Creighton University Compliance Plan For Health Sciences Billing and Patient Services

BILLING AUDIT HANDBOOK

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UNIVERSITY

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1.0 Initial Steps

1.1 SELECTING THE AUDIT ITEMS

1. Select the physician(s) and/or nonphysician practitioner(s) and date(s) for encounters to be audited.

2. Obtain a computer printout from the electronic billing system of patient encounters by provider and date, to include codes and diagnoses billed for those encounters

3. Select the type of encounters to be audited (i.e., office visits, inpatient visits, procedures, teaching physician encounters, encounters with certain modifiers, Medicare "incident to" services), ten per provider. The type of encounters selected **MUST BE** reflective of the types of services rendered or expected to be rendered by the provider.

4. Audits for providers who are established with CMA will be performed on a retrospective basis (after the patient encounter has been entered into the electronic billing system).

5. Audits for providers who are new to CMA (new provider) will be performed on a prospective basis (after the patient encounter has been entered into the electronic billing system, but prior to processing and/or generation of any claims or statements), with limited exceptions.

6. To the extent possible, encounters selected for a new provider audit may need to be accumulated until there is a sufficient mix of patient encounters, as per the selection criteria outlined above. Collect EHR encounter forms, inpatient charge tickets/cards and operative reports, as applicable, to coincide with the services selected for audit.

7. Retrieve the medical record (clinic and/or hospital). For surgical procedures (including OB delivery) it may be necessary to review the surgery schedule for the dates being audited.

8. If necessary, obtain a copy of the provider's calendar and/or clinic schedule for the period of time under review/audit. This may be necessary for Primary Care Exception Clinics under the Teaching Physician Rule, surgical procedures, psychotherapy services, etc.

1.2 THE AUDIT FACE SHEET—PROVIDER APPENDIX A, A-2 & A-3, CODER APPENDIX A

1.2.1 Purpose

1. The Audit Face Sheet (Appendix A, A-2, A-3) provides the necessary information to identify and track billing errors for each encounter audited.

   Provider Appendix A and Coder Appendix A: Should be used to record audit findings for all Departments, except Pathology.

   Appendix A-2: Should be used only to report Anatomical Pathology audit findings (i.e., professional component services, cytopathology).

   Appendix A-3: Should be used to report Reference Laboratory quarterly audit findings.

2. Audit findings identified on the Audit Face Sheet need to be transferred to the provider tracking spreadsheet where points will automatically be calculated. Findings based on errors by coders shall be identified on the Coder Appendix A, so that Coding Managers can address those issues. Errors attributable to coding staff shall be considered for purposes of determining any corrective action for the provider and/or coder under the Corrective Action Policy.

1.2.2 Instructions

1. Complete an Audit Face Sheet, (Appendix A, A-2) for each patient encounter (not CPT/HCPCS code) audited. Specifics regarding each encounter audited, including the provider name and the audit number will flow to this document from the provider Appendix B.

1.3 PROVIDER AUDIT REPORT SHEET--APPENDIX B

1.3.1 Purpose

The Provider Audit Report Sheet, Appendix B, is distributed to each audited provider for review and signature, and is retained by the Physician Coding Audit division of Creighton Medical Associates (CMA Audit), under the Audit Policy. A summary of audit activity completed for each department will be forwarded to the designated Coding Manager and to the Compliance Auditor on a quarterly basis. The Provider and designated Coding Manager will receive a copy of the final Audit Report Sheet, as well as the Provider Summary and Provider Scorecard as part of the corrective action process. The Coding Manager will also receive copies of the Coder Appendix B, Coder Summary, and Coder Scorecard. To the extent possible, these documents attribute findings to the provider, to coding staff, or to both for the purpose of determining

corrective action. The Coding Manager will review the Appendix B with the provider and coder, obtaining signatures on the respective documents and forward to the Physician Coding Audit division of CMA for recording on the provider audit database. If unable to obtain signatures, the Coding Manager shall indicate so, and the reason why a signature cannot be obtained.

1.3.2 Instructions

1. Insert Information regarding the audit purpose, the provider, and the audit date in the header of the document.
    a. Insert an audit number in each row. The audit number should be in sequential order (i.e. 1-10) for each provider for the quarter and/or calendar year, beginning with the number 1. A provider should not have any duplicate audit numbers during the same quarter or calendar year.
    b. Insert information regarding the date of service and location of service being audited in columns 2 and 3.
    c. Record information regarding the payer, if known, in column 4.
    d. Insert a resident name, if applicable, in column 5. (For educational purposes)
    e. Note whether or not the charge has been entered into the billing system in column 6.
    f. Insert the patient's medical record number, the invoice number for the service, and the patient's name into the corresponding rows of column 8
    g. In columns 9 and 10 record the CPT codes and ICD-9 codes, respectively, as submitted by the provider on the Provider Appendix B and as submitted by the coder on the Coder Appendix B.
    h. In columns 11 and 12, record the CPT codes and ICD-9 codes, respectively, as determined appropriate by the auditor.
    i. Insert audit findings from the Audit Face Sheet in column 15. Include the type of finding (i.e., A-4; B-1) and the summary information noted on the Audit Face Sheet.
    j. Record the points due to any findings for each encounter that are attributable to the provider in column 13.
    k. Record the points due to any findings for each encounter that are attributable to coding staff in column 14.

1.4. PROVIDER SCORECARD AND CODER SCORECARD

1.4.1 **Purpose:** To provide an individualized document that depicts the encounters audited, the findings by type, and the points accumulated for each encounter audited, plus a total number of points for the audit.

1.4.2 **Instructions**: Enter findings for each encounter from the Provider Appendix B into the Provider Scorecard and from the Coder Appendix B into the Coder Scorecard. Points will automatically accumulate according to the formulas incorporated into the documents (Excel) based on the Billing Compliance Policy for Billing Documentation and Coding Deficiencies, Attachment A.

1.5 PROVIDER SUMMARY AND CODER SUMMARY

1.5.1 **Purpose:** Information flows from the Provider Appendix B and the Coder Appendix B, respectively, to these documents.

1.5.2 **Instructions:** Enter information including expanded comments and note the required corrective action, including, but not limited to:

1. Required education under the University corrective action policy,
2. Required oral/written notice,
3. Required additional auditing under University corrective action policies,
4. Any other corrective action.

1.6 ERROR CORRECTION

1.6.1 **Purpose:** To provide information to Coding Managers and Departments regarding necessary coding changes based on audit findings. Also identifies required refund actions.

1.6.2 **Instructions:** Error Corrections – Include any charge corrections that need to be completed and note any refunds that will need to be effected. Forward to the appropriate Coding Manager for follow up.

2.0 Auditing Evaluation and Management Services, In-Office Procedures, and Diagnostic Services

2.1 General Principles (CMS' 1995 and 1997 E/M Documentation Guidelines)

2.1.1 The Medical Record

1. The medical record should be complete and legible.
2. Documentation of each patient encounter should include:
   a. Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   b. Assessment, clinical impression or diagnosis;
   c. Plan for care; and
   d. Date and legible identity of the provider.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. Documentation should support the CPT/HCPCS and ICD-9-CM codes reported on the health insurance claim form or billing statement.

2.1.2 Key Components of an Evaluation and Management (E/M) Service

HISTORY, EXAMINATION AND MEDICAL DECISION MAKING

(Certain patients, e.g., infants, children, pregnant women, may have additional or modified information recorded in the history and examination areas.)

OR

TIME

1) The visit is documented as consisting predominately (more than 50% physician-patient face to face encounter) of counseling or coordination of care; **OR**

2) The E/M service is a time-based code (e.g., critical care, prolonged services).

2.2 E/M Services, Minor Procedures and In-Office Diagnostic Services Worksheet—Appendix C

2.2.1 Purpose

Use worksheet, Appendix C, for each encounter that is audited involving E/M services, minor procedures and/or in-office diagnostic services. E/M services include, but are not limited to inpatient hospital visits, office visits, nursing home visits, critical care services, etc. Minor procedures include, but are not limited to, minor surgical procedures (i.e. stitches), injections, etc. In-office diagnostic services, for purposes of this type of audit, do not include invasive procedures, but would include X-rays, lab tests, etc.

2.2.2 Instructions

1. **Questions 1–3, Identifying Information:** Complete the information requested. The audit number should be the same as the audit number on the Audit Face Sheet (Appendix A or A-2) and the Provider Audit Report Sheet (Appendix B).

2. **Questions 4–7, CPT/HCPCS Information:** List **ALL** CPT/HCPCS code(s) reported on the encounter form or posted to the electronic billing system for the encounter.

   a. If the E/M is time based, complete #5. In completing question #5 for time-based codes, the following must be considered:

      1) The provider must document the time to support the code.

      2) If the code is based on time due to counseling/coordination of care, then the provider must document all of the following:

         Total Time; and

         Time spent face-to-face with the patient in counseling/coordination of care activities; and

         The general issues discussed with the patient.

      If any of these items are missing, then the services must be coded based on the history, exam and medical decision making components documented.

3) Select the E/M code based on total time, using the CPT/HCPCS coding book in effect at the time of the encounter. Select the appropriate code based on the type of visit, place of service and amount of time which is shown for each code.

b. If the E/M code is not time based, complete Appendix D to verify the level of the E/M service. Identify any incorrect CPT/HCPCS code(s) and list the code(s) that should have been reported. See Section 2.4 for in-depth instructions for auditing the level of E/M Service.

c. If the code is incorrect, regardless of documentation (i.e., should have been coded an office visit rather than a consult), then mark either **A-1** or **A-2** on the Audit Face Sheet depending upon whether the wrong code resulted in a downcoding (A-1 Finding) or upcoding (A-2 Finding).

d. If the code is incorrect because documentation supports a higher code, then mark **A-1**.

e. If the E/M code is upcoded by one level due to inadequate documentation (excluding teaching physician documentation) mark **B-2**; if upcoded by two or more levels, then mark **B-3** on the Audit Face Sheet.

f. If no documentation exists to support the code, then mark **B-4** on the Audit Face Sheet

g. If the code is incorrect due to lack of teaching physician documentation, refer to Questions 20-23 to determine the audit finding.

3. **Questions 8–10, Diagnosis (ICD-9) Information**: List all ICD-9 diagnoses documented on the encounter form or billing system and compare them to the record for accuracy and relevancy to the encounter. List any ICD-9 code(s) or diagnoses that were not accurate or not relevant to the encounter and provide the ICD-9 code(s)/diagnoses that are correct. Mark appropriate findings under Section C **(C-1 or C-2)** of the Audit Face Sheet (Appendix A or A-2).

4. **Questions 11-12, Medicare ABN Information:** If the patient is a Medicare beneficiary and services may be subject to denial as "not reasonable and necessary" mark "Yes." If Question #11 is "Yes", then determine whether an ABN was properly obtained in accordance with CMA Policy. If Question #12 is "No", then mark D-5 on the Audit Face Sheet.

5. **Questions 13–14, Modifier Information**: Explain any modifier errors, and mark **A-3** on the Audit Face Sheet **ONLY** if the error results in upcoding. Mark A-3a if the error does not result in upcoding.

6. **Questions 15-16, Medicare "Incident To":** If the patient is a Medicare beneficiary, and services were provided "incident to" a physician's service, mark "Yes" on Question #15.

If Question #15 is "Yes", verify that services met Medicare's "incident to" requirements (e.g., presence of physician in the office suite, established condition with first visit by physician; physician participation at a proper frequency, etc.) to answer Question #16. Please refer to CMA's Medicare "Incident To" Policy for further guidance. If Question #16 is "No", then mark A-4 if services provided by ancillary staff (e.g., nurse visit) or D-4 if services provided by a Medicare credentialed non-physician provider.

7. **Questions 17-19, Location and Patient Type**: Identify the location (office, hospital) where services were provided. If clinic or outpatient hospital services were not provided at CUMC or CMA clinic, then identify the location (e.g., Immanuel Medical Center). Verify proper use of Place of Service (POS) code. If Question #18 is "No", then mark D-3 on the Audit Face Sheet. Mark the type of patient.

8. **Questions 20–23, Teaching Physician Issues—General**

   a. ***Question 20***: Answer and follow the instructions.

   b. ***Question 21***: This question only applies to minor procedures (i.e.,. a procedure that generally takes less than 5 minutes and involves little decision making once the need for the procedure is determined). Teaching Physician presence (required for the entire procedure) can be documented by the Resident or Teaching Physician. If the answer is "No", then mark B-1 on the Audit Face Sheet.

   c. ***Question 22***: For E/M services, the Teaching Physician must personally document his/her participation in the key or critical portion(s) of the service and management of the patient. The resident's documentation may be used to support the level of E/M service (See Teaching Physician Requirements—Evaluation and Management (E/M) Services and Time Based Codes Policy/Procedure) on the Health Sciences Billing Compliance websites at: http://www.creighton.edu/generalcounsel/billingcompliance/

      Examples of acceptable Teaching Physician documentation are outlined in Appendix "K". If the Answer is "No", then:

      1) Mark **B-1** on the Audit Face Sheet if insufficient teaching physician documentation and it will not support any billable service, or

      2) Mark **B-2** or **B-3**, as appropriate on the Audit Face Sheet, if insufficient Teaching Physician documentation, but Teaching Physician documentation would support a lower level code, (i.e. Teaching Physician fails to tie into Resident's note, and therefore can only code based on Teaching Physician's documentation). Mark B-3 if a lower code category can be billed (ex: code billed was admission, but due to lack of reference to resident documentation, Teaching Physician's documentation only supports a subsequent hospital visit).

9. **Questions 23 a–c, Teaching Physician—Primary Care Exception Setting**: Only answer items "a–c" if services were provided in a Primary Care Exception Clinic.

   a. ***Question 23a***: If the answer is more than 4, then services cannot be billed under the Primary Care Exception and mark **A-4** on the Audit Face Sheet.

   b. ***Question 23b***: If the answer is "Yes", then services cannot be billed under the Primary Care Exception and mark **A-4** on the Audit Face Sheet.

   c. ***Question 23c***: See Teaching Physician Requirements—Evaluation and Management Services, Primary Care Exception on the Health Sciences Billing Compliance websites at http://www.creighton.edu/generalcounsel/billingcompliance/index.php). The Teaching Physician must document his review of the patient's care with resident either while the patient was in the clinic or immediately thereafter and note his/her concurrence with or revisions to the plan of care.) Use the Resident's and Teaching Physician's documentation to determine level of service. If the answer is "No", then mark **B-1** on the Audit Face Sheet.

2.3 TEACHING PHYSICIAN RULES—E/M SERVICES

2.3.1 Overall Teaching Physician Requirements

The Teaching Physician rules ONLY APPLY where a Teaching Physician involves a Graduate Medical Education (GME) resident, **not a medical student**, in the care of his/her patients (outside the Primary Care Exception setting). A GME resident is an individual included in the CUMC/CU's GME count. If you have any questions regarding the status of a resident, contact the GME office at 402-280-4677. The Teaching Physician rules do not apply to Nurse Practitioners who involve student nurse practitioners in the care of their patients. A resident or fellow who is not included in the GME count is not a "resident" and therefore services cannot be billed unless **personally provided and documented** by the Faculty Physician.

The Resident cannot reference or use a medical student's documentation of HPI, Exam or Medical Decision Making for documentation purposes. If the Resident has referenced the medical student's documentation of HPI, Exam or Medical Decision Making, then the Teaching Physician must personally document the level of service to be billed.

The Resident or Teaching Physician can reference the medical student's documentation of ROS and PFSH, which can be counted in determining the level of service as to those components of History only; as well as the medical student's documentation of vital signs, which can be used for purposes of counting the Constitutional element under the Exam.

Non-physician practitioners, i.e., Physician Assistants, Nurse Practitioners, etc., may not utilize the documentation of residents or students for billing purposes.

2.3.2 General Rule (Non-Primary Care Exception Setting)

1. The Teaching Physician should reference the Resident's documentation/service. Documentation provided by a Resident may be included when determining the level of service, if the Teaching Physician personally documents his/her participation (See paragraph 2 below).

2. The Teaching Physician must personally document his/her participation in or presence during the key or critical portion(s) of the E/M service and in the management of the patient. See Appendix K for Acceptable and Non-Acceptable examples of Teaching Physician documentation.

2.3.3 Primary Care Exception

1. The Teaching Physician must be present at the clinic and not involved in other billable activity when the Resident performs the service, but does not have to be physically present in the exam room with the Resident and patient.

2. This exception **ONLY** applies to lower level E/M services (99201-99203; 99211-99213) and to the Medicare IPPE (G0402), and Medicare Annual Wellness Visits (G0438, G0439). **IT DOES NOT** apply to procedures.

3. If the scheduled patient's problem is more complex than anticipated, then the Teaching Physician may see the patient, but must meet the presence and documentation requirements under the General Teaching Physician Rule (§2.3.2 above) to bill a higher level (i.e. 99204, 99205, 99214, 99215). The key is that at the time the patient was scheduled, the condition was not considered complex (i.e. 99204, 99205, 99214 or 99215).

4. Teaching Physician **must document** that:

   a. He/She reviewed patient-specific information from the resident's notes, including diagnostic tests, and

   b. The review occurred with the Resident while the patient was in the clinic **OR** immediately after the Resident saw the patient.

5. Phrases such as "Discussed and agree with Resident's assessment and plan" are not adequate. Documentation must indicate when the discussion with the resident occurred (while patient was present or immediately after patient left) and must contain patient specific information.

6. Acceptable templates:

Example 1: "Case discussed with Dr. [Resident] at time of visit. Patient presents with a diagnosis of _____ and treatment with _____. Agree with (revise) diagnosis of _____ and plan of care to _____."

Example 2: "Patient case reviewed and discussed with Resident at the time of visit. Given history of _____. Exam and assessment show _____. I agree (revise) plan of care as _____."

The primary care exception teaching physician attestation in the Allscripts electronic health record is acceptable documentation of teaching physician presence and participation, when personally added by the teaching physician in the password protected system.

2.4 AUDITING LEVEL OF E/M SERVICES ONLY—APPENDIX D

2.4.1 Purpose

E/M Documentation Guidelines: Either the 1995 or 1997 E/M Documentation Guidelines may be used to determine the level of E/M service. Complete Sections A–C of Appendix D for any E/M service, other than those E/M services determined solely on documentation of time (e.g., critical care codes, discharge codes). For preventive services (e.g., annual examinations), complete Section A (except for the HPI and as otherwise restricted by the patient's age) and Section B.

2.4.2 Instructions—Documentation of History (Section A, Appendix D)

2.4.2.1 History Table

1. CHIEF COMPLAINT

Definition—A concise statement describing the symptom, problem conditions, diagnosis, physician recommended return (i.e., follow-up visit), or other factor that is the reason for the encounter, usually stated in the patient's words. *(Health Care Financing Administration, 1997)*

- The medical record should clearly reflect the Chief Complaint for all encounters.
- If the visit is for follow-up treatment of a known condition, then it is sufficient to note "follow-up" (F/U) for _____ (listing the complaint/condition).
- Subsequent inpatient hospital visits—Referencing the patient's status as an inpatient and current condition is sufficient to support a chief complaint.

Action—Mark "Yes" if there is a Chief Complaint (CC) documented in the record; otherwise mark "No" under Chief Complaint.

2. *History of Present Illness (HPI)*

Definition— A 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 (from E/M Documentation Guidelines, Health Care Financing Administration, 1997). The provider (resident and/or teaching physician in the case of teaching setting) must obtain this information. It includes:

- ***Location:*** A description of specific place(s) on the patient's body where the symptom(s) are experienced. This can include a drawing with the location marked.
- ***Quality:*** A description of how the problem feels, looks, behaves, such as "acute", "chronic", "stable", "worsening","improving", etc.
- ***Severity:*** A description of how the symptom(s) feel or how bad the condition is to the patient. In some cases the patient may "grade" the pain on a scale of 1–10 or describe it as "low", "moderate", "great" or "severe".
- ***Duration:*** A description of how long the patient has experienced the symptom(s), which may include information on when the symptom(s) first appeared.
- ***Timing:*** A description of when the patient experiences the symptom(s), such as "continuous", "daily", "only at night".
- ***Context:*** A description of what caused or causes the patient to experience the symptom(s), or information that explains how the problem was identified. This includes "fell during recess", "shortness of breath while running", "found during monthly breast exam".
- ***Modifying factors:*** A description of steps taken by the patient or things that makes the symptom(s) better or worse.
- ***Associated signs and symptoms:*** A description of any additional sensations or feelings experienced by the patient when the symptom(s) occur. [This could include elements that could be used in the ROS, but can only be counted once, either in the HPI or ROS.]

(Information digested from the CPT Assistant Volume 6, Issue 4, April 1996)

Action—Mark each documented element and select the level of HPI (as more fully described below). Record the level on the History Table.

Selecting the Type of HPI

- **No HPI Documented**: There is insufficient documentation to support any history level for purposes of determining level of service.
- **Brief**: Circle if 1–3 elements are documented.
- **Extended HPI**: Circle if:

- **1995 and 1997**: 4 or more elements are documented.
- **1997 only**: The status of at least 3 chronic or inactive conditions is documented. Ex: "brittle diabetic", "well-controlled asthma", "chronic low back pain"

3. REVIEW OF SYSTEMS (ROS)

Definition—An ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms (noted as positive or pertinent negative) that the patient may be experiencing or has experienced *(Health Care Financing Administration, 1997).* This information may be obtained by ancillary staff or through use of a patient-completed questionnaire, but review by the provider must be documented (e.g. signature and date; initial and date). Systems (or lack thereof) may include:

- ***Constitutional:*** Symptom(s) or problem(s) related to temperature (afebrile, fever) weight gain or loss, fatigue.
- ***Eyes:*** Symptoms such as watering, itching, discharge, vision changes, history of past eye exams, injuries or infections, use of corrective lenses or diseases of the eye (i.e. glaucoma, cataracts)
- ***Ears, Nose, Throat and Mouth (ENT and Mouth):*** Symptoms in the ears, nose, throat or mouth, such as hearing problems, nasal discharge or bleeding, sneezing, scratchy throat, excessive salivation, sense of smell or taste, past or present lesions, last dental exam, loss of teeth, etc.
- ***Cardiovascular (CV):*** Heart and vascular system, such as heart palpitations, sweating, excessive thirst, fainting, swelling of arms/legs, leg pain, hypertension, chest pains, heart murmurs, pulse irregularities, etc.
- ***Respiratory:*** Breathing symptoms, such as asthma, chronic coughing, wheezing, bronchitis or pneumonia, etc.
- ***Gastrointestinal (GI):*** Digestive system, including heartburn, swallowing difficulties, hiatal hernia, nausea and/or vomiting; gall bladder problems, constipation, diarrhea, hemorrhoids, use of digestive aids including laxatives, hemocult exam results, if any, etc.
- ***Genitourinary (GU):*** The male or female reproductive system or urinary system, such as number of births, vaginal discharge, genital itching, libido, urinary problems, toilet training (for children), incontinence, etc.
- ***Musculoskeletal:*** Symptoms or problems experienced with the muscles, joints and tendons, such as muscle aches, joint pain/swelling/noise, spinal deformity (scoliosis), back pain, weakness, limitations on movement/activities, etc.
- ***Integumentary (skin and/or breast):*** Symptoms/problems on the skin or breast area, such as scars, moles, color changes, lesions, last mammography result (if relevant), pattern of breast self-exam, nipple discharge/changes, etc, breastfeeding (if relevant), etc.

- ***Neurological:*** Neurological experiences, such as fainting, seizure history, anticonvulsant therapy, memory loss, hallucinations, speech or language problems, sensory or motor disturbances, etc.
- ***Psychiatric:*** Any psychological conditions or treatment, such as auditory hallucinations, anxiety attacks, psychiatric conditions (bi-polar, schizophrenic), etc.
- ***Endocrine:*** Responses related to the endocrine system, such as thyroid disease, adrenal problems or diabetes, unexplained changes in height or weight, increased appetite, thirst or urinary output, heat or cold intolerance, goiter, pancreatitis, etc.
- ***Hematologic/Lymphatic:*** Responses related to the lymphatic or hematologic areas, such as anemia, bleeding, easy bruising or fatigue, blood transfusions, liver problems, etc.
- ***Allergic/Immunologic:*** Responses related to the immunologic system, such as HIV status, seasonal allergies, food allergies, medication allergies, etc.

NOTE: This information may be counted in either the ROS or PFSH, but not both.

(Digested from Physician Practice Coder, March 1998)

Action—Mark the documented elements and select the level as described below. Record the level on the History Table.

SELECTING THE TYPE OF ROS

- **No ROS**: Circle the 1st column.
- **Problem Pertinent ROS** (at least 1 system related to the problem(s) identified in the HPI is documented): Circle the 2nd column.
- **Extended ROS** (2–9 systems related to the problem(s) identified in the HPI are documented): Circle the 3rd column.
- **Complete ROS** (A minimum of 10 systems must be reviewed. This can be documented as those with positive or pertinent negative responses with the remaining noted as "all other systems are negative"): Circle the 4th column.

4. PAST MEDICAL, FAMILY AND/OR SOCIAL HISTORY (PFSH)

Definition—The PFSH consists of a review of items in the following areas:

- ***Past History:*** A review of the patient's past experiences with illnesses, injuries and treatments (NOT OTHERWISE COUNTED IN THE ROS) that includes significant information about:
  - Prior major illnesses/injuries;
  - Prior operations
  - Prior hospitalizations;

- Current medications;
- Allergies
- Age appropriate immunization status
- Age appropriate feeding/dietary status

- ***Family History:*** A review of medical events in the patient's family that includes significant information about:

  Health status or cause of death of parents, siblings, children or other close blood relatives,

  Specific diseases related to problems identified in the Chief Complaint or HPI and/or ROS

  Diseases of family members that may be hereditary or place the patient at risk.

- ***Social History:*** Age appropriate review of past and current activities, including:
  - Marital status and/or living arrangements
  - Current employment
  - Occupational history
  - Use of drugs, alcohol, and/or tobacco
  - Level of education
  - Sexual history
  - Other relevant social factors

(From CPT 2007, Introduction to E/M Coding Section.)

No PFSH is required for categories of E/M services that require only an interval history (i.e., subsequent hospital care, certain nursing facility care, etc).

Action—Mark the appropriate boxes based on documented past medical, social and/or family history. Record the level on the History Table.

SELECTING THE TYPE OF PFSH

- **No PFSH Required**: Mark through and don't consider this element in determining the level of History.
- **No PFSH Documented:** Circle the word "None" in the 2nd column of the History Table.
- **Pertinent PFSH:** Supported if only 1 item from any of the 3 histories is documented.
- **Complete PFSH:** Supported if:
  - 2 PFSH areas for established office and subsequent nursing facility care. Ex: Past History and Social History

- All 3 PFSH areas (Past, Family and Social) for new office; initial hospital care; consultations and comprehensive nursing facility assessments. **If only 2 areas are marked for these types of services, then circle pertinent level of PFSH.**

5. *SELECTING THE LEVEL OF HISTORY*

- If a column has 3 circles, then circle the level of History at the bottom of that column.
- If no column has 3 circles, find the column with the circle farthest to the left and circle the level of History at the bottom of that column. Ex: If you have a Brief HPI (Column 2), Extended ROS (Column 3), and no PFSH (Column 2), then the level of History is **Expanded Problem Focused (Column 2)**.

SECTION A, APPENDIX D, HISTORY TABLE

	☐ Problem Focused	☐ Expanded Problem Focused	☐ Detailed	☐ Comprehensive
HPI	Brief	Brief	Extended	Extended
ROS	None	Pertinent (1)	Extended (2-9)	Complete (10+)
PFSH	None	None	Pertinent	Complete

2.4.2.2 Auditing Guidance—Counting History Elements

1. The HPI, ROS and PFSH may be documented as separate elements of history, or they may be included in the description of the HPI. You can only count an element once, either in the HPI, ROS, or PFSH, not two or more places.

2. Information obtained from someone other than the patient (e.g. parent) may be "counted" as part of the History component(s) or as an element of Medical Decision Making (data section, obtaining history from someone other than the patient). Note: If counted in Medical Decision Making, proper documentation would require the name of the individual providing the information, his or her relationship to the patient, and the information discussed.

3. The treating provider may, upon performing a complete ROS, state "All systems reviewed and were negative, except as noted".

4. To count a ROS and/or PFSH obtained during a previous encounter or as documented by ancillary staff (i.e. medical students, nursing staff) or the patient, the treating provider and/or Teaching Physician (if the treating provider is a Resident) must document his/her review, by initial or countersignature and date, and update of the previous information by:

   a. Noting no change from previous ROS/PFSH and providing date of previous ROS/PFSH; or

b. Noting changes from previous ROS/PFSH and providing date of previous ROS/PFSH, and

c. Noting any supplementing or confirming information.

5. The treating provider must document why he/she is unable to obtain any component of the history (CC, HPI, ROS and/or PFSH) from the patient and his/her attempts to obtain history from other sources. This could include family members, other medical personnel, obtaining old medical records (if available) and using information contained therein to document some of the history components (past medical, family, social). (See question 3 under Section A) In such a case, the provider documents the work performed and coding is based on the work performed.

6. Allergy symptoms can either be counted under the ROS or PFSH (past medical history), not both.

7. Medications can be counted under the PFSH as past medical history.

2.4.3 Instructions—Documentation of Examination (Section B, Appendix D)

2.4.3.1 Elements of the Examination—1995 Guidelines

1. *BODY AREAS (10)*

Head, including the face	Neck
Chest, including breasts & axillae	Abdomen
Genitalia, groin, buttocks	Back, including spine
Right Upper Extremity	Left Upper Extremity
Right Lower Extremity	Left Lower Extremity

2. *ORGAN SYSTEMS (12)*

Eyes	Constitutional (Vitals/Appearance)
ENT and Mouth	Cardiovascular
Respiratory	Gastrointestinal
Genitourinary	Musculoskeletal
Skin	Neurologic
Psychiatric	Hematologic/Lymphatic/Immunologic

3. Examples of Acceptable Documentation for exam elements (1995)

a. Constitutional: Vital signs (3 required), such as Blood pressure 110/80, respirations 16, temperature 101°, OR general appearance, such as: patient poorly groomed, appears cachetic

b. Eyes: PERRL(A), extraocular muscles intact, non-icteric or anicteric sclerae
c. ENT: Nares are clear, mucous membranes are moist
d. GI: Bowels sounds heard/positive; abdomen is soft, nontender
e. Cardiovascular: Trace of edema in extremities; RRR; No cyanosis or edema; no jugular venous distention
f. Musculoskeletal: No joint swelling, instability, pain; full ROM in both upper extremities
g. Neurological: sensation intact; reflexes 2+ in all extremities; alert, oriented x 3
h. Skin: No rashes, lesions, ulcers; scars from previous surgery present on _____
i. Psychiatric: Flat affect; extremely anxious, agitated, oriented x 3 (or not)

PROBLEM DESCRIPTORS FOR EXAM ARE: "NEGATIVE" OR "UNREMARKABLE". WHILE IT MAY BE LOGICAL TO PRESUME THAT AN EXAM WAS PERFORMED BASED UPON THESE DESCRIPTORS, THE LEVEL OF BODY AREAS/ORGAN SYSTEMS EXAMINED MIGHT NOT BE COUNTED AT AN OPTIMAL LEVEL AS IT IS IMPOSSIBLE TO DETERMINE EXACTLY WHAT WAS EXAMINED.

4. *LEVEL OF EXAMINATION (1995)*

- Do not count an exam element as both a body system and organ system.
- Mark the relevant body areas or organ systems documented.
- Check the appropriate level of exam.

Problem Focused	1 body area or organ system documented
Expanded Problem Focused	A limited examination of the affected body area or organ system and other symptomatic or related organ systems
Detailed	An extended examination of the affected body area(s) and other symptomatic or related organ system(s).
Comprehensive	A general multi-system exam which includes findings in 8 or more organ systems; or complete exam of a single organ system.

(Excerpts from the CPT, 2012 and CMS E&M Documentation Guidelines, 1995)

2.4.3.2 *Elements of the Examination—1997 Guidelines*

1. *TYPES*

- General Multi-System; OR
- Single Organ System (Selected Ones are listed below)
  - Cardiovascular
  - Eye
  - Genitourinary (Male and Female)
  - Hematologic/Lymphatic/Immunologic
  - Musculoskeletal
  - Neurological
  - Psychiatric
  - Respiratory
  - Skin

The content and documentation requirements for each type and level of exam are described in detail in the Worksheet, Appendix E. Organ systems and body areas are shown in the left column, while the content of the examination pertaining to that organ system/body area are identified by bullets (•) in the right column.

Parenthetical examples "(e.g.)" are used to clarify and provide guidance regarding documentation.

Documentation for each element must satisfy any numeric requirements included in the description of the element (such as "Measurement of any 3 of the following 7 . . .", requires documentation of 3 items to count the element).

Elements with multiple components, but with no specific numeric requirement (such as "Examination of liver and spleen) require documentation of at least one component.

(Excerpts from CMS E&M Documentation Guidelines, 1997)

2. Level of Examination (1997)

- Mark the elements documented.
- Count the marked elements, then check and circle the appropriate level of exam.

Problem Focused	1–5 bullets documented
Expanded Problem Focused	6 or more bullets documented
Detailed—Excludes Eye and Psychiatric Single Organ Exams:	2 bullets from 6 or more organ systems/body areas documented; or 12 bullets from 2 or more organ systems/body areas documented
Detailed—Eye and Psychiatric Only	9 bullets from 2 or more organ systems/body areas documented
Comprehensive **General Multi-System** **Single Organ**	 2 bullets from 9 organ systems/body areas documented. All elements in each bolded box and 1 element in each unbolded box

2.4.3.3 Auditing Guidance—1995 and 1997 Examinations

- Any abnormalities or relevant negative findings of the examination must be documented. A notation of "abnormal" without elaboration is insufficient and you cannot count that element of the examination.
- A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected body area(s) or asymptomatic organ system(s). Pertinent negative findings must be documented.
- **1995 Guidelines only**—The record should reflect documentation of 8 or more of the 12 *organ systems* for a comprehensive level general multi-system examination. You may not combine elements for body areas with elements for organ systems in order to support a comprehensive level general multi-system exam.

An exam element may not be counted as both a body area and an organ system. For example:

- "No jugular venous distention" can either be counted as the "Neck" (body area) or "Cardiovascular" (organ system), not both.

- "Normal range of motion" in both upper extremities can either be counted as "Right and Left Upper Extremities" (2 body areas) or "Musculoskeletal" (1 organ system).

- ROS elements cannot be counted in the examination nor can exam elements be counted in the History.

- The treating provider must document the entire examination, with the following exceptions:

    1. Ancillary staff, including medical students, may document the vital signs.

    2. Teaching Physician Rules - may rely on Resident Documentation as long as the Teaching Physician has appropriately documented his/her presence or participation in the key components.

2.4.4 Instructions—Documentation of Medical Decision Making (Section C, Appendix D)

(Portions excerpted from CMS's E/M Documentation Guidelines 1995 and 1997)

2.4.4.1 Selecting the Level of Medical Decision Making

Definition—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 problems(s), the diagnostic procedure(s) and/or the possible management options.

1. *Number of Diagnoses or Management Options (Section C.1)*

- Identify each problem the provider is **actively managing** or that reasonably impacts on the management of the patient's condition as mentioned in the record and enter the number in each of the categories in the second column of the table.
- Follow-up visits may or may not include new problems to the examining physician. An established patient can have a new problem with or without additional work-up planned.
- Multiply the numbers in the second and third columns of the table and put the product in the last column. Total the last column and put in the Total line and bring this total to line 1 of C.4 (Final Result Table) and circle the appropriate box.

2. *Amount and/or Complexity of Data to be Reviewed (Section C.2)*

- Circle the number in each row for data reviewed or tests ordered and total the points.
- Only one point is counted for ALL:

- lab tests ordered or reviewed.
- radiology tests ordered or reviewed.
- other tests ordered or reviewed.

- Provider must document independent visualization of an image, tracing or specimen in order to count 2 points. If the provider separately bills for the independent visualization (e.g. prepares a written report for an X-ray), do not count this for purposes of Data Reviewed as the provider is receiving separate reimbursement for this service.
- A letter sent to a requesting provider, as in a consultation, does not constitute discussion of the case with another health care provider and cannot be so counted.
- Add all rows in the last column for the Total and bring the total to line 2 of C.4 (Final Result Table) and circle the appropriate box.

3. *Risk of Complications and/or Morbidity or Mortality (Section C.3)*

This is based on the risks associated with the presenting problem(s), diagnostic procedure(s) and the possible management options.

- Circle the type of presenting problem(s)
- Circle any diagnostic procedures ordered or performed, if applicable.
- Circle the management options documented in the record.
- The highest level of risk in any one category (presenting problem, diagnostic procedures and management options) determines the overall risk.
- Bring the level of risk identified to line 3 of C.4 (Final Result Table) and circle the appropriate box.

4. *Final Results Table (Section C.4)*

- Make sure all information from C.1; C.2; and C.3 has been identified in the Final Results Table, C.4.
- If a column has 2 or 3 circles, the level of Decision Making is found at the bottom of that column.
- If no column has 2 or more circles, find the column with the second circle from the left and the level of Decision Making is found at the bottom of that column.

2.4.4.2 *Auditing Guidance*

- Symptoms of a problem with an established diagnosis should not be counted in addition to the problem itself. For example, congestion should not be counted as a problem in addition to an upper respiratory infection or seasonal allergies; knee pain should not be counted as a problem in addition to osteoarthritis of the knee.

- Assessments, clinical impressions, or diagnoses may be explicitly stated or implied in the documented decisions regarding management plans and/or further evaluation.

- A simple notation for review of tests, such as "WBC elevated" or "chest x-ray unremarkable" is acceptable documentation.

2.4.5 Instructions—Coding Tables (last page of Appendix D)

2.4.5.1 *Selecting the Code*

Use the Coding Tables found on the last page of Appendix D to determine the level of E/M code based on documentation of the key components.

1. First determine the location of service and the status of the patient (i.e., new office, initial hospital, subsequent hospital, etc.) - See Appendix C, questions 17-19.

2. Circle the level of History as determined on Appendix D. An interval history does not require that a PFSH be documented.

3. Circle the level of Exam as determined on Appendix D 1995 or 1997.

4. Circle the level of Medical Decision Making as determined on Appendix D.

5. If the audited service is New Outpatient; Initial Hospital; Observation or Initial Nursing Facility Care:

    a. If a column has three circles, then select the appropriate code at the bottom of the column.

    b. If no column has three circles, then select the appropriate code from the column with a circle farthest to the left.

6. If the audited service is Established Office; Subsequent Inpatient; Subsequent Observation or Subsequent Nursing Facility Care:

    a. If a column has at least two circles, then select the appropriate code at the bottom of the column.

b. If no column has at least two circles, then select the appropriate code from the column with the second circle from the left.

c. **99211** does not require physician documentation, but the medical record must reflect that an evaluation and management service was provided by ancillary staff.

d. For services provided to Medicare beneficiaries only: 99211 provided by staff must meet Medicare's "incident to" requirements, which are:

- Physician is on site when "incident to" services are provided.
- Services are provided as part of a continuing treatment plan for a condition for which the physician initially saw the patient.

See Policy entitled "Medicare's 'Incident To' Rule" on the Health Sciences Billing Compliance website.

2.4.5.2 *Auditing E/M Time-Based Codes (Not Including Psychotherapy or Other non-E/M Time-Based Codes)*

1. Critical Care—Physician's floor time for a specific patient can be included in "total time" for determining the level of service. Floor time spent with other patients may not be counted.

2. Teaching Physician Rules: Rely **ONLY** upon the teaching physician's documented time to determine the level of service. DO NOT COUNT Resident time.

3. Time must be personally documented by the provider providing the service.

4. "Time" may be used as the sole factor in reporting the level of service when counseling and/or coordination of care represent more than 50% of the time spent with the patient. This must be documented by listing the total time of the encounter and the time involved in counseling and coordination of care. The nature of the counseling/coordination of care must also be documented.

3.0 Auditing Procedures/Operations

3.1 MINOR PROCEDURES - APPENDIX C

Action—Use Appendix C to audit minor procedures performed in or out of the office (i.e., removal of wart, simple suture of small wound, lumbar puncture, circumcision, etc.)

Definition—Medicare rules define minor procedures as those usually taking only a few minutes to complete (5 minutes or less) with minimal decision making required.

Teaching Physician Rules—The Teaching Physician must be physically present for the entire procedure. The Teaching Physician's presence may be documented by the Resident, the nurse, or the Teaching Physician. Sample documentation:

- "Dr. [Teaching Physician] was present during the entire procedure".
- "Dr. [Teaching Physician] observed me perform this procedure".
- The Teaching Physician procedure attestation in the Allscripts electronic health record is acceptable documentation of teaching physician presence during a minor procedure.

3.2 AUDITING OPERATIONS/PROCEDURES/OB DELIVERIES—APPENDIX F

3.2.1 Purpose

Use Appendix F for each encounter involving operations and procedures, including, but not limited to, invasive radiologic procedures, OB deliveries and endoscopies. This includes interventional radiologic and cardiologic services, cardiac catheterization, transesophageal echocardiography, etc. Do not use Appendix F for minor procedures (see §3.1 above).

3.2.2 Instructions

1. **Questions 1–3**: Complete the information requested.

2. **Questions 4–6**: List all procedures and surgical services performed, identify any CPT/HCPCS code(s) that were incorrect and provide the CPT/HCPCS code(s) that should have been used. If the code is incorrect, regardless of documentation, then mark either **A-1** or **A-2** on the Audit Face Sheet, as appropriate. Example: Documentation indicates that the procedure was performed laparoscopically, but it is reported using a CPT/HCPCS code for an open procedure. If any CPT/HCPCS codes were not billed, but services were provided, then mark **A-5** on the Audit Face Sheet.

3. **Questions 7–9**: List all ICD-9 codes/diagnoses for this encounter, identify any ICD-9 code(s)/diagnoses that were not accurate and provide the ICD-9 code(s)/diagnoses that should have been used. Mark appropriate findings under Section C **(C-1 or C-2)** of the Audit Face Sheet.

4. **Questions 10-11:** If the patient is a Medicare beneficiary and the service could be denied as not reasonable and necessary based on National Coverage Decisions or published Local Coverage Determinations, mark "Yes". If Question #10 is "Yes" and an ABN was not obtained, mark **D-5** on the Audit Face Sheet.

5. **Questions 12–13**: If there were any modifier errors that resulted in upcoding, then mark **A-3** on the Audit Face Sheet. Modifier errors that do not result in upcoding should be reported as **A-3a**.

6. **Question 14**: Note the type of service provided.

7. **Questions 15–17:** If #17 is "No", mark **B-1** on the Audit Face Sheet.

8. **Question 18:** Only answer if the encounter is an OB delivery. If the answer is "No" and the global was billed, then mark **A-6** on the Audit Face Sheet.

9. **Questions 19-23:** Answer the questions as applicable.

   a. If #20 or #21 is "No", then mark **B-1** on the Audit Face Sheet.

   b. If #22 is "No", and global code was billed, then mark **A-6** on the Audit Face Sheet.

   c. If #23 is "No", then mark **B-5**: if some, but not all documentation is there; or **B-1** if there is no documentation of Teaching Physician presence during all portions.

10. **Question 24:** Identify the location (office, hospital) where services were provided. If clinic or outpatient hospital services were not provided at CUMC or CMA clinic, then identify the location (e.g., Immanuel Medical Center). Verify proper use of Place of Service (POS) code. If Question #18 is "No", then mark **D-3** on the Audit Face Sheet. Mark the type of patient.

3.2.3 Teaching Physician Requirements—Operations, Surgeries, or Procedures

1. Documentation must reflect that the:

   a. Teaching Physician was present during all critical and key portions of a single procedure or two "overlapping procedures" and a Teaching Surgeon is immediately available at all other times.

      - The Teaching Physician determines the key or critical portions.

- The Teaching Physician does not need to be present during opening or closing if that is not key/critical, as determined by the Teaching Physician.
- The Teaching Physician cannot become involved in a second overlapping procedure until all key portions of the first procedure are completed and another teaching surgeon is immediately available for the first procedure.

b. Teaching Physician was immediately available during the entire procedure, including opening and closing, if necessary.

c. Teaching Physician personally performed or observed Resident perform the post-operative visit(s) considered by the Teaching Physician to be key/critical.

2. The Teaching Physician's presence may be documented by the Teaching Physician, Resident or Operating Room Nurse, unless the Teaching Physician is involved in two "overlapping" surgeries.

3. **Teaching Physician is Present During Entire Procedure**: Teaching Physician, Resident or Nurse may document Teaching Physician's presence.

"Dr. [Teaching Physician] was present during the entire procedure."

4. **Teaching Physician is Present During the Key Portion(s) of a Single Procedure:** The Teaching Physician or Resident may document the Teaching Physician's presence during the key portion(s) and that the Teaching Physician (or another qualified Teaching Physician) was immediately available at all other times during the procedure.

"Dr. [Teaching Physician] was present during the key portions of this procedure and Dr. [Teaching Physician] was immediately available at all other times."

5. **Teaching Physician is Involved in Two "Overlapping" Surgeries**: The Teaching Physician must personally document his/her presence during the key or critical portion(s) of each surgery (which cannot occur at the same time), and identify who was immediately available at all other times. It is preferable if the Teaching Physician identifies the key or critical portion(s) for which he/she was present.

The individual who is immediately available cannot be involved in any other billable activity and cannot be a Resident.

"I was present and I participated during the critical and key portions of this procedure [identify key and critical portions], and I/Dr. [Teaching Physician] was immediately available during the remainder of the procedure."

a. Can't bill either procedure if the key or critical portions occur at the same time or overlap.

b. If key or critical portions don't overlap, the Teaching Physician must personally document his/her participation in the key portions of both operations AND identify who was immediately available at all other times for both procedures.

6. **Three Concurrent Procedures:** If three concurrent procedures are performed, then we cannot bill for any of them.

7. **Endoscopic Procedures (Diagnostic)**: Documentation must reflect that the Teaching Physician was available during the entire procedure, including insertion and removal of the scope.

8. **OB Delivery**

   a. Vaginal—Documentation must reflect that the Teaching Physician was present during the delivery.

   b. Cesarean—Follow rules for documenting presence during surgeries.

4.0 Auditing Other CPT/HCPCS Codes

4.1 PSYCHIATRIC SERVICES (EXCLUDING E/M SERVICES)—APPENDIX G

4.1.1 Purpose

Use Appendix G and the appropriate audit worksheet, G-1 through G-4, for each encounter involving psychiatric services, excluding E/M services. Use Appendix C to audit Psychiatric E/M services. Psychiatric Services—General Issues:

- Time should be documented as "time in" and "time out" (e.g., 10:00–10:45) for all services that involve psychotherapy.
- The record must reflect total time as well as the type of psychotherapy provided, goals, and progress toward goals. .
- If services involve a group, then documentation should identify all group members.
- Teaching Physician Rules: Medicare requires that the Teaching Physician must be present or personally view the service with the Resident through one-way mirror or current time video monitoring. **Note:** Some payers, including NE Medicaid, do not require presence of the Teaching Physician during the psychotherapy session.

4.1.2 Instructions

1. **Questions 1–3:** Complete the information requested.

2. **Questions 4–7**: List all services performed, include time and identify any CPT/HCPCS code(s) that were incorrect and provide the CPT/HCPCS code(s) that should have been used. If the code is incorrect, regardless of documentation (i.e., should have been coded an E/M service rather than psychotherapy), then mark either **A-1** or **A-2** on the Audit Face Sheet. If the code(s) is wrong due to inadequate documentation (i.e. no time), then mark **B-5** on the Audit Face Sheet. For non-time based services, documentation must include specific elements, based on CPT/HCPCS or payer requirements. Ex.: CPT code 90801 must include a history, a complete mental status exam, the disposition, and a written treatment plan. If any of these elements are missing, mark **B-5** on the Audit Face Sheet.

3. **Questions 8–10**: List all ICD-9/diagnoses for this encounter, identify any ICD-9 code(s)/diagnoses that were not accurate and provide the ICD-9 code(s)/diagnoses that should have been used. Mark appropriate findings on the Audit Face Sheet.

4. **Questions 11–12:** Explain any modifier errors (excluding GC) and, mark **A-3** on the Audit Face Sheet, if it results in upcoding.

5. **Question 13**: Indicate whether a Resident was involved.

6. **Question 14:** If the answer is "No", then mark **B-1** on the Audit Face Sheet.

7. **Question 15:** If the answer is "No", then mark **C-2** on the Audit Face Sheet.

8. **Question 16:** If the answer is "No", then mark **B-1** on the Audit Face Sheet.

9. **Questions 17-18:** Answer these questions if the patient is a Medicare beneficiary and the provider is a clinical psychologist. If any answer is "No", mark **B-5** on the Audit Face Sheet.

4.2 DIAGNOSTIC RADIOLOGY SERVICES—APPENDIX H

4.2.1 Purpose

Use Appendix H to audit each encounter involving diagnostic radiology services, excluding E/M services (Appendix C) and invasive procedures (Appendix F).

4.2.2 Instructions

1. **Questions 1–3:** Complete the information requested.

2. **Questions 4–6**: List all services performed, identify any CPT/HCPCS code(s) that were incorrect and provide the CPT/HCPCS code(s) that should have been used. If the code is incorrect, regardless of documentation (i.e., one view instead of two views, incorrect number of fractions reported for radiation therapy treatment), then mark either **A-1** or **A-2** on the Audit Face Sheet. If the code(s) is incorrect due to inadequate documentation, then mark **A-6** on the Audit Face Sheet.

3. **Questions 7–9**: List all ICD-9/diagnoses for this encounter, identify any ICD-9 code(s)/diagnoses that were not accurate and provide the ICD-9 code(s)/diagnoses that should have been used. Mark appropriate findings under Section C **(C-1 or C-2)** on the Audit Face Sheet.

4. **Questions 10–12:** Mark **A-3** on the Audit Face Sheet if #10 or #11 is "No". For #12, explain any modifier errors and if it resulted in upcoding, mark **A-3** on the Audit Face Sheet.

5. **Questions 13-14:** Determine whether or not an ABN was required for a Medicare beneficiary. If the answer to #14 is "No", then mark **D-5** on the Audit Face Sheet.

6. **Question 15–18:** If #15 is "No" mark **B-4** on the Audit Face Sheet. If #18 is "No" mark **B-1** on the Audit Face Sheet.

4.3 ANESTHESIOLOGY SERVICES—APPENDIX I

4.3.1 Purpose

Use appendix I and the Audit Face Sheet, Appendix A to audit anesthesia services, excluding E/M services. Use the E/M worksheets for E/M services.

4.3.2 Instructions

Section A

1. **Question 1-3** Complete the information requested.

2. **Questions 4-6** List all services performed, identify any ASA/CPT/HCPCS code(s) that were incorrect and provide the ASA/CPT/HCPCS code(s) that should have been used. If the code is incorrect, regardless of documentation, then mark either A-1 or A-2 on the audit face sheet. If the code(s) is incorrect due to inadequate documentation, then mark A-6 or B-5 on the audit face sheet based on the type of finding.

3. **Questions 7-9** List all diagnoses for this encounter, identify any diagnoses that were not accurate and provide the diagnoses that should have been used. Mark appropriate findings under Section C (C-1 or C-2) on the Audit Face Sheet.

4. **Question 10** List the start/stop and total times. Verify that they match with the time billed for this encounter. If time is not documented, mark B-4. If the time does not match, then mark A-1 if downcoded or A-2 if upcoded based on time.

5. **Question 11** Mark if services were personally provided by the Anesthesiologist, medically directed by the anesthesiologist, medically directed SRNA by a CRNA or non-medically directed CRNA.

6. **Questions 12-14** Provide the physical status modifier used as well as other modifiers for the service. If there is an error in a modifier, resulting in upcoding, mark A-3 on the Audit Face Sheet.

7. **Question 15** If the answer is "yes", go to Section B. If the answer is "no" continue to question 16 to address medical direction issues.
8. **Question 16** Answer as requested.
9. **Question 17** If #17 "yes" mark A-4 if billed.
10. **Question 18** Complete as requested.
11. **Question 19** If #19 is "yes", mark A-4 if billed
12. **Question 20** Complete as requested.

Section B

1. **Questions 1-7** Only answer #4, #5, #6 if the anesthesiologist provided medical direction. In all other cases, answer all of the questions. If all questions are answered "No" then mark B-4 on the Audit Face Sheet; if one or more (but not all) are answered "No" then mark B-5 on the Audit Face Sheet.

2. **Questions 8-11** Only answer these questions if the services were provided by a non-medically directed CRNA. If any answer to these four questions is "No", mark B-5.

Section C

1. **Questions 1-3** If #2 is "No" mark B-5 on the Audit Face Sheet. If #3 is "No", mark D-4 on the Audit Face Sheet.

2. **Questions 4-5** If #5 is "No" mark A-4 on the Audit Face Sheet.

3. **Question 6** If "Yes" mark A-5 on the Audit Face Sheet.
4. If #7 is "Yes", mark A-6 on the Audit Face Sheet.

4.3.3 Anesthesia Levels and Modifiers

1. **Personally performed**, includes:
   Personally provided entire case (Modifier "AA")
   A single case with one student CRNA (Modifier "AA")
   A single case with one CRNA and the services of both are deemed medically necessary. (Non-medically directed) (Modifier "AA" for the M.D. and "QZ" for the CRNA)

2. **Medically Directed**, includes:
   Medical direction of one CRNA by an anesthesiologist. A single case and the physician is performing medical direction (Modifier "QY" for the M.D. and "QX" for the CRNA), or
   Medical direction of two to four concurrent cases conducted by CRNA's ("QK" for the M.D. and "QX" for the CRNA), or
   Medical direction of a combination of two SRNA's or one CRNA and one SRNA.
   Medical Direction of one or two SRNA's by a CRNA "QZ"

3. **Medically Supervised**, includes:
   The anesthesiologist is involved in furnishing more than four procedures concurrently or two procedures concurrently with an SRNA involved, or is performing other services while directing concurrent procedures (Modifier "AD" for the M.D. and "QZ" for the CRNA)

4. **Monitored Anesthesia Care**, no matter what level (Modifier "QS")

4.4 PATHOLOGY SERVICES – ANATOMIC, APPENDIX J

4.4.1 Purpose

Use Worksheet, Appendix J, and the Audit Face Sheet, Appendix A-2 to audit anatomic pathology services only, excluding reference laboratory services.

4.4.2 Instructions

1. **Demographic Information**. Complete the demographic information requested in the first one-third of the Worksheet.

2. **CPT Coding of Specimen and Tests Information.** Insert the CPT/HCPCS code(s) that were coded for the services, along with any modifier(s) in the "coder applied" column.

3. **Billing Information.** Insert the information requested under the "auditor supplied codes" column. Note any problems identified in the column labeled "Comments".

4. **Diagnosis Coding.** In the first columns, "coder applied", list all ICD-9 and/or narrative diagnosis. In the next column, list the auditor applied ICD-9. Note any problems identified in the column labeled "Comments".

5. **Appendix A-2**. Complete Appendix A-2 based on the findings identified using Worksheet J.

4.5 PATHOLOGY REFERENCE LABORATORY – APPENDIX A-3

4.5.1 Purpose

Use Appendix A-3 to audit and report findings on reference laboratory services only, excluding anatomic pathology services.

4.5.2 Instructions

1. **Requisition Audit – Section A.** This section deals with the information (demographic, completeness of information) on the Requisition Form. It does not include CPT/HCPCS or ICD-9 errors. Pick an audit date and count the number of requisitions received for that date. Place the total number of requisitions for that date in item #1. Identify, by payer, the number of requisitions for a) Client billing; b) Private Payer; c) Medicare; and d) Medicaid. In item #3 place the number of clean requisitions in one of the four corresponding categories. In item #4, identify, by category and payer, each problem area,

as listed; or indicate any identified problems not listed in the "Other" category under "e" or "f." Note any trends (more than 2 similar errors in a category under #4) in item #5.

2. **Coding Audit – Section B.** This section deals with CPT/HCPCS and ICD-9 coding errors.

   a. Problem listed translated to ICD-9 Code in billing system. From the number identified in Section A, select a number of requisitions to audit for this Section and place that in item #1a. Identify the number of incorrectly translated ICD-9 codes and place in item #1b. Determine the percentage (1b divided by 1a) and place in #1c. Identify any problems in item#1d.

   b. ABN Review. List the number of Medicare requisitions selected in item#2a and the number of ABN's not completed correctly in #2b. Determine the error percentage (2b divided by 2a) and place in item#2c. Indicate in item#2d if any of those listed in 2b were billed to Medicare and if the answer is "Yes", indicate the number in item2e.

   c. Correct Test(s)/CPT/HCPCS Selected. List the number of CPT/HCPCS codes for all requisitions in item#3a. Identify the number of incorrectly ordered tests in item#3b. Determine the percentage (3b divided by 3a) and place in #3c.

2. The Auditor should sign at the bottom of page 3 where indicated.

5.0 Auditing the ICD-9 Code

5.1 General Principles

1. Listed first should be the ICD-9-CM code for the diagnosis, condition, problem or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided. Additional codes that describe any coexisting conditions that are relevant to the specific patient encounter and that affect patient care may be listed as well.

2. Diagnoses that are documented as "probable, suspected, questionable, or rule-out" should NOT be reported using the codes for the actual conditions. Code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. (Ex. An encounter with a patient who has an abnormal, chronic cough in whom the physician suspects a lung cancer, would be coded for the cough unless and until a definitive diagnosis of a cancer is established and documented.)

3. Chronic diseases treated on an ongoing basis will be coded and reported as many times as the patient receives treatment and care for the condition(s).

4. All documented conditions that co-exist at the time of the encounter/visit and require or affect patient care, treatment, or management should be coded. Conditions that were previously treated and that no longer exist, should not be coded. However, history codes (V10-V19) may be used if the historical condition or family history has an impact on current care or influences treatment.

5. An ICD-9 screening code (V code) should be reported when a physician orders an ancillary service such as an X-ray, EKG, ECG, mammography, etc., in the absence of illness, injury, symptoms, or active medical condition.

6. Codes must be reported to their highest specificity e.g.,
   - 3-digit codes should be assigned only if there are no 4-digit codes within that code category,
   - 4-digit codes should be assigned only if there is no fifth digit sub-classification for that category; and
   - The fifth digit sub-classification code should be assigned for those categories where it exists.

7. Where Medicare policies dictate specific diagnosis codes, those policies will be followed.

8. If two physicians are treating the same patient on the same date of service for different conditions, each should report a different, appropriate diagnosis code as the primary reason for the encounter.

9. Medicare Screening Pelvic Exam—Must indicate either V76.2 (low risk) or V15.89 (high risk)

5.2 ICD-9 AUDITING PROCESS

1. Identify and transfer the ICD-9 codes from the encounter form or the computer report to the audit worksheet.

2. Refer to the medical record and identify each diagnosis, condition, or other reason for the encounter as documented in the "impression" or the "assessment".

3. Look up in Volume II and cross reference in Volume I of ICD-9 to locate the correct, complete ICD-9 code(s) for the primary diagnosis and compare to the code listed on the encounter form or from the electronic billing system.

   a. If the ICD-9 code is incorrect, report finding **C-1** on the audit face sheet and record the appropriate code on the audit worksheet.

   b. If the ICD-9 code is correct, is it reported to the highest level of specificity? (4^{th} and 5^{th} digits). If not, report finding **C-1** on the audit face sheet and record the appropriate ICD-9 code on the audit worksheet.

   c. If the ICD-9 code requires an additional code to be reported (*code first, use additional code, secondary malignant neoplasms*) is it included? If not, report finding **C-1** and record the appropriate code on the audit worksheet.

   d. Repeat for all ICD-9 codes listed.

4. If the encounter requires that an E-code(s) be included to report an external cause of injury or a poisoning, is the E-code reported? If not, (exclusive of carrier stipulations) report finding **C-1** and record the appropriate E-code(s).

5. Is each problem or diagnosis that the provider is **actively managing** or that reasonably impacts the management of the patient's condition reported? If not, report finding **C-1** and record the appropriate ICD-9 code on the audit worksheet. (A "laundry list" of problems should not be coded and reported unless the provider is truly managing each of the conditions reported.) It is not necessary to report ICD-9 code for symptoms in addition to the code(s) for a specific condition or diagnosis.

6. Is each ICD-9 code supported in the documentation? If not, report a **C-2** finding.

5.3 MEDICARE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) REQUIREMENTS

1. Medicare requires that the provider obtain a written Advance Beneficiary Notice of Noncoverage (ABN) from the beneficiary whenever there is reason to believe that the item or service may not be covered by Medicare (i.e., is not medically necessary, exceeds the frequency limits), which would allow the provider to bill the beneficiary IF the service is denied by Medicare as "not medically necessary". Otherwise, the service cannot be billed to the beneficiary.

2. Medicare has specific requirements for the written ABN, which must be followed for the ABN to be effective. See Advanced Beneficiary Notice of Noncoverage Policy located on the Health Sciences Billing Compliance website.

3. An ABN is NOT required if Medicare NEVER covers the service. For example, Medicare never pays for routine eye care and therefore, no ABN is required in order to bill the patient for the service.

4. An ABN should be obtained for services that Medicare deems to be not "reasonable and necessary as reflected in Medicare's National Coverage Determinations (NCD) at the National level and Local Coverage Determinations (LCD) at the Contractor level. In addition, an ABN should be obtained for covered screening services (i.e., PAP smears, mammographies), to ensure that frequency limitations have not been exceeded since the beneficiary may have received those services from another provider since last treated by a Creighton provider.

5. If an item or service is provided that requires a written ABN and there is no written ABN in the file, then mark **D-5** on the Audit Face Sheet.

6. If an item or service is provided that requires a written ABN, and there is no written ABN in the file AND the item/service was billed to Medicare or the beneficiary, then mark **A-4** on the Audit Face Sheet.

7. If an ABN is submitted for a service that is not reasonable and necessary according to Medicare standards (i.e., denial for secondary payer purposes) without the proper modifier, such as "GZ" or "GY", then mark **A-3a**, on the Audit Face Sheet.

6.0 Other Auditing Tips

6.1 CRITICAL CARE

Make sure that any procedures bundled into the code (as outlined in CPT/HCPCS) that were performed, were not billed separately (ex: pulse oximetry, etc.). Make sure that all critical care time based codes have time documented as "in-time" and "out-time" and that Resident time was not counted.

6.2 MODIFIER "-25"

Modifier "-25" is required when a separately identifiable E/M service is provided on the same day as a procedure. An example would be: "Patient seen for sore throat and mole removed from neck."

6.3 MODIFIER "-59"

Modifier "-59" may be used to indicate that a procedure or service is distinct or independent from other services performed on the same day, e.g., separate site or separate session. It is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. It is NOT to be used for the purpose of circumventing CCI edits, resulting in "unbundling". An example of appropriate use would be: "surgeon performs a medial meniscectomy on the right knee and performs a lateral chondroplasty on the right knee". This would be reported as 29881, 29877-59. Note: for this example this would not apply to Medicare and other payers who will accept the G0289 code, created for the purpose of indicating a different compartment of the same knee.

6.4 NEW PATIENT V. ESTABLISHED PATIENT

6.4.1 New Patient

A New Patient is one who has not received any professional services (face to face) from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three (3) years.

If no E/M service is performed, the patient may be treated as a new patient. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an evaluation and management service does not affect the designation of a new patient.

6.4.2 Established Patient

An established patient is one who has received professional (face-to-face) services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three (3) years.

6.5 PREVENTIVE CARE, IMMUNIZATIONS, SCREENING PELVIC

1. Preventive Care codes (99381-99397) are age specific and include both new and established patients. Follow the rules for "New v. Established" patient to determine the patient's status.

2. If the patient is scheduled for an annual examination or other routine physical, then a preventive service should be coded

   a. Medicare Initial Preventive Physical Exam (IPPE), effective 1/1/05. Medicare requires that seven elements be provided and documented in the medical record as part of the IPPE (See Appendix M of the Handbook). If any one of the seven elements is not documented, then mark A-6 on the Audit Face Sheet. If the screening electrocardiogram is referred to another provider, the results must be documented in the beneficiary's medical record to complete the IPPE.

   b. Medicare Annual Wellness Visit (AWV), effective January 1, 2011. Medicare covers an Annual Wellness Visit that provides Personalized Prevention Plan Services (PPPS). All components of the AWV must be provided, or provided and referred, prior to submitting a claim for the AWV (see Appendix N of the Handbook. The AWV is a separate service from the IPPE and is not covered during the first 12 months of the beneficiary's initial enrollment into Medicare Part B. Note that the AWV is a preventive wellness visit and not a "routine physical checkup", Medicare does not provide coverage for routine physical exams.

   c. Only a significant abnormality or pre-existing condition addressed during the preventive exam, IPPE or AWV which requires additional work to perform the key components of a problem-oriented E/M service should be coded with the appropriate E/M code (99201-99205; 99212-99215) with a "-25" modifier along with the IPPE or AWV.

      An insignificant or trivial problem/abnormality encountered during the preventative exam should not be separately coded.

3. The "comprehensive" components of the preventive medicine services reflects an age and gender appropriate history/exam and is NOT synonymous with the "comprehensive" exam required in E/M codes 99201-99350. It is expected that the provider will conduct a

comprehensive exam of various body areas/organ systems based on the patient's gender and age to determine the presence or absence of problems. **Note:** Some private payers have specific requirements for annual exams/preventive services.

4. Immunizations, diagnostic tests and other procedures performed in conjunction with the preventative service should be coded separately. Medicare may not cover certain screening tests for asymptomatic individuals (i.e., no signs or symptoms) beyond those covered under its policy.

5. Medicare covered Screening Pelvic Examination. Use the 1997 E/M Documentation Guidelines for the Single Organ Genitourinary Exam. At least seven "bullets" from the GU-Female body area/organ system must be documented.

   a. Use code G0101

   b. Effective 1/1/99, G0101 may be coded with an E/M visit, if the E/M visit is separate from the G0101 service (i.e. problem-oriented visit other than GU)

   c. Pap smear is coded separately from the G0101, even if performed on the same date.

7.0 Auditing Electronic Health Record Encounters

7.1 INTRODUCTION

Electronic health records introduce both benefits and risks to the documentation of medical care. Potential benefits include improved access to medical records both within a practice and with other health care providers and improved legibility. Potential risks include those that arise from documentation aids (including templates, macros and copy forward functions) and multiple users, including students and residents, documenting within the same record of an encounter. In addition to auditing for appropriate documentation, coding and compliance with billing rules, audits will also be performed on attributes unique to the electronic health record.

7.2 PROCEDURE

1. For every 10 encounters audited for a provider, CMA Audit will select 3 encounters to complete an audit of attributes unique to the electronic health record.

2. For each of the 3 selected encounters, CMA Audit will complete the audit form attached as "Appendix O" to the Handbook.

3. In the event the audit indicates a potential risk of noncompliance (e.g., reliance on medical student documentation, inappropriate use of copy forward function, or indications of cloning), CMA Audit will refer the findings to the Billing Compliance Office for additional review.