SouthEast Eye Regional Meeting

Presents:

Why & How to Set Up a Medical Record Review Program

Presented By:

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July 26, 2013
Destin, Florida
Chart reviews - Why you should consider it

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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

What are “they” looking at?

- OIG issues
  - Modifier 25
  - Drug Inventory
  - DMEPOS
- RAC issues
  - POS errors
  - New vs Est. patient
  - Global surgery rules
- Other observations
  - HPI attestation
  - Diagnostic Test requirements

Targets for Scrutiny 2013 OIG Work Plan

- Place of Service Errors
- Use of Modifiers During Global Surgery Periods
- E/M Services Inappropriate Payments
- Error-Prone providers
- Payments for drugs
- Incident-To Services
- Ambulatory Surgical Centers – Payment System
- Incentive Payments for Electronic Health Records

OIG Work Plans (2011 – 2013)

<table>
<thead>
<tr>
<th>Issue</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<tr>
<td>Place of Service errors</td>
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<td>Payment for Drugs (Lucentis/Avastin)</td>
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<td>DME Claims</td>
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Source: HHS OIG FY 2013 Work Plan

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Slides2013/072613_KAM_SouthEast Eye Regional Meeting
Billing Office Visit with Minor Procedure

“Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status.”

Source: Medicare Claims Processing Manual, Chapter 12, §40.1C

Modifier 25 Controversy

• 2005 OIG Report stated 35% of 2002 claims with modifier 25 did not meet the requirements
• 2001 – 2007 – Utilization of modifier 25 for ophthalmology was approximately 6.5% annually
• 2008 utilization of modifier 25 increased to 8.7%


Discarded Drugs and Biologicals

Recent Questions:

• The vial contains more drug than necessary to treat a single patient. What about the overfill?
• Is each dose reimbursable at $1,961?

Aflibercept (Eylea)

First Coast Service Options – FL Medicare (3/21/12)

Payment for Eylea is for the entire content of the single-use vial, which is labeled as providing a 2 mg dose of aflibercept. Each vial should only be used for the treatment of a single eye. If the contralateral eye requires treatment, a new vial must be used and the sterile field, syringe, gloves, drapes, eyelid speculum, filter, and injection needles must be changed before Eylea is administered to the other eye. After injection, any unused product must be discarded.


Discarded Drugs and Biologicals

“The CMS encourages physicians, hospitals and other providers and suppliers to care for and administer to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner. When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.”

Source: MCPM 17 §40 Discarded Drugs and Biologicals

ASP Payment Determination

(i) CMS calculates an average sales price payment limit based on the amount of product included in a vial or other container as reflected on the FDA-approved label.
(ii) Additional product contained in the vial or other container does not represent a cost to providers and is not incorporated into the ASP payment limit.
(iii) No payment is made for amounts of product in excess of that reflected on the FDA-approved label.

Source: 42 Code of Federal Regulations Chapter IV §414.904(a)(3)
Managing Overfill

“Any excess product (that is, overfill) is provided without charge to the provider. In accordance with our current policy as explained above, providers may not bill Medicare for overfill harvested from single use containers, including overfill amounts pooled from more than one container, because that overfill does not represent a cost to the provider. Claims for drugs and biologicals that do not represent a cost to the provider are not reimbursable, and providers who submit such claims may be subject to scrutiny and follow up action by CMS, its contractors, and OIG.”


Dr. Outlier

In early 2012, Dr. Outlier received letter from the PSC comparing his payments for Lucentis to his purchases of the drug. The PSC found a discrepancy of several hundred vials that were charged to Medicare, but without a record of a purchase.

• PSC instructed Dr. Outlier to complete a self audit and send to PSC
• Make any self-disclosures that are necessary
• Refund any overpayments

Create Inventory Tracking System

- Serial number each vial
- Create labels
  - Manufacturer’s invoice
  - Patient chart
  - Injection log book
  - Superbill and practice management system

Post-Cataract Eye Glasses

Common Billing Errors

- Wrong date of service
- Wrong place of service
- Wrong HCPCS code
- Wrong copayment
- Balance billing violations
- Failure to collect for non-covered items
- Failure to get forms signed
- Failure to get proof of delivery
- Misuse of modifiers

What are “they” looking at?

- OIG issues
  - Modifier 25
  - Drug Inventory
  - DMEPOS
- RAC issues
  - POS errors
  - New vs Est. patient
  - Global surgery rules
- Other Issues
  - HPI attestation
  - Diagnostic Test requirements

Recovery Audit Contractors

- Diversified Collection Services, Inc. of Livermore, California, in Region A, working in CT, DE, DC, ME, MA, NH, NJ, NY, PA, RI, and VT.
- CGI Technologies and Solutions, Inc. of Fairfax, Virginia, in Region B, working in MN, WI, MI, OH, IN, IL, KY.
- HealthDataInsights, Inc. of Las Vegas, Nevada, in Region D, working in AL, AZ, CA, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, and Guam, American Samoa, Northern Marianas.

Source: CMS website
RAC Issues

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<th>CGI</th>
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<td>Services during global periods</td>
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<td>Visudyne used w/o FA or ICG testing</td>
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Source: RAC websites

Place of Service Error

- The purpose of this automated edit is to ensure that the physician is reporting the correct place of service when services are rendered in a facility entity.
- ... when physicians perform these services in facility settings such as an Ambulatory Surgical Center (ASC), Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate. An improper payment exists when physicians bill certain services with the incorrect place of service.

Source: http://racb.cgi.com/Issues.aspx

POS 11 vs POS 24

- Multispecialty ophthalmic practice with a clinic and ASC. Nine surgeons each received a letter from the CERT. The letter stated that there appears to be some POS errors.
  - Each letter provided 5 to 10 examples that were believed to be POS errors
  - All were laser procedures
  - Asked practice to review the claims listed and to do a 3 year look back at all ASC claims for POS errors
  - Instructed practice to complete this review within 60 days and refund any overpayments

POS 11 vs POS 24

- Practice hired an outside firm to do the 3 year review. The findings were:
  - POS was defaulted with last PM conversion. Never customized for claim/provider.
  - Laser procedures were routinely billed as being done in clinic POS 11 when performed in ASC (POS 24)
  - 3 year look back resulted in ≈ 750 claims that were billed with wrong place of service
  - Services included: 65855, 66761, 66821, 67228, 67210, 67145
  - Refund of ≈ $30K

POS Financial Impact

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Source: 2012 MPFS national rates
New Patient

• Medicare interprets the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. New patient CPT codes are only payable for beneficiaries without office based face-to-face services in the previous 3 years.

Sources: www.connolly.com/healthcare/pages/ApprovedIssues.aspx
http://racinfo.healthdatainsights.com/Public1/NewIssues.aspx

New vs. Established

• Multispecialty ophthalmic practice with 2 retinal surgeons. All providers under one tax ID, operating as a group practice.
• RAC writes Dr. Retina
  • Billing new patient exams for established patients for same specialty in a group practice
  • Ophthalmologists = Specialty 18
  • Overpayment demand < $5,000
  • Dr. Retina indicated all patients billed as “new”

New vs. Established

• Alternatives for the practice
  • Defend position until bitter end
  • Write check and hope it goes away
• Sets a precedent; these are not new patients
• Cope with many more encounters with overpayments; make refunds
• Final election
  • Write the check
  • Stop billing internal referrals as new
  • Refund past 3 years as a voluntary self-disclosure
  • Fix specialty designation

Dr. Outlier

• In April, Dr. Retina receives letter from CMS stating he is an outlier for new patient office visits
  • 98.3% of all new patients billed as 99204
  • Detailed letter with very specific statistics (not a form letter)
  • Letter shows typical patterns
  • Recommends reviewing E/M guidelines
• Does nothing
  • No response
  • No internal review
  • No education

Dr. Outlier

• December 1, Dr. Retina receives another letter from CMS stating: we informed you in April that you were an outlier, your utilization pattern has not changed, therefore we are now placing you on prepayment review for new patient E/M coding.
  • 20 – 40 charts
  • Request documentation after claim is chosen
  • 30 day to submit
  • Threshold <34% error rate

Global Surgery Package

• Procedures with MPFS global days values of 000 include only E&M services rendered on the day of the surgery. Procedures with 010 global days include E&M services on the day of the procedure and up to 10 post-operative days. Procedures with 090 global days include E&M services the day before, the day of the procedure and up to 90 post-operative days. Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (Unrelated Evaluation and Management Service By Same Physician During Post-operative Period), 25 (Significant Evaluation and Management Service By Same Physician On Date of Global Procedure) and 57 (Decision For Surgery Made Within Global Surgical Period) on the E&M service.

Source: http://racinfo.healthdatinsights.com/Public1/NewIssues.aspx
Postoperative Complications

Medicare global surgical package does not include:
“Treatment for postoperative complications which require a return trip to the operating room (OR)”

Source: MCPM Ch 12 §40.1B

Group Practice

Physicians in Group Practice
“When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing physician.”

Source: MCPM Ch 12 §40.2A2

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History

History of Present Illness
“The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present.”

Source: 1997 E/M Documentation Guidelines (DG)

Illustrative Chart Note

CC: Vision OK
HPI: Cataracts

What's wrong?

Billed: Medical Plan
Code: 99214
Dx: 366.16 (Nuclear cataracts)

History

History of Present Illness

- History of Present Illness (HPI)
  - Location
  - Quality
  - Severity
  - Modifying factors
  - Timing
  - Context
  - Duration
  - Associated signs and symptoms
Better Chart Note

CC: 6 mo cataract check per Dr. A

HPI: Cataracts OU \( \times 2 \) yrs, VA fluctuates for last 6 mos, current glasses no help, worse @ night, difficulty with reading

Billed: Medical Plan
Code: 99214
Dx: 366.16 (Nuclear cataracts)

History of Present Illness

- Elements of HPI must be performed by the physician in order to be counted for E/M coding
  - Consultations (9924x, 9925x)
  - Office visits (9920x, 9921x)
  - Hospital and nursing home visits (9922x, 9923x, 993xx)

- Chart notes may be dictated to a scribe

- Use an attestation:
  - Performed by Dr. I. M. Better and scribed by Sally Scribe

Source: CMS, WPS (10/06), Palmetto (3/07), Noridian (5/07)

Chart Documentation

**History of Present Illness**

CC

HPI

Performed by scribed by

Summary

- Monitor targeted areas of scrutiny by payers
- Develop process to ensure correct POS for all procedures
- Watch new vs established patients
- Review global surgery rules and modifiers
- Strengthen HPI
- Create system to complete test interpretations
- Review EMR entries for authenticity and usefulness
- Compliance plan, periodic review, ongoing training

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

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 reviewer(s)
- Post-payment or pre-payment
- Review several components
  - Medical Records
    - Exams, tests, op-notes, correspondence
  - Financial Records
  - Forms
  - Consents, waivers, registration
  - 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(s) 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 (homework)
  - Bulletins, transmittals and notices
  - Manuals including all current regulations
  - Statutes
- Fee schedules
- Checklists

Getting Started

- Statutes
- Fee schedules
- Checklists

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

<table>
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<tr>
<th>Overbilling</th>
<th>Underbilling</th>
<th>Other errors</th>
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<td>Overbilling</td>
<td>Downcode LOS</td>
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<td>Upcode LOS</td>
<td>Wrong CPT (high)</td>
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<td>Poor documentation</td>
<td>Missed charges</td>
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<td>Missing entries</td>
<td>Bilateral or multiple procedures</td>
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<td>Patient responsibility</td>
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### 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

Checklists

- 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

Spreadsheet

- Name
- POS
- DOS
- ID #
- Code chosen
- Modifier

- Code should be
- Modifier
- Dollar impact
- Comments
- Provider
Spreadsheet

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Set Alpha Scores

- A – OK
- B – Date Error
- C – Missed Charge
- D – Wrong Code
- E – Modifier
- F – Undercharge
- G – Over charge
- H – No documentation
- I – Poor Documentation
- J – Fragmentation
- K – Diagnosis
- L – Medical necessity
- P – No complaint
- S – Not signed

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

Common Audit Areas

- Office Visits
- EMR Entries
- Diagnostic testing
- Modifier 25
- Medical necessity for surgical procedures
### 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 claim supported?  Yes, 92004 was performed  
Should other codes have been billed?  92015-refraction

### Auditor Score For This Entry

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| 92014 | Billed to wrong payer; s/b patient pay  
Documentation supports the code, but this level may be challenged for blepharitis |
| 92015 | Missed charge |

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### Patient #2

**CC:** Eye injury, emergency

**HPI:** Lid laceration, today, struck by post, headache (obtained by MD)

**DX:** Inferior canalicular laceration, globe intact

**Tx:** Repair in OR today

**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?

---

**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 only for chart documentation

---

**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

---

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**Patient #2 – With A Twist**

**CC:** Eye injury, emergency

**HPI:** Lid laceration 1, today 1, struck by post, headache 2

(MD 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
### History
#### 3 of 3 Key Components

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| PF    | EPF    | DETAILED | COMPREHENSIVE |

### New Patient Office Visit
#### 3 of 3 Key Components

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### 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

### Common Audit Areas
- Office Visits
- EMR Entries
- Diagnostic testing
- Modifier 25
- Medical necessity for surgical procedures

### Target for Scrutiny
**E/M: Potentially Inappropriate Payments**

“We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported.”

*Source: HHS OIG FY 2013 Work Plan*

### Problematic Chief Complaints
**Examples**

- “Decreased vision in both ears”
- “Patient complains, no complaints”
- “Diabetes in both eyes 4 years”
- “Borderline diabetes, it affects vision, not affected”
- “IOL eval in both eyes for one year”

© 2013 Corcoran Consulting Group (800) 399-6565 www.corcorancsg.com
Slides2013\07\2613_KAM_SouthEast Eye Regional Meeting
EMR “hic-ups”

- 53 year old female complains of growth in left eye for 1 year. The timing is described as constant.

- 66 year old female presented for evaluation of existing condition, ARMD. Timing is described as all the time. Severity is described as unknown.

- 66 year old male presented for evaluation of existing condition, lattice degeneration in both eyes for a few years. The timing is described as constant. Severity is described as faint.

EMR “hic-ups”

- 65 year old male presented for evaluation of existing condition, GLAUCOMA in both eyes for several years. The timing is described as all the time. Quality is fixed. Relief is experienced from using drops as directed. Patient described the following signs and symptoms: none currently to report.

- 66 year old male complains of blur at near in both eyes. The timing is described as all the time. Quality is unchanging. Context is reported without glasses.

Problematic Exam Documentation Examples

- CVF – fixes and follows OU – patient is monocular
- Lens – “clear OD” – patient is scheduled for cataract surgery OD
- External / lids – “WNL OS” – Procedure note for epilation of lashes LLL
- SLE – blank – impression indicates corneal ulcer OD
- VA = 20/20 OS – Patient had enucleation OS 3 mos. prior

Problems from Copy-Paste

- Integrity of record questioned – misrepresentation
- Confusion from nonsensical language
- Note bloat
- Difficulty identifying relevant information
- HIPAA violation where information copied from one patient record to another
- Copying prior records that contain errors
- Potential patient care issues
- Possible malpractice concerns

Living with Copy-Paste

- Minimize use
- Employ alternative approaches
  - Drop down menus
  - Pick lists
- Edit copied notations with new information
- Verify every copied notation and “click it”

EMR Concerns

We’ve always heard:

“If it wasn’t documented, it wasn’t done”

With EMR, there is concern that:

“If it was documented, doesn’t guarantee it was done”
Common Audit Areas

- Office Visits
- EMR Entries
- Diagnostic testing
- Modifier 25
- Medical necessity for surgical procedures

Audit Considerations - Tests

- Review tests for completeness and appropriateness
- Common documentation errors
  - Missing order
  - Missing or incomplete interpretation
- Common billing errors
  - Unilateral vs bilateral
  - Bundles
  - Assigning wrong diagnosis code to service.
- Hints to improve chart documentation
  - Template for interpretation to serve as report
  - Technician instructions
  - Monitoring activities

Interpretation & Report

"Carriers generally distinguish between an ‘interpretation and report’ of an x-ray or an EKG procedure and a ‘review’ of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete written report similar to that which would be prepared by a specialist in the field does not meet the conditions for separate payment of the service. This is because the review is already included in the … E/M payment."

Source: CMS MCPE Chapter 13, §100

Interpretation & Report

"For example, a notation in the medical records saying ‘fx tibia’ or ‘EKG-normal’ would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An ‘interpretation and report’ should address the findings, relevant clinical issues, and comparative data (when available)."

Source: CMS MCPE Chapter 13, §100

Chart Documentation

Diagnostic Test Interpretation

- Physician’s order
- Date performed
- Technician’s initials
- Reliability of the test
- Patient cooperation
- Test findings
- Assessment, diagnosis
- Impact on treatment, prognosis
- Physician’s signature

Chart Documentation

Diagnostic Test Interpretation

- Physician’s order – Why is the test desired?
- Date performed – When was it performed?
- Technician’s initials – Who did it?
- Reliability of the test – Was the test of any value?
- Patient cooperation – Was the patient at fault?
- Test findings – What are the results of the test?
- Assessment, diagnosis – What do the results mean?
- Impact on treatment, prognosis – What’s next?
- Physician’s signature – Who is the physician?
Visual Field Interpretation

• Plan: Threshold perimetry to re-evaluate POAG
• October 10, 2012
• Mary Smith, COA
• 1 false positive
• Good patient cooperation
• Arcuate scotoma, OU
• POAG, shows progression since last visit
• Add another anti-glaucoma medication

Illustrative Test Interpretation

TEST: Visual Field Humphrey 24-2
Interpretation: Stable VF
Dx: POAG

What's wrong?

Illustrative Test Interpretation

TEST: Visual Field Humphrey 24-2
Interpretation: Enlarged blind spot OD. No change from previous visual field 6 months ago. Continue current treatment.
Dx: POAG

Improved Interpretation

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Illustrative Test Interpretation

TEST: Optic nerve OCT
Interpretation: Normal
Dx: POAG

What's wrong?
Illustrative Test Interpretation

TEST: Optic nerve OCT

Interpretation: Normal

Why was test done? Observations? Data?

Dx: POAG

OCT for POAG. No retinal nerve fiber layer loss or changes at this time. No treatment indicated.

Dx: POAG

Improved Interpretation

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Illustrative Test Interpretation

TEST: Optic nerve OCT

Interpretation: Normal

Why was test done? Observations? Data?

Dx: POAG

Why was test done?

Observations?

Data?

Dx: POAG

Improved Interpretation

Illustrative Test Interpretation

TEST: Optic nerve OCT

Interpretation: OCT for POAG. No retinal nerve fiber layer loss or changes at this time. No treatment indicated.

Dx: POAG

Interpretation & Report

You review a visual field with a note that states “POAG”. Other than the physician’s signature, there are no other notations. Is this sufficient to support an “interpretation and report”?  
a) Yes  
b) No

Medicare Test Policy

42 CFR §410.32 Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

(a) Ordering diagnostic tests. All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary’s specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary.

Diagnostic Test Order

- Tests are ordered by the physician for a medically appropriate reason, generally after the eye exam
- Technicians cannot order tests
- Order may be scribed by staff on physician’s direction
  - “VF for COAG next visit per Dr. Smith”
- Standing orders pose challenges. They may be screening and not covered. When not individualized, they might not be reimbursed.
Testing During Postop Period

- Services not included in the global surgery package:
  - Diagnostic tests and procedures, including diagnostic radiological procedures
- Examples:
  - Testing unrelated to the prior surgery
  - Testing to evaluate an unfortunate outcome
  - Testing to prepare for another surgery
- Not covered: testing to confirm the expected outcome

Source: MPCM, Chapter 12, §40.1B

Testing Following Surgery

You review a note showing a VF performed two months after cataract surgery for pre-existing COAG. Which of the following is true?

a) Testing within postop period is not separately reimbursed
b) Tests are not part of the global surgery package
c) Only the technical component of a test is billable during postop – not the interpretation
d) Testing must be delayed until after the postop period

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Coverage Policies Vary

- Medicare's policies are not universal
- Local policies differ from place to place
- Policies change from time to time
- Basis for coverage vary
- IMPORTANT: Monitor payers’ websites frequently

Noncovered Tests

- For an indication not in the coverage policy
- Screening
- Prophylactic
- Refractive
- Investigational or experimental

Testing for Suspected Condition

In your review, you note a test ordered to assess whether a suspected condition is present or not. It was not; the patient is normal. How should the claim have been handled?

a) No charge the test
b) Bill the patient for a noncovered service
c) Berate the technician who didn’t obtain a signed ABN
d) Bill the test to the payer using the ICD-9 for the suspected condition
Common Audit Areas

- Office Visits
- EMR Entries
- Diagnostic testing
- Modifier 25
- Medical necessity for surgical procedures

Office Visit & Minor Procedure

"CPT Modifier 25 – Significant Evaluation and Management Service By Same Physician On Date of Global Procedure
Pay for an evaluation and management service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable evaluation and management service that is above and beyond the pre- and post-operative work of the procedure."

Source: MCPM, Chapter 12, §40.2.A8

Office Visit & Minor Procedure

“Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery
...where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.”

Source: MCPM, Chapter 12, §40.2A4

Nov 2012 AAO Coding Bulletin

“A frequently asked question is: Isn’t modifier -25 associated with minor procedures in the same way that modifier -57 is associated with a decision for a major surgery? The answer is no. Modifier -25 does not indicate it is the visit to determine the need for a minor surgery.”

“If the need for the intravitreal injection has been established at an earlier visit and the patient is in the office solely to be injected, an E&M or Eye code service should not be billed.”

Source: OIG Report, Nov. 2005, OEI-07-03-00470

Modifier -25 and the OIG

- 35% of claims in 2002 with modifier 25 did not meet requirements
- Excessive use of modifier -25 garners (unwanted) attention
- OIG’s 2011 Work Plan will scrutinize it
  - Particular attention for intravitreal injections

Source: OIG Report, Nov. 2005, OEI-07-03-00470

Modifier -25

- Use modifier -25
  - Est. patient with ≥2 problems
  - OD vs. OS
  - Anterior vs. posterior seg
  - Eye vs. systemic dx
  - Multiple eye conditions

- Don’t use modifier -25
  - Decision for surgery
  - Only one reason for exam
  - Special case - new patients
Minor Surgery
Key Points

- Require sufficient chart documentation
- Subject to a global surgery package
- They have short postop periods (0, 10 days)
- Generally, includes the exam on the same day
  - Exception – exams for another reason unconnected with the minor procedure (needs modifier -25)

Modifier -25 Yes or No?

Your established patient returns with a complaint of pain and FB sensation. During your slit lamp exam, you find a FB and remove it. The rest of the exam is unremarkable. Does modifier -25 apply?

1) Yes
2) No

Modifier -25 Yes or No?

Your patient returns for a Plaquenil checkup. Today, he complains of chronic FB sensation. During your slit lamp exam, you find keratitis sicca from Sjogren’s syndrome. You perform punctal occlusion of LLL and RLL. Fundus exam is unremarkable. Does modifier -25 apply?

1) Yes
2) No

Common Audit Areas

- Office Visits
- EMR Entries
- Diagnostic testing
- Modifier 25
- Medical necessity for surgical procedures
Audit Considerations - Surgeries

- The chart must include the indications and medical necessity for each surgical procedure
- Review necessary diagnostic tests to support medical necessity
- Read the body operative report, not just the header or the preoperative plan
- Appraising surgical claims involves more than reviewing the operative report

Illustrative Chart Note

**What's wrong?**

CC: Blurred vision
HPI: Difficult at distance OU, constant for several months
DVA cc: 20/40
MR: -
Dx: NSC OD > OS
Plan: Phaco/IOL OD

Auditor's Notes

- Indications for surgery include:
  - Subjective complaints of decreased vision and ADLs limited by decreased vision - Not noted
  - BCVA acuity - Not done

  **Auditing the surgery, but often need to look at previous chart notes to determine medical necessity.**

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NCCI

- National Correct Coding Initiative
  - Bundles
  - Mutually exclusive
  - Quarterly publication
  - Published at www.cms.gov/physicians/cciedits/

Physician's Claim

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</table>

Signatures
• Through audit process, watch for signatures
  
  **Physician**
  Exam notes  
  Correspondence  
  Operative notes  
  Test orders/interpretations
  
  **Patient**
  Signature on File  
  ABN  
  HIPAA Notice  
  Consent Forms  
  Records Release

Next Steps
• Following a chart review:
  - Discuss results with physician
  - Identify strengths and weaknesses
  - Formulate a plan for improvement
  - Make necessary refunds of overpayments

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

Distance Learning Module
• corcoranccg.net/products/distance-learning-for-medical-billers/conducting-an-internal-chart-review/
More help…

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

(800) 399-6565
or
www.CorcoranCCG.com