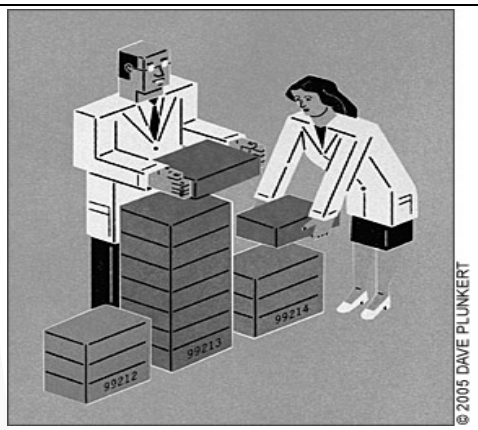
JUST HOW MUCH DOCUMENTATION IS REQUIRED



99213 or 99214 Visit?

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Presented by:
Leslie C. Bembry CPC
Coding and Compliance Manager
Montgomery Hospital Health Systems
Fornance Physician Services Inc.
Norristown Pennsylvania

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Overview

- Basic Documentation Requirements
  - General Documentation Requirements
  - Medical Necessity
  - Starting with Medical Decision Making
  - Minimal Requirements
    - Level 3 problem focused return
    - Level 4 chronic disease or problem focused return
  - Choosing the E/M based on time

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General Documentation Principles

- **The medical record should be complete and legible**
- **Documentation of each patient encounter should include:**

*** Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results.**

*** Assessment, clinical impression or diagnosis**

*** Plan for care**

*** Date and legible identity of the observer**

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REMEMBER…...

"If it wasn't written, it wasn't done."
"If you can't read it, it wasn't done"
"If you can't find it, it wasn't done"
"If it is not filed in the record,it wasn't done."
"If it was not ordered, it wasn't necessary."

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If you…..

- Considered it
- Suspected it
- Reviewed it
- Discussed it
- Monitored it
- Ruled it out

Document it!

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Does Medical Necessity really drive code selection?

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 volume 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 practicable after it is provided in order to maintain an accurate medical record.

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When deciding on the most appropriate E/M code for a visit, remember **FIRST** the three key areas of consideration:

1. **History**
2. **Examination**
3. **Medical Decision Making**

Generally better to use the 1995 rules

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Did you know …...

Roughly 80% of encounters in a typical Family practice office will involve deciding between level 3 and level 4 return visit.

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Start with the MDM

1. **Calculate the MDM before any other component.**
   ***For example*…why do a comprehensive H&P for a sore throat?**
2. **The extent of information obtained and documented determines the overall level of decision making**
   - ***Number of diagnoses/treatment options***
   - ***Amount and complexity of data reviewed***
   - ***Risk of complications***
3. **Then let the level of MDM guide the other components.**
4. **After calculating MDM you now need to document an appropriate level of History and/or Physical Exam**

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Medical Decision Making

Although nothing in CPT or the documentation guidelines requires that medical decision making be one of the two required components for a 99214, it seems logical that it serve as the foundation.

It may be more difficult than documenting the history and exam, but documenting your medical decision making and letting it guide your selection will probably lead you to the appropriate code.

Family Practice Management - American Academy of Family Physicians.

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Decision-Making: *Low*

Presenting Problems

- **1 or 2 self-limited or minor problems**
- **1 stable chronic illness**
- **Acute, self-limited uncomplicated illness or injury**
- **Risk is low**

Treatment Options

- **Rest or exercise, diet, stress management**
- **Medication management with minimal risk (OTC)**
- **Referrals not requiring detailed discussion or detailed care plan**

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Decision-Making: *Moderate*

Presenting problems

- 3+ self-limited problems
- 1+ chronic illnesses or self-limited problem with ***mild*** exacerbation
- 3 stable chronic illnesses
- Undiagnosed new illness, injury, or problem with uncertain prognosis
- Acute illness with systemic symptoms

Treatment options

- Referrals requiring detailed discussion
- Management of medications with moderate risk
- Hospitalization for non-critical illness/injury
- Initiation of total parenteral nutrition
- Referral for comprehensive pain management rehabilitation

This might be a patient with three stable illnesses who is being managed on prescription drugs.

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Decision-Making: *High*

Presenting problems

- 1+ chronic illnesses w/severe exacerbation
- 4+ stable chronic illnesses
- Acute complicated injury
- Acute/chronic illness or injury posing threat to life or bodily function
- An abrupt change in bodily function

Treatment options

- Emergency hospitalization
- Medications requiring intensive monitoring
- Surgery or procedure with ASA 2* or higher risk status
- Decision not to resuscitate or to de-escalate care because of poor prognosis
- Mechanical ventilator management

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Level 3 Established Patient
Any 2 of 3 (Hx, Exam, Decision Making)

The presenting problem characteristic of a **99213** visit consists of:

one stable chronic illness,
two or more self-limited illnesses or
an acute uncomplicated illness.

Substantiation of this level of coding requires ***either*** of the following:

- **At least one HPI element**
- **A Review of Systems pertinent to the problem.**
- **An expanded problem-focused physical exam.**

Patients who are correctly assigned this code **are not very sick.**.

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Level 3 Problem Oriented Return

An established office patient with osteoarthritis

CC : " knee pain."

Interval History: Patient with known osteoarthritis which had been previously controlled on Tylenol. Now states his left knee has been aching for about two weeks despite two to three doses of Tylenol per day.
***ROS* : Musculoskeletal--Negative for arthralgias or worsening joint pain elsewhere**

Physical Exam: Mild swelling of left knee compared to the right. Some pain with passive rotation. No overlying warmth or erythema.

Assessment: Worsening osteoarthritis
Plan: Start OTC ibuprofen 400 mg po TID, PRN : Return visit in two weeks if no improvement

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Coding Tip

- It is difficult to believe that **over fifty percent** of established office patients in the Medicare population fall into this category.
- Many physicians may choose this level of care because it is located "in the middle" and seems like the right code to use for "routine" visits.
- If you take the time to calculate the MDM for many of these "routine" encounters you will find that the cognitive labor required rises above the level of the 99213 and cross the threshold to the 99214.

Peter R. Jensen, MD, CPC. EM University; http://emuniversity.com

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"Moderate Complexity"

- a new complaint that could become serious if left untreated,
- three or more old problems,
- a new problem requiring a prescription,
- three stable problems that require medication refills,
- one stable problem plus an inadequately controlled problem requiring medication refills or adjustments.

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Examples of Moderate Risk

1. Patient has well controlled diabetes and sub-optimally controlled hypertension. You increase their current medication.

- hypertension (established problem, worsening)
- diabetes (established patient stable).

The risk qualifies as moderate due to either two stable chronic illnesses or prescription drug management.

2. Otherwise healthy established patient complains of intermittent light headedness. You perform an EKG and review the tracing, which is normal. You order a Holter monitor and schedule the patient for a follow-up visit in one week.

The risk is moderate based on the presence of an undiagnosed new problem with uncertain prognosis.

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Level 4 Problem Oriented Return

Any 2 of 3 (Hx, Exam, Decision Making)

Detailed History

Chief complaint (May be part of HPI)

HPI: 4 elements *or* Status of 3 chronic or inactive

1 PFSH (Link to problem list and/or med list)

ROS: 2 systems. OK to include systems documented in HPI. A symptom can't be counted both as an element and a ROS.

Detailed Exam: 5-7 Organ systems (1995 guidelines)

Moderately Complex Decision Making (Needs 2 of the 3 that follow)

- Mild exacerbation of a chronic illness
- Undiagnosed new problem (e.g., breast lump)
- Prescription drug management or medication side effect
- Multiple diagnoses/management options
- Moderate complexity of data

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Level 4 Chronic Disease Mgmt Return

Any 2 of 3 of Hx, Exam, Decision Making

✓**Detailed History**

- Chief Complaint
- HPI: Status of 3 chronic or inactive conditions or 4 elements
- 1 PFSH
- ROS: 2 systems.

✓**Detailed Exam:** 5-7 Organ systems (1995 guidelines)

✓**Moderate Decision Making**

Moderate risk includes (among other things):

– Two or more stable or chronic conditions

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Chronic Disease Return

When you treat patients with chronic illnesses on an ongoing basis, you should begin notes with a summary list that mirrors the assessment and plan (A/P) at the end of the note.

Label and number each problem addressed, and provide a quick status of each. For example, such a note may read, "HTN well controlled, no side effects, blood pressures running in the 130s."

If you clearly indicate each problem you handle during a visit, you effectively create an outline of the encounter that will leave no room for confusion.

Careful documentation is vitally important If you don't make clear from the outset the number and nature of the problems addressed during a patient visit, you run the risk of recording notes in which the HPI area looks quite different from the A/P area.

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Did you prescribe a medication to manage the Type II diabetes that you've just diagnosed in an established patient?

The **new problem and prescription** satisfy the medical decision-making requirement for 99214.

Furthermore, a case of Type II diabetes that requires medication management meets the definition of a presenting problem with moderate to high severity, which usually accompanies this code.

If you also performed and documented a **detailed exam or took a detailed history**, you can circle that code with confidence!

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Example of a Detailed Exam

Patient presenting with a fever, cough and chest discomfort. It might be documented as follows:

* Vitals: temperature 101.5, BP 140/80;
* ENT: negative;
* Neck: supple;
* Chest: rales in both bases;
* CV: negative;
* Abd: benign

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New Patient MDM

- For a **99203** visit, the medical decision making is the same as for a 99213, but ***both*** the history and physical components of the 99203 must have the elements of a 99214.
- For a **99204** visit, the medical-decision-making criteria are the same as for a 99214, while the history and physical criteria are the same as for a 99215. ***Both*** the history and physical are required.

Requires all THREE Key Components

(Hx,Exam,and Decision Making)

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Established Patients – Think:

- **99212** – One stable condition
- **99213** – Two stable problems, OTC tx.
- **99214**:
  - 3 chronic stable on meds
  - 2 unstable on meds
  - 1 stable and one unstable on meds
- **99215** – Sick enough to admit

Also check to make sure you document the correct history and examination

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Putting your "Time" to Work

Time-based coding may not be the primary way of selecting E/M codes, but for encounters that involve extensive counseling it offers the best opportunity to get paid for your work.

Each E & M service code is associated with an amount of Time. Evaluation and management documentation guidelines state that if **more than 50%** of your face-to-face time with the patient is spent in counseling and/or coordination of care, the E/M service can be selected based on time.

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E/M Based on Time

- **First,** the medical decision making portion of your E/M documentation must detail the counseling and/or coordination of care. It is not enough to use generic statements such as "Spoke w/ Dr. X" or "Orders written". **The documentation must include the results of that conversation and detail about the physician's care orders for the patient.**

- **Second,** and most importantly, your time caveat statement **MUST** show that more than 50% of the **total** encounter time was spent in counseling and coordination activities. This can be stated either by using the exact minutes or as a clear statement of percentages. Good examples of this are:

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Time Statement Examples:

- I spent 20 minutes with the patient, over half of which was counseling/coordination of care.
- The office visit was 25 minutes and 15 minutes were spent counseling the patient.
- I spent 15 minutes with the patient, over half of which was discussing her diagnosis and treatment.
- I spent 30 minutes with the patient and family, over half of which was discussing whether surgery was a good option at this time.

following examples DO NOT work:

I had a lengthy discussion with the patient.

I spent 20 minutes in supportive counseling.

I spent 15 minutes talking about the treatment options.

Documentation that simply states "I spent 30 minutes with the patient" is **NOT** sufficient for choosing your CPT code based on time.

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The following time guidelines applies to office visit codes:

New Patients	Established Patients
• 99201 10 minutes	. 99211 5 minutes
• 99202 20 minutes	. 99212 10 minutes
• 99203 30 minutes	. 99213 15 minutes
• 99204 45 minutes	. 99214 25 minutes
• 99205 60 minutes	. 99215 40 minutes

Be careful what you count as "counseling": Time spent taking the patient's history or performing an examination does NOT count as counseling time.

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Regardless of which E&M code you submit, you need to back it up with documentation!

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Regardless of which E&M code you submit, you need to back it up with documentation!

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QUESTIONS?

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Physician Coding Initiative

Health Care Compliance Association
Physician Practice Conference
October 17, 2010

Bill Friedel, CPC, CHC
Institutional Compliance Manager
Corporate Compliance Department
Memorial Sloan-Kettering Cancer Center

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Why Comes to Mind When You Think About E/M Services?

- From the Association of American Physicians and Surgeons (AAPS):
  - "cumbersome, destructive, unusable"
  - "unnecessary and burdensome"
  - "a terrible waste of time, confusing, complicated"
  - "destructive of natural medical thought processes"
  - Increases my paperwork documentation time by about 25%"

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Why So Much Focus on E/M Services?

- Always on the government's radar
- Nation wide E/M makes up approximately 90% of the CERT error rate
- Density of the documentation guidelines

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Today's Focus

- Outpatient E/M
- Challenges surrounding physician education
- Why is E/M education often ineffective?
- Other ways to approach to physician education and training

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Why Focus on Outpatient E/M Services?

- Inpatient E/M Services
  - CPT and ICD-9 codes assigned by professional coders
  - Based on physician documentation once the patient is discharged.
- Outpatient E/M Services
  - CPT and ICD-9 codes assigned by MD's
  - No professional coder review
  - Greater risk for billing errors

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MD Billing Training at MSKCC

Prior to 2006:

- Lecture style format
- Focus on E/M documentation guidelines and teaching physician rules
- Not effective

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Why Was MD Billing Training Ineffective?

- Too much general information at one time; physicians lose interest
- Inconsistent follow-up; not frequent enough; hard to get an entire service together at one time
- Billing rules do not always make clinical sense
- Cranky Physician Syndrome

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Assessment to Improve Training

- Considered professional coders as a solution
- Physicians still need to know the rules
- "Review my notes, tell me what I am doing wrong and how to fix it"
- Consistent, frequent, feedback

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Physician Coding Initiative

- Initiative started by the Corporate Compliance Office in 2006
- Design a program to provide physicians with direct, personalized feedback regarding outpatient E/M services
- Ongoing, consistent feedback
- Physician Outpatient Evaluation and Management Compliance Auditing Application (POEM-CAP)

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Goals of Program

- Ensure accurate physician coding in the outpatient setting
- To provide physicians with consistent, direct personalized feedback related to their outpatient E/M services.

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Audit/Feedback Process

- Audit sample = 10 Initial Visits and 10 Follow-up Visits
- Review billing patterns for initial visits and for follow-up visits to select sample
- Audit charts in POEM-CAP
- QA Process
- Review results and present to service chief

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Audit/Feedback Process

- 13 possible errors (aka “root cause errors”)
  - Category
  - Medical decision making (over or under)
  - Physical exam
  - Review of Systems
  - Family History
  - History of Present Illness (taken by non-MD)
  - NPP Billing
  - Teaching Physician Statement
  - Coding on the Basis of Time
  - E/M Service and Procedure on the Same Date of Service
  - Global Surgery Window
  - Date of Service Missing from Note
  - Handwriting

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Audit/Feedback Process

- Review errors for each service with service chief and departmental administrator first
- Focus on 1 – 3 errors; errors with biggest financial impact
- Meet with each physician individually and review each chart audited
- Develop tools for physician use
- New physician training

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Meetings with Physicians

- Face-to-Face (1:1)
  - New physicians
  - Physicians with higher error rates
  - Physicians with complex errors (e.g. medical decision making)
- Web meetings (1:1)
- E-mail communication for physicians with high accuracy rates

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Physician E/M Tools

- Handouts that physicians can walk away with that will help improve E/M accuracy
- Hang in clinic, dictation rooms, offices
- Make them service specific
- Examples of tools developed:
  - Clinical scenarios
  - Time
  - Global Surgery Window

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FOLLOWUP VISITS – Breast Medicine				
Patient Status	**Actions**	**Physical Exam (# Organ Systems)**	**Time***	**LEVEL OF SERVICE**
Hx Breast CA No active Rx	• 2 reviews of system • Review/Order Labs **and** • Review/Order Radiology	4 or more	25	4
		2-3	15	3
		1	10	2
Hx Breast CA On Adjuvant Hormone Feels well **OR** • New problem • Worsening active problem • Address problem others manage	• Check for Rx side effects • Review/Order Labs **and/or** • Review/Order Radiology • Order Meds	4 or more	25	4
		2-3	15	3
		1	10	2
Hx Breast CA On Adjuvant Hormone **New Mets**	• Check for Rx side effects	8 or more	40	5
		4-7	25	4
		2-3	15	3
		1	10	2

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Billing Based on Time

- If counseling or coordination of care dominates (more than 50%) the total time the ***attending*** spent face-to-face with the patient, it may be appropriate to bill based on time.
- When you bill based on time, the complexity of the encounter (i.e, the number of organ systems examined, and the details of the history) does not count in determining the level of service. Instead, the encounter is billed solely on the total time spent by the ***attending*** face-to-face with the patient.

You must document:

- total ***attending*** face-to-face time spent with patient;
- that more than half of the total face-to-face time was spent in counseling and/or coordinating care; and
- the content of the counseling and/or coordination of care.*
- Example: "I have spent a total of 45 minutes, face-to-face, with the patient. More than half the time was spent in counseling the patient. We discussed (describe the counseling discussion)."

*Counseling/coordination of care includes discussing diagnostic results, recommendations, prognosis, risks/benefits of diagnostic tests or treatments, education, risk factor reduction, etc.

Documented total time spent face-to-face with the patient must meet or exceed the minimum requirements shown in the table to the right.

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Minimum Attending Time Face to Face with Patient (more than 50% of time must be in counseling/coordinating care)	
New Patient Visits	
99205	60 minutes
99204	45 minutes
99203	30 minutes
99202	20 minutes
99201	10 minutes
MD Requested Consultation	
99245	80 minutes
99244	60 minutes
99243	40 minutes
99242	30 minutes
99241	15 minutes
Established Patient Visits	
99215	40 minutes
99214	25 minutes
99213	15 minutes
99212	10 minutes
99211	5 minutes

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Follow-up is Key!

- Frequency of audit depends on error rate
  - 3 month follow-up
  - 6 month follow-up
  - 9 month follow-up
  - 12 month follow-up
- New physicians audited within 3 months of start date

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Does the Process Work?

- Every physician, except new physicians, has been audited numerous times
- Over- and under-billing error rates have improved; fewer errors are being made
- Feedback from physicians has been positive

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What Are Our Physicians Saying?

"The auditing process has been extremely helpful in teaching physicians how to optimize their clinical efforts for both compliance purposes as well as clearly communicating the patient's medical condition."

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What Are Our Physicians Saying?

"At no time during medical training does one learn E&M coding. Over the years, at MSKCC, there have been confusing messages about how coding should be done. Most academic physicians are uncomfortable, and maybe a little embarrassed, about billing. Yet, they want to do it right. The educational process initiated by Compliance has been extremely helpful to the Medical Oncologists in the Regional Care Network." The regular feedback has helped reinforce and fine-tune what we have learned. There is little doubt that our coding compliance has improved considerably."

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Physician Coding Initiative

Bill Friedel, CPC, CHC
Institutional Compliance Manager
Corporate Compliance Department
Memorial Sloan-Kettering Cancer Center
(646) 227-3714
friedelb@mskcc.org

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