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Sample Physician Network

Sample Doctor, MD

The annual audit reviews have been completed. The audit findings and score are based on documentation that was present at the time of the review.
This score may be varied upon further evidence of supporting documentation. We will be working on setting up an education session for you to attend for further educational feedback.

NAMAS AUDITOR

Auditing and Regulatory Compliance
Report of Findings

December 2022

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Audit and Regulatory Compliance
Professional Services Audit Summary
2022

PROVIDER NAME: Sample Doctor, MD
DM AUDITOR: NAMAS AUDITOR, CPC, CEMA, RHIT
AUDIT DATE: 12/13/2022

OBJECTIVE: To ensure that Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System Level II (HCPCS II), Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes and related modifiers are assigned in accordance with regulatory requirements and supported by documentation in the patient's medical record.

METHODOLOGY: Each encounter was reviewed for compliance in following areas:

a. Evaluation and management (E/M) coding accuracy.
b. Charges documented in the medical record but not billed (missed charges);
c. Missing or deficient documentation (billed but not documented);
d. Accuracy of ICD-10 coding based on medical record documentation;
e. Accuracy of procedural coding (non E/M);
f. Accuracy of modifier assignment;
g. Code bundling issues;

The following tools and authoritative sources were used for the audit as applicable:

a. Centers for Medicare and Medicaid Services National Coverage Determinations;
b. Centers for Medicare and Medicaid Services Local Coverage Determinations;
c. Commercial and other governmental payer guidelines as applicable and available;
d. Current Procedural Terminology
e. Current Procedural Terminology Assistant;
f. Centers for Medicare and Medicaid Services Evaluation and Management Guidelines, 2021 version
g. Centers for Medicare and Medicaid Service National Correct Coding Initiative (NCCI);
h. International Classification of Diseases, Tenth Revision, Clinical Modification; and
i. Additional authoritative sources as indicated, which are specified in conjunction with findings.

Dates of Service Reviewed: Sample submitted by the Client and included 10 encounters from August 2022. Specific findings for each encounter reviewed may be found in the audit spreadsheet provided.

Encounter Type	Total Codes Audited	Reported Accurately	Not Reported Accurately			Accuracy Rate
			Lower Level Supported	Higher Level Supported	No EM Supported	
E/M Codes	10	6	4	0	0	60%
			Not Supported	Alternate Code Supported	Supported but Not Coded	
CPT/HCPCS Codes	9	9	0	0	0	100%

REVIEW OF FINDINGS

Evaluation and Management Documentation and Code Level Selection

Each encounter has been audited two ways. The first is by the traditional audit grid using 2021 E/M Documentation and Coding Guidelines. The second is to determine medical necessity. 2021 Documentation Guidelines confer with CMS Guidelines that medical necessity is the overarching criterion in code selection.

While the 2021 Documentation Guidelines along with the Expansion Guidelines permit leveling of E&M services with 2 of 3 MDM criteria, there is a rule noted on page 14 that states:

The evaluation and/or treatment should be consistent with the likely nature of the condition.

In other words, columns 2 and 3- the workup and treatment plan of the MDM should not out score the complexity of the presenting problem. By analyzing each encounter in this regard, we are ensuring that medical necessity is in balance.

The CMS Claims Processing Manual was NOT modified with the updated AMA Guidelines. The same previous statements regarding medical necessity exist as previous. *CMS Claims Processing Manual Publication 100-04, Chapter 12, Section 30.6.1* which states:

> "*Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.*"

MEDICAL NECESSITY FINDINGS OF THIS REVIEW:

Based on the records reviewed, the encounters that were down coded appeared to have been under-documented. The patient's medical necessity appeared to represent the level of service as reported by the provider, however the medical necessity as expressed through the risk of complications of treatment or considerations of patient management was identified in addition to the treatment plan. The inclusion of this information could have allowed these services to be supported the identified level of service.

Selection of E/M Service Based on Supporting Documentation and MDM

Four (4) encounters reviewed were coded as 99214/99204, but documentation supports a lower level 99213/99203. As documented, the encounter identified patients seen for follow up of chronic conditions and/or acute complaints (moderate column one) with treatment plans that include additional diagnostic testing such as rhythm monitoring and Transthoracic Echo tests (low column three). Combined, these levels of service support Low MDM and 99213/99203. Column 2 was not a variable in consideration. In cases reviewed, the provider is either/or receiving reimbursement for the testing or ordering the test which negates the ability to count within column 2.

Of note, there is also an option of billing based on time for visits that take an extended amount of time. However, keep in mind that separately reportable services must carved out of the total time reported by the physician, and only the physicians personal time qualifies. There must be a time qualification statement included within the documentation of the encounter that identifies the total time spent by the physician on the date of the encounter and additionally it should include a carve out statement of any separately reportable service time.

Post Audit Recommendations

Based on the findings of this compliance audit, the following suggestions should be recommended to the organization leadership team as a continued path toward documentation and compliance improvement:

1. Review these audit findings and feedback with the provider
2. Ensure proper understanding of medical necessity and 2021 Documentation Guidelines with the provider
3. Based on non-compliance rating, per organizational standards, re-audit in 3 months

2021 E/M Documentation and Coding Guidelines Reference Card

Elements of MDM:	Straightforward/Minimal Complexity Encounter	
	MDM Level Two New Patient: 99202 Est. Patient: 99212	Level of Service: Total Minutes Required
Nature of Presenting Problem(s)	Self–Limited OR Minor	New Patient 99202: 15-29 minutes
Data Reviewed/Analyzed	Minimal **OR** None	Established Patient 99212: 10-19 Minutes
Patient Management Risk	Examples Could Include (e.g. rest, gargle, elastic bandages)	Prolonged services not applicable If total time on date of encounter meets above ranges, codes are supported on time w/qualifying time statement

Elements of MDM:	Low Complexity Encounter	
	MDM Level Three New Patient: 99203 Est. Patient: 99213	Level of Service: Total Minutes Required
Nature of Presenting Problem(s)	1 Chronic; **OR** 1 Acute Uncomplicated 2+ self-limited or minor problems	New Patient: 99203: 30-44 Minutes
Data Reviewed/Analyzed	(2 of the following: Review external notes, Review Unique* Test, Order Unique* Test); **OR** Independent Historian	Established Patient 99213: 20-29 Minutes
Patient Management Risk	Examples Could Include: (e.g. OTC meds, physical therapy, minor procedure w/o risk factors)	Prolonged Services NOT Applicable If total time on date of encounter meets above ranges, codes are supported on time w/ qualifying time statement

Elements of MDM:	Moderate Complexity Encounter	
	MDM Level Four New Patient: 99204 Est. Patient: 99214	Level of Service: Total Minutes Required
Nature of Presenting Problem(s)	2+ Chronic Stable; **OR** 1 Chronic Exacerbated, **OR** 1 Acute Complicated **OR** 1 undiagnosed new problem /w uncertain prog; OR 1 acute illness /w systemic sx	New Patient 99204: 45-59 Minutes
Data Reviewed/Analyzed	Any 3 from the following: (Review external notes, Review Unique* Test, Order Unique* Test, Independent Historian); **OR** Independent Review & Interpretation of Test; **OR** Discussion w/another Provider	Established Patient 99214: 30-39 Minutes
Patient Management Risk	Examples Could Include: (e.g. RX meds, minor procedure /w risk, major procedure w/o risk, SDOH limiting care)	Prolonged Services NOT Applicable If total time on date of encounter meets above ranges, codes are supported on time w/ qualifying time statement

Elements of MDM:	High Complexity Encounter	
	MDM Level Five New Patient: 99205 Est. Patient: 99215	Level of Service: Total Minutes Required
Nature of Presenting Problem(s)	1 Chronic Severe Exacerbated, **OR** 1 Acute/ Chronic w/Threat to life/loss of bodily function	New Patient 99205: 60-74 Minutes 60-74 Minutes
Data Reviewed/Analyzed	**REQUIRES 2 OF 3 Options:** Review external notes, Review Unique* Test, Order Unique* Test, Independent Historian); **OR** Independent Interpretation of Test; **OR** Discussion w/another Provider	Established Patient 99215: 40-54 Minutes
Patient Management Risk	Examples Could Include: (e.g. high-risk medication, major surgery w/ risk factors, emergency surgery, DNR due to poor prognosis, decision regarding hospitalization)	Prolonged Services Add-on Codes Allowed per each additional 15 min: **Listed minutes below are the minimums* New Patient (99205, +G2212 **OR** 99205, +99417) Medicare (+G2212 x1): 89 min • CPT (+99417 x1): 75 min Establish Patient (99215, +G2212 **OR** 99215, +99417) Medicare (+G2212 x1): 69 min • CPT (+99417 x1): 55 min

Disclaimer

DoctorsManagement has conducted this audit at the request of the client. All information that was reviewed was chosen by the client and released under patient confidentiality to DoctorsManagement for collective review.
It is the job of an auditor to find deficiency within a practice and make them known to the providers in an effort to improve the current level of individual and corporate compliance. The findings of this audit are therefore deemed confidential between the client and DoctorsManagement.

The findings of this audit are specific only to the records that have been reviewed for the audit. It is possible for a practice to manipulate the information that is sent for the audit, and therefore, DoctorsManagement cannot be responsible for chart findings that were not audited.

DoctorsManagement performs Coding Audits based on the guidelines set forth by the 2021 E/M Documentation Guidelines and those rules set forth by CMS.

This audit has been performed in a manner that meets the necessary OIG Compliance Plan Standards. DoctorsManagement recommends that the practice incorporate these findings into the Compliance Plan currently in place.

An audit is a tool to be used by a practice to increase compliance. Not properly using this audit as a tool and making changes based on the recommendations will not ensure compliance. DoctorsManagement cannot be responsible for recommendations/findings that are reported and no corrective action is taken.

CMS mandates require that any identified instances of inappropriate coding/billing that are identified by a practice (regardless of the way in which it is identified), must have restoration to the CMS system. Failure to do so may be interpreted by CMS as a false claim.