Documentation Reviews by Medical Education Services, LLC.

Medical documentation standards and coding is complex and the "rules" are ever-changing. The impact that improper coding and documentation can have on your physician practice is dramatic and can lead to delays in filing claims, receiving reimbursements, over/underpayment, erroneous claims that can lead to litigation, fines, or penalties.

Accurate and timely analysis of physician coding can identify practice insufficiencies that may compromise your profitability! Armed with the most up-to-date information, the certified coding experts of MES can show you not only how to generate the optimum reimbursement for your services and boost your profits. In addition, our expert staff can help you build a documentation process that will demonstrate appropriate documentation in the event of a payer audit. MES staff will analyze your charts and will ensure that all members of your staff are knowledgeable about correct and appropriate documentation. Consider that Medicare states: *A provider is responsible to know the rules and regulations that apply to all services he/she bills to the Medicare program*. Our job is to keep you informed of the latest Medicare regulations and requirements for accurate reporting to alleviate concerns you may have about fulfilling these responsibilities.

This is not a cookie-cutter solution to your auditing problems! We will tailor our services to your practice needs.

MES is affiliated with the American Academy of Professional Coders, the American Health Information Management Association, the Healthcare Compliance Association, the Medical Management

Association and the Healthcare and Billing and Management Association.

MES chart audit services:

- Chart documentation reviews by certified professional coders
- Basic and advanced evaluation and management coding seminars
- CMS approved documentation guideline education
- Complete programs to ensure compliance with governmental regulations and guidelines
- Coding and documentation recommendations
- The latest information on assignment of CPT and ICD-9-CM codes
- Medical records management
- Responding to Medicare fraud and abuse directives

Additional MES services:

- HIPAA privacy training seminars and personalized practice assistance
- Medical practice compliance assistance
- Specialty operative report coding reviews in:
  - General orthopedics
  - Hand surgery
  - General surgery
  - Plastics and facial reconstruction
  - E.N.T.

MES has the answers if you want to **optimize** reimbursement, **protect** yourself against litigation from improper documentation, and be **assured** that you are being paid for the work you do.

WHY? – Quotes from the OIG's Compliance Program for Individual and Small Group Physician Practices

Voluntary compliance programs provide benefits by not only helping to prevent erroneous or fraudulent claims, but also by showing that the physician practice is making additional good faith efforts to submit claims appropriately. Physicians should view compliance programs as analogous to practicing preventive medicine for their practice. Practices that embrace the active application of compliance principles in their practice culture and put efforts towards compliance on a continued basis can help to prevent problems from occurring in the future.

Step One: Auditing and Monitoring

An ongoing evaluation process is important to a successful compliance program. This ongoing evaluation includes not only whether the physician practice's standards and procedures are in fact current and accurate, but also whether the compliance program is working, *i.e.*, whether individuals are properly carrying out their responsibilities and claims are submitted appropriately. Therefore, an audit is an excellent way for a physician practice to ascertain what, if any, problem areas exist and focus on the risk areas that are associated with those problems. There are two types of reviews that can be performed as part of this evaluation: (1) A standards and procedures review; and (2) a claims submission audit.

1. Standards and Procedures

It is recommended that an individual(s) in the physician practice be charged with the responsibility of periodically reviewing the practice's standards and procedures to determine if they are current and complete. If the standards and procedures are found to be ineffective or outdated, they should be updated to reflect changes in Government regulations or compendiums generally relied upon by physicians and insurers (*i.e.*, changes in Current Procedural Terminology (CPT) and ICD–9–CM codes).

2. Claims Submission Audit

In addition to the standards and procedures themselves, it is advisable that bills and medical records be reviewed for compliance with applicable coding, billing and documentation requirements. The individuals from the physician practice involved in these self-audits

would ideally include the person in charge of billing (if the practice has such a person) and a medically trained person (*e.g.*, registered nurse or preferably a physician (physicians can rotate in this position)). Each physician practice needs to decide for itself whether to review claims retrospectively or concurrently with the claims submission. In the Third-Party Medical Billing Compliance Program Guidance, the OIG recommended that a baseline, or ''snapshot,'' be used to enable a practice to judge over time its progress in reducing or eliminating potential areas of vulnerability. This practice, known as ''benchmarking,'' allows a practice to chart its compliance efforts by showing a reduction or increase in the number of claims paid and denied.

The practice's self-audits can be used to determine whether:

• Bills are accurately coded and accurately reflect the services provided (as documented in the medical records);

• Documentation is being completed correctly;

• Services or items provided are reasonable and necessary; and

• Any incentives for unnecessary services exist.

Following the baseline audit, a general recommendation is that periodic audits be conducted at **least once each year** to ensure that the compliance program is being followed. Optimally, a randomly selected number of medical records could be reviewed to ensure that the coding was performed accurately. Although there is no set formula to how many medical records should be reviewed, a basic guide is five or more medical records per Federal payor (*i.e.*, Medicare, Medicaid), or five to ten medical records per physician. The OIG realizes that physician practices receive reimbursement from a number of different payors, and we would encourage a physician practice's auditing/monitoring process to consist of a review of claims from all Federal payors from which the practice receives reimbursement.

- If problems are identified, the physician practice will need to determine whether a focused review should be conducted on a more frequent basis. When audit results reveal areas needing additional information or education of employees and physicians, the physician practice will need to analyze whether these areas should be incorporated into the training and educational system.