CODING, BILLING E/M CODE AUDIT REQUIREMENTS

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DISCLAIMER

This presentation is a general summary for audit requirements.

OVERVIEW

- Discuss Purpose of Audits.
- Documentation
- Tools for Auditing
- Navigating through format of scoring sheets
- Examples of Audit E/M Cases

PURPOSE OF AN AUDIT

AUDITING

- What is being audited?
- key components
- documentation

- Types
- – Internally or External audits
- – Pre and post payment audits

AUDIT TOOL'S

AUDITING TOOLS

1995 Guidelines – Format

vs

1997 Guidelines - Format

DOCUMENTATION

- Medical record is required to record the high quality of care for patients
- Auditing - services provided are accurately reported and documented
- Appropriate utilization review and quality care evaluations

DOCUMENTATION

- Medical Record documentation – records medical facts, findings and observations.
- choose between the ‘95 and ’97 guidelines.
- Choose the tool with the most benefit .
- Some non-Medicare payers follow Medicare documentation guidelines; check payer policies.

DOCUMENTATION GUIDELINES

- MAC's have different guidance for documentation requirements for selecting E/M services. Best practice is to inquire with your MAC's or non- Medicare payers.
- Some non-Medicare payers follow Medicare documentation guidelines.

SEVEN COMPONENTS FOR LEVELS OF E/M

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of presenting problem; chief complaint
- Time

NAVIGATING THROUGH GUIDELINES

Exam – ’95 & ’97

Difference between exam criteria

EXAM – 1995 GUIDELINES

Problem Focused	One body area and/or system
Expanded Problem Focused	Limited two to seven body areas and/or systems
Detailed	Extended two to seven body area and/or systems
Comprehensive	Eight or more systems

EXAM FOR 1995 GUIDELINES

- Various Rules for EPF versus Detailed
  - The amount of detail per body system and/or area
  - EPF= 2 to 4 body areas, Detailed= 5 to 7 body area and/or systems
  - Five elements must be documented for at least five systems for Detailed
  - Some payers allow for 8+ body areas and/or systems for Comprehensive

EXAM – 1997 GUIDELINES
GENERAL MULTISYSTEM

Problem Focused	One to five elements
Expanded Problem Focused	At least six elements
Detailed	At least two elements form six areas/systems OR at least twelve elements in two or more areas/systems
Comprehensive	Perform **all elements** identified by a bullet in **at least nine** organ systems or body areas and document **at least two** elements identified by a bullet **from each of nine areas/systems.**

SECOND COMPONENT/EXAMINATION

Based on either the 1995 or 1997 documentation guidelines.

1995 examination are based on Body systems and areas.

1997 examinations are based on bullets outlined through specific system examinations.

AUDITING

- What is being audited?
- key components within documentation

- Types
- – Internally or External audits
- – Pre and post payment audits

WHAT DO PAYERS WANT AND WHY?

ICD-9 and CPT codes billed correctly and supported by medical record documentation

Medical necessity, relevance of diagnostic/therapeutic service provided

Up coding, down coding, creating their own rules

EMR/EHR systems

- Unacceptable terminology
- Choosing level of visit for providers
- Cut and paste, same note for each patient

WHAT ARE WE LOOKING FOR……MORE

Use of improper language

Abnormal documentation

Proper signatures and dates

Coding Guidelines are followed

Payer and CMS rules and regulation

Government rules and regulations

Most important Medical Necessity

PREPARING FOR THE AUDIT

- Run Reports
  - Random selections
  - E/M documentation
- How often, how much……
  - Monthly, quarterly, semi- annually, yearly
  - Per provider or visit type

AUDITING THE RECORDS

Evaluate encounter for documentation content and medical necessity of the visit

Three notations of each performed audit

*Services billed

*Documentation of level of services

*Medical necessity of services billed

DELIVERING THE AUDIT RESULTS

Formal Report given to Compliance Office of type of audits performed and findings

* Overall results
* Individual provider

Overview letter that summarizes the specific identified problems

Practice should take necessary steps to ensure the billing error doesn’t recur

DELIVERING THE AUDIT RESULTS

- Documentation of problem areas or those areas that need immediate attention
- Show why practice/provider did not meet necessary standards and show in writing
- Recommend: training to reach/maintain compliance and enhance their coding billing skills, develop Corrective Action Plan

MEDICAL NECESSITY

Some issues that are relevant to I/T/U's

- Nurse only visits – Continuation of care
- Chart Reviews
- Service provided from a treatment plan without seeing a physician, mid-level

MEDICAL NECESSITY - MORE

Consider the documentation

Who is delivering of service

Who is the provider

Why is the service being rendered

Variations to medical necessity, preventive services, etc.

EVALUATION AND MANAGEMENT CASES

SOAP NOTES

S – Subjective.....history

O – Objective ..... exam

A – Assessment ..... medical decision making - MDM

P – Plan..... medical decision making – MDM

EHR - Entry of attending or ordering Healthcare Provider

THREE COMPONENTS

E/M services are scored based on the documentation of necessary components

- 1st History
- 2nd Examination
- 3rd MDM

Contributing factors

- Counseling, coordination of care, nature of presenting problem and time.

COMPONENTS

New Patient: Three of Three Components

> lowest component of all three

Established Patient:Two of Three Components

> Middle or level with 2 components

3 OF 3 COMPONENTS – NEW PT

Comprehensive History (99205)

Detailed Examination (99203)*

MDM or Moderate Complexity (99204)

Comprehensive History (99205)

Comprehensive Examination (99204)

Straightforward MDM (99202)*

2 OF 3 COMPONENTS – ESTAB PT

Problem Focused History (99212)

Exp Problem Focused Exam (99213)

MDM of Low Complexity (99213)*

Problem Focused History (99212)

Exp Problem Focused Exam (99213)*

MDM of Moderate Complexity (99214)

CHIEF COMPLAINT

Invalid chief complaints:

> Follow up

> Routine visit

Chief Complaint helps to identify the medical necessity of the service.

HISTORY OF PRESENT ILLNESS (HPI)

HPI

Patient Symptoms and Chief Complaint – What they are presently experiencing

Location – Severity – Timing	Brief 1-3	Extended
Modifying Factors – Quality – Context	elements	4>elements or status of
Duration -Associated Signs & Symptoms		3>chronic or inactive conditions

HPI

Location – where located on the body

Severity – ranking of system, severe, sharp, dull

Timing – frequency, comes & goes, intermittent

Modifying Factors – makes better or worse

Quality – character – burning, gnawing, sharp, dull

Duration – how long present

Context – on exertion, injury, what they were doing

Associated Signs and Symptoms – other things that are happening

HPI

Patient is a 52 yr old established female patient who comes in complaining of **intermittent** episodes of **right lower quadrant** pain, bloody stools, **diarrhea x 1 week** and has to urinate often. She has had a couple of episodes of vomiting and mild chest pain. She has **tried Imodium** but has found no relief. The pain wakes her **occasionally at night** and complains of fatigue and shortness of breath.

*Location *Severity *Timing

*Modifying Factors *Quality *Context

*Duration *Associated Signs & Symptoms

HPI

Timing – Intermittent

Location – RLQ

Associated signs/symptoms

- Diarrhea

Duration – 1 week

Modifying Factors – Tired Imodium

Context – Occasionally wakes her at night

Location – Severity – Timing	**Brief 1-3**		***** Extended *****
Modifying Factors – Quality – Context	elements	=	4>elements or status of
Duration -Associated Signs & Symptoms			3>chronic or inactive conditions

REVIEW OF SYSTEMS - ROS

ROS - Inventory of body systems obtained by questions from the Provider to identify signs/ symptoms the patient may be experiencing or has experienced.

None Pertinent	Extended	Complete
1 system	2-9 systems	10 systems or all neg

***Constitutional *ENT * Eyes *Cardiovascular *Respiratory *GU *GI *Neurology * Musculoskeletal *Psychiatric *Integumentary *Endocrine *Hem/Lymph**

***Allergy/Immunology**

*** All others Negative**

ROS

Constitutional – Weight, fever, sweating

ENT – Ears, Nose, Throat

Eyes – Glasses, vision problems

Cardiovascular –Heart, palpitations chest pain

GI –diarrhea/vomiting

GU –Urinary, Male/Female problems

Respiratory- SOB, coughing

Musculoskeletal– Joint pains, backaches, stiffness

Psychiatric –Depression, anxiety, mood swings

Integumentary –Rashes, dryness, hair, nails, lesions

Endocrine – Thyroid, excessive sweating

Hem/Lymph – Easy bruising/bleeding, swollen glands

Allergy/Immunology – Allergies to food, hepatitis HIV

Neurologic – Blackouts, seizures, memory loss, speech

ROS

Patient is a 52 yr old established female patient who comes in complaining of intermittent episodes of right lower quadrant pain **bloody stools**, diarrhea x 1 week and has to **urinate often**. She has had a couple of episodes of vomiting and mild **chest pain**. She has tried Imodium but has found no relief. The pain wakes her occasionally at night and complains of **fatigue** and **shortness of breath.**

*Constitutional *ENT * Eyes	*Cardiovascular	*Respiratory
*GI *Neurology * Musculoskeletal	*Psychiatric	*Integumentary
*Endocrine	*Hem/Lymph	*Allergy/Immunology
* All others Negative		

ROS

Constitutional – fatigue, vitals

GI – blood in stools

Respiratory – shortness of breath

Cardiovascular – chest pain

GU – urinary problems

***Constitutional** *ENT * Eyes	None	Pertinent	Extended	Complete
***Cardiovascular *Respiratory *GU**		to	2-9	10
***GI** *Neurology * Musculoskeletal		1 system	systems	systems or
*Psychiatric *Integumentary				all negative
*Endocrine *Hem/Lymph				
*Allergy/Immunology				
* All others Negative				

NO DOUBLE DIPPING

If you use a symptom or system in the History of Present Illness, you can't use it in Review of Systems

Example:

Patient woke up with a headache today.

Using headache as location (HPI) and

Neurologic (ROS) - is not permitted

HISTORY- PFSH – PAST MEDICAL, FAMILY & SOCIAL HISTORY

PFSH – The provider asks the patient information about past history of illnesses and diseases, social hx, and family hx of diseases and illness.

	Hx of episodes /Est. Patient		1	2 or 3
Past Medical Hx	None	**None**	History	History
Family Hx		**None**	History	History
Social Hx				

	New	None	None	1	2 or 3
Past Medical Hx	Patient	None	None	History	History
Family Hx				Area	Area
Social Hx					

PAST, FAMILY, SOCIAL HISTORY - PFSH

Past History – Current medications, past surgeries, past illnesses

Family History – Family: i.e., parents, siblings, children, aunts, uncles, grandparents

Social History – Smoking, alcohol intake, marital status, sexual history, employment status, education information

PFSH

Patient is a 52 yr old **established** female **patient** who comes in complaining of intermittent episodes of right lower quadrant pain, bloody stools and diarrhea x 1 week and has to urinate often. She **has had a couple of episodes** of vomiting and mild chest pain. She has tried Imodium but has found no relief. The pain wakes her occasionally at night and complains of fatigue and some shortness of breath.

* Past Medical History
* Family History
* Social History

PFSH

Past Medical History – diverticulosis (example)

Social History – Smoking/alcohol intake (example)

Past Medical Hx	**Established**			1	2 or 3
Family Hx	**Patient**	None	None	**History**	History
Social Hx				Area	Area

Past Medical Hx	**New**	None	None	**1or 2**	3
Family Hx	**Patient**	None	None	**History**	History
Social Hx				Area	Area

PUT IT ALL TOGETHER

Location – Severity – Timing	Brief 1-3		*** Extended ***
Modifying Factors – Quality – Context	elements	=	4>elements or status of
Duration -Associated Signs & Symptoms			3>chronic or inactive conditions

	None	Pertinent	Extended	Complete
*Constitutional *ENT * Eyes		to	2-9	10
*Cardiovascular *Respiratory *GU		1 system	systems	systems or
*GI *Neurology * Musculoskeletal				all negative
*Psychiatric *Integumentary				
*Endocrine *Hem/Lymph				
*Allergy/Immunology				
* All others Negative				

Past Medical Hx	**Established**			1	2 or 3
Family Hx	**Patient**	None	None	History	History
Social Hx					

History = COMPREHENSIVE HISTORY

COMPREHENSIVE HISTORY

HPI – Extended (4>elements)

ROS: Extended

PFSH: Complete (2 or 3 history)

SECOND COMPONENT/EXAMINATION

Based on either the 1995 or 1997 documentation guidelines.

1995 examination are based on Body areas and systems.

1997 examinations are based on bullets outlined through specific system examinations.

95 EXAMINATION – BODY AREAS

O: Vital signs 120/85 WT 134, Temp 99.3. The patient is comfortable appearing and in no apparent distress. Neck:Supple. Thyroid:Normal. Heart: regular rate & rhythm. No edema. Lungs: clear to auscultation. Abdomen: soft & non-tender w/normal bowel sounds and no masses. No guarding or rebound. Skin clear, no rashes or ulcer

Total: 6 Body Areas – Expanded or Detailed Exam

THIRD COMPONENT - MDM

Tells the diagnosis of the patient and how the diagnosis or diagnoses will be treated.

Three area of documentation:

- Diagnosis
- Complexity
- Risk

DIAGNOSIS (DX)

Self Limited or minor(stable, improved, or worsening:

Established, stable, improved: 1dx x #

Established problem, worsening: 2dx x #

New problem, no additional workup planned: 3 x 1

New problem, additional work up planned,

i.e.., referred; testing: 4 x 1

DIAGNOSIS

Cannot get credit for mentioning a diagnosis that may not be applicable to the days visit.

Minimum of 1 dx treated with a developed plan of care.

Dx should have relevance to the treatment.

Mentioning dx may be a secondary issue**.

WHAT IS ADDITIONAL WORKUP?

Extensive procedures that do not have the results on the date of service can be considered as additional workup.

These may include biopsies, MRI, CT, nuclear medicine testing, lab testing/send outs, etc.

COMPLEXITY OF DATA

Review and/or order clinical lab tests – 80000	1
Review and/or test in radiology – 70000	1
Review and/or tests in medicine section – 9000	1
Decision to obtain old records and/or obtain hx from someone other than patient	1
Review and summarization of old records and/or discussion of case with another health provider	2
Independent visualization of image, tracing or specimen itself (not simple review of report)	2

Total: _

COMPLEXITY OF DATA

Providers are assigned points based on the category of test ordered.

One point per category ordered and based on the number of tests ordered

Example:

CBC & Strep test are ordered – only one point for review and/or order of clinical lab tests

COMPLEXITY OF DATA

- Requesting medical information from the patient's previous provider.
  - Must be documented
- Reviewing of the medical record
  - Guidelines require a brief summarization of the findings and not a simple statement that they were reviewed

COMPLEXITY OF DATA

One point for tests reviewed and/or ordered

Two points are give for every test interpreted

- Must document findings and interpretation of test results to obtain credit

COMPLEXITY OF DATA

MDM: (Diagnosis given)

A: Right Lower quadrant pain, etiology unclear**

P: We will schedule her today for a abdominal **ultra sound** and **CBC** today. I do not believe her abdominal pain is associated with the diverticulosis, however depending on ultra sound results, we may proceed with the **colonoscopy**. I will also let her know of the CBC results. Patient was informed to go directly to the emergency room if pain worsens.

RISK

The level of risk must be assigned to every patient's medical record as the level of risk assigned should mirror the ***medical necessity*** of the documentation.

The level of risk identifies to the reader of the note exactly what it implies….

The level of risk the provide has assumed in treating the patient on the date of service…..

RISK

There are three tables/columns to the table of risks:

Presenting Problem(s)

Diagnostic Procedures

Management Options

RISK –PRESENTING PROBLEM

Minimal – One self limited, minor problem: cold insect bite

Low – 2 or more self limited or minor problems, 2 stable chronic, acute illness or injury uncomplicated

Moderate –One or more Chronic illness with mild exacerbation, 2 or more chronic illness, acute illness with uncertain prognosis, acute complicated injury

High -1 or more chronic illness with severe exacerbation, progression or side effect of treatment, acute or chronic illness or injury that may pose a threat to life or body function abrupt change in neurological status

RISK – DIAGNOSTIC PROCEDURE

Minimal – Lab testing requiring venipuncture, chest x-ray or US, EKG/EEG, prep or UA

Low – Physiological test not under stress, PFT, non cardiovascular image study with contrast, superficial needle biopsy, clinical lab requiring arterial puncture, skin biopsy

Moderate –Physiological test under stress, diagnostic endoscopy with no identified risk factors, deep needle or incision biopsy, cardio imaging study with contrast no identified risk factors, obtain fluid from body cavity

High – Cardiovascular imaging studies with contrast with identified risk factors, cardiac electrophysiological test, diagnostic endoscopy with identified risk factors, discography

RISK – MANAGEMENT OPTIONS

Minimal – Rest, gargles, dressing, band-aid

Low – OTC drugs, PT or OT, IV fluids w/o additives. Minor surgery no identified risk factors

Moderate –Minor surgery with identified risk factors, elective major surgery with no identifiable risk factors, prescription drug management, therapeutic nuclear medicine, IV with additives, closed treatment of fracture or dislocation w/o manipulation

High – Elective major surgery with identifiable risk factors, emergency major surgery, IV controlled substances, drug therapy require intensive monitoring for toxicity, decision not to resuscitate or de-escalate because of poor prognosis

WHAT IS THE LEVEL OF RISK?

Level is determined with 2-3 circles or center level

Diagnosis:	1 or less	2	3	*4 or more
Complexity:	1 or less	* 2	3	4 or more
Risk:	Minimal	Low	*Mod	High

SCORE SHEET

History:	Min	Problem Focused	Exp Problem Focused	***Detailed**	Comprehensive
Exam:	N/A	Problem	***Exp Problem Focused**	Detailed	Comprehensive
MDM:	N/A	Straight	Low	***Moderate**	High
Level:	99211	99212	99213	***99214**	99215

Established or New patient? Does this level of visit require 2 of 3 components or 3 of 3? Lowest component, middle, highest level? What level does documentation support?

MEDICAL NECESSITY

All visits should be scored on medical necessity of the level charged.

If the medical decision making is the lowest component – (2 out of 3), this will be the level billed.

Why?

>Comprehensive History/Exam, ask yourself,

but is it medically necessary?

>OIG – RAC Target

TIME DOCUMENTATION

- Provider spends more than 50% of the visit counseling the patient – Must be documented in the patient medical record
- Time can not be used with Emergency Dept or Preventive Medicine codes
- Time should not be used for every visit, this will send out a red flag

COUNSELING DOCUMENTATION

Counseling

- The physician spends a majority of the visit talking with the patient and due to this is unable to fulfill all of the necessary components needed in order to meet documentation guidelines.
- Test results consume the visit
- Risk and benefits of a tx are discussed
- Patient education
- Multiple treatment options are discussed

MEDICAL NECESSITY

Some issues that are relevant to I/T/U's

- Nurse only visits – Continuation of care
- Chart Reviews – not for orders
- Service provided from a treatment plan without seeing a DR, NP, PA etc. – continuation of tx plan; incident to services; etc.,

RESOURCES:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764.pdf

https://www.novitas-solutions.com/calendar/partb/webinar/index.html

https://learn.emuniversity.com/

http://www.mdtools.com/mdtools/coding-review-tool/cpt-coding-review-tool.asp

Questions??

Thank you for attending!!!!

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1.5 CEU'S