Chart Review Table of Findings – Attachment C

FINDINGS	**Code**
Record illegible such that assessment of compliance cannot be made	A
Established patient should have been coded as new patient	B
New patient should have been coded as established patient	B
Consult should have been coded as new patient	B
Dental Service billed using the wrong code, but in the correct category of service (i.e. D0220 vs. D0230, D4341 vs. D4342)	B
Provider's time not documented when billing time-based code	C
Resident's time added to TP's time for billing	C
Psychiatric services – Actual time spent not documented	C
Dental Service Only: Service(s) provided by hygienist/pre-doc/post-doc student does not have faculty sign.	D
Dental Service Only: Service provided by pre-doc/post-doc student entered under wrong faculty member	D
TP's note must stand alone – insufficient tie/documentation of resident's work (1 level)	E
Level coded is incorrect – service up-coded one level	E
Improper use of modifier	F
Incorrect area/surface/tooth number coded	F
Area/surface/tooth number not clearly documented in note	F
Modifier required – not used	F
Date of Service is within Global Period	G
Global fee was billed for TP who was only involved in surgery with no care past patient discharge date	H
TP's note must stand alone – insufficient tie/documentation of resident's work (2+ levels)	I
Level coded is incorrect – service up-coded two+ levels	I
Record does not reflect teaching physician's (TP) presence during key portion of the encounter	J
Co-signature only, no documentation by the TP	J
No signature and/or date by TP	J
Psychiatric services – TP not present for entire time spent with patient or concurrently observing	J
Psychiatric services – Provider presence not documented	J
Documentation does not state that the TP personally reviewed image and resident's interpretation	J
No documentation of request or order for procedure billed	J
Documentation does not reflect medical necessity for service	J
Specimen or slide not reviewed by TP	J
No documentation as to TP presence for a single surgery	J
Insufficient documentation of provider presence for Medicare billing	J
TP not present for any portion of the service, only involved in discussion regarding patient	K
Record does not validate service or procedure billed	K
No documentation or signature in record for date of service	K
Improper use of medical student/hygienist/scribe documentation	K
Psychiatric services – Documentation of mental health services insufficient for code billed	K
TP involved in two surgeries concurrently, no documentation of key portions	K
CLIA waiver not met	L
Chart note not dated, or incorrectly dated	N
Multi-visit service billed with a date of service prior to completion date.	N
ICD-9-CM code used requires missing 4^{th} or 5^{th} digit	O
ICD-9-CM code used is incorrect	O
Service/procedure provided to patient and not coded/billed	P
Service/procedure provided jointly by resident/faculty member with no resident signature	Q
Necessity for dental service not documented in note	R
Patient's name is not on front or back of each chart note sheet	S
Material used in procedure not documented	T
Radiographs not documented in chart note	U
Radiograph film not found in chart	U
Service down-coded by 1 or more levels	V