

Chart Audits Results
ABC Practice
Dr. Whomever

May 1, 2009

Patient Number	Date
# 1	4-23-09
E/M Billed	E/M Met
99231	99232
ICD-9 Billed	ICD-9 Met
728.3	342.90
854.00	V54.16
852.00	854.00
824.8	824.8

Comments

This encounter meets the criteria for reporting code **99232**. Immobilization syndrome, code 728.3, should only be reported when clearly documented in the assessment. Hemiparesis, S/P TBI, and orthopedic aftercare, should all be reported as documented in the assessment for this date of service. Auditor finds no mention of subarachnoid, subdural or extradural hemorrhage to report code 852.00.

Patient Number	Date
# 2	4-8-09
E/M Billed	E/M Met
99213	99213
ICD-9 Billed	ICD-9 Met
312.9	V40.9
907.0	

Comments

Diagnoses listed in assessment should reflect the entire visit (especially the history portion of the visit). If the patient is presenting for status post TBI and orbital fracture, this should also be documented in the assessment. If billing according to time, the time spent counseling should be documented in addition to the total time spent with the patient. See the general recommendations sheet regarding billing according to time. The diagnosis for this encounter is only stated as behavior problems, therefore code V40.9 is the only reportable ICD-9 code for this date of service.

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Patient Number	Date
# 3	3-27-09
E/M Billed	E/M Met
99202	99201
ICD-9 Billed	ICD-9 Met
905.4	891.0 905.4 E929.0

Comments

History form was not signed or referred to by the physician and may not be used when choosing the level of service for this encounter. The exam does not meet the criteria for reporting code 99202. If only **2** additional bullets had been identified on the general multi-system exam form, this would meet code 99202. There is also no definitive diagnosis documented in the medical decision making portion of this encounter. Auditor used diagnosis found in the history of present illness (HPI). The reason for the encounter or definitive diagnosis should always be documented in the medical decision making portion of the encounter.

Patient Number	Date
# 4	3-11-09
E/M Billed	E/M Met
99231	99231
ICD-9 Billed	ICD-9 Met
728.3	323.9
323.9	344.40
344.41	782.0
782.0	530.81

Comments

Immobilization syndrome, code 728.3, should only be reported when clearly documented in the impression. Paresthesia is not documented as affecting the dominant or non-dominant side. It must state either the patient's dominant or non-dominant side **or** right handed patient affected on right side in order to report the dominant side fourth digit.