Presentation should be given by a knowledgeable chapter member who is comfortable with the subject content

E/M Chart Auditing

Developed by Pam Brooks, CPC, CPC-H, PCS

2013 AAPCCA Board of Directors

Why Audit?

- OIG/Compliance Plan

OIG Voluntary Compliance Plan

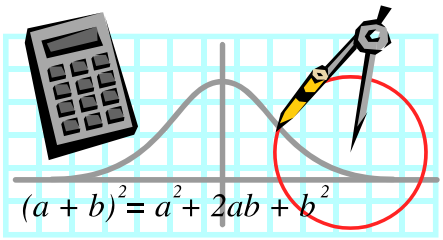
The Seven Basic Components of a Voluntary Compliance Program

- • Conducting internal monitoring and auditing through the performance of periodic audits;
- • Implementing compliance and practice standards through the development of written standards and procedures;
- • Designating a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards;
- • Conducting appropriate training and education on practice standards and procedures;
- • Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate Government entities;
- • Developing open lines of communication, such as (1) discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct and (2) community bulletin boards, to keep practice employees updated regarding compliance activities; and
- • Enforcing disciplinary standards through well-publicized guidelines

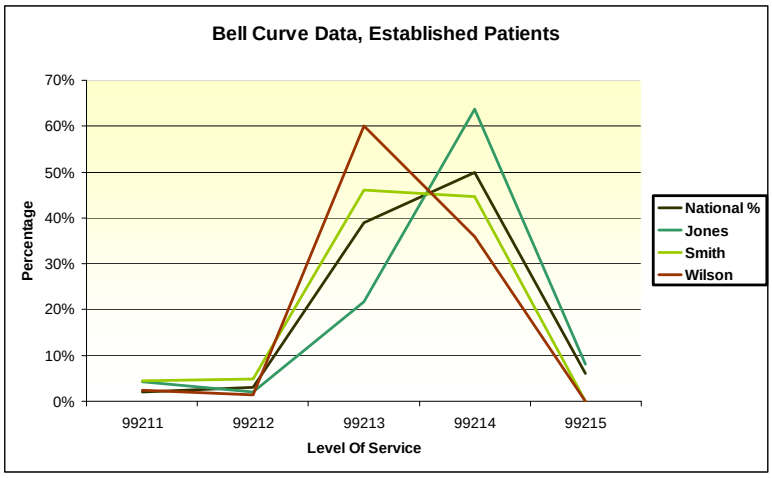
Federal Register / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices

Why Audit?

- ☑ OIG/Compliance Plan
- Bell Curve Data (MGMA or Decision Health)



The Bell Curve



Why Audit?

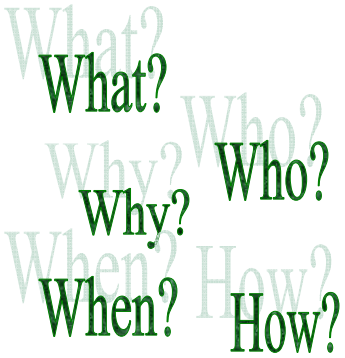
- ☑ OIG/ Compliance Plan
- ☑ Bell Curve
- Increased insurance denials
- Increase in provider queries
- New Provider
- Old Provider
- Payer requests for refunds
- New EHR

What needs to be audited?

- The booking/appointment process
- The legal medical record
- Services and procedures
- Reimbursement
  - Payment
  - Adjustment
  - Balance
- Coder Compliance

Audit process steps

You need a plan….



Identifying Your Records and Parameters

- By provider
- By DOS
- By LOS
- Individual service
- Particular time frame

What's Random?

Define Your Scope and Key References

- 1995 Guidelines
- 1997 Guidelines
- CMS/NHIC
- Professional Associations (STA, ACOG)
- CPT®
- ICD-9
- ICD-10

Organize your Tools

- Reporting Spreadsheet
- Audit Tool
- Resources (regulatory guidance)
- Medical Records
- Schedules, Fee ticket, 1500 form
- Coding Books
- Coding Companions
- Netter's, Bates, Taber's

Tracking Your Results

Patient Name	MR #	DOS	MD	CPT Billed	Mod.	CPT Audited	Mod.	ICD-9 Billed	ICD-9 Audited	Comments

Define Your Methodology and Approach

- The rationale (what and why)
- Number of Records
- Provider
- DOS
- LOS or specific procedure

In paragraph format for the executive summary.

Example:

- Internal audit
- Services rendered by James G. Wilson, MD
- Dates of service in the month of July, 2012
- Ten records were audited
- Charges submitted with the E&M code 99215
- The 1995 E&M Guidelines
- NHIC's E&M Services Billing Guidelines (March 2012) (referenced for clarification)
- Appropriate level of service
- Appropriate modifier usage
- Diagnosis reporting
- Medical necessity.

Create a Timeline

- July 2012 Dates of Service
- September 10-21: Audit performed
- September 24: Preliminary results
- Week ending September28: Coder Rebuttal

- October 5: Results finalized
- October 8: Executive Summary published
- October 8-December 31: Education Plan and rebilling

E&M: The Key Components

- History
- Exam
- Medical Decision Making

The Chief Complaint

- Concise statement describing the symptom, problem or condition
- Presenting problem
  - Disease
  - Condition
  - Illness
  - Injury
  - Sign/Symptom
  - Finding
  - Complaint

- REQUIRED for every professional E&M service billed

The Nature of the Presenting Problem

- Minimal-may not require physician presence
  - BP check, minor suture removal
- Self-limited or minor-typically will resolve by itself
  - Rash, splinter
- Low severity-with treatment, usually full recovery or adequate management
  - Simple sprain, well-controlled chronic illness
- Moderate Severity-treatment necessary to avoid risk of mortality, uncertain prognosis or some risk of impairment
  - Acute injury, problem with uncertain prognosis
- High Severity-extreme or high risk of mortality if untreated or prolonged functional impairment
  - Multiple trauma, change in neurological status

KEEP THESE IN MIND AS YOU MOVE FORWARD!

HPI (History of Present Illness)

- Description of the development of the problem
  - Location
  - Duration
  - Quality
  - Severity
  - Context
  - Timing
  - Modifying Factors
  - Associated Signs and Symptoms

SUBJECTIVE: This is a 29-year-old Vietnamese female, established patient of dermatology, last seen in our office on 07/13/12. She comes in today as a referral from Paul Deen, D.O. for a reevaluation of her hand eczema. I have treated her with Aristocort cream, Cetaphil cream, increased moisturizing cream and lotion, and wash her hands in Cetaphil cleansing lotion. She comes in today for reevaluation because she is flaring. Her hands are very dry, they are cracked, she has been washing with soap. She states that the Cetaphil cleansing lotion apparently is causing some burning and pain because of the fissures in her skin. She has been wearing some gloves also apparently. The patient is single. She is unemployed.

FAMILY, SOCIAL, AND ALLERGY HISTORY: The patient has asthma, sinus, hives, and history of psoriasis. No known drug allergies.
MEDICATIONS: The patient is a nonsmoker. No bad sunburns or blood pressure problems in the past.
CURRENT MEDICATIONS: Claritin and Zyrtec p.r.n.
PHYSICAL EXAMINATION: The patient has very dry, cracked hands bilaterally.
IMPRESSION: Hand dermatitis.

TREATMENT:
1. Discussed further treatment with the patient and her interpreter.
2. Apply Aristocort ointment 0.1% and equal part of Polysporin ointment t.i.d. and p.r.n. itch.
3. Discontinue hot soapy water and wash her hands with Cetaphil cleansing lotion.
4. Keflex 500 mg b.i.d. times two weeks with one refill. Return in one month if not better; otherwise, on a p.r.n. basis and send Dr. XYZ a letter on this office visit.

History of Present Illness (HPI)

This is a 29-year-old Vietnamese female, established patient of dermatology, last seen in our office on 07/13/12. She comes in today as a referral from Paul Deen, DO for a reevaluation of her hand eczema. I have treated her with Aristocort cream, Cetaphil cream, increased moisturizing cream and lotion, and wash her hands in Cetaphil cleansing lotion. She comes in today for reevaluation because she is flaring. Her hands are very dry, they are cracked, she has been washing with soap. She states that the Cetaphil cleansing lotion apparently is causing some burning and pain because of the fissures in her skin. She has been wearing some gloves also apparently.

HPI, cont.

- Quality: hands dry/cracked
- Location: reevaluation of her hand eczema
- Modifying Factors: I have treated her with Aristocort cream, Cetaphil cream, increased moisturizing cream and lotion, and wash her hands in Cetaphil cleansing lotion.
- Severity: she is flaring (worsening)

Review of Systems (ROS)

- Inventory (subjective) of the body systems
- Patient can fill out form
- Ancillary staff may record,
  There must be documentation of provider's confirmation

ROS

- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/ Lymphatic
- Allergic/Immunologic

History of Present Illness (HPI)

This is a 29-year-old Vietnamese female, established patient of dermatology, last seen in our office on 07/13/12. She comes in today as a referral from Paul Deen, DO, for a reevaluation of her hand eczema. I have treated her with Aristocort cream, Cetaphil cream, increased moisturizing cream and lotion, and wash her hands in Cetaphil cleansing lotion. She comes in today for reevaluation because she is flaring. Her hands are very dry, they are cracked, she has been washing with soap. She states that the Cetaphil cleansing lotion apparently is causing some burning and pain because of the fissures in her skin. She has been wearing some gloves also apparently.

Review of Systems (ROS), cont.

This is a 29-year-old Vietnamese female, established patient of dermatology, last seen in our office on 07/13/04. She comes in today as a referral from Paul Deen, DO, for a reevaluation of her hand eczema. I have treated her with Aristocort cream, Cetaphil cream, increased moisturizing cream and lotion, and wash her hands in Cetaphil cleansing lotion. She comes in today for reevaluation because she is flaring. Her hands are very dry, they are cracked, she has been washing with soap. She states that the Cetaphil cleansing lotion apparently is causing some burning and pain because of the fissures in her skin. She has been wearing some gloves also apparently.

ROS: Integumentary

ROS

- Have we addressed the nature of the presenting problem?
- Are all others negative?
- Can be done with form: completed by patient or ancillary staff
- Can it be obtained?

Past, Family, Social History (PFSH)

- Past History
  - Prior illnesses
  - Allergies
  - Prior surgeries/procedures
  - Age appropriate immunization status
  - Prior hospitalizations
  - Age appropriate feeding/dietary status
  - Current medications

Past, Family, Social History

- Family History
  - Health status/death of parents, siblings and children
  - Family diseases related to presenting problem
  - Family diseases that are hereditary or place patient at risk.

Non Contributory?

Caution: Cloned documentation in the EHR!

Past, Family, Social History

- Social History
  - Marital status and/or living arrangements
  - Level of education
  - Current employment
  - Sexual history
  - Occupational history
  - Other relevant social factors
  - Use of drugs, ETOH, tobacco.

PFSH

FAMILY, SOCIAL, AND ALLERGY HISTORY: The patient has asthma, sinus, hives, and history of psoriasis. No known drug allergies.
The patient is a nonsmoker. No bad sunburns or blood pressure problems in the past.
CURRENT MEDICATIONS: Claritin and Zyrtec p.r.n.

From HPI: The patient is single. She is unemployed.

PFSH

FAMILY, SOCIAL, AND ALLERGY HISTORY: The patient has asthma, sinus, hives, and history of psoriasis. No known drug allergies.
The patient is a nonsmoker. No bad sunburns or blood pressure problems in the past.
CURRENT MEDICATIONS: Claritin and Zyrtec p.r.n.

Past History: The patient has asthma, sinus, hives, and history of psoriasis. No known drug allergies. On Claritin and Zyrtec. No history of sunburns or BP problems.

Social History: The patient is a nonsmoker. The patient is single. She is unemployed.

Note: Headings don't always identify what's documented!

Calculating HPI

HPI	Brief 1-3 HPI Elements		Extended ≥ 4 HPI elements or documentation/update of 3 chronic conditions	
ROS	None	1	Extended 2-9 ROS	Complete > 10 or some systems + statement "all others negative".
PFSH (Established, subsequent, ED)	None		1	2
PFSH (New or Initial)	None		1-2	3
History Level	**Problem Focused**	**Expanded Problem Focused**	**Detailed**	**Comprehensive**
Circle the entry farthest to the right for each history area. To determine History Level, draw a line down the column with the circle farthest to the left.				

Calculating HPI

HPI	Brief 1-3 HPI Elements		Extended ≥ 4 HPI elements or documentation/update of 3 chronic conditions	
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Circle the entry farthest to the right for each history area. To determine History Level, draw a line down the column with the circle **farthest to the left**.				

Physical Examination

- Objective: Hands on by provider
- Can't be done by ancillary staff
- Don't confuse with ROS
- If exam "can't be done" due to patient status, can't count
- Are BA/OS pertaining to presenting problem documented?
- "abnormal" is insufficient
- "Negative/normal" is sufficient for unaffected BA/OS

Physical Examination—1995 Guidelines

- Body Areas
  - Head, including face
  - Neck
  - Chest
  - Abdomen
  - Genitalia
  - Groin
  - Buttocks
  - Back
  - Extremities
- Organ Systems
  - Constitutional
  - Eyes
  - Ears, nose, mouth, throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Skin
  - Neurologic
  - Psychiatric
  - Hematologic/Lymphatic/ Immunologic

Exam

- **PHYSICAL EXAMINATION:** The patient has very dry, cracked hands bilaterally.
  - OS: Integumentary or
  - BA: Extremities

1995 Exam Guidelines

1 (BA) or (OS)	2-4 (OS) and/or (BA)	5-7 (OS) and/or (BA)	8 or more (OS)
Limited exam of affected BA or OS	Limited exam of affected BA or OS and other symptomatic or related OS(s)	Extended exam of affected BA(s) and other or related OS(s)	A general multisystem exam or complete exam of a single organ system
PF	**EPF**	**D**	**C**

Medical Decision Making

- **The Assessment-** the physician's thought process
  - Problem/Status
  - Contributing factors
    - Co-morbidities
    - Patient compliance/non-compliance
    - Previous treatment
    - Conditions affecting treatment
    - Input from others
    - Provider uncertainty
- **The Plan**
  - Diagnostics ordered
  - Medications
  - Referrals
  - Procedures scheduled
  - Therapy
  - Further (or no) treatment

Medical Decision Making

Medical Decision Making

Medical decision making (MDM) is considered the thought process of the physician. MDM refers to the complexity of establishing a diagnosis and selecting a management and treatment option as measured by the following:

The number of possible **diagnoses and/or the number of management options that must be considered.**

The amount and/or complexity of **data - medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed.**

The **risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with that patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.**

The complexity of MDM should be documented accordingly and not inferred or implied. For each encounter, an assessment, clinical impression, or diagnosis should be documented. **Physician MDM is critical to determine the overall level of care provided during a patient encounter.** MDM may vary on a visit-to-visit basis depending on the patient's condition and what the physician performed that day. The fact that the patient has an underlying disease or co-morbidity is significant only if their presence significantly increases the complexity of the MDM. Only conditions that impact the encounter are determining factors that affect the level of E/M service. The current status of the patient's diagnosis is also a determining factor i.e. stable, improved, worsening etc. Diagnoses count in the MDM leveling only if they impact the presenting problem. Generally, decision making with respect to a diagnosed problem is less complex than an identified but undiagnosed problem.

Number of Diagnoses and Treatment Options

A Presenting Problems to the **Treating Provider**				
# of Diags. Require Active Management or Affect Treatment Options				
	Points = Result			
Self-limited/minor (stable, improved or worse)	Max = 2	1		
Est. problem (stable, improved)		1		
Est. problem (worsening)		2		
New problem (to provider) (no addt'l workup)	Max = 1	3		
New problem (to provider) (addt'l workup)		4		
Bring total to Line A in Final Result for Complexity **TOTAL**				

Amount and/or Complexity of Data to Be Reviewed

B Amount **and/or** Complexity of Data to be Reviewed	**Pts.**
Review or order of clinical lab tests	1
Review or order of tests in the radiology section of CPT	1
Review or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decide to **obtain** old records or **to obtain** history from someone else	1
Review and summarize old records **or get Hx** from someone **or** talk with other provider	2
Independent visualization of image, tracing, or specimen itself (not simply review of the paper copy report	2
Bring total to Line B in Final Result for Complexity **TOTAL**	

Risk

- Minimal
  - One self-limited problem
  - Lab tests ordered
  - CXR, EEG, EKG
  - U/A
  - KOH
  - Rest, dressings,

Risk

- Low
  - Two self-limited/minor problems
  - One stable chronic illness
  - Acute uncomplicated illness/injury
  - Tests w/o stress
  - Imaging studies (not cardiovascular)
  - Needle or skin Bx
  - Lab tests w/ arterial puncture
  - OTC drugs
  - Minor surgery w/o risk factors
  - PT, OT
  - IV fluids w/o additives

Risk

- Moderate
  - Chronic illness(es) with mild exacerbation or progression, or side effects of Tx
  - Two stable chronic illnesses
  - Undiagnosed new problem w/uncertain prognosis
  - Acute illness w/systemic symptoms
  - Acute complicated injury
  - Stress testing
  - Diagnostic endoscopies w/o risk factors
  - Deep needle or incisional Bx
  - CV imaging with contrast w/o risk factors
  - Obtain fluid for diagnostics
  - Minor surgery w/risk factors
  - Elective major surgery w/o risk factors
  - Rx drugs
  - Nuclear medicine Tx
  - IV fluids w/additives
  - Closed Fx treatment w/o manipulation

Risk

- High
  - Severe exacerbation of chronic illness
  - Illness progression /side effects of treatment
  - Life-threatening illness or injury
  - Abrupt change in neurological status
  - CV imaging w/contrast/risk
  - Electrophysiology
  - Endoscopies w/risk
  - Discography
  - Major surgery w/risk, or emergent
  - Parenteral (injection, infusion, implantation) Tx
  - Drug Tx w/intensive monitoring for toxicity
  - DNR

The Assessment and Plan

- **IMPRESSION:**
  Hand dermatitis.
  - 692.9
  - L30.9 (ICD-10)
    - Dermatitis, unspecified

- **TREATMENT:**
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  2. Apply Aristocort ointment 0.1% and equal part of Polysporin ointment t.i.d. and p.r.n. itch.
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Can we use this?

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Review and summarize old records **or get Hx** from someone **or** talk with other provider	2
Independent visualization of image, tracing, or specimen itself (not simply review of the paper copy report	2
Bring total to Line B in Final Result for Complexity **TOTAL**	

Level	Presenting Problems(s) or	Diagnostic Procedure or	Management Options
Straight-Forward	[]One self-limited or minor problem, I.e.: cold, insect bite, tinea corporis	[]Laboratory tests requiring venipuncture []Chest X-Ray []EKG/EEG []Urinalysis []Ultrasound, e.g., echocardiography []KOH prep	[]Rest [] Gargles []Elastic Bandages []Superficial Dressing
Low	[]Two or more self-limited or minor problems []One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH []Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain	[] Non-cardiovascular imaging studies with contrast, e.g. barium enema []Superficial needle biopsies []Clinical laboratory tests requiring arterial puncture [] Skin biopsies	[] Over-the-counter drugs []Minor surgery with no identified risk factors []Physical therapy []Occupational therapy []IV fluids without additives
Moderate	[]One or more chronic illnesses with mod exacerbation, progression, or side effects of treatment []Two or more stable chronic illnesses []Undiagnosed new problem with uncertain prognosis, e.g. lump in breast []Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis	[]Physiological tests under stress, e.g. cardiac stress test, fetal contraction stress test []diagnostic endoscopies with no identified risk factors []Deep needle or incisional biopsy []Cardiovascular imaging studies with contrast & no identified risk factors e.g., arteriogram, cardiac catheterization []Obtain fluid from body cavity e.g., lumbar puncture, thoracentesis, culdocentesis	[]Minor surgery with identified risk factors []Elective major surgery (open, percutaneous or endoscopic) []Prescription drug management []Therapeutic nuclear medicine []IV fluids with additives []Closed treatment of fracture or dislocation w/o manipulation
High	[]One or more chronic illnesses w/severe exacerbation, progression, or side effects of treatment []Acute or chronic illness or injuries that pose a threat to life or bodily function e.g., multiple trauma, acute ML pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure []An abrupt change in neurologic status, e.g., seizure TIA, weakness, or sensory loss	[]Cardiovascular imaging studies with contrast with identified risk factors []Cardiac electrophysiological tests []Diagnostic endoscopies with identified risk factors []Discography	[]Elective major surgery (open, percutaneous or endoscopic) with identified risk factors []Emergency major surgery (open, percutaneous or endoscopic) []Parenteral control substances []Drug therapy requiring intensive monitoring for toxicity []Decision not to resuscitate or to de-escalate care because of poor prognosis

Calculating level of MDM

A	Circle the Total Number in Section **A**	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Circle the Total Number in Section **B**	≤ 1 Minimal or none	3 Limited	4 Multiple	≥ 4 Extensive
C	Circle the Level in Section **C**	Minimal	Low	Moderate	High0
Complexity Level of MDM		Straightforward **SF**	Low **L**	Moderate **M**	High **H**

Draw a line down the column with 2 or 3 circles and circle decision making level

OR draw a line down the column with the center circle + level of MDM

Putting it all together

- History: EPF
- Exam: PF
- MDM: Low

Established Patient (2 out of 3)					
Code	99211	99212	99213	99214	99215
History	MIN	PF	EPF	D	C
Exam	MIN	PF	EPF	D	C
MDM	MIN	SF	L	M	H
Time	5	10	15	25	40

Tracking Your Results

Patient Name	MR #	DOS	MD	CPT Billed	Mod.	CPT Audited	Mod.	ICD-9 Billed	ICD-9 Audited	Issues/Comments
LK	2585	7/13	JW	99213		99213		250.00 185		2 stable chronics, no issues
WR	3025	7/12	JW	99214		99213		300.00	300.00	New problem, with Low MDM, could have documented time in counseling
BM	6852	7/13	JW	99214		99215		786.50 784.92	786.50	Chest and jaw pain, acute, with 8 system exam and high MDM based on discussions and diagnostics ordered
SM	4487	7/11	JW	99212		99214		611.72	611.72	Acute new problem, workup planned, MDM moderate, uninsured patient (provider courtesy)
KQ	4589	7/15	JW	99212		99212		493.90	493.90	est. problem, resolved.
JM	2544	7/15	JW	99214		99214		427.31 412	427.31 412	two stable chronics, change in meds, time documented.
AW	3773	7/15	JW	99202		99202		487.1 V12.69	487.1 V12.69	new problem with Rx meds. Lab/rad and records review. Could have increased LOS w/ detailed exam.

What's next?

- Education Plan
  - Physicians
  - Coders
  - Billers
- Rebilling/Refund
  - If you identify an error, you must refund
- Re-audit
- Auditing Education for Coders
  - NAMAS (CPMA)
  - AAPC (CEMC)

Thank You!

References:

http://www.medicarenhic.com/ne_prov/publications.shtml

https://oig.hhs.gov/reports-and-publications/workplan/index.asp#current

Part B Physician/Supplier National Data - CY – 2010

www.medicarenhic.com/providers/articles/E_M_complete.pdf

Questions?

The information contained in this presentation is current as of 6/1/2013.

This material is designed to offer basic information for AAPC local chapter meetings. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, AAPC and AAPCCA Board of Directors do not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational guide and should not be considered a legal/consulting opinion.

Questions on the content can be sent to localchapters@aapc.com