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On the topic:
How to Successfully Transition from Coder to Auditor
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How to Successfully Transition from Coder to Auditor

Presented by:
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Taking the Business of Medicine to the Next Level
Overview

• Identify problems with clinical documentation
• Strategies for maintaining effective communication with clinicians
• Writing an effective query
• The documentation impact on patient quality care
• What to do if you have information about fraud or abuse in your organization

As a Coder

• As a coder you provide a vital link between physicians caring for patients and the health insurance companies that cover their services.
• Medical coders are indispensable for translating doctors’ notes and treatment plans into simplified language for reimbursement.
• Without the accurate work of medical coders, insurers would likely reject claims or repay too little.
As a Coder

• Medical coders should hold at least a certification for coding and billing.
• Earning at a minimum a two-year associate degree in medical coding or health information technology is also preferred in order to transition to auditing.
• Attention to detail is one of the foremost character traits required in coding and auditing.

Transitioning

• Demonstrate an in-depth knowledge of human anatomy and physiology like healthcare practitioners.
  – For example, knowing the difference between medical terms like periosteum and peritoneum or endocrine and exocrine is imperative.
• Even though medical coding isn’t a patient/doctor-facing role, being a skilled communicator is a must.
• Auditors need to sharpen their speaking skills to effectively discuss patient records.
  – On any given day, you will interact with doctors, surgeons, nurses, medical billers, and front office staff.
As an Auditor

- Learn to communicate with medical professionals and assess medical documents
- Develop the skills needed for detail to work in medical auditing
- Learn the legal standards necessary to perform well on the job
- Understand best insurance and reimbursement practices to relay them to patients

As an Auditor

- Strong Moral Character
  – It’s essential that auditors treat records with anonymity, avoid conflicts of interest, and follow coding standards to avoid punishable legal consequences.
- Independent Drive and Focus
  – Staying motivated and productive without constant external feedback is critical.
Identify problems with clinical documentation

Incomplete or inaccurate documentation.
• Codes affect billing and, if assigned erroneously, can lead to denied claims or inaccurate reimbursements.
  – The latest health care technology can recommend potentially missed clinical indicators or documents lacking required specificity that, if caught early, can lead to higher quality care, exact coding and accurate reimbursement.
• Truth time – how thorough is your physicians’ documentation?
  – Does the documentation really give a clear picture of what the reason for the visit was.

THE FACTS

• 98% of all Medical Records/Progress Notes are incorrectly documented to meet Coding and Billing Guidelines.
• Over 75% of all EMR/EHR software templates are incorrectly set up.
• Every Payers knows these facts and will eventually audit your records to recover monies they have already paid you.
Errors Found-During Previous Payor Audits

- Medically Unnecessary: 40% ($391.3 million)
- Incorrectly Coded: 35% ($331.8 million)
- Other: 8% ($160.2 million)
- No/Insufficient Documentation: 17% ($74.3 million)

* (in millions)

40% of the Progress Notes where found to be not Medically Necessary

The patient record should tell a story

- The chief complaint is the title of the story
- The History sets up the story/book
- The Exam is the details of the story
- The Medical Decision Making is the ending
Statement regarding Record Cloning....

- According to the 1997 Documentation Guidelines for Evaluation and Management Services, "Medical record documentation is required to record pertinent facts, findings, and observations about an individual’s health history... (Emphasis added)“ Medical record cloning will not satisfy that E/M requirement.

Statement regarding Record Cloning....

- Physicians’ documentation must support the medical necessity and appropriateness of the services they provide. Electronic medical record templates can assist them in this process, if care is taken to edit records to accurately reflect the condition of a patient at every patient/physician encounter. In the absence of such editing, cloning of records will most likely lead to denial of services due to lack of medical necessity and may lead to investigation of potentially fraudulent practices.
The Common Mistakes

- **The Chief Complaint**
  - “Here for a follow up”….of what??
  - ROS issues
- **The Exam**
  - Elements documented that are not in the guidelines or not enough is documented to meet the E/M levels billed...such as bowel sounds
  - Look to see if there is a mix of 1995 and 1997 documentation guidelines
- **The Medical Decision Making**
  - Diagnoses don’t match billing or are listed as incomplete or unspecified

Medical Record Documentation

- **Medical Record Documentation Should:**
  - Be Complete and Legible
  - Include:
    - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
    - assessment, clinical impression or diagnosis
    - plan for care
    - date and provider signature (electronic)
Medical Record Documentation

- Medical Record Documentation Should:
  - Include (continued):
    - rationale for ordering diagnostic and other ancillary services
    - past and present diagnoses
    - appropriate health risk factors
    - the patient's progress, response to and change in treatment, and revision of diagnosis
  - Support the CPT and Diagnosis Codes Reported on the Health Insurance Claim Form or Billing Statement

When Reviewing the History

- Look for a clearly documented chief complaint.
- ROS and PFSH may be obtained by ancillary staff and reviewed/signed by the physician.
- When the updating of ROS and PFSH is referred back to earlier encounter, is the date & location noted?
- Review of Systems: If a complete ROS is performed, was there documentation of the pertinent positives and negatives with a statement “of all other systems negative?” *(always provide the # of systems reviewed)*
- If they were unable to obtain history, was the reason noted?
When Reviewing the Examination

• E/M services health care professionals may use either version of the 1995 or 1997 documentation guidelines, not a combination of the two, for a patient encounter.


• A notation of "abnormal" without elaboration is insufficient documentation.

• Normal or negative findings must be listed by each body area within the organ system.

• “Exam normal" or "exam negative" is unacceptable documentation.

Medical Decision Making

The Assessment and Plan aka Medical Decision Making

• When reviewing the records, make sure all 3 of these are looked at:
  – Number of diagnosis and/or Management Options
  – Amount and/or Complexity of Data
  – Overall Risk
Reviewing the Medical Decision Making

Documentation review of the diagnosis, look for the following:

– If there is severe exacerbation, progression, or side effects of side effects of treatment
– Acute or chronic condition that may pose a threat to life or bodily function
– If the problem is not stable it should be indicated as, worsening or failing to progress

Reviewing the Medical Decision Making

• When reviewing the Documentation of the Management options make sure they have indicated:
  – RX with dosage and directions (even if it’s a refill)
  – Any diagnostic procedure, ordered, plan, performed or reviewed
  – Documented in detail what the plan of care is for each diagnosis
When Reviewing Surgical Notes

A surgeon’s operative notes should stand alone to provide all the necessary documentation to describe the procedure(s) performed. Every operative note should include:

- Patient’s name
- Date
- Preoperative Diagnosis
- Postoperative Diagnosis
- Surgeon’s Name
- Assistant Surgeon/Co-Surgeon
- Procedure

When possible, differentiate pre-operative and post-operative diagnoses.

For instance, a pathology report may provide additional details that allow for a more specific post-operative diagnosis. You may also report underlying, co-morbid conditions that can affect the surgical outcome.
When Reviewing Surgical Notes

• **Look for key words**—Key words may include locations and anatomical structures involved, surgical approach, procedure method (debridement, drainage, incision, repair, etc.), procedure type (open, closed, simple, intermediate, etc.), size and number, and the surgical instruments used during the procedure.

• **Highlight unfamiliar words**—Research for understanding.

• **Read the body**—All procedures reported should be documented within the body of the report. The body may indicate a procedure was abandoned or complicated, which may indicate a need for a different procedure code, or to append a modifier.

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Writing an Effective Query

• **Consistency and attention to detail are key when crafting the query in support of better documentation.**

• Complete and accurate documentation within each patient’s medical record is one facet of the mission to ensure patient safety and quality of care. Querying is a vital part of that documentation process, but it’s a skill that can be difficult to master.

• Having an open dialog and knowing your providers personally are key to the approach.
Examples of Query Documentation

The documentation of verbal or written queries should follow a standard format to include all necessary information.

Example Open-Ended Query

- A patient is admitted with pneumonia. The admitting H&P examination reveals WBC of 14,000; a respiratory rate of 24; a temperature of 102 degrees; heart rate of 120; hypotension; and altered mental status. The patient is administered an IV antibiotic and IV fluid resuscitation.
- Leading: The patient has elevated WBCs, tachycardia, and is given an IV antibiotic for Pseudomonas cultured from the blood. Are you treating for sepsis?
- Nonleading: Based on your clinical judgment, can you provide a diagnosis that represents the below-listed clinical indicators? Is this patient admitted with pneumonia, the admitting history and physical examination reveals the following:
  - WBC 14,000
  - Respiratory rate 24
  - Temperature 102°F
  - Heart rate 120
  - Hypotension
  - Altered mental status
  - IV antibiotic administration
  - IV fluid resuscitation
  - Please document the condition and the causative organism (if known) in the medical record.

Examples of Query Documentation

Example Multiple Choice Query

- A patient is admitted for a right hip fracture. The H&P notes that the patient has a history of chronic congestive heart failure. A recent echocardiogram showed left ventricular ejection fraction (EF) of 25 percent. The patient’s home medications include metoprolol XL, lisinopril, and Lasix.
- Leading: Please document if you agree the patient has chronic diastolic heart failure.
- Nonleading: It is noted in the impression of the H&P that the patient has chronic congestive heart failure and a recent echocardiogram noted under the cardiac review of systems reveals an EF of 25 percent. Can the chronic heart failure be further specified as:
  - Chronic systolic heart failure____________________
  - Chronic diastolic heart failure__________________
  - Chronic systolic and diastolic heart failure_______
  - Some other type of heart failure________________
  - Undetermined________________________________
Example’s of Query Documentation

Example Yes/No Queries (Compliant Example 1)

• **Clinical Scenario:** A patient is admitted with cellulitis around a recent operative wound site, and only cellulitis is documented without any relationship to the recent surgical procedure.

• **Query:** Is the cellulitis due to or the result of the surgical procedure? Please document your response in the health record or below.

  • Yes
  • No
  • Other
  • Clinically Undetermined

• **Name:** ____________________ **Date:** __________

• **Rationale:** This is an example of a yes/no query involving a documented condition potentially resulting from a procedure.

Example’s of Query Documentation

Compliant Example 2

• **Clinical Scenario:** Congestive heart failure is documented in the final discharge statement in a patient who is noted to have an echocardiographic interpretation of systolic dysfunction and is maintained on lisinopril, Lasix, and Lanoxin.

• **Query:** Based on the echocardiographic interpretation of systolic dysfunction in this patient maintained on lisinopril, Lasix, and Lanoxin can your documentation of “congestive heart failure” be further specified as systolic congestive heart failure? Please document your response in the health record or below.

  • Yes
  • No
  • Other
  • Clinically Undetermined

• **Name:** ____________________ **Date:** __________

• **Rationale:** This yes/no query provides an example of determining the specificity of a condition that is documented as an interpretation of an echocardiogram.
Example’s of Query Documentation

Compliant Example 3

- **Clinical scenario**: During the removal of an abdominal mass, the surgeon documents, in the description of the operative procedure, a “serosal injury to the stomach was repaired with interrupted sutures.”
- **Query**: In the description of the operative procedure a serosal injury to the stomach was noted and repaired with interrupted sutures. Was this serosal injury and repair:
  - A complication of the procedure ______________
  - Integral to the above procedure ________________
  - Not clinically significant ________________
  - Other ______________
  - Clinically Undetermined ______________
  - Please document your response in the health record or below accompanied by clinical substantiation.
  - Name: ___________________ Date: ____________
  - **Rationale**: This is an example of a query necessary to determine the clinical significance of a condition resulting from a procedure.

Example’s of Query Documentation

Non-Compliant Example 1

- **Clinical scenario**: On admission bilateral lower extremity edema is noted, however, there are no other clinical indicators to support malnutrition.
- **Query**: Do you agree that the patient’s bilateral lower extremity edema is diagnostic of malnutrition? Please document your response in the health record or below.
  - Yes ______________
  - No ______________
  - Other ______________
  - Clinically Undetermined ______________
  - Name: ___________________ Date: ____________
  - **Rationale**: Malnutrition is not a further specification of the isolated finding of a bilateral lower extremity edema. *An open-ended or multiple choice query should be used under this circumstance to ascertain the underlying cause of the patient’s edema.*
Example’s of Query Documentation

Non-Compliant Example 2

• **Clinical scenario:** A patient is admitted with an acute gastrointestinal bleed, and the hemoglobin drops from 12 g/dL to 7.5 g/dL and two units of packed red blood cells are transfused. The physician documents anemia in the final discharge statement.

• **Query:** In this patient admitted with a gastrointestinal bleed and who underwent a blood transfusion after a drop in the hemoglobin from 12 g/DL on admission to 7.5 g/dL, can your documentation of anemia be further specified as an acute blood loss anemia? Please document your response in the health record or below accompanied by clinical substantiation.

  • Yes __________
  • No __________
  • Other __________
  • Clinically Undetermined __________
  • Name: ___________________ Date: __________

• **Rationale:** In this example, a yes/no query is not appropriate for specifying the type of anemia. A multiple-choice or open-ended query is a better option.

Example’s of Query Documentation

Non-Compliant Example 3

• **Clinical Scenario:** In the ED, a foley catheter was inserted for the patient with dysuria and elevated WBCs that was removed two days after admission. The cultures were positive for E.coli and the progress note reflect a catheter associated urinary tract infection (CAUTI) and this was coded. Quality has requested review of the HAC condition to ensure it should be coded as it does not meet the CDC definition for CAUTI.

• **Query:** The quality department has indicated that your documented diagnosis of CAUTI does not meet the CDC definition which impacts the Hospital Acquired condition statistics for your profile as well as the hospital. Does your patient have a catheter associated urinary tract infection?

  • Yes __________
  • No __________
  • Other __________
  • Clinically Undetermined __________
  • Name: ___________________ Date: __________

• **Rationale:** This query is inappropriate as it explains the impact of the addition or removal of the diagnosis for the physician and hospital profiles. This query questions the physician’s clinical judgment which may be more appropriate in an escalation policy and/or physician education regarding the CDC definition of CAUTI.
The documentation impact on patient quality care

Improving patient quality care and safety

• Every provider and nurse handoff, creates a potential miscommunication and mistakes

What’s the solution?

• Culture
• Analytics
• Evidence based practice
• Adoption of protocols for improvement

Culture

• If your healthcare organization doesn’t have a culture that values teamwork, accountability, and an environment that encourages speaking up, then you’re more likely to experience quality issues.

Clinical Analytics

• Clinical analytics plays an important role in scalable, sustainable quality improvement. Data is a vital component of patient safety and quality. But data without the aforementioned supportive culture isn’t as effective.
The documentation impact on patient quality care

Evidence-based Practices

• While there are unique cases and exceptions in patient care, we should leverage clinical analytics to enable providers to spend their time on the difficult cases, while ensuring quality standard care is given in all cases.

Adoption

• Established and approved evidence-based practices, while critical components of ensuring patient safety and quality of care, are only effective if they are adopted. Adoption includes educating and training frontline clinicians and healthcare workers, engaging patients, and collaborating with clinician leadership to drive best practices adoption.

What to do if you have information about fraud or abuse in your organization

Recommended Steps for Reporting

• Immediately stop engaging in any activity that you believe to be a compliance violation.
• Discuss concerns and questions with your immediate supervisor.
  – Although concerns are best addressed directly, remember that only compliance officers are legally bound to ensure confidentiality and whistleblower protections.
• Contact your facility and/or corporate compliance officer or hotline.
  – Go to the compliance officer for your direct employer if you are not employed by the facility where you work. If they do not respond satisfactorily, you can go to your facility compliance officer, as well.
What to do if you have information about fraud or abuse in your organization

If you are unable to satisfactorily resolve the issue through the available internal channels:

• For Medicare and Medicaid compliance issues, report your concerns to the Department of Health and Human Services (HHS), Office of Inspector General (OIG).
• For issues related to state regulations, consider reporting your concerns to your state ombudsman programs and/or your state’s Office of the Attorney General.
• If you have concerns about your liability or protections, seek professional legal counsel.
• Contact your national professional association (American Occupational Therapy Association [AOTA], American Physical Therapy Association [APTA], and American Speech-Language-Hearing Association [ASHA]) for guidance if you have questions.
• Department of Health and Human Services (HHS), Office of Inspector General (OIG)
  – The OIG is responsible for fraud and abuse prevention, detection, and reporting.

Questions??
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