E/M Coding – Fact and Fiction

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Overview of Today's Session

- This session will cover Facts and Fiction about E/M Coding
  - Medical Necessity
  - Coding Guidelines & Payer Insights
  - Potential "Gray" Areas
  - Evaluation and Management Process
    - Presenting Results
    - Case Studies
    - Recommendations for Future E/M Compliance

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NOTICES

Medical Necessity

- What is Medical Necessity?
  - Medicare defines as services or items reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body area
    - Can be determined on a case-by-case basis
  - Other payers define as:
    - "Reasonable and necessary" or "Appropriate"
  - Coverage may be limited if:
    - Service is provided more frequently than allowed under either a national or local coverage policy or a clinically accepted standard of practice

CMS Guidance

- FACT:
  - "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The amount of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as possible after it is provided in order to maintain an accurate medical record."

  - Comprehensive Error Rate Testing Program 2009; https://www.cms.gov/cert

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In Today's Regulatory Environment . . .

- Post payment reviews and audits are increasingly prevalent

- Good documentation is the only defense for the physician

- The auditor's motto is "Not documented, not done!"

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Measuring Medical Necessity

- What Methods do Payers use to ensure Medical Necessity when reviewing claims?
  - Claim edits
    - Ensure payment is made for a specific procedure code or predetermined diagnosis code
  - Automated denial/review commands
  - Diagnosis code is important for supporting Medical Necessity

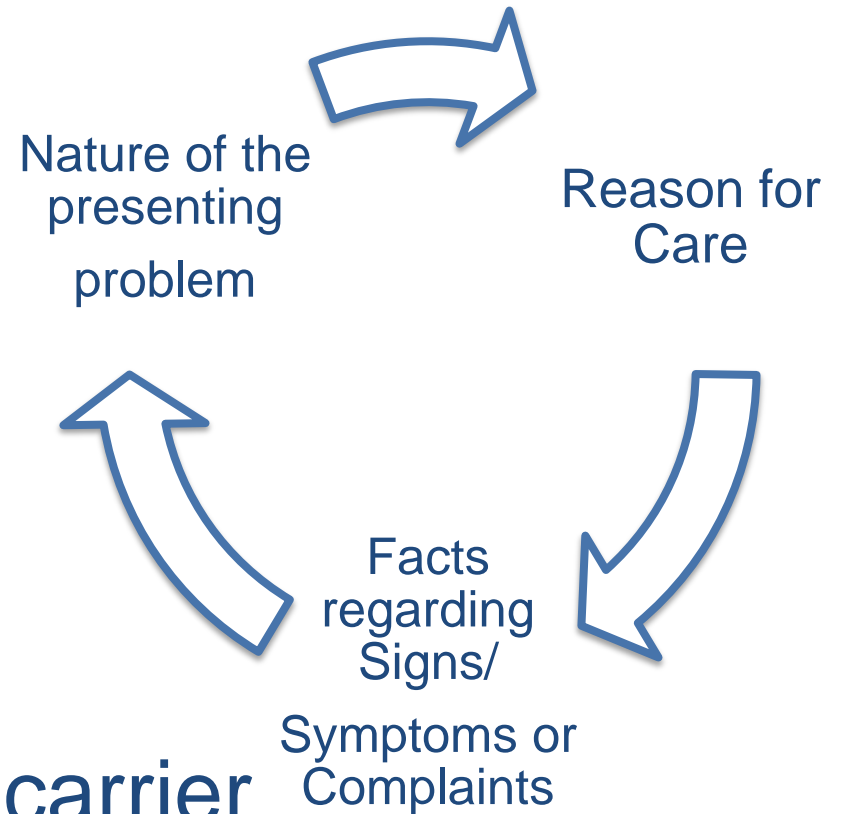# Keys to Demonstrating Medical Necessity in E/M Services

- Document all diagnoses the provider is managing during the visit

- For each established diagnosis, specify if the patient's condition is stable, improved, worsening, etc.

- Make sure the rationale for ordering diagnostic tests is either documented or easily inferred

- Clearly describe management of the patient, (i.e., prescription drugs, over the counter medication, surgery, etc)

Why is it Important?

- Practice of Medicine has undergone a significant transformation due to:
  - Federal regulations
  - Coding
  - Reimbursement
- Medical Coding is a language all its own
  - Coding is not an exact science
  - Documentation and Medical Necessity must be supported in the medical record
  - Coding is subject to intense review by insurance industry
- Insurance industry uses statistical analysis to recover dollars spent for fraud, waste, and abuse

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Supporting Medical Necessity

- Diagnostic codes identify circumstances of patient's condition

- To justify care provided you MUST provide pertinent information to the insurance carrier

Nature of the presenting problem

Reason for Care

Facts regarding Signs/ Symptoms or Complaints

Top E/M Coding Errors

- Lack of Medical Necessity
- Overcoding or Undercoding
- Wrong E/M category chosen
  - Consult requirements not met
  - Preventive service should be billed
- Chief Complaint missing or incorrect
- Assessment and/or Plan not clearly documented
- Missing Documentation
- Illegible Documentation
- Time not documented correctly
  - Total time is documented but not that more than 50% was devoted to counseling and/or coordination of care

Top E/M Coding Errors

- Documentation not authenticated
- Tests ordered & billed but not documented on the patient encounter
- Incorrect Diagnoses
  - Signs & Symptoms with Definitive Diagnosis
  - Incorrect Sequencing
- Unbundling
- Missing or invalid modifiers
  - -24
  - -25
  - -57

Auditing Procedures Performed with E/M Services

- Accurately translating surgical and medical services into CPT® and ICD-9-CM codes is challenging
    - Auditor must understand the surgery coding guidelines, insurance carrier rules, Correct Coding Initiative (CCI) edits, and how to code an operative report
    - Knowledge of procedural and diagnostic rules, as well as a background in medical terminology is needed
    - Specific understanding of the procedure and services performed by the physician is essential to assign the proper CPT code(s)
    - Many insurance carriers monitor a physician's billing practices closely for possible inappropriate billing and/or unbundling. It is essential that the CPT description accurately describe what actually transpired during the patient encounter.

Billed: 99213-25 57511
Dx: V13.29

Audited: E/M is supported   EPF/EPF/L
but lacks medical necessity
Dx: 622.11 Consented for different
procedure

9/7/2012 Established patient here for cryo

HPI: this patient is in for treatment of her abnormal pap. Last colposcopy showed a low-grade squamous lesion with mild dysplasia. She has a history of irregular pap smears in the past. Informconsent for colposcopy was obtained.

Allergies: None

Patient is non-smoker, works as RN in ER. Family history of cancer in GGM and HTN in mother, father has Diabetes. G6P2

ROS: Constitutional: negative for fever, Respir: negative for SOB, Cardio: negative for chest pain, GI: negative for N&V, Neuro: negative for HA, Psych: negative for depression, patient is not anxious.

Objective:

Oriented to time, place, person, head is normocephalic and atraumatic, PEERLA, neck has normal ROM, no thyromegaly, no respiratory distress, no abdominal distension, alert and oriented to time, place, person, skin is warm and dry, normal mood and affect.

Assessment: History of abnormal pap, mild dysplasia of cervix

Plan: Cryotherapy is performed – return in 4-6 months for test of cure pap smear.

99213 -25 20550

99213- 25
20600-RT
J1100, J0702X2

Patient presents with complaint of pain and soreness on the left foot. Has been sore for several months and is getting worse. Also has compliant of painful right great toe.

Medical history – negative

Medications – none

Allergies NKDA

Social history – no tobacco

Exam: Skin temperature of lower extremities is warm to cool on proximal to distal. Pulses palpable bilaterally, no edema, cyanosis or crepitus.

Sensations are normal, tenderness with palpation of the right great toe.

Tenderness of right 3rd to 4th interspace.

Muscle strength is 5/5 for all groups tested. Muscle tone is normal. Inspection and palpation of bones, joints, and muscle unremarkable.

Impression: Neuroma, Capsulitis

Plan: Injection of Lidocaine 20 m/ml, ¾ cc Dexamethasone 1 mg /ml and 4 cc Celestone soluspan 3mg /ml in right *great interspace*. Patient tolerated injection w/o complications. Discussed exercise - instructed to call with increased pain or redness.

AMA Surgery Guidelines

- The CPT® manual describes the surgery package as including:
  - Subsequent to the decision for surgery, one E/M visit on the date immediately prior to or on the date of the procedure (including history and physical)
  - Local anesthesia: defined as local infiltration, metacarpal/digital block, or topical anesthesia
  - Intraoperative services that are normally a usual and necessary part of a surgical procedure and any related supplies, services, procedures normally required for the particular surgery
  - Immediate post-operative care, including dictation of operative notes, talking with family and other physicians
  - Writing orders
  - Evaluation of patient in post-anesthesia recovery
  - Normal, TYPICAL follow-up care
  - All additional medical or surgical services required of the physician within 90 days of the surgery because of complications, which do not require additional trips to the operating room
    - Related follow-up visits made within the postoperative period and post-surgical pain management by the surgeon
    - Normal, TYPICAL follow-up care

Modifiers for E/M with Major or Minor Procedures

- -25
  - Minor procedures: 0-10 global days
    - Patient presents to her PCP with chest pain. Physician documents a Detailed History, Detailed Exam and Moderate MDM. He orders an EKG, which is performed in the office.
      - Report 99214-25 and 93000.

- -57
  - Major Procedures: 1 day preoperative and 90 days postoperative
    - Patient (non-Medicare) presents to ER with knee pain and is admitted by her PCP. He consults an orthopedic surgeon, who personally reviews her CT, labs and EKG and decides to operate that day. He documents a Detailed History, Detailed Exam and High MDM.
      - Report 99253-57

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National Correct Coding Initiative (NCCI)

- 1996 CMS implemented this National Policy
  - Aimed at controlling improper coding and billing practices of Part B claims
  - Many third party payers rely on CCI for implementing policy
  - NCCI published quarterly
  - Reviews coding combinations and implements correct code edits
- Code combinations in 2 categories
  - Mutually exclusive
    - Denies combination that should not be separately reported based on standards of medical practice
    - If necessary to report modifier 59 should be appended
  - Modifier 59 reviewed by CMS when claims are submitted for these code pairs that are normally prohibited
  - What if this is a private payer?

Unbundling

- Similar to coding an incidental procedure
- Unbundling can result from two problems:
  - Unintentional results from not having a good understanding of coding
  - Intentional when practitioners manipulate the coding to maximize payment
- Medicare closely monitors physician billing practices for possible abuse or fraudulent billing. Private payers also watch for unbundling.

Unbundling Prevention

- Use current code books
- Educate yourself on:
  - CPT® guidelines
  - NCCI
  - Insurance Carrier Regulations
- Be specific when using charge tickets for coding
- Code directly from operative note or chart note
- Update codes annually
  - ICD-9-CM in October and CPT ® in January
- Avoid fragmented billing
- Make sure physicians provide complete information and documentation
- Use modifiers correctly
- Use caution when reporting integral procedures

E/M Levels

How to Select E/M Level

- Select the appropriate E/M category
  - New patient, Established patient
  - Office or other outpatient, Inpatient, Consultation, Observation, Consultation
- Review Components used to Define Level:
  - Key Elements
    - Medical Decision Making
    - History
    - Exam
- Counseling
- Coordination of Care
- Nature of presenting problem
- Time as controlling factor
  - Determine Complexity of MDM
- Determine Extent of History and Exam Obtained

Medical Decision Making

Medical Decision Making (MDM)

- Number of Diagnoses or Treatment Options
  - Section A on MDM worksheet
  - Each diagnosis "earns" points
    - Self-limited or Minor: 1 pt (maximum of 2)
    - Established problem, stable or improved: 1 pt each
    - Established problem, worsening: 2 pts each
    - New problem, no add'l workup planned: 3 pts (maximum 1 prob)
    - New problem, add'l. workup planned: 4 pts

Diagnosis/Treatment Options (Section A)

Problem Status	#	Pts=	Results
Self limited or minor – max of 2		1	
Est. prob. (to examiner) stable/improving		1	
Est. prob. (to examiner) worsening		2	
New prob. (to examiner) no add. w/u planned – max 1 problem		3	
New prob. (to examiner) add. w/u planned		4	

Medical Decision Making (MDM)

- Amount and/or Complexity of Data to be Reviewed
  - 1 point is assigned for:
    - Review and/or order clinical lab tests (max 1 pt)
    - Review and/or order tests in CPT radiology section (max 1 pt)
    - Review and/or order tests in CPT medicine section (max 1 pt)
    - Discussion of test results with performing physician
    - Decision to obtain old records or obtain additional history
  - 2 points is assigned for:
    - Independent visualization of image, tracing or specimen (not simply a review of a report)
    - Review and summarization of old records and/or history from someone other than patient and/or discussion with another healthcare provider

Amount/Complexity of Data

Type of Data	Pts	Total
Review and/or order clinical labs	1	
Review and/or order X-rays	1	
Review and/or order other tests	1	
Discussion of tests with performing MD	1	
Independent review of image, tracing, or specimen	2	
Decision to obtain records and/or obtain History from someone other than pt	1	
Review and summarize old records, obtain history from someone other than pt, discuss case with other MD	2	

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Medical Decision Making (MDM)

- Risk of Complications and/or Morbidity or Mortality
    - Presenting Problem(s)
        - 1 self-limited or minor problem (insect bite) = Minimal
        - 1 stable chronic illness = Low
        - 2+ stable chronic illnesses = Moderate
        - 1+ chronic illness with mild exacerbation, progression or side effects of treatment = Moderate
        - Unknown new problem with unknown prognosis = Moderate
        - 1+ chronic illness with severe exacerbation… = High
        - Acute or chronic illness or injury that may pose a threat to life or bodily function = High

Medical Decision Making (MDM)

- Risk of Complications and/or Morbidity or Mortality
- Diagnostic Procedure(s) Ordered
  - Chest x-ray, EKG or Ultrasound = Minimal
  - Skin biopsy = Low
  - Diagnostic endoscopy without identified risk factors = Moderate
  - Diagnostic endoscopy WITH identified risk factors = High
  - Cardiovascular imaging study without identified risk factors (cardiac cath) = Moderate
  - Cardiovascular imaging study WITH identified risk factors = High
  - Cardiac EP Test (EP study in lab, not Holter monitor) = High

Medical Decision Making (MDM)

- Risk of Complications and/or Morbidity or Mortality
  - Management Option(s) Selected
    - Rx drug mgt = Moderate
    - Elective major surgery without identified risk factors = Moderate
    - Elective major surgery WITH identified risk factors = High
    - Emergency major surgery = High
    - Decision not to resuscitate = High

Risk of Complications and/or Mortality

	Presenting Problems	Diagnostic Procedure	Management Options
Min	One self-limited, minor problem e.g. cold, insect bite, Tinea Corporis	Lab Test requiring Venipuncture Chest x-ray or US, EKG/EEG, KOH prep or UA	Rest, Gargles, Elastic Bandage, Dressing
Low	2 or more self-limited or minor problems, 1 stable chronic illness, Acute illness or injury uncomplicated	Physiologic test not under stress e.g PFT Non cardiovascular image study with contrast, Superficial needle biopsy, Clinical lab requiring arterial puncture, Skin biopsies	OTC drugs, PT or OT, IV Fluids w/o additive Minor surgery no identified risk factors
Mod	One or more chronic illness with mild exacerbation or side effects of treatment, 2 or more chronic illness, Acute illness with uncertain prognosis, Acute complicated injury	Physiologic test not under stress, Diagnostic endoscopy with no identified risk factors, Deep needle or incision biopsy, Cardio/Vascular imaging study with contrast no identified risk factors, Obtain fluid from body cavity	Minor surgery with identified risk factors, Elective major surgery with no identifiable risk factors, Prescription drug management, Therapeutic Nuclear Medicine, IV's with additives, Closed treatment of fracture or dislocation w/o manipulation
High	1 or more chronic illness with severe exacerbation, progression or side effects of treatment, Acute or chronic illnesses or injury that may pose a threat to life or body function, Abrupt change in neurological status	Cardiovascular imaging studies with contrast with identified risk factors, Cardiac electrophysiological tests Diagnostic endoscopy with identified risk factors, Discography	Elective major surgery with identifiable risk factors, Emergency major surgery, IV controlled substances, Drug therapy requiring intensive monitoring for toxicity, Decision not to resuscitate or de-escalate because of poor prognosis

Medications

- Medications that likely indicate High Risk (Risk Table)

  - IV Antihypertensives
  - IV Anti-arrythmics
  - IV Controlled substances
  - IV Insulin
  - Coumadin initiation
  - tPA Drugs

Documentation Reminder
Be sure to overtly state whether the patient's condition is MILD vs MODERATE vs SEVERE exacerbation, progression, or side effect of treatment.

MDM Facts & Fiction

- FICTION: Three points may be assigned for an EKG done at the patient visit (one for ordering the test and two for the interpretation and report

- FACT: If the physician is billing globally for the EKG (93000), he "earns" one point for the order because he is being reimbursed for interpretation as part of the CPT code

MDM Facts & Fiction

- FICTION: If a provider plans surgery, today's risk is high

- FACT: All surgeries have risk factors. Documentation of identified risk factors (other than those inherent to the procedure) make a surgery high risk.

MDM Example

- This 77 year old woman returns for further evaluation of her weakness. She was in the hospital in the end of September, was doing a little better. Steroids worked to improve her weakness, but she has deteriorated in the last several weeks. She had a UTI in November, treating with amoxicillin, is not sure if it has helped.
She is restless, up in the night, not using CPAP as well. She is having hallucinations, remembering things poorly, not recognizing family. She has been complaining of abdominal pain as well, no BM since Friday. She is not sleeping well. Her PCP is Dr. Booth.

- Review of Systems:
Constitutional: Negative for fatigue, fever and night sweats.
HEENT: Positive for Ringing in ears
Respiratory: Positive for-Dyspnea- occurs at rest /activity/laying down. Negative for asthma
Cardiovascular: Positive for-Irregular heartbeat/palpitations - Negative for claudication
Comments: pacemaker
Gastrointestinal: Positive for Constipation-Fecal Incontinence
Genitourinary: Positive for Urinary Incontinence Negative for polyuria
Reproductive comments: not sexually active
Metabolic/Endocrine: Negative for cold intolerance, excessive diaphoresis, heat intolerance, polydipsia and polyphagia
Neuro/Psychiatric: Positive for Depression, Difficulty concentrating, Gait Disturbance
-Gen. weakness, Hallucinations, Memory Impairment, Mood Swings, Psychiatric Symptoms, -Speech Changes, Tremors, Negative for diff. w coordination

MDM Con't

- Dermatologic: Negative for acne, change in shape/size of mole(s), excessive sun exposure, frequent skin infections, hair loss, hirsutism, nail changes, photosensitivity, pigment change, pruritus, rash, skin lesion and utricaria
  Musculoskeletal: Positive for Bone/joint symptoms
  Hematology: Negative for bleeding, bleeding diathesis, cytopenias, easy bruising, hypercoagulability, lymphadenopathy, petechiae and thromboembolic events
  Immunology: Negative for angioneurotic edema, animals at home, animals in work place, bee sting allergies, chemicals at home, chemicals in work place, contact allergy, contact dermatitis environmental allergies, food allergies and hay fever.

- Exam:

- Neurological
  Alert, but confused. Only oriented to self, not time or place. Language fluent, but words often times meaningless. Flight of ideas, not making sense. Follows simple commands appropriately. No drift, but weakness in BUE and LE, poor resistance throughout. Normal heart sounds and lung sounds, no bowel sounds.

- Assessment/Plan: Myasthenia gravis (358.00) Recurrent pneumonia (486) CHF (congestive heart failure) (428.0) Delirium (780.09)
  Gradually worsening debility since discharge from the hospital, worse delirium.
  -steady decline since recent hospitalization
  -steroids were a temporary measure but helped at the time
  -admit to hospital for evaluation of possible infection, evaluation to see risk of immunosuppression with her history of recurrent PNA, and to get PT/OT/ST to see her, make sure her breathing is ok with PFTs. Repeat UA and culture to make sure UTI adequately treated.   -Will follow her in hospital, RTC in 1 month.

MDM example

- Weakness, was improving – recently deteriorating
- Myasthenia gravis –
  - "She is restless, up in the night, not using CPAP as well. She is having hallucinations, remembering things poorly, not recognizing family. She has been complaining of abdominal pain as well, no BM since Friday"
  - "Gradually worsening debility since discharge from the hospital, worse delirium.
    -steady decline since recent hospitalization"
- Dx/Treatment options -   New problem or exacerbation
- Data - UA and culture
- Risk -   Abrupt change in neurologic status

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HISTORY

History

- **Chief Complaint**
  - Required for Every Service

- **History of Present Illness (HPI) – MUST be performed and recorded by provider**
  - Location, Duration, Quality, Severity, Timing, Context, Modifying Factor(s), Associated Sign(s) or Symptom(s)
  - Some are very similar, i.e. Quality and Severity
  - Brief: 1-3 descriptors
  - Extended: 4 or more descriptors
  - 1997 guidelines: status of 3 chronic conditions

History

- Status of 3 Chronic Conditions
- Supports a complete HPI under 1997 Documentation Guidelines (and sometimes under 1995 as well – per payer)
- Does not have to be stated in the heading under HPI
  - Often the status can be pulled from other areas of documentation.
- Will usually require auditor to use 1997 exam guidelines
- When additional information on chronic conditions is included, it can be used for ROS

History

- Review of Systems (ROS)
  - Review of patient's current or past SYMPTOMS (not chronic conditions)
  - Problem Pertinent: 1 system reviewed
  - Extended: 2-9 systems reviewed
  - Complete: 10 or more systems reviewed
  - Some payers allow provider to note positives and pertinent negatives, then summarize remaining negatives

History

- **Past, Family & Social History (PFSH)**
  - PAST HISTORY
    - Meds, allergies, surgeries, chronic conditions, immunizations, etc
  - FAMILY HISTORY
    - Health status of parents, siblings, children
    - Document if patient does not know his/her family history
    - Some payers do not recognize "FHx noncontributory" or "FHx negative"
  - SOCIAL HISTORY
    - Use of alcohol or tobacco, marital status, employment, extent of education, etc.
    - Pediatric social history could include whether patient attends daycare, where patient lives (with grandmother, etc) and/or if there are any smokers/pets in the home

History Facts & Fiction

- FICTION:
  - Only symptoms can be used as HPI elements
- FACT:
  - If patient is asymptomatic but provider is following chronic conditions, statements about that condition can support HPI elements
  - Patient is seen in follow-up for her DM. Blood sugars have been running in the 120s. She has modified her diet and is eating less carbs. Severity and Modifying Factor

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History Facts & Fiction

- FICTION:
  - Statements about negative symptoms in the HPI section cannot be used as ROS.

- FACT:
  - ROS does not have to neatly listed in a paragraph with a heading of "Review of Systems" – can be listed anywhere in History

She Has Multiple Concerns…

①She is very concerned about the expense involved in avoiding lactose and wants to ask to talk about alternatives. She gets ②flare-ups of ③ irritable bowel symptoms in ④ spite of being careful with lactose intake. She has significant pain in her feet and she is getting no relief with topical Voltaren. Her neuropathy continues to be an issue. Her glucose readings have been in the 120-130 range. She is now on a higher dose of thyroxine replacement. She inquires as to whether she uses the right amount.

She Has Multiple Concerns…

Patient is status post hospitalization for COPD – he had an ① exacerbation. He had been on exercise but stopped it on own. Patient was discharged on ③Levoquin and prednisone which he is currently taking. Has ② occasional ④wheezing but has improved significantly. He was admitted for 2 days at RMC. Patient has cardiomyopathy, gastro-esophageal reflux, ischemic heart disease, hypertension, and hyperlipidemia. Patient is accompanied by caregiver. Medications were reviewed in detail with both patient and caregiver. Patient has had decreased appetite and continues to lose weight.

She Has Multiple Concerns…

The patient is a 23 year old female. Patient wants to discuss PMS. ①Currently using OCP. Age of menarche is 12, ② LMP 2/10/2012, ③moderate pain/cramping and ④ uses 3 pads/tampons per day. She does perform SBE monthly.

She Has Multiple Concerns…

Patient presents complaining of not being able to move his ①left arm ②when he was waking up and ③ being off balance. States ④ several days ago, prior to this episode, he had left arm weakness that seemed to resolve and return to normal

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She Has Multiple Concerns…

Was scratched ①by a cat ②25 days ago. Now complains of ④ swelling and⑤ redness, ③Rt forearm. No fever, no chills

PMH–SHx-FHx : See problem list

ROS: negative and as above.

Exam - 1995

- Organ Systems
  - Constitutional
  - Eyes
  - Ears, nose, mouth & throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Skin
  - Neurologic
  - Psychiatric
  - Hematologic/Lymphatic/Immunologic

- Body Areas
  - Head, including Face
  - Neck
  - Chest, including breasts & axillae
  - Abdomen
  - Genitalia, groin buttocks
  - Back, including spine
  - Each extremity

Exam - 1997

- – General Multi-System
- – Cardiovascular
- – Eye
- – Ear, Nose & Throat
- – Genitourinary (Female)
- – Genitourinary (Male)
- – Hematological/Lymphatic/Immunologic
- – Musculoskeletal
- – Neurological
- – Psychiatric
- – Respiratory
- – Skin

Exam Levels

	PF	EPF	Detailed	Comprehensive
1995	1 BA/OS	2-7 BA/OS	2-7 BA/OS in detail	8+ OS
1997 General Multi-System	1-5 bullets	6-11 bullets	2 bullets from each of 6 systems	2 bullets from each of 9 systems
1997 Psychiatric	1-5 bullets	6-8 bullets	9+ bullets	All bullets in shaded boxes and at least one from each unshaded box
1997 other Single System	1-5 bullets	6-11 bullets	12+ bullets	All bullets in shaded boxes and at least one from each unshaded box

Common Exam Statements

- Constitutional
- Vital signs
- General appearance of patient
  - No acute distress
  - Alert
  - Well developed, well nourished, well groomed (WDWNWGW
  - Disheveled
  - Patient appears uncomfortable
- Eye
- Conjunctivae & lids normal
- Sclera clear
- Left eye has purulent discharge
- PERRLA (pupils equal, round, reactive to light and accommodation)
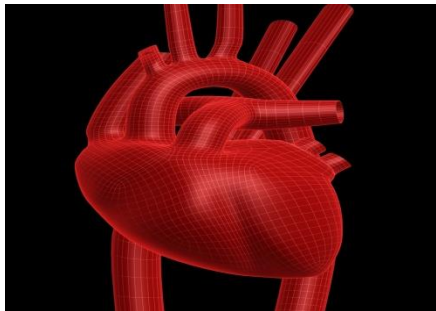- EOM intact

Sample Exam Statements

- ENT
  - Hearing normal
  - Nasal mucosa pink, moist
  - Good dentition
  - Ooropharynx clear
  - Maxillary sinus tenderness

- Cardiovascular
  - No JVD (jugular venous distention) or carotid bruits
  - RRR (regular rate & rhythm), no murmurs, rubs or gallops
  - PMI (point of maximal impact) non-displaced
  - No abdominal bruits
  - Mild edema
  - Pulses normal

Sample Exam Statements

- Respiratory
  - Lungs CTA (clear to auscultation) throughout
  - No wheezes, rales or rhonchi
  - No evidence of respiratory distress
  - Thorax symmetrical with good diaphragmatic expansion
 - No use of accessory muscles, normal effort
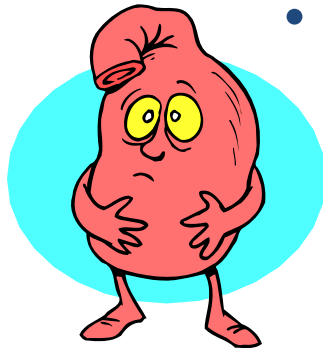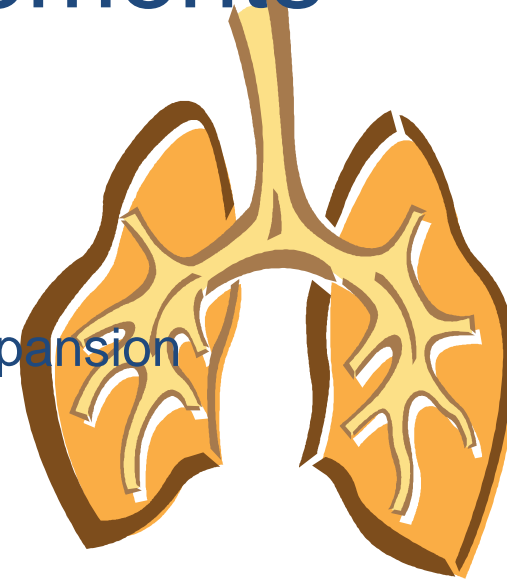
- Gastrointestinal
  - Abdomen soft, tender, no masses
  - No hepatosplenomegaly
  - No hernia appreciated
  - Bowel sounds normal

Sample Exam Statements

- Genitourinary (Male)
  - Normal scrotum without significant lesions or rashes
  - Normal size testes descended bilaterally without masses
  - Urethral meatus is normally located and nonstenotic
  - Normal penis without lesions

- Genitourinary (Female)
  - Breasts symmetrical and non-tender
  - External genitalia normal
  - BUS normal
  - Bladder without masses or tenderness

Sample Exam Statements
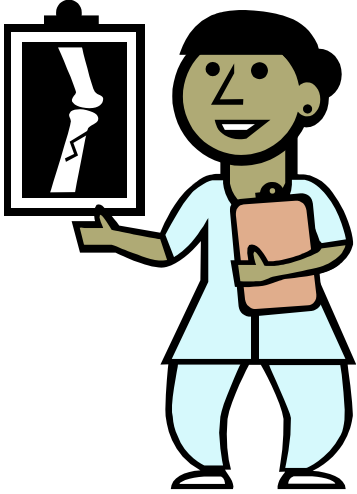
- Musculoskeletal
  - Patient is limping
  - No clubbing
  - Full ROM (range of motion) of left lower extremity
  - Normal muscle strength
  - Crepitus
  - Right knee laxity is appreciated

- Neurological
  - Cranial nerves II-VII intact
  - Tongue is midline
  - Face symmetric
  - Shoulder shrug normal
  - DTRs (deep tendon reflexes) +4
  - Normal sensation

Sample Exam Statements

- Psychiatric
  - Alert & oriented x 3
  - Slightly depressed mood and affect
  - Good judgment and insight
  - Recent memory is good
  - Speech slurred
  - Logical reasoning

- Hematologic/Lymphatic/Immunologic
  - No adenopathy (cervical, axillary, inguinal, other)

Sample Exam Statements

- Integumentary
  - No rashes or lesions
  - Male pattern baldness noted
  - Skin warm & dry
  - No breast lumps

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Exam Facts & Fiction

- FICTION:
  - Pt WD/WN, PERRLA, Lungs CTA, Heart RRR, Abd soft & nontender = DETAILED exam by 1995 guidelines

- FACT:
  - Payers have different standards for Detailed Exam
    - Some define as 5-7 Areas or Systems
    - Others define as 2-7 BA/OS with detail in one

Exam Facts & Fiction

- FICTION:
  – Neck: no JVD or carotid bruits = BODY AREA: NECK

- FACT:
  – Do not use headings to determine which Areas/Systems is supported

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Exam Facts & Fiction

- FICTION:
  - A specialist has to use "his" single system specialty exam under 1997 guidelines

- FACT:
  - Use of Multi-system exam or any of the specialty exams is allowed for any physician/provider

EXAM – EPF or DETAILED?

- Constitutional: BP 118/64, P 70, T 98.0. Patient in NAD.
- HEENT: PERRLA. Neck supple. Lungs CTA. Heart RRR, no murmurs, rubs or gallops. Abdomen soft, nontender, no masses.

EPF

- Constitutional: BP 118/64, P 70, T 98.0. Patient in NAD.
- HEENT: PERRLA. Neck supple, no JVD or bruits. Lungs CTA. Heart RRR, no murmurs, rubs or gallops. No edema. Abdomen soft, nontender, no masses.

DETAILED

EXAM – EPF or DETAILED?

- VITAL SIGNS: BP 134/89, P 77, R 12, Wt 161.4.
- GENERAL: Well developed, well nourished in no acute distress. EYES: PERRLA. ENT: Hearing acuity good. Nasal mucosa unremarkable. Teeth & gums unremarkable. Oral mucosa moist. NECK: No adenopathy. Lungs CTA. Heart RRR.

DETAILED

- Wt: 110, BP: 180/90, P 76. Pt in NAD. Extremities: No clubbing or cyanosis. Mild edema. MS: Bilateral knees examined, no tenderness in either knee. Limited ROM on right. Normal sensation. Standing alignment is normal. Excellent stability. Negative McMurray. Negative Steinman.

DETAILED

Differing Payer Guidelines

	HPI element used more than once	ROS summary statement ("all others negative")	Family History "noncontributory"	MDM must be one of two key elements for established patient level selection
First Coast	NO	YES	NO	---
Novitas	YES	YES	YES	---
Palmetto	NO	YES	NO	---
WPS	RARELY	YES	---	---

GRAY AREA: If your Medicare carrier does not answer one of these questions on their website, what standard do you follow?

ICD-9 Coding Principles

- Apply the following principles to diagnosis coding to appropriately demonstrate medical necessity:
  - List the principal diagnosis, condition, problem, or other reason for the medical service or procedure
  - Assign the ICD-9 code to the highest level of specificity
  - For office and/or outpatient professional services, never use a "rule-out" statement (a suspected but not confirmed diagnosis)
    - A clerical error could permanently tag a patient with a condition that does not exist
    - Code symptoms if no definitive diagnosis is yet determined
- These facts must be substantiated by the patient's medical record, and that record must be available to payers upon request.

Diagnosis Documentation Tips

- Be specific in describing the patient's condition, illness, or disease
  - Distinguish between acute and chronic conditions, when appropriate
- Identify the acute condition of an emergency situation
  - Coma, loss of consciousness, hemorrhage, etc.
- Identify chronic complaints, or secondary diagnoses, when:
  - Treatment for them is provided
  - They impact the overall management of the patient's care
- Identify how injuries occur

Audit Benefits

An audit gives the physician and medical practice staff the opportunity to identify:

1. incorrect coding and billing patterns

2. over utilization of procedures and services before an outside auditor

3. Can prevent recovered payments or assessed fines/penalties

Goals of Audit

Two categories that are important

- Revenue
  - Underbilled services
  - Overbilled services
  - Frequency/upcoding
  - Undocumented services
  - Denied services
  - Downcoded services
  - Services not billed or missed charges

- Compliance
  - False Claim Act
  - OIG
  - HIPAA

Audit Basics

- Review the medical record
  - What procedures and services were performed? Do they:
    - Meet coding guidelines
    - Meet carrier guidelines
    - Support medical necessity
- Examples:
  - Adherence to clinical protocols
  - Patient adherence with medication regimens
  - Provider compliance
- Develop a Clear Plan of Action
  - Be prepared for the eventual payer audit
 - Compliance audits are preventive

What Can Trigger a Carrier Audit?

- Consistently using one level of E/M service or routinely using higher levels
- Ordering excessive tests
- Billing Medicare or another government program for care not provided
- Unbundling of procedures
- Waiving coinsurance and deductibles in absence of financial hardship
- Changing codes to get paid
- Coding based only on reimbursement and not medically necessary services
- Practitioner's profile (utilization pattern) does not meet the standards of the industry

Understanding the Process

- The medical record facilitates:
- Evaluation and planning of treatment
- Communication and continuity of care
- Accurate and timely claims review/payment
- Appropriate Utilization review and quality of care evaluations
- Data collection used in research and education

Scope Conceptually
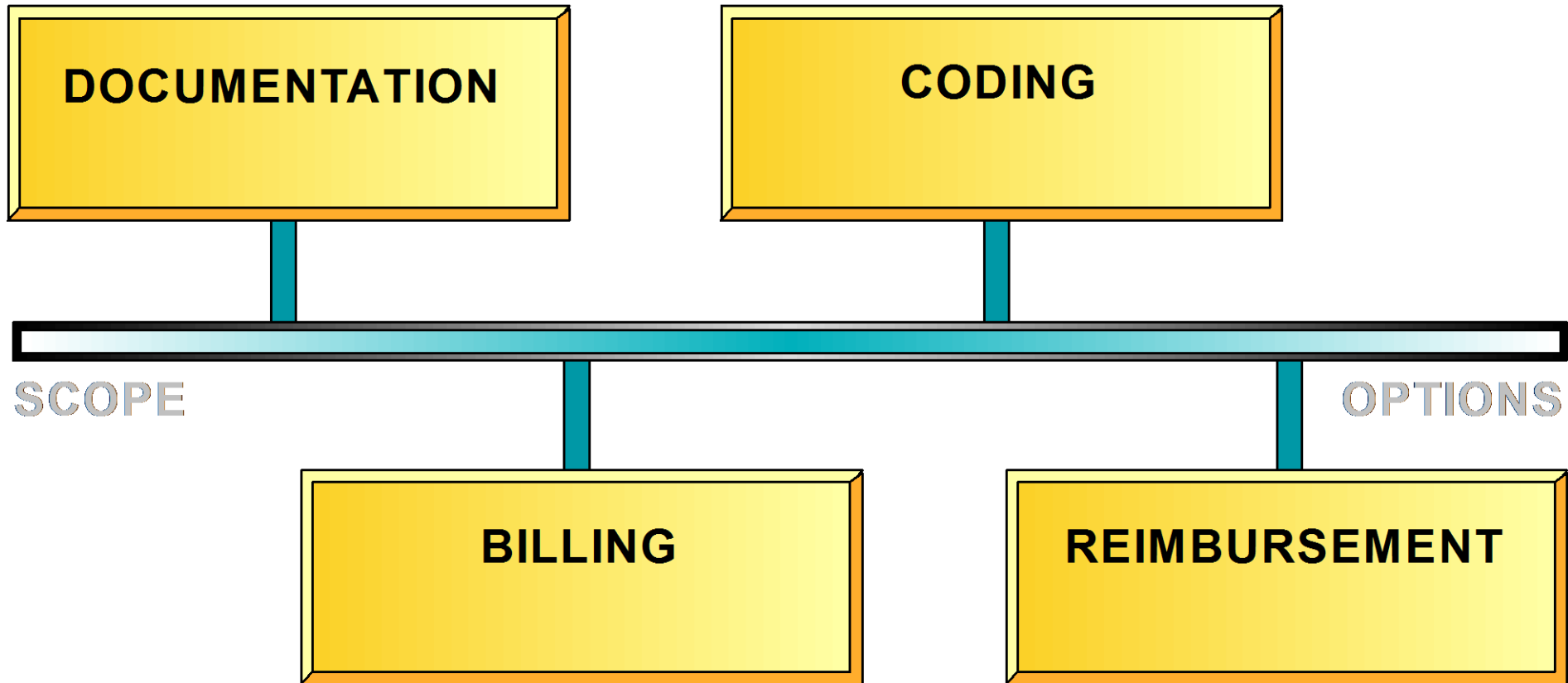
Auditing vs. Monitoring

- Auditing
  - Process of examining the medical record, verifying information, and gathering baseline information to identify risk areas
- Monitoring
  - Ongoing process of reviewing coding practices and the adequacy of documentation and code selection
  - Monitoring should be conducted on a regularly scheduled basis and include such activities as:
    - Auditing
    - Reviewing utilization patterns
    - Reviewing computerized reports
    - Reimbursement

What Are You Looking For?

- Nonbilled services
  - Compare the medical record to the billing to identify services that are documented in the medical record but overlooked in coding
- Overbilled and/or underbilled services
  - All services, including E/M and surgical procedures, should be documented with sufficient detail to allow coders to select the proper CPT® and/or HCPCS and ICD-9-CM codes
- Undocumented services
  - A good audit (review) will identify instances where codes are billed without proper supporting documentation
- Denied or down-coded services
  - Analyze those services that are denied or down coded by payers to discover the cause of the denial
  - Information comes from comparing the billed services to the EOB or remittance advice (RA) from Medicare

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E/M Audit Guidelines to Use

- Two sets of Guidelines for CMS
  - 1995
  - 1997
  - CMS Guidelines
    - http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp
    - AMA Guidelines are in CPT® code book and are vague in the required amount of detail that should be documented
    - Other carriers such as Novitas, Palmetto have their own unique criteria
    - Marshfield Tool

Five Parts of the Audit

- Identify who/what service is being audited
  - Physician
  - Coder
  - EMR
- Perform the audit
- Report the results
- Discuss results with provider
- Identify repayment – self-disclosure
- Perform ongoing auditing and monitoring

Beginning the Audit Process

- Questions to Ask
  - What is the focus of the audit (e.g., new patient visits, consultation, office, hospital, etc.)?
  - Who/What is the focus of the audit (e.g., physician, coder, EMR)?
  - Are you performing a prospective or retrospective audit?
  - What is the number of charts you are going to review?
  - Is there a measure for the focus such as utilization patterns?
  - Has the provider been audited before where data is available?
    - If "yes", then a benchmark or standard exists
    - if "no", then a standard for comparison may not exist
  - What type of audit tool will you use?
    - Electronic
    - Paper

Audit Tools

- A "must have" for any medical record auditor
- There are a variety of prepackaged audit tools for general use
- Beneficial for the auditor to
    - Create his or her own audit tool
    - Tailor the tool to the specialty that is being audited
- Can be created in a template format in MS Word or other software programs
- Should be compliant with coding and documentation guidelines

Electronic Audit Tools

- Electronic (Software)
  - Variety of software programs to assist with the audit process
  - These tools are good for
    - Report generation
    - Tracking utilization deviations
    - Providing help with guidelines integrated into the software
  - Downside of using software as an audit tool
    - Calculation of medical necessity
    - A software program cannot analyze medical decision-making
    - Reports are not always accurate

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Auditing Tools

- Use tools for auditing E/M visits and services for the physician
  - Audit tool or grid
  - Charge ticket
  - Codebooks (CPT®, ICD-9-CM, HCPCS Level II)
  - NCCI (book or software)
  - Other pertinent coding publications
  - Detailed analysis-for summarizing audit results
  - Summary report-reporting audit results

Beginning the Audit Process

- Select type of services to review which might include:
    - Office or Hospital
    - New versus established patients
    - Consultation
    - Nursing home visits
    - Surgical procedures
    - Identify measures (levels of services)
    - Identify patient population based on insurance carrier

Medical Record

- Review the medical record
  - The Medical Record is not a document created for billing purposes
    - Its real purpose is to ensure continuity of care among provider
    - Evaluated for billing purposes
  - Clinical Judgment
    - Physician determines a specific type of exam is medically necessary for patients with the same symptoms or conditions
    - Do not consider this cloning, overcoding or undercoding
  - Example next slide

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Example: Specialty Exam

Physical Exam
VITAL SIGNS Temperature 98 6, pulse 82, respirations 16, blood pressure
124/78
GENERAL Alert and oriented x3 No acute distress
LEFT HAND EXAM The patient has no angulation or rotation There is no
open wounds or sings of infection He has 90% range of motion of his left
small finger His metacarpal phalangeal joint is a little stiff He has
no tenderness to deep palpation

- A hand surgeon – exam limited to upper extremities
  - Typical exam supports EPF or Detailed
  - Don't instruct to over-document

Questions that May Arise

- EMR Calculator
- Physician Understanding
- Coder Education or Knowledge

Questions that May Arise

- EMR Calculator
  - Does the provider "free text"
    - This does not calculate
    - Is all documentation flowing through to the printed page?
      - If not, auditor will not have complete documentation
    - Does EMR correctly calculate based on E/M category?
      - Established patients only require 2 of 3 key elements

Questions that May Arise

- Physician Understanding
  - Education
    - Does he/she know the required elements for each level?
    - Ask provider to walk you through a typical exam
      - Is it detailed, comprehensive, etc.
  - Who is responsible for entering elements of ROS and PFSH?
    - Physician
    - Coder
    - EMR
      - Is the record authenticated?

Questions that May Arise

- Coder Education or Knowledge
  - Having your work audited may cause stress
  - It can be insightful
  - Problems or misconceptions can be identified
  - Can ALWAYS gain knowledge
    - Tip, tidbit, hint, etc.
  - Sometimes you can be too close to the problem or feel obligated to code a certain way
 - May not be aware of deficiencies apparent to someone "looking in"

What Happens If a Problem Is Identified?

- STOP !
- If you identify any aberrant coding patterns, more frequent auditing may be beneficial
- Education and Training
- Careful pre-submission monitoring and review of similar types of claims may safeguard against errors which could result in either claim denial or audit recovery from:
  - a commercial payer
  - third-party payer
  - government carrier

Where Do We Go From Here?

- Determine steps necessary to resolve the issues identified
  - Education
    - Provider
    - Charge capture staff
  - Changes to operational process
  - Identify timeframe to complete the steps
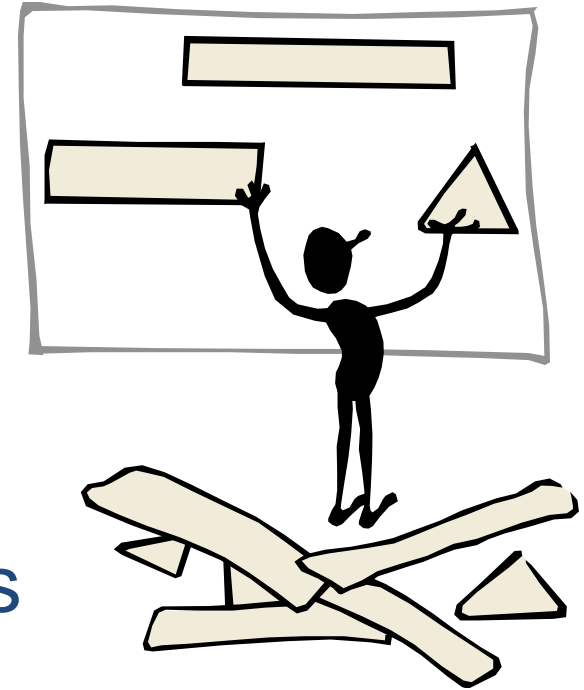
Where Do We Go From Here?

- Develop a process to monitor on a periodic basis
- Implement a plan to validate that steps taken have corrected the problem
- All types of audits findings should be reported
  - Identifying errors (coding and billing)
  - Review utilization-both CPT®/HCPCS Level II and diagnosis codes
  - Medically necessary services
  - Self disclosure

Periodic Monitoring for Accuracy

- To accomplish goal of validating that steps taken have corrected the problem and it does not recur:
  - Develop a schedule for subsequent audits
  - The frequency of the audits will depend on the number of problematic areas and the overall error rate of the organization
  - Normally audits are conducted monthly, quarterly, semi-annually, or annually

Conclusion

- Medical Chart Auditing is important to maintain compliance which will be mandated by 2014 based on Health care reform

- E/M Coding and auditing is not an exact science—there are gray areas

- Check with each payer regarding guidelines, medical policies etc

- When speaking with the practitioner, make sure you can provide official guidance for problematic areas

Thank You for Attending

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