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Part B Insider (Multispecialty) Coding Alert

AUDITS: Can You Spot These 7 Red Flags in Your Charts?

Notice 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? Although you might find your coding practices routine, auditors might see them as red flags.

"It is difficult to say what carriers are deeming to be 'red flags' in determining which services to audit," says **Devona Slater, CHC, CMCP,** president and compliance auditor with ACE Auditors in Leawood, Kan. However, "it is true that many sophisticated tools are available and physician profiling does occur with many payers."

Read on to learn about seven potential red flags that you might find taking place at your practice.

1) The same diagnosis code for every visit. One consultant recalls a 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 E/M visit plus supplies. Simple foot pain shouldn't require $600 worth of services, much less $1,200. In many cases, the patient probably had a fracture instead of simple foot pain, but the diagnosis code did not reflect that.

"Each encounter must correlate to the indication for the visit; it is inconceivable for one diagnosis to apply universally," says **Robyn Lee,** principal with Lee-Brooks Consultants in Chicago.

"The selections of levels and associated diagnoses rests solely with the physician, surgeon, or other clinical provider," she advises.

Look at it through an auditor's lens: "As an auditor, it would make me suspicious if I audited 50 claims and they were all exactly the same," Slater says.

2) Billing the same CPT code over and over. If all of your patients are level four or five E/M visits, you've got trouble. The same is true if they're all level two or three.

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.

4) 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. "Many EHR system objectives are 'justified' based on the ability to accurately reach 1995 or 1997 E/M guidelines," Lee says. "This is, of course, accomplished by populating the subsequent visit with those existing fields completed during a prior visit -- the complete review of systems (ROS) is one good example."

Two misperceptions exist, Lee says. "The first is the medical-legal liability of 'missing' a minor change in an ROS. The second is that what's missing is the obvious -- visits and E/M level assignment must first be supported by medical necessity. A 'templated' note cannot meet these compliance obligations."

5) Illegible documentation. If auditors can't read your physician's writing, they won't bother to audit the chart. They'll just disregard it.

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

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amount. One consultant tells the Insider that she audited some urologists who failed to document when they did a urinalysis, so they were losing money every time.

7) Tests documented but not done. One orthopedic surgeon couldn't produce the interpretation reports on x-rays, or even the xrays' results -- despite billing for several x-ray interpretations.

Physicians must be able to prove that they provided a service, Slater says. "It may be that the hard copy film resides at the hospital with the report or at the radiology facility. I would definitely recommend having the interpretations in the office but as long as they can be produced from some source to prove that the physician did the service, I believe they would be entitled to keep the payment."

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