicians appreciate feedback in coding because they are interested in receiving the correct reimbursement, and understand that coding directly affects payment for their services.

When problem areas are identified, the focus can then turn to education where most needed. Training needs vary, and auditing allows the organization to design an education model to specific needs. Auditing also will provide information on patterns and trends that may affect the organization.

The Baseline Audit

A baseline audit informs the organization how it fairs in relation to correct coding and billing, and serves as a tool to identify errors. Most baseline audits are random and should include all coding practices. The audit should be a resident sampling of all records and services and should include all physicians and practitioners in the organization.

Begin by auditing a random sample of records. A random sample is one in which each record has an equal probability of being chosen for review (random sampling). If you select specific records or levels of service, the audit is not random, but a focused review. An example of selecting a random sample would be to select dates of service and a specific number of patient records for each practitioner. The records also should be recent (within past three months), and are flagged for review upon completion of the documentation and billing process.

Step 2: Sample Size

The audit sample should include a certain percentage of patient encounters to ensure a representative sample. Auditing too few records may distort results, while auditing too many records becomes too time consuming and labor intensive, and normally is not any more effective. The compliance officer, office manager, and/or practitioner should help determine the appropriate number of medical records

to review. A good sample size is 10 to 20 charts. It is a good idea to concentrate on visits that took place during a specific time period so that trends can be observed. Merely pulling charts at random will not always accomplish this goal. Reviewing charts that are six months to a year old serves no benefit. The OIG recommends five to ten random charts per physician when conducting an audit.

Where Do You Perform the Audit?

An audit can be performed on-site, which gives the auditor access to the entire medical record, as well as any pertinent information the auditor might need when reviewing the patient encounter. This is the preferred method of auditing. With an off-site audit, the auditor will only have access to what was provided to review, such as the superbill/charge ticket, the claim form, and the patient record for the date of service. There may be other documents referenced in the note that are not available. In a facility audit, many facilities will not allow records or copies to leave the facility. These must be analyzed on site.

Different Type of Audits

As with prospective, retrospective and focused reviews, there are different types of samples.

- Random sample (any type, level of service, visit, or procedure)
- Controlled sample (a specific level or type of service)
- High volume services
- High risk services
- Frequent denials
- Past errors

If the practice has conducted previous audits, past audit reports might identify focus areas; whereas, if this is the first audit conducted, the auditor might focus on a random sampling initially.

Step 3: Develop or Select an Audit Tool

A good audit tool is important when auditing the medical record. If the auditor is conducting an evaluation and management audit, for example, the auditor must identify which set of guideline the practitioner is using, and the tool needs to reflect the guidelines. If the auditor is reviewing surgical notes, a surgical audit tool should be used. If an audit of psychiatric or ophthalmology records are reviewed, the audit tool used would be specific to the specialty, and so forth. There are several samples of audit tools in the addendum of this chapter you can copy and use.

Some auditors use an electronic audit tool to audit records. This is generally in the form of software that will print audit reports and analyze the data after you enter the detail of the E/M level. Keep in mind: Medical necessity also must be determined when reporting an E/M level. The computer software does not have the capability to analyze medical necessity. Sometimes the level selected by the audit software affords a higher level of service based on documentation alone, and the medical necessity element cannot be incorporated into the software. This element is a "thinking" process. A good clinical background is imperative when analyzing medical necessity.

Other Necessary Tools

You cannot audit successfully without additional tools to help guide you. In addition to the audit tool (s) described above, the auditor will need:

- Evaluation and Management Documentation Guidelines (1995 and 1997)
- CPT® code book
- ICD-9-CM code book
- HCPCS Level II code book
- Payer guidelines
- Payment policies
- CPT® Assistant references
- AHA Coding Clinic references
- Frequency reports by physician (utilization of levels of service obtained by the medical billing software)
- Utilization based on specialty (can be obtained by insurance carrier)
- Physician's fee schedule by insurance carrier
- Medical Dictionary
- OIG Workplan
- Other coding references

Step 4: Perform the Audit

As stated earlier, auditing your charts can be a valuable learning experience and provides much needed analysis for compliance. Four of the most important reasons to audit your medical records are to:

1. Assess the completeness of the medical record
2. Determine the accuracy of the physician's documentation
3. Ensure the coding is correct (both procedure and diagnosis)
4. Uncover lost revenue

An auditor (internal or external) examines the documentation to determine whether it adequately substantiates the service billed and identifies medical necessity. If the quality of the medical record is not reviewed on an ongoing basis, incorrect or inappropriate documentation and coding

practices may not be uncovered. Because compliance with government and private payor guidelines is important, the audit or medical record review is critical in all medical practices. Be consistent when choosing a sampling of medical records to eliminate confusion.

Select patient encounters (chart notes) to review that are no more than three months old. If you are auditing services before the claim is submitted, audit services performed the same week as the audit. If performing a retrospective audit, for each patient encounter you will need the superbill/charge ticket, patient chart or date of service, claim form or billing record (validates what was submitted), and the explanation of benefits or Remittance Advice.

Familiarize yourself with the chart organization, special forms including the history form, problem list, medication sheet, etc., and be familiar with the coding criteria for services provided.

- New versus established patient
- Consult versus transfer of care (referral)
- Time based code requirements
- Critical care services
- Hospital services

When auditing a group of 10-20 charts, be sure they services are comparable. Hospital and critical care services are like services, for example, as are office visits and office consults. It is not recommended that you mix hospital, surgical, and office services on one audit report.

Audit a minimum of 10-20 medical records for each provider. Identify problem areas, such as:

- Improper use of CPT® codes
- E/M code(s) not supported by the documentation
- Diagnosis code that is incorrect or does not support medical necessity
- Missing modifiers and/or incorrect modifier usage
- Other procedures or services improperly reported
- Incorrect diagnosis linkage
- Services performed but not billed

Step 5: Complete the Review Analysis and Summary Report

Complete the summary report identifying the number of encounters documented correctly and incorrectly, other coding issues, and suggestions for improvement. Audit reporting mechanisms will be discussed later in the chapter.

Step 6: Meet With the Practitioner

Schedule a meeting with the provider to review coding errors, offer suggestions, and answer questions. Allow enough time to review all the medical records in which you found incorrect coding based on documentation. Provide handouts with official carrier and/or coding guidance to the provider that will help him or her maintain compliance. Suggest periodic audits to monitor and maintain compliance.

Step 7: Make Recommendations for Improvement

An audit is not effective after completed if the auditor does not develop constructive recommendations for improving documentation. This might be accomplished by creating "cheat sheets" or templates to help the physician/practitioner capture all the services provided during the patient encounter, and to ensure that the documentation supports the level of service based on the complexity of the patient treated. A good way to identify recommendations is in the report you develop for the provider after the audit is completed. You can identify utilization pattern abnormalities, coding errors, and documentation errors when developing your report.

Step 8: Provide Monitoring and Guidance

After the baseline audit the auditor—along with the practitioner, compliance officer and/or practice administrator—should decide, based on the audit results, how often the practitioner's documentation should be reviewed. For example, if auditing 10 medical records and 40 percent (four records) meet the documentation guideline requirements, it would be beneficial to perform audits more frequently than for the practitioner who is 90 percent compliant with coding and documentation. The physician who has more documentation and/or coding errors will need help and guidance more frequently than the practitioner who has minimal errors.

Audit Tools

The audit tool is a "must have" for any medical record auditor. There are a variety of pre-packaged audit tools for general use; however, it is beneficial for the auditor to create his or her own audit tool and tailor the tool to the specialty that is being audited.

A paper tool can be created in a template format in word or other software programs. Keep in mind that the tool should be compliant with coding and documentation guidelines.

Make sure before conducting the audit, you use a chart review checklist to help guide the scope and type of audit you will perform.

The sample audit tool on the next few pages outlines elements pertinent to the E/M guidelines. This is just a sample audit tools for a general multi-system patient exam encounter for either the 1995 or 1997 guidelines. Review the chart review checklist and audit tool below. You will use this audit tool when performing all exercises.

Chart review checklist	YES	NO	N/A
Consider the following items when preparing records for review:			
1. Chart note/hospital note for date of service			
2. Any previous notes referenced in chart being audited (e.g., "No change from 2/02/20xx")			
3. Supporting/supplemental information (history form, patient-assessment form, technician form, medication list)			
4. Reference material, including an abbreviation list, common terminology, and signature list			
5. Billing information indicating Current Procedural Terminology (CPT®), and International Clinical Documentation, Ninth Revision, Clinical Modification (ICD-9-CM) codes submitted for service			
6. Copies of claims of services reviewed			
7. Remittance advice			
Coding review			
E/M coding review should encompass the following:			
1. Review of the medical records, claims, and payments			
2. Reconciliation that demonstrates items and services ordered by the physician or practitioner were documented, rendered, and billed accurately			
3. Review of physician coding and documentation:			
4. Verification CPT® E/M coding assignment			
5. Review of ICD-9-CM code assignment			
6. Review of the chart for medical necessity			
Comments:			
The E/M audit form on next page may be used to complete an E/M coding review.			

E/M Audit Form Example

Patient Name:____________________ **Date of service:**___/___/___ **Provider**__________________ **MR #:**________________

HISTORY

☐ Chief complaint (required all levels):

History of Present Illness (HPI) ☐Brief (1-3) ☐ Extended (4 or more or update of 3+ chronic illnesses)

☐ Location ☐ Severity ☐ Timing ☐ Modifying factors
☐ Update 3+ chronic ☐ Quality ☐ Duration ☐ Context ☐ Assoc. signs /symptoms

Review of systems (ROS): ☐ None ☐ Problem pertinent (1) ☐ Extended (2-9) ☐ Complete (10+)

☐ Constitutional ☐ Cardiovascular ☐ Gastrointestinal ☐ Integumentary ☐ Endocrine
☐ Eyes ☐ Respiratory ☐ Genitourinary ☐ Neurological ☐ Hematologic/lymphatic
☐ ENT ☐ Musculoskeletal ☐ Psychiatric ☐ Allergic/Immunologic ☐ All others negative

Past, family, and social history (PFSH): ☐ None ☐ Pertinent (1 of any) ☐ Complete est. (2 of 3) ☐ Complete new (3 of 3)

☐ Past: Allergies, current medications, immunizations, previous trauma, surgeries, previous illnesses/hospitalizations.
☐ Family: Health of parents, siblings, children. Family members w/ diseases related to the chief complaint.
☐ Social: Drug, alcohol, tobacco use. Employment. Sexual history. Marital status. Education. Occupational history.

SCORE: HISTORY COMPONENT

☐ **Problem focused**	☐ **Expanded problem focused**	☐ **Detailed**	☐ **Comprehensive**	☐ **Not Documented**
CC; Brief HPI (1-3)	CC; Brief HPI;	CC; Extended HPI (4+)	CC; Extended HPI;	
ROS: None	Problem Pertinent (1 system)	ROS: 2-9 systems	Complete ROS; 10+	
PFSH: None	PFSH: None	PFSH-1 history area	PFSH – 2 established patient 3 new patient	

PHYSICAL EXAM

General multi-system examination (Body area/organ system elements of examination)

Organ Systems

☐ Constitutional: ☐ Vital signs: sit/stand BP, sup BP, temp, pulse rate, resp, ht, wt **or** ☐ General appearance
☐ Eyes: ☐ conjunctivae/lids, ☐ pupils/irises, ☐ optic discs
☐ ENT: ☐ ext exam ears/ nose, ☐ ext aud canal/tymp memb, ☐ hearing assessment, ☐ nasal mucosa/septum/turbinates, ☐ lips/teeth/gums, ☐ oropharynx—oral mucosa, palates
☐ Respiratory: ☐ resp. effort, ☐ chest percussion, ☐ chest palpation, ☐ auscultation of lungs
☐ Cardiovascular: ☐ palpation heart, ☐ auscultation, exam of: ☐ carotid, ☐ femoral arteries, ☐ abdominal aorta, ☐ pedal pulses, ☐ extremities
☐ Gastrointestinal: ☐ abdominal, ☐ liver/spleen, ☐ hernia, ☐ stool sample taken, ☐ anus, perineum, rectum
☐ Genitourinary: ☐ Male: scrotum, ☐ penis, ☐ digital rectal exam of prostate
☐ Female: ☐ pelvic, ☐ ext genitalia, ☐ urethra, ☐ bladder, ☐ cervix, ☐ uterus, adnexa/parametria
☐ Musculoskeletal: ☐ gait/station, ☐ digits/nails,
Exam of head/neck or spine/ribs/pelvis, Rt upper or Lt upper or Rt lower or Lt lower: ☐ inspect & palpate, ☐ stability, ☐ motion, ☐ strength & tone
☐ Skin: ☐ inspect skin/sub-q tissue, ☐ palpation skin/subcutaneous tissue
☐ Neurologic: ☐ cranial nerves, ☐ deep tendon reflexes, ☐ sensation
☐ Psychiatric: ☐ judgment/ insight, ☐ orientation, ☐ remote & recent memory, ☐ mood & affect
☐ Hematological/lymphatic ☐ neck, axillae, groin, other, ☐ immunologic:

Body Areas

☐ Head, including the face ☐ Neck: ☐ neck (masses, symmetry, etc ☐ thyroid ☐ Chest (breasts): ☐ inspection breast, ☐ palpation breast/axillae ☐ Abdomen ☐ Genitalia, groin, buttocks

☐ 1 or more in detail

☐ Back, including spine
☐ Left upper extremity
☐ Right upper extremity

Score: Physical Examination Component

☐ Problem focused ☐ Expanded problem focused ☐ Detailed ☐ Comprehensive ☐ Not documented

Medical decision making

Number of diagnoses and management options	**Pts**	**Total**	**Amount and complexity of data**	**Pts**	**Total**
Self limiting or minor problems (stable, improved, or worsening); *maximum of 2 points*	1		Ordered and/or reviewed clinical lab	1	
Established problem—stable, improved	1		Ordered and/or reviewed radiology	1	
Established problem—worsening	2		Ordered/reviewed test in the CPT® medicine section	1	
New problem—no additional work-up planned *Maximum of 1 problem given credit*	3		Discussed tests with performing or interpreting physician.	1	
New problem—additional work-up planned	4		Independent visualization and direct view of image, tracing, specimen	2	
Total points:			Decision to obtain old records/additional HX from other than patient, e.g., family, caretaker, prev. phys.	1	
			Reviewed and summarized old records and/or obtained history from someone other than patient.	2	
			Total points:		

Table of Risk—The highest level in ONE area determines the overall risk

Level	Presenting problem(s) or	Diagnostic procedure or	Management options
Minimal ☐	☐ One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	☐ Laboratory tests requiring venipuncture ☐ Chest x-rays ☐ EKG/EEG ☐ Urinalysis ☐ Ultrasound, e.g., echo ☐ KOH prep	☐ Rest ☐ Gargles ☐ Elastic bandages ☐ Superficial dressings
Low ☐	☐ Two or more self-limited or minor problems ☐ One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH ☐ Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	☐ Physiologic tests not under stress, e.g., pulmonary function tests ☐ Non-cardiovascular imaging studies with contrast, e.g., barium enema ☐ Superficial needle biopsies ☐ Clinical laboratory tests requiring arterial puncture ☐ Skin biopsies	☐ Over-the-counter drugs ☐ Minor surgery with no identified risk factors ☐ Physical therapy ☐ Occupational therapy IV fluids without additives
Moderate ☐	☐ One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment ☐ Two or more stable chronic illnesses ☐ Undiagnosed new problem with uncertain prognosis, e.g., lump in breast ☐ Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness	☐ Physiologic tests under stress, e.g., cardiac stress test, fetal-contraction stress test ☐ Diagnostic endoscopies with no identified risk factors ☐ Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath ☐ Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	☐ Minor surgery with identified risk factors ☐ Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ☐ Prescription drug management ☐ Therapeutic nuclear medicine ☐ IV fluids with additives ☐ Closed treatment of fracture or dislocation without manipulation
High ☐	☐ One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment ☐ Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ☐ An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	☐ Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests ☐ Diagnostic endoscopies with identified risk factors ☐ Discography	☐ Elective major surgery (open, percutaneous or endoscopic with identified risk factors) ☐ Emergency major surgery (open, percutaneous or endoscopic) ☐ Parenteral controlled substances ☐ Drug therapy requiring intensive monitoring for toxicity ☐ Decision not to resuscitate or to de-escalate care because of poor prognosis

Decision-making total: —2 of 3 must be met

Pts	Number of DX	Amount of data	Risk of complications	Medical decision-making level
1	☐ Minimal	☐ Minimal	☐ Minimal	☐ Straight forward
2	☐ Limited	☐ Limited	☐ Low	☐ Low complexity
3	☐ Multiple	☐ Moderate	☐ Moderate	☐ Moderate complexity
4	☐ Extensive	☐ Extensive	☐ High	☐ High complexity

Score: E&M service

History	Exam	Medical decision-making level
☐ **Problem focused**	☐ **Problem focused**	☐ **Straightforward**
☐ **Expanded problem focused**	☐ **Expanded problem focused**	☐ **Low complexity**
☐ **Detailed**	☐ **Detailed**	☐ **Moderate complexity**
☐ **Comprehensive**	☐ **Comprehensive**	☐ **High complexity**

Number needed: ☐ 2 of 3 (MDM must be 1 of 2 to support medical necessity)

Please review the medical record for the following elements:

	Yes	No N/A
1. Was the medical record for this service found?	☐	☐
2. Is the medical record legible?	☐	☐
3. Is the attending/teaching physician's note written by the billing physician?	☐	☐
4. Does the date of service billed agree with the date of the progress note?	☐	☐
5. If a resident was involved in providing this service, review teaching physician documentation and answer the following questions:	☐	☐
A. Does this service meet the primary care exception?	☐	☐
B. Does the medical record demonstrate teaching physician involvement?	☐	☐
C. Does the teaching physician's note link to the resident's note?	☐	☐
6. Does the documentation support the ICD-9 codes billed?	☐	☐
7. Does the documentation support the level of service billed?	☐	☐

☐ Dictated ☐ Handwritten EMR ☐ ☐ Form ☐ Illegible ☐ Note signed

☐ Signature missing ☐ Diagnosis Code(s) supported ☐ Other Service provided

TIME ☐ A description of what was discussed must also be detailed

Face-to-face time: Indicate the total face-to-face time (or total floor time for inpatient services) spent with the patient

Counseling/Co-ord. Time: Time spent counseling or coordinating care (must be greater than 50% of total face-to-face/floor time)

Code (s) selected: ______________ **Code(s) audited:** __________ ☐ **Over** ☐ **Under** ☐ **Correct** ☐ **Miscoded**

Dx code(s) billed: ____________ **Dx code(s) documented:** ____________ **Other services** ______________

Comments:

Auditor's Signature ____

The Audit Report

The audit report should be quick and easy for the practitioner to read. A 50-page report is less likely to be reviewed. You can design your own report, but listed below are elements that must be included:

1. Practice name
2. Physician or provider audited
3. Auditor's name
4. Date of audit
5. Findings
6. Recommendations
7. Summary based on findings and recommendations

Review the example of a simple audit report that is easy to read and understand, below:

Medical Record Chart Audit Summary Report

Practice: ABC Medical Group
Date of Audit: 09/15/20xx

Provider: Mark Welby, MD
Auditor: Annie Taylor, CPC, CPMA, CEMC

A total of 10 records were reviewed using the 1997 Cardiovascular System and 1995 General Multi-system E/M Guidelines, CPT® Coding rules, and Insurance carrier guidelines. Chart notes were received for the following physicians:

John Doe, M.D
The findings and recommendations based on the review of the office, and diagnostic procedures are as follows:

Findings

E/M documentation in the record appeared to support service billed	6
E/M documentation in the record appears to support a lower level of service than billed	3
Documentation appeared to be missing or could not be located in the Record	1

Findings and Recommendations:

1. Three medical records reviewed (chart #1-3) for a comprehensive level consultation (99244) did not contain all the key component requirements. The documentation requirements for a level four office or other outpatient consultation (99244-99245) require the following three elements to be met:
   - Comprehensive History
   - Comprehensive Examination
   - Medical Decision Making Moderate

The documentation concerned contained a comprehensive history with decision making supporting the comprehensive consultation (99244), but the examination did not appear to meet either the 1995 or 1997 guidelines for all three consultation codes reported.

Recommendation: Review the exam requirements for comprehensive level of service for both the 1995 and 1997 documentation guidelines.

2. One date of service (chart #7), the history met the detailed level for the established patient level four (99214 visit), but the examination was expanded problem focused and the medical decision making was low complexity. Two of three key components must be met to report the level of service. Medical necessity did support a 99214, but one of the other key components must contain the detail to support the level of service billed.

Recommendation: Review the documentation requirements for a level four new and established patient visit for both the 1995 and 1997 documentation guidelines.

3. For one patient, a level four established patient visit was reported, but the documentation supports billing the EKG, Echo, and Doppler studies in addition to the evaluation and management service. There was evidence the services were provided to the patient on the date of service reviewed.

Recommendation: Review the importance of capturing all charges and service performed and documented during the patient encounter.

4. One date of service (chart #7) the documentation was not available and could not be located by the compliance manager. After further investigation it was discovered, dictation did not exist for the date of service, but the patient schedule indicates the patient was seen on the date of service.

Recommendation: Review the importance of dictating or ensuring a written patient encounter is documented for each date of service. Recommended the provider handwrite the chart note when seeing the patient, and keeping it in the chart until the dictation is signed and placed in the chart. Recommended the physician dictate a note for patient documenting that he is dictating from memory and that the original dictation was missing and/or was never dictated appropriately for the patient encounter.

Recommendation Summary

1. The provider needs to review the documentation guidelines for the higher levels of evaluation and management services.
2. A mechanism should be implemented to make sure all dictation is evident in every chart for each patient encounter.
3. The provider should use caution to ensure all charges are captured and reported on the claim form.
4. A follow up audit should be performed in six months until the provider reaches 95 percent compliance and then yearly thereafter.

Detailed Analysis

Practice: ABC Medical Group | **Provider:** Mark Welby, MD

Date of Audit: 09/15/20xx | **Auditor:** Annie Taylor, CPC, CPMA, CEMC

Chart #	Patient	Date of Service	CPT® Code Reported	CPT® Code Documented	ICD-9-CM Reported	ICD-9-CM documented
1	Bryson Hyatt	08/15/20xx	99244 93000	↑99242-25 93000	785.2	785.2
2	Faith Hyall	08/22/20xx	99244 93000	↑99241-25 93000	785.2	785.2
3	Mara Dittimore	08/22/20xx	99244	↑99242	785.2 427.9	785.2 427.9
4	Danny Keys	08/22/20xx	99243 93000	99243-25 93000	785.2 427.9	785.2 427.9
5	Maggie May	08/03/20xx	99213 93000	99213-25 93000	745.5 786.50 746.9	745.5 786.50 746.9
6	Mark Ruffles	08/29/20xx	99214	99214	745.69 424.0	745.69 424.0
7	Rosa Sanders	08/26/20xx	99215	↑99214	745.10	745.10
8	Jake Jones	08/22/20xx	99244 93000	**documentation could not be located**	759.82 424.0	**Documentation could not be located**
9	Lena Hill	08/23/20xx	99214-25 93000 93303 93320 93325	99214-25 93000 93303 93320 93325	745.2 747.3 429.3 794.31	745.2 747.3 429.3 794.31
10	Autumn Range	08/29/20xx	99214	99214-25 **93000** **93303** **93320** **93325**	745.11 745.10 747.3 794.31	745.11 745.10 747.3 794.31

Completing a coding audit accomplishes very little unless a serious effort is undertaken to fix the problems identified. Establishing an ongoing reporting and feedback system for each practitioner is important. Error rates should be recorded, but trends in documentation also should be recognized. If one physician is not documenting a thorough history, for example, that should be noted. If another physician is not recording a definitive chief complaint, that should be improved.

If the practice or physician can show evidence of improvement from one quarter to the next, this is an excellent sign to committing to correct coding, fixing errors, and maintaining compliance. Correcting any systematic undercoding uncovered in an audit will allow the practice to collect the payment deserved. Fixing coding and documentation errors can save the practice time and money if audited by an insurance carrier, while reducing overall financial risk.

Communicating Audit Results

After the review analysis and summary report are completed for each practitioner, the next step is to schedule a meeting with the practitioner to discuss results. Set a convenient time for the practitioner to allow for questions and time to review medical record documentation. The focus of the meeting should be to explain the deficit areas related to the documentation and coding. Often an audit discussion concentrates on errors, rather than highlighting the correct documentation and coding; however, good results reinforce the best coding practices and show where the organization excels.

Target areas that need improvement: Look for trends and patterns that indicate coding and reimbursement variances or changes in procedures. This will help determine follow-up procedures. Review and analyze findings in a timely manner. Set priorities to address findings and take immediate action. It is always difficult to defend against accusations of fraud when you are aware of problems and do nothing to correct them.

Have a copy of the chart in front of you to show the provider specifically, on the basis of E/M and coding guidelines, where the problem areas are so that he or she will understand were improvement is needed. As an auditor, it is also beneficial to have supporting carrier documentation available to back up what you are telling the practitioner. Some of these tools are:

- Medicare carrier manual
- Medicaid carrier manual
- Third-party payer manual
- Reliable coding and billing publications

Ongoing audits and training should be standard within the practice to maintain compliance. For example, if the problematic area is not enough documentation for a detailed level of service, the focus of the next review should be reviewing 10 to 20 detailed visits (You might also identify lost revenue if, for example, the practitioner consistently is billing at a lower level than the documentation supports—just be sure medical necessity supports the higher level service). If the problem area is documentation of hospital visits, the next review should focus on hospital visits, and so on.

When the practitioner understands the areas in which he or she needs to improve, offer suggestions for how you can help him or her achieve that goal. Coding training might be the next step in expediting change in the practitioner's documentation.

After the meeting, write a synopsis of the outcome of the meeting to help you with future audits and to document that you covered all deficit areas. Often, the practitioner will have unrelated coding and/or documentation questions. The auditor will need to research the answers and report back to the provider with supporting documentation. The auditor must be certain to follow up with the practitioner on a timely basis.

In many cases, the auditor will review findings with a compliance officer, medical director, and/or others who are involved in the maintenance of compliance in the organization.

After the baseline audit is completed and deficiencies are identified, monitor any internal risk areas on an ongoing basis. Communication is an important step in auditing medical records. Use the meeting with the provider as an education opportunity and deliver the results in person, whenever possible. It is important to involve the staff in any educational sessions or meetings because they are the providers' team members in the coding and documenting process.

Keep coding audit results professional and educational. Providers should be given the opportunity to review and study the results of their coding audit and to discuss openly areas that need improvement. Improvement is encouraged when the entire staff is committed to the goal of compliance. Avoid a heavy-handed response to the chart

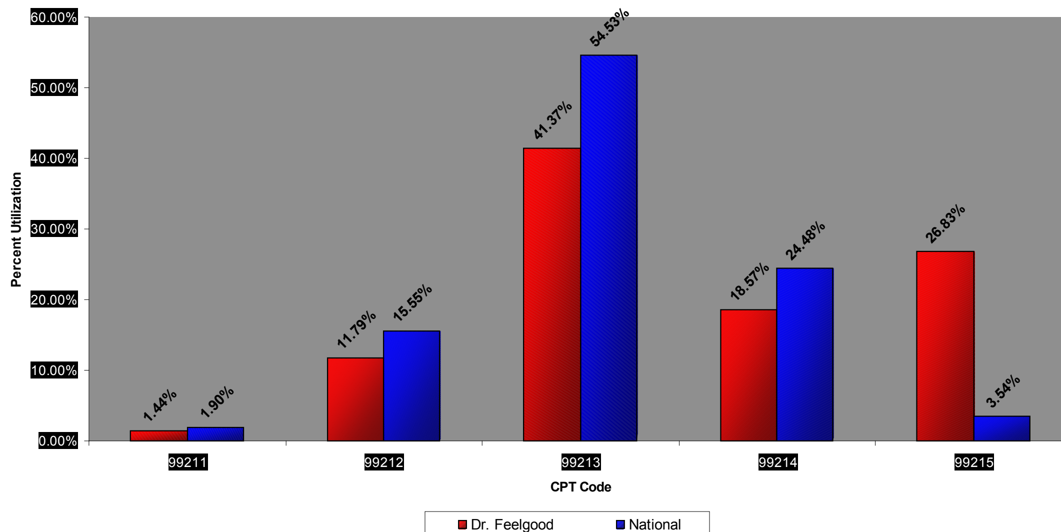
audit results: Making coding audits punitive for the parties involved does not benefit the practice and can lead to defensive behaviors that are more harmful than miscoding.

When communicating with the provider it is important to remain positive. Start by identifying the positive issues in relation to the medical record: Maybe the provider's handwriting is easy to read, or the provider documents a complete examination consistently. If you start with identification of the good issues related to the medical record, you will not put the practitioner on the defensive. Let him/her know that you are in their corner and you are auditing the records as a "preventive" measure and not to penalize the practitioner. Provide coding specifics in writing using a report mechanism.

Charts and grafts showing the provider his or her utilization pattern is also helpful. A utilization pattern is a coding profile that helps to evaluate coding patterns for E/M and other services. Most medical billing software programs have the capability to produce a CPT® Productivity or Utilization report to reflect specific insurance carrier claims for accurate comparison.

After you run the reports, the frequency of the codes submitted can be determined for each group of patients per Insurance carrier, or you may group all carriers together. It recommended that the report is generated based on the majority of services the provider reports. It is a good idea to reflect twelve months of production. The report will allow you to calculate frequency percentages simply by dividing the number of times each procedure code is used during a given period. A spreadsheet can be created to compare the practitioners' coding frequency with one another and the national benchmarks. The Centers for Medicare and Medical Services and the Medical Group Management Association (to name a few) publish these benchmarks.

See the illustration of a utilization pattern or graph below:



Risk Areas

The definition of a risk area is any area that falls below the threshold for accuracy. Determine the acceptable threshold prior to performing a baseline audit. Although 100 percent accuracy should be a goal for the practitioner, reasonable and obtainable goals should be set. It is helpful to classify variances by source. Review a few of the potential deficiencies below (this listing is not all inclusive):

- violation of official coding guidelines
- documentation inadequate to support level of service billed (code selection)
- noncompliance with third-party payor directives
- code assigned, but not billed on claim form
- service billed to the wrong provider
- incorrect place of service
- incorrect category of service (hospital, office, consultation, etc)
- signature requirements not met
- incorrect modifier usage

Monitoring for Accuracy

It is important after the initial audit to continue to monitor for compliance and to ensure that improvements have been made. Develop a method or process to measure compliance and the effectiveness of the training that has been provided. To accomplish this goal, develop a schedule for subsequent audits.

The frequency of the audits will depend on the number of problem areas and the overall error rate of the organization. Normally, audits are conducted monthly, quarterly, semi-annually, or annually. If you are auditing your medical records internally, perform an external audit at least once per year to ensure that the internal findings are objective. It also is important to maintain records or documentation of the follow-up monitoring activities, to be able to report later on progress and findings.

Education

After problem areas are identified and a plan for improvement is outlined, a training plan should be implemented. The type and the focus of training are dependent on the problem areas discovered during the baseline and subsequent audits.

Some successful training programs include small groups and one-on-one training. Education should include all staff nurses and billing and coding staff, along with the practitioners. Attendance records should be maintained in addition to copies of the material used. An education schedule should be developed to ensure compliance.

Some training suggestions include:

- Review topics where deficit areas are prevalent
- Review coding policies, Medicare bulletins, fraud alerts, etc.
- Highlight quarterly correct coding initiative changes
- Discuss annual coding changes
- Review specific topics related to the specialty
- Present E/M documentation guideline update annually as a review

When a problem is an area identified by a carrier or the OIG, schedule training immediately after the audit to ensure compliance, and that appropriate steps are taken to resolve problem areas.

Corrective Action

After problem areas have been addressed and training is scheduled, a corrective action plan should be implemented. A provider has a legal obligation to refund any overpayments made for improper coding and/or documentation. It is always a good policy to consult legal counsel before implementing corrective action and repayment. Policies and procedures should be established for reconciliation of audit findings before the baseline audit occurs. Ongoing auditing and monitoring may be conducted according to the established policies and procedures in the organization's compliance plan.

The OIG's self-disclosure protocol is published in the *Federal Register*, and is designed "to address the concerns of practitioners by removing disincentives to participation." The OIG also emphasizes that providers have a legal and ethical obligation to identify and correct incidents of noncompliance. The OIG has stated, "[although] voluntary disclosure under the protocol does not guarantee provider protection from civil, criminal, or administrative actions, the fact that the provider voluntarily disclosed possible wrongdoing is a mitigating factor in OIG's recommendations to prosecuting agencies."

Self-reporting offers providers the opportunity to minimize the potential cost and disruption of a full-scale audit and investigation to negotiate a fair monetary settlement, and to avoid an OIG permissive exclusion preventing the provider from doing business with federal health care programs. The OIG publication encourages providers to report suspected fraud, and will provide this information to determine action required after the audit.

The OIG also recommends that practitioners consult legal counsel before self-disclosing errors and/or overpayments to the OIG. Practitioners or organizations that discover errors that result in overpayment should consult an attorney experienced in health care compliance and the law.

Beginning the Surgical Audit Process

The four steps in auditing the surgical chart are:

1. **Determine what you are going to review (scope of review).**
   - Type of services
   - Date of services
2. **Review operative note for the following:**
   - Preoperative information
   - Patient demographics
   - Surgery date
   - Preoperative anesthesia
   - Indications for procedure
   - Diagnostic reports
   - Intraoperative information
   - Preoperative diagnosis
   - Postoperative diagnosis
   - Surgeon/assistant surgeon/co-surgeons
   - Procedure title
   - Findings
   - Procedure details
   - Tissue/organ removed
   - Materials removed/inserted
   - Closure information
   - Blood loss/replacement
   - Wound status
   - Drainage
   - Complications noted
   - Postoperative condition of patient
   - IV infusion record
   - Signatures
   - Legibility
   - Support of procedure (CPT®/HCPCS)
   - Support of medical necessity (ICD-9-CM)
3. **Report findings**
   - Complete a detailed analysis and/or summary report for the practitioner.
4. **Educate**
   - Provide education on CCI edits, unbundling issues, problematic areas, and coding updates.

Auditing the Surgical Medical Record

When beginning to review the operative report, it is important that you organize the tools you will need. The same types of tools are necessary as for auditing E/M visits and services for the physician. They are:

- Audit tool
- Superbill/Charge ticket
- CPT® code book
- ICD-9-CM code book
- HCPCS Level II code book
- National Correct Coding Initiative (NCCI) edits (books or software)
- Other pertinent coding publications
- Detailed analysis—for summarizing audit results
- Summary report—reporting audit results

Review the following steps when auditing a surgical medical record:

1. Begin by making a copy of the operative report, if possible
2. Underline/highlight important information.
3. Use medical references for unfamiliar terms
4. Cross out non-code-related documentation
5. Check bundling issues
6. Verify code sequencing when multiple procedures are performed
7. Apply necessary modifiers

Surgical Coding Worksheet

Patient Name:	
Insurance:	
Comments:	
Referring Dr.:	
Surgeon:	
Asst. Surgeon:	

CPT® Code(s)	ICD-9 Code(s) or descriptions	Link
		1
		2
		3
		4
		5

Hospital Admit Date:__________ *Discharge Date:_____________*

Date	DR	POS	Hosp	CPT®	Description	Mod	Link	Qty	Fee

HOSP: Hospital name and initials here

POS: OP-Outpatient-22 IP-Inpatient-21 ER-Emergency Room-23 Off-Office-11

Surgery Audit Tool

Physician: ______________________________ Date of Review: ____________

Patient Name: ______________________________ MR#: ______________

Date of Birth: ____________ Date of Visit: ____________ Insurance Carrier: ____________

Surgical Service (s) billed: ______________________________

Diagnosis Code (s) billed: ______________________________

Comments: ______________________________

Documented	Y	N	N/A	Comments
Preoperative information	☐	☐	☐	
Patient demographics	☐	☐	☐	
Surgery date	☐	☐	☐	
Preoperative anesthesia	☐	☐	☐	
Indication for Procedure	☐	☐	☐	
Diagnostic Reports	☐	☐	☐	
Intra-operative information	☐	☐	☐	
Preoperative diagnosis	☐	☐	☐	
Postoperative diagnosis	☐	☐	☐	
Surgeon/asst/co-surgeons	☐	☐	☐	
Procedure title	☐	☐	☐	
Findings	☐	☐	☐	
Procedure details	☐	☐	☐	
Tissue/organ removed	☐	☐	☐	
Materials removed/inserted	☐	☐	☐	
Closure information	☐	☐	☐	
Blood loss/replacement	☐	☐	☐	
Wound status	☐	☐	☐	
Drainage	☐	☐	☐	
Complications noted	☐	☐	☐	
Post-operative condition of patient	☐	☐	☐	
IV infusion record	☐	☐	☐	
Signatures	☐	☐	☐	
Legibility	☐	☐	☐	
Supports procedure (CPT®/HCPCS)	☐	☐	☐	
Supports medical necessity (ICD-9-CM)	☐	☐	☐	

Medical Record Auditor; 2nd edition, Grider, 2008, American Medical Association

The Detailed Analysis and Audit Summary

As with E/M services, a detailed analysis and summary report will help to identify key areas that require improvement, as well as validate correct documentation and coding. The surgical audit tool is similar to the E/M audit tool but may identify key areas such as documentation requirements that are essential to a good operative report.

Review the sample Surgery Summary Report and detailed analysis that identifies areas that are compliant and non-compliant. There is a section to detail key areas that are problematic with the last section for recommendations for improvement.

Sample Surgery Audit Tool

Surgery Audit Tool

Physician: Mark Welby, M.D. **Date of Review:** 2/10/20xx

Patient Name: Paula Pekin, CPC, CPMA, CEMC **MR#:** 245678

Date of Birth: 04/10/32 **Date of Visit:** 01/20/200x **Insurance Carrier:** Medicare

Surgical Service (s) billed: 31641 Bronchoscopy with destruction of tumor

Diagnosis Code (s) billed: 162.4 Malignant neoplasm of middle lobe

Comments: Surgeon did not sign operative report; missing anesthesia on note

Documented	Y	N	N/A	Comments
Preoperative information	☒	☐	☐	
Patient demographics	☒	☐	☐	
Surgery date	☒	☐	☐	01/20/200x
Preoperative anesthesia	☐	☒	☐	Not documented
Indication for Procedure	☒	☐	☐	Malignant neoplasm of middle lobe
Diagnostic Reports	☒	☐	☐	
Intra-operative information	☒	☐	☐	
Preoperative diagnosis	☒	☐	☐	Rule out malignancy
Postoperative diagnosis	☒	☐	☐	Malignant neoplasm of middle lobe
Surgeon/asst/co-surgeons	☐	☐	☒	
Procedure title	☒	☐	☐	
Findings	☒	☐	☐	Sent to pathology
Procedure details	☒	☐	☐	
Tissue/organ removed	☒	☐	☐	Malignancy
Materials removed/inserted	☒	☐	☐	
Closure information	☒	☐	☐	
Blood loss/replacement	☒	☐	☐	1 pint blood
Wound status	☒	☐	☐	
Drainage	☒	☐	☐	
Complications noted	☐	☐	☒	No complications indicated
Post-operative condition of patient	☒	☐	☐	
IV infusion record	☒	☐	☐	
Signatures	☐	☒	☐	Signature missing on dictation
Legibility	☒	☐	☐	Dictated
Supports procedure (CPT/HCPCS)	☒	☐	☐	31641-Bronchoscopy
Supports medical necessity (ICD-9-CM)	☒	☐	☐	162.4 Malignant neoplasm of middle lobe

Summary Report

Physician: Mark Welby, M.D. **Date of Review:** 02/10/20xx

Reviewer: Paula Pekin, CPC, CPMA, CEMC

Number of Operative Notes Reviewed: 10

Operative notes were reviewed for completeness and appropriateness of care along with coding documentation and medical necessity.

Documentation in the operative note appears to provides preoperative information	100%
Surgery date appears to be documented in the note	100%
Preoperative anesthesia appears to be documented in the note	80%
Indication for Procedure appears to be documented in the operative report	100%
Preoperative diagnosis appears to be documented in the operative report	100%
Postoperative diagnosis appears to be documented in the note and supported by findings	100%
Surgeon/asst/co-surgeons are listed in the operative note	70%
Findings appear to be indicated in the operative report	100%
Procedure details appear to be documented appropriately in the operative report	100%
Post-operative condition of patient appears to be indicated in the operative report	100%
The operative report appears to support procedure (CPT®/HCPCS)	60%
The operative report appears to support medical necessity (ICD-9-CM)	100%

Other Documentation and Coding Issues:

1. Operative report #1-The service for the colonoscopy appeared to be unbundled. Only the therapeutic colonoscopy should be billed. The charge ticket indicated that a diagnostic and the therapeutic colonoscopy were billed together.
2. Two operative notes were not signed by the physician
3. One operative report indicated multiple procedures, but the charge ticket did not appear to bill a modifier for multiple procedures (51).

Recommendations

1. Review problem area(s) with provider.
2. Review unbundling guidelines.
3. Review use of modifiers when billing for surgery.
4. Review coding guidelines for therapeutic versus diagnostic procedures on same day.
5. Perform a follow up audit review in six months.

Detailed Analysis

Physician: Mark Welby M.D.

Date of Review: 02/10/20xx

Reviewer: Paula Pekin, CPC, CPMA, CEMC

Number of Operative Notes Reviewed: 10

	Billed			Documented		
Patient	CPT®	ICD-9-CM	MOD	CPT®	ICD-9-CM	MOD
Mary Doe	11301	176.3		11301	173.6	
John Renner	20600 20605	354.9 712.90		20600 20605	712.86 354.3	59
Marie Thomas	42820	474.02		42820	474.02	
Jake Rice	65436 65450 67250	370.55 370.55 370.55	51 51	65436 65450	370.55 370.55	51
Donna James	32020 33031	423.2 423.2	51	33031	423.2	
Susan Grimes	32110 32151 31622	861.32 861.32 861.32	59 59	32110 32151	861.32 861.32	51
Renee Patterson	44110	230.3		44110	230.3	
Phil Miller	47425	574.30		47425	574.21	
Sarah Trotta	58661 58720	614.1 620.0	51	58661	614.1 620.0	
Norman Peeler	60505 60225	250.21 250.21	59	60505	252.01	

Auditing Exercises

Begin by auditing exercises 1-6 for Mark Welby, M.D. Check for correct CPT® coding and modifier use, appropriate diagnostic coding, and possible unbundling. Verify which procedures are documented in the operative report, versus those reported and/or billed on the charge ticket. Write a summary report for the E/M services, and a separate report for the surgical services.

Case #1—Provider: Mark Welby, M.D.

Patient: Delaney Greensword **Date of Service:** 08/21/20xx **MR#** 123456

Patient was seen in the office for cardiac evaluation of chest pain. This is the first visit for this patient, who was referred by her nephew. The patient's daughter is with her today. The patient has been complaining of hurting in the chest for four days and the Nitroglycerin helps. Patient has chest pressure which is moderate, but difficult for the patient to describe on the 1-10 scale

PAST MEDICAL HISTORY: She does have Alzheimer's, described by her daughter as being mild in the early stages. Surgeries include cataract and a hysterectomy. She also had foot surgery. She has a fallen bladder, for which no therapy is recommended. She had the usual childhood illnesses. Patient is taking Vitamin E, aspirin, stool softener.

FAMILY HISTORY: Father deceased at age 75 of Alzheimer's. Mother lived to age 93. A brother has coronary artery disease. One brother is deceased from cancer.

SOCIAL HISTORY: Patient does not smoke or drink alcohol. She's been married 43 years and her husband is retired.

REVIEW OF SYSTEMS: Negative for cough, edema, positive for heart palpitations, dizziness, history of pulmonary embolism, occasional constipation. The reviews of systems were negative.

PHYSICIAL EXAMINATION: The patient is pleasant and well groomed. She can carry a conversation, but has a memory space of less than 15 seconds. Lids and sclera are normal. Pupils, PERRLA. Oral mucosa is normal. Pulse is 72 and regular. Weight is 127 pounds. Height: 5'3" Dentures are present. Carotids are brisk. Chest is clear to auscultation and percussion. Cardiac examination reveals no murmurs or gallops. There's no abdominal hepatosplenomegaly, tenderness or masses. Pedal pulses are full and there's no clubbing, cyanosis or edema. Skin clear.

ASSESSMENT AND PLAN: Angina, non-specific. Alzheimer's mild-no treatment. Patient was prescribed a Nitro-Dur® patch .2q.d. and Toprol XL® 25 mg. 1 p.o.q.d.. She is to take an aspirin and to use Nitroglycerin. Additionally, patient was placed on Protonix® 40 mg. 1 q.d. in hopes that her chest discomfort is gastro-intestinal. She is to see me back for reevaluation in 3-4 weeks.

Mark Welby, M.D.

Charge Ticket Case #1

Physician: Mark Welby, M.D.

Patient Information		**Payment Method**		**Visit Information**	
Patient ID number	123456	**Primary**		Visit date	08/21/200x
Patient name	Delaney Greensword	Primary ID number		Visit number	21

E/M Modifiers	Procedure Modifiers	Other Modifiers
24 — Unrelated E/M service during post-op.	50 — Bilateral procedure	
25 — Significant, separately identifiable E/M	51 — Multiple surgical procedures in same day	
57 — Decision for surgery	52 — Reduced/incomplete procedure	
	55 — Postop. management only	
	59 — Distinct multiple procedures	

CATEGORY	CODE	MOD	FEE	CATEGORY	CODE	MOD	FEE
Office Visit — New Patient				Wound Care			
Level 1	99201			Debride partial thick burn	11040		
Level II	99202			Debride full thickness burn	11041		
Level III	99203			Debride wound, not a burn	11000		
Level IV	99204 (circled)		155.00	Unna boot application	29580		
Level V	99205			Unna boot removal	29700		
Other				Other			
Office Visit — Established				Supplies			
Level I	99211			Ace bandage, 2”	A6448		
Level II	99212			Ace bandage, 3”-4”	A6449		
Level III	99213			Ace bandage, 6”	A6450		
Level IV	99214			Cast, fiberglass	A4590		
Level V	99215			Coban wrap	A6454		
Other				Foley catheter	A4338		
General Procedures				Immobilizer	L3670		
Anoscopy	46600			Kerlix roll	A6220		
Audiometry	92551			Oxygen mask/cannula	A4620		
Breast aspiration	19000			Sleeve, elbow	E0191		
Cerumen removal	69210			Sling	A4565		
Circumcision	54150			Splint, ready-made	A4570		
DDST	96110			Splint, wrist	S8451		
Flex sigmoidoscopy	45330			Sterile packing	A6407		
Flex sig. w/ biopsy	45331			Surgical tray	A4550		
Foreign body removal—foot	28190			Other			
Nail removal	11730			OB Care			
Nail removal/phenol	11750			Routine OB care	59400		
Trigger point injection	20552			OB call	59422		
Tympanometry	92567			Ante partum 4–6 visits	59425		
Visual acuity	99173			Ante partum 7 or more visits	59426		
Other				Other			

Fees	**Diagnosis Code**
Total Charges:	$155.00 1. 413.9-Angina Unspecified; 2. 331.0-Alzheimer’s

E/M Audit Form Case #1

Patient Name:______________________ Date of service:___/___/___ Provider____________________ MR #:__________________

HISTORY

☐ Chief complaint (required all levels):

History of Present Illness (HPI) ☐ Brief (1-3) ☐ Extended (4 or more or update of 3+ chronic illnesses)

☐ Location ☐ Severity ☐ Timing ☐ Modifying factors

☐ Update 3+ chronic ☐ Quality ☐ Duration ☐ Context ☐ Assoc. signs /symptoms

Review of systems (ROS): ☐ None ☐ Problem pertinent (1) ☐ Extended (2-9) ☐ Complete (10+)

☐ Constitutional ☐ Cardiovascular ☐ Gastrointestinal ☐ Integumentary ☐ Endocrine

☐ Eyes ☐ Respiratory ☐ Genitourinary ☐ Neurological ☐ Hematologic/lymphatic

☐ ENT ☐ Musculoskeletal ☐ Psychiatric ☐ Allergic/Immunologic ☐ All others negative

Past, family, and social history (PFSH): ☐ None ☐ Pertinent (1 of any) ☐ Complete est. (2 of 3) ☐ Complete new (3 of 3)

☐ Past: Allergies, current medications, immunizations, previous trauma, surgeries, previous illnesses/hospitalizations.

☐ Family: Health of parents, siblings, children. Family members w/ diseases related to the chief complaint.

☐ Social: Drug, alcohol, tobacco use. Employment. Sexual history. Marital status. Education. Occupational history.

SCORE: HISTORY COMPONENT

☐ **Problem focused**	☐ **Expanded problem focused**	☐ **Detailed**	☐ **Comprehensive**	☐ **Not Documented**
CC; Brief HPI (1-3)	CC; Brief HPI;	CC; Extended HPI (4+)	CC; Extended HPI;	
ROS: None	Problem Pertinent (1 system)	ROS: 2-9 systems	Complete ROS; 10+	
PFSH: None	PFSH: None	PFSH-1 history area	PFSH – 2 established patient 3 new patient	

PHYSICAL EXAM

General multi-system examination (Body area/organ system elements of examination)

Organ Systems

☐ Constitutional: ☐ Vital signs: sit/stand BP, sup BP, temp, pulse rate, resp, ht, wt **or** ☐ General appearance

☐ Eyes: ☐ conjunctivae/lids, ☐ pupils/irises, ☐ optic discs

☐ ENT: ☐ ext exam ears/ nose, ☐ ext aud canal/tymp memb, ☐ hearing assessment, ☐ nasal mucosa/septum/turbinates, ☐ lips/teeth/gums, ☐ oropharynx—oral mucosa, palates

☐ Respiratory: ☐ resp. effort, ☐ chest percussion, ☐ chest palpation, ☐ auscultation of lungs

☐ Cardiovascular: ☐ palpation heart, ☐ auscultation, exam of: ☐ carotid, ☐ femoral arteries, ☐ abdominal aorta, ☐ pedal pulses, ☐ extremities

☐ Gastrointestinal: ☐ abdominal, ☐ liver/spleen, ☐ hernia, ☐ stool sample taken, ☐ anus, perineum, rectum

☐ Genitourinary: ☐ Male: scrotum, ☐ penis, ☐ digital rectal exam of prostate
☐ Female: ☐ pelvic, ☐ ext genitalia, ☐ urethra, ☐ bladder, ☐ cervix, ☐ uterus, adnexa/parametria

☐ Musculoskeletal: ☐ gait/station, ☐ digits/nails,
Exam of head/neck or spine/ribs/pelvis, Rt upper or Lt upper or Rt lower or Lt lower: ☐ inspect & palpate, ☐ stability, ☐ motion, ☐ strength & tone

☐ Skin: ☐ inspect skin/sub-q tissue, ☐ palpation skin/subcutaneous tissue

☐ Neurologic: ☐ cranial nerves, ☐ deep tendon reflexes, ☐ sensation

☐ Psychiatric: ☐ judgment/ insight, ☐ orientation, ☐ remote & recent memory, ☐ mood & affect

☐ Hematological/lymphatic ☐ neck, axillae, groin, other, ☐ immunologic:

Body Areas

☐ Head, including the face ☐ Neck: ☐ neck (masses, symmetry, etc ☐ thyroid ☐ Chest (breasts): ☐ inspection breast, ☐ palpation breast/axillae ☐ Abdomen ☐ Genitalia, groin, buttocks

☐ 1 or more in detail

☐ Back, including spine

☐ Left upper extremity

☐ Right upper extremity

Score: Physical Examination Component

☐ Problem focused ☐ Expanded problem focused ☐ Detailed ☐ Comprehensive ☐ Not documented

Medical decision making

Number of diagnoses and management options	Pts	Total	Amount and complexity of data	Pts	Total
Self limiting or minor problems (stable, improved, or worsening); *maximum of 2 points*	1		Ordered and/or reviewed clinical lab	1	
Established problem—stable, improved	1		Ordered and/or reviewed radiology	1	
Established problem—worsening	2		Ordered/reviewed test in the CPT® medicine section	1	
New problem—no additional work-up planned *Maximum of 1 problem given credit*	3		Discussed tests with performing or interpreting physician.	1	
New problem—additional work-up planned	4		Independent visualization and direct view of image, tracing, specimen	2	
Total points:			Decision to obtain old records/additional HX from other than patient, e.g., family, caretaker, prev. phys.	1	
			Reviewed and summarized old records and/or obtained history from someone other than patient.	2	
			Total points:		

Table of Risk—The highest level in ONE area determines the overall risk

Level	Presenting problem(s) or	Diagnostic procedure or	Management options
Minimal ☐	☐ One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	☐ Laboratory tests requiring venipuncture ☐ Chest x-rays ☐ EKG/EEG ☐ Urinalysis ☐ Ultrasound, e.g., echo ☐ KOH prep	☐ Rest ☐ Gargles ☐ Elastic bandages ☐ Superficial dressings
Low ☐	☐ Two or more self-limited or minor problems ☐ One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH ☐ Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	☐ Physiologic tests not under stress, e.g., pulmonary function tests ☐ Non-cardiovascular imaging studies with contrast, e.g., barium enema ☐ Superficial needle biopsies ☐ Clinical laboratory tests requiring arterial puncture ☐ Skin biopsies	☐ Over-the-counter drugs ☐ Minor surgery with no identified risk factors ☐ Physical therapy ☐ Occupational therapy IV fluids without additives
Moderate ☐	☐ One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment ☐ Two or more stable chronic illnesses ☐ Undiagnosed new problem with uncertain prognosis, e.g., lump in breast ☐ Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness	☐ Physiologic tests under stress, e.g., cardiac stress test, fetal-contraction stress test ☐ Diagnostic endoscopies with no identified risk factors ☐ Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath ☐ Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	☐ Minor surgery with identified risk factors ☐ Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ☐ Prescription drug management ☐ Therapeutic nuclear medicine ☐ IV fluids with additives ☐ Closed treatment of fracture or dislocation without manipulation
High ☐	☐ One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment ☐ Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ☐ An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	☐ Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests ☐ Diagnostic endoscopies with identified risk factors ☐ Discography	☐ Elective major surgery (open, percutaneous or endoscopic with identified risk factors) ☐ Emergency major surgery (open, percutaneous or endoscopic) ☐ Parenteral controlled substances ☐ Drug therapy requiring intensive monitoring for toxicity ☐ Decision not to resuscitate or to de-escalate care because of poor prognosis

Decision-making total: —2 of 3 must be met

Pts	Number of DX	Amount of data	Risk of complications	Medical decision-making level
1	☐ Minimal	☐ Minimal	☐ Minimal	☐ Straight forward
2	☐ Limited	☐ Limited	☐ Low	☐ Low complexity
3	☐ Multiple	☐ Moderate	☐ Moderate	☐ Moderate complexity
4	☐ Extensive	☐ Extensive	☐ High	☐ High complexity

Score: E&M service

History	Exam	Medical decision-making level
☐ **Problem focused**	☐ **Problem focused**	☐ **Straightforward**
☐ **Expanded problem focused**	☐ **Expanded problem focused**	☐ **Low complexity**
☐ **Detailed**	☐ **Detailed**	☐ **Moderate complexity**
☐ **Comprehensive**	☐ **Comprehensive**	☐ **High complexity**

Number needed: ☐ 2 of 3 (MDM must be 1 of 2 to support medical necessity)

Please review the medical record for the following elements:

	Yes	No N/A
1. Was the medical record for this service found?	☐	☐
2. Is the medical record legible?	☐	☐
3. Is the attending/teaching physician's note written by the billing physician?	☐	☐
4. Does the date of service billed agree with the date of the progress note?	☐	☐
5. If a resident was involved in providing this service, review teaching physician documentation and answer the following questions:	☐	☐
A. Does this service meet the primary care exception?	☐	☐
B. Does the medical record demonstrate teaching physician involvement?	☐	☐
C. Does the teaching physician's note link to the resident's note?	☐	☐
6. Does the documentation support the ICD-9 codes billed?	☐	☐
7. Does the documentation support the level of service billed?	☐	☐

☐ Dictated ☐ Handwritten EMR ☐ ☐ Form ☐ Illegible ☐ Note signed

☐ Signature missing ☐ Diagnosis Code(s) supported ☐ Other Service provided

TIME ☐ A description of what was discussed must also be detailed

Face-to-face time: Indicate the total face-to-face time (or total floor time for inpatient services) spent with the patient

Counseling/Co-ord. Time: Time spent counseling or coordinating care (must be greater than 50% of total face-to-face/floor time)

Code (s) selected: ______________ **Code(s) audited:** ___________ ☐ **Over** ☐ **Under** ☐ **Correct** ☐ **Miscoded**

Dx code(s) billed: _____________ **Dx code(s) documented:** _____________ **Other services** _______________

Comments:

Auditor's Signature ____

Case #2—Provider: Mark Welby, M.D.

Patient: Maryann Marzette **Date of Service:** 08/11/20xx **MR#** 23456

This established patient presents with three complaints related to her right extremity, which have been ongoing and have not resolved. She has joint swelling in the fingers of her right hand for the past two weeks, with some pain and some morning stiffness. She also complains of some proximal forearm medial pain with wrist motion. She complains of some palmar wrist pain and cramping, and has been wearing a splint that has improved the symptoms. She has not had any skin changes with these complaints, or other joint problems except in the hand.

Past Medical History—Not significant for major illnesses. She had a T&A at 22 years old. Right ectopic tubal pregnancy at 25, and has never smoked. Patient drinks alcohol rarely and exercises regularly. She has been married for 15 years and works as a secretary doing lots of typing. She has regular periods and is not currently pregnant. There is a family history with both parents having DM type II and a brother with coronary artery disease. No history of cancer in the family.

On exam she is no longer tender in her forearm or wrist. She does have some mild tenderness in her index and second PIP associated with some synovitis, and possibly a small ganglion on the ulner aspect of the first PIO. Tinel's and Phalen's are negative. There is no synovitis of the left hand and currently is not bothering her. The patient denies shoulder or hip pain. She does complain of knee pain related to working out. Does have neck pain, but through compression and extension did not produce any pain.

Assessment and Plan: 1. Synovitis in the PIP joints of the right hand. X-ray performed in office does not demonstrate any significance. Possibly some subchondral erosions in the DIPs consistent with osteoarthritis. We will try Motrin®, 600 mg, p.r.n. for the synovitis. She is to follow up in 2 weeks if not improving. 2-Flexor tendonitis and possible carpal tunnel syndrome. She is to continue splinting. If no improvement in the next 3 months, will refer her to a hand surgeon for evaluation.

Mark Welby, M.D.

Charge Ticket Case #2 Physician: Mark Welby, M.D.

Patient Information		**Payment Method**		**Visit Information**	
Patient ID number	123456	**Primary**		Visit date	08/11/20xx
Patient name	Mary Ann Marzette	Primary ID number		Visit number	27

E/M Modifiers	Procedure Modifiers	Other Modifiers
24 — Unrelated E/M service during post-op.	50 — Bilateral procedure	
25 — Significant, separately identifiable E/M	51 — Multiple surgical procedures in same day	
57 — Decision for surgery	52 — Reduced/incomplete procedure	
	55 — Postop. management only	
	59 — Distinct multiple procedures	

CATEGORY	CODE	MOD	FEE	CATEGORY	CODE	MOD	FEE
Office Visit — New Patient				Wound Care			
Level 1	99201			Debride partial thick burn	11040		
Level II	99202			Debride full thickness burn	11041		
Level III	99203			Debride wound, not a burn	11000		
Level IV	99204			Unna boot application	29580		
Level V	99205			Unna boot removal	29700		
Other				Other			
Office Visit — Established				Supplies			
Level I	99211			Ace bandage, 2”	A6448		
Level II	99212			Ace bandage, 3”-4”	A6449		
Level III	99213			Ace bandage, 6”	A6450		
Level IV	99214 (circled)		125.00	Cast, fiberglass	A4590		
Level V	99215			Coban wrap	A6454		
Other				Foley catheter	A4338		
General Procedures				Immobilizer	L3670		
Anoscopy	46600			Kerlix roll	A6220		
Audiometry	92551			Oxygen mask/cannula	A4620		
Breast aspiration	19000			Sleeve, elbow	E0191		
Cerumen removal	69210			Sling	A4565		
Circumcision	54150			Splint, ready-made	A4570		
DDST	96110			Splint, wrist	S8451		
Flex sigmoidoscopy	45330			Sterile packing	A6407		
Flex sig. w/ biopsy	45331			Surgical tray	A4550		
Foreign body removal—foot	28190			Other			
Nail removal	11730			OB Care			
Nail removal/phenol	11750			Routine OB care	59400		
Trigger point injection	20552			OB call	59422		
Tympanometry	92567			Ante partum 4–6 visits	59425		
Visual acuity	99173			Ante partum 7 or more visits	59426		
Venipuncture	36415 (circled)		15.00	Other			

Fees	**Diagnosis Code**
Total Charges: $140.00	727.00-synovitis

E/M Audit Form Case #2

Patient Name:_____________________ **Date of service:** __/__/__ **Provider**___________________ **MR #:**_________________

HISTORY

☐ Chief complaint (required all levels):

History of Present Illness (HPI) ☐ Brief (1-3) ☐ Extended (4 or more or update of 3+ chronic illnesses)
☐ Location ☐ Severity ☐ Timing ☐ Modifying factors
☐ Update 3+ chronic ☐ Quality ☐ Duration ☐ Context ☐ Assoc. signs /symptoms

Review of systems (ROS): ☐ None ☐ Problem pertinent (1) ☐ Extended (2-9) ☐ Complete (10+)
☐ Constitutional ☐ Cardiovascular ☐ Gastrointestinal ☐ Integumentary ☐ Endocrine
☐ Eyes ☐ Respiratory ☐ Genitourinary ☐ Neurological ☐ Hematologic/lymphatic
☐ ENT ☐ Musculoskeletal ☐ Psychiatric ☐ Allergic/Immunologic ☐ All others negative

Past, family, and social history (PFSH): ☐ None ☐ Pertinent (1 of any) ☐ Complete est. (2 of 3) ☐ Complete new (3 of 3)
☐ Past: Allergies, current medications, immunizations, previous trauma, surgeries, previous illnesses/hospitalizations.
☐ Family: Health of parents, siblings, children. Family members w/ diseases related to the chief complaint.
☐ Social: Drug, alcohol, tobacco use. Employment. Sexual history. Marital status. Education. Occupational history.

SCORE: HISTORY COMPONENT

☐ **Problem focused**	☐ **Expanded problem focused**	☐ **Detailed**	☐ **Comprehensive**	☐ **Not Documented**
CC; Brief HPI (1-3)	CC; Brief HPI;	CC; Extended HPI (4+)	CC; Extended HPI;	
ROS: None	Problem Pertinent (1 system)	ROS: 2-9 systems	Complete ROS; 10+	
PFSH: None	PFSH: None	PFSH-1 history area	PFSH – 2 established patient 3 new patient	

PHYSICAL EXAM

General multi-system examination (Body area/organ system elements of examination)

Organ Systems

☐ Constitutional: ☐ Vital signs: sit/stand BP, sup BP, temp, pulse rate, resp, ht, wt **or** ☐ General appearance
☐ Eyes: ☐ conjunctivae/lids, ☐ pupils/irises, ☐ optic discs
☐ ENT: ☐ ext exam ears/ nose, ☐ ext aud canal/tymp memb, ☐ hearing assessment, ☐ nasal mucosa/septum/turbinates, ☐ lips/teeth/gums, ☐ oropharynx—oral mucosa, palates
☐ Respiratory: ☐ resp. effort, ☐ chest percussion, ☐ chest palpation, ☐ auscultation of lungs
☐ Cardiovascular: ☐ palpation heart, ☐ auscultation, exam of: ☐ carotid, ☐ femoral arteries, ☐ abdominal aorta, ☐ pedal pulses, ☐ extremities
☐ Gastrointestinal: ☐ abdominal, ☐ liver/spleen, ☐ hernia, ☐ stool sample taken, ☐ anus, perineum, rectum
☐ Genitourinary: ☐ Male: scrotum, ☐ penis, ☐ digital rectal exam of prostate
☐ Female: ☐ pelvic, ☐ ext genitalia, ☐ urethra, ☐ bladder, ☐ cervix, ☐ uterus, adnexa/parametria
☐ Musculoskeletal: ☐ gait/station, ☐ digits/nails,
Exam of head/neck or spine/ribs/pelvis, Rt upper or Lt upper or Rt lower or Lt lower: ☐ inspect & palpate, ☐ stability, ☐ motion, ☐ strength & tone
☐ Skin: ☐ inspect skin/sub-q tissue, ☐ palpation skin/subcutaneous tissue
☐ Neurologic: ☐ cranial nerves, ☐ deep tendon reflexes, ☐ sensation
☐ Psychiatric: ☐ judgment/ insight, ☐ orientation, ☐ remote & recent memory, ☐ mood & affect
☐ Hematological/lymphatic ☐ neck, axillae, groin, other, ☐ immunologic:

Body Areas

☐ Head, including the face ☐ Neck: ☐ neck (masses, symmetry, etc ☐ thyroid ☐ Chest (breasts): ☐ inspection breast, ☐ palpation breast/axillae ☐ Abdomen ☐ Genitalia, groin, buttocks

☐ 1 or more in detail

☐ Back, including spine
☐ Left upper extremity
☐ Right upper extremity

Score: Physical Examination Component

☐ Problem focused ☐ Expanded problem focused ☐ Detailed ☐ Comprehensive ☐ Not documented

Medical decision making

Number of diagnoses and management options	Pts	Total	Amount and complexity of data	Pts	Total
Self limiting or minor problems (stable, improved, or worsening); *maximum of 2 points*	1		Ordered and/or reviewed clinical lab	1	
Established problem—stable, improved	1		Ordered and/or reviewed radiology	1	
Established problem—worsening	2		Ordered/reviewed test in the CPT® medicine section	1	
New problem—no additional work-up planned *Maximum of 1 problem given credit*	3		Discussed tests with performing or interpreting physician.	1	
New problem—additional work-up planned	4		Independent visualization and direct view of image, tracing, specimen	2	
Total points:			Decision to obtain old records/additional HX from other than patient, e.g., family, caretaker, prev. phys.	1	
			Reviewed and summarized old records and/or obtained history from someone other than patient.	2	
			Total points:		

Table of Risk—The highest level in ONE area determines the overall risk

Level	Presenting problem(s) or	Diagnostic procedure or	Management options
Minimal ☐	☐ One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	☐ Laboratory tests requiring venipuncture ☐ Chest x-rays ☐ EKG/EEG ☐ Urinalysis ☐ Ultrasound, e.g., echo ☐ KOH prep	☐ Rest ☐ Gargles ☐ Elastic bandages ☐ Superficial dressings
Low ☐	☐ Two or more self-limited or minor problems ☐ One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH ☐ Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	☐ Physiologic tests not under stress, e.g., pulmonary function tests ☐ Non-cardiovascular imaging studies with contrast, e.g., barium enema ☐ Superficial needle biopsies ☐ Clinical laboratory tests requiring arterial puncture ☐ Skin biopsies	☐ Over-the-counter drugs ☐ Minor surgery with no identified risk factors ☐ Physical therapy ☐ Occupational therapy IV fluids without additives
Moderate ☐	☐ One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment ☐ Two or more stable chronic illnesses ☐ Undiagnosed new problem with uncertain prognosis, e.g., lump in breast ☐ Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness	☐ Physiologic tests under stress, e.g., cardiac stress test, fetal-contraction stress test ☐ Diagnostic endoscopies with no identified risk factors ☐ Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath ☐ Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	☐ Minor surgery with identified risk factors ☐ Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ☐ Prescription drug management ☐ Therapeutic nuclear medicine ☐ IV fluids with additives ☐ Closed treatment of fracture or dislocation without manipulation
High ☐	☐ One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment ☐ Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ☐ An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	☐ Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests ☐ Diagnostic endoscopies with identified risk factors ☐ Discography	☐ Elective major surgery (open, percutaneous or endoscopic with identified risk factors) ☐ Emergency major surgery (open, percutaneous or endoscopic) ☐ Parenteral controlled substances ☐ Drug therapy requiring intensive monitoring for toxicity ☐ Decision not to resuscitate or to de-escalate care because of poor prognosis

Decision-making total: —2 of 3 must be met

Pts	Number of DX	Amount of data	Risk of complications	Medical decision-making level
1	☐ Minimal	☐ Minimal	☐ Minimal	☐ Straight forward
2	☐ Limited	☐ Limited	☐ Low	☐ Low complexity
3	☐ Multiple	☐ Moderate	☐ Moderate	☐ Moderate complexity
4	☐ Extensive	☐ Extensive	☐ High	☐ High complexity

Score: E&M service

History	Exam	Medical decision-making level
☐ **Problem focused**	☐ **Problem focused**	☐ **Straightforward**
☐ **Expanded problem focused**	☐ **Expanded problem focused**	☐ **Low complexity**
☐ **Detailed**	☐ **Detailed**	☐ **Moderate complexity**
☐ **Comprehensive**	☐ **Comprehensive**	☐ **High complexity**

Number needed: ☐ 2 of 3 (MDM must be 1 of 2 to support medical necessity)

Please review the medical record for the following elements:

		Yes	**No N/A**
1.	Was the medical record for this service found?	☐	☐
2.	Is the medical record legible?	☐	☐
3.	Is the attending/teaching physician's note written by the billing physician?	☐	☐
4.	Does the date of service billed agree with the date of the progress note?	☐	☐
5.	If a resident was involved in providing this service, review teaching physician documentation and answer the following questions:	☐	☐
	A. Does this service meet the primary care exception?	☐	☐
	B. Does the medical record demonstrate teaching physician involvement?	☐	☐
	C. Does the teaching physician's note link to the resident's note?	☐	☐
6.	Does the documentation support the ICD-9 codes billed?	☐	☐
7.	Does the documentation support the level of service billed?	☐	☐

☐ Dictated ☐ Handwritten EMR ☐ ☐ Form ☐ Illegible ☐ Note signed

☐ Signature missing ☐ Diagnosis Code(s) supported ☐ Other Service provided

TIME ☐ A description of what was discussed must also be detailed

Face-to-face time: Indicate the total face-to-face time (or total floor time for inpatient services) spent with the patient

Counseling/Co-ord. Time: Time spent counseling or coordinating care (must be greater than 50% of total face-to-face/floor time)

Code (s) selected: _____________ **Code(s) audited:** __________ ☐ **Over** ☐ **Under** ☐ **Correct** ☐ **Miscoded**

Dx code(s) billed: ____________ **Dx code(s) documented:** ____________ **Other services** ______________

Comments:

Auditor's Signature ____

Case #3—Provider: Mark Welby, M.D.

Patient: Sarah Carter **Date of Service:** 09/11/20xx **MR#** 34567

This healthy 12 year-old girl was seen in my office for an initial evaluation and treatment of a lesion on her left calf, which has been present for approximately one year. She was a patient of Dr. Smythe who referred the patient to me for treatment. It is the patient's feeling that this is enlarging over that period of time. On exam the lesion measures between 1 and 1.5 cm, closely adherent to the overlying dermis along the proximal aspect of her left calf.

After obtaining informed consent from her mother, she was brought into the procedure room and placed in a prone position. The areas surrounding the lesion were infiltrated with 1% xylocaine with 1:100,000 Epinephrine to which 1 to 10 dilution of sodium bicarbonate had been added for pH adjustment. After prepping and draping in the routine fashion, the procedure was begun by an incision along normal skin tension lines, directly overlying the nodule. Dissection was carried down to the level of the lesion which appeared to be of an epidermal origin. The lesion was removed with its surrounding capsule and passed off the field for pathologic examination. The wound was then checked for hemostasis and closed using a Dermabond®. After application of steri-strips and sterile dressings to the incision lines, the patient was allowed to leave and will return in 1 week for follow up.

Mark Welby, M.D.

Charge Ticket Case #3

Physician: Mark Welby, M.D.

Patient Information		**Payment Method**		**Visit Information**	
Patient ID number	34567	**Primary**		Visit date	09/11/20xx
Patient name	Sarah Carter	Primary ID number		Visit number	57

E/M Modifiers	Procedure Modifiers	Other Modifiers
24 — Unrelated E/M service during post-op.	50 — Bilateral procedure	
25 — Significant, separately identifiable E/M	51 — Multiple surgical procedures in same day	
57 — Decision for surgery	52 — Reduced/incomplete procedure	
	55 — Postop. management only	
	59 — Distinct multiple procedures	

CATEGORY	CODE	MOD	FEE	CATEGORY	CODE	MOD	FEE
Office Visit — New Patient				Wound Care			
Level 1	99201 (circled)	57	25.00	Debride partial thick burn	11040		
Level II	99202			Debride full thickness burn	11041		
Level III	99203			Debride wound, not a burn	11000		
Level IV	99204			Unna boot application	29580		
Level V	99205			Unna boot removal	29700		
Other				Lesion excision	11301 (circled)		100.00
Office Visit — Established				Supplies			
Level I	99211			Ace bandage, 2”	A6448		
Level II	99212			Ace bandage, 3”-4”	A6449		
Level III	99213			Ace bandage, 6”	A6450		
Level IV	99214			Cast, fiberglass	A4590		
Level V	99215			Coban wrap	A6454		
Other				Foley catheter	A4338		
General Procedures				Immobilizer	L3670		
Anoscopy	46600			Kerlix roll	A6220		
Audiometry	92551			Oxygen mask/cannula	A4620		
Breast aspiration	19000			Sleeve, elbow	E0191		
Cerumen removal	69210			Sling	A4565		
Circumcision	54150			Splint, ready-made	A4570		
DDST	96110			Splint, wrist	S8451		
Flex sigmoidoscopy	45330			Sterile packing	A6407		
Flex sig. w/ biopsy	45331			Surgical tray	A4550		
Foreign body removal—foot	28190			Other			
Nail removal	11730			OB Care			
Nail removal/phenol	11750			Routine OB care	59400		
Trigger point injection	20552			OB call	59422		
Tympanometry	92567			Ante partum 4–6 visits	59425		
Visual acuity	99173			Ante partum 7 or more visits	59426		
Venipuncture	36415			Other			

Fees	**Diagnosis Code**
Total Charges: $125.00	216.7 Benign neoplasm of lower extremity

E/M Audit Form Case #3

Patient Name:____________________ **Date of service:** __/__/__ **Provider**__________________ **MR #:**________________

HISTORY

☐ Chief complaint (required all levels):

History of Present Illness (HPI) ☐ Brief (1-3) ☐ Extended (4 or more or update of 3+ chronic illnesses)

☐ Location ☐ Severity ☐ Timing ☐ Modifying factors

☐ Update 3+ chronic ☐ Quality ☐ Duration ☐ Context ☐ Assoc. signs /symptoms

Review of systems (ROS): ☐ None ☐ Problem pertinent (1) ☐ Extended (2-9) ☐ Complete (10+)

☐ Constitutional ☐ Cardiovascular ☐ Gastrointestinal ☐ Integumentary ☐ Endocrine

☐ Eyes ☐ Respiratory ☐ Genitourinary ☐ Neurological ☐ Hematologic/lymphatic

☐ ENT ☐ Musculoskeletal ☐ Psychiatric ☐ Allergic/Immunologic ☐ All others negative

Past, family, and social history (PFSH): ☐ None ☐ Pertinent (1 of any) ☐ Complete est. (2 of 3) ☐ Complete new (3 of 3)

☐ Past: Allergies, current medications, immunizations, previous trauma, surgeries, previous illnesses/hospitalizations.

☐ Family: Health of parents, siblings, children. Family members w/ diseases related to the chief complaint.

☐ Social: Drug, alcohol, tobacco use. Employment. Sexual history. Marital status. Education. Occupational history.

SCORE: HISTORY COMPONENT

☐ **Problem focused**	☐ **Expanded problem focused**	☐ **Detailed**	☐ **Comprehensive**	☐ **Not Documented**
CC; Brief HPI (1-3)	CC; Brief HPI;	CC; Extended HPI (4+)	CC; Extended HPI;	
ROS: None	Problem Pertinent (1 system)	ROS: 2-9 systems	Complete ROS; 10+	
PFSH: None	PFSH: None	PFSH-1 history area	PFSH – 2 established patient 3 new patient	

PHYSICAL EXAM

General multi-system examination (Body area/organ system elements of examination)

Organ Systems

☐ Constitutional: ☐ Vital signs: sit/stand BP, sup BP, temp, pulse rate, resp, ht, wt **or** ☐ General appearance

☐ Eyes: ☐ conjunctivae/lids, ☐ pupils/irises, ☐ optic discs

☐ ENT: ☐ ext exam ears/ nose, ☐ ext aud canal/tymp memb, ☐ hearing assessment, ☐ nasal mucosa/septum/turbinates, ☐ lips/teeth/gums, ☐ oropharynx—oral mucosa, palates

☐ Respiratory: ☐ resp. effort, ☐ chest percussion, ☐ chest palpation, ☐ auscultation of lungs

☐ Cardiovascular: ☐ palpation heart, ☐ auscultation, exam of: ☐ carotid, ☐ femoral arteries, ☐ abdominal aorta, ☐ pedal pulses, ☐ extremities

☐ Gastrointestinal: ☐ abdominal, ☐ liver/spleen, ☐ hernia, ☐ stool sample taken, ☐ anus, perineum, rectum

☐ Genitourinary: ☐ Male: scrotum, ☐ penis, ☐ digital rectal exam of prostate
☐ Female: ☐ pelvic, ☐ ext genitalia, ☐ urethra, ☐ bladder, ☐ cervix, ☐ uterus, adnexa/parametria

☐ Musculoskeletal: ☐ gait/station, ☐ digits/nails,
Exam of head/neck or spine/ribs/pelvis, Rt upper or Lt upper or Rt lower or Lt lower: ☐ inspect & palpate, ☐ stability, ☐ motion, ☐ strength & tone

☐ Skin: ☐ inspect skin/sub-q tissue, ☐ palpation skin/subcutaneous tissue

☐ Neurologic: ☐ cranial nerves, ☐ deep tendon reflexes, ☐ sensation

☐ Psychiatric: ☐ judgment/ insight, ☐ orientation, ☐ remote & recent memory, ☐ mood & affect

☐ Hematological/lymphatic ☐ neck, axillae, groin, other, ☐ immunologic:

Body Areas

☐ Head, including the face ☐ Neck: ☐ neck (masses, symmetry, etc ☐ thyroid ☐ Chest (breasts): ☐ inspection breast, ☐ palpation breast/axillae ☐ Abdomen ☐ Genitalia, groin, buttocks

☐ 1 or more in detail

☐ Back, including spine

☐ Left upper extremity

☐ Right upper extremity

Score: Physical Examination Component

☐ Problem focused ☐ Expanded problem focused ☐ Detailed ☐ Comprehensive ☐ Not documented

Medical decision making

Number of diagnoses and management options	**Pts**	**Total**
Self limiting or minor problems (stable, improved, or worsening); *maximum of 2 points*	1	
Established problem—stable, improved	1	
Established problem—worsening	2	
New problem—no additional work-up planned *Maximum of 1 problem given credit*	3	
New problem—additional work-up planned	4	
Total points:		

Amount and complexity of data	**Pts**	**Total**
Ordered and/or reviewed clinical lab	1	
Ordered and/or reviewed radiology	1	
Ordered/reviewed test in the CPT® medicine section	1	
Discussed tests with performing or interpreting physician.	1	
Independent visualization and direct view of image, tracing, specimen	2	
Decision to obtain old records/additional HX from other than patient, e.g., family, caretaker, prev. phys.	1	
Reviewed and summarized old records and/or obtained history from someone other than patient.	2	
Total points:		

Table of Risk—The highest level in ONE area determines the overall risk

Level	Presenting problem(s) or	Diagnostic procedure or	Management options
Minimal ☐	☐ One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	☐ Laboratory tests requiring venipuncture ☐ Chest x-rays ☐ EKG/EEG ☐ Urinalysis ☐ Ultrasound, e.g., echo ☐ KOH prep	☐ Rest ☐ Gargles ☐ Elastic bandages ☐ Superficial dressings
Low ☐	☐ Two or more self-limited or minor problems ☐ One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH ☐ Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	☐ Physiologic tests not under stress, e.g., pulmonary function tests ☐ Non-cardiovascular imaging studies with contrast, e.g., barium enema ☐ Superficial needle biopsies ☐ Clinical laboratory tests requiring arterial puncture ☐ Skin biopsies	☐ Over-the-counter drugs ☐ Minor surgery with no identified risk factors ☐ Physical therapy ☐ Occupational therapy IV fluids without additives
Moderate ☐	☐ One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment ☐ Two or more stable chronic illnesses ☐ Undiagnosed new problem with uncertain prognosis, e.g., lump in breast ☐ Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness	☐ Physiologic tests under stress, e.g., cardiac stress test, fetal-contraction stress test ☐ Diagnostic endoscopies with no identified risk factors ☐ Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath ☐ Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	☐ Minor surgery with identified risk factors ☐ Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ☐ Prescription drug management ☐ Therapeutic nuclear medicine ☐ IV fluids with additives ☐ Closed treatment of fracture or dislocation without manipulation
High ☐	☐ One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment ☐ Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ☐ An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	☐ Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests ☐ Diagnostic endoscopies with identified risk factors ☐ Discography	☐ Elective major surgery (open, percutaneous or endoscopic with identified risk factors) ☐ Emergency major surgery (open, percutaneous or endoscopic) ☐ Parenteral controlled substances ☐ Drug therapy requiring intensive monitoring for toxicity ☐ Decision not to resuscitate or to de-escalate care because of poor prognosis

Decision-making total: —2 of 3 must be met

Pts	Number of DX	Amount of data	Risk of complications	Medical decision-making level
1	☐ Minimal	☐ Minimal	☐ Minimal	☐ Straight forward
2	☐ Limited	☐ Limited	☐ Low	☐ Low complexity
3	☐ Multiple	☐ Moderate	☐ Moderate	☐ Moderate complexity
4	☐ Extensive	☐ Extensive	☐ High	☐ High complexity

Score: E&M service

History	Exam	Medical decision-making level
☐ **Problem focused**	☐ **Problem focused**	☐ **Straightforward**
☐ **Expanded problem focused**	☐ **Expanded problem focused**	☐ **Low complexity**
☐ **Detailed**	☐ **Detailed**	☐ **Moderate complexity**
☐ **Comprehensive**	☐ **Comprehensive**	☐ **High complexity**

Number needed: ☐ 2 of 3 (MDM must be 1 of 2 to support medical necessity)

Please review the medical record for the following elements:

	Yes	No N/A
1. Was the medical record for this service found?	☐	☐
2. Is the medical record legible?	☐	☐
3. Is the attending/teaching physician's note written by the billing physician?	☐	☐
4. Does the date of service billed agree with the date of the progress note?	☐	☐
5. If a resident was involved in providing this service, review teaching physician documentation and answer the following questions:	☐	☐
A. Does this service meet the primary care exception?	☐	☐
B. Does the medical record demonstrate teaching physician involvement?	☐	☐
C. Does the teaching physician's note link to the resident's note?	☐	☐
6. Does the documentation support the ICD-9 codes billed?	☐	☐
7. Does the documentation support the level of service billed?	☐	☐

☐ Dictated ☐ Handwritten EMR ☐ ☐ Form ☐ Illegible ☐ Note signed

☐ Signature missing ☐ Diagnosis Code(s) supported ☐ Other Service provided

TIME ☐ A description of what was discussed must also be detailed

Face-to-face time: Indicate the total face-to-face time (or total floor time for inpatient services) spent with the patient

Counseling/Co-ord. Time: Time spent counseling or coordinating care (must be greater than 50% of total face-to-face/floor time)

Code (s) selected: ______________ **Code(s) audited:** ___________ ☐ **Over** ☐ **Under** ☐ **Correct** ☐ **Miscoded**

Dx code(s) billed: _____________ **Dx code(s) documented:** _____________ **Other services** _______________

Comments:

Auditor's Signature ____

Medical Record Chart Audit Summary Report

Practice: **Provider:**

Date of Audit: **Auditor:**

A total of _____ records were reviewed using the ________________ Guidelines, _____ CPT® Coding rules, and Insurance carrier guidelines. Chart notes were received for the following physicians:

Findings

The findings and recommendations based on the review of the office, and diagnostic procedures are as follows:

E/M documentation in the record appeared to support service billed ______

E/M documentation in the record appears to support a lower level of service than billed ______

Documentation appeared to be missing or could not be located in the Record ______

Findings and Recommendations:

1.

Recommendation:

2.

Recommendation:

3.

Recommendation:

4.

Recommendation:

Recommendation Summary

Detailed Analysis

Practice: **Provider:**

Date of Audit: **Auditor:**

Chart #	Patient	Date of Service	CPT® Code Reported	CPT® Code Documented	ICD-9-CM Reported	ICD-9-CM Documented
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Surgical Coding Charge Ticket Case #4

Patient Name	Parker Stevenson
Medical Record Number/Account Number	145678
Surgeon	Mark Welby, M.D.
Referring Physician	Thomas Jones M.D.
Asst Surgeon	None
Anesthesiologist	local
Insurance Company	Medicare
Comments	Post operative follow up 2 weeks

Date of Surgery	Facility	Place of service	CPT® Code	Diagnosis Code(s)	Modifier	Quantity	Fee
01/04/200x	Methodist Surg Cntr	24	45380	455.0		1	900.00
01/04/200x	Methodist Surg Cntr	24	45378	787.91	51	1	400.00

Surgical Coding Case #4

PATIENT: Parker Stephenson **MR# 145678**

Date of Procedure: 01/04/200x

PREOPERATIVE DIAGNOSIS: Refractory severe diarrhea with negative stool cultures.

POSTOPERATIVE DIAGNOSIS:

1. No active colitis
2. No pseudomembranes noted
3. Normal terminal ileum that was visualized
4. Internal hemorrhoids

SURGEON: Mark Welby, M.D.

PROCEDURE: Colonoscopy to the terminal ileum with random biopsies.

DESCRIPTION OF PROCEDURE: Following informed consent the patient was brought to the endoscopy suite and given IV sedation. Colonoscope was inserted into the rectum and advanced to the colon and beyond the splenic flexure, maneuvered through the hepatic flexure and moved down the ascending colon to the cecum. The appendiceal orifice was visualized and photographed and was within normal limits. The scope was withdrawn from the right colon, pulled back to the transverse, descending, sigmoid and rectum; all adequately visualized and there was no active colitis and no pseudomembranes noted. There were no masses palpable or mucosal abnormalities. Random rectalsigmiod biopsies were obtained and the scope was withdrawn.

PATHOLOGY REPORT:

Specimens: Tissue rectosigmoid biopsy.
Diagnosis: Histologically unremarkable fragments of superficial colonic mucosa. No evidence of significant inflammation; no evidence of dysplasia.

Mark Welby, M.D.
Electronically signed by Mark Welby M.D.

Surgery Audit Tool Case #4

Physician: ______________________ Date of Review: __________

Patient Name: ______________________ MR#: __________

Date of Birth: __________ Date of Visit: __________ Insurance Carrier: __________

Surgical Service (s) billed: ______________________

Diagnosis Code (s) billed: ______________________

Comments: ______________________

Documented	Y	N	N/A	Comments
Preoperative information	☐	☐	☐	
Patient demographics	☐	☐	☐	
Surgery date	☐	☐	☐	
Preoperative anesthesia	☐	☐	☐	
Indication for Procedure	☐	☐	☐	
Diagnostic Reports	☐	☐	☐	
Intra-operative information	☐	☐	☐	
Preoperative diagnosis	☐	☐	☐	
Postoperative diagnosis	☐	☐	☐	
Surgeon/asst/co-surgeons	☐	☐	☐	
Procedure title	☐	☐	☐	
Findings	☐	☐	☐	
Procedure details	☐	☐	☐	
Tissue/organ removed	☐	☐	☐	
Materials removed/inserted	☐	☐	☐	
Closure information	☐	☐	☐	
Blood loss/replacement	☐	☐	☐	
Wound status	☐	☐	☐	
Drainage	☐	☐	☐	
Complications noted	☐	☐	☐	
Post-operative condition of patient	☐	☐	☐	
IV infusion record	☐	☐	☐	
Signatures	☐	☐	☐	
Legibility	☐	☐	☐	
Supports procedure (CPT®/HCPCS)	☐	☐	☐	
Supports medical necessity (ICD-9-CM)	☐	☐	☐	

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Surgical Coding Charge Ticket Case #5

Patient Name	Susan Hiverson
Medical Record Number/Account Number	145679
Surgeon	Mark Welby M.D.
Referring Physician	None
Asst Surgeon	None
Anesthesiologist	local
Insurance Company	CIGNA
Comments	Follow up 3 days packing removal

Date of Surgery	Facility	Place of service	CPT® Code	Diagnosis Code(s)	Modifier	Quantity	Fee
01/21/200x	Univ Hosp	22	11406	706.2		1	225.00
01/21/200x	Univ Hosp	22	11423	706.2		1	125.00
01/21/200x	Univ Hosp	22	12002	706.2		1	75.00

Surgical Coding Case #5

PATIENT: Susan Hiverson **MR#** 145679

Date of Procedure: 01/21/200x

PREOPERATIVE DIAGNOSIS: 4.1-cm infected sebaceous cyst, back. 2.5-cm infected sebaceous cyst, posterior neck

ANESTHESIA: Local

POSTOPERATIVE DIAGNOSIS: Same.

OPERATION PERFORMED:
1. Excision of 4.1-cm benign cyst, back
2. Excision of 2.5-cm benign cyst, neck

PROCEDURE: The patient was placed in the prone position, after which the back and posterior neck were prepped with Betadine® scrub and solution. Sterile towels were applied in the usual fashion, and 0.25% Marcaine® was injected subcutaneously in a linear fashion transversely over each of the cysts asynchronously. Additional local anesthetic was administered around the cysts. The lower cyst was excised. The cavity was irrigated with copious amounts of Marcaine solution and then the skin edges loosely re-approximated throughout with #3-0 nylon suture. Following this, Marcaine was injected around the superior of the cyst and an incision was made transversely across this and the cyst was completely excised as well. Consequently, reexploration of the wound revealed scar tissue in the base of the wound, and this was excised as well as possible to ensure that the cyst was completely removed. The wound was irrigated with Marcaine and packed with Iodoform, and sterile dressings were applied. The patient was discharged with verbal and written instructions, as well as Tylenol® #3 for pain and a prescription for 30. Return visit in 3 days for packing removal.

Mark Welby, M.D.

Electronically signed by Mark Welby, MD

Surgery Audit Tool Case #5

Physician: ______________________________ Date of Review: ____________

Patient Name: ______________________________ MR#: ____________

Date of Birth: ____________ Date of Visit: ____________ Insurance Carrier: ____________

Surgical Service (s) billed: ______________________________

Diagnosis Code (s) billed: ______________________________

Comments: ______________________________

Documented	Y	N	N/A	Comments
Preoperative information	☐	☐	☐	
Patient demographics	☐	☐	☐	
Surgery date	☐	☐	☐	
Preoperative anesthesia	☐	☐	☐	
Indication for Procedure	☐	☐	☐	
Diagnostic Reports	☐	☐	☐	
Intra-operative information	☐	☐	☐	
Preoperative diagnosis	☐	☐	☐	
Postoperative diagnosis	☐	☐	☐	
Surgeon/asst/co-surgeons	☐	☐	☐	
Procedure title	☐	☐	☐	
Findings	☐	☐	☐	
Procedure details	☐	☐	☐	
Tissue/organ removed	☐	☐	☐	
Materials removed/inserted	☐	☐	☐	
Closure information	☐	☐	☐	
Blood loss/replacement	☐	☐	☐	
Wound status	☐	☐	☐	
Drainage	☐	☐	☐	
Complications noted	☐	☐	☐	
Post-operative condition of patient	☐	☐	☐	
IV infusion record	☐	☐	☐	
Signatures	☐	☐	☐	
Legibility	☐	☐	☐	
Supports procedure (CPT®/HCPCS)	☐	☐	☐	
Supports medical necessity (ICD-9-CM)	☐	☐	☐	

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The next case that will be audited is an office surgical note. Pay special attention to the note; an office note is less formal and more of a narrative in general. You may need to determine if other services could be billed with the surgery. Remember to have your CPT®, ICD-9-CM, and HCPCS codebooks available, along with the NCCI edits for the current quarter.

Surgical Coding Charge Ticket Case #6

Patient Name	Jerry Lister
Medical Record Number/Account Number	145785
Surgeon	Mark Welby, M.D.
Referring Physician	Howard Bruner, M.D.
Asst Surgeon	None
Anesthesiologist	local
Insurance Company	Continental Insurance
Comments	Post operative follow up 2 weeks

Date of Surgery	Facility	Place of service	CPT® Code	Diagnosis Code(s)	Modifier	Quantity	Fee
02/02/200x	Office	11	99213-25	726.32	25	1	75.00
02/02/200x	Office	11	20605	726.32		1	150.00
02/02/200x	Office	11	J3303	726.32		2	65.00

Surgical Coding Case #6

PATIENT: Jerry Lister **MR#** 145785

DATE OF SERVICE: 02/02/200x

This is an established patient who presents to the office with a new complaint of left elbow pain. The pain started about a month ago and progressively has gotten worse. It is exacerbated by rotation, flexion, and extension of the elbow. The patient is an avid tennis player and it seems that the pain is aggravated during play. He is in a tournament next week and is requesting help with pain relief. He has been on NSAIDs with very little effect. Denies any trauma, swelling, or warmth to the joint area. Examination revealed the left elbow has no swelling or ecchymosis. There is tenderness over the lateral epicondyle. The left shoulder and wrist are normal. The right upper extremity is normal. Neurological examination was unremarkable. After considering multiple diagnoses and determining the risk to the patient is moderate, the physician's impression is left lateral epicondylitis. The patient was given an injection of Aristospan® (triamcinolone hexacetonide) 10 mg into the left elbow at the area of tenderness. He was told to use ibuprofen 600 mg and return for reevaluation in 2 weeks or sooner if the elbow gets worse.

Dictated: 02/04/200x not proofed

E/M Audit Form Case #6

Patient Name:____________________ Date of service:___/___/___ Provider_________________ MR #:_______________

HISTORY

☐ Chief complaint (required all levels):

History of Present Illness (HPI) ☐Brief (1-3) ☐ Extended (4 or more or update of 3+ chronic illnesses)
☐ Location ☐ Severity ☐ Timing ☐ Modifying factors
☐ Update 3+ chronic ☐ Quality ☐ Duration ☐ Context ☐ Assoc. signs /symptoms

Review of systems (ROS): ☐ None ☐ Problem pertinent (1) ☐ Extended (2-9) ☐ Complete (10+)
☐ Constitutional ☐ Cardiovascular ☐ Gastrointestinal ☐ Integumentary ☐ Endocrine
☐ Eyes ☐ Respiratory ☐ Genitourinary ☐ Neurological ☐ Hematologic/lymphatic
☐ ENT ☐ Musculoskeletal ☐ Psychiatric ☐ Allergic/Immunologic ☐ All others negative

Past, family, and social history (PFSH): ☐ None ☐ Pertinent (1 of any) ☐ Complete est. (2 of 3) ☐ Complete new (3 of 3)
☐ Past: Allergies, current medications, immunizations, previous trauma, surgeries, previous illnesses/hospitalizations.
☐ Family: Health of parents, siblings, children. Family members w/ diseases related to the chief complaint.
☐ Social: Drug, alcohol, tobacco use. Employment. Sexual history. Marital status. Education. Occupational history.

SCORE: HISTORY COMPONENT

☐ **Problem focused**	☐ **Expanded problem focused**	☐ **Detailed**	☐ **Comprehensive**	☐ **Not Documented**
CC; Brief HPI (1-3)	CC; Brief HPI;	CC; Extended HPI (4+)	CC; Extended HPI;	
ROS: None	Problem Pertinent (1 system)	ROS: 2-9 systems	Complete ROS; 10+	
PFSH: None	PFSH: None	PFSH-1 history area	PFSH – 2 established patient 3 new patient	

PHYSICAL EXAM

General multi-system examination (Body area/organ system elements of examination)

Organ Systems

☐ Constitutional: ☐ Vital signs: sit/stand BP, sup BP, temp, pulse rate, resp, ht, wt **or** ☐ General appearance
☐ Eyes: ☐ conjunctivae/lids, ☐ pupils/irises, ☐ optic discs
☐ ENT: ☐ ext exam ears/ nose, ☐ ext aud canal/tymp memb, ☐ hearing assessment, ☐ nasal mucosa/septum/turbinates, ☐ lips/teeth/gums, ☐ oropharynx—oral mucosa, palates
☐ Respiratory: ☐ resp. effort, ☐ chest percussion, ☐ chest palpation, ☐ auscultation of lungs
☐ Cardiovascular: ☐ palpation heart, ☐ auscultation, exam of: ☐ carotid, ☐ femoral arteries, ☐ abdominal aorta, ☐ pedal pulses, ☐ extremities
☐ Gastrointestinal: ☐ abdominal, ☐ liver/spleen, ☐ hernia, ☐ stool sample taken, ☐ anus, perineum, rectum
☐ Genitourinary: ☐ Male: scrotum, ☐ penis, ☐ digital rectal exam of prostate
☐ Female: ☐ pelvic, ☐ ext genitalia, ☐ urethra, ☐ bladder, ☐ cervix, ☐ uterus, adnexa/parametria
☐ Musculoskeletal: ☐ gait/station, ☐ digits/nails,
Exam of head/neck or spine/ribs/pelvis, Rt upper or Lt upper or Rt lower or Lt lower: ☐ inspect & palpate, ☐ stability, ☐ motion, ☐ strength & tone
☐ Skin: ☐ inspect skin/sub-q tissue, ☐ palpation skin/subcutaneous tissue
☐ Neurologic: ☐ cranial nerves, ☐ deep tendon reflexes, ☐ sensation
☐ Psychiatric: ☐ judgment/ insight, ☐ orientation, ☐ remote & recent memory, ☐ mood & affect
☐ Hematological/lymphatic ☐ neck, axillae, groin, other, ☐ immunologic:

Body Areas

☐ Head, including the face ☐ Neck: ☐ neck (masses, symmetry, etc ☐ thyroid ☐ Chest (breasts): ☐ inspection breast, ☐ palpation breast/axillae ☐ Abdomen ☐ Genitalia, groin, buttocks
☐ 1 or more in detail
☐ Back, including spine
☐ Left upper extremity
☐ Right upper extremity

Score: Physical Examination Component

☐ Problem focused ☐ Expanded problem focused ☐ Detailed ☐ Comprehensive ☐ Not documented

Medical decision making

Number of diagnoses and management options	**Pts**	**Total**	**Amount and complexity of data**	**Pts**	**Total**
Self limiting or minor problems (stable, improved, or worsening); *maximum of 2 points*	1		Ordered and/or reviewed clinical lab	1	
Established problem—stable, improved	1		Ordered and/or reviewed radiology	1	
Established problem—worsening	2		Ordered/reviewed test in the CPT® medicine section	1	
New problem—no additional work-up planned *Maximum of 1 problem given credit*	3		Discussed tests with performing or interpreting physician.	1	
New problem—additional work-up planned	4		Independent visualization and direct view of image, tracing, specimen	2	
Total points:			Decision to obtain old records/additional HX from other than patient, e.g., family, caretaker, prev. phys.	1	
			Reviewed and summarized old records and/or obtained history from someone other than patient.	2	
			Total points:		

Table of Risk—The highest level in ONE area determines the overall risk

Level	Presenting problem(s) or	Diagnostic procedure or	Management options
Minimal ☐	☐ One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	☐ Laboratory tests requiring venipuncture ☐ Chest x-rays ☐ EKG/EEG ☐ Urinalysis ☐ Ultrasound, e.g., echo ☐ KOH prep	☐ Rest ☐ Gargles ☐ Elastic bandages ☐ Superficial dressings
Low ☐	☐ Two or more self-limited or minor problems ☐ One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH ☐ Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	☐ Physiologic tests not under stress, e.g., pulmonary function tests ☐ Non-cardiovascular imaging studies with contrast, e.g., barium enema ☐ Superficial needle biopsies ☐ Clinical laboratory tests requiring arterial puncture ☐ Skin biopsies	☐ Over-the-counter drugs ☐ Minor surgery with no identified risk factors ☐ Physical therapy ☐ Occupational therapy IV fluids without additives
Moderate ☐	☐ One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment ☐ Two or more stable chronic illnesses ☐ Undiagnosed new problem with uncertain prognosis, e.g., lump in breast ☐ Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness	☐ Physiologic tests under stress, e.g., cardiac stress test, fetal-contraction stress test ☐ Diagnostic endoscopies with no identified risk factors ☐ Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath ☐ Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	☐ Minor surgery with identified risk factors ☐ Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ☐ Prescription drug management ☐ Therapeutic nuclear medicine ☐ IV fluids with additives ☐ Closed treatment of fracture or dislocation without manipulation
High ☐	☐ One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment ☐ Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ☐ An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	☐ Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests ☐ Diagnostic endoscopies with identified risk factors ☐ Discography	☐ Elective major surgery (open, percutaneous or endoscopic with identified risk factors) ☐ Emergency major surgery (open, percutaneous or endoscopic) ☐ Parenteral controlled substances ☐ Drug therapy requiring intensive monitoring for toxicity ☐ Decision not to resuscitate or to de-escalate care because of poor prognosis

Decision-making total: —2 of 3 must be met

Pts	Number of DX	Amount of data	Risk of complications	Medical decision-making level
1	☐ Minimal	☐ Minimal	☐ Minimal	☐ Straight forward
2	☐ Limited	☐ Limited	☐ Low	☐ Low complexity
3	☐ Multiple	☐ Moderate	☐ Moderate	☐ Moderate complexity
4	☐ Extensive	☐ Extensive	☐ High	☐ High complexity

Score: E&M service

History	Exam	Medical decision-making level
☐ **Problem focused**	☐ **Problem focused**	☐ **Straightforward**
☐ **Expanded problem focused**	☐ **Expanded problem focused**	☐ **Low complexity**
☐ **Detailed**	☐ **Detailed**	☐ **Moderate complexity**
☐ **Comprehensive**	☐ **Comprehensive**	☐ **High complexity**

Number needed: ☐ 2 of 3 (MDM must be 1 of 2 to support medical necessity)

Please review the medical record for the following elements:

	Yes	No N/A
1. Was the medical record for this service found?	☐	☐
2. Is the medical record legible?	☐	☐
3. Is the attending/teaching physician's note written by the billing physician?	☐	☐
4. Does the date of service billed agree with the date of the progress note?	☐	☐
5. If a resident was involved in providing this service, review teaching physician documentation and answer the following questions:	☐	☐
A. Does this service meet the primary care exception?	☐	☐
B. Does the medical record demonstrate teaching physician involvement?	☐	☐
C. Does the teaching physician's note link to the resident's note?	☐	☐
6. Does the documentation support the ICD-9 codes billed?	☐	☐
7. Does the documentation support the level of service billed?	☐	☐

☐ Dictated ☐ Handwritten EMR ☐ ☐ Form ☐ Illegible ☐ Note signed

☐ Signature missing ☐ Diagnosis Code(s) supported ☐ Other Service provided

TIME ☐ A description of what was discussed must also be detailed

Face-to-face time: Indicate the total face-to-face time (or total floor time for inpatient services) spent with the patient

Counseling/Co-ord. Time: Time spent counseling or coordinating care (must be greater than 50% of total face-to-face/floor time)

Code (s) selected: ______________ **Code(s) audited:** ___________ ☐ **Over** ☐ **Under** ☐ **Correct** ☐ **Miscoded**

Dx code(s) billed: _____________ **Dx code(s) documented:** _____________ **Other services** _______________

Comments:

Auditor's Signature ____

Surgery Audit Tool Case #6

Physician: ______________________ Date of Review: ____________

Patient Name: ______________________ MR#: ____________

Date of Birth: ____________ Date of Visit: ____________ Insurance Carrier: ____________

Surgical Service (s) billed: ______________________

Diagnosis Code (s) billed: ______________________

Comments: ______________________

Documented	Y	N	N/A	Comments
Preoperative information	☐	☐	☐	
Patient demographics	☐	☐	☐	
Surgery date	☐	☐	☐	
Preoperative anesthesia	☐	☐	☐	
Indication for Procedure	☐	☐	☐	
Diagnostic Reports	☐	☐	☐	
Intra-operative information	☐	☐	☐	
Preoperative diagnosis	☐	☐	☐	
Postoperative diagnosis	☐	☐	☐	
Surgeon/asst/co-surgeons	☐	☐	☐	
Procedure title	☐	☐	☐	
Findings	☐	☐	☐	
Procedure details	☐	☐	☐	
Tissue/organ removed	☐	☐	☐	
Materials removed/inserted	☐	☐	☐	
Closure information	☐	☐	☐	
Blood loss/replacement	☐	☐	☐	
Wound status	☐	☐	☐	
Drainage	☐	☐	☐	
Complications noted	☐	☐	☐	
Post-operative condition of patient	☐	☐	☐	
IV infusion record	☐	☐	☐	
Signatures	☐	☐	☐	
Legibility	☐	☐	☐	
Supports procedure (CPT®/HCPCS)	☐	☐	☐	
Supports medical necessity (ICD-9-CM)	☐	☐	☐	

Medical Record Auditor; 2nd edition, Grider, 2008, American Medical Association

Surgery Audit Summary Report

Physician: **Date of Review:**

Reviewer:

Number of Operative Notes Reviewed:

Operative notes were reviewed for completeness and appropriateness of care along with coding documentation and medical necessity.

Documentation in the operative note appears to provides preoperative information

Surgery date appears to be documented in the note

Preoperative anesthesia appears to be documented in the note

Indication for Procedure appears to be documented in the operative report

Preoperative diagnosis appears to be documented in the operative report

Postoperative diagnosis appears to be documented in the note and supported by findings

Surgeon/asst/co-surgeons are listed in the operative note

Findings appear to be indicated in the operative report

Procedure details appear to be documented appropriately in the operative report

Post-operative condition of patient appears to be indicated in the operative report

The operative report appears to support procedure (CPT®/HCPCS)

The operative report appears to support medical necessity (ICD-9-CM)

Other Documentation and Coding Issues:

1.
2.
3.
4.
5.

Recommendations

1.
2.
3.
4.
5.

Surgery Audit Detailed Analysis

Physician: **Date of Review:**

Reviewer:

Number of Operative Notes Reviewed:

	Billed			Documented		
Patient	CPT®	ICD-9-CM	MOD	CPT®	ICD-9-CM	MOD

Appendix A

Evaluation and Management Documentation Guidelines

New vs. Established Patient

In selecting many evaluation and management codes, it is necessary to determine whether the patient is a new or established patient. In 1992, the description of a new and established patient was revised:

New Patient—A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belong to the same group practice, within the past three years

Established Patient—An established patient is one who has received professional services from the physician, or another physician of the same specialty who belong to the same group practice, within the past three years. In the instance where a physician is on call for and/or covering for another physician, the patient encounter is classified as if it would have been by the physician who is not available.

A practitioner within the same specialty with the same tax identification number (even though each practitioner would have his or her own provider number) would be considered the same group. Many practitioners are located physically in different parts of a city, state, or country, but are of the same group.

If a practitioner has the same tax identification number, but is of a different specialty, the patient would not be considered an established patient unless the practitioner has seen the patient within the past three years.

The Components of an E/M Service

E/M services descriptors recognize seven components, which are used in defining E/M service levels. Three of these components are considered key to the selection of a service level. Four more components are considered contributory to the choice of the service level:

The three (3) key components are:

- **History** relative to the patient's clinical picture
- **Examination** relative to present and concurrent problems
- Physician's **medical decision making** process in managing the patient

The four (4) contributory elements are:

- Counseling **with the patient and/or family**
- **Coordination of care** with other health care professionals or facilities
- Nature of the patient's **presenting problem**
- **Time**

Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (e.g., examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service. In the case of visits that consist predominantly (greater than 50 percent) of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.

Remember: If a patient is admitted to the hospital in the course of the office encounter, all E/M services provided by that physician with the admission are considered part of the initial hospital care, when performed on the same date of admission. A separate code for the office visit is not reported.

Definition of Key Components

History

The levels of E/M services are based on four (4) types of history:

- problem focused
- expanded problem focused
- detailed
- comprehensive

The extent of the history that is obtained and documented is dependent upon the clinical judgment of the physician and the nature of the presenting problem(s). Each type of history includes some or all of the following elements:

Chief Complaint (CC): is included in all history levels and must be documented clearly in the medical record. It is defined by CPT® as 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 words."

Example: Rapid heart beat, shortness of breath and some chest pain

Inappropriate Chief Complaint: Follow up; New Patient; Recheck

History of the Present Illness (HPI): is defined by CPT® "as the chronological description of the development of the patient's present illness from the first sign and/or symptom, or from the previous encounter to the present." The following is a brief narrative of potential qualifiers within the HPI elements.

Location: A site of complaint, injury, illness, etc. Not every patient visit will qualify for a location. The location should be specific, such as *abdominal* pain, *facial* swelling, twisted *knee, chest* pain, etc. If one is short of breath, it cannot be assumed that it is from the "lungs." It could be due to the heart, fatigue, or some other malady.

Quality: A quality statement is often one of description. It may be to describe a type of pain such as throbbing, sharp, zinging, radiating, or stabbing. A patient with poor circulation may describe their skin as *purple and blotchy*. A rash may be described as *itchy*.

Severity: Often pain is measured on a *scale of 1-10*. Severity itself is considered a "quality." One needs to look at the context of the statement being made. Patients describe conditions with terms such as *severe, slight, worse*, and positive results such as *much better* or *improving*.

Duration: Typically, statements are made such as: "Onset three days ago," "Since last Monday," since (date), "for about two months," "yesterday," "in the last two weeks," "approximately one year ago."

Timing: Timing descriptions can be seen as *frequently, recurrent, constant, intermittent*, etc. These terms often are used to describe the regularity of the recurrence.

Context: Context describes how a condition, injury, complaint, etc. has occurred. Statements such as "while skiing," "sustained in a motor vehicle accident," "walking down the stairs," "playing baseball," "cutting wood," "carrying boxes," etc.

Modifying Factors: This often is found in the form of statements given by the patient as to remedies tried for relief of a condition. For example, "patient has been using Tylenol without relief," "ice was applied to reduce swelling," "tried inhalers and nebulizing." Anything that the "patient" tried to *better or modify* the complaint/condition would count.

Associated Signs and Symptoms: A patient may have urinary frequency *associated with blood in the urine*, a cough *with congestion*, fatigue *with bruising, nausea, and vomiting*, etc. This is sometimes captured along side the chief complaint.

Review of Systems (ROS): is defined by CPT® as an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

For the purposes of ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

The review of systems is the area where most audits fail. The provider reviews systems based on information gathered from the history of the present illness. The common prompt of questions asked by providers often is lacking in the documentation, however. Simple statements such as, "*Patient denies fever and cough*" would count as a constitutional and respiratory review of system.

The review of systems is not to be confused with the "examination" component. This is a question and answer series only.

Constitutional – Patients often are asked about fever, weight loss and other problems that may have been experienced. These problems are not necessarily defined to a particular cause or body area (such as weakness, fatigue, night sweats, etc.).

Eyes – Questions asked will include: the date of the patient's last eye examination; when he or she was last checked for glaucoma (patient over 50); the history of any eye infections or injury; use of corrective lenses; any eye discharge, itching, excessive tearing, or pain; any spots or if floaters; any history of glaucoma or cataracts; blurred or double vision; twitching; light sensitivity; swelling around eyes or eye lids; visual disturbances, spots, or flashing lights; any history of retinal detachment, amblyopia, or strabismus.

Nose, Throat and Mouth – questions will regard: the date and results of the last hearing test; sensitivity to noise; ear

pain; ringing in the ear; history of ear infections; vertigo; feeling of fullness in the ears; ear wax abnormality; history of nose bleeds; post nasal drip; frequent sneezing; frequent nasal drainage (if positive, note amount and color); impaired ability to smell; pain over the sinuses; history of nasal trauma; difficulty breathing; history of sinus infection and treatment; history of sore throats; a current or past lesion in the mouth; history of oral herpes infections; update of last dental exam; a overall description of dental health; use dentures or bridges; bleeding gums; history of hoarseness; changes in voice quality; difficulties swallowing or ability to taste.

Cardiovascular – questions asked include: history of chest pain; palpitations; heart murmurs; irregular pulse; hypertension; any need to sit in a particular position to breathe; any coldness or numbness in extremities; color changes in fingers or toes; edema; leg pain when walking; any hair loss on legs.

Respiratory – history of asthma or other breathing problems; a chronic cough; hemoptysis; breathing problems after exercise; sputum production (note color and amount); wheezy or noisy respirations; any history of bronchitis or pneumonia.

Gastrointestinal – indigestion or pain associated with eating; history of hematemsis; any burning sensation in the esophagus; frequent nausea and/or vomiting; history of liver disease or jaundice; history of gallbladder disease; abdominal swelling or ascites; changes in bowel habits; stool characteristics; history of diarrhea or constipation; history of hemorrhoids; use of digestive aids or laxatives; date and result of last hemocult exam (for patients over age 50).

Genitourinary – painful urination; urine characteristics; patterns in urination; a hesitancy starting stream; changes in urine stream; history of any renal calculi or flank pain; hematuria; history of decreased or increased urine output; dribbling; incontinence; frequent urination at night; and for children, toilet training or bed wetting.

Musculoskeletal – history of fractures; muscle cramping; twitching or pain; weakness; limitations on walking, running or participation in sports; any joint swelling, redness, or pain; a joint deformity; joint stiffness; noise with joint movement; spinal deformity; chronic back pain; interference with activities of daily living.

Integumentary – any known skin diseases; history of itching; skin reactions to hot/cold; presence of scars; moles; sores; color changes of lesions; changes in nail color or texture; date and result of last mammogram and/or breast exam; pattern of self examination; breast pain; tenderness or swelling; history of nipple discharge or changes; history breast feeding.

Neurological – history of fainting or unconscious; history of seizures or anticonvulsant therapy; history of memory loss; hallucinations; disorientation; speech or language dysfunction; inability to concentrate; history of sensory disturbances; history of motor disturbances including problems with gait, balance, or coordination; tremor or paralysis; any interference of daily living.

Psychiatric – history of any psychiatric conditions or treatment, hospitalizations, etc.

Endocrine – history of endocrine disease such as thyroid disease, adrenal problems, or diabetes; unexplained changes in height and/or weight; increased appetite, thirst, or urinary output; heat or cold intolerance; history of goiter; unexplained weakness; previous or current hormone therapy; changes in hair distribution or skin pigmentation.

Hematologic/Lymphatic: history of anemia; bleeding tendencies; easy bruising or fatigue; low platelet count; history of blood transfusion; unexplained granular swelling; history a systemic infections.

Allergic/Immunologic: history of allergies including eczema; any hives and/or itching; frequent sneezing; chronic clear nasal drainage; conjunctivitis; any allergy that interferes with activities of daily living.

Past, Family, and Social History (PFSH): consists of three (3) elements that are defined in the CPT® guidelines:

- **Past history:** the patient's past experiences with illnesses, operations, injuries, and treatments
- **Family history:** a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk
- **Social history:** an age-appropriate review of past and current activities

Example PAST MEDICAL HISTORY: He has had no other major hospitalizations or surgeries.

Allergies: He has no known allergies. Tetanus shot gave him local swelling.

Medications: His medicines include:

1. Plavix® 75 mg q.d.
2. Lanoxin® 0.25 mg q.d.

Example FAMILY HISTORY: Mother has had diabetes and hypertension. Father had three heart attacks and died at 52. He has two sisters, one of which had brain cancer

and there is thus a strong family history of coronary artery disease and heart disease, as well as myocardial infraction.

Example SOCIAL HISTORY: He continues to smoke about a pack a day. He has decreased from three packs a day. He states on sometimes he will smoke only a pack every four days. Apparently he also has been a fairly heavy drinker in the past. His wife was here with him today and he tends to be noncompliant.

PFSH: Complete-Established patient

Complete-New patient

At least **one** specific item from any of the **three history areas** must be documented for a pertinent PFSH. A complete PFSH is a review of two or all three PFSH history areas, depending on the category of the E/M service, with at least one specific item being documented from the history area reviewed.

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations, and subsequent nursing facility care.

Review the History Grid below.

History Grid (meet three of three criteria)

Type of History	History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)
Problem focused (PF)	Brief (1-3 elements)	N/A	N/A
Expanded problem focused (EPF)	Brief (1-3 elements)	Problem pertinent	N/A
Detailed (D)	Extended (> 4 elements or status of > 3 multiple chronic conditions)	Extended (2-9 systems)	Pertinent (one history area)
Comprehensive	Extended (> 4 elements or status of > 3 multiple chronic conditions) or inactive conditions	Complete (10 systems or some systems with “all others negative)	Complete (2 history areas for established, 3 history areas for new patient)

Documentation Guidelines:

- The CC, ROS, and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.
- A ROS and/or a PFSH obtained during an earlier encounter do(es) not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record, or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by any new ROS and/or PFSH information, or noting there has been change in the information; and noting the date and location of the earlier ROS and/or PFSH

The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must a notation supplementing or confirming the information recorded by others.

If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history. The physician must document the history of present illness.

Examination

The documentation in this key area often is assumed in the dictation or writing of the progress note. Without thorough documentation, however, there is no actual evidence of examination during the patient encounter. The levels of E/M services are based on four (4) types of examination:

- **problem focused:** a limited examination of the affected body area or organ system
- **expanded problem focused:** a limited examination of the affected body area or organ system and other symptomatic or related body area(s) or organ system(s)
- **detailed:** an extended examination of the affected body area(s) or organ system(s) and any other symptomatic body area(s) or related organ system(s)
- **comprehensive:** a general multi-system examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

A general multi-system examination or a single organ system examination may be performed by any physician regardless of specialty. The type (general multi-system or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s).

Review the examination grid. Notice the difference between the General Multi-system examination and the single organ system examination. Review the General Multi-system exam table. After you have reviewed the elements in the General Multi-system exam table, review the single organ system exam table. Also, review the examination requirements for the 1995 guidelines.

1995 Versus 1997 Examination Documentation Guidelines

Exam type	Problem focused	Expanded problem focused	Detailed	Comprehensive
1995 Exam elements	**1** system or body area	**2-7** systems or body areas	**2-7** systems or body areas	**8** or more organ systems
1997 - Multisystem performance and documentation of elements identified by a bullet	**1-5** elements identified by a bullet from one or more body areas or organ systems	**6** elements identified by a bullet from one or more body areas or organ systems	**2** elements identified by a bullet from **six body areas or organ systems** OR **12 elements from two more body areas or organ systems**	**2** elements identified by a bullet **from nine body areas or organ systems**
1997 - Single organ system	**1-5** elements identified by a bullet	at least **6** elements identified by a bullet	at least **12** elements identified by a bullet **Except: eye and psychiatric** 9 elements identified by a bullet	Perform **all** elements identified by a bullet; document every element in a box with a shaded border and at least one element in a box with an unshaded border.

***For the 1995 examination systems/body areas some insurance carriers or contractors use the 2-4 systems/body areas for expanded problem focused and 5-7 for detailed.**

Components of The Physical Exam 1995

Required System and/ or body areas	Exam Type	Requirements
1 or more	Problem Focused (PF)	Limited exam of affected body area or organ system
2-4	Expanded Problem Focused (EPF)	Limited exam of the affected body area or organ system and other symptomatic or related organ system(s)
2-7	Detailed (D)	Extended exam of affected body areas(s) and other symptomatic or related organ system(s)
8 or more organ systems	Comprehensive (Comp)	Multi-system exam of 8 or more organ systems
Body areas: Head and face, Neck, Chest/Breasts/Axillae, Abdomen, Back/spine, Each extremity, Genitalia/groin/buttock Organ Systems: Constitutional, Eyes, ENT, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurologic, Psychologic, Hematologic/lymphatic/immunology		

1997 General Multi-System Examination Guidelines Table

System/Body Area	Elements of Examination
Constitutional	■ Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) ■ General appearance of patient (eg, development, nutrition, body habitus, deformities,attention to grooming)
Eyes	■ Inspection of conjunctivae and lids ■ Examination of pupils and irises (eg, reaction to light and accommodation, size and symmetry) ■ Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	■ External inspection of ears and nose (eg, overall appearance, scars, lesions, masses) ■ Otoscopic examination of external auditory canals and tympanic membranes ■ Assessment of hearing (eg, whispered voice, finger rub, tuning fork) ■ Inspection of nasal mucosa, septum and turbinates ■ Inspection of lips, teeth and gums ■ Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	■ Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) ■ Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	■ Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) ■ Percussion of chest (eg, dullness, flatness, hyperresonance) ■ Palpation of chest (eg, tactile fremitus) ■ Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	■ Palpation of heart (eg, location, size, thrills) ■ Auscultation of heart with notation of abnormal sounds and murmurs Examination of: ■ • carotid arteries (eg, pulse amplitude, bruits) ■ • abdominal aorta (eg, size, bruits) ■ • femoral arteries (eg, pulse amplitude, bruits) ■ • pedal pulses (eg, pulse amplitude) ■ • extremities for edema and/or varicosities
Chest (Breasts)	■ Inspection of breasts (eg, symmetry, nipple discharge) ■ Palpation of breasts and axillae (eg, masses or lumps, tenderness)

System/Body Area	Elements of Examination
Gastrointestinal (Abdomen)	■ Examination of abdomen with notation of presence of masses or tenderness ■ Examination of liver and spleen ■ Examination for presence or absence of hernia ■ Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses ■ Obtain stool sample for occult blood test when indicated
Genitourinary	**MALE:** ■ Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass) ■ Examination of the penis ■ Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness) **FEMALE:** Pelvic examination (with or without specimen collection for smears and cultures), including ■ Examination of external genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) ■ Examination of urethra (eg, masses, tenderness, scarring) ■ Examination of bladder (eg, fullness, masses, tenderness) ■ Cervix (eg, general appearance, lesions, discharge) ■ Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) ■ Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)
Lymphatic	Palpation of lymph nodes in two or more areas: ■ Neck ■ Axillae ■ Groin ■ Other
Musculoskeletal	■ Examination of gait and station ■ Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) Examination of joints, bones and muscles of one or more of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: ■ Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions ■ Assessment of range of motion with notation of any pain, crepitation or contracture ■ Assessment of stability with notation of any dislocation (luxation), subluxation or laxity ■ Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

System/Body Area	Elements of Examination
Skin	■ Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers) ■ Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)
Neurologic	■ Test cranial nerves with notation of any deficits ■ Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski) ■ Examination of sensation (eg, by touch, pin, vibration, proprioception)
Psychiatric	■ Description of patient's judgment and insight Brief assessment of mental status including: ■ orientation to time, place and person ■ recent and remote memory ■ mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least two** elements identified by a bullet **from each of six areas/systems** OR **at least twelve** elements identified by a bullet **in two or more areas/systems**.
Comprehensive	Perform **all elements** identified by a bullet in **at least nine** organ systems or body areas and document **at least two** elements identified by a bullet **from each of nine areas/systems**.

Documentation Guidelines:

1. Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.
2. Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.
3. A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

Medical Decision Making

Treatment of a patient is not entirely counseling, care coordination, examination, and history-taking. Based on all subjective, objective, and assessment data available, as well as concurrent injuries or illnesses, the physician must evaluate and recommend options to the patient before pursuing a treatment protocol or therapy.

The levels of E/M service in CPT® recognize four (4) types of medical decision making:

- straight-forward
- low complexity
- moderate complexity
- high complexity

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

Determining medical decision making: the following chart shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be met or exceeded**:

The number of possible diagnoses or options: the number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician.

Number of Diagnoses/Management Options	Total Points
Self-limited or minor (Stable, improved or worsened) ➔ Maximum 2 points in this category.	1 point
Established problem (to examining MD); stable or improved	1 point
Established problem (to examine MD); worsening	2 points
New problem (to examining MD); no additional work-up planned ➔ Maximum 1point in this category.	3 points
New problem (to examining MD); additional work-up (e.g. admit/transfer)	4 points
Total	

Documentation Guidelines:

1. For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be stated explicitly or implied in documented decisions regarding management plans and/or further evaluation
   - for a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.
   - for a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible," "probable," or "rule out" (R/O) diagnosis.
2. The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.
3. If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.
4. The amount and/or complexity of data reviewed: the amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records, and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Amount and/or Complexity of Data Reviewed	
Lab ordered and/or reviewed (regardless of # ordered)	1 point
X-ray ordered and/or reviewed (regardless of # ordered)	1 point
Medicine section (90701-99199) ordered and/or reviewed	1 point
Discussion of test results with performing physician	1 point
Decision to obtain old record and/or obtain hx from someone other than patient	1 point
Review and summary of old records and/or obtaining hx from someone other than patient and/or discussion with other health provider	2 points
Independent visualization of image, tracing, or specimen (not simply review of report)	2 points
Total	

Documentation Guidelines:

1. If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, e.g., lab or x-ray, should be documented.
2. The review of lab, radiology and/or other diagnostic tests should be documented. A simple notation such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.
3. A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.
4. Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "old records reviewed", "additional history obtained from family" without elaboration is insufficient.
5. The results of discussion of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.
6. The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.

Risk of significant complications, morbidity, and/or mortality: The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options. A Table of Risk may be used to determine if risk of significant complications, morbidity, and/or mortality is ***minimal, low, moderate, or high***.

Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. **The highest risk in any one category—presenting problem(s), diagnostic procedure(s), or management option(s)—determines the overall risk**.

Additional Documentation Guidelines:

1. Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.
2. If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure (e.g., laparoscopy) should be documented.
3. If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.
4. The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

Table of Risk

Level	Presenting problem(s) or	Diagnostic procedure or	Management options
Minimal ☐	☐ One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	☐ Laboratory tests requiring venipuncture ☐ Chest x-rays ☐ EKG/EEG ☐ Urinalysis ☐ Ultrasound, e.g., echo ☐ KOH prep	☐ Rest ☐ Gargles ☐ Elastic bandages ☐ Superficial dressings
Low ☐	☐ Two or more self-limited or minor problems ☐ One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH ☐ Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	☐ Physiologic tests not under stress, e.g., pulmonary function tests ☐ Non-cardiovascular imaging studies with contrast, e.g., barium enema ☐ Superficial needle biopsies ☐ Clinical laboratory tests requiring arterial puncture ☐ Skin biopsies	☐ Over-the-counter drugs ☐ Minor surgery with no identified risk factors ☐ Physical therapy ☐ Occupational therapy IV fluids without additives
Moderate ☐	☐ One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment ☐ Two or more stable chronic illnesses ☐ Undiagnosed new problem with uncertain prognosis, e.g., lump in breast ☐ Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness	☐ Physiologic tests under stress, e.g., cardiac stress test, fetal-contraction stress test ☐ Diagnostic endoscopies with no identified risk factors ☐ Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath ☐ Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	☐ Minor surgery with identified risk factors ☐ Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ☐ Prescription drug management ☐ Therapeutic nuclear medicine ☐ IV fluids with additives ☐ Closed treatment of fracture or dislocation without manipulation
High ☐	☐ One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment ☐ Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ☐ An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	☐ Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests ☐ Diagnostic endoscopies with identified risk factors ☐ Discography	☐ Elective major surgery (open, percutaneous or endoscopic with identified risk factors) ☐ Emergency major surgery (open, percutaneous or endoscopic) ☐ Parenteral controlled substances ☐ Drug therapy requiring intensive monitoring for toxicity ☐ Decision not to resuscitate or to de-escalate care because of poor prognosis

Final Results of Medical Decision Making

The highest level attained in 2 out of 3 categories will determine your level of E/M code as it relates to medical decision making.

	SF	LOW	MOD	HIGH
Number of Dx or Tx Options	1	2	3	4
Amount and/or Complexity of data to be reviewed	1	2	3	4
Risk of Complications, Morbidity, Mortality	Minimal	Low	Moderate	High
E/M Level=2 out of 3				

Medical Decision Making Grid

(meet two of three criteria)

Type of decision making	Number of diagnoses or options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality
Straight-forward	minimal	minimal	minimal
Low complexity	limited	limited	low
Moderate complexity	multiple	moderate	moderate
High complexity	extensive	extensive	high

Instructions for Selecting a Level of E/M Service

1. **Determine the extent of history obtained:** the extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). The four (4) types of history are:
    a. problem focused
    b. expanded problem focused
    c. detailed
    d. comprehensive

2. **Determine the extent of examination performed:** the extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The four (4) types of examinations are:
    - problem focused
    - expanded problem focused
    - detailed
    - comprehensive

3. Determine the complexity of medical decision making: medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the number of possible diagnoses and/or the number of management options that must be considered; the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and the risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options. The four (4) types of medical decision making are:
    - straightforward
    - low complexity
    - moderate complexity
    - high complexity

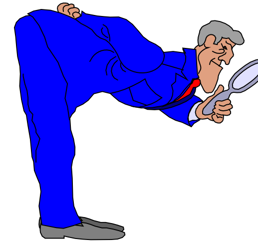
Select the appropriate level of E/M service based on the following:

a. For the following categories/subcategories, **all of the key components**, (i.e., history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; initial hospital care; office consultations; initial inpatient consultations; confirmatory consultations; emergency department services; comprehensive nursing facility assessments; domiciliary care, new patient; and home, new patient.

b. For the following categories/subcategories, **two of the three key components**, (i.e. history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; follow-up inpatient consultations; subsequent nursing facility care; domiciliary care, established patient; and home visit, established patient.

c. In the case where counseling and/or coordination of care dominates (more than 50 percent) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** is considered the key or controlling factor to qualify for a particular level of E/M service. The extent of counseling and/or coordination of care must be documented in the medical record.

Slide Presentation



How to Perform A Successful Chart Audit

Presented by:

1

Overview of Today's Session

- This session will cover:
  1. Medical Necessity.
  2. Evaluation and Management Service Audits.
  3. Surgical Audits.
  4. The Audit Process.
  5. Audit Steps.
  6. Designing an audit report with corrective action.
  7. Hands-on Evaluation and Management and Surgical Cases to audit.

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Disclaimer

This course was current at the time it was published. This course was prepared as a tool to assist the participant in understanding how to perform a successful internal audit to protect your medical practice. Although every reasonable effort has been made to assure the accuracy of the information within these pages the ultimate responsibility all of the information has does not accept responsibility or liability with regard to errors, omissions, misuse and misinterpretation. Please keep in mind that every insurance company has processing and reimbursing procedures that are individual to each particular company. Instructions and recommendations given in this booklet should not be interpreted as applying specifically to every insurance carrier. Please confirm with your carriers coding practices that are applicable to each carrier. The American Academy of Professional Coders (AAPC) employees, agents, and staff make no representation, warranty or guarantee that this compilation of information is error-free and will bear no responsibility, or liability for the results or consequences of the use of this course.

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Medical Necessity

- Definition: When a service is rendered to a patient by a practitioner
  - Service should be necessary to effect cure or a change in the condition for which the patient is being seen
- Term Medical necessity difficult to define
  - Insurers use terms such as:
    - “Reasonable and necessary”
    - “Appropriate”

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Medicare Definition

- Definition: Services or items reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body area
  - Can be determined on a case-by-case basis
- For all payers and insurers even if services are "reasonable and necessary"
  - Coverage may be limited if:
    - Service is provided more frequently than allowed under either a national or local coverage policy, or
      - Clinically accepted standard of practice

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Medical Necessity

- Payers use the following methods when reviewing claims for procedures and to ensure medical necessity:
  - Claim "edits" or
  - Automated denial/review commands

  Edits ensure payment is made for a specific procedure code or predetermined diagnosis code

  Diagnosis code is important for supporting medical necessity

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Diagnosis Coding Principles

- Apply the following principles to diagnosis coding to properly demonstrate medical necessity:

1. List the principal diagnosis, condition, problem, or other reason for the medical service or procedure.
2. Assign the code to the highest level of specificity.
3. For office and/or outpatient services, never use a “rule-out” statement (a suspected but not confirmed diagnosis); a clerical error could permanently tag a patient with a condition that does not exist. Code symptoms, if no definitive diagnosis is yet determined, instead of using rule-out statements.
4. Be specific in describing the patient’s condition, illness, or disease.
5. Distinguish between acute and chronic conditions, when appropriate.

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Diagnosis Coding Principles

- Apply the following principles to diagnosis coding to properly demonstrate medical necessity:

6. Identify the acute condition of an emergency situation, eg, coma, loss of consciousness, or hemorrhage.
7. Identify chronic complaints, or secondary diagnoses, only when treatment is provided or when they impact the overall management of the patient’s care.
8. Identify how injuries occur.
9. These facts must be substantiated by the patient’s medical record, and that record must be available to payers upon request.

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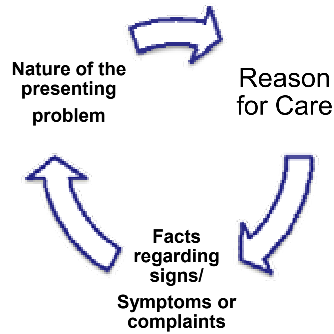
Supporting Medical Necessity

Diagnostic codes identify circumstances of patient's condition

To justify care provided you MUST provide pertinent information to the insurance carrier



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Improper Medicare Fee-For-Service Payments Report - November 2009 Medically Unnecessary Errors

Type Of Error	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
	Net	Net	Net	Net	Net	Net	Net	Net	Gross	Gross	Gross	Gross	Gross	Gross
Medically Unnecessary Errors	**5.1%**	**4.2%**	**3.9%**	**2.6%**	**2.9%**	**2.7%**	**3.6%**	**1.1%**	**1.6%**	**1.6%**	**1.4%**	**1.3%**	**1.4%**	**4.0%**

Paid Claims Error Rate by Error Type
Summary of Error Rates by Category

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CMS Memorandum on "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 evaluation and management service when a lower level of service is warranted. The **amount 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. The service should be documented during, or as soon as possible after it is provided in order to maintain an accurate medical record."
- Comprehensive Error Rate Testing Program 2009;https://www.cms.gov/cert

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QUESTION . . .

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

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In Today's Regulatory Environment . . .

- Post payment review and audit are increasingly prevalent
- Good documentation is the only defense for the physician
- The auditor's motto is **"Not documented, not done"!**

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Evaluation and Management Services and Medical Necessity

1. Documenting all diagnoses the provider is managing during the visit,
2. For an established diagnosis, the documentation details whether the patient's condition is stable, improved, worsening, etc,
3. When diagnostic tests are ordered, the rationale for ordering the tests are either documented or easily inferred, and
4. Management of the patient is clearly documented, (i.e., prescription drugs, over the counter medication, surgery, etc).

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The Practice of Medicine

- Practice of Medicine has undergone a significant transformation due to:
  - Federal regulations
  - Coding
  - Reimbursement
- Medical Coding is a language all its own
  - Coding is not an exact science
  - Documentation and Medical Necessity must be supported in the medical record
  - Coding is subject to intense review by insurance industry
- Insurance industry uses statistical analysis to recover dollars spent for fraud, waste, and abuse

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Auditing the Medical Record

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Purpose of Auditing and Monitoring

- Evaluation of the medical record
  - What procedures and services performed
    - Meet with coding guidelines
    - Carrier guidelines
    - Support medical necessity
- Examples:
  - Adherence to clinical protocols
  - Patient adherence with medication regimens
  - Provider compliance

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Purpose of Auditing and Monitoring

- Clear plan of action should be developed
  - Be prepared for the eventual audit
  - Compliance audits are preventative
- Reasons to audit
  - Find missed charges
  - Correcting denials
  - Improper coding (over or under coding)
  - Improve documentation

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Why Perform the Audit?

- To identify potential risks to organization
- Ensures compliance with:
  - Medical policies
  - Claim procedures
  - Payer regulations
  - Coding guidelines

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Why Perform the Audit?

- Audit will assist in correcting problems before further damage occurs
  - can reveal errors hidden in the medical record such as services not provided
  - services billed under the wrong provider
  - services not ordered by the licensed professional
  - wrong procedures and diagnoses reported
  - other coding and billing errors

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Audits

- If you identify any abhorrent coding patterns
  - a more frequent audit might be beneficial
- Careful pre-submission monitoring and review of similar types of claims may safeguard against errors which could result in either claim denial or audit recovery from an insurance carrier whether it is from:
  - a commercial payer
  - third-party payer
  - government carrier

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Audits

- An audit gives the physician and medical practice staff the opportunity to identify incorrect coding and billing patterns and over utilization of procedures and services before an outside auditor recovers payments or assesses fines and penalties
- An Internal Billing Audit can help insure appropriate payment and compliance with applicable laws and carrier regulations
- Auditing physician services and billing practices is a difficult task, but will typically improve:
  - coding
  - documentation
  - cash flow
  - claims management
  - compliance with applicable laws and insurance carrier regulations

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Internal versus External Audit

- Internal audit-employed staff to conduct audit
- External audit-hire an auditor to perform audit
- Benefits to both
  - Internal auditor-may audit more frequently
  - External auditor-provide more objective opinion
  - Can save money on salary and benefits

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Type of Audits

- Pre-payment—prior to submission of claim
- Retrospective—after payment is submitted and paid/denied
- Focused Review—review of significant number of chart notes
  - Similar types of service
- All types of audits findings should be reported
  - Identifying errors (coding and billing)
  - Review utilization-both CPT®/HCPCS Level II and diagnosis codes
  - Medical necessary services
  - Self disclosure

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Focused Medical Review

- Section 1 842(a) (2) (b) of the Social Security Act requires contractors to apply safeguards against unnecessary utilization of service
  - Identify inappropriate claims or questionable patterns of practice
  - Ensure coding and documentation compliance
- Objectives of FMR
  - Maximize program protection
  - Physician education and policy development major components resulting from FMR
    - Provider can be placed on claim monitoring

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Top Billing and Coding Errors

1. Duplicate claims
2. Non-covered services
3. Lack of Medical Necessity
4. Unbundling
5. Eligibility
6. Incorrect carrier
7. Medicare is the secondary payer
8. Incorrect diagnosis reported
9. Missing or invalid modifiers

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Top E/M Coding Errors

1. Upcoding
2. Downcoding
3. Chief Complaint/reason for visit missing or incorrect
4. Assessment not clearly documented
5. Documentation not initialed or signed
6. Tests ordered not always documented on the patient encounter, but billed
7. Assessment and Plan not clearly documented
8. Incorrect Diagnosis or not referenced correctly
9. Documentation missing
10. Lost dictation
11. Superbill/charge ticket/encounter not available
12. Superbill/charge tickets/encounter incorrect or incomplete
13. Illegible documentation

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Understanding the Process

The medical record facilitates:

- Evaluation and planning of treatment
- Communication and continuity of care
- Accurate and timely claims review/payment
- Appropriate Utilization review and quality of care evaluations
- Data collection used in research and education

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Auditing E/M Services

- Two sets of Guidelines for CMS
  - 1995
  - 1997
  - CMS Guidelines
    - http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp
    - AMA Guidelines are in CPT® code book and are vague in the required amount of detail that should be documented
    - Other carriers such as Trailblazers have their own unique criteria

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Auditing The Surgical Medical Record

- 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.
- To accurately audit the surgical medical record, the auditor must have a good understanding of surgical terminology and anatomy

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Auditing the Surgical Medical Record

- 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. Many activities are common to many or all procedures.

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CPT's Global Surgical 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

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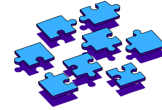
Examples of What's Included in a Surgical Procedure



- 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

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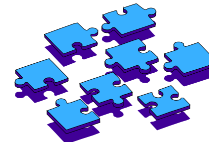
Examples of What's Included



- 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

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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

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Major versus Minor Procedures

- 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 0-10 global days (post operative period)
    - Includes same day services (pre and post) and
    - Intraoperative care

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Major versus Minor Procedures

- Major procedures global days
  - One day preoperative and
  - 90 day postoperative
- Global fee includes
  - 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

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National Correct Coding Initiative (NCCI)

- 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
  - NCCI published quarterly
  - Reviews coding combinations and implements correct code edits

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National Correct Coding Initiative (NCCI)

- 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

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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.
- Medicare closely monitors physician billing practices for possible abuse or fraudulent billing. Private payers also watch for unbundling.

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Example #1

Comprehensive Code	Description	Edit	Mod	Effective Date	Termination Date
52310	Cystoscopy and treatment				
52355	Cystouretero w/excise tumor				
52310	Cystoscopy and treatment	1	0	10/ 1/2001	

Interpreting the Report:
The Comprehensive Code is also referred to as the Column 1 code. To the right of each Comprehensive code is a line that acts only as a separator. The codes listed below that line are the associated component codes. Another blank line means there are no associated codes.

Legend for Edit Codes

1 - Standards of Medical Practice
2 - CPT Separate Procedures Definition
3 - Most Extensive Procedure
4 - "With" versus "Without" Services
5 - Anesthesia Included in Surgical Procedures
6 - Laboratory Panels
7 - Sequential Procedures
8 - Standard Preparation / Monitoring Service
9 - CPT Coding Manual Instruction/Guideline
10 - CPT Procedure Code Definition
11 - Misuse of Column 1 with Column 2
12 - Mutually Exclusive Codes
13 - Designation of Sex Procedures

Legend for Modifier Codes

0 - Modifiers -58 and -59 are not allowed and will not bypass the edit.
1 - Modifiers -58 and -59 are allowed and will bypass the edit.

41

Example #2

Comprehensive Code	Description	Edit	Mod	Effective Date	Termination Date
43610	Excision of stomach lesion				
49000	Exploration of abdomen	4	0	1/ 1/1997	
49000	Exploration of abdomen				

Interpreting the Report:
The Comprehensive Code is also referred to as the Column 1 code. To the right of each Comprehensive code is a line that acts only as a separator. The codes listed below that line are the associated component codes. Another blank line means there are no associated codes.

Legend for Edit Codes

1 - Standards of Medical Practice
2 - CPT Separate Procedures Definition
3 - Most Extensive Procedure
4 - "With" versus "Without" Services
5 - Anesthesia Included in Surgical Procedures
6 - Laboratory Panels
7 - Sequential Procedures
8 - Standard Preparation / Monitoring Service
9 - CPT Coding Manual Instruction/Guideline
10 - CPT Procedure Code Definition
11 - Misuse of Column 1 with Column 2
12 - Mutually Exclusive Codes
13 - Designation of Sex Procedures

Legend for Modifier Codes

0 - Modifiers -58 and -59 are not allowed and will not bypass the edit.
1 - Modifiers -58 and -59 are allowed and will bypass the edit.
9 - This edit pair has been terminated and is no longer effective

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Unbundling Prevention

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

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Unbundling Prevention

6. Avoid fragmented billing
7. Make sure physicians provide complete information and documentation
8. Use modifiers correctly
9. Use caution when reporting integral procedures

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Five Parts of the Audit

1. Perform the audit
2. Reporting
3. Discussing Results
4. Identifying repayment-self disclosure
5. Ongoing auditing and monitoring

45

Auditing vs. Monitoring

- Auditing—process of examining the medical record, verifying information, and gathering baseline information to identify risk areas
- Monitoring—ongoing process of reviewing coding practices and the adequacy of documentation and code selection
- Monitoring should
  - Be conducted on a regularly scheduled basis
  - Include such activities as
    - Auditing
    - Reviewing utilization patterns
    - Reviewing computerized reports
    - Reimbursement

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Goals of Audit

- Two categories that are important
  - Revenue
  - Compliance
- Revenue
  - Underbilled services
  - Overbilled services-frequency—upcoding
  - Undocumented services
  - Denied services
  - Downcoded services
  - Services not billed or missed charges

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Conducting a Chart Audit Step by Step

- Select type of services to review which might include:
  - Office or Hospital
  - New versus established patients
  - Consultation
  - Nursing home visits
  - Surgical procedures
  - Identify measures (levels of services)
  - Identify patient population based on insurance carrier

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Beginning the Audit Process

- Questions to Ask
  - What is the focus of the audit (e.g., new patient visits, consultation, office, hospital, etc.)?
  - Are you performing a prospective or retrospective audit?
  - What is the number of charts you are going to review?
  - Is there a measure for the focus such as utilization patterns?
  - Has the provider been audited before where data is available?
    - If "yes", then a benchmark or standard exists
    - if "no", then a standard for comparison may not exist
  - What type of audit tool will you use?
    - Electronic
    - Paper

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Step 1—Audit Objectives

- Type of services to audit
- Scope of Audit
- Number of records to audit
- What to accomplish (revenue, compliance, utilization, etc.)
- How will we communicate results/findings

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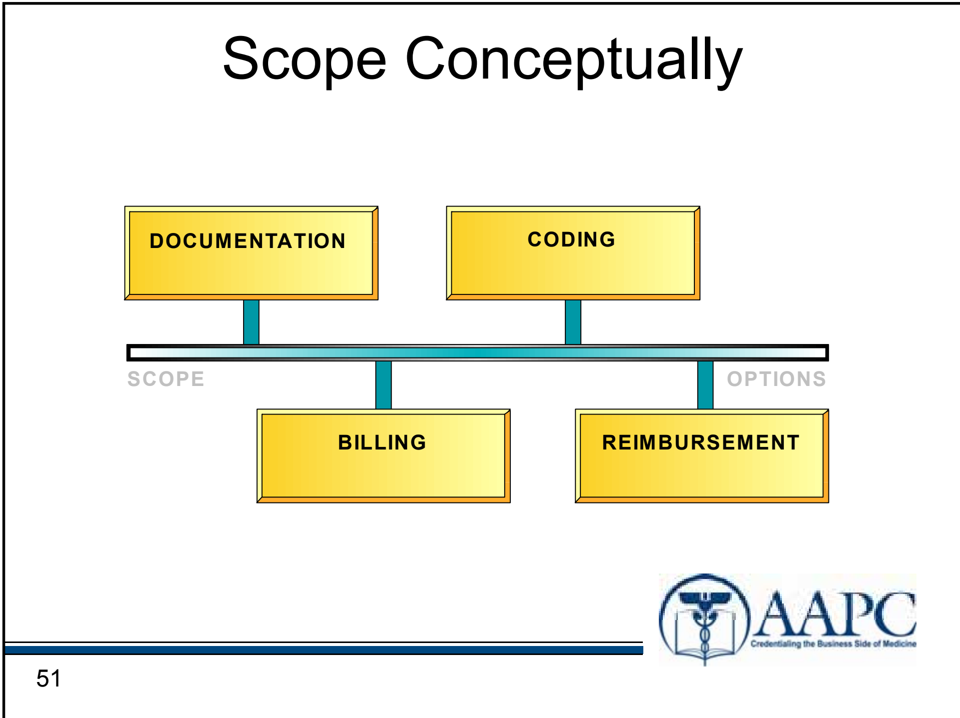
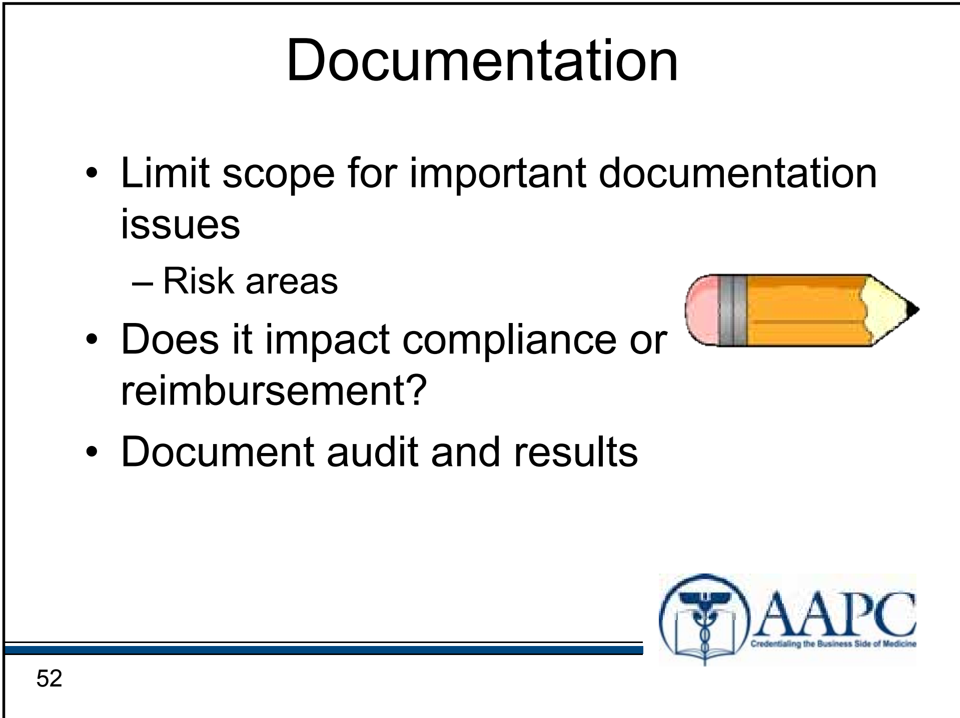

Scope Conceptually
DOCUMENTATION
CODING
SCOPE
OPTIONS
BILLING
REIMBURSEMENT
AAPC
Credentialing the Business Side of Medicine
51


Documentation
• Limit scope for important documentation issues
– Risk areas
• Does it impact compliance or reimbursement?
• Document audit and results
AAPC
Credentialing the Business Side of Medicine
52

Step 2—Sample Size

- An auditor (internal or external) examines documentation to determine whether it adequately substantiates the service billed and identifies medical necessity
- Good rule of thumb is to audit 10-20 records selected randomly for each practitioner
- Another rule of thumb: Be consistent when choosing a sampling of medical records to eliminate confusion
- Types of visits
  - Inpatient versus outpatient
  - New patient versus established patient

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Types of Audits

- Audits can be divided into three basic groups
  - Presubmission audits
    - Performed prior to services being billed to insurance carrier
  - Postpayment audits
    - Performed after the service(s) are billed to insurance carrier
  - Focused audit
    - Focuses on a specific area in the practice or group that may pose potential problematic issues
    - Normally will follow a pre-payment or post-payment audit after a problem is identified

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Types of Audits

- Random sample-any type, level of service visit or procedure
- Controlled sample-a specific level or type of service
- High volume services
- High risk services
- Frequent denials
- Past errors

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Types of Audits

- Revenue objectives of an audit involve
  - Examining coding practices for lost revenue due to the improper use of codes
  - Identifying inappropriate billing for incorrectly high reimbursement—an open invitation to a payer audit
- When considering revenue, look at
  - Under billed services
  - Overbilled services - frequency or up-coding
  - Undocumented services
  - Denied services
  - Down coded services

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Step 3—The Audit Tool

- Important element of the audit process
- Many audit tools available
- Important to be comfortable with the tool used
- In addition to paper audits, several software vendors offer auditing software to help in the audit process
- Once you begin auditing patient encounters regularly, research all options available to find the best method for you

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Paper Audit Tools

- A "must have" for any medical record auditor
- There are a variety of prepackaged audit tools for general use
- Beneficial for the auditor to
  - Create his or her own audit tool
  - Tailor the tool to the specialty that is being audited
- Can be created in a template format in MS Word or other software programs
- Should be compliant with coding and documentation guidelines

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Electronic Audit Tools

- Electronic (Software)
  - Variety of software programs to assist with the audit process
  - These tools are good for
    - Report generation
    - Tracking utilization deviations
    - Providing help with guidelines integrated into the software
  - Downside of using software as an audit tool
    - Calculation of medical necessity
    - A software program cannot analyze medical decision-making
    - Reports are not always accurate

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Step 4—Perform the Audit

- Four of the most important reasons to audit your medical records are
  - To assess the completeness of the medical record
  - To determine the accuracy of the physician's documentation
  - Ensure correct coding
  - To discover lost revenue

60

What Are You Looking For?

- Nonbilled services—Compare the medical record to the billing to identify services that are documented in the medical record but overlooked in coding
- Overbilled and/or underbilled services—All services, including E/M and surgical procedures, should be documented with sufficient detail to allow coders to select the proper CPT® and/or HCPCS and ICD-9-CM codes
- Undocumented services—A good audit (review) will identify instances where codes are billed without proper supporting documentation
- Denied or down-coded services—Analyze those services that are denied or down coded by payers to discover the cause of the denial
  - Information comes from comparing the billed services to the EOB or remittance advice (RA) from Medicare

61

Step 5—Analysis and Report

- Review Analysis and Summary report
  - Detailed report provided to the provider
  - Indicates documentation compliance
  - Identifies problem areas
  - Offers suggestions for improvement
  - Valuable tool when meeting with the provider after the audit is completed

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Step 6—Meet with the Practitioner

- Review the audit summary and findings with the physician and/or practitioner.
- Communication between the practitioner and auditor is vital
- Taking action based on findings in the chart audit process is a critical step in the audit process.
- On-going training is the next step in the auditing process once the problematic areas are identified
- Training includes coding and documentation guidelines, coding updates, and changes in carrier and government requirements
- Establish a time frame to make needed changes based on the physician's or practice administrator's determination of the issues that require immediate attention
- Followed later by those that can wait for long-term revision and implementation

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Step 7—Make Recommendations for Improvement

- Once problem areas are identified, focus can then turn to education where most needed
- Training needs vary
  - Auditing allows the organization to design education modeled to specific needs
- Auditing will also provide information on patterns and trends that may affect the organization

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Step 8—Provide Monitoring and Guidance

- At a minimum
  - Annually audit 10-20 records (prospectively) for each physician
  - Compliance rates observed in the industry have range from 80-95%
  - OIG standard is 5% error rate
- Audit determines rate lower than expected a larger sample of records are reviewed (15 to 30)
- If rate continues to fall below expected compliance rate, either all services are reviewed for a period of 30-90 days until an average expected compliance rate is achieved
- Billing is ceased, education is provided

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Risk Areas

- Falls below threshold for accuracy
  - 5% OIG allowed error rate under Corporate Integrity Agreement
- Other Risk Areas include:
  - Violation of official coding guidelines
  - Documentation inadequate to support level of service billed (code selection)
  - Noncompliance with third-party payer directives
  - Code assigned, but not billed on claim form
  - Service billed to the wrong provider
  - Incorrect place of service
  - Incorrect category of service (hospital, office, consultation, etc)
  - Signature requirements not met
  - Incorrect modifier usage

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Monitoring for Accuracy

- Develop a method or process to measure compliance and the effectiveness of the training that has been provided
  - To accomplish this goal, develop a schedule for subsequent audits
  - The frequency of the audits will depend on the number of problematic areas and the overall error rate of the organization
  - Normally audits are conducted monthly, quarterly, semi-annually, or annually

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Education

- Outline plan for improvement
- Type and/or focus of training dependent on problem areas
- Education should be developed to ensure compliance

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Education

- Some training suggestions include:
  - Review topics where deficit areas are prevalent
  - Review coding policies, Medicare bulletins, fraud alerts, etc.
  - Highlight quarterly correct coding initiative changes
  - Discuss annual coding changes
  - Review specific topics related to the specialty
  - Present E/M documentation guidelines update annually as a review
  - When the problem is an area identified by a carrier or the Office of the Inspector General (OIG) schedule training immediately after the audit to ensure that compliance and the appropriate steps to resolve the problem areas are taken

69

Corrective Action

- Analyzing the findings and determining steps necessary to resolve the issues identified
- Identifying timeframe to complete the steps
- Implementing a plan to re-test and validate that steps taken have corrected the problem
- Develop a process to monitor on a periodic basis
- Establish a baseline pass/fail rate per provider
- Determine and classify what constitutes an “error”

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Corrective Action

- Determine if education and/or operational process changes are needed to resolve the issue
  - Provider education
  - Charge-capture
    - Encounter form/Superbill/Charge ticket/Other
    - Documentation template
    - Data entry error

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Corrective Action Plans

- Non-compliant providers
  - Provide additional education
  - Expand sample scope & size
  - Review all services prior to billing
- Disciplinary Actions
  - Oral Warnings
  - Written Warnings

72

What Can Trigger a Carrier Audit?

- Consistently using one level of E/M service or routinely using higher levels
- Ordering excessive tests
- Billing Medicare or another government program for care not provided
- Unbundling of procedures
- Waiving coinsurance and deductibles in absence of financial hardship
- Changing codes to get paid
- Coding based only on reimbursement and not medically necessary services
- Practitioner's profile (utilization pattern) does not meet the standards of the industry

73

Auditing Surgical Medical Records

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Auditing Surgical Medical Records

- In order to accurately audit the surgical medical record, auditor must have a good understanding of surgical terminology and anatomy
- Auditor must also understand
  - Surgery coding guidelines
  - Insurance carrier rules
  - National Correct Coding Initiative (NCCI) edits
  - How to code an operative report

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Surgical Audit Process

- Four steps in auditing surgical medical records
  - Determine what you are going to audit (scope of review)
  - Review operative report
  - Report findings
  - Educate

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Auditing Tools

- Use the same tools as for auditing E/M visits and services for the physician
  - Audit tool
  - Charge ticket
  - Codebooks (CPT®, ICD-9-CM, HCPCS Level II)
  - NCCI (book or software)
  - Other pertinent coding publications
  - Detailed analysis-for summarizing audit results
  - Summary report-reporting audit results

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Auditing Surgical Records

- Steps to take when auditing the operative report or surgeon's notes
- Begin by making a copy of the operative report, if possible
  - Underline/highlight important information
  - Use medical references for unfamiliar terms
  - Cross out non–code-related documentation
  - Check bundling issues
  - Verify code sequencing when multiple procedures are performed
  - Apply necessary modifiers

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Detailed Analysis and Audit Summary

- As with E/M services, a detailed analysis and summary report will help to
  - Identify key areas that require improvement
  - Validate correct documentation and coding
- Please review Examples-pages 29-34
  - Example of surgery audit tool
  - Example of surgery summary report
  - Example of detailed analysis

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Auditing the Medical Record

Let's Audit!

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Audit Exercise Instructions

- Begin by auditing exercises 1 through 6 for Mark Welby, M.D.
- For E/M services use both the 1995 and 1997 (Multi-system exam) in the Appendix
- Check for correct CPT® coding, diagnostic coding, and codes that are unbundled including correct modifier usage.
- Verify what procedures are documented in the operative report versus reported and/or billed on the charge ticket.
- Write a summary report for the E/M services and a separate report for the surgical services.

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Case #1

- Provider billed 99204 with Diagnosis of 413.9-angina unspecified and 331.0-Alzheimer's
- Documentation supports
  - Comprehensive History
  - Comprehensive examination
    - Keep in mind review both the 1995 and 1997 documentation guidelines
  - Medical Decision Making-Moderate
- Provider documented:
  - 99204
  - 413.9 and 331.0

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Case #2

- Provider reported:
  - 99214-Level IV E/M
  - 36415-venipuncture
  - 727.00-synovitis
- Provider documented:
  - Detailed history
  - Expanded-problem focused examination
  - Medical Decision Making-Moderate

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Case #2

- Documented services:
  - 99214
  - 727.00
- The E/M service is billed correctly.
- The charge for venipuncture is not supported. There is no order and no indication that venipuncture is performed.
- There is an indication of an X-ray being performed but we are missing an order, the number of views and anatomic site of the X-ray as well as the interpretation. Although it seems the service was provided, the provider was correct not to bill for it because the documentation does not support the service.

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Case #3

- Provider reported:
  - 99201-57
  - 11301
- Provider documented
  - Problem focused history
  - Problem focused examination
  - Medical Decision Making-Straightforward

85

Case #3

- Provider documented:
  - 11302-Lesion excision 1.0 to 1.5
  - The documentation does not support a separate E/M service. The history and exam performed were directly related to the complaint for which a procedure is performed. If the E/M was billable, modifier 57 is not the correct modifier to use because it is only used with major procedures.
  - The procedure performed is a minor procedure. If a separate and identifiable E/M service was performed, modifier 25 would be the appropriate modifier.
  - The lesion removed measured 1.0 to 1.5 which is reported with 11302. The lesion is sent for pathology so we are unsure if it is benign.
  - The correct ICD-9 code to report in this case is 239.2. Until pathology returns, you cannot code as benign or malignant. The best option is to wait for the pathology report in order to report the most accurate diagnosis code.

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Detailed Analysis
Practice: Mark Welby, MD
Date of Audit: June 15, 200X

Provider: Mark Welby, MD
Auditor: Your Name

Chart #	Patient	Date of Service	CPT Code Reported	CPT Code Documented	ICD-9-CM Reported	ICD-9-CM documented
1	Delaney Greensword	8/21/200X	99204	99204	413.9, 331.0	413.9, 331.0
2	Mary Ann Marzette	8/11/200X	99214 36415	99214	727.00	727.00
3	Sarah Carter	9/11/200X	99201-57 11301	11302	216.7	239.2

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Medical Record Chart Audit Summary Report

Practice: Mark Welby, MD
Provider: Mark Welby. MD

Date of Audit: June 15, 200X
Auditor: Your Name

A total of 3 records were reviewed using the 1995 and 1997 Documentation Guidelines, CPT Coding rules, and Insurance carrier guidelines. Chart notes were received for the following physicians/practitioners:

Mark Welby, MD

The findings and recommendations based on the review of the office, and diagnostic procedures are as follows:

Findings

E/M documentation in the record appeared to support service billed	2
E/M documentation in the record appears to support a lower level of service than billed or does not support an E/M	1
Documentation appeared to be missing or could not be located in the Record	0

Findings and Recommendations:

1. Chart #2. There is a charge for venipuncture but there is no order or indication venipuncture was performed. There is a notation regarding an X-ray that is not billed. Although it is appropriate not to bill the X-ray because we are missing the order, anatomic site, number of views and interpretation, if documented properly this would be missed revenue.

Recommendation: Review the medical record in it's entirety to look for missing charges and charges not supported. Review the coding guidelines for reporting ancillary services.

Surgical Audit Cases

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Surgical Coding Charge Ticket Case #4

Case #4

Date of Surgery	Facility	Place of service	CPT Code	Diagnosis Code(s)	Modifier	Quantity	Fee
01/04/200x	Methodist Surg Cntr	24	45380	455.0		1	900.00
01/04/200x	Methodist Surg Cntr	24	45378	787.91	51	1	400.00

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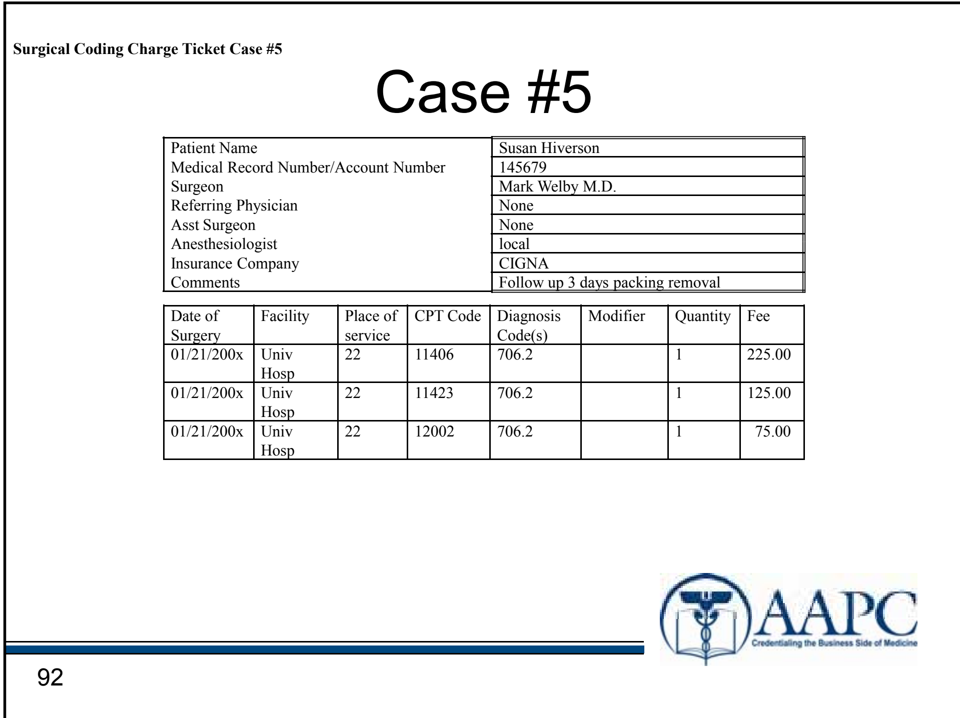
Physician Mark Welby Date of Review 06/15/200X
Patient Name Parker Stevenson MR# 145678
Date of Birth __________ Date of Visit 01/04/200X Insurance Carrier: Medicare
Surgical Service (s) billed 45380, 45378-51 Diagnosis Code (s) billed 455.0, 787.91
Comments The services are unbundled. When a diagnostic and therapeutic colonoscopy are performed during the same encounter, only report the therapeutic service.

Documented	Y	N	N/A	Comments
Preoperative information				
Patient demographics				
Surgery date				
Preoperative anesthesia				IV Sedation
Indication for Procedure				
Diagnostic Reports				
Intra-operative information				
Preoperative diagnosis				
Postoperative diagnosis				
Surgeon/asst/co-surgeons				
Procedure title				
Findings				
Procedure details				
Tissue/organ removed				
Materials removed/inserted				
Closure information				
Blood loss/replacement				
Wound status				
Drainage				
Complications noted				
Post-operative condition of patient				
IV infusion record				
Signatures				
Legibility				
Supports procedure (CPT/HCPCS)				The services are unbundled, only 45380 should be reported.
Supports medical necessity (ICD-9-CM				



Surgical Coding Charge Ticket Case #5

Case #5

Patient Name	Susan Hiverson
Medical Record Number/Account Number	145679
Surgeon	Mark Welby M.D.
Referring Physician	None
Asst Surgeon	None
Anesthesiologist	local
Insurance Company	CIGNA
Comments	Follow up 3 days packing removal

Date of Surgery	Facility	Place of service	CPT Code	Diagnosis Code(s)	Modifier	Quantity	Fee
01/21/200x	Univ Hosp	22	11406	706.2		1	225.00
01/21/200x	Univ Hosp	22	11423	706.2		1	125.00
01/21/200x	Univ Hosp	22	12002	706.2		1	75.00

Surgery Audit Tool Case #5

Physician Mark Welby, MD Date of Review June 15, 200X
Patient Name Susan Hiverson MR# 145679
Date of Birth ________ Date of Visit 1/21/200X Insurance Carrier: Cigna
Surgical Service (s) billed 11406, 11423,12002
Diagnosis Code (s) billed 706.2
Comments 12002 should not be reported. According to CPT Coding Guidelines, simple closures are included when an excision of a benign or malignant lesion is performed

Documented	Y	N	N/A	Comments
Preoperative information				
Patient demographics				
Surgery date				
Preoperative anesthesia				Local anesthesia
Indication for Procedure				
Diagnostic Reports				
Intra-operative information				
Preoperative diagnosis				
Postoperative diagnosis				
Surgeon/asst/co-surgeons				
Procedure title				
Findings				
Procedure details				
Tissue/organ removed				
Materials removed/inserted				
Closure information				
Blood loss/replacement				
Wound status				
Drainage				
Complications noted				
Post-operative condition of patient				
IV infusion record				
Signatures				
Legibility				
Supports procedure (CPT/HCPCS)				12002 should not be reported
Supports medical necessity (ICD-9-CM				

Surgical Coding Charge Ticket Case #6

Case #6

Patient Name	Jerry Lister
Medical Record Number/Account Number	145785
Surgeon	Mark Welby, M.D.
Referring Physician	Howard Bruner, M.D.
Asst Surgeon	None
Anesthesiologist	local
Insurance Company	Continental Insurance
Comments	Post operative follow up 2 weeks

Date of Surgery	Facility	Place of service	CPT® Code	Diagnosis Code(s)	Modifier	Quantity	Fee
02/02/200x	Office	11	99213-25	726.32	25	1	75.00
02/02/200x	Office	11	20605	726.32		1	150.00
02/02/200x	Office	11	J3303	726.32		2	65.00

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Case #6

Surgical Coding Case #6

PATIENT: Jerry Lister

MR 145785

DATE OF SERVICE: 02/02/200x

This is an established patient who presents to the office with a new complaint of left elbow pain. The pain started about a month ago and has progressively gotten worse. It is exacerbated by rotation, flexion, and extension of the elbow. The patient is an avid tennis player and it seems that the pain is aggravated during play. He is in a tournament next week and is requesting help with pain relief. He has been on NSAIDs with very little effect. Denies any trauma, swelling, or warmth to the joint area. Examination revealed the left elbow has no swelling or ecchymosis. There is tenderness over the lateral epicondyle. The left shoulder and wrist are normal. The right upper extremity is normal. Neurological examination was unremarkable. After considering multiple diagnoses and determining the risk to the patient is moderate, the physician's impression is left lateral epicondylitis. The patient was given an injection of Aristospan (triamcinolone hexacetonide) 10 mg into the left elbow at the area of tenderness. He was told to use ibuprofen 600 mg and return for reevaluation in 2 weeks or sooner if the elbow gets worse.

Mark Welby, M.D.
Mark Welby, M.D.
Dictated: 02/04/200x not proofed

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Detailed Analysis

Surgery Audit Detailed Analysis
Physician: Mark Welby, MD
Date of Review: 0x/xx/xxxx
Reviewer: Name of Auditor
Number of Operative Notes Reviewed: 3

		Billed			Documented		
Chart #	Patient	CPT	ICD-9-CM	MOD	CPT	ICD-9-CM	MOD
1	Parker Stevenson	45380 45378	455.0 787.91	51	45380	787.91 455.0	
2	Susan Hiverson	11406 11423 12002	706.2		11406 11423	706.2	
3	Jerry Lister	99213 20605 J3303	726.32	25	Signature is missing from dictation services are not billable	Missing Dictation cannot report	

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SURGERY AUDIT SUMMARY REPORT

Physician: Mark Welby, MD — Date of Review: xx/xx/xxxx
Reviewer: Your Name
Number of Operative Notes Reviewed: 3

Operative notes were reviewed for completeness and appropriateness of care along with coding documentation and medical necessity.

Documentation in the operative note appears to provide preoperative information	3
Surgery date appears to be documented in the note	3
Preoperative anesthesia appears to be documented in the note	0
Indication for Procedure appears to be documented in the operative report	3
Preoperative diagnosis appears to be documented in the operative report	3
Postoperative diagnosis appears to be documented in the note and supported by findings	2
Surgeon/asst/co-surgeons are listed in the operative note	3
Findings appear to be indicated in the operative report	2
Procedure details appear to be documented appropriately in the operative report	2
Post-operative condition of patient appears to be indicated in the operative report	2
The operative report appears to support procedure (CPT/HCPCS)	0
The operative report appears to support medical necessity (ICD-9-CM	3

Other Documentation and Coding Issues:
1. Chart #4. The services were unbundled for this case. When diagnostic and therapeutic colonoscopies are performed during the same session, only code the therapeutic service.
2. Chart #5. The services are unbundled. The simple closure is included in the excisions of the cysts.
3. Chart #6. The physician did not verify and sign the dictation. The services are not billable without the physician's verification of the dictation and signature. The E/M, HCPCS Level II and diagnosis codes are correct. The joint injection of the elbow is lacking detail.

RECOMMENDATIONS

1. Recommend a coding training to review the surgical package and CPT surgical coding guidelines
2. Review the documentation requirements for surgical procedures
3. Chart #6. The provider should review and sign the dictation. Without a review and signature the procedure is not billable unless the chart contains a hand-written note detailing the visit in addition to the dictation.
4. Due to 100% error rate for surgical coding, recommend prepayment review of all surgical cases until the provider reaches a 5% error rate.

Conclusion

- Medical Chart Auditing is important to maintain compliance which will be mandated by 2014 based on Health care reform
- Medical chart auditing is not an exact science—there are gray areas
- Check with each payer regarding guidelines, medical policies etc
- When speaking with the practitioner, make sure you can provide official guidance for problematic areas

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Thank You for Attending

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Auditing Exercises Answer Key

Case #1—Provider: Mark Welby, M.D.

Patient: Delaney Greensword **Date of Service:** 08/21/20xx **MR#** 123456

Patient was seen in the office for cardiac evaluation of chest pain. This is the first visit for this patient, who was referred by her nephew. The patient's daughter is with her today. The patient has been complaining of hurting in the chest for four days and the Nitroglycerin helps. Patient has chest pressure which is moderate, but difficult for the patient to describe on the 1-10 scale

PAST MEDICAL HISTORY: She does have Alzheimer's, described by her daughter as being mild in the early stages. Surgeries include cataract and a hysterectomy. She also had foot surgery. She has a fallen bladder, for which no therapy is recommended. She had the usual childhood illnesses. Patient is taking Vitamin E, aspirin, stool softener.

FAMILY HISTORY: Father deceased at age 75 of Alzheimer's. Mother lived to age 93. A brother has coronary artery disease. One brother is deceased from cancer.

SOCIAL HISTORY: Patient does not smoke or drink alcohol. She's been married 43 years and her husband is retired.

REVIEW OF SYSTEMS: Negative for cough, edema, positive for heart palpitations, dizziness, history of pulmonary embolism, occasional constipation. The reviews of systems were negative.

PHYSICIAL EXAMINATION: The patient is pleasant and well groomed. She can carry a conversation, but has a memory space of less than 15 seconds. Lids and sclera are normal. Pupils, PERRLA. Oral mucosa is normal. Pulse is 72 and regular. Weight is 127 pounds. Height: 5'3" Dentures are present. Carotids are brisk. Chest is clear to auscultation and percussion. Cardiac examination reveals no murmurs or gallops. There's no abdominal hepatosplenomegaly, tenderness or masses. Pedal pulses are full and there's no clubbing, cyanosis or edema. Skin clear.

ASSESSMENT AND PLAN: Angina, non-specific. Alzheimer's mild-no treatment. Patient was prescribed a Nitro-Dur® patch .2q.d. and Toprol XL® 25 mg. 1 p.o.q.d.. She is to take an aspirin and to use Nitroglycerin. Additionally, patient was placed on Protonix® 40 mg. 1 q.d. in hopes that her chest discomfort is gastro-intestinal. She is to see me back for reevaluation in 3-4 weeks.

Mark Welby, M.D.

Charge Ticket Case #1 **Physician: Mark Welby, M.D.**

Patient Information		**Payment Method**		**Visit Information**	
Patient ID number	123456	**Primary**		Visit date	08/21/200x
Patient name	Delaney Greensword	Primary ID number		Visit number	21

E/M Modifiers	**Procedure Modifiers**	**Other Modifiers**
24 — Unrelated E/M service during postop.	50 — Bilateral procedure	
25 — Significant, separately identifiable E/M	51 — Multiple surgical procedures in same day	
57 — Decision for surgery	52 — Reduced/incomplete procedure	
	55 — Postop. management only	
	59 — Distinct multiple procedures	

CATEGORY	CODE	MOD	FEE	CATEGORY	CODE	MOD	FEE
Office Visit — New Patient				**Wound Care**			
Level 1	99201			Debride partial thick burn	11040		
Level II	99202			Debride full thickness burn	11041		
Level III	99203			Debride wound, not a burn	11000		
Level IV	99204 (circled)		155.00	Unna boot application	29580		
Level V	99205			Unna boot removal	29700		
Other				Other			
Office Visit — Established				**Supplies**			
Level I	99211			Ace bandage, 2”	A6448		
Level II	99212			Ace bandage, 3"-4”	A6449		
Level III	99213			Ace bandage, 6”	A6450		
Level IV	99214			Cast, fiberglass	A4590		
Level V	99215			Coban wrap	A6454		
Other				Foley catheter	A4338		
General Procedures				Immobilizer	L3670		
Anascopy	46600			Kerlix roll	A6220		
Audiometry	92551			Oxygen mask/cannula	A4620		
Breast aspiration	19000			Sleeve, elbow	E0191		
Cerumen removal	69210			Sling	A4565		
Circumcision	54150			Splint, ready-made	A4570		
DDST	96110			Splint, wrist	S8451		
Flex sigmoidoscopy	45330			Sterile packing	A6407		
Flex sig. w/ biopsy	45331			Surgical tray	A4550		
Foreign body removal—foot	28190			Other			
Nail removal	11730			**OB Care**			
Nail removal/phenol	11750			Routine OB care	59400		
Trigger point injection	20552			OB call	59422		
Tympanometry	92567			Ante partum 4–6 visits	59425		
Visual acuity	99173			Ante partum 7 or more visits	59426		
Other				Other			

Fees	**Diagnosis Codes**
Total Charges: $155.00	1. 413.9-Angina Unspecified; 2. 331.0-Alzheimer’s

E/M Audit Form Case #1

Pt Name: Delaney Greensword Date of service: 08/ 21 /200X Provider Mark Welby, MD MR #:123456

HISTORY

☒Chief complaint (required all levels):

History of present illness (HPI): ☐ Brief (1-3) ☒ Extended (4 or more or update of 3+ chronic illnesses)

☒ Location ☒ Severity ☐ Timing ☒ Modifying factors

☐ Update 3+ chronic ☒ Quality ☒ Duration ☒ Context ☐ Assoc. signs /symptoms

Review of systems (ROS): ☐ None ☐ Problem pertinent (1) ☐ Extended (2-9) ☒ Complete (10+)

☒ Constitutional ☒ Cardiovascular ☒ Gastrointestinal ☐ Integumentary ☐ Endocrine

☐ Eyes ☒ Respiratory ☐ Genitourinary ☒ Neurological ☐ Hematologic/lymphatic

☐ ENT ☐ Musculoskeletal ☐ Psychiatric ☐ Allergic/Immunologic ☒ All others negative

Past, family, and social history (PFSH): ☐ None ☐Pertinent (1 of any) ☐ Complete est. (2 of 3) ☒Complete new (3 of 3)

☒ Past: Allergies, current medications, immunizations, previous trauma, surgeries, previous illnesses/hospitalizations.

☒ Family: Health of parents, siblings, children. Family members w/ diseases related to the chief complaint.

☒ Social: Drug, alcohol, tobacco use. Employment. Sexual history. Marital status. Education. Occupational history.

SCORE: HISTORY COMPONENT

☐ **Problem focused**	☐ **Expanded problem focused**	☐ **Detailed**	☒ **Comprehensive**	☐ **Not Documented**
CC; Brief HPI (1-3) ROS: None PFSH: None	CC; Brief HPI; Problem Pertinent (1 system) PFSH: None	CC; Extended HPI (4+) ROS: 2-9 systems PFSH-1 history area	CC; Extended HPI; Complete ROS; 10+ PFSH – 2 established patient 3 new patient	

PHYSICAL EXAM

General multi-system examination (Body area/organ system elements of examination)

Organ Systems

☒ Constitutional: ☒Vital signs: sit/stnd BP, sup BP, temp, pulse rate, resp, ht, wt **or** ☒General appearance

☒ Eyes: ☒conjunctivae/lids, ☒pupils/irises, ☐optic discs

☒ ENT: ☐ext exam ears/ nose, ☐ext aud canal/tymp memb, ☐hearing assessment, ☐nasal mucosa/septum/turbinates, ☒ lips/teeth/gums, ☒oropharynx—oral mucosa, palates

☒ Respiratory: ☐resp. effort, ☒chest percussion, ☐chest palpation, ☒auscultation of lungs

☒ Cardiovascular: ☐palpation heart, ☒auscultation, exam of: ☒carotid, ☐femoral arteries, ☐abdominal aorta, ☒pedal pulses, ☐ extremities

☒ Gastrointestinal: ☒abdominal, ☒liver/spleen, ☐hernia, ☐stool sample taken, ☐anus, perineum, rectum

☐ Genitourinary: Male: ☐scrotum, ☐penis, ☐digital rectal exam of prostate
Female: ☐pelvic, ☐ext genitalia, ☐urethra, ☐bladder, ☐cervix, ☐uterus, ☐adnexa/parametria

☐ Musculoskeletal: ☐gait/station, ☒digits/nails,
Exam of head/neck or spine/ribs/pelvis, Rt upper or Lt upper or Rt lower or Lt lower: ☐ inspect & palpate, ☐stability, ☐motion, ☐strength & tone

☒Skin: ☒inspect skin/ subc tissue, ☐palpation skin/ subcutaneous tissue

☐Neurologic: ☐cranial nerves, ☐deep tendon reflexes, ☐sensation

☒Psychiatric: ☐judgment/ insight, ☐orientation, ☒remote & recent memory, ☐mood & affect

☐Hematological/lymphatic ☐neck, axillae, groin, other, ☐immunologic:

Body Areas

☐ Head, including the face ☐ Neck: ☐neck (masses, symmetry,etc ☐thyroid ☐ Chest (breasts): ☐inspection breast, ☐palpation breast/axillae ☐ Abdomen ☐ Genitalia, groin, buttocks

☐ **1 or more in detail**

- ☐ Back, including spine
- ☐ Left upper extremity
- ☐ Right upper extremity

SCORE: PHYSICAL EXAMINATION COMPONENT

☐ Problem focused ☐ Expanded problem focused ☐Detailed ☒Comprehensive ☐ **Not Documented**

Medical decision making

Number of diagnoses and management options	Pts	Total
Self limiting or minor problems (stable, improved, or worsening); *maximum of 2 points*	1	
Established problem – stable, improved	1	
Established problem – worsening	2	
New problem – no additional work-up planned *Maximum of 1 problem given credit*	3	1
New problem – additional work-up planned	4	
Total points:		3

Amount and complexity of data	Pts	Total
Ordered and/or reviewed clinical lab	1	
Ordered and/or reviewed radiology	1	
Ordered/reviewed test in the CPT medicine section	1	
Discussed tests with performing or interpreting physician.	1	
Independent visualization and direct view of image, tracing, specimen	2	
Decision to obtain old records/additional HX from other than patient, e.g., family, caretaker, prev. phys.	1	
Reviewed and summarized old records and/or obtained history from someone other than patient.	2	
Total points:		0

Table of risk—The highest level in ONE area determines the overall risk

Level	Presenting problem(s) or	Diagnostic procedure or	Management options
Minimal ☐	☐ One self-limited or minor problem,e.g., cold, insect bite, tinea corporis	☐Laboratory tests requiring venipuncture ☐Chest x-rays ☐EKG/EEG ☐Urinalysis ☐Ultrasound, e.g., echo ☐KOH prep	☐Rest ☐Gargles ☐Elastic bandages ☐Superficial dressings
Low ☐	☐Two or more self-limited or minor problems ☐One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH ☐Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	☐Physiologic tests not under stress, e.g., pulmonary function tests ☐Non-cardiovascular imaging studies with contrast, e.g., barium enema ☐Superficial needle biopsies ☐Clinical laboratory tests requiring arterial puncture ☐Skin biopsies	☐Over-the-counter drugs ☐Minor surgery with no identified risk factors ☐Physical therapy ☐ Occupational therapy ☐ IV fluids without additives
Moderate ☒	☐One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment ☐Two or more stable chronic illnesses ☐Undiagnosed new problem with uncertain prognosis, e.g., lump in breast ☐Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis ☐ Acute complicated injury, e.g., head injury with brief loss of consciousness	☐Physiologic tests under stress, e.g., cardiac stress test, fetal-contraction stress test ☐Diagnostic endoscopies with no identified risk factors ☐ Deep needle or incisional biopsy ☐Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath ☐ Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	☐Minor surgery with identified risk factors ☐Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ☒Prescription drug management ☐Therapeutic nuclear medicine ☐IV fluids with additives ☐Closed treatment of fracture or dislocation without manipulation
High ☐	☐One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment ☐Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ☐An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	☐Cardiovascular imaging studies with contrast with identified risk factors ☐Cardiac electrophysiological tests ☐Diagnostic endoscopies with identified risk factors ☐Discography	☐Elective major surgery (open, percutaneous or endoscopic with identified risk factors) ☐Emergency major surgery (open, percutaneous or endoscopic) ☐Parenteral controlled substances ☐Drug therapy requiring intensive monitoring for toxicity ☐Decision not to resuscitate or to de-escalate care because of poor prognosis

Decision-making total: — 2 of 3 must be met

Pts	Number of DX	Amount of data	Risk of complications	Medical decision-making level
1	☐ Minimal	☒ Minimal	☐ Minimal	☐ Straight forward
2	☐ Limited	☐ Limited	☐ Low	☐ Low complexity
3	☒ Multiple	☐ Moderate	☒ Moderate	☒ Moderate complexity
4	☐ Extensive	☐ Extensive	☐ High	☐ High complexity

Score: E&M service

History	Exam	Medical decision-making level
☐Problem focused	☐Problem focused	☐Straightforward
☐Expanded problem focused	☐Expanded problem focused	☐Low complexity
☐Detailed	☐Detailed	☒Moderate complexity
☒Comprehensive	☒Comprehensive	☐High complexity

Number needed: ☐ **2 of 3** (MDM must be 1 of 2 to support medical necessity)

Please review the medical record for the following elements:

		Yes	No N/A
1.	Was the medical record for this service found?	☒	☐
2.	Is the medical record legible?	☒	☐
3.	Is the attending/teaching physician's note written by the billing physician?	☒	☐
4.	Does the date of service billed agree with the date of the progress note?	☒	☐
5.	If a resident was involved in providing this service, review teaching physician documentation and answer the following questions:	☐	☒
	A. Does this service meet the primary care exception?	☐	☒
	B. Does the medical record demonstrate teaching physician involvement?	☐	☒
	C. Does the teaching physician's note link to the resident's note?	☐	☒
6.	Does the documentation support the ICD-9 codes billed?	☒	☐
7.	Does the documentation support the level of service billed?	☒	☐

☐Dictated ☐Handwritten EMR ☒ ☐ Form ☐Illegible ☐Note signed

☐Signature missing ☐ Diagnosis Code(s) supported ☐Other Service provided

TIME☐ A description of what was discussed must also be detailed
Face-to-face time: Indicate the total face-to-face time (or total floor time for inpatient services) spent with the patient
Counseling/Coor. Time: Time spent counseling or coordinating care (must be greater than 50% of total face-to-face/floor time)

Code (s) selected: __99204___Code(s) audited:____99204________ ☐ **Over** ☐ **Under** ☒ **Correct** ☐**Miscoded**

Dx code(s) billed: __413.9, 331.0_____Dx code(s) documented: __413.9, 331.0___ Other services __________________

Comments: The E/M code and diagnosis codes are correct.

Auditor's Signature _______Your name________________________________

Case #2—Provider: Mark Welby, M.D.

Charge Ticket Case #2 **Physician: Mark Welby, M.D.**

Patient Information		Payment Method		Visit Information	
Patient ID number	23456	Primary		Visit date	08/11/20xx
Patient name	Marry Ann Marzette	Primary ID number		Visit number	27

E/M Modifiers	Procedure Modifiers	Other Modifiers
24 — Unrelated E/M service during postop.	50 — Bilateral procedure	
25 — Significant, separately identifiable E/M	51 — Multiple surgical procedures in same day	
57 — Decision for surgery	52 — Reduced/incomplete procedure	
	55 — Postop. management only	
	59 — Distinct multiple procedures	

CATEGORY	CODE	MOD	FEE	CATEGORY	CODE	MOD	FEE
Office Visit — New Patient				**Wound Care**			
Level 1	99201			Debride partial thick burn	11040		
Level II	99202			Debride full thickness burn	11041		
Level III	99203			Debride wound, not a burn	11000		
Level IV	99204			Unna boot application	29580		
Level V	99205			Unna boot removal	29700		
Other				Other			
Office Visit — Established				**Supplies**			
Level I	99211			Ace bandage, 2"	A6448		
Level II	99212			Ace bandage, 3"-4"	A6449		
Level III	99213			Ace bandage, 6"	A6450		
Level IV	99214 (circled)		125.00	Cast, fiberglass	A4590		
Level V	99215			Coban wrap	A6454		
Other				Foley catheter	A4338		
General Procedures				Immobilizer	L3670		
Anascopy	46600			Kerlix roll	A6220		
Audiometry	92551			Oxygen mask/cannula	A4620		
Breast aspiration	19000			Sleeve, elbow	E0191		
Cerumen removal	69210			Sling	A4565		
Circumcision	54150			Splint, ready-made	A4570		
DDST	96110			Splint, wrist	S8451		
Flex sigmoidoscopy	45330			Sterile packing	A6407		
Flex sig. w/ biopsy	45331			Surgical tray	A4550		
Foreign body removal—foot	28190			Other			
Nail removal	11730			**OB Care**			
Nail removal/phenol	11750			Routine OB care	59400		
Trigger point injection	20552			OB call	59422		
Tympanometry	92567			Ante partum 4–6 visits	59425		
Visual acuity	99173			Ante partum 7 or more visits	59426		
Venipuncture	36415 (circled)		15.00	Other			

Fees	Diagnosis Codes
Total Charges: $140.00	727.00 synovitis

E/M Audit Form Case #2

Pt Name: _ Maryann Marzette ___________Date of service: _08_/ 11 / 200x_ Provider_Welby MR #:23456________

HISTORY

☒Chief complaint (required all levels):

History of present illness (HPI): ☐ Brief (1-3) ☒ Extended (4 or more or update of 3+ chronic illnesses)

☒ Location ☐ Severity ☒ Timing ☒ Modifying factors

☐ Update 3+ chronic ☒ Quality ☒ Duration ☐ Context ☐ Assoc. signs /symptoms

Review of systems (ROS): ☐ None ☐ Problem pertinent (1) ☒ Extended (2-9) ☐ Complete (10+)

☐ Constitutional ☐ Cardiovascular ☐ Gastrointestinal ☒ Integumentary ☐ Endocrine

☐ Eyes ☐ Respiratory ☐ Genitourinary ☐ Neurological ☐ Hematologic/lymphatic

☐ ENT ☒ Musculoskeletal ☐ Psychiatric ☐ Allergic/Immunologic ☐ All others negative

Past, family, and social history (PFSH): ☐ None ☐Pertinent (1 of any) ☒ Complete est. (2 of 3) ☐Complete new (3 of 3)

☒ Past: Allergies, current medications, immunizations, previous trauma, surgeries, previous illnesses/hospitalizations.

☒ Family: Health of parents, siblings, children. Family members w/ diseases related to the chief complaint.

☒ Social: Drug, alcohol, tobacco use. Employment. Sexual history. Marital status. Education. Occupational history.

SCORE: HISTORY COMPONENT

☐ **Problem focused**	☐ **Expanded problem focused**	☒ **Detailed**	☐ **Comprehensive**	☐ **Not Documented**
CC; Brief HPI (1-3)	CC; Brief HPI;	CC; Extended HPI (4+)	CC; Extended HPI;	
ROS: None	Problem Pertinent (1 system)	ROS: 2-9 systems	Complete ROS; 10+	
PFSH: None	PFSH: None	PFSH-1 history area	PFSH – 2 established patient 3 new patient	

PHYSICAL EXAM

General multi-system examination **(Body area/organ system elements of examination)**

Organ Systems

☐ Constitutional: ☐Vital signs: sit/stnd BP, sup BP, temp, pulse rate, resp, ht, wt **or** ☐General appearance

☐ Eyes: ☐conjunctivae/lids, ☐pupils/irises, ☐optic discs

☐ ENT: ☐ext exam ears/ nose, ☐ext aud canal/tymp memb, ☐hearing assessment, ☐nasal mucosa/septum/turbinates, ☐ lips/teeth/gums, ☐oropharynx—oral mucosa, palates

☐ Respiratory: ☐resp. effort, ☐chest percussion, ☐chest palpation, ☐auscultation of lungs

☐ Cardiovascular: ☐palpation heart, ☐auscultation, exam of: ☐carotid, ☐femoral arteries, ☐abdominal aorta, ☐pedal pulses, ☐ extremities

☐ Gastrointestinal: ☐abdominal, ☐liver/spleen, ☐hernia, ☐stool sample taken, ☐anus, perineum, rectum

☐ Genitourinary: Male: ☐scrotum, ☐penis, ☐digital rectal exam of prostate
Female: ☐pelvic, ☐ext genitalia, ☐urethra, ☐bladder, ☐cervix, ☐uterus, ☐adnexa/parametria

☒ Musculoskeletal: ☐gait/station, ☒digits/nails, ☒ Exam of head/neck or spine/ribs/pelvis, Rt upper or Lt upper or Rt lower or Lt lower: ☐ inspect & palpate, ☐stability, ☐motion, ☐strength & tone

☐Skin: ☒ Inspect skin/ subc tissue, ☐palpation skin/ subcutaneous tissue

☒Neurologic: ☐cranial nerves, ☐deep tendon reflexes, ☐sensation

☐Psychiatric: ☐judgment/ insight, ☐orientation, ☐remote & recent memory, ☐mood & affect

☐Hematological/lymphatic ☐neck, axillae, groin, other, ☐immunologic:

Body Areas

☐ Head, including the face ☐ Neck: ☐neck (masses, symmetry,etc

☐thyroid ☐ Chest (breasts): ☐inspection breast, ☐palpation breast/axillae ☐ Abdomen ☐ Genitalia, groin, buttocks

☐ **1 or more in detail**

☐ Back, including spine

☐ Left upper extremity

☐ Right upper extremity

SCORE: PHYSICAL EXAMINATION COMPONENT

☐ Problem focused ☒ Expanded problem focused ☐ Detailed ☐ Comprehensive ☐ **Not Documented**

Medical decision making

Number of diagnoses and management options	Pts	Total
Self limiting or minor problems (stable, improved, or worsening); *maximum of 2 points*	1	
Established problem – stable, improved	1	
Established problem – worsening	2	2
New problem – no additional work-up planned *Maximum of 1 problem given credit*	3	
New problem – additional work-up planned	4	
Total points:		4

Amount and complexity of data	Pts	Total
Ordered and/or reviewed clinical lab	1	
Ordered and/or reviewed radiology	1	1
Ordered/reviewed test in the CPT medicine section	1	
Discussed tests with performing or interpreting physician.	1	
Independent visualization and direct view of image, tracing, specimen	2	
Decision to obtain old records/additional HX from other than patient, e.g., family, caretaker, prev. phys.	1	
Reviewed and summarized old records and/or obtained history from someone other than patient.	2	
Total points:		1

Table of risk—The highest level in ONE area determines the overall risk

Level	Presenting problem(s) or	Diagnostic procedure or	Management options
Minimal ☐	☐ One self-limited or minor problem,e.g., cold, insect bite, tinea corporis	☐Laboratory tests requiring venipuncture ☐Chest x-rays ☐EKG/EEG ☐Urinalysis ☐Ultrasound, e.g., echo ☐KOH prep	☐Rest ☐Gargles ☐Elastic bandages ☐Superficial dressings
Low ☐	☐Two or more self-limited or minor problems ☐One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH ☐Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	☐Physiologic tests not under stress, e.g., pulmonary function tests ☐Non-cardiovascular imaging studies with contrast, e.g., barium enema ☐Superficial needle biopsies ☐Clinical laboratory tests requiring arterial puncture ☐Skin biopsies	☐Over-the-counter drugs ☐Minor surgery with no identified risk factors ☐Physical therapy ☐ Occupational therapy ☐ IV fluids without additives
Moderate ☒	☐One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment ☐Two or more stable chronic illnesses ☐Undiagnosed new problem with uncertain prognosis, e.g., lump in breast ☐Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis ☐ Acute complicated injury, e.g., head injury with brief loss of consciousness	☐Physiologic tests under stress, e.g., cardiac stress test, fetal-contraction stress test ☐Diagnostic endoscopies with no identified risk factors ☐ Deep needle or incisional biopsy ☐Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath ☐ Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	☐Minor surgery with identified risk factors ☐Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ☒Prescription drug management ☐Therapeutic nuclear medicine ☐IV fluids with additives ☐Closed treatment of fracture or dislocation without manipulation
High ☐	☐One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment ☐Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ☐An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	☐Cardiovascular imaging studies with contrast with identified risk factors ☐Cardiac electrophysiological tests ☐Diagnostic endoscopies with identified risk factors ☐Discography	☐Elective major surgery (open, percutaneous or endoscopic with identified risk factors) ☐Emergency major surgery (open, percutaneous or endoscopic) ☐Parenteral controlled substances ☐Drug therapy requiring intensive monitoring for toxicity ☐Decision not to resuscitate or to de-escalate care because of poor prognosis

Decision-making total: — 2 of 3 must be met

Pts	Number of DX	Amount of data	Risk of complications	Medical decision-making level
1	☐ Minimal	☒ Minimal	☐ Minimal	☐ **Straight forward**
2	☐ Limited	☐ Limited	☐ Low	☐ **Low complexity**
3	☐ Multiple	☐ Moderate	☒ Moderate	☒ **Moderate complexity**
4	☒ Extensive	☐ Extensive	☐ High	☐ **High complexity**

Score: E&M service

History	Exam	Medical decision-making level
☐**Problem focused**	☐**Problem focused**	☐**Straightforward**
☐**Expanded problem focused**	☒**Expanded problem focused**	☐**Low complexity**
☒**Detailed**	☐**Detailed**	☒**Moderate complexity**
☐**Comprehensive**	☐**Comprehensive**	☐**High complexity**

Number needed: ☐ **2 of 3** **(MDM must be 1 of 2 to support medical necessity)**

Please review the medical record for the following elements:

		Yes	No N/A
1.	Was the medical record for this service found?	☒	☐
2.	Is the medical record legible?	☒	☐
3.	Is the attending/teaching physician's note written by the billing physician?	☒	☐
4.	Does the date of service billed agree with the date of the progress note?	☒	☐
5.	If a resident was involved in providing this service, review teaching physician documentation and answer the following questions:	☐	☒
	A. Does this service meet the primary care exception?	☐	☒
	B. Does the medical record demonstrate teaching physician involvement?	☐	☒
	C. Does the teaching physician's note link to the resident's note?	☐	☒
6.	Does the documentation support the ICD-9 codes billed?	☒	☐
7.	Does the documentation support the level of service billed?	☒	☐

☐Dictated ☐Handwritten EMR ☐ ☐ Form ☐Illegible ☐Note signed

☐Signature missing ☐ Diagnosis Code(s) supported ☐Other Service provided

TIME☐ A description of what was discussed must also be detailed
Face-to-face time: Indicate the total face-to-face time (or total floor time for inpatient services) spent with the patient
Counseling/Coor. Time: Time spent counseling or coordinating care (must be greater than 50% of total face-to-face/floor time)

Code (s) selected: 99214 Code(s) audited: 99214 ☐ **Over** ☐ **Under** ☒ **Correct** ☐**Miscoded**

Dx code(s) billed: 727.00 Dx code(s) documented: 727.00 Other services ___________________

Comments: The E/M service is billed correctly. The charge for venipuncture is not supported. There is no order and no indication that venipuncture is performed. There is an indication of an X-ray being performed but we are missing an order, the number of views and anatomic site of the X-ray as well as the interpretation. Although it seems the service was provided, the provider was correct not to bill for it because the documentation does not support the service.

Auditor's Signature Your name

Charge Ticket Case #3 **Physician: Mark Welby, M.D.**

Patient Information		Payment Method		Visit Information	
Patient ID number	34567	Primary		Visit date	09/11/20xx
Patient name	Sarah Carter	Primary ID number		Visit number	57

E/M Modifiers	Procedure Modifiers	Other Modifiers
24 — Unrelated E/M service during postop.	50 — Bilateral procedure	
25 — Significant, separately identifiable E/M	51 — Multiple surgical procedures in same day	
57 — Decision for surgery	52 — Reduced/incomplete procedure	
	55 — Postop. management only	
	59 — Distinct multiple procedures	

CATEGORY	CODE	MOD	FEE	CATEGORY	CODE	MOD	FEE
Office Visit — New Patient				**Wound Care**			
Level 1	99201	57	25.00	Debride partial thick burn	11040		
Level II	99202			Debride full thickness burn	11041		
Level III	99203			Debride wound, not a burn	11000		
Level IV	99204			Unna boot application	29580		
Level V	99205			Unna boot removal	29700		
Other				Lesion excision	11301		100.00
Office Visit — Established				**Supplies**			
Level I	99211			Ace bandage, 2”	A6448		
Level II	99212			Ace bandage, 3"-4”	A6449		
Level III	99213			Ace bandage, 6”	A6450		
Level IV	99214			Cast, fiberglass	A4590		
Level V	99215			Coban wrap	A6454		
Other				Foley catheter	A4338		
General Procedures				Immobilizer	L3670		
Anascopy	46600			Kerlix roll	A6220		
Audiometry	92551			Oxygen mask/cannula	A4620		
Breast aspiration	19000			Sleeve, elbow	E0191		
Cerumen removal	69210			Sling	A4565		
Circumcision	54150			Splint, ready-made	A4570		
DDST	96110			Splint, wrist	S8451		
Flex sigmoidoscopy	45330			Sterile packing	A6407		
Flex sig. w/ biopsy	45331			Surgical tray	A4550		
Foreign body removal—foot	28190			Other			
Nail removal	11730			**OB Care**			
Nail removal/phenol	11750			Routine OB care	59400		
Trigger point injection	20552			OB call	59422		
Tympanometry	92567			Ante partum 4–6 visits	59425		
Visual acuity	99173			Ante partum 7 or more visits	59426		
Venipuncture	36415			Other			

Fees	Diagnosis Codes
Total Charges: $125.00	216.7 Benign neoplasm of lower extremity

E/M Audit Form Case #3

Pt Name: ___Sarah Carter_______Date of service: _9_/11_/200x__ Provider_Mark Welby_____MR #:34567

HISTORY

☒Chief complaint (required all levels):

History of present illness (HPI): ☒ Brief (1-3) ☐ Extended (4 or more or update of 3+ chronic illnesses)

☒ Location ☐ Severity ☐ Timing ☐ Modifying factors

☐ Update 3+ chronic ☐ Quality ☒ Duration ☐ Context ☐ Assoc. signs /symptoms

Review of systems (ROS): ☐ None ☐ Problem pertinent (1) ☐ Extended (2-9) ☐ Complete (10+)

☐ Constitutional ☐ Cardiovascular ☐ Gastrointestinal ☐ Integumentary ☐ Endocrine

☐ Eyes ☐ Respiratory ☐ Genitourinary ☐ Neurological ☐ Hematologic/lymphatic

☐ ENT ☐ Musculoskeletal ☐ Psychiatric ☐ Allergic/Immunologic ☐ All others negative

Past, family, and social history (PFSH): ☐ None ☐Pertinent (1 of any) ☐ Complete est. (2 of 3) ☐Complete new (3 of 3)

☐ Past: Allergies, current medications, immunizations, previous trauma, surgeries, previous illnesses/hospitalizations.

☐ Family: Health of parents, siblings, children. Family members w/ diseases related to the chief complaint.

☐ Social: Drug, alcohol, tobacco use. Employment. Sexual history. Marital status. Education. Occupational history.

SCORE: HISTORY COMPONENT

☒ **Problem focused**	☐ **Expanded problem focused**	☐ **Detailed**	☐ **Comprehensive**	☐ **Not Documented**
CC; Brief HPI (1-3) ROS: None PFSH: None	CC; Brief HPI; Problem Pertinent (1 system) PFSH: None	CC; Extended HPI (4+) ROS: 2-9 systems PFSH-1 history area	CC; Extended HPI; Complete ROS; 10+ PFSH – 2 established patient 3 new patient	

PHYSICAL EXAM

General multi-system examination (Body area/organ system elements of examination)

Organ Systems

☐ Constitutional: ☐Vital signs: sit/stnd BP, sup BP, temp, pulse rate, resp, ht, wt **or** ☐General appearance

☐ Eyes: ☐conjunctivae/lids, ☐pupils/irises, ☐optic discs

☐ ENT: ☐ext exam ears/ nose, ☐ext aud canal/tymp memb, ☐hearing assessment, ☐nasal mucosa/septum/turbinates, ☐ lips/teeth/gums, ☐oropharynx—oral mucosa, palates

☐ Respiratory: ☐resp. effort, ☐chest percussion, ☐chest palpation, ☐auscultation of lungs

☐ Cardiovascular: ☐palpation heart, ☐auscultation, exam of: ☐carotid, ☐femoral arteries, ☐abdominal aorta, ☐pedal pulses, ☐ extremities

☐ Gastrointestinal: ☐abdominal, ☐liver/spleen, ☐hernia, ☐stool sample taken, ☐anus, perineum, rectum

☐ Genitourinary: Male: ☐scrotum, ☐penis, ☐digital rectal exam of prostate
Female: ☐pelvic, ☐ext genitalia, ☐urethra, ☐bladder, ☐cervix, ☐uterus, ☐adnexa/parametria

☐ Musculoskeletal: ☐gait/station, ☐digits/nails,
Exam of head/neck or spine/ribs/pelvis, Rt upper or Lt upper or Rt lower or Lt lower: ☐ inspect & palpate, ☐stability, ☐motion, ☐strength & tone

☒Skin: ☐inspect skin/ subc tissue, ☐palpation skin/ subcutaneous tissue

☐Neurologic: ☐cranial nerves, ☐deep tendon reflexes, ☐sensation

☐Psychiatric: ☐judgment/ insight, ☐orientation, ☐remote & recent memory, ☐mood & affect

☐Hematological/lymphatic ☐neck, axillae, groin, other, ☐immunologic:

Body Areas

☐ Head, including the face ☐ Neck: ☐neck (masses, symmetry,etc ☐thyroid ☐ Chest (breasts): ☐inspection breast, ☐palpation breast/axillae ☐ Abdomen ☐ Genitalia, groin, buttocks

☐ **1 or more in detail**

- ☐ Back, including spine
- ☐ Left upper extremity
- ☐ Right upper extremity

SCORE: PHYSICAL EXAMINATION COMPONENT

☒ Problem focused ☐ Expanded problem focused ☐ Detailed ☐ Comprehensive ☐ **Not Documented**

Medical decision making

Number of diagnoses and management options	Pts	Total	Amount and complexity of data	Pts	Total
Self limiting or minor problems (stable, improved, or worsening); *maximum of 2 points*	1		Ordered and/or reviewed clinical lab	1	
Established problem – stable, improved	1		Ordered and/or reviewed radiology	1	
Established problem – worsening	2		Ordered/reviewed test in the CPT medicine section	1	
New problem – no additional work-up planned *Maximum of 1 problem given credit*	3	4	Discussed tests with performing or interpreting physician.	1	
New problem – additional work-up planned	4		Independent visualization and direct view of image, tracing, specimen	2	
Total points:			Decision to obtain old records/additional HX from other than patient, e.g., family, caretaker, prev. phys.	1	
			Reviewed and summarized old records and/or obtained history from someone other than patient.	2	
			Total points:		0

Table of risk—The highest level in ONE area determines the overall risk

Level	Presenting problem(s) or	Diagnostic procedure or	Management options
Minimal ☐	☒ One self-limited or minor problem,e.g., cold, insect bite, tinea corporis	☐Laboratory tests requiring venipuncture ☐Chest x-rays ☐EKG/EEG ☐Urinalysis ☐Ultrasound, e.g., echo ☐KOH prep	☐Rest ☐Gargles ☐Elastic bandages ☒Superficial dressings
Low ☐	☐Two or more self-limited or minor problems ☐One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH ☐Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	☐Physiologic tests not under stress, e.g., pulmonary function tests ☐Non-cardiovascular imaging studies with contrast, e.g., barium enema ☐Superficial needle biopsies ☐Clinical laboratory tests requiring arterial puncture ☐Skin biopsies	☐Over-the-counter drugs ☐Minor surgery with no identified risk factors ☐Physical therapy ☐ Occupational therapy ☐ IV fluids without additives
Moderate ☐	☐One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment ☐Two or more stable chronic illnesses ☐Undiagnosed new problem with uncertain prognosis, e.g., lump in breast ☐Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis ☐ Acute complicated injury, e.g., head injury with brief loss of consciousness	☐Physiologic tests under stress, e.g., cardiac stress test, fetal-contraction stress test ☐Diagnostic endoscopies with no identified risk factors ☐ Deep needle or incisional biopsy ☐Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath ☐ Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	☐Minor surgery with identified risk factors ☐Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ☐Prescription drug management ☐Therapeutic nuclear medicine ☐IV fluids with additives ☐Closed treatment of fracture or dislocation without manipulation
High ☐	☐One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment ☐Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ☐An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	☐Cardiovascular imaging studies with contrast with identified risk factors ☐Cardiac electrophysiological tests ☐Diagnostic endoscopies with identified risk factors ☐Discography	☐Elective major surgery (open, percutaneous or endoscopic with identified risk factors) ☐Emergency major surgery (open, percutaneous or endoscopic) ☐Parenteral controlled substances ☐Drug therapy requiring intensive monitoring for toxicity ☐Decision not to resuscitate or to de-escalate care because of poor prognosis

Decision-making total: — 2 of 3 must be met

Pts	Number of DX	Amount of data	Risk of complications	Medical decision-making level
1	☐ Minimal	☒ Minimal	☒ Minimal	☒ Straight forward
2	☐ Limited	☐ Limited	☐ Low	☐ Low complexity
3	☒ Multiple	☐ Moderate	☐ Moderate	☐ Moderate complexity
4	☐ Extensive	☐ Extensive	☐ High	☐ High complexity

Number needed: ☐ **2 of 3** (MDM must be 1 of 2 to support medical necessity)

Score: E&M service

History	Exam	Medical decision-making level
☐Problem focused	☐Problem focused	☐Straightforward
☐Expanded problem focused	☐Expanded problem focused	☐Low complexity
☐Detailed	☐Detailed	☐Moderate complexity
☐Comprehensive	☐Comprehensive	☐High complexity

NONE:

Please review the medical record for the following elements:

		Yes	No N/A
1.	Was the medical record for this service found?	☒	☐
2.	Is the medical record legible?	☒	☐
3.	Is the attending/teaching physician's note written by the billing physician?	☐	☒
4.	Does the date of service billed agree with the date of the progress note?	☒	☐
5.	If a resident was involved in providing this service, review teaching physician documentation and answer the following questions:	☐	☒
	A. Does this service meet the primary care exception?	☐	☒
	B. Does the medical record demonstrate teaching physician involvement?	☐	☒
	C. Does the teaching physician's note link to the resident's note?	☐	☒
6.	Does the documentation support the ICD-9 codes billed?	☐	☒
7.	Does the documentation support the level of service billed?	☐	☒

☐Dictated ☐Handwritten EMR ☒ ☐ Form ☐Illegible ☐Note signed

☐Signature missing ☐ Diagnosis Code(s) supported ☐Other Service provided

TIME☐ A description of what was discussed must also be detailed
Face-to-face time: Indicate the total face-to-face time (or total floor time for inpatient services) spent with the patient
Counseling/Coor. Time: Time spent counseling or coordinating care (must be greater than 50% of total face-to-face/floor time)

Code (s) selected: 99201-57, 11301 Code(s) audited: 11302 ☒ **Over** ☐ **Under** ☐ **Correct** ☐**Miscoded**

Dx code(s) billed: 216.7 Dx code(s) documented: 239.2 Other services ___________________

Comments: The documentation does not support a separate E/M service. The history and exam performed were directly related to the complaint for which a procedure is performed. If the E/M was billable, modifier 57 is not the correct modifier to use because it is only used with major procedures. The procedure performed is a minor procedure. If a separate and identifiable E/M service was performed, modifier 25 would be the appropriate modifier. The lesion removed measured 1.0 to 1.5 which is reported with 11302. The lesion is sent for pathology so we are unsure if it is benign. The correct ICD-9 code to report in this case is 239.2. Until pathology returns, you cannot code as benign or malignant. The best option is to wait for the pathology report in order to report the most accurate diagnosis code.

Auditor's Signature Your name

Medical Record Chart Audit Summary Report

Practice: Mark Welby, MD | Provider: Mark Welby. MD

Date of Audit: June 15, 200X | Auditor: Your Name

A total of 3 records were reviewed using the 1995 and 1997 Documentation Guidelines, CPT Coding rules, and Insurance carrier guidelines. Chart notes were received for the following physicians/practitioners:

Mark Welby, MD

The findings and recommendations based on the review of the office, and diagnostic procedures are as follows:

Findings

E/M documentation in the record appeared to support service billed	2
E/M documentation in the record appears to support a lower level of service than billed or does not support an E/M	1
Documentation appeared to be missing or could not be located in the Record	0

Findings and Recommendations:

1. Chart #2. There is a charge for venipuncture but there is no order or indication venipuncture was performed. There is a notation regarding an X-ray that is not billed. Although it is appropriate not to bill the X-ray because we are missing the order, anatomic site, number of views and interpretation, if documented properly this would be missed revenue.

Recommendation: Review the medical record in it's entirety to look for missing charges and charges not supported. Review the coding guidelines for reporting ancillary services.

2. Chart #3. A separately identifiable E/M service is not supported. The lesion removed by the shave measures 1.0 to 1.5 and should be coded with 11302 instead of 11301. If the E/M service was supported, the appropriate modifier would be 25 not 57 which is used when a major procedure is performed.

Recommendation: Review the 1995 and 1997 CMS Documentation Guidelines and CPT coding rules for selecting surgical procedures and proper modifiers.

RECOMMENDATION SUMMARY

The provider would benefit from a coding class that covers E/M services and minor procedures performed on the same date of service. We recommend a follow up audit in three months that will target E/M services with ancillary and minor surgical services.

Detailed Analysis

Practice: Mark Welby, MD

Provider: Mark Welby, MD

Date of Audit: June 15, 200X

Auditor: Your Name

Chart #	Patient	Date of Service	CPT Code Reported	CPT Code Documented	ICD-9-CM Reported	ICD-9-CM documented
1	Delaney Greensword	8/21/200X	99204	99204	413.9, 331.0	413.9, 331.0
2	Mary Ann Marzette	8/11/200X	99214, 36415	99214	727.00	727.00
3	Sarah Carter	9/11/200X	99201-57, 11301	11302	216.7	239.2

Surgical Coding Charge Ticket Case #4

Patient Name	Parker Stevenson
Medical Record Number/Account Number	145678
Surgeon	Mark Welby, M.D.
Referring Physician	Thomas Jones M.D.
Asst Surgeon	None
Anesthesiologist	local
Insurance Company	Medicare
Comments	Post operative follow up 2 weeks

Date of Surgery	Facility	Place of service	CPT Code	Diagnosis Code(s)	Modifier	Quantity	Fee
01/04/200x	Methodist Surg Cntr	24	45380	455.0		1	900.00
01/04/200x	Methodist Surg Cntr	24	45378	787.91	51	1	400.00

Surgical Coding Case #4

Surgery Audit Tool Case #4

Physician ______Mark Welby________________________ Date of Review _06/15/200X_____

Patient Name ___Parker Stevenson__________________MR# _______145678_____________

Date of Birth __________ Date of Visit ___01/04/200X______Insurance Carrier:__Medicare___

Surgical Service (s) billed ___45380, 45378-51 Diagnosis Code (s) billed ___455.0, 787.91___

Comments __The services are unbundled. When a diagnostic and therapeutic colonoscopy are performed during the same encounter, only report the therapeutic service.

Documented	Y	N	N/A	Comments
Preoperative information	☒	☐	☐	
Patient demographics	☐	☒	☐	
Surgery date	☒	☐	☐	
Preoperative anesthesia	☐	☐	☒	IV Sedation
Indication for Procedure	☒	☐	☐	
Diagnostic Reports	☒	☐	☐	
Intra-operative information	☒	☐	☐	
Preoperative diagnosis	☒	☐	☐	
Postoperative diagnosis	☒	☐	☐	
Surgeon/asst/co-surgeons	☒	☐	☐	
Procedure title	☒	☐	☐	
Findings	☒	☐	☐	
Procedure details	☒	☐	☐	
Tissue/organ removed	☒	☐	☐	
Materials removed/inserted	☒	☐	☐	
Closure information	☐	☐	☒	
Blood loss/replacement	☐	☒	☐	
Wound status	☐	☐	☒	
Drainage	☐	☐	☒	
Complications noted	☐	☒	☐	
Post-operative condition of patient	☐	☒	☐	
IV infusion record	☐	☐	☒	
Signatures	☐	☐	☐	
Legibility	☒	☐	☐	
Supports procedure (CPT/HCPCS)	☐	☒	☐	The services are unbundled, only 45380 should be reported.
Supports medical necessity (ICD-9-CM	☒	☐	☐	787.91 should be the first listed Dx code to support medical necessity.

Surgical Coding Charge Ticket Case #5

Patient Name	Susan Hiverson
Medical Record Number/Account Number	145679
Surgeon	Mark Welby M.D.
Referring Physician	None
Asst Surgeon	None
Anesthesiologist	local
Insurance Company	CIGNA
Comments	Follow up 3 days packing removal

Date of Surgery	Facility	Place of service	CPT Code	Diagnosis Code(s)	Modifier	Quantity	Fee
01/21/200x	Univ Hosp	22	11406	706.2		1	225.00
01/21/200x	Univ Hosp	22	11423	706.2		1	125.00
01/21/200x	Univ Hosp	22	12002	706.2		1	75.00

Surgical Coding Case #5

Surgery Audit Tool Case #5

Physician _Mark Welby, MD____________________ Date of Review __June 15, 200X_______

Patient Name ___Susan Hiverson_________________MR# __145679___________________

Date of Birth __________ Date of Visit _1/21/200X___Insurance Carrier:__Cigna__________

Surgical Service (s) billed ___11406, 11423,12002_ ____________________________

Diagnosis Code (s) billed ____706.2____

Comments __12002 should not be reported. According to CPT Coding Guidelines, simple closures are included when an excision of a benign or malignant lesion is performed_____

Documented	Y	N	N/A	Comments
Preoperative information	☒	☐	☐	
Patient demographics	☐	☒	☐	
Surgery date	☒	☐	☐	
Preoperative anesthesia	☐	☐	☒	Local anesthesia
Indication for Procedure	☒	☐	☐	
Diagnostic Reports	☐	☒	☐	
Intra-operative information	☒	☐	☐	
Preoperative diagnosis	☒	☐	☐	
Postoperative diagnosis	☒	☐	☐	
Surgeon/asst/co-surgeons	☒	☐	☐	
Procedure title	☒	☐	☐	
Findings	☐	☒	☐	
Procedure details	☒	☐	☐	
Tissue/organ removed	☒	☐	☐	
Materials removed/inserted	☐	☐	☒	
Closure information	☒	☐	☐	
Blood loss/replacement	☐	☒	☐	
Wound status	☒	☐	☐	
Drainage	☐	☐	☒	
Complications noted	☐	☒	☐	
Post-operative condition of patient	☐	☒	☐	
IV infusion record	☐	☐	☒	
Signatures	☒	☐	☐	
Legibility	☒	☐	☐	
Supports procedure (CPT/HCPCS)	☐	☒	☐	12002 should not be reported
Supports medical necessity (ICD-9-CM	☒	☐	☐	

The next case that will be audited is an office surgical note. Pay special attention to the note; an office note is less formal and more of a narrative in general. You may need to determine if other services could be billed with the surgery. Remember to have your CPT®, ICD-9-CM, and HCPCS codebooks available along with the NCCI edits for the current quarter.

Surgical Coding Charge Ticket Case #6

Patient Name	Jerry Lister
Medical Record Number/Account Number	145785
Surgeon	Mark Welby, M.D.
Referring Physician	Howard Bruner, M.D.
Asst Surgeon	None
Anesthesiologist	local
Insurance Company	Continental Insurance
Comments	Post operative follow up 2 weeks

Date of Surgery	Facility	Place of service	CPT® Code	Diagnosis Code(s)	Modifier	Quantity	Fee
02/02/200x	Office	11	99213-25	726.32	25	1	75.00
02/02/200x	Office	11	20605	726.32		1	150.00
02/02/200x	Office	11	J3303	726.32		2	65.00

Surgical Coding Case #6

E/M Audit Form Case #6

Pt Name: ___Jerry Lister_____Date of service: _02/02?200X_ Provider_Mark Welby, MD MR #: 14585

HISTORY

☒Chief complaint (required all levels):
History of present illness (HPI): ☐ Brief (1-3) ☒Extended (4 or more or update of 3+ chronic illnesses)
☒Location ☒ Severity ☐ Timing ☒ Modifying factors
☐ Update 3+ chronic ☐ Quality ☒ Duration ☐ Context ☐ Assoc. signs /symptoms

Review of systems (ROS): ☐ None ☒ Problem pertinent (1) ☐ Extended (2-9) ☐ Complete (10+)
☐ Constitutional ☐ Cardiovascular ☐ Gastrointestinal ☐ Integumentary ☐ Endocrine
☐ Eyes ☐ Respiratory ☐ Genitourinary ☐ Neurological ☐ Hematologic/lymphatic
☐ ENT ☒ Musculoskeletal ☐ Psychiatric ☐ Allergic/Immunologic ☐ All others negative

Past, family, and social history (PFSH): ☐ None ☒Pertinent (1 of any) ☐ Complete est. (2 of 3) ☐Complete new (3 of 3)
☐ Past: Allergies, current medications, immunizations, previous trauma, surgeries, previous illnesses/hospitalizations.
☐ Family: Health of parents, siblings, children. Family members w/ diseases related to the chief complaint.
☒ Social: Drug, alcohol, tobacco use. Employment. Sexual history. Marital status. Education. Occupational history.

SCORE: HISTORY COMPONENT

☐ **Problem focused**	☒ **Expanded problem focused**	☐ **Detailed**	☐ **Comprehensive**	☐ **Not Documented**
CC; Brief HPI (1-3) ROS: None PFSH: None	CC; Brief HPI; Problem Pertinent (1 system) PFSH: None	CC; Extended HPI (4+) ROS: 2-9 systems PFSH-1 history area	CC; Extended HPI; Complete ROS; 10+ PFSH – 2 established patient 3 new patient	

PHYSICAL EXAM

General multi-system examination (Body area/organ system elements of examination)

Organ Systems

☐ Constitutional: ☐Vital signs: sit/stnd BP, sup BP, temp, pulse rate, resp, ht, wt **or** ☐General appearance
☐ Eyes: ☐conjunctivae/lids, ☐pupils/irises, ☐optic discs
☐ ENT: ☐ext exam ears/ nose, ☐ext aud canal/tymp memb, ☐hearing assessment, ☐nasal mucosa/septum/turbinates, ☐ lips/teeth/gums, ☐oropharynx—oral mucosa, palates
☐ Respiratory: ☐resp. effort, ☐chest percussion, ☐chest palpation, ☐auscultation of lungs
☐ Cardiovascular: ☐palpation heart, ☐auscultation, exam of: ☐carotid, ☐femoral arteries, ☐abdominal aorta, ☐pedal pulses, ☐ extremities
☐ Gastrointestinal: ☐abdominal, ☐liver/spleen, ☐hernia, ☐stool sample taken, ☐anus, perineum, rectum
☐ Genitourinary: Male: ☐scrotum, ☐penis, ☐digital rectal exam of prostate
Female: ☐pelvic, ☐ext genitalia, ☐urethra, ☐bladder, ☐cervix, ☐uterus, ☐adnexa/parametria
☒ Musculoskeletal: ☐gait/station, ☐digits/nails,
Exam of head/neck or spine/ribs/pelvis, Rt upper or Lt upper or Rt lower or Lt lower: ☐ inspect & palpate, ☐stability, ☐motion, ☐strength & tone
☐Skin: ☐inspect skin/ subc tissue, ☐palpation skin/ subcutaneous tissue
☒Neurologic: ☐cranial nerves, ☐deep tendon reflexes, ☐sensation
☐Psychiatric: ☐judgment/ insight, ☐orientation, ☐remote & recent memory, ☐mood & affect
☐Hematological/lymphatic ☐neck, axillae, groin, other, ☐immunologic:

Body Areas

☐ Head, including the face ☐ Neck: ☐neck (masses, symmetry,etc ☐thyroid ☐ Chest (breasts): ☐inspection breast, ☐palpation breast/axillae ☐ Abdomen ☐ Genitalia, groin, buttocks

☐ **1 or more in detail**

☐ Back, including spine
☐ Left upper extremity
☐ Right upper extremity

SCORE: PHYSICAL EXAMINATION COMPONENT

☐ Problem focused ☒ Expanded problem focused ☐ Detailed ☐ Comprehensive ☐ **Not Documented**

Medical decision making

Number of diagnoses and management options	Pts	Total	Amount and complexity of data	Pts	Total
Self limiting or minor problems (stable, improved, or worsening); *maximum of 2 points*	1		Ordered and/or reviewed clinical lab	1	
Established problem – stable, improved	1		Ordered and/or reviewed radiology	1	
Established problem – worsening	2		Ordered/reviewed test in the CPT medicine section	1	
New problem – no additional work-up planned *Maximum of 1 problem given credit*	3	1	Discussed tests with performing or interpreting physician.	1	
New problem – additional work-up planned	4		Independent visualization and direct view of image, tracing, specimen	2	
Total points:		3	Decision to obtain old records/additional HX from other than patient, e.g., family, caretaker, prev. phys.	1	
			Reviewed and summarized old records and/or obtained history from someone other than patient.	2	
			Total points:		0

Table of risk—The highest level in ONE area determines the overall risk

Level	Presenting problem(s) or	Diagnostic procedure or	Management options
Minimal ☐	☐ One self-limited or minor problem,e.g., cold, insect bite, tinea corporis	☐Laboratory tests requiring venipuncture ☐Chest x-rays ☐EKG/EEG ☐Urinalysis ☐Ultrasound, e.g., echo ☐KOH prep	☐Rest ☐Gargles ☐Elastic bandages ☐Superficial dressings
Low ☒	☐Two or more self-limited or minor problems ☐One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH ☐Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	☐Physiologic tests not under stress, e.g., pulmonary function tests ☐Non-cardiovascular imaging studies with contrast, e.g., barium enema ☐Superficial needle biopsies ☐Clinical laboratory tests requiring arterial puncture ☐Skin biopsies	☐Over-the-counter drugs ☐Minor surgery with no identified risk factors ☐Physical therapy ☐ Occupational therapy ☐ IV fluids without additives
Moderate ☐	☐One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment ☐Two or more stable chronic illnesses ☐Undiagnosed new problem with uncertain prognosis, e.g., lump in breast ☐Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis ☐ Acute complicated injury, e.g., head injury with brief loss of consciousness	☐Physiologic tests under stress, e.g., cardiac stress test, fetal-contraction stress test ☐Diagnostic endoscopies with no identified risk factors ☐Deep needle or incisional biopsy ☐Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath ☐Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	☐Minor surgery with identified risk factors ☐Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ☐Prescription drug management ☐Therapeutic nuclear medicine ☐IV fluids with additives ☐Closed treatment of fracture or dislocation without manipulation
High ☐	☐One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment ☐Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ☐An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	☐Cardiovascular imaging studies with contrast with identified risk factors ☐Cardiac electrophysiological tests ☐Diagnostic endoscopies with identified risk factors ☐Discography	☐Elective major surgery (open, percutaneous or endoscopic with identified risk factors) ☐Emergency major surgery (open, percutaneous or endoscopic) ☐Parenteral controlled substances ☐Drug therapy requiring intensive monitoring for toxicity ☐Decision not to resuscitate or to de-escalate care because of poor prognosis

Decision-making total: — 2 of 3 must be met

Pts	Number of DX	Amount of data	Risk of complications	Medical decision-making level
1	☐ Minimal	☒ Minimal	☐ Minimal	☐ Straight forward
2	☐ Limited	☐ Limited	☒ Low	☒ Low complexity
3	☒ Multiple	☐ Moderate	☐ Moderate	☐ Moderate complexity
4	☐ Extensive	☐ Extensive	☐ High	☐ High complexity

Score: E&M service

History	Exam	Medical decision-making level
☐Problem focused	☐Problem focused	☐Straightforward
☒Expanded problem focused	☒Expanded problem focused	☒Low complexity
☐Detailed	☐Detailed	☐Moderate complexity
☐Comprehensive	☐Comprehensive	☐High complexity

Number needed: ☐ **2 of 3** (MDM must be 1 of 2 to support medical necessity)

Please review the medical record for the following elements:

		Yes	No N/A
1.	Was the medical record for this service found?	☒	☐
2.	Is the medical record legible?	☒	☐
3.	Is the attending/teaching physician's note written by the billing physician?	☐	☒
4.	Does the date of service billed agree with the date of the progress note?	☒	☐
5.	If a resident was involved in providing this service, review teaching physician documentation and answer the following questions:	☐	☒
	A. Does this service meet the primary care exception?	☐	☒
	B. Does the medical record demonstrate teaching physician involvement?	☐	☒
	C. Does the teaching physician's note link to the resident's note?	☐	☒
6.	Does the documentation support the ICD-9 codes billed?	☒	☐
7.	Does the documentation support the level of service billed?	☒	☐

☒Dictated ☐Handwritten EMR ☐ Form ☐Illegible ☐Note signed

☐Signature missing ☒ Diagnosis Code(s) supported ☒Other Service provided

TIME☐ A description of what was discussed must also be detailed
Face-to-face time: Indicate the total face-to-face time (or total floor time for inpatient services) spent with the patient
Counseling/Coor. Time: Time spent counseling or coordinating care (must be greater than 50% of total face-to-face/floor time)

Code (s) selected: __99213-25, 20605, J3303 x 2 Code(s) audited:__ 99213-25, 20605, J3303 x 2 ____ ☐ Over ☐ Under ☒ Correct ☐Miscoded

Dx code(s) billed: _726.32____ Dx code(s) documented: __726.32____ Other services ________________

Comments: The procedure note for the joint injection is lacking detail. A procedure note should contain if local anesthetic is used, the type of instruments and supplies used, the location of the procedure, dose of medication, if a dressing is applied and the patient's condition following the procedure. The physician did not verify and sign the dictation so the services are not billable.

Auditor's Signature _____Your name________________________________

Surgery Audit Tool Case #6

Physician ____Mark Welby, MD________________ Date of Review __June 15, 2010___

Patient Name _Jerry Lister______________________MR# ____14585_______________

Date of Birth ________ Date of Visit __02/02/200X_Insurance Carrier: Continental Insurance

Surgical Service (s) billed ____20605____

Diagnosis Code (s) billed _____726.32____

Comments ___The procedure note is lacking detail____________________________________

Documented	Y	N	N/A	Comments
Preoperative information	☒	☐	☐	
Patient demographics	☐	☒	☐	
Surgery date	☒	☐	☐	
Preoperative anesthesia	☐	☒	☐	
Indication for Procedure	☒	☐	☐	
Diagnostic Reports	☐	☐	☒	
Intra-operative information	☐	☒	☐	
Preoperative diagnosis	☒	☐	☐	
Postoperative diagnosis	☐	☒	☐	
Surgeon/asst/co-surgeons	☒	☐	☐	
Procedure title	☐	☒	☐	
Findings	☐	☐	☒	
Procedure details	☐	☒	☐	
Tissue/organ removed	☐	☐	☒	
Materials removed/inserted	☐	☐	☒	
Closure information	☐	☐	☒	
Blood loss/replacement	☐	☒	☐	
Wound status	☐	☐	☒	
Drainage	☐	☒	☐	
Complications noted	☐	☒	☐	
Post-operative condition of patient	☐	☒	☐	
IV infusion record	☐	☐	☒	
Signatures	☐	☒	☐	Dictate but not approved and signed
Legibility	☒	☐	☐	
Supports procedure (CPT/HCPCS)	☐	☒	☐	
Supports medical necessity (ICD-9-CM	☒	☐	☐	

SURGERY AUDIT SUMMARY REPORT

Physician: Mark Welby, MD Date of Review: xx/xx/xxxx

Reviewer: Your Name

Number of Operative Notes Reviewed: 3

Operative notes were reviewed for completeness and appropriateness of care along with coding documentation and medical necessity.

Documentation in the operative note appears to provide preoperative information	3
Surgery date appears to be documented in the note	3
Preoperative anesthesia appears to be documented in the note	0
Indication for Procedure appears to be documented in the operative report	3
Preoperative diagnosis appears to be documented in the operative report	3
Postoperative diagnosis appears to be documented in the note and supported by findings	2
Surgeon/asst/co-surgeons are listed in the operative note	3
Findings appear to be indicated in the operative report	2
Procedure details appear to be documented appropriately in the operative report	2
Post-operative condition of patient appears to be indicated in the operative report	2
The operative report appears to support procedure (CPT/HCPCS)	0
The operative report appears to support medical necessity (ICD-9-CM	3

Other Documentation and Coding Issues:

1. Chart #4. The services were unbundled for this case. When diagnostic and therapeutic colonoscopies are performed during the same session, only code the therapeutic service.
2. Chart #5. The services are unbundled. The simple closure is included in the excisions of the cysts.
3. Chart #6. The physician did not verify and sign the dictation. The services are not billable without the physician's verification of the dictation and signature. The E/M, HCPCS Level II and diagnosis codes are correct. The joint injection of the elbow is lacking detail.

RECOMMENDATIONS

1. Recommend a coding training to review the surgical package and CPT surgical coding guidelines
2. Review the documentation requirements for surgical procedures
3. Chart #6. The provider should review and sign the dictation. Without a review and signature the procedure is not billable unless the chart contains a hand-written note detailing the visit in addition to the dictation.
4. Due to 100% error rate for surgical coding, recommend prepayment review of all surgical cases until the provider reaches a 5% error rate.

Surgery Audit Detailed Analysis

Physician: Mark Welby, MD

Date of Review: 0x/xx/xxxx

Reviewer: Name of Auditor

Number of Operative Notes Reviewed: 3

		Billed			Documented		
Chart #	Patient	CPT	ICD-9-CM	MOD	CPT	ICD-9-CM	MOD
1	Parker Stevenson	45380 45378	455.0 787.91	51	45380	787.91 455.0	
2	Susan Hiverson	11406 11423 12002	706.2		11406 11423	706.2	
3	Jerry Lister	99213 20605 J3303	726.32	25	Signature is missing from dictation services are not billable	Missing Dictation cannot report	