2019 Audit Elements	Description of Review	Remedies	Passing Error Rate %	Performed By
1. E&M Coding and Documentation a) Prospective Baseline Review for <u>new</u> providers - 25 office encounters (15 new patient encounters, and 10 established patient encounters b) Annual Prospective Review for all providers - 25 office encounters - 25 hospital encounters, and c) Accuracy of Diagnosis Coding (ICD-10CM)	All chart reviews are performed prospectively unless otherwise identified. E/M chart reviews will be performed using the 1995 E/M documentation guidelines except for those specialties and subspecialties utilizing the 1997 E/M documentation guidelines. For those providers performing in-office procedure there should be a sampling of these when they are billed in conjunction to an E/M and have a modifier applied. For those providers performing these categories of EM Service(s). For any providers not performing these services they will select additional new and established patient encounters. Diagnosis codes must be assigned to the highest level of specificity	If greater than a 5% error rate refer to the Coding and Audit Escalation Policy. If greater than a 5% error rate refer to the Coding and Audit Escalation Policy. If greater than a 5% error rate refer to the Coding and Audit Escalation Policy.	<5% error rate <5% error rate <5% error rate	
2. 99211 Medical Necessity a) In the medical group setting (Incident-To) b) When billed in the Coumadin Clinic. - 20 per year per provider	Incident-To Services must be performed in the physician office setting (refer to Incident-To Guidelines Policy). In the In-Patient setting refer to Split/Shared Services policy. ** There should an extensive review of Incident-To and split/shared services beginning Q2 CY 2019 and completed Q4 CY 2019. Groups where issues are detected should refer to their specific Corrective Action*	If greater than a 5% error rate refer to the Coding and Audit Escalation Policy. If greater than a 5% error rate refer to the Coding and Audit	<5% error rate <5% error rate	

	Plan (CAP) for how to proceed in CY 2019. There will be a review of these services as part of your annual audit elements in CY 2019. Coumadin Clinic guidelines- All services provided in this setting must meet the established guidelines for billing a 99211. There must vitals documented, questions regarding bruising, bleeding or any other abnormal signs or symptoms the patient has identified. There must be education and/or counseling provided and documented by the nurse.	Escalation Policy.		
3. Modifiers -25 &/or -59 a) 5 per year per provider 4. Modifier-22 ** 15 per provider if these modifiers are applicable…*	When the Modifier 25 is used on an E/M service in conjunction to a minor procedure the E/M service is considered bundled into the procedure unless the provider is able to demonstrate a "significant, separately identifiable service" outside of the patient's reason for having the procedure. (i.e. a patient presenting for an arthrocentesis of the right knee but also complains of neck pain with numbness and tingling down the arms which prompts the provider to order a CT or MRI) The modifier 59 should only be used in the absence of a more applicable modifier. Overutilization of this modifier could create a "Red Flag" in a payor's system prompting an audit of the provider. Auditors should be evaluating the new "X"	If greater than a 5% error rate refer to the Coding and Audit Escalation Policy. If greater than a 5% error rate refer to the Coding and Audit Escalation Policy.	<5% error rate <5% error rate	

	modifiers to ensure they are being properly applied to services where a Modifier 59 would be appropriate. Modifier 22 is used to identify Unusual Circumstances or those where a greater than normal period of time was required to complete a procedure than what is normally required. Documentation should clearly indicate the surgeon's difficulty with performance of the procedure or those circumstances that lead to the procedure taking longer than normal to complete. These would include but are not limited to: excessive blood loss >than 700cc, extensive lysis of adhesions, obese patient, etc.	If greater than a 5% error rate refer to the Coding and Audit Escalation Policy.	<5% error rate	
5. Medical Necessity of Patients with Frequent Visits a) More than 6 visits in 3 months	Patients who are seen on a basis more frequent than what would be considered generally accepted standards of medical practice may require you to flag their claims in the system to ensure a more focused review to ensure there is no excessive billing for patient services. Certain specialties will require patients to present for visits more frequently in certain situations than others. Discretion must be used when reviewing these encounters.	If greater than a 5% error rate refer to the Coding and Audit Escalation Policy.	<5% error rate	