



# Using Provider Audits to Ensure Proper Documentation

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# Chart audits may measure:

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- Adherence to clinical protocols
- Patient adherence with medication regimens
- Provider compliance with coding and documentation requirements for E/M services, office procedures, modifier use, diagnoses code(s) supporting medical necessity and surgical procedures





# What is an audit?

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- Process of examining the health record, verifying information, and gathering baseline information to identify risk areas.





# Types of Audits

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- Internal vs. External
- Focused vs. Random
- Prospective vs. Retrospective
- Peer Review





# Steps in the Audit Process

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- Determine the scope or service that will be audited
- Determine the sample that will be used
- Consider what tools or resources will be needed to conduct the audit
- Gather the documentation and perform the audit
- When the audit has been completed, report the results





# General Things to look for

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- Chief Complaint
- 3 Key Components (History, Exam and Medical Decision Making)
- Start and End time for time-based codes
- Additional codes based on actual code selection
- Age and Sex specific codes matching the patient
- GPRA items patient is eligible for listed on encounter
- Signed Note





# Getting started

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## Scope of Audit:

- Timeframe for Audit
- Type of Encounter
- Provider(s) to Audit
- How Many Encounters to Audit





# Pull information from RPMS

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## RPMS Pathway:

IHS Core → Health Applications → Patient Care Component → PCC Management Reports → Quality Assurance Reports → Random Sample of Visits by DX and Date

- Enter Beginning Visit Date
- Enter Ending Visit Date
- Decide if you want to restrict it by patient Age (e.g. 0-15 yrs)
- Decide if you want to restrict it by patient Sex (e.g. male/female)
- Decide if you want to restrict it to a particular Service Category (e.g. Ambulatory)
- Decide if you want to restrict it by Visit Type (e.g. IHS, Contract)
- Decide if you want to restrict it by Clinic Type







# Pull information from rpms



## RPMS Pathway:

IHS Core → Health Applications → Patient Care Component → PCC Management Reports → Quality Assurance Reports → Random Sample of Visits by DX and Date

- Decide if you want to restrict it by Location of Encounter
- Decide if you want all ICD coded diagnoses (you can exclude Medication Refills or Administrative codes if you want)
- Decide if you want the Audit search by provider (you can look at specific providers or all providers)
- Print All visit for the providers or a Random sample (suggest Random Sample)
  - If you choose Random Sample, decide how many encounters you want to look at (e.g. 10, 15, 30)
- Exclude Demo Patients
- Print your list





# Pull Information From RPMS

HRCN	Visit Date ICD9	Primary Provider DIAGNOSIS	Patient Name	DOB
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---> ICD Code Range: ALL ICD Codes. Total Matches: 1    Matches Selected: 1				
5080	JAN 11,2019 R06.00	PROVIDER 8 Dyspnea, unspecified	DEMO, PATIENT 1	02/15/1963
---> ICD Code Range: ALL ICD Codes. Total Matches: 157    Matches selected: 15				
6028	MAR 8,2019 E66.3	PROVIDER 1 Overweight	DEMO, PATIENT 2	02/05/2006
985	JAN 12,2019 F81.9	PROVIDER 1 Learning disability	DEMO, PATIENT 3	01/20/2009
23	JAN 11,2019 F90.0	PROVIDER 1 Attention deficit hyperactivity disorder, predominantly	DEMO, PATIENT 4	06/03/2000



# Audit Spreadsheet

Provider	Visit Reviewer	Patient HRN	Service Date	ICD-10 Code(s) Used	Is Code Appropriate? (Yes/No)	CPT Code(s) used	Is Code Appropriate? (Yes/No)	General Notes about visit
PROVIDER 8	Coder 1	5080	01/11/19	Z23	Yes	None	No – Need administration code and vaccine supply code	Chief Compliant: Flu Shot Note to Provider: – None Note to Coder: – Add administration codes and vaccine supply code
PROVIDER 1	Coder 12	6028	03/08/19	E66.3	Yes  Need code for BMI	99213	No – Documentation supports 99212	Chief Compliant: Concerned about weight History: Problem Focused Examination: Problem Focused MDM: Moderate Note to Provider: – None Note to Coder: – Add BMI code – Change E/M code to one supported by documentation





# Audit Summary

**Location for Review:** [Name of Site]

**Reviewer:** Kristina Rogers, MMI, CPC, CPM, CPC-I

**Date of Review:** January 1, 2019 – May 1, 2019

**Number of Providers Reviewed:** 11 care providers

- Provider 2, Provider 6, Provider 1, Provider 7, Provider 14, Provider 3, Provider 5, Provider 12, Provider 11, Provider 10, Provider 8

**Number of Visits Reviewed:** 103 (10 visits for all providers except Provider 10 (4), and Provider 3 (9))  
- # of visits "In Review Status" = 65

**Number of Visit Reviewers:** 5 (Coder 1, Coder 2, Coder 12, Coder 5)

- # completed by Coder 1 = 15
- # completed by Coder 2 = 10
- # completed by Coder 12 = 7
- # completed by Coder 5 = 6

**General:**

- % of completed visits for the specified timeframe:	38/103 =	37%
- % of completed visits where ICD code(s) was appropriate:	15/38 =	39%
- % of completed visits where CPT code(s) were appropriate:	28/38 =	74%
- % of visits "In Review Status" that have enough documentation to be completed:	50/65 =	77%

NOTE: Indian Health Manual, Part 5 – Management Services, Chapter 1, Section 5-1.3.F states "all applicable codes must be entered, verified and completed in RPMS within 4 business days of the date of service for all outpatient services". It also states, "Providers have 1 business day to address and provide any additional information once an issue is identified and communicated".

**Provider Documentation Notes:**

No issues at this time for:

- Provider 2, Provider 6, Provider 1, Provider 7 and Provider 14

Provider 3:

- Even if the patient was a "no show", if refill of meds was completed there should be a note associated with the visit
- Every visit should have a brief note about what was done with the patient

Provider 5:

- Document start and stop times, total time helps – but it's ideal to have start and stop times

Provider 12:

- All visits should have a brief note about what was done with the patient

Provider 11:

- Document exam and if there were abnormalities

Provider 10:

- Document that it's a tele-psych visit in the note

Provider 8:

- All visits should have a brief note about what was done with the patient

**Coder Notes:**

- Code all items documented and identified as a POV
- Code E/M codes based on what is documented, not what the provider selected
- Add additional diagnose and procedure codes, based on documentation
- If note is incomplete, query provider for additional documentation
- Change ZZZ.999 codes to actual ICD-10 code
- When Hygienist and Dentist see the patient on the same day, both should be listed as a provider
  - one primary and one secondary
- Add BMI code when Obesity or Overweight is a diagnoses
- Delete codes not supported by documentation
- Delete unnecessary codes
- Delete duplicate codes
- Delete invalid codes
- Merge visits by the same provider on the same date of service
  - o When you merge the visits, delete unnecessary codes and each visit can only have one primary provider listed
- If you query the provider, be sure to follow-up to ensure all visits are completed in a timely manner

**Recommendations:**

**General:**

- Providers of care should ensure documentation is complete and timely; someone should be able to pull up a record and know exactly why the patient came in, what was addressed during the encounter and how treatment will proceed for each patient encounter.

**Providers:**

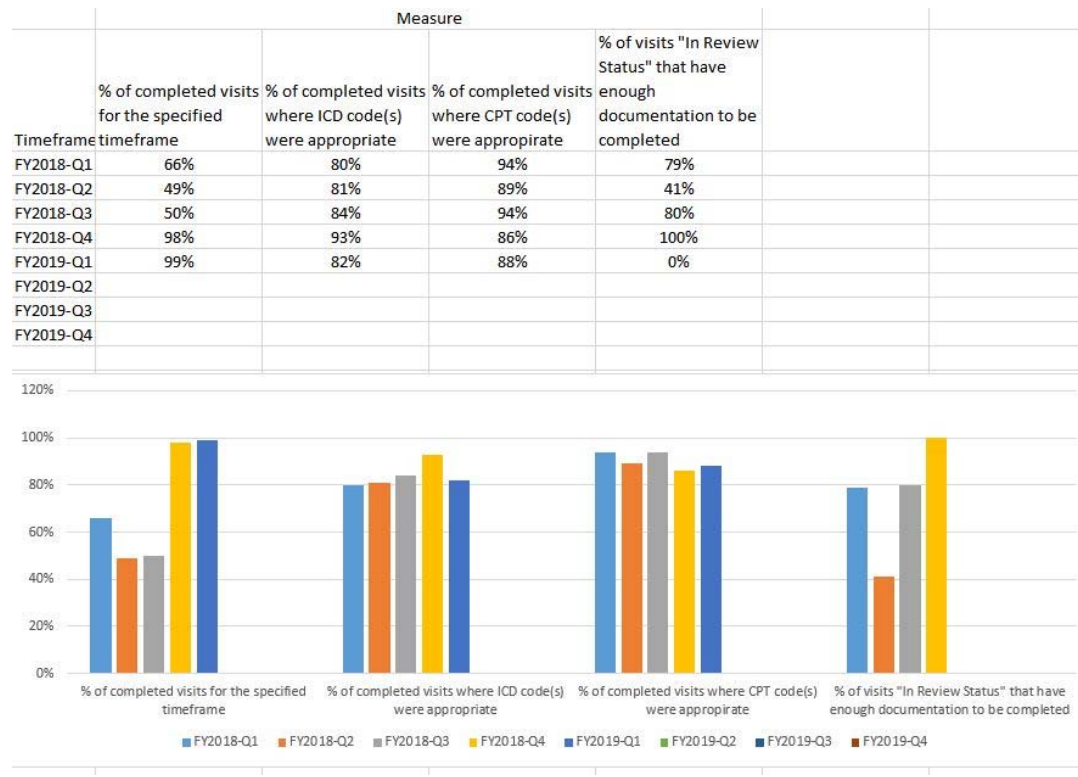
- Complete documentation within 1 business day.
- Work with coders when they request additional documentation, respond to queries within 1 business day
- Documentation for each diagnoses needs to be in the note. Codes cannot be used if documentation doesn't support them.

**Coders:**

- Outpatient visits should be coded within 4 business days from the date of service.
- Code all encounters regardless of if they are billable; there should be no "Visits in Review Status" unless the provider needs to add additional documentation.



# Audit Info Graphed





# After the audit is completed

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- Send it to all stakeholders
  - Through Secure File Transfer or print it and hand it to them
- Talk to them about the findings and devise a plan for improvement
- Note those items for next audit





# Scenario 1

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Provider is an Nurse Practitioner

CC: Female presents today (52 yrs) to discuss abnormal menses cycle

S: Painful for 2 days, period did not end until 1/7 but was really bad

O: Vitals normal, Psych normal, Resp, normal, Skin normal. Labs reviewed.

A: Premenstrual menorrhagia and Anemia

P: Wait to see about next period

Codes used: N92.4, D64.9, 99213 (EPF+EPF+Straightforward)





# Scenario 2

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Provider is a Nurse

CC: Lab Draw

No Note

Codes used: E11.9, 36416, 83036, 36415, 99211







## Scenario 3

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A 10 year-old girl is scheduled for her yearly physical with her pediatrician. At the time of the visit, the patient complains of watery eyes, scratchy throat and stuffy nose for the past two days. The provider performs a physical. He also performs an expanded problem history and exam and treats the patient for a URI.

What GPRA measures is this patient also eligible for?





# Scenario 4

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Provider is Psychiatrist providing telehealth service

Clinic is Telebehavioral Health

Service Category is Ambulatory

CC: “Exhausted mentally and emotionally”

S: Patient onsite TN, psychiatrist offsite in NM. Hx of Bipolar who presents for evaluation. Time in: 10:10; Time out: 10:50. Tired, newly sober (6 mos), anxious at night, no suicidal ideations, quit smoking, having gastrointestinal issues, chronic pain and irritability

O: Vitals normal, mental status exam normal, no labs

A: MMD, rec, mod; anxiety, Alcohol use d/c; will change DX from bipolar to MMD, believe Alcohol played role in mood.

P: Increase meds, try OTC melatonin

Codes used: F33.1, F41.9, F10.20, 90792





## Scenario 5

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A 35 year-old type II diabetic is feeling weak. The physician performs a stat glucose test in which a finger stick is done placing the drop of blood on a reagent strip. The test indicates the patient is hypoglycemic. The physician gives the patient some glucose supplements and performs another stat glucose test using the same lab test as before 30 minutes later. The second test shows the glucose levels returned to normal

What GPRA measures is the patient also eligible for?





# Other types of audits

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- E/M Codes
- Health Factors
- Patient Education
- Merged encounters
- Condition specific
  - Diabetes
  - Asthma
  - Eye care
  - Patients with Depression





# Good documentation

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- Health record should be complete and legible
- Documentation should include:
  - Reason for the encounter (chief complaint)
  - Relevant history (related to why the patient is here)
  - Physical Examination (findings, observations)
  - Test ordered and their results
  - Assessment (clinical impression or diagnosis)
  - Plan of care
  - Date and signature of provider





# Additional items

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- Rationale for ordering diagnostic or ancillary services should be documented or easily inferred
- Past and present diagnoses available for review
- Health risk factors should be identified
- Documentation should support charges submitted on claim form
- Health record should be:
  - Complete
  - Concise
  - Legible
  - Timely





# Documentation improvement in physician practice

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- Education
- Documentation Improvement Programs
- Physician Queries
- Follow-up, Repetition, and Persistence





# A query should be considered when...

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“Guidelines for Achieving a Compliant Query Practice” (AHIMA, 2016 Update)

Consider the following:

- Conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent?
- Description or associated clinical indicator without a definitive relationship to an underlying diagnosis?
- Clinical indicator, diagnostic evaluation and/or treatment not related to a specific condition or procedure?
- Provides a diagnoses without underlying clinical validation
- Is unclear for present on admission indicator assignment







# A query should be considered when...

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Remember:

- Do not lead
- Do not question the clinical judgment of the provider
- Do not indicate the financial impact
- Include clinical indicators





# Query Formats

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Acceptable query formats:

- Open-ended
- Multiple Choice
- Yes/No





# Timelines for queries

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Medicare = No specific timeline for queries

General Rules to follow:

- Only attending physician can correct the health record
- Corrections should be made within 30 days of the initial documentation and substantial reasoning must be provided for the change
- Amendment should be based on an observation of the patient on the date of service and signed by the observing physician





# Bottom line

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Queries should be related to information or action taken during the specific date of service being queried.

Examples:

- Results of lab, imaging, etc.
- Diagnoses of active problem without documentation
- Clinical indicators documented in the visit note without an accompanying diagnosis
- Diagnoses coded/billed without indicating it was addressed/assessed
- Contradictory information in the visit note





# Sample query templates

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## Diabetes Mellitus and Complication not tied together.

- " This patient has diabetes mellitus and hyperlipidemia. Please addend the visit note dated xx/xx/xx to document the relationship, if any, between diabetes and hyperlipidemia. Thanks you."

## Contradictory Visit Note.

- "There is contradictory information in the visit note. Documentation in the respiratory section of the note states the patient does not have any respiratory diagnose, yet the Assessment state the patient does have COPD. If the patient does have COPD, please addend the visit note. If the patient does not have COPD, please remove the diagnoses. Thank you.





# Sample query template

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For abnormal findings.

- “Foot exam indicates abnormal findings of reduced sensation found on monofilament test and reduced vibration sense. Is there a resulting diagnosis for these clinical findings? If yes, please addend the visit note with any resulting diagnose. Thank you.”

For test results not addended to visit note,.

- “Ultrasound ordered from office visit xx/xx/xx indicates atherosclerosis of extremity. If you agree with this diagnosis, please addend the visit note dated xx/xx/xx with the test findings and resulting diagnosis. Thank you.”





# Make it work

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- Work with your physicians
- Engage physicians in the process
- Develop a policy
- Utilize secure methods of messaging and responding





# QUESTIONS?

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