E-BRIEF SERIES

Healthicity

7 Common Auditing Mistakes

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7 Common Auditing Mistakes

1

MISTAKE:
Forgetting To Check The Data:

One common error that coders and auditors make is not giving credit for amount and/or complexity of data reviewed/ordered in the Medical Decision Making component of an evaluation and management service.

SOLUTION:

Credit should be given for labs that are reviewed/ordered, X-rays reviewed/ordered, and/or injections of medication ordered. If history is obtained from someone other than the patient (caregiver, family member, etc) credit should be given. If the provider discussed the case with another provider (specialist, radiologist, etc) during the encounter, credit should be given. All of this data is important when calculating MDM.

2

MISTAKE:
Miscalculation of Exam patient risk:

Auditors sometimes perceive a lower MDM (medical decision making) complexity than the documentation supports, when the established problems are stable or improving. This is especially noticed in the inpatient setting. For example, a patient who is diagnosed with sepsis or acute respiratory failure, who also has hypertension, anemia, and diabetes, all being managed by the physician.

SOLUTION:

For a subsequent visit when the physician documents “some improvement,” it does not mean that the MDM is no longer high complexity. The patient still has sepsis or acute respiratory failure which places them at high risk. Even if all four established problems are improving, high complexity MDM is still supported based on the audit guidelines.

3

MISTAKE:
Diagnosis Codes (Audits):

Sometimes, auditors will not perceive a diagnosis as being supported if there is not an entry of some type stating the condition is specifically addressed at the visit.

SOLUTION:

The ICD-10 guidelines for outpatient services states “Code all documented conditions that coexist at the time of the encounter/ visit, and require or affect patient care treatment or management.” There are multiple conditions that impact other conditions so it’s appropriate for the physician to report all of the codes. A patient with multiple chronic conditions is at higher risk, and many conditions can impact treatment for other conditions. For example, a patient who presents with an open wound who also has diabetes, is at a higher risk due to slower healing and/or fluctuation of blood sugar levels. It is important for both diagnosis codes to be assigned because diabetes impacts the treatment for the wound. Another example is that the risk for stroke increases for patients with atrial fibrillation who also are diagnosed with history of congestive heart failure, hypertension, diabetes, previous stroke, or are 75 years old or older.

4

MISTAKE:
EMR Inconsistencies:

The advent of Electronic Medical Records has been both a blessing and a curse. It has decreased manual labor on the physician's part, who no longer need to document in a patient's chart by hand, but it can also create an inaccurate picture of the encounter due to inconsistencies, quirks in voice-recognition software, and contradictory information through use of templates that are not updated.

SOLUTION:

Auditors should tune in to look for errors such as a templated ROS being used for a patient with a head cold as the chief complaint but the ROS says "no congestion, no nasal drainage," and the exam says "boggy nasal turbinates." Or, if a female patient is being seen, make sure the assessment and plan doesn't say, "We will send HIM for xxx test," and vice versa. You'll be one step closer to becoming a valuable asset to your organization if you can point out these inconsistencies and strengthen your provider's documentation of the whole patient encounter.

5

MISTAKE:
Time-Based Coding:

Many times auditors see statements to the effect of "xx minutes spent face to face with the patient, greater than 50% of the time spent counseling and coordination of care"....and there it stops. It is all too easy to say, "That shows face-to-face time with the majority spent counseling," and move on through a compliance audit without stopping to look at the big picture.

SOLUTION:

Auditors must scrutinize documentation to determine if the provider is appropriately billing a time-based visit, as well as if the focus of the time-based documentation is present and justifies the medical necessity of the counseling-based service. A time-based visit may be excellently suited for outlining a cancer treatment plan following an undesirable biopsy report, when medication and survivability are being discussed, and the patient is not acutely ill. It may not be appropriate, however, for every single cancer treatment follow-up the patient receives, especially if there's marked improvement and/or no change in the patient's overall status. It would be inappropriate to allow time-based billing just because the provider's statement "checks all the boxes" but may not demonstrate the need for such a service.

6

MISTAKE:
Detailed Exam:

The CMS and CPT both describe the 1995 detailed examination as "an extended examination of the affected body area(s) and other symptomatic or related organ system(s)." Most Medicare Contractors (MACs) do not offer any additional explanation to what is considered a detailed exam. This vagueness often leads to confusion among auditors as well as providers. Additionally, auditors often neglect to check with their local MACs regarding the MAC's guidelines for the 1995 detailed exam.

SOLUTION:

Auditors should follow up with their MACs to find out specifically what constitutes for a detailed exam. In cases where local MACs don't offer any additional explanation that goes beyond CMS' definition, the best solution would be for the practices to establish practice-specific 1995 detailed examination guidelines. This will help with a consistent auditing process as well as provide consistent education to physicians to ensure documentation compliance.

7

MISTAKE:
Subjective interpretation of the coding guidelines for HPI elements OR Not using a clinical mindset when auditing the history component of an E/M:

One of the hardest areas in which auditors get a consensus is with the history of present illness (HPI) element of associated signs and symptoms. The controversy is whether or not a negative sign or symptom can be counted towards the EM leveling. Many auditors assume that because Associated Signs/Symptoms is defined as "other problems or symptoms that accompany the main symptom(s)," a negative symptom should not be counted towards the HPI but rather counted as a Review of Systems.

SOLUTION:

While it's good practice to follow this industry standard there are exceptions to the rule that can be made. Clinically, one can argue that the absence of a specific sign or symptom will provide as much information as it does if the sign or symptom were present. CMS has clarified that there are clinical exceptions when counting the elements for the History component of an E/M services. CMS states:

- For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area will be different for pregnant women and children.
- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf

As auditors, we need to look at a provider's documentation from a clinical perspective and allow exceptions for counting negative signs or symptoms when it makes sense. Ask yourself, is the negative statement pertinent to the reason for the visit? Would you be able to (without the doctor) defend or explain the clinical significance and importance of the negative or absence of a sign or symptom?

Palmetto GBA provides us with an excellent example of when to apply this exception to the rule:

> If a physician documents negative findings for the HPI, for example (subsequent hospital visit for CHF), provider states, 'Denies any SOB,' he/she may use this information under 'Associated Signs/Symptoms.'

http://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/JM%20Part%20B~EM%20Help%20Center~General%20Articles~History%20Component?open&Expand=1

AUTHOR BIO

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Lamon Willis is a healthcare professional with more than 20 years of experience in hospital and physician revenue cycle, practice management, compliance, coding, billing, and client services. He has been providing healthcare consulting and solution services to hospitals and physician organizations throughout the country.

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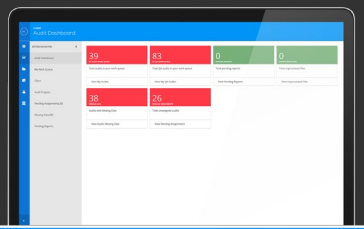

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