Internal Chart Auditing:
Part 1 of 2

Mary Pat Johnson, COMT, CPC, COE, CPMA
Senior Consultant
Corcoran Consulting Group

Financial Disclosure

Mary Pat Johnson is a consultant for Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

Who’s watching?

- Office of Inspector General (OIG)
- Comprehensive Error Rate Testing (CERT)
- Recovery Audit Contractors (RAC)
- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Zone Program Integrity Contractors (ZPIC)
- Program Safeguard Contractors (PSC)

Have You Been Flagged?

- Large practice
- Complaints
  - Patients
  - Doctors
- Frequent claims for abused services
- Frequent errors on claims
- Abnormal utilization patterns
- PRO recommendation

Indications of Non-Compliance

- Staff turnover
- Claims paid slowly
- Frequent problems with claims
- Problem claims unresolved
- Staff takes work home
- Poor morale
- Irregular accounting
- You are under scrutiny by Medicare or other payers

OIG Guidance

- Office of Inspector General (OIG), HHS
- Published “Compliance Program Guidance for Individual and Small Group Physician Practices”
- Not mandatory but advisable
- Mandatory CP is coming soon…

Source: Federal Register Vol 65, No 194, October 5, 2000
7 Elements of an Effective CP

• Conducting internal monitoring and auditing
• Implementing compliance and practice standards
• Designating a compliance officer or contact
• Conducting appropriate training and education
• Responding appropriately to detected offenses and developing corrective action
• Developing open lines of communication
• Enforcing disciplinary standards through well-publicized guidelines

The Best Defense is a Good Offense

• Be proactive
• Make compliance a priority
• Stress importance of accurate, complete documentation
• Get buy-in from management, physicians and staff
• Establish expectations and protocols
• Conduct training
• Monitor the results... this is auditing!

True or False?

Compliance Plans are now mandatory for physician Practices?

a) True
b) False

Source: CMS website

Compliance Plans

If establishing a Quality Assurance or Compliance Program for your practice, chart audits...

a) must be included and performed quarterly
b) are not necessary
c) should be included as part of program
d) must be completed by a physician or registered nurse

Compliance Program

Which of the following is not an element of the "Compliance Program Guidance for Individual and Small Group Physician Practices" provided by OIG?

a) Conducting internal monitoring and auditing
b) Implementing compliance and practice standards
c) Scheduling monthly compliance meetings
d) Designating a compliance officer or contact
e) Responding appropriately to detected offenses and developing corrective action

Compliance Program

Under a Compliance Program, employees with concerns regarding activities in the practice should...

a) have an open line of communication available to communicate their concerns
b) should report their concerns directly to OIG
c) can be terminated for causing trouble
d) do their own investigation to determine if there is really a problem before coming forward
Auditing and Monitoring

- Review standards and procedures
- Claims submission audit
  - Are bills accurately coded?
  - Is documentation complete?
  - Are services reasonable and necessary?
  - Any incentives for unnecessary services?
- Baseline audit within 3 mos of initial training, and thereafter on an annual basis
  - 5-10 records per physician

Source: Federal Register Vol 65, No 194, October 5, 2000

Things to Consider

- Select your reviewers
- Post-payment or pre-payment
- Review several components
  - Medical Records
  - Medical Records
  - Exams, tests, ophthalmology
  - Correspondence
  - Documentation and billing rules
  - Forms
  - Policies and procedures
  - Legal and financial arrangements

Who Are Your Reviewers?

- Create a Quality Assurance Team
  - Physicians
  - Management
  - Staff
- Potential auditors in the practice
  - Understand ophthalmology
  - Understand documentation and billing rules
  - Consider a team approach
    - Members of clinical staff (technicians, nurses)
    - Members of the billing staff

Attitude

- Extremely important
- Choose auditor carefully
  - Objective
  - Reasonable
  - Respected
  - Moderate authority
- Goal is to educate and correct
- Don’t punish or intimidate

Prospective Audit

- Review before claims are filed
- Emphasis on prevention
- Identify improper billings – correct it
- Identify inadequate chart documentation – fix it
- Less time consuming
- Less costly

Retrospective Audit

- Reviewed after claims are filed
- Emphasis on remediation
- Response to a complaint or investigation
- Identify improper billing
- Identify improper reimbursement
- Make restitution for overpayments
- Initiate remedies to prevent future errors
True or False?
If the results of your internal compliance plan are unfavorable, it is acceptable to ignore the results and audit again in 6 months?

a) True
b) False

Source: CMS website

How Large Is The Review?

- Comprehensive review
  - Look at a little of everything
- Focused review
  - By doctor
  - By location (site)
  - By subspecialty
  - By procedure
  - By department
  - By payer

How To Select The Sample?

- Random chart sample
- Based on utilization
- What carriers are auditing
- Complicated claims
- Novel or new services
- Complaint

Resources

- CPT-4, ICD-9, HCPCS reference handbooks
- NCCI edits (i.e., bundles)
- Coverage and Payment Policies
  - Bulletins, transmittals and notices
  - Manuals including all current regulations
  - Statutes
- Fee schedules
- Checklists

Getting Started

What To Look For?

- Quality of documentation
  - Accuracy of notes
  - Appropriate forms
  - Appropriate signatures
- Accuracy of claims
- Efficiency or inefficiency of internal procedures
Subjective Findings

- Legibility
- Organization
- Quality of forms or EHR
- Registration
- Signatures
- Corrections
- Timeliness

Objective Findings

- Overbilling
  - Upcode LOS
  - Wrong CPT (high)
  - Poor documentation
  - Missing entries
  - Duplicate billing
  - Fragmentation
  - Not medically necessary
- Underbilling
  - Downcode LOS
  - Wrong CPT code (low)
  - Missed charges
  - Bilateral or multiple procedures
  - Supplies

Objective Findings

- Coding errors
  - CPT code error with no financial impact
  - Modifier omitted
  - Incorrect modifier
  - Diagnosis code errors
- Other errors
  - Date errors
  - Too frequent services
  - Indications unclear
  - Wrong provider (credentialing)
  - Patient responsibility

Categories of Services

- Exams and consultations
- Diagnostic tests
- Surgical procedures
- Anesthesia
- Pharmaceuticals (injected)
- Post-cataract eyeglasses, CLs

Basic Requirements

- New patients
  - Registration and demographics
  - HIPAA notice
  - Assignment of benefits (signature on file)
- Established patients
  - Update registration and demographics
  - Update insurance information

Reviewing Eye Exams

- Appropriate CC and valid indication for care
- Written request for consultation (if applicable)
- Appropriate medical history
- HPI documented by physician (critical for E/M)
  - Identity of scribe noted
- Relevant exam elements documented
- Impression and plan documented
- Consult letter to requesting physician (if applicable)
- Accurately coded (either eye code or E/M)
Reviewing Diagnostic Tests

- Indications for service
- Appropriate order
- Technicians’ notes
- Adequate interpretation
  - On date of test or later?
- Reasonable frequency for patient’s condition
  - Policy
  - Preferred Practice Patterns
- Coding accuracy

Reviewing Surgical Procedures

- Indications for surgery
- Adherence surgery billing rules
  - Minor vs. major surgery
  - Exam on day of surgery
  - Global period
  - Assistant surgeon
  - Multiple or bilateral surgery
  - NCCI edits
- Informed consent
- ABN if needed
- Coding accuracy
- Place of service

Your Tools

- 1997 E/M specialty guidelines published by CMS
- Eye exam coding criteria (see checklist in handout)
- Audit checklists for assessing
  - Medical history documentation
  - Office visits – E/M vs. Eye code
  - Diagnostic tests
  - Surgical services

Noting Subjective Findings

- Chart organization and completeness
- Quality and extent of documentation
- Quality of care

Noting Objective Findings

- Organize by type of error
- Easy to sort, count (Excel)
- Entire practice vs. individual doctor
- Keep detailed notes for future reference
  - Sensitive issues
  - Sensitive people
Summary of Common Mistakes

- Undercharging for services
  - Lost charges
  - Downcoding
- Coding errors
- Overcharging for services
  - Inadequate chart documentation
  - Missing documentation
  - Fragmentation

Source: CCG’s Chart Reviews

Computing the Score

- Two separate scores
  - Frequency of each error
  - Financial impact of errors

Discussing Your Findings

- Praise first
- Select your audience
- Limit your battles
- Have your facts ready
- Get back up if needed
- Stay calm
- Be prepared to offer solutions

What Next?

- Fix identified problems
  - Rebill
  - Refund overpayments
  - Train physicians and staff
  - Create or update practice policies
- Repeat chart review
  - Focus on problems previously identified
  - Look for new issues
  - Follow Compliance Program

Refund Overpayments

- Explanation:
  - Why the voluntary refund was made
  - How it was identified
  - What sampling techniques were employed
  - What steps were taken to assure that the issue leading to the overpayment was corrected
  - The dates the corrective action was in place
  - Specific claims involved in the inappropriate payments
  - Methodology used to arrive at the amount of the refund
  - Whether a full assessment was performed to determine the extent of the refund

Source: Medicare Transmittal AB-00-41, May 2000

Return of Overpayments

- Solitary vs. broad overpayments
- Refund payer claim by claim
  - Send with letter and copy of EOB
  - Check for carrier instructions
    - Full refund with corrected claim
    - Refund claim difference
- Refund patients
  - 60 days for incorrectly collected
  - 30 days for services not covered (no ABN)
  - Violation of provider agreement if refunds not timely
Compliance

- Fine line
- Daily activity
- Requires diligence
- Payoff can be substantial

Practice

With this in mind, let’s audit a few records

Patient #1

CC: Requests CEE
HPI: Reading glasses 4 yrs old
Near vision blurry

Dx:
1) Blepharitis
2) Presbyopia

Tx:
1) Baby shampoo lid scrubs
2) Replace readers w +2.50

Exam: CE, DFE, OU

lids inflamed and red
Tests: External photos

Billed 92014 with diagnosis blepharitis to Medicare

Exam Coverage

What do we know about Medicare coverage?

Did this patient’s exam warrant a Medicare claim?

What was the reason for the visit?

What diagnosis was listed as primary?

Was a claim supported?

Should other codes have been billed?

Auditor’s Notes

What do we know about Medicare coverage?

No benefit for routine eye exam w/o a medical complaint

Did this patient’s exam warrant a Medicare claim?

No. Bill patient or patient’s vision plan

What was the reason for the visit? Refractive error

What diagnosis was listed as primary? Blepharitis

Was the a claim supported? Yes, 92004 was performed

Should other codes have been billed? 92015-refraction

Auditor Score For This Entry

92014 Billed to wrong payer; s/b patient pay
Documentation supports the code, but this level may be challenged for blepharitis

92015 Missed charge
**Patient #2**

- **CC:** Eye injury, emergency
- **HPI:** Lid laceration\(^1\), today\(^2\), struck by post, headache\(^3\) (obtained by MD)
- **Dx:** Inferior canalicular laceration, globe intact
- **Tx:** Repair in OR today
- **Hx:** Comprehensive Hx
- **Exam:** CE, DFE
- **Tests:** External photos

Billed 99205 and 92285 to medical insurance today

---

**Level 5 E/M Service**

What do we know about this code?
- Requires comprehensive history
  - 4 elements of History of Present Illness (HPI)
  - Complete Review of Systems (ROS)
  - Past, Family, Social Histories (PFSH)
- Requires comprehensive exam (CE, DFE)
- Requires high level medical decision making

Does same day surgery affect the claim for this exam charge?

---

**Level 5 E/M Service**

What do we know about this code?
- Requires comprehensive history
  - 4 elements of HPI
  - Complete ROS
  - PFSH
- Requires CE, DFE
- Requires high level MDM

Does same day surgery affect the claim for this exam charge?

---

**Audit Score For This Entry**

- 99205: Should be billed as 92004-57
  - Represents an overcharge
  - Modifier omission
  - History insufficient for 99205
  - If using E/M code, 99202 is appropriate
- 92285: Omit charge. Documentation only

Verify that claim was submitted for same day surgery

---

**Patient #2 – With A Twist**

- **CC:** Eye injury, emergency
- **HPI:** Lid laceration\(^1\), today\(^2\), struck by post, headache\(^3\) (obtained by technician)
- **Dx:** Inferior canalicular laceration, globe intact
- **Tx:** Repair in OR today
- **Hx:** Comprehensive Hx
- **Exam:** CE, DFE
- **Tests:** External photos

Billed 99205 and 92285 to medical insurance today

---

**Auditor's Notes**

Level 5 E/M code not supported by documentation
- Limited by the HPI
- If using E/M codes, use 99202
- CPT 92004 is a better option
- Append modifier -57 since this is in pre-op portion of global period for major surgery performed same day
- External photos for chart documentation only – not diagnostic
**History**

3 of 3 Key Components

<table>
<thead>
<tr>
<th>Component</th>
<th>Brief 1-3</th>
<th>Brief 1-3</th>
<th>Extended 4+</th>
<th>Extended 4+</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROS</td>
<td>None</td>
<td>None</td>
<td>Complete 2-9</td>
<td>Complete 2-9</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>Complete 1</td>
<td>Complete 1</td>
</tr>
<tr>
<td>PF</td>
<td>EPF</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

**New Patient Office Visit**

3 of 3 Key Components

<table>
<thead>
<tr>
<th>Component</th>
<th>PF</th>
<th>EPF</th>
<th>Detail</th>
<th>Comp</th>
<th>Comp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>PF</td>
<td>EPF</td>
<td>Detail</td>
<td>Comp</td>
<td>Comp</td>
</tr>
<tr>
<td>DM</td>
<td>STRT FWD</td>
<td>STRT FWD</td>
<td>LOW</td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Code</td>
<td>99201</td>
<td>99202</td>
<td>99203</td>
<td>99204</td>
<td>99205</td>
</tr>
</tbody>
</table>

**Auditor Guidance**

In recent Medicare audits, HPI is closely scrutinized. If not performed by provider, it is not counted at all. 3 of 3 rule requires HPI by MD for any level history. NP rule (also 3 of 3) requires HPI for any NP code.

Without HPI attestation, this exam supports eye code only - bill 92004-57

**Conclusion**

- Compliance Program and Quality Assurance require periodic chart reviews.
- Carefully select auditors.
- Review a representative sample of charts.
- Organize your resources and tools.
- Keep detailed notes throughout.
- Summarize with an objective score.
- Use results to address errors and train staff.

**More help...**

For additional assistance or confidential consultation, please contact us at:

(800) 399-6565

or

www.CorcoranCCG.com