



**General Recommendations for ABC Practice  
Presented by Medical Staff SOS, Inc.  
May 1, 2009**

Per your request, an audit and written report of 53 encounters for the above named practice has been completed. During the auditing process, several areas of concern were identified, by the auditor involved. Therefore, it is highly recommended by this company these concerns be addressed immediately.

These recommendations are as follows:

- 1) ABC Practice should immediately put into place a “**Coding Compliance Manual**” and a “**Compliance Officer**” should be appointed.

During the auditing process, several abbreviations were encountered that are “uncommon to the typical medical practice”. It became very difficult to audit these encounters due to the fact these abbreviations were developed either by the provider or by the staff member providing the transcription service and therefore could not be correctly interpreted by the auditor. When employees or providers were asked to explain the definitions of these abbreviations they were unable to do so nor were they able to produce a coding manual that could be used as a reference. It is acceptable practice for a provider to use abbreviations in their documentation but “any uncommon or made up medical abbreviations” used by the practice, should be admitted into the medical practice “**Coding Compliance Manual**”. It is recommended that **ALL abbreviations** (common and uncommon) used in this practice be recorded in the Coding Compliance Manual with a *complete explanation* of each abbreviation.

The following are examples of “common medical abbreviations”:

NAD	No Acute Distress
U/A	Urine Analysis
TM	Tympanic Membranes
B/P	Blood Pressure
WT	Weight
F/U	Follow up



The following are examples of “uncommon medical abbreviations” encountered during audit:

O/E	NYD	LEE	IX	MX	LOM
BS	OP	U/L	HSM	DRE	

- 2) Each provider’s name and credentials should be admitted into the **Coding Compliance Manual** along with their full signature and written initials.

**For example:**

**Dr. Matt, MD** (Family Practice)

Full Signature: \_\_\_\_\_

Written Initials: \_\_\_\_\_

**Andrea Pentwater, NP** (Nurse Practitioner)

Full Signature: \_\_\_\_\_

Written Initials: \_\_\_\_\_

Etc., etc., etc., until all providers names are listed in this manual. This portion of the manual **should also identify** how the provider will **sign off** on each encounter (date of service).

**Please Note:**

All providers (Physicians, NP’s, PA’s) and all employees involved in this medical practice, especially those involved in billing, coding, and compliance should be **required to read, initial, and date** this coding compliance manual to indicate they have reviewed and understand the policies set forth. All **new employees** should **also** be **required to read, initial, and date** the coding compliance manual to indicate they have reviewed and understand the policies set forth.



- 3) During our 4-28-09 visit, two areas of concern were brought to our attention, by the employees. The **first** being that some of the transcriptionist(s) are stamping the patient's encounter when they are finished and the chart is then submitted to the medical records department for filing. The chart is **not** being returned to the provider for review and approval before being submitted to the medical records department for filing. The **second** concern is that an employee(s) may have been instructed to change the patient's diagnosis. No staff member should ever change a diagnosis code. If there is a discrepancy found by an employee, the medical record should be returned to the provider in question and a "formal amendment" should be made. The provider should then review and approve this amendment by providing a full signature or initialing.

**NOTE:**

Progress notes, test results, medical records of any kind should **never** be stamped by the transcriptionist and should **always** be reviewed by the provider before being placed permanently into the patient's medical record! The **provider's full signature or initials** on progress notes, test results, etc. identifies that the **provider has reviewed and approved** the documentation for that particular date of service. If the provider finds the dictation to be incorrect then a "formal amendment" regarding that date of service should be added to the patient's medical record. The provider should then review and approve this amendment by providing a full signature or initialing.

- 4) Recommendations were made in the past to remove all ICD-9-CM codes from the patient's fee ticket. Since then, the fee ticket has been modified by removing the diagnosis codes but the diagnostic descriptors remain. Complete removal of all diagnostic information is still encouraged. Writing the patient's diagnosis on the fee ticket encourages more specificity in reporting the correct diagnosis. A majority of the diagnoses codes encountered in this audit were unspecified. An **unspecified ICD-9-CM** code does **not** accurately describe the patient's true level of severity of illness nor does it properly demonstrate the medical necessity of the patient's E/M visit. While it is recommended the provider "write in" the patient's diagnosis rather than select a code descriptor on the fee ticket there can still be potential problems when a Coding Compliance Manual has not been established or the employee submitting the claim has **not** reviewed the documentation for the date of service in question prior to the claim being submitted.



**For example:** The initials “V/D” was written on a patient’s fee ticket. The employee took these initials to mean “venereal disease”, and the insurance claim was submitted as such. When in fact the documentation showed the patient had “vomiting and diarrhea”. This is the type of mistake that can happen when no Coding Compliance Manual has been established. Once a diagnosis has been submitted to the insurance company for payment it is rarely, if ever, changed. This could pose a problem for the patient in the future when they try to apply for insurance (ie, cancer policy, life insurance, etc). They may be rejected or face possible rejection, due to a previous diagnosis that was submitted on the patient’s insurance claim.