Common Issues Found in Audits

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Scope of This Course

- Frequent Findings on Audits
- Not Intended to Teach Coding
- Emphasize
  - Missing Documentation
  - Contradictory Documentation
- Point Out Common Misunderstandings
- Assist with conducting Internal Audits

Issues With Patient Histories

Chief Complaints/HPI

- Missing Patient Complaint or Condition Being Followed
  - “Re” “IOP” “Injection OD” “Here for F/Up”
- Brief Mention of Condition Buried in discussion about glasses, contacts, etc.
- “Off Cycle” Visit not Addressed

Chief Complaints/HPI

- Entries Troublesome
  - Elements erroneously counted by EHR
    - Example: CC: DME OS, HPI: Pt states no floaters, no flashes of bright light, no blurred vision, no pain
      - EHR counted – Location: Right; Quality: Blurred; Associated Symptoms: floaters flashes pain; Modifying Factors: Light
    - Example: CC: Pt states no visual symptoms OU. Referred by Dr. X for retinal eval. HPI: Pt states no floaters or flashes, no blurred vision, no pain.
      - EHR counted – Location OU; Quality: Blurred; Associated Symptoms: floaters, flashes, pain; Modifying Factors: Light.

Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.
Provider Requirements

- History of Present Illness Must Be Obtained by the Rendering Provider
  - Can be Dictated – Document as such
    - HPI Dictated by I.C. Well, MD
    - HPI Scribed Ida Wright, COA
- Mental Status Must be Observed & Documented by the Rendering Provider
  - Oriented to Person, Place & Time or not
  - Mood & Affect Appropriate or not

“Hop-Scotch” Visits

- Occurs with Multi-Physician Practice
  - Often Multi Sub-Specialty
    - Each physician addressing a different disease for the patient
      - Each with Different Follow-up Regimens
- Leads to “Off Cycle” Visits
  - Can impinge on Medical Necessity for any visit
    - If the date of the visit doesn’t match a return plan, there may be a scheduling error

“Hop-Scotch” Visits

- “Hopscotch” visit example
  - Diabetic Check – 9/5/2014 – RTC 1 yr
    - Due Back 9/5/2015 “ish”
  - POAG IOP – 12/18/14 – RTC 4 mos IOP✓
    - Due Back 4/18/15 “ish”
  - Cataract eval – 2/1/15 – RTC 1 yr or PRN
    - Due Back 2/1/16 “ish”
  - Patient presents 3/29/15 – CC: “I got a card”
    - Which follow-up is it?

Review of Systems

- All Systems Marked Negative Yet CC/HPI list symptoms
- Statement of “All Systems Negative” is Inadequate – Not Comprehensive
  - Must have Pertinent Positives/Negatives
    - Then can have “All Other Systems Normal”

Patient Medications

- Ophthalmic Medications
  - Prescribed but not Taken – Non-compliance
    - Example: Atropine 1% prescribed for Iridocyclitis. HPI indicates patient did not purchase. The physician didn’t see. Plan “continue A1%.”
  - Reduced Dosage in Plan – Not updated
    - Example: Taper regimen of corticosteroid. QIDx1wk, TIDx1wk, BIDx1 wk, QDx1 wk, QOD x 1wk then D/C. Seen week 3 but drops still documented at QID.

Patient Medications

- Ophthalmic Medications
  - Contradictory Plan
    - Example: Start XYZ drop – but patient has been taking for months
      - Example: 1. D/C XYZ drop 2. ERx XYZ drop.
    - Cataract Surgery Post-op Meds in 2013
      - Still Taking, Never Stopped
Issues With Exams

- Performance of All Elements
  - Regardless the Reason for the Exam
    - Main Culprits
      - Confrontation Visual Fields
      - Ocular Motility
      - Mental Status
    - Level of Exam Billed May Vary
      - Documentation is the same
    - Can Lead to Inflating the Service
      - 2 of 3 sections needed for EP E&M codes

Confrontation Visual Fields

- Inappropriate Documentation
  - “See Previous”
  - “See HVF”
- Performed “In Case the Doctor Needs Them”
  - He/She may want to bill a CEE
- Long History of VF Cuts
  - Now suddenly normal

CVF: Full to Finger Counting OU

But the Automated Visual Field Looks Like This...

Or This...

Exam Issues

- Contradictory findings
  - Optic Nerve both “Pale” and “Good Color” over multiple visits
  - Patient is pseudophakic but “Nucleus” & “Cortex” are “clear”
- Division of Exam Code Reasons
  - E&M Codes for Medical
  - Eye Codes Refractive
    - May be true for Commercial or Vision Plans

Exam Issues

- Billing an Exam once the Decision for Surgery has Been Made
- Disease Being Followed by Another Provider
  - This Doctor Seeing Patient for Same Disease
- New vs. Established Patient
  - New – Not seen in greater than 3 years
  - Controversial – OD to MD, Merged Practices
Exam Issues

• New Patient E&M Exams (99204 & 99205)
  – Comprehensive History (HPI, ROS, PFSH)
  – Comprehensive Exam (12 + Mental Status)
  – Medical Decision Making (Moderate/High)
  • Often Falls Short
    – Too Few Diagnosis & Management Options
    – Only the Table of Risk is Used
    – Assume Decision for Major Surgery is Enough

Cloned Documentation

• Cloned Documentation
  – Previous visit findings brought forward including typos & misspelling
• Pre-populating Fields
  – Load exam with pre-programmed findings
• Causes documentation to look dubious
  – Creates contradictions
  – Was the element actually performed
  – Makes it difficult to code

Comprehensive Eye Exams

• Billing CEE:
  – When w/Unilateral Exam – Patient is Bilateral
  – Recent CEE billed
    • Mixed Practice - OD bills CEE & Refers to MD for Medical &or Surgical Evaluation
  – Missing Key Elements
  – Missing Whole Sections
  – Assuming “Dilation = CEE”

Issues With Diagnoses/Assessment & Plans

Diagnoses

• Bilateral Disease on Exam Unilateral in the Assessment
• Disease in Assessment not supported by Exam findings
• No Longer Apply
• Listed as “New” when the disease is long-standing
• Disease Listed for an Eye Not Examined

Diagnoses

• Canned Assessments
• Glaucoma Type or Stage not Documented
• Parsing out individual diagnoses when one diagnosis code is appropriate
• Unspecified Diagnoses and/or Codes
  – Type, Disease Specifics are Documented
• All Diseases in the History of Patient Listed as if Addressed Today
## Plans

- “Start” medication patient has been taking
- Canned Plans
  - Include Counseling as if the Diagnosis was New even if it was Long-Standing
- D/C medication yet a Script is dispensed
- No indication when or why the patient is to return
- Missing Altogether

## Issues With Procedures

## Minor Procedures

- Missing
  - Consents
  - Procedure Details
    - Lot numbers
    - Injection placement
    - Instrumentation
  - “Operative Notes”
  - Patient Complaints
    - Benign Lid lesions
    - Trichiasis

## Modifier -25

- Not the Decision for the Minor Surgery
- Does Not Need another Diagnosis Code
  - Can Make it Clearer to Apply
- May Apply if:
  - Patient has new problem that is addressed
  - More time has passed than anticipated
  - Off cycle visit
  - Patient has no History of Problem
    - Could be a number of Diseases

## Major Procedures

- Missing…
  - Consents in the Clinic Chart
  - Operative Notes in the Clinic Chart
  - Lifestyle Impairments
  - Surgeon Signature
- Canned Operative Notes
- Inadequate ADL Questionnaires
- Glare Testing Problems
  - Light Level, w/BC not CC

## Major Procedures

- Objective Findings Don’t Support Medical Necessity
  - Lens(es) are Not Described
  - BCVA significantly improves with MR
- Complex Cataract Surgery
  - Lacks Chart Documentation for Justification
  - Details of What Made it Complex in Op-Note
    - Pupil expansion, iris support, dyes for staining
    - Not Concurrent vitrectomy, lost nucleus, broken capsule
**Blepharoplasties**

- External Photos noted
  - Canthus to Canthus or From the side
    - Appropriate to bill?
- Some LCDs have eliminated VF requirement
  - Recommend still perform
    - Appropriate to bill?
- Some Contractors 100% Pre-Payment Review

**Blepharoplasties**

- Billing Patient for Bundled Procedure
- Lack of Supporting Objective Findings
  - Examples: Palpebral fissures, MRD, Levator Function, Herring’s Test, etc.
- Operative Note Incomplete/Inadequate
  - Gives details of the 1st eye, nothing on left
    - All Verbiage is “singular” but which eye?
- Operative note describes different surgery than what was billed

**Co-Management**

- Missing
  - Consent
    - Which Eye is Being Consented
  - Transfer Date
  - Post-Operative Progress from Co-Managing Doctor
- Surgeons Not Billing His/Her Portion of Post-Operative Care

**Issues With the ASC**

- Conditions for Coverage
  - Patient Bill of Rights
    - Provided to patient once before 1st surgery
- Anesthesia for reconstructive procedures of eyelid 00103
  - Out of sequence – 00140 – is unspecified

**ASC**

- Conditions for Coverage
  - H&P
    - Brief H&P
    - Too Old
      - Who performed H&P is not clear
  - No Admit Time
  - Unclear Re-Assessment
  - Inadequate Discharge
  - Person Accompanying Patient not Clear

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results@roseandassociates.com
### Issues With Diagnostic Tests

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Order</strong></td>
<td>- Missing Altogether</td>
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<tr>
<td></td>
<td>- Incomplete</td>
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<td></td>
<td>- Lacks Indication, Specifics of Test</td>
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<td>- Ordering Provider is Treating Provider</td>
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<td></td>
<td>- Orders in Previous Plan not Performed</td>
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<td></td>
<td>- Lost Revenue</td>
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<tr>
<td></td>
<td>- Patient Care Schedule Disrupted</td>
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<tr>
<td><strong>Physician Interpretation</strong></td>
<td>- Missing Altogether</td>
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<tr>
<td></td>
<td>- Embedded within the Assessment/Plan</td>
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<td></td>
<td>- Only Measurements Found</td>
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<td></td>
<td>- “Normal”</td>
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<tr>
<td></td>
<td>- “WNL”</td>
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<tr>
<td></td>
<td>- “Baseline”</td>
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<td></td>
<td>- “Bad Test”</td>
</tr>
<tr>
<td></td>
<td>- No Impact of Test on Treatment</td>
</tr>
<tr>
<td><strong>Fundus Photos</strong></td>
<td>- Diagnosis is Glaucoma</td>
</tr>
<tr>
<td></td>
<td>- Fundus photos are centered on Macula</td>
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<td></td>
<td>- Both fundus photos &amp; macular SCODI were ordered but fundus photos billed</td>
</tr>
<tr>
<td></td>
<td>- Poor quality – blurred or artifacts</td>
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<tr>
<td></td>
<td>- Interpretation reiterates what was already seen on exam</td>
</tr>
<tr>
<td><strong>Extended Ophthalmoscopy</strong></td>
<td>- Pre-Drawn Anatomy</td>
</tr>
<tr>
<td></td>
<td>- No Labels</td>
</tr>
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<td></td>
<td>- Indiscriminate Marks</td>
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<tr>
<td></td>
<td>- Difficult to Find in EHR</td>
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<td></td>
<td>- Description is Nothing More Than What was Found on Ophthalmoscopy as Part of the Exam</td>
</tr>
<tr>
<td><strong>Angiography</strong></td>
<td>- Simultaneous FA &amp; ICG</td>
</tr>
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<td></td>
<td>- Bullous Injection – Dual Dye Injection</td>
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<td></td>
<td>- Camera with Dual Filter Function</td>
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<td></td>
<td>- Interpretation for FA</td>
</tr>
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<td></td>
<td>- “Suspect PED, Get ICG”</td>
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<tr>
<td></td>
<td>- Bilateral Test, Disease Unilateral</td>
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</tbody>
</table>
Axial Length Biometry

- A-Scan (76519) & IOL Master (92136)
  - Bilateral technical component
    - At times billed twice
  - Unilateral professional component
    - At times billing is missed
  - IOL Master ordered, A-Scan performed
  - IOL Calculation is found, No Scan
    - No Technical Component Documented

SCODI & Visual Fields

- Glaucoma Testing
  - Medicare expects
    - SCODI in mild to moderate stages
    - Visual Fields in moderate to late stages
  - Should Not be Performed on Same Day

Visual Fields

- Lid Fields
  - Taped & Untaped – single stimulus – 92081
    - Not 92082
- Macular Fields
  - Full Threshold – 92083
    - Not 92082

Dry Eye Testing & Treatment

- Testing
  - Osmolarity Testing
  - Meibography
  - Basic Tear Testing
  - Interferometry
- Treatment
  - Punctal Plugs
  - Meibomian Gland Expression
  - Medications

VEPs & ERGs

- Visual Evoked Potential – Tests the Brain’s Response to Repetitive External Stimuli
  - Can Explain Visual Loss not Otherwise Known
  - Being used for Glaucoma
- Electroretinograms – Tests the Function of the Retina to External Stimuli
  - Being used for Glaucoma
    - Early Detection
<table>
<thead>
<tr>
<th>Storage of Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Not found</td>
</tr>
<tr>
<td>• Inconsistently filed</td>
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<tr>
<td>– File Date Different from Date of Service</td>
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<tr>
<td>– Different Files or Sections Across Patients</td>
</tr>
<tr>
<td>• Filed under wrong name</td>
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<tr>
<td>• If stored on instrument, not documented</td>
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</tbody>
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<thead>
<tr>
<th>Refractions</th>
</tr>
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<tbody>
<tr>
<td>• Not Covered by Medicare – Bill Patient</td>
</tr>
<tr>
<td>– Frequently Missed Charge</td>
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<tr>
<td>• Inconsistent within a practice</td>
</tr>
<tr>
<td>• Can be billed in Post-op Period or Anytime</td>
</tr>
<tr>
<td>– Recommend Billing When a Glasses Prescription is Dispensed to the Patient</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Issues With Miscellaneous Forms</th>
</tr>
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<tbody>
<tr>
<td>• Missing…</td>
</tr>
<tr>
<td>– Patient's Printed Name</td>
</tr>
<tr>
<td>– HIC Number</td>
</tr>
<tr>
<td>– Secondary Insurance/Medigap</td>
</tr>
<tr>
<td>– Signatures</td>
</tr>
<tr>
<td>– Dates</td>
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<tr>
<td>– Altogether</td>
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<tr>
<th>Assignment/Medicare Benefits</th>
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<tbody>
<tr>
<td>• Hard to Find</td>
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<tr>
<td>• Inadequate Language</td>
</tr>
<tr>
<td>• Out of Date</td>
</tr>
<tr>
<td>– CMS</td>
</tr>
<tr>
<td>– Practice details</td>
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<tr>
<td>– New Providers</td>
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<tr>
<td>– Providers No Longer</td>
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<thead>
<tr>
<th>Other Forms</th>
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<tbody>
<tr>
<td>• Missing Patient Identity on All Pages</td>
</tr>
<tr>
<td>– Of the Consent</td>
</tr>
<tr>
<td>– ADL Questionnaire</td>
</tr>
<tr>
<td>• Practice Templates/Canned Notes</td>
</tr>
<tr>
<td>– Missing New Providers</td>
</tr>
<tr>
<td>– Include Providers No Longer Part of Practice</td>
</tr>
<tr>
<td>• Practice Designed Forms</td>
</tr>
<tr>
<td>– Designates Spots Left Blank</td>
</tr>
<tr>
<td>– Missing Important Information</td>
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<table>
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<tr>
<th>Rendering Provider</th>
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<tbody>
<tr>
<td>• Billing Under Other Provider Number</td>
</tr>
<tr>
<td>– Optometrists Billing Under Ophthalmologist</td>
</tr>
<tr>
<td>– MDs &quot;sign off&quot; on PA's Services</td>
</tr>
<tr>
<td>– Non-Credentialled Doctors Billing Under Credentialled Doctor</td>
</tr>
<tr>
<td>• Surgery Performed without Surgeon Exam</td>
</tr>
<tr>
<td>– All Pre-operative exam/work Performed by OD</td>
</tr>
</tbody>
</table>
Interesting Chart Entries

Interesting Entries

• Documentation not for Support Staff
  – CVF: “Progressive Field Loss”
• Documentation that is non-descript
  – Lids: “Normal for Age”

Medical Record

• The Basis For Proper Billing
  – Is the Documentation…
    • Accurate?
    • A Representation of What Was Really Performed?
    • Medically Necessary for the Reason for the Visit?
• A Legal Document
  – Is the Documentation…
    • Accurate?
    • Believable?
    • Specific to That Patient?

Questions