THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
ACTION AGENDA SUMMARY

DEPT: HEALTH SERVICES AGENCY

Urgent_____ Routine___X___

CEO Concurs with Recommendation YES pht NO____
(Information Attached)

BOARD AGENDA # *B-15

AGENDA DATE June 5, 2001

4/5 Vote Required YES____ NO X

SUBJECT:

APPROVAL OF INDEPENDENT CONTRACTOR AGREEMENT WITH SAGE ASSOCIATES FOR PERFORMANCE AND COMPLETION OF A COMPLIANCE AUDIT AT THE HEALTH SERVICES AGENCY.

STAFF RECOMMEN-DATIONS:

1. APPROVE THE AGREEMENT WITH SAGE ASSOCIATES FOR PERFORMANCE AND COMPLETION OF A COMPLIANCE AUDIT OF MEDICAL RECORDS AND ASSOCIATED BILLING DOCUMENTS AT THE HEALTH SERVICES AGENCY.

2. AUTHORIZE THE HEALTH SERVICES AGENCY MANAGING DIRECTOR OR HER DESIGNEE TO SIGN AND EXECUTE THE AGREEMENT.

FISCAL IMPACT:

The cost of the project is $75,500 of which $25,500 will be paid in FY 2001 and has been included in this approved budget, and $51,000 will be paid in FY 2002, which dollar amount has been included in the FY 2002 budget.

BOARD ACTION AS FOLLOWS:

No. 2001-385

On motion of Supervisor Simon , **Seconded by Supervisor** Caruso
and approved by the following vote,
Ayes: Supervisors: Mayfield, Blom, Simon, Caruso, and Chair Paul
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

1) X **Approved as recommended**
2) _____ **Denied**
3) _____ **Approved as amended**

Motion:

Christine Ferraro

ATTEST: CHRISTINE FERRARO TALLMAN, Clerk **By: Deputy** **File No.**

DISCUSSION: A Compliance Program provides for self assessment of practices, policies, and procedures related to medical record documentation and billing practices for all payor classes of patients. However, the Office of Inspector General (OIG) investigates and can level civil and/or monetary penalties against individuals or organizations who are found non-compliant with Medicare and/or Medicaid billing policies. The creation of a Compliance Program, which includes performance and completion of a Compliance Audit, is a major initiative of the OIG in its effort to preventing the submission of erroneous reimbursement claims and in combating fraudulent behavior in health care organizations. Included in the OIG's recommended compliance program is the performance of baseline audits of provider's medical records and associated billing documents to determine whether or not the medical record documentation is sufficient to substantiate the corresponding charges billed.

The proposed compliance audit will consist of a selected sample of medical records for 129 physicians/providers. The scope of the audit will address:

- billing for items and services not provided, as well as not billing for services provided
- appropriate and documented use of diagnostic (ICD-9) and procedure (CPT) codes
- appropriate use of billing procedure code modifiers
- upcoding and downcoding of services,
- completeness and legibility of medical record entries
- adherence of recommended coding guidelines
- documentation of the patients' changing health status, change in diagnosis, or changes in treatment
- summary reports by individual physician and by specialty on the results of the audit

With the recent OIG emphasis on fraud and abuse, it is incumbent upon organizations to identify and correct practices which result in erroneous and/or fraudulent billings, since both civil and monetary penalties can be assessed. For example, earlier this year the Regents of the University of California agreed to pay the federal government $22.5 million for overcharges to federally funded health care programs, including Medicare.

DISCUSSION – Continued

Results of a compliance audit by objective, trained, and qualified staff will provide the necessary information to management to implement corrective action programs to avoid penalties or sanctions and to improve upon billing and collection efforts.

POLICY ISSUES:

Approval of this contract will allow completion of a compliance audit of the medical records and associated billing documents at the Health Services and is consistent with the Board's policy of efficient government operations.

STAFFING IMPACTS:

None.

AGREEMENT
FOR
INDEPENDENT CONTRACTOR - NON MEDICAL

This Agreement is made and entered into by and between the County of Stanislaus (hereinafter referred to as "County") located at 1010 10th Street, Modesto, California 95354, and The Sage Associates, (hereinafter referred to as "Contractor").

INTRODUCTION

WHEREAS, the County has a need to conduct a thorough and comprehensive compliance audit of select providers;

WHEREAS, the Contractor is specially trained, experienced, and competent to perform such services;

NOW, THEREFORE, in consideration of the mutual promises, covenants, terms and conditions hereinafter contained, the parties hereby agree as follows:

TERMS AND CONDITIONS

1. SCOPE OF WORK:

1.1. The Contractor shall furnish to the County, those services and work set forth in Exhibit "A", attached hereto and by this reference incorporated herein.

1.2. Services and work provided by the Contractor at the County's request under this Agreement will be performed in a timely manner consistent with the requirements and standards established by applicable federal, state, and County laws, ordinances, regulations, and resolutions.

2. CONSIDERATION:

2.1 County shall compensate pay Contractor as set forth in Exhibit "A".

2.2 Except as expressly provided in Exhibit "A" of this Agreement, Contractor shall not be entitled to nor receive from County any additional consideration, compensation, salary, wages, or other type of remuneration for services rendered under this Agreement. Specifically, Contractor shall not be entitled by virtue of this Agreement to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever.

2.3 County will not withhold any Federal or State income taxes or Social Security tax from any payments made by County to contractor under the terms and conditions of this Agreement. Payment of all taxes and other assessments on such sums is the sole responsibility

of Contractor. County has no responsibility or liability for payment of contractor's taxes or assessments.

3. TERM:

3.1 The term of this Agreement shall be from June 1, 2001 to September 30, 2001, unless sooner terminated as provided below or unless some other term, method or time of termination is listed in Exhibit A.

3.2 Should Contractor default in the performance of this Agreement or materially breach any of its provisions, County, at County's option, may terminate this Agreement by giving written notification to Contractor.

3.3 Should County fail to pay Contractor all or any part of the compensation set forth in Exhibit A of this Agreement on the date due, Contractor, at the Contractor's option, may terminate this Agreement if the failure is not remedied by the County within thirty (30) days from the date payment is due.

3.4 This Agreement shall terminate automatically on the occurrence of any of the following events:

A. Bankruptcy or insolvency of either party;

B. Sale of Contractor's business; or

C. Death of Contractor.

4. WORK SCHEDULE:

Contractor's obligation is to perform in a timely manner those services and work identified in Exhibit "A". It is understood by Contractor that the performance of these services and work will require a varied schedule with the hours and times for completion of said services to be set by Contractor.

5. REQUIRED LICENSES, CERTIFICATES, AND PERMITS:

Any licenses, certificates, or permits required by the federal, state, county, or municipal governments for Contractor to provide the services and work described in Exhibit "A" must be procured by Contractor and be valid at the time Contractor enters into this Agreement. Further, during the term of this Agreement, Contractor must maintain such licenses, certificates, and permits in full force and effect. Licenses, certificates, and permits may include but are not limited to driver's licenses, professional licenses or certificates, and business licenses. Such licenses, certificates, and permits will be procured and maintained in force by Contractor at no expense to the County.

6. OFFICE SPACE, SUPPLIES, EQUIPMENT, ETC.:

Unless otherwise provided in Exhibit "A", County shall provide such office space, supplies, equipment, vehicles, reference materials, and telephone service as is necessary for Contractor to provide the services identified in Exhibit "A" to this Agreement.

7. WORKERS' COMPENSATION:

Contractor shall provide Workers' Compensation insurance coverage in the legally required amount for all Contractor's employees utilized in providing work and services pursuant to this Agreement. By executing a copy of this Agreement, Contractor acknowledges its obligations and responsibilities to its employees under the California Labor Code with regard to its employees. Contractor, at the time of execution of this Agreement, will provide County evidence of the required Workers' Compensation insurance coverage.

8. INSURANCE:

If Contractor utilizes a motor vehicle in performing any of the work or services identified in Exhibit "A" (Scope of Work), Contractor shall procure and maintain in force throughout the duration of this Agreement a business auto liability insurance policy with minimum coverage levels of $300,000 per occurrence combined single limit for bodily injury liability and property damage liability. The coverage shall include all contractor-owned vehicles and all hired and on-owned vehicles used in performing under this Agreement. A certificate of insurance shall be provided to the County at least ten (10) days prior to the start of services to be performed by the Contractor. The policy shall contain a provision prohibiting the cancellation or modification of said policy except upon thirty (30) days prior written notice to the County.

9. LIABILITY FOR ACTS OR OMISSIONS OF REPRESENTATIVES AND EMPLOYEES.

9.1. Each of the parties hereto shall be solely liable for negligent or wrongful acts or omissions of itself and its representatives and employees occurring in the performance of this Agreement, and if either party becomes liable for damages caused by its representatives and employees, it shall pay such damages without contribution by the other party. Contractor's obligation under the provisions of this paragraph is not limited to or restricted by any requirement in this Agreement for Contractor to have insurance.

9.2. To the extent permitted by law, County shall defend, indemnify, and hold harmless Contractor, its agents, officers and employees from and against all claims, damages, losses, judgements, liabilities, expenses, and other costs including litigation costs and attorney's fees arising out of or resulting from the active negligence or wrongful acts of County, its officers, or employees.

9.3 It is understood and agreed that Contractor shall be liable for any acts or omissions which occur outside the course or scope of performance of this Agreement and shall defend, indemnify and hold harmless COUNTY, its agents, officers and employed from and against all claims, damages, losses, judgments, liabilities, expenses, and other costs including litigation costs and attorney's fees arising out of or resulting from the active negligence or wrongful act of Contractor.

10. STATUS OF CONTRACTOR:

10.1. All acts of Contractor, its agents, officers, employees, and all other action on behalf of Contractor relating to the performance of this Agreement, shall be performed as independent contractors and not as agents, officers or employees of County. Contractor, by virtue of this Agreement, has no authority to bind or incur any obligation on behalf of County. Except as expressly provided in Exhibit "A", Contractor has no authority or responsibility to exercise any rights or power vested in the County. No agent, officer, or employee of the county is to be considered an employee of Contractor. It is understood by both Contractor and County that this Agreement shall not under any circumstances be construed or considered to create an employer-employee relationship or a joint venture.

10.2. Contractor, its agents, officers, and employees are and at all times during the term of this Agreement shall represent and conduct themselves as independent contractors and not as employees of County.

10.3. Contractor shall determine the method, details, and means of performing the work and services to be provided by Contractor under this Agreement. Contractor shall be responsible to County only for the requirements and results specified in this Agreement, and, except as expressly provided in this Agreement, shall not be subjected to County's control with respect to the physical action or activities of Contractor in fulfillment of this Agreement. Contractor has control over the manner and means of performing the services under this Agreement. Contractor is permitted to provide services to others during the same period service is provided to County under this Agreement. If necessary, Contractor has the responsibility for employing other persons or firms to assist Contractor in fulfilling the terms and obligations under this Agreement.

10.4. If in the performance of this agreement any third persons are employed by Contractor, such persons shall be entirely and exclusively under the direction, supervision, and control of Contractor. All terms of employment including hours, wages, working conditions, discipline, hiring, and discharging or any other term of employment or requirements of law shall be determined by the Contractor.

10.5. It is understood and agreed that as an independent Contractor and not an employee of county neither the Contractor nor Contractor's assigned personnel shall have any entitlement as a County employee, right to act on behalf of the County in any capacity whatsoever as an agent, or to bind the County to any obligation whatsoever.

10.6. It is further understood and agreed that Contractor must issue W-2 forms or other forms as required by law for income and employment tax purposes for all of Contractor's assigned personnel under the terms and conditions of this Agreement.

10.7. As an independent Contractor, Contractor hereby indemnifies and holds county harmless from any and all claims that may be made against County based upon any contention by any third party that an employer-employee relationship exists by reason of this agreement.

11. RECORDS AND AUDIT:

11.1. Contractor shall prepare and maintain all writings, documents, and records prepared or compiled in connection with the performance of this Agreement for a minimum of four (4) years from the termination or completion of this Agreement. This includes any handwriting, typewriting, printing, photostatic, photographing and every other means of recording upon any tangible thing, any form of communication or representation including letters, words, pictures, sounds or symbols or any combination thereof.

11.2. Any authorized representative of County shall have access to any writings as defined above for the purposes of making audit, evaluation, examination, excerpts, and transcripts during the period such records are to be maintained by Contractor. Further, County has the right at all reasonable times to audit, inspect, copy or otherwise evaluate the work performed or being performed under this Agreement.

12. NONDISCRIMINATION:

12.1. During the performance of this Agreement, Contractor, its agents, officers, and employees shall not unlawfully discriminate in violation of any federal, state, or local law, rule, or regulation against any employee, applicant for employment, or person receiving services under this Agreement because of race, religion, color, national origin, ancestry, physical or mental handicap, medical condition, marital status, age, political affiliation, or sex. Contractor and its agents, officers and employees shall comply with the provisions of the Fair Employment and Housing Act (Government Code section 12900, et. seq.) and the applicable regulations promulgated thereunder in the California code of Regulations. Contractor shall also abide by the Federal Civil Rights Act of 1964 (P.L. 88-352) and all amendments thereto and all administrative rules and regulations issued pursuant to said act. Contractor further agrees to abide by the County's nondiscrimination policy.

13. ASSIGNMENT:

This is an agreement for the services of Contractor. County has relied upon the skills, knowledge, experience, and training of Contractor, the Contractor's firm, associates, and employees of said Contractor as an inducement to enter into this Agreement. Contractor shall not assign or subcontract this Agreement without the express written consent of County. Further, Contractor shall not assign any monies due or to become due under this Agreement without the prior written consent of County.

14. WAIVER OF DEFAULT

Waiver of any default by either party to this Agreement shall not be deemed to be waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach, and shall not be construed to be a modification of the terms of this Agreement unless this Agreement is modified as provided below.

15. CONFLICTS

Contractor agrees that it has no interest and shall not acquire any interest direct or indirect which would conflict in any manner or degree with the performance of the work and services under this Agreement.

16. SEVERABILITY

If any portion of this Agreement or application thereof to any person or circumstance shall be declared invalid by a court of competent jurisdiction or if it is found in contravention of any federal, state, or county statute, ordinance, or regulation the remaining provisions of this Agreement or the application thereof shall not be invalidated thereby and shall remain in full force and effect to the extent that the provisions of this Agreement are severable.

17. AMENDMENT:

This Agreement may be modified, amended, changed, added to, or subtracted from by the mutual consent of the parties hereto if such amendment or change is in written form and executed with the same formalities as this Agreement and attached to the original Agreement to maintain continuity.

18. NOTICE:

18.1. Any notice, communication, amendments, additions, or deletions to this Agreement including change of address of either party during the term of this Agreement which Contractor or County shall be required or may desire to make shall be in writing and may be personally served or sent by prepaid first class mail to the respective parties as follows:

County of Stanislaus
Health Services Agency
Attention: Beverly M. Finley
P.O. Box 3271
Modesto, CA 95353

Contractor:
Mary Jean Sage
President
The Sage Associates
122 LePoint Street, Suite 201
Arroyo Grande, CA 93420

20. ENTIRE AGREEMENT:

This Agreement contains the entire agreement of the parties and no representations, inducements, promises, or agreements otherwise between the parties not embodied herein or incorporated herein by reference shall be of any force or effect. Further, no term or provision

hereof may be changed, waived, discharged, or terminated unless the same be in writing executed by the parties hereto.

EXECUTED THIS 1st DAY OF May 2001.

COUNTY OF STANISLAUS

APPROVED AS TO CONTENT:

Beverly M. Finley
Managing Director
Health Services Agency

APPROVED AS TO CONTENT:

CHIEF EXECUTIVE OFFICE

By: John Lens
Title: H. Management Consultant
Dated: 6/15/01

APPROVED AS TO FORM FOR USE
THROUGH JUNE 30, 2001:

STANISLAUS COUNTY COUNSEL

By: Dean Wright
Title: Deputy County Counsel
Dated: June 20, 2000

CONTRACTOR

Mary Jean Sage
President
The Sage Associates

Taxpayer's Identification or
Social Security Number:

_____

Exhibit "A"

This Exhibit A and the attachments referenced herein are hereby incorporated and considered integral parts of this Agreement. Any term or condition explicitly addressed in this Exhibit shall supercede and take precedence over any similar or conflicting term or condition contained in any attachment.

A. Scope

Contractor agrees to conduct a thorough and complete Compliance Audit (Project) of medical records and associated billing documents, including charge documents, individual bills, and remittance advices as stipulated in Attachment I (Request for Proposal/revised) and Attachment II (Sage Proposal).

Clarification to these Attachments are as follows:

A.1. Project Start and Duration. Per the Sage Proposal, the parties will mutually agree on a start date for the Project which will begin no later than 8 weeks from the date this Agreement has been signed by all parties. The Project will be deemed to have started when one or more consultants working with the Contractor begin the on-site audit process. Once started, the audit phase of the Project will be completed by Contractor no later than 6 continuous weeks after it has started. All on-site work by Contractor shall be performed during normal working hours (8:00 a.m. to 5:00 p.m.), Monday through Friday, exclusive of any County observed holidays. Contractor agrees that all abstracting, medical record, billing, and associated reviews will be done on-site. County shall have the responsibility to ensure that documentation, charts, and records needed for review by Contractor is compiled and readily available to Contractor to optimize their productivity. The audit phase of the Project will be deemed to be completed once Contractor has completed on-site audits of provider records as indicated in Attachment I Finally, the Contractor agrees to present a written report and oral presentation, in person, at County facilities at a time mutually convenient to both parties no later than 5 weeks from the on-site conclusion of the audit process. The Project will be deemed complete once this on-site oral presentation has been made.

County agrees that the timely and complete provision of the necessary records for audit review is critical to the performance of the Contractor, and will endeavor to provide the agreed upon quantity of record sets at the beginning of each business day. Repeated failure of the County to provide complete Record Sets to Contractor in sufficient number to optimize Consultant's productivity, will be grounds for immediate termination of this Agreement by Contractor. chedule of Record Sets is to be defined by mutual agreement between County and Contractor and become a part of this Exhibit A.

A.2. Record Sets. For the purpose of this Agreement, Record Sets shall be defined as the following complete set of documents available for review by Consultant for each Provider whose records are being audited.

- Copy of encounter form/charge document
- Comolete medical record inclusive of the dates of service being audited

- Hard copy ledger of the individual patient account, including account activity 30 days prior to the dates being audited and through collection until the account has been zero balanced
- Hard copy of any EOB/Remittance advice for dates of service being audited

A.3. Consultants. If during the course of the Project, the County has determined for any reason that one or more consultants utilized or assigned by Contractor to the Project are dysfunctional, Contractor agrees to promptly remove and replace consultant(s) once a formal, written request has been made by County.

A.4. Summary Reports. At a minimum, the summary reports provided by Contractor at the conclusion of the Project shall contain and be presented in a format similar to Attachment III and shall contain elements and sub-reports identified by Contractor in Attachment III

A.5. Number of Audits. Although Attachment I identifies the number of providers to be audited by specialty, County reserves the right to modify this list, upon mutual written agreement with Consultant, provided the number of providers to be audited does not exceed 129, which is the number of providers identified in Attachment I.

B. Confidentiality.

Contractor agrees that all information obtained during the course of the Project shall remain confidential and shall be treated as confidential by Contractor and any subcontractor utilized by Contractor in fulfillment of this Agreement. Vendor shall implement and maintain such safeguards as are necessary to ensure that all patient information made directly available by County to Contractor and/or indirectly seen, observed, or discerned during the course of the Project is not used or disclosed by Contractor except as provided in this Agreement.

Contractor shall promptly report to County any use or disclosure of patient information in any form of which Contractor becomes aware that is outside the scope of this Agreement. Contractor agrees to not disclose any findings of the compliance audit or any information obtained during the course of the Project to any third party without the expressed written consent of County.

Upon the termination or conclusion of this Agreement, Contractor shall return to County all identifiable, patient information obtained during the course of the Project. This Section B shall survive the termination or conclusion of this Agreement and shall survive indefinitely.

C. Compensation.

The total fee for the Project is $76,500 which fully compensates Contractor for all services provided up to and including on-site oral presentation to County on the findings and results of the Project. Such fee is inclusive of all out-of-pocket expenses which include but are not limited to per diem expenses, travel expenses, lodging, communication, mail, and/or courier service.

Payment will be made by County to Contractor in 3 equal installments, as follows;

1st Installment	Payable once all parties have signed the Agreement	$25,500.00
2nd Installment	Payable when on-site audit phase of Project is completed	$25,500.00
3rd Installment	Payable upon delivery of written summary reports	$25,500.00

If , for any reason, this Agreement is terminated in accordance with Section D, Contractor shall only be obligated for payment up to any documented out-of-pocket and incurred, direct expenses associated with the Project up to the maximum set forth in the above schedule, subject to the following conditions:

- If the project is terminated before the 15th calendar day preceding the scheduled on-site audit phase of the project begins, no payment will be due Contractor, and Contractor agrees to promptly reimburse County any monies paid by County prior to the termination date.
- If the project is terminated on or after the 15th day preceding the on-site audit phase of the project begins, any payments made by County in excess of the documented direct expenses identified above shall be promptly remitted to County by Contractor.

D. Term and Termination

The term of this contract will begin June 1, 2001 and terminate September 30, 2001. Either party may terminate this Agreement for convenience and without cause upon providing ninety (90) days prior written notice to the other party. Upon termination of this Agreement, the County will pay to Contractor all amounts owing to Contractor for services and work satisfactorily performed.

ATTACHMENT I

REVISED COMPLIANCE CHART REVIEW RFP

The RFP for the compliance and medical record documentation audit is amended to reflect a reduction in the scope of the original project.

The scope for the Compliance Audit phase of the RFP is revised as follows.

1. Number of claims/physician to be reviewed against medical record documentation shall be as indicated below.

SPECIALTY	No.	# CLAIMS/PROVIDER
Primary care	70	10
Residents (1st,2nd)	18	10
Specialists		
ENT	3	10
Cardiology	3	10
Comm. Dis.	1	10
Dentist	2	10
Endocrin	1	10
Neurology	5	10
OB/GYN	5	10
Oncology	1	10
Opthalmology	1	10
Ortho	8	10
Podiatry	3	10
Urology	8	10

The individual claims to be reviewed will be selected by HSA based on claims submitted within the previous 90 days and will be representative of our payor mix.

2. Coding and Billing Audits. Based on the above sampling size, an audit of billing information compared to medical record documentation will be conducted. HSA in conjunction with consultant will develop audit criteria for this phase of the project which will include at a minimum, review of billing and medical record entries against the following criteria.
   - billing for items or services not rendered or not provided (over-billing) and not billing for items or services provided (under-billing).
   - submitting claims for supplies and services not deemed "reasonable and necessary".
   - double billing
   - billing for non-covered services as if covered
   - billing for unbundled services
   - appropriate us of CPT modifiers
   - upcoding/downcoding of levels of service
   - accuracy, appropriateness, and specificity of ICD-9 codes based on medical record documentation
   - review of written policies and procedures related to billing with specific recommendations made relative to suggested improvement and/or changes in existing policies, procedures, and practices to enhance compliance

3. Medical Record Audit. The Medical Record Audit will be performed in conjunction with the Coding and Billing Audit. The consultant and HSA shall develop audit criteria for a comprehensive review of medical record entries. At a minimum, the audit will review,
   - the appropriateness of the service provided
   - the completeness and legibility of entries

- adherence to recommended E&M coding guidelines
- documentation of the need for diagnostic and/or ancillary services and supplies including documented medical necessity for testing
- documentation of the patient's changing health status, change in diagnosis, or changes in treatment.

4. Summary Reports. Consultant will compile and present a summary report of findings and recommendations based on the results of the above audits. These reports will include,
   - An overall summary specifying the results by specialty group and aggregate for the facility with any corresponding recommendations and corrective action.
   - An individual provider report for each provider compared to the group category.
   - A summary of recurring examples of non-compliance by individual, group category, and for all specialties.
   - A summary of findings relative to written billing procedures and observations.

5. Education and Training. Based on the findings and results of the Compliance Audit, the Agency may request subsequent individual and group training for physicians and support staff.

OVERVIEW:

This proposal is submitted in response to the revisions to the scope of the original Request for Proposal (RFP), dated December 7, 2000. It is directed toward the professional completion of all elements specified in the revised RFP, in a timely manner.

This proposal and incorporated action plan will require the on-site activity of a minimum of two highly skilled consultants for a continuous period of approximately five weeks. These on-site consultants will be scheduled to work 8 hours/day, 5 days/week until all audit data has been collected. The Sage Associates may select to rotate on-site consultants during this phase of the project, to address other business commitments. All on-site consultants will be selected from the consultant list included in this proposal. Following this period of on-site data collection, we will require approximately three weeks for summary reports' development and recommendations for performance improvement action.

The on-site data collection phase of this project will include the review and analysis of patient chart entries, medical billing records including financial tracking records, and explanation of benefits (EOB) reports of ten randomly selected patients and dates of service, for each provider. Additional dates of service documentation for each patient selected must be available to evaluate changing health status, change in diagnosis, or changes in treatment. We will utilize Sage Associate proprietary forms, as approved by the client, for this data collection activity. All data collection forms will be forwarded to The Sage Associates headquarters in Arroyo Grande, California for database loading and summary report generation.

We request a copy of all written policies and procedures related to billing, be provided to The Sage Associates at the start date of this project. These policies and procedures will be reviewed for clarity, completeness and adherence to established compliance guidelines. We will submit a report of our evaluation with specific recommendations for changes to enhance compliance with the established guidelines.

We will commence database loading of audit analysis reports concurrent with the on-site review and analysis activity. At the conclusion of the on-site data collection activity, performance summary reports will be developed; by individual provider; by specialty group; and, in aggregate for the facility. In addition, we will provide a summary report of recurring non-compliant examples by individual provider, specialty group, and in aggregate for the facility. Delivery of the summary reports will include a statement of overall findings and our recommendations for performance improvement action.

At the conclusion of this project and as findings warrant, The Sage Associates will submit a subsequent proposal to provide individual or group training directed toward meeting the billing and coding compliance goals of the Stanislaus County Health and Services Agency.

ACTION PLAN:

ON SITE RECORD AUDIT:

Record Selection

The Stanislaus County Health Services Agency will select and make available a full set of all documents needed to effect the billing and chart documentation audit. Selection of records should meet the following criteria:

- To insure a complete audit trail, dates of service selected should be limited to those where an EOB has been received.
- Records selected should include multiple range of services and diagnosis.
- All records to be selected for an individual provider should be provided to the consultants at one time. This allows the consultants to acclimate to individual writing and documentation styles.
- Record selection should be by specialty grouping and include resident providers in the specialty.
- A minimum of 60 record sets should be available to the consultants daily.
- The full patient chart should be provided for documented evidence of changing health status, change in diagnosis, or changes in treatment.

Audit Criteria

Our on-site consultants will utilize audit forms specially developed by The Sage Associates to collect and report all audit details. Completed audit forms will be mailed daily to The Sage Associates headquarters for entry to the summary report database. Data collected will include at a minimum, each of the following elements:

- Identification of under-billing or over-billing.
- Services provided vs services billed.
- Billing for services or supplies deemed "not reasonable or necessary".
- Double billing.
- Billing for unbundled services.
- Billing for non-covered services.
- Support for level of service (upcoding/down-coding)
- Appropriate selection of CPT codes and modifiers based on documentation specified in the patient chart.
- Accuracy, appropriateness, and specificity of ICD-9 codes based on documentation in patient chart.

- Documentation of the need for diagnostic and/or ancillary services and supplies including documentation of medical necessity for testing.
- Documentation of the patient's changing health status, change in diagnosis, and/or changes in treatment.
- Match of medical record diagnosis to encounter form diagnosis codes
- Use of non-physician providers (PA,NP, PT,OT)
- Services billed by RN, Nutritionist, Dietician, etc.
- Presence and involvement of Teaching M.D., Residents, and /or Attending M.D.
- Completeness and legibility of chart entries, including:
    - Patient Identification
    - Patient and family histories, testing, diagnosis and treatment
    - Verification of provider's signature
    - Verification of date of service and match with billing record.
- Accuracy and completeness of billing document.
    - ICD-9 and CPT code match to patient chart entries.
    - Date of service match to patient chart entries.
    - Appropriate use of Provider ID.
    - Appropriate reporting of discounts.
    - Resolution of credit balances.
- EOB analysis:
    - Requests for additional information.
    - Non-covered services.
    - Duplicate billing.

SUMMARY REPORTS:

Analysis and Conclusions

Following the conclusion of all on-site data collection activity, The Sage Associates primary consultant will prepare an analysis report of the findings of the audit, with identification of specific areas of non-compliance and recommendations for performance improvement. This report will include sub-reports in the following categories:

- results by provider specifying areas of non-compliance
- results by specialty group specifying areas of non-compliance
- facility results specifying areas of non-compliance by each specialty
- results by non-compliance item for each specialty group

Report Presentation

The Sage Associates will initially submit a complete summary report set, to the Stanislaus County Health Agency management team for their review. We will then provide an oral presentation of the report findings at a date specified by the Stanislaus County Health Agency.

BILLING POLICIES AND PROCEDURES:

Policies and Procedures Review

Concurrent with the start of the on-site audit activity, The Sage Associates will be provided a complete set of the written policies and procedures for billing services used by the Stanislaus County Health Services Agency. We will review these documents to insure completeness and consistency with current compliance guidelines. We will provide a written report identifying areas of concern or non-compliance and provide recommendations for change.

PROJECT START AND DURATION:

The Sage Associates will require a minimum of 6 weeks advance notice of the project start date to ensure allocation of the specialized consultants to this project. We will schedule a minimum of two consultants on site for a period of 8 hours per day, 5 days per week during the chart audit and data collection process. This proposal anticipates that the on-site audit activity will continue for consecutive weeks until the total of 1290 encounters have been reviewed.

Audit conclusion and summary reports will require approximately 3-4 weeks to prepare and will commence upon completion of the on-site audit activity. Summary reports will be provided first via mail service, and subsequently by oral report to the client.

PROJECT FEE:

The total fee for the project as defined in this proposal is **$ 76,500.00**

Our usual and customary practice is to request payment be provided in 3 equal installments.

1/3	Payable at Project Contract Date:	$ 25,500.00
1/3	Payable at completion of on-site activity:	$ 25,500.00
1/3	Payable upon delivery of written summary reports.	$ 25,500.00

ATTACHMENT III

1. Report of Findings: E/M Documentation Assessment
2. Summary of Internal Audit
3. Summary of External Audit

Report of Findings

E/M DOCUMENTATION ASSESSMENT

FACILITY XYZ

FACILITY XYZ

Documentation Assessment Report
April, 2000

Scope of Assessment:

The Sage Associates was asked to perform a documentation assessment for Facility XYZ at the request of their attorney, Frank Smith, Esq. This assessment focused on appropriate selection of procedure/service codes using the Health Care Financing Administration's Common Procedure Coding System (HCPCS), of which the American Medical Association's *Physicians' Current Procedural Terminology, Fourth Edition (CPT-4)* system is a part. Health record entries were reviewed for completeness by applying documentation principles. Both the 1995 and 1997 "Documentation Guidelines" as issued by HCFA and the AMA were considered when performing this assessment.

The records reviewed, provided a sample of the evaluation and management (E/M) services that are performed by providers at Facility XYZ. Inpatient hospital services were reviewed from Hospital ABC in Oakland, CA and DEF Hospital in San Leandro, CA. Services provided in the Skilled Nursing Facility (SNF) were also reviewed.

The functions completed during the assessment were:

- A comparison of frequently performed E/M services with the CPT codes and modifiers assigned to these procedures in the CPT manual.
- Assessment of the accuracy of the written documentation in the patient record in comparison to the CPT manual description of assigned codes and HCFA/AMA documentation guidelines for supporting the level of service billed
- Identification of opportunities to improve physician documentation regarding levels of care
- Provision of a written report of findings, problems and solutions.

Findings:

1. CPT Code Bundling/Unbundling

In January, 1996 HFA adopted a set of national correct coding policies developed under its National Correct Coding Initiative (CCI). The purpose of this initiative was to develop, for the Health Care Financing Administration's Bureau of Program Operations, correct coding methodologies to control improper coding that leads to inappropriate increased payment of Part B Medicare claims. In an effort to promote correct coding nationwide and assist physicians in correctly coding their services for payment, the policies that were developed took into account the coding conventions outlined in the AMA' CPT manual, national and local policies and edits, coding guidelines developed by national societies, analyses of standard medical and surgical practice, and reviews of current coding practice The national correct coding policies identify two types of unbundling:

- *Intentional unbundling*, a technique utilized by providers to manipulate coding in order to maximize payment; and

- *Unintentional unbundling;*, which results from a misunderstanding of coding guidelines

Unbundling is essentially the billing of multiple procedure codes for a group of procedures covered by a single, comprehensive code. Rebundling correctly bundles a group of procedures into the appropriate comprehensive code.

Each physician practice should maintain a copy of the pertinent sections of the CCI guidelines and refer to them as necessary to ensure correct coding under current Medicare guidelines.

Recommendation:

Unbundling was not identified as a problem area during this assessment. However, the billing company should review your remittance advice notices carefully and if bundling occurs the practice should be notified.

2. Evaluation and Management (EM) Consultation Coding:

A consultation is an E/M service provided to a patient by a physician (usually, but not always, a specialist) at the request of the patient's attending physician. If the consultant assumes the responsibility of providing continuing care for the patient, the subsequent services are no longer considered consultations.

The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the patient's medical record. A consultation may include additional surgical opinions sought by a patient or ordered by a physician. The consulting physician must recommend a treatment plan to the referring physician for approval. The consulting physician can write orders initiating treatment at the request of the attending physician. After the consulting physician takes over the patient's care, the physician should use office visit or inpatient visit codes instead of consultation codes to repot his or her further services.

Documentation required to substantiate a consultation: A consultation includes a patient history and physical exam as well as a written report to the attending physician, which must contain findings and recommendations for the treatment of the case, and must be included in the patient's permanent medical record. When the consulting physician, at the request of the attending physician, writes orders initiating the treatment plan, the medical record must reflect that the attending physician requested that the consultant write these orders. For Medicare patients, the unique physician identification number (UPIN) of the referring physician must be reported on the consulting physician's claim.

Recommendation:

Consultation coding was not identified as a major problem area during this assessment. However, most of the "pre operative" exams performed by the group are billed out as outpatient consultations and the documentation presented does not meet the requirements set forth for a consultation service. See the discussion that follows under "Other Recommendations".

3. ICD-9-CM Coding:

Guidelines for coding outpatient diagnoses must always be followed. Follow the American Hospital Association's (AHA's) *Coding Clinic for ICD-9-CM* reporting guidelines for outpatient hospital and physician offices effective October 1, 1995 and HCFA's CCI guidelines for diagnosis coding. Of particular importance are the following guidelines:

- The chief reason for the visit should be listed as the first diagnosis - with hospital patients this may vary from day to day
- Signs and symptoms should be coded when there is no definitive diagnoses
- Rule-out conditions should not be coded as confirmed
- More than one diagnosis may be coded when appropriate

Specific ICD-9-CM codes should be selected. Care should be taken to select the most specific diagnosis code that corresponds to the documentation in the progress notes. In

addition, fourth and fifth digits - which add specificity to the diagnosis - must be used when listed in the ICD-9-CM code book.

The diagnosis linked to the service should always be the one demonstrating the medical necessity for the service. Medicare will not permit patient billing for services deemed to be medically unnecessary in the absence of a waiver obtained at the point of service in which the patient is informed that the service will likely not be covered and agrees to be responsible for the charges.

Recommendation:

While the specific ICD-9 codes were not analyzed during this assessment it did come to my attention that the coder was using the same list of ICD-9 codes that came from the medical records department at the hospital. In some instances there were multiple physicians rendering services to the patient and providing diagnoses for the record.

Most insurance carriers will pay for a patient to be seen by only one physician per diagnosis. If multiple physicians report the same service (i. e. a hospital visit) for the same diagnosis not everyone gets paid. It is imperative that each physician diagnostically code only the reason he or she is seeing the patient. This allows physicians to be paid for concurrent care.

4. Chart Documentation:

Both the billed ICD-9 diagnosis code and CPT service code must match the chart documentation. It is a legal requirement, a Medicare mandate, and an industry norm that all codes appearing on the HCFA-1500 claim form or electronic format - both diagnosis and procedure - must be substantiated by chart documentation. All encounter forms, (if used), visit notes and test reports should include a diagnosis list or an indication for the procedure performed. Physicians and coding staff should receive periodic training on the importance of accurately documenting all diagnoses treated and services provided during each encounter, and coding the chart entry exactly as stated.

All portions of the progress notes must be legible. During an audit, if the auditor cannot read a portion of the progress notes, that section is considered not to have been done.

Additionally, each encounter must "stand on its own" - if the auditor is given the documentation of the physician for a given date of service, that documentation must portray everything that is considered in caring for the patient at that encounter. In other words, if the reviewer is given a daily hospital note, that note should either have everything documented within the note that allows that service to be billed - if medications are ordered it needs to be stated on that record, if tests are ordered it needs to be stated on that record, if a problem list or diagnosis list is used, but located

somewhere else in the chart, a notation should be made that would lead the reviewer to the appropriate record.

Recommendation:

Many of the subsequent hospital services (visits) that were reviewed did not have a diagnosis listed on the record for the day. Often there was a diagnosis on the initial hospital admission record and a diagnosis on the hospital discharge summary, but no diagnosis for the follow up or daily visits. It is important that each provider give your coder the information needed on each visit for her/him to abstract the diagnosis (the reason you were seeing the patient) for each day.

5. CPT Code Accuracy:

Each progress note should contain the key elements necessary to assign the E/M code accurately. The components necessary to determine code selection are: chief compliant, history, physical exam, diagnosis and treatment plan. Diagnosis and treatment plan make up the elements of medical decision making.

E/M levels should be assigned based on the amount of work necessary to provide a diagnosis and treatment plan. This should be reflected in the assignment of the three key components used to establish the proper level of service - history, physical exam and medical decision making. Examples of normal standards of care for presenting problems are listed in the CPT manual under each E/M code. Even if the physician's normal practice is to perform a comprehensive evaluation on each patient, the standard of care for each presenting problem will usually dictate the appropriate level of service.

When counseling dominates an encounter, the time spent performing counseling can be used to determine the level of service provided. In such a case (i.e. your family conference), the actual amount of time spent counseling and the total visit time must be documented in the medical record.

CPT coding changes should be reviewed as they are announced by the AMA and Medicare to ensure proper CPT coding on the medical claim form. In addition, it is important to monitor carrier guidelines as they are published in the *Federal Register*, as well as local Medicare carrier newsletters, AMA guidelines published in *CPT Assistant,* and other periodicals addressing reimbursement issues.

Modifiers should be used appropriately for those carriers and insurance plans requiring them.

When the patient is taking prescription medications, these should be documented in the medical record progress notes. The physician may then list corresponding diagnoses as

having been treated that day. Changes to dosage or recommendations to continue the current dosage should be documented in the medical record progress notes.

Physician progress notes should match ancillary report findings. For example, if an x-ray report in the medical record states that the patient had a fractured humerus, the progress note should indicate the same finding if the x-ray report was available at the time of the visit.

The attending physician identified by the PIN entered on the claim form (paper or electronic) **must be the same as the physician who signed the progress note.**

Per HCFA coding and documentation guidelines for physician billing, when the postoperative diagnosis differs from the preoperative diagnosis for a definitive or therapeutic (as opposed to a diagnostic) procedures, the indications for/reason for ordering the procedure should be sequenced first. However, the findings from the diagnostic procedure should also be coded.

Recommendation:

CPT coding was identified as problematic with many of the encounters/charts reviewed for this assessment. However, all dates of service selected for this review were prior to the practice coder receiving adequate instruction on selection of appropriate CPT code based on the documentation presented. On the date of my initial site visit to review documentation, I spent nearly the entire day reviewing with the coder how to select the appropriate level of service for the E/M services performed. I do believe she got a good grasp of what elements she was looking for when assigning the appropriate level of service. I would expect the compliance of code billed to documentation supplied to improve dramatically.

There were several areas of concern regarding lack of documentation:

- Elements of history of present illness (HPI) were minimal on most subsequent hospital visits. They were very comprehensive on nearly all initial hospital admissions as well as on most discharge summaries.

- Review of Systems was minimal on most records - this element of the history was what kept most of the services to a lower level - especially on the initial hospitalizations. If the history is detailed the highest service that can be billed is a level 1. To reach a comprehensive history level the ROS must be complete - review 10+ systems.

- Family history was not documented on many visits, including initial visits. It was unclear to me whether the family history had not been reviewed, or whether it was reviewed, but was noncontributory. Remember, if it isn't documented, it is assumed it did not happen. Negatives on PFSH (past family social history) and ROS (review of system) should be documented as well as positives.

- By CPT definition the services for discharge day management codes (99238 and 99239) are to be used to report the total duration of time spent by a physician for final hospital discharge of the patient. The codes include, as appropriate:
    - Final examination of the patient
    - Discussion of the hospital stay
    - Instructions for continuing care to all relevant caregivers
    - Preparation of discharge records, prescriptions and referral forms

    The discharge summaries generally did not mention anything about final examination of the patient and therefore, would not qualify for this management service. Further, these
    codes are time based - 30 minutes or less and more than 30 minutes. It is essential that the provider communicate to the coder/abstractor how much time was spent on this discharge management.

- There were a number of occasions when the financial record (or billing record) indicated services performed by one provider, but the patient's medical record had a signature on the date of service by another provider. Even though the group as a whole bills under one provider ID number, it is required that you report the individual "performing provider" correctly.

- There was minimally one or two dates of service that I found services billed, but no documentation could be found in the medical record to support a service having been performed that day. This was the exception rather than the norm. However, I would suggest an audit process be put in place to assure that services are not billed if they are not rendered.

6. Other Recommendations:

- Duplicate Billing:

  Many of the financial records from EFG indicated duplicate billings - you need to establish some type of audit system to prevent duplicate billings from being reported. Most insurance carriers will catch it and not pay for two services on the same day, but if you continue to bill it that way and let the carriers do the auditing/editing of the claims it appears that you are trying to "game the system".

- Pre-operative Consultations

  Pre-operative visits/services are performed for the Ambulatory Surgery Service and these services are being billed as "pre-op exam", reported as outpatient/office consults. It is not clear on the documentation/dictation that this is a consult - who is asking opinion and your opinion of what diagnosis. Most of these services are being billed with the diagnosis for which the patient is scheduled for surgery - it doesn't

indicate that you are rendering an opinion on the surgery. See the attached information sheets on consultations and what documentation needs to be present.

- Provider signature vs provider billing

  Let me once again reiterate: *The attending physician identified by the PIN entered on the claim form (paper or electronic) must be the same as the physician who signed the progress note.*

  This appears problematic at EFG - there were numerous services billed under one provider ID, but the record had the signature of a different provider having performed the service. I recommend you set up a system at that facility to verify provider performing the service and provider billing.

Final Comments:

Thank you for asking me to provide this assessment. There are a number of documentation issues that should be addressed and I would be happy to assist you in any further review after you have implemented some of the recommendations. I would also be happy to assist with implementation of any of the recommendations with which you wish assistance.

The entire staff of XYZ was very cooperative during the assessment - please thank them for the assistance they all gave us during this assessment.

CONSULTATION VS REFERRAL

Which Service Is It?

	Consult	Referral
Request in writing	• "Please see patient for a consult." • "Consulting services requested for . . . . . ."	"Patient as been referred by.. . . . . ."
Problem	• Suspected or known diagnosis • Consulting physician unsure of condition or assumption of management	Identified
Treatment	• Undetermined or possibly known	Known
Requested Physician	• Decides which physician will administer care • Uncertain at the time of consult	Oversees and manages care
Report	• Written report to requesting physician	Written report to requesting physician not necessary
CPT Code	• Consult	New/established patient

Examples:

- A specialist can bill a consult even if she/she runs diagnostic tests and isn't sure who will provide continuing care as long as the primary physician requests the consult in writing. The primary is asking for an opinion and didn't transfer care.
- Primary care physicians can bill for consults when a patient will be having surgery and the surgeon requests an opinion from the primary. The request must be stated in writing.
- Follow-up visits in consultant's office or other outpatient facility ***initiated by the physician consultant*** are reported with office visit codes for established patients

No longer a consultation when:

1. Diagnosis has been made **and**
2. Treatment has begun

Consultation vs Referral Visit

If you're still confused on what's a consult versus a visit, just this handy chart of tips to help you decipher. Remember . . . . every tip has an exception, so you have to look at each service individually to determine what service you really have.

Consultation	Referral Visit
Suspected problem	Known problem
Undetermined course of treatment	Prescribed and known course of treatment
Only opinion or advice sought. Subsequent to the opinion, treatment may be initiated even if same encounter	Transfer of total patient care for management of the specified condition
Written request for opinion or advice received from attending physician, including the *specific* reason the consultation is requested	Patient appointment made for the purpose of providing treatment or management or other diagnostic or therapeutic services
Written opinion returned to attending physician (if a telephone call is made, there *must* be documentation of the call by both physicians in the patient record)	No further communication (or limited contact) with referring physician is required
Patient advised to follow up with attending physician	Patient advised to return for additional discussion, testing, treatment or continuation of treatment and management
Final diagnosis is probably unknown	Final diagnosis is typically known at the time of referral
Recommended request language: "Please examine patient and provide me with your opinion and recommendation on his/her condition"	Typical verbiage: "Patient is referred to your office for treatment or management of his/her condition".
Source: Compiled from MCM 15506	

[Medical Practice Name]
Department:
Provider:
Summary of Internal Audit

Patient #	Date of Service	Physician E/M	Auditor E/M	Physician ICD-9	Auditor ICD-9	Physician Other CPT	Auditor Other CPT	Med. Neces.	Non-Cvred	Comment

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive

SF = Straight forward
L = Low
M = Moderate
H = High

H = History
E = Exam
MDM = Medical Decision Making

CC = Chief Complaint
ROS = Review of System

HPI = History of Present Illness
PFSH = Past Family Social History

SUMMARY

Total E/M Codes Reviewed:	#
Total E/M Codes Overcoded:	#
Total E/M Codes Undercoded:	#
Total E/M Codes Correct:	#
E/M Overcoded Error Rate:	%
E/M Undercoded Error Rate:	%
E/M Correct:	%
Total Other CPT Codes Reviewed:	#
Total Other CPT Overcoded Errors:	#
Total Other CPT Undercoded Errors:	#
Other CPT Overcoded Rate:	%
Other CPT Undercoded Rate:	%
Other CPT Codes Rate:	%
Total Resident/Attending M.D. Services Reviewed:	#
Total Services Billed in Error	#
Total Teaching Physician Rules Error Rate:	%

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive

SF = Straight forward
L = Low
M = Moderate
H = High

H = History
E = Exam
MDM = Medical Decision Making

CC = Chief Complaint
ROS = Review of System

HPI = History of Present Illness
PFSH = Past Family Social History

FACILITY XYZ

Summary of External Audit

Date: March 16, 2001

Patient #/ Physician	Date of Service	Physician E/M	Auditor E/M	Physician Other CPT	Auditor Other CPT	Comments	Accuracy
#1 Dr. A	11/15/00	99205	99203	93000	93000 (C)	H=D, E=C, MDM=L. This is documented as a level three new patient visit. Only five systems were reviewed and only two of the three PFSH were documented, which keeps the history to a lower level. Medical decision making is at low - there is no indication if the patient is under prescription drug management which would have brought the MDM up one level to moderate.	O
#2 Dr. A	11/15/00	99213	none	none	none	This record is illegible. No provider signature for this date	O
#3 Dr. A	11/15/00	99214	99211	none	none	Blood pressure reading is the only thing legible on this record	O
#4 Dr. A	11/15/00	99245	99244	none	none	H=D, E=C, MDM=M. This should be a level four, rather than five consultation. There is a referring physician indicated in the dictation, but it is not clear what the reason for the request was. The dictation is	O
#5 Dr.A	11/16/00	99215	99212	93000	93000 (O)	H=0, E=EPF, MDM=SF. This pre-operative exam shows no indication why the surgeon should not have done this pre-operative service - this is a healthy patient with no indication of problems. The form indicates what systems were examined, otherwise the record is illegible. The insurance claim was filed to Medicare with a diagnosis of 785.1 (heart palpitations) - there is no indication on the record to support this problem/diagnosis. Records says patient is "well" – no history to indicate a history of heart irregularities.	O

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive

SF = Straight forward
L = Low
M = Moderate
H = High

H = History
E = Exam
MDM = Medical Decision Making

CC = Chief Complaint
ROS = Review of System

HPI = History of Present Illness
PFSH = Past Family Social History

O=Overcoded
U=Undercoded

Patient #/ Physician	Date of Service	Physician E/M	Auditor E/M	Physician Other CPT	Auditor Other CPT	Comments	Accuracy
#1 Dr. B	12/26/00	99244	99244	94010	94010 (C)	H=D, E=C, MDM=H. A more extensive review of systems would have allowed this visit to easily have been a level five.	C
#2 Dr. B	12/26/00	99213	99214	none	none	H=D, E=EPF, MDM=M. This documentation supports a level four visit (based on history and medical decision making). The chart note is not signed by the provider	U
#3 Dr. B	12/26/00	99214	99214	none	none	H=D, E=D, MDM=M. Service is documented as billed.	C
#4 Dr. B	10/20/00	99215	99214	93000 81002	93000 (C) 81002 (C)	H=D, E=D, MDM=M. This service should have been paid by Medicare at a level four, not a level three - should go back in for appeal. There is no mention on the encounter note about the UA or EKG that was billed that day (record does indicate EKG was "paced" – but no indication of date done). See sample note for appeal submission.	U
#5 Dr. B	11/14/00	99215	99214	82270	none	H=D, E=C, MDM=M. Documentation supports a level four service - more systems reviewed as part of history and complete PFSH would have brought history up a level higher and would then have made the visit a 99215. The patient records does not indicate an order for the hematest that was billed. Provider signature could not be found on this encounter	O
#6 Dr. B	12/21/00	99215	99214	93000 82270-28 90658	93000 (C) 82270 (C) 90658 (C)	H=D, E=C, MDM=M. This documentation supports a level four service. Medical necessity present for ancillary services	O
#7 Dr. B	3/15/01	99214	99214	none	none	H=EPF, E=D, MDM=M. Documentation supports a level four service. No provider signature present. Five diagnosis were marked on encounter form - what system is in place to match these on the claim form?	C
	3/15/01	99214	99214	93000	93000 (C)	H=EPF, E=D, MDM=M. Documentation supports this service as billed	C

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive

SF = Straight forward
L = Low
M = Moderate
H = High

H = History
E = Exam
MDM = Medical Decision Making

CC = Chief Complaint
ROS = Review of System

HPI = History of Present Illness
PFSH = Past Family Social History

O=Overcoded
U=Undercoded

Patient #/ Physician	Date of Service	Physician E/M	Auditor E/M	Physician Other CPT	Auditor Other CPT	Comments	Accuracy
#1 Dr.C	11/15/00	99214	99213	none	none	H=EPF, E=EPF, MDM=L. This is documented as a level three service	O
#2 Dr.C	11/14/00	99215	99213	none	none	H=EPF, E=EPF, MDM=L. The documentation supports a level three service.	O
#3 Dr.C	12/29/00	99213	99213	none	none	H=EPF, E=EPF, MDM=SF. Documentation supports service billed	C
#4 Dr.C	11/14/00	99214	99213	none	none	H-EPF, E=EPF, MDM=M. Documentation only supports level three service	O
#5 Dr.C	11/14/00	99213	99212	none	none	H=PF, E=EPF, MDM=SF. Documentation supports level two office visit	O
#1 Dr.D	12/27/00	99213	99213	none	none	H=PF, E=EPF, MDM=L. History says patient returns for follow-up visit – follow up of what?? Diagnosis on chart is renal insufficiency and foot pain. Also marked on encounter form is hypertension, which is what was billed in insurance claim form. **Of note:** All claims for this provider are billed with 401.9 (Hypertension) the primary diagnosis – it is the diagnosis marked farthest to the left on the encounter form!	C
#2 Dr.D	11/15/00	99214	99213	none	none	H-EPF, E=EF, MDM=M. Documentation supports level three service	O
#3 Dr. D	11/15/00	99244	99243	none	none	H=D, E=D, MDM=M. This is documented as a level three consult - reason for the consult is unclear – what advice or opinion is being requested?	O
#4 Dr. D	12/28/00	99214	99212	none	none	H=PF, E=EPF, MDM=SF. Patient here for six months follow-up - of what??	O
#5 Dr.D	12/17/00	99244	99243	none	none	H=D, E=C, MDM=M. Lower level of history keeps this service to a level three - could have reviewed some history (ROS) from previous visit	O
Patient #/ Physician	**Date of Service**	**Physician E/M**	**Auditor E/M**	**Physician Other CPT**	**Auditor Other CPT**	**Comments**	**Accuracy**

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive

SF = Straight forward
L = Low
M = Moderate
H = High

H = History
E = Exam
MDM = Medical Decision Making

CC = Chief Complaint
ROS = Review of System

HPI = History of Present Illness
PFSH = Past Family Social History

O=Overcoded
U=Undercoded

#1 Dr.E	12/28/00	99213	99213	none	none	H=EPF, E=O, MDM=M	C
#2 Dr. E	11/14/00	99213	99213	none	none	H=EPF, E=EPF, MDM=M	C
#3 Dr.E	11/14/00	99214	99211	none	none	No reason for encounter, no diagnosis, no physical exam. This documentation is incomplete - can't support the reason for, need or necessity of the visit	O
#4 Dr.E	11/14/00	99215	99214	none	none	H=D, E=D, MDM=L. The documentation supports level four service	O
#5 Dr.E	12/29/00	99214	99213	none	none	H=D, E=EPF, MDM=L. The documentation supports level three visit.	O
#1 Bowen	11/13/00	99214	99214	none	none	H=PF, E=D, MDM=M. Documentation supports the service billed	C
#2 Bowen	11/13/00	99215	99214	none	none	H-EPF, E=D, MDM=M. Documentation supports a level four service - Medicare lowered this level of service from 99215 to 99214 and paid for that service	O
#3 Bowen	11/16/00	99205	99204	none	none	H=C, E=C, MDM=M. Service should be billed as 99204	O
#4 Bowen	11/15/00	99214	99213	none	none	H=PF, E=EPF, MDM=M. Documentation supports a level three service	O
#5 Bowen	12/29/00	99213	99213	none	none	H=EPF, E=EPF, MDM=SF. Documentation supports level of service billed	C
#1 Singh	11/7/00	99213	99213	81002	81002 (O)	H=PF, E=EPF, MDM=L. Documentation supports services billed. No order in the chart for the urinalysis, but could be supported with the diagnosis. No diagnosis marked on the encounter for to support the urinalysis - where did UTI diagnosis that was billed on claim come from??	C
#2 Singh	11/7/00	99214	99214	none	none	H=D, E=D, MDM=M. Documentation supports the service billed	C
Patient #/ Physician	**Date of Service**	**Physician E/M**	**Auditor E/M**	**Physician Other CPT**	**Auditor Other CPT**	**Comments**	**Accuracy**

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive

SF = Straight forward
L = Low
M = Moderate
H = High

H = History
E = Exam
MDM = Medical Decision Making

CC = Chief Complaint
ROS = Review of System

HPI = History of Present Illness
PFSH = Past Family Social History

O=Overcoded
U=Undercoded

#3 Singh	11/16/00	99213	99213	none	none	H=PF, E=EPF, MDM=M. Documentation supports level of service billed	C
#4 Singh	11/16/00	99215	99214	none	none	H=EPF, E=C, MDM=M. Documentation supports level four service. **Of note:** service has been denied by Medicare, because requested information (chart notes) were not received - had been filed in patient chart by mistake. Records have been submitted as of 3/6/01. Record of history indicates patient was in for "annual physical examination" which is not a covered Medicare service. **Watch to see if Medicare pays this service.** The patient does have several chronic illnesses that the physician is following.	O
#5 Singh	11/7/00	99214	99214	none	none	H=PF, E=D, MDM=M. Documentation supports service billed	C
#1 Howard	11/15/00	99244	99243	none	none	H=D, E=C, MDM=M. Documentation supports level three consultation service. Reason for the consultation request is unclear and not stated in the consultation note.	O
#2 Howard	12/29/00	99213	99213	none	none	H=EPF, E=D, MDM=SF. Documentation supports service billed	C
#3 Howard	12/26/00	99215	99214	none	none	H=D, E=C, MDM=SF. Documentation supports level four service. This record is illegible and I had to ask for it to be dictated and transcribed to consider it. There is no chief complaint and no reason given for the visit.	O
#4 Howard	11/15/00	99215	99214	none	none	Record was illegible. Transcribed documentation reveals H=D, E=C, MDM=M. Should be billed as a level four service	O
#5 Howard	11/14/00	99213	99214	none	none	H=EPF, E=D, MDM=M. This service should have been billed one level higher – 99214	U
							Accuracy

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive

SF = Straight forward
L = Low
M = Moderate
H = High

H = History
E = Exam
MDM = Medical Decision Making

CC = Chief Complaint
ROS = Review of System

HPI = History of Present Illness
PFSH = Past Family Social History

O=Overcoded
U=Undercoded

							O
							O
							O
							C
							O
							O
							O
							O
							O
							O

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive

SF = Straight forward
L = Low
M = Moderate
H = High

H = History
E = Exam
MDM = Medical Decision Making

CC = Chief Complaint
ROS = Review of System

HPI = History of Present Illness
PFSH = Past Family Social History

O=Overcoded
U=Undercoded

SUMMARY

Total E/M Codes Reviewed:	53
Total E/M Codes Overcoded:	34
Total E/M Codes Undercoded:	3
Total E/M Codes Correct:	16
E/M Overcoded Error Rate:	64.15%
E/M Undercoded Error Rate:	5.66%
E/M Correct:	30.19%
Total Other CPT Codes Reviewed:	10
Total Other CPT Overcoded Errors:	2
Total Other CPT Undercoded Errors:	0
Total Other CPT Codes Correct	8
Other CPT Overcoded Rate:	20%
Other CPT Undercoded Rate:	n/a
Other CPT Codes Correct Rate:	80%

Summary of Deficiencies Found:

1. Reason for consultation services not documented
2. Medical necessity of doing preoperative services for surgeon not documented
3. No diagnosis to support the medical necessity of some ancillary services (EKG and urinalysis)
4. Writing is not legible – several providers
5. Documentation incomplete, sometimes not supporting any E/M service, other than 99211
6. Patient encounter records are not signed by provider
7. Significant repetitions are noted in documentation, regardless of diagnosis of patient:
    - All blood pressures by one provider are 134/82
    - All exams are expanded problem focused, regardless of presenting problem or diagnosis
    - All patients are in for follow-up – with no elaboration
    - All patients have primary diagnosis of unspecified hypertension – 401.9
8. Vital signs are not made part of the documentation for the encounter
9. Medicare billed for non-covered services as though covered – i.e. "annual history & physical"
10. Minimal documentation for elements of medical decision making
11. Review of systems (ROS) is minimally documented

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive

SF = Straight forward
L = Low
M = Moderate
H = High

H = History
E = Exam
MDM = Medical Decision Making

CC = Chief Complaint
ROS = Review of System

HPI = History of Present Illness
PFSH = Past Family Social History

O=Overcoded
U=Undercoded

Recommendations for Training/Review:

- Documenting "reason for the encounter" – i.e. chief complaint
- Documenting review of systems – using health history questionnaires and ancillary staff
- Documenting the elements of complexity of medical decision making: presenting diagnosis and their status; review of data; risk of complications
- Using templates and other tools to assure documentation is legible
- Supporting medical necessity of visits and ancillary services
- Defining a consultation vs a visit and the appropriate documentation to support the service

Attachments:

1. General Principles of Medical Record Documentation
2. Documentation Guidelines, 1995
3. Documentation Guidelines, 1997
4. Audit Tool
5. Summaries by Physician

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive

SF = Straight forward
L = Low
M = Moderate
H = High

H = History
E = Exam
MDM = Medical Decision Making

CC = Chief Complaint
ROS = Review of System

HPI = History of Present Illness
PFSH = Past Family Social History

O=Overcoded
U=Undercoded