Part B Insider (Multispecialty) Coding Alert

AUDITS: Can You Spot These 12 Red Flags In Your Charts?

Spot the trouble signs before they turn into disasters

When you're auditing your charts, will you know how to recognize the signs of a major problem? Here are some red flags our chart-auditing experts come across:

1) The same diagnosis for every visit. Consultant **Maxine Lewis** just finished an audit of one practice which used the same ICD-9 code for foot pain with every visit. On average, it was billing $600 per visit, and some visits were as high as $1,200 for the evaluation and management visit plus supplies. Simple foot pain shouldn't require $600 worth of services, much less $1,200, notes Lewis, with **Medical Coding Reimbursement Management** in Cincinnati.

In many cases, the patient probably had a fracture instead of simple foot pain, but the diagnosis code did not reflect that, says Lewis. If you're using a superbill, it may attach ICD-9 codes in random order, but it's up to the coder to make sure the most important code goes first, Lewis adds.

"The diagnosis coding is very important in these audits because it determines the medical necessity for what's being done," Lewis notes.

2) Billing the same code over and over. If all of your patients are level four or five, you've got trouble, but the same is true if they're all level two or three, says Lewis.

3) Hospital admissions. Often, physicians don't understand how much documentation they need to provide to justify a hospital admission. You need a comprehensive history and a comprehensive examination to justify a level two or three hospital admission, and one of those is often missing, says **Barb Pierce**, coding & reimbursement director for **Professional Management Midwest** in Omaha, NE.

4) Consults. Now that the rules for consults have recently changed (see PBI, Vol. 7, No. 4), you need to make doubly sure you have the request for a consult documented in your files and in the requesting physician's files, warns Thompson.

Some physicians think they're in consultation mode 100 percent of the time, because they're specialists, says Pierce.

5) Non-physician practitioners. CMS has clarified that physicians and NPPs can't perform shared visits for consultations, notes Pierce. And if an NPP does perform a consult, the requesting physician must have specifically asked for the NPP to perform the consult.

6) Canned documentation. If you have a template that you use for visits, make sure your physician doesn't just keep reusing the same answers. If a patient comes in with chest pain, and the doctor already has the box that says "no chest pain" checked, then it won't justify the work your physician did, says Lewis.

"People need to be cautious about cutting and pasting, and having too much canned documentation," says Pierce.

7) Illegible documentation. If the auditors can't read your physician's writing, they won't bother to audit the chart--they'll just throw it out, warns Lewis.

8) Blank documentation. You choose an X-ray code by the number of views the physician performed, notes Lewis. But often a physician will leave the number of views blank, and an auditor will downcode that claim to two views, the

minimum amount, she adds. Also, she audited some urologists who failed to document when they did a urinalysis, so they were losing money every time.

9) Tests documented but not done. One orthopedic surgeon couldn't produce the report on an X-ray or even its results. In an audit, Lewis found that 60 percent of the X-rays he'd ordered weren't happening because the patients were leaving without having them. His chart showed that he'd ordered the X-ray, but there was no follow-through. Lewis helped him come up with a system to make sure the patient actually had the X-ray after he ordered it.

10) Time-based coding. If you're billing for counseling and coordination of care, then you're entitled to bill based on time. But you should make sure the physician has documented the time spent with the patient, and how much of it was counseling or coordination, warns **Valerie Thompson**, a consultant with **Gates Moore & Company** in Atlanta.

11) Teaching physicians. Pierce still sees charts where the teaching physician has written "agree with above" after the resident's documentation. CMS has clarified that the teaching physician has to write something more positive.

12) Undercoding. If you're undercoding all your visits, that's just as illegal as overcoding, says Thompson. "You have to code per what's documented."