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Meet the Presenters…

Tom Stevens, CMC, CMIS, CMOM, CCS-P, CPC

On the topic:
Audit You Before They Do
Welcome to Practice Management Institute’s Webinar and Audio Conference Training. We hope that the information contained herein will give you valuable tips that you can use to improve your skills and performance on the job. Each year, more than 40,000 physicians and office staff are trained by Practice Management Institute. For 30 years, physicians have relied on PMI to provide up-to-date coding, reimbursement, compliance and office management training. Instructor-led classes are presented in 400 of the nation’s leading hospitals, healthcare systems, colleges and medical societies.

PMI provides a number of other training resources for your practice, including national conferences for medical office professionals, self-paced certification preparatory courses, online training, educational audio downloads, and practice reference materials. For more information, visit PMI’s web site at www.pmiMD.com

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Audit You Before “They” Do

Presented by
Tom Stevens CMC, CMIS, CMOM, CPC, CCS-P

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• All references from CMS, the Department of HHS, OIG, ACA, or any payer is for instructional and educational use only and is subject to change.
Self Audit

• Why self audit?
• Who should perform them?
• When should we perform them?
• How do we Self Audit?
• What should be Audited?
• What process should be used?
• Which worksheets should be used?
• What do we do with the results?

The medical practice may have one or more designated staff members sharing the compliance responsibilities depending on the size of the practice.

This presentation provides information and resources for medical office professional at all levels to identify and solve the issues typically targeted for audits by payers.
Motivation for Compliance and Self Audit

“To put the importance of reducing fraud and abuse in perspective, just remember that fraud and abuse recoveries totaled $4.3 billion in just fiscal year 2013 alone, and over NINETEEN BILLION dollars have been recovered just in the last five years!”

1. Palmetto GBA - ACA Webinar, June 26, 2014

Avoiding Medicare Fraud & Abuse: A Roadmap For Physicians

- An example may be a physician who knowingly submits claims to Medicare for medical services not provided.
- Civil penalties for violating the FCA may include fines of up to three times the amount of damages sustained by the Government as a result of the false claims, plus up to $21,916 (in 2017) per false claim filed.
- Additionally, under various Federal criminal statutes, individuals or entities may face criminal penalties for submitting false claims, including fines, imprisonment, or both.


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Federal Enforcement

• The government has multiple entities assigned to enforce compliance:
  – The Office of Inspector General (OIG)
  – The Department of Health and Human Services (DHHS)
  – The Federal Bureau of Investigation (FBI)
  – The Department of Justice (DOJ)

OIG states:

• The failure of a physician practice to: (i) document items and services rendered; and (ii) properly submit the corresponding claims for reimbursement is a major area of potential erroneous or fraudulent conduct involving Federal health care programs. The OIG has undertaken numerous audits, investigations, inspections and national enforcement initiatives in these areas.

Source: Federal Register / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices, page 59439
Risk Areas (per OIG)

• To assist physician practices in performing this initial assessment, the OIG has developed a list of four potential risk areas affecting physician practices.

• These risk areas include:
  (a) Coding and billing
    - Billing for items or services not rendered or not provided as claimed
    - Submitting claims for equipment, medical supplies and services that are not reasonable and necessary
    - Double billing resulting in duplicate payment

Source: Federal Register / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices, Page 59438

Risk Areas (per OIG) CONTINUED

- Billing for noncovered services as if covered
- Knowing misuse of provider identification numbers, which results in improper billing
- Unbundling (billing for each component of the service instead of billing or using an all-inclusive code)
- Failure to properly use coding modifiers
- Clustering (This is the practice of coding/charging one or two middle levels of service codes exclusively, under the philosophy that some will be higher, some lower, and the charges will average out over an extended period (in reality, this overcharges some patients while undercharging others).
- Upcoding the level of service provided

Source: Federal Register / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices, Page 59439
Three Other Risk Areas (per OIG)

(b) Reasonable and necessary services
- Medicare will only pay for services that meet the Medicare definition of reasonable and necessary.

(c) Documentation
- …. one of the most important physician practice compliance issues is the appropriate documentation of diagnosis and treatment.

(d) Improper inducements, kickbacks, self-referrals

OIG Compliance Plan for Individual and Small Group Physician Practices

- Sample Compliance Plan
  https://www.oig.hhs.gov/authorities/docs/physician.pdf
  Federal Register / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices (page 59434)

OIG Main website
  https://oig.hhs.gov/compliance/compliance-resource-portal/
technology to minimize the information collection burden.

1. Type of Information Collection Request: New Collection;
2. Title of Information Collection: Employee Building Pass Application and File;
3. Form No. HCF-736 & 182 (OMB # 0990-NEW);
4. Use: The purpose of this system and the forms are to control United States Government Building Passes issued to all HCFA employees and non-HCFA employees who require continuous access to HCFA buildings in Baltimore and other HCFA and HEHS buildings;
5. Frequency: Other: as needed;
6. Affected Public: Federal Government, and business or other for-profit; Number of Respondents: 150;
7. Total Annual Responses: 150;
8. Total Annual Hours: 37.5A;
9. Type of Information Collection Request: Extension of a currently approved collection;
10. Title of Information Collection: Limitation on Liability and Information Collection Standards; Related to;

Office Building, Room 10235,
Washington, D.C. 20503.


John P. Burke III, HCO; Reports Contractor Officer, HCFA, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

FR Doc. 99-23541 Filed 10-4-00; 8:47 am
BILLING CODE 4505-0L-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Inspector General
OIG Compliance Program for Individual and Small Group Physician Practices

AGENCY: Office of Inspector General (OIG), HEHS.

ACTION: Notice.

SUMMARY: This Federal Register notice sets forth the recently issued

Compliance Guidance, Compliance Guidance, and

Compliance Resources.

Copies of these compliance program guidelines can be found on the OIG web site at http://www.hhs.gov/oig.

Developing the Compliance Program Guidance for Individual and Small Group Physician Practices

On September 6, 1999, the OIG published a solicitation notice seeking information and recommendations for developing formal guidance for individual and small group physician practices (64 FR 48466). In response to that solicitation notice, the OIG received 83 comments from various outside sources. We carefully considered those comments, as well as previous OIG publications, such as other compliance program guidance and Special Fraud Alerts, in developing a guidance for individual and small group physician practices. In addition, we have consulted with the Health Care Financing Administration and the Department of Justice. In an effort to ensure that all parties had a reasonable opportunity to provide input into a final product, draft guidance for individual

Compliance Guidance.

OIG has developed a series of voluntary compliance program guidance documents directed at various segments of the health care industry, such as hospitals, ambulatory care, ambulatory surgery, and durable medical equipment suppliers. To encourage the development and use of internal controls to monitor adherence to applicable policies, regulations, and program requirements.

The compliance program guidance documents are listed below.

- Accountable Care Organizations
- Advisory Opinions
- Compliance Resources Portal
- Compliance Guidance
- Compliance Resources

Compliance Resources

9-30-2008

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Additional Resources

MEDICARE LEARNING NETWORK® (MLN)
PROVIDER COMPLIANCE PRODUCTS

These Medicare Learning Network (MLN) products help health care professionals understand how to avoid improper activities.

<table>
<thead>
<tr>
<th>PUBLICATION TITLE</th>
<th>LEARN ABOUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complying with Documentation Requirements for Laboratory Services (ICN 99823)</td>
<td>• Documentation requirements for laboratory services</td>
</tr>
<tr>
<td>Complying With Medical Record Documentation Requirements (ICN 99018)</td>
<td>• Tips to remember for signing requirements and ordering/receiving services to help avoid errors in claim submissions</td>
</tr>
<tr>
<td>Complying with Medicare Signature Requirements (ICN 99386)</td>
<td>• Proper medical record documentation requirements</td>
</tr>
<tr>
<td></td>
<td>• How to provide accurate and supportive medical record documentation</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive Error Rate Testing (CERT) Program errors related to</td>
</tr>
</tbody>
</table>
**Affordable Care Act**

- **Resource:**
  - ACA PPT on Compliance Plans by Lauren Gillooly Robbins, Manager for Provider Education Support Services with Palmetto GBA
  

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**Commercial Plans**

- Many commercial plans require providers to “attest” that they have a compliance plan and provide training to all employees as a conditions of participation.
- If the provider does not have a compliance plan, the commercial carrier will want the provider to complete their compliance training.

Source: Palmetto GBA - ACA Webinar, June 26, 2014
OIG Comments

- The OIG acknowledges that patient care is, and should be, the first priority of a physician practice.
- However, a practice’s focus on patient care can be enhanced by the adoption of a voluntary compliance program.
- For example, the increased accuracy of documentation that may result from a compliance program will actually assist in enhancing patient care.
  - Speed and optimize proper payment of claims
  - Minimize billing mistakes
  - Reduce the chances that an audit will be conducted by HCFA (CMS) or the OIG
  - Avoid conflicts with the self-referral and anti-kickback statues

OIG Comments CONTINUED

- Each physician practice can undertake reasonable steps to implement compliance measures, depending on the size and resources of that practice.
- Voluntary compliance programs also provide benefits by not only helping to prevent erroneous or fraudulent claims, but also by showing that the physician practice is making additional good faith efforts to submit claims appropriately.
Components of an Effective Compliance Program

This compliance program guidance for individual and small group physician practices contains seven components that provide a solid basis upon which a physician practice can create a voluntary compliance program:

1. Conducting internal monitoring and auditing;
2. Implementing compliance and practice standards;
3. Designating a compliance officer or contact;
4. Conducting appropriate training and education;
5. Responding appropriately to detected offenses and developing corrective action;
6. Developing open lines of communication; an
7. Enforcing disciplinary standards through well-publicized guidelines.

1. Conducting Internal Monitoring and Auditing

• .... (a) an (self) audit is an excellent way for a physician practice to ascertain what, if any, problem areas exist and focus on the risk areas that are associated with those problems.
• There are two types of reviews that can be performed as part of this evaluation: (1) A standards and procedures review; (2) A claims submission audit.
Step One: Auditing and Monitoring

1. Standards and Procedures

• It is recommended that an individual(s) in the physician practice be charged with the responsibility of periodically reviewing the practice’s standards and procedures to determine if they are current and complete.

• If the standards and procedures are found to be ineffective or outdated, they should be updated to reflect changes in Government regulations or compendiums generally relied upon by physicians and insurers (i.e., changes in Current Procedural Terminology (CPT) and ICD codes).

Resources

• Updated coding tools (i.e., ICD-10-CM, HCPCS, CPT®)

• Provider Manuals

• Medicare, Medicaid, & Other Carrier Newsletters

• National Correct Coding Initiative (NCCI) Edits
  https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

• Local and National Coverage Determinations (LCDs & NCDs)

• CMS and other Carrier websites
Step One: Auditing and Monitoring CONTINUED

2. Claims Submission Audit

- ...it is advisable that bills and medical records be reviewed for compliance with applicable coding, billing and documentation requirements

2. Claims Submission Audit

- The practice’s self-audits can be used to determine whether:
  - Bills are accurately coded and accurately reflect the services provided (as documented in the medical records);
  - Documentation is being completed correctly;
  - Services or items provided are reasonable and necessary; and
  - Any incentives for unnecessary services exist.
2. Claims Submission Audit

- The individuals from the physician practice involved in these self-audits would ideally include the person in charge of billing (if the practice has such a person) and
- A medically trained person (e.g., registered nurse or preferably a physician (physicians can rotate in this position)).

2. Claims Submission Audit

- Each physician practice needs to decide for itself whether to review claims retrospectively or concurrently with the claims submission
  
  *(pre-submittal is optimal)*

- In the Third-Party Medical Billing Compliance Program Guidance, the OIG recommended that a baseline, or “snapshot,” be used to enable a practice to judge over time its progress in reducing or eliminating potential areas of vulnerability.
Step One: Auditing and Monitoring

CONTINUED

2. Claims Submission Audit

• This practice, known as “benchmarking,” allows a practice to chart its compliance efforts by showing a reduction or increase in the number of claims paid and denied.

• The practice’s self-audits can be used to determine whether the physician practice’s standards and procedures are in fact current and accurate, but also whether the compliance program is working, i.e., whether individuals are properly carrying out their responsibilities and claims are submitted appropriately.

Third-Party Medical Billing Compliance Program Guidance

The OIG identified the following specific risk areas for billing companies:

• billing for services or items that have not been documented;
• duplicate billing;
• unbundling;
• upcoding;
• inappropriate balance billing;
• inadequate resolution of overpayments;
• lack of integrity of computer systems;
• failure to properly use modifiers;
• routine waiver of copayments;
• and improper discounts on professional services

SOURCE: https://oig.hhs.gov/fraud/docs/complianceguidance/tpbpress.htm
Step One: Auditing and Monitoring CONTINUED

2. Claims Submission Audit

- “A general recommendation is that periodic audits be conducted at least once each year to ensure that the compliance program is being followed. Although there is no set formula to how many medical records should be reviewed, a basic guide is five or more medical records per Federal payor (i.e., Medicare, Medicaid), or five to ten medical records per physician.”

Step One: Auditing and Monitoring CONTINUED

2. Claims Submission Audit

- Bills are accurately coded and accurately reflect the services provided (as documented in the medical records);
- Documentation is being completed correctly;
- Services or items provided are reasonable and necessary; and
- Any incentives for unnecessary services exist.
Step One: Auditing and Monitoring

CONTINUED

2. Claims Submission Audit

• A baseline audit examines the claim development and submission process, from patient intake through claim submission and payment, and identifies elements within this process that may contribute to non-compliance or that may need to be the focus for improving execution.

• This audit will establish a consistent methodology for selecting and examining records, and this methodology will then serve as a basis for future audits.

2. Claims Submission Audit

• There are many ways to conduct a baseline audit. The OIG recommends that claims/services that were submitted and paid during the initial three months after implementation of the education and training program be examined, so as to give the physician practice a benchmark against which to measure future compliance effectiveness.
Step One: Auditing and Monitoring

CONTINUED

2. Claims Submission Audit

• If problems are identified, the physician practice will need to determine whether a focused review should be conducted on a more frequent basis.

• When audit results reveal areas needing additional information or education of employees and physicians, the physician practice will need to analyze whether these areas should be incorporated into the training and educational system.

Following the baseline audit, a general recommendation is that periodic audits be conducted at least once each year to ensure that the compliance program is being followed.
2. Claims Submission Audit

- The OIG recommends that the physician practice evaluate claims/services selected to determine if the codes billed and reimbursed were accurately ordered, performed, and reasonable and necessary for the treatment of the patient.

- One of the most important components of a successful compliance audit protocol is an appropriate response when the physician practice identifies a problem.

- Optimally, a randomly selected number of medical records could be reviewed to ensure that the coding was performed accurately.

- Although there is no set formula to how many medical records should be reviewed, a basic guide is five or more medical records per Federal payer (i.e., Medicare, Medicaid), or five to ten medical records per physician.
Step One: Auditing and Monitoring

CONTINUED

2. Claims Submission Audit

• Of course, the larger the sample size, the larger the comfort level the physician practice will have about the results.

• If problems are identified, the physician practice will need to determine whether a focused review should be conducted on a more frequent basis.

Another method is to identify risk areas or potential billing vulnerabilities. The codes associated with these risk areas may become the universe of claims/services from which to select the sample.

The OIG recommends that the physician practice evaluate claims/services selected to determine if the codes billed and reimbursed were accurately ordered, performed, and reasonable and necessary for the treatment of the patient.
OIG Guidance

- A physician practice can also institute a policy that the **coder and/or physician review all rejected claims pertaining to diagnosis and procedure codes**. This step can facilitate a reduction in similar errors.

Step One: Auditing and Monitoring

2. **Claims Submission Audit**
   - One of the most important components of a successful compliance audit protocol is an appropriate response when the physician practice identifies a problem.
   - This action should be taken as soon as possible after the date the problem is identified.
   - The specific action a physician practice takes should depend on the circumstances of the situation.
Step One: Auditing and Monitoring

CONTINUED

2. Claims Submission Audit

• In some cases, the response can be as straightforward as generating a repayment with appropriate explanation to Medicare or the appropriate payor from which the overpayment was received.

• In others, the physician practice may want to consult with a coding/billing expert to determine the next best course of action.

Step One: Auditing and Monitoring

CONTINUED

2. Claims Submission Audit

• It is a good business practice to create a system to address how physician practices will respond to and report potential problems.

• In addition, preserving information relating to identification of the problem is as important as preserving information that tracks the physician practice’s reaction to, and solution for, the issue.
Step One: Auditing and Monitoring

CONTINUED

2. **Claims Submission Audit**
   - **Purpose of Billing Audits**
     - Meets Industry standard for compliance
     - Shows “Good Faith Effort to Comply”
     - Assures appropriate reimbursement
     - Validates that billing & coding guidelines are being followed
     - Identifies potential lost revenue

**Self Audits**

- Identify Purpose of Audit
- Who Will Conduct
- Identify Sample
- Determine Collection Tool
- Analyze Results
- Communicate Results
- Follow-up &/or Corrective Action
Step One: Auditing and Monitoring

CONTINUED

2. Claims Submission Audit

• Identify the sample selection to be audited
  - Select the provider(s) & dates of service
  - Select the type of encounters
  - Select ten (5-10) encounters per provider

• Determine what data collection tool/worksheet will be used
  - Templates
  - Billing & coding guidelines i.e., BCBS of Texas
  - 95 or 97 E/M Documentation guidelines?
  - Strictly CMS rules or other payer rules?
  - Which Payers?

CMS Requirements for Medical Records

1. Complete and legible
2. Each patient encounter should include:
   • reason for the encounter
   • relevant history & physical examination findings
   • prior diagnostic test results;
   • assessment, clinical impression or diagnosis;
   • plan for care; and
   • date and legible identity of the observer.
3. Rationale for ordering diagnostic and other ancillary services
4. Accessible past and present diagnoses
5. Identification of appropriate health risk factors
6. Patient's progress, response to and changes in treatment
7. Support the CPT® & ICD-10-CM codes submitted for reimbursement
Medical Necessity

• Does the rationale support the level of care provided?
• Are all acute and chronic diagnoses with the current status and treatment plans listed in the progress note?
• Is there documentation supporting that conservative medical management was tried and failed?
• Is the complexity, intensity, frequency, duration and scope of service documented?
• Is there a signed order with an appropriate Dx for services indicating the clinical rationale for the order?
• Is there a legible signature of the person rendering the service, ordering and approving treatment plans?
• Is the procedure proposed medically necessary with regards to medical community standards?
### Sample History Audit Form

<table>
<thead>
<tr>
<th>Patient Facility</th>
<th>DOB Encounter Date</th>
<th>MRN</th>
</tr>
</thead>
</table>

#### History Components

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Chief Complaint is required in ALL documentation</th>
</tr>
</thead>
</table>

- **HPI (History of Present Illness)**
  - Status of 3 chronic problems
    - 1
    - 2
    - 3

- **OCR Choose Elements**
  - Quality
  - Location
  - Duration
  - Severity
  - Timing
  - Context
  - Modifying factors
  - Associated Signs/Symptoms

- **ROS (Review of Systems)**
  - NA
  - Eyes
  - CV
  - Sinus/Respiratory
  - Skin
  - GI
  - GU
  - Home/Lymph
  - MD
  - Neuro
  - Psych
  - Allergy/Immunology

- **PFSH (Past Medical, Family Social History)**
  - NA
  - NA
  - Relevant to problem
  - 1 Area
  - 2-3 Areas

*Complete PFSH
3 history areas for ALL NEW Patients
2 history areas for ALL, Follow Up/Established Visits
55 Patients seen in Emergency Department

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Status of 3 Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status of 3 Chronic Conditions</td>
<td>Status of 3 Chronic Conditions</td>
</tr>
</tbody>
</table>

- Status of 3 Chronic Conditions
  - OR
  - Extended 4 Elements
  - OR
  - Extended 4 Elements

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Status of 3 Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status of 3 Chronic Conditions</td>
<td>Status of 3 Chronic Conditions</td>
</tr>
</tbody>
</table>

- Status of 3 Chronic Conditions
  - OR
  - Extended 4 Elements
  - OR
  - Extended 4 Elements

### Sample Exam Tool

#### Examination Criteria

<table>
<thead>
<tr>
<th>Examination</th>
<th>1995 Guideline</th>
<th>1997 Guideline</th>
<th>Type of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to affected body area or organ system</td>
<td>□ 1 Body Area or Organ System</td>
<td>□ 1-5 Bulleted Items</td>
<td>□ PROBLEM FOCUSED</td>
</tr>
<tr>
<td>Affected body area/organ system and other symptomatic or related organ systems</td>
<td>□ 2-7</td>
<td>□ 6-11 or more</td>
<td>□ EXPANDED PROBLEM FOCUSED</td>
</tr>
<tr>
<td>Extended exam of affected body areas/organ systems and other symptomatic or related organ systems</td>
<td>□ 2-7</td>
<td>□ 12-17 or more for 2 or more systems</td>
<td>□ DETAILED</td>
</tr>
<tr>
<td>General Multi-System</td>
<td>□ ≥8</td>
<td>□ 18 or more for 9 or more systems</td>
<td>□ COMPREHENSIVE</td>
</tr>
<tr>
<td>Complete Single Organ System</td>
<td>Not Defined</td>
<td>Refer to Guideline</td>
<td></td>
</tr>
</tbody>
</table>

See 1995 or 1997 Guidelines for Evaluation & Management Services for specific requirements

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Sample MDM Tool

### A. Complexity of Medical Decision Making

#### Number of Diagnoses or Treatment Options

<table>
<thead>
<tr>
<th>Problem (Status)</th>
<th>Number</th>
<th>Points</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major inpatient, severe, increased care, severe</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor inpatient, severe, increased care, severe</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor inpatient, non-severe, increased care, severe</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major inpatient, severe, non-inpatient</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Minor inpatient, severe, non-inpatient</td>
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<tr>
<td>Minor inpatient, non-severe, non-inpatient</td>
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<td></td>
</tr>
<tr>
<td>Major non-inpatient, severe, increased care, severe</td>
<td>1</td>
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<td></td>
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<tr>
<td>Minor non-inpatient, severe, increased care, severe</td>
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<td>Minor non-inpatient, severe, non-inpatient</td>
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<tr>
<td>Minor non-inpatient, non-severe, non-inpatient</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total**

### B. Amount and/or Complexity of Data Reviewed

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
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<tbody>
<tr>
<td>New data - OUS lab tests</td>
<td>1</td>
</tr>
<tr>
<td>New data - OUS lab tests in the prior 30 days</td>
<td>1</td>
</tr>
<tr>
<td>Prior data for the same patient</td>
<td>1</td>
</tr>
<tr>
<td>Prior data for the same patient in the prior 30 days</td>
<td>1</td>
</tr>
<tr>
<td>Prior data for the same patient in the prior 60 days</td>
<td>1</td>
</tr>
<tr>
<td>Prior data for the same patient in the prior 90 days</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total**

### C. Risk of Complications, Mortality and/or Morbidity

<table>
<thead>
<tr>
<th>Min.</th>
<th>1 or more severe</th>
<th>1 or more moderate</th>
<th>1 or more mild</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total**

---

**Final Result for Complexity of Medical Decision Making**

**A**

<table>
<thead>
<tr>
<th>Decision Making Level</th>
<th>Minimal</th>
<th>Limited</th>
<th>Moderate</th>
<th>High</th>
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</table>

**B**

<table>
<thead>
<tr>
<th>Amount of Data</th>
<th>Minimal</th>
<th>Limited</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
</table>

**C**

<table>
<thead>
<tr>
<th>Highest Risk Tier</th>
<th>Minimal</th>
<th>Limited</th>
<th>Moderate</th>
<th>High</th>
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**Diagnostic Codes**

- Must be accurate for each encounter
- Use additional codes to describe the circumstances of the patient’s condition
- Primary Diagnosis should be clear
- Use as many diagnoses as needed to show relevant conditions
- Code to the highest level of specificity
Diagnostic Codes

• Use additional codes as directed by each code instructions (i.e., "code also")
• Use "Other specified" rather than "Unspecified" when able
• If no definitive diagnosis, code signs and symptoms present
• Link the proper diagnoses to the proper CPT/HCPCS code

Surgical Procedures

• Do not unbundle service included in the surgical package
• Operative note should indicate procedure completed and any adequate descriptions of any complications
• Ensure separate procedure guidelines are being followed correctly
• Ensure that modifiers are assigned correctly and match the documentation
• Know if the surgical follow up is included in the procedure
Step Two: Establish Practice Standards and Procedures

• In light of the documentation requirements faced by physician practices, it would be to the practice’s benefit if its standards and procedures contained a section on the retention of compliance, business and medical records.

• These records primarily include documents relating to patient care and the practice’s business activities.

• A physician practice’s designated compliance contact could keep an updated binder or record of these documents, including information relating to compliance activities.

Step Two: Establish Practice Standards and Procedures CONTINUED

• The primary compliance documents that a practice would want to retain are those that relate to educational activities, internal investigations and internal audit results.

• We suggest that particular attention should be paid to documenting investigations of potential violations uncovered by the compliance program and the resulting remedial action.

• Although there is no requirement that the practice retain its compliance records, having all the relevant documentation relating to the practice’s compliance efforts or handling of a particular problem can benefit the practice should it ever be questioned regarding those activities.
QUESTIONS

• Thank you!

• PMI’s Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp