OPTUM360°

Five Minute Audits

Nichole VanHorn, CPC, CCS-P

Presentation disclaimer

All of the information provided is believed to be accurate and reliable; however, Optum360® assumes no responsibility for any errors. Optum360 is providing this information for educational purposes only and not as a replacement for professional judgment and experience; therefore any use of this information is at your sole risk and Optum360 neither assumes nor is responsible for its use.

Why Should I Audit?

Auditing physician charges and billing practices is a large task to undertake, but the results typically lead to:

- Efficient claims management processes
- Appropriate reimbursement
- Improved cash flow
- Compliance with payer rules and regulations

Why Should I Audit?

There are a number of performance components that can be measured in a chart audit, including:

- Provider and staff compliance with documentation requirements
- Provider and staff compliance with payer guidelines
- Adherence to practice policies

Practice Policies

- Develop written policies and procedures and distribute them to the clinical and administrative staff.
- Create a written compliance plan and educate all employees on its content.
- Provide coding and billing education to clinical staff on a regular basis (i.e., annual code and guideline changes).
- Provide access to current coding books and regulation manuals as references.
- Conduct periodic internal audits and document the results.
- Educate, educate, educate.

Ten Steps to Auditing

1. Determine who will perform the audit.
2. Define the scope of the audit.
3. Determine the type of audit to be performed and the areas to be reviewed.
4. Request necessary medical record, billing, and reporting documentation.
5. Assemble reference materials, such as current code books, transmittals, etc.
6. Develop customized data capture tools.
7. Develop a reporting mechanism for findings.
8. Determine recommendations and corrective actions.
9. Implement quality improvement initiatives.
10. Determine if corrective actions have resolved issues.

CERT Errors

Documentation and Coding Errors Identified by the CERT Program

- Missing/no documentation for the services provided
- Missing signature or illegible signature
- Medical record does not support medical necessity
- Medical record documentation received from a provider is insufficient to substantiate a claim
- Incorrect coding

CERT Errors

Part B Services (BETOS Codes)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Hospital visit - critical care	$214,936,291	20.9%	16.5% - 25.4%	5.8%	49.3%	0.0%	43.9%	1.0%	0.5%

www.cms.gov Research Statistics Data and Systems 2016 CERT Report

Critical Care Audits

Critical care, evaluation and management of the critically ill or critically injured patient (99291–99292)

These services are rendered for the care of a patient who has an illness or injury to one or more vital organ systems such that there is the high probability of imminent or life-threatening deterioration to the patient's condition. These services are based upon the time spent involved in activities directly related to the patient's care and need not be strictly spent at the bedside but rather on a patient's floor or unit.

2017 CPT

Clinician Documentation Tip

The Clinician documentation must indicate:

- The time spent providing the critical care services
- The procedures and services performed
- The nature of the condition requiring the service
- Note that critical care services that are not reported separately there are a number of procedures bundled into critical care services and, therefore, not reported separately.

Time

The guidelines for time in *CPT 2017* state: “A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and 60 minutes). A second hour is attained when a total of 91 minutes have elapsed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used.”

E/M Code	Patient Status	Physician Attendance	Time
99291	Critically ill or critically injured	Constant	First 30-74 minutes
99292	Critically ill or critically injured	Constant	Each additional 30 minutes beyond the first 74 minutes

Clinician Documentation Checklist

Clinician documentation should indicate the following:

- Identify illness or injury reason for encounter
- Type of vital organ failure:
  - Central nervous system failure
  - Circulatory failure
  - Shock
  - Renal
  - Hepatic
  - Metabolic
  - Respiratory

Procedures that are included in Critical Care

- 36000 Introduction of needle or intracatheter, vein
- 36410 Venipuncture, age 3 years or older, necessitating physician's skill or other QHCP(separate procedure), for diagnostic or therapeutic purposes
- 36415 Collection of venous blood by venipuncture
- 36591 Collection of blood specimen from a completely implantable venous access device
- 36600 Arterial puncture, withdrawal of blood for diagnosis
- 43752 Naso- or oro-gastric tube placement, requiring physician’s skill and fluoroscopic guidance
- 43753 Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill
- 71010-71020 Radiologic examination, chest
- 92953 Temporary transcutaneous pacing

2017 CPT

Procedures that are included in Critical Care

- 93561 -93562 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurements
- 94002 - 94004 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day/each subsequent day
- 94660 Continuous positive airway pressure ventilation (CPAP), initiation and management
- 94662 Continuous negative pressure ventilation (CNP), initiation and management
- 94760-94762 Noninvasive ear or pulse oximetry for oxygen saturation; single/multiple determinations/overnight
- 99090 Analysis of clinical data stored in computers (e.g., ECGs, blood pressures, hematologic data)

2017 CPT

Critical Care Audit Worksheet

Critical Care Worksheet

Patient's Name: _____ Patient's Medical Record Number: _____

Date of service: _____

Date of review: _____

Reviewer: _____

Type of review: ☐ Prepayment ☐ Postpayment

Reason for encounter: _____

Type of vital organ failure:

- ☐ central nervous system failure
- ☐ circulatory failure
- ☐ shock
- ☐ renal
- ☐ hepatic
- ☐ metabolic
- ☐ respiratory

Critical Care Audit Worksheet

Were any additional services documented? (This time is included in the total Critical Care time.)

- ☐ 36000 Introduction of needle or intracatheter, vein
- ☐ 36410 Venipuncture, age 3 years or older, necessitating physician's skill or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes
- ☐ 36415 Collection of venous blood by venipuncture
- ☐ 36591 Collection of blood specimen from a completely implantable venous access device
- ☐ 36600 Arterial puncture, withdrawal of blood for diagnosis
- ☐ 43752 Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance
- ☐ 43753 Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill (e.g., for gastrointestinal hemorrhage), including lavage if performed
- ☐ 71010 Radiologic examination, chest; single view, frontal
- ☐ 71015 Radiologic examination, chest, stereo, frontal
- ☐ 71020 Radiologic examination, chest, 2 views, frontal and lateral
- ☐ 92953 Temporary transcutaneous pacing
- ☐ 93561 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurements
- ☐ 93562 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output

Critical Care Audit Worksheet

- ☐ 94002 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day
- ☐ 94003 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day
- ☐ 94004 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day
- ☐ 94660 Continuous positive airway pressure ventilation (CPAP), initiation and management
- ☐ 94662 Continuous negative pressure ventilation (CNP), initiation and management
- ☐ 94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination
- ☐ 94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (e.g., during exercise)
- ☐ 94762 Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring
- ☐ 99090 Analysis of clinical data stored in computers (e.g., ECGs, blood pressures, hematologic data)

Critical Care Audit Worksheet

Time spent in Critical Care	Start Time	End Time	Total Time	Was provider in constant attendance when critical care was provided?	
				Yes ☐ No ☐ If no, critical care codes should not be reported.	
Code Assigned	Units	Code Documented	Units		Comments
99291					
99292					
Additional Procedures (not included in bundled list)	Code Assigned	Code Documented	Modifier Assigned	Modifier Documented	

Critical Care Audit Worksheet

Financial Impact				
Undercoding		Overcoding		
Code	Payment	Code	Payment	
				Total Impact on Claim

Endoscopy

Lower Endoscopy Auditing Tool

Patient's Name: _____ Patient's Medical Record Number:_____

Date of Service _____

Preoperative Diagnosis:_____

Procedure performed: _____

Findings:_____

Postoperative Diagnosis_____

□Diagnostic □Screening

Surgical with:

□ Removal of foreign body-Location _____ Substance injected:_____

□ With biopsy(ies) -Location _____ _____

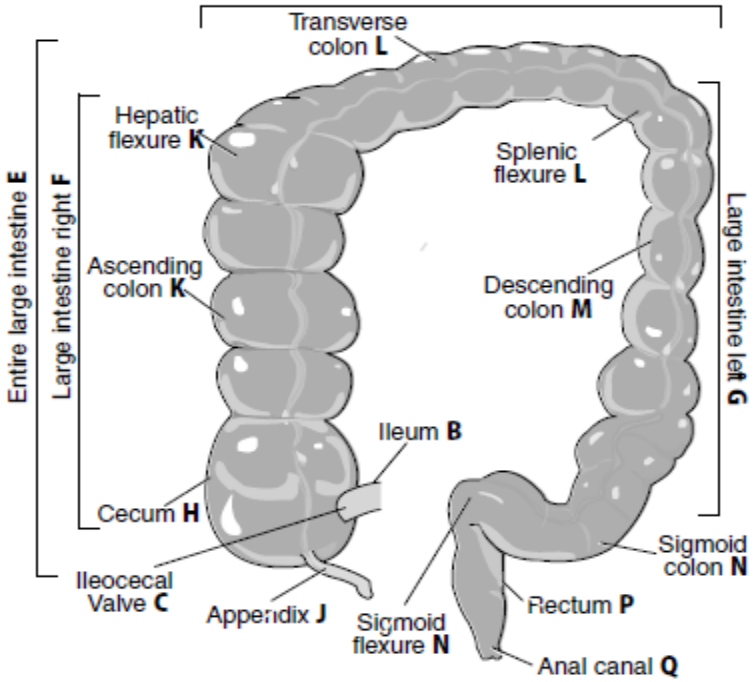
□ With directed submucosal injections -Location _____ _____

Endoscopy

Were any of the following performed:

- ☐ With control of bleeding (unrelated to surgical procedures)
- ☐ With removal of foreign body-Location _____
- ☐ With decompression of volvulus-Location _____
- ☐ With ablation of lesions at -Location _____
- ☐ With removal of lesion by:
  - ☐ Snare -Location _____
  - ☐ Hot biopsy -Location _____
  - ☐ Bipolar- Location _____
- ☐ Dilation by balloon - Location _____ size of balloon _____mm
- ☐ Stent Placement -Location _____
- ☐ Endoscopic ultrasound -Location _____
- ☐ Ultrasound guided intramural or transmural FNA/Bx -Location _____

Endoscopy



Endoscopy

Procedure	Code Assigned	Code Documented	Modifier Assigned	Modifier Documented	Comments

Number of Units	
Indicated on Claim	Documented

Financial Impact				
Undercoding		Overcoding		
Code	Payment	Code	Payment	
				Total Impact on Claim

After the Audit

Many practices develop excellent policies and procedures for auditing medical records, but fail to use the results of the audit. Before an audit can be considered complete, the practice should:

- Compile a complete report of audit findings
- Develop an executive summary
- Calculate potential risks to revenue or the practice
- Determine the root cause of the error
- Develop recommendations for a corrective action plan
- Implement an action plan
- Reevaluate the issue

After the Audit

An audit report should identify a number of factors:

- Number of records reviewed
- Number of potential coding errors
- What the errors were
- Financial impact of errors
- Extrapolated impact of errors
- Recommendations
- Corrective action plan including costs
- Implementation time frame
- Reevaluation date

Successful Audit

In the end, the following should be achieved:

- Provider and staff compliance with documentation requirements
- Provider and staff compliance with payer guidelines
- Adherence to office protocols
- Increased/correct revenue

Thank you.

Contact information:
Nichole VanHorn
CPC, CCS-P
tel: 612-632-2816