

Avoiding the Median Coding Phenomenon

Honing Your E/M Compliance Awareness

Presented By

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What is 'Median Coding' ?

Defining the Phenomenon
within Select E/M Services

What is 'Median Coding'?

The Busy Physician



- Busy providers find the E/M documentation guidelines (DGs) cumbersome and time-consuming
- They also feel the E/M criteria are too complicated to EASILY apply in real-life clinical scenarios, e.g., OVs, consultation services, and inpatient hospital services

● [Photo courtesy AAFP]

What is 'Median Coding'

- Median coding (loosely '*averaged*' coding) is a method of coding 'up-the-middle' of the available code options to quickly assign a more-or-less appropriate code for the E/M service rendered
- Found by audit, median codes applied in these scenarios predominantly include:
 - 99203 and 99213 (new & established office visit)
 - 99222 and 99232 (initial & F/U inpatient hospital)
 - 99243/99244 (median code groups or "clustering") and 99254 (consults: office & IP hospital)

Median Coding Clinical Scenario - #1

- Dr. Smith, a family physician, evaluates a long-standing patient well known to him for DM and HTN, among other things. Assessing new complaints & changes in the pt.'s DM and HTN, he spends time/attention focusing on these changes; he documents new points of her history as well as extending her ROS, and modifies the pt.'s medication regimen in light of these new changes. He initially encircles 99214 on the superbill but thinks it simply "looks too high" for a well-known, well-established pt. He then encircles and ultimately bills 99213.

Median Coding Clinical Scenario - #2

- Dr. Jones briefly sees/treats a patient during a F/U office visit. The patient reports total abatement of his flu symptoms and feels well, as noted on the MR by the intake nurse. Dr. Jones quickly examines the patient, performs a cursory auscultation of key areas of the lungs, notes this as her sole PE documentation and tells the pt. to “finish your meds and RTC if your symptoms come back.” Dr. J checks off 99213 as a “typical follow up OV for my services” and does not consider the key elements of this level of service.

Median Coding Clinical Scenario - #3

- A PA – based in a private practice with 5 GI physicians – is tasked with performing services in the hospital setting. Depending on info from the practice physicians, the PA either performs F/U hospital visits or IP consults. He documents scantily, & does not document in accordance with either set of E/M guidelines for the hospital visits or inpatient consultations, and none of the criteria for the consultations is ever considered. He summarily codes these visits as 99232 or 99254, regardless of work done or documentation entered. These services are also reported under the collaborating physician’s NPI, who routinely co-signs the hospital charts later in the week.

Why are Providers ‘Median Coding’

- It’s the ‘middle-of-the-road’ coding approach:
“Brushing aside the potential for any gross E/M coding errors as well as playing it safe by eventually averaging out – at the end of the day – any overcoding and undercoding done.”
 - Providers feel there is equity in using median coding approaches by not coding too high so as to call audit attention to themselves or the practice, as well as by not coding too low so as to negatively impact revenue
 - Providers habitually select codes such as 99213 to fairly represent – in their estimation – both their time and services

Why ‘Median Coding’ is Wrong

- I.A.W. the OIG and CMS (including Medicaid) program integrity regulations, every line item of the submitted claim form is generally considered an individual claim, and
 - CPT/ICD-9-CM codes reported on the claim should be supported by specific, individual documentation in the MR
 - There is no overarching philosophical support for “*it all comes out even in the end*”
- Therefore, every service rendered (i.e., every claim line item) must ‘stand alone’ and have documentary evidence, and
- Therefore, every service audited in the spirit of individual documentary support can be verified // validated within the MR

Why 'Median Coding' is Wrong

- And, obviously, median coding does not meet or fulfill –
 - CPT coding guidelines (level criteria) for specific E/M services coded/billed
 - AMA's and CMS' E/M Documentation Guidelines (DGs) for MR recording of the scope, nature and services provided

Claim Statistics for E/M Services

CMS Data Files for 2007:
Rankings by Charges &
Services

2007 CMS Data – Office Svcs Ranking by Chg's & Volume

Ranking by Charges – Top 200 Services	E/M CPT Codes	Reported Volume in 2007	Ranking by Volume - Top 200 Services	CMS-Allowed Charges for Services
#1 - First Ranked of All 200 Trended Services by Charges	99213	104,351,776	#1 - First Ranked by Volume Also	\$6,047,833,951
2nd	99214	65,570,696	3rd	\$5,782,803,119
11th	99215	8,081,466	29th	\$974,738,983
17th	99212	21,669,488	9th	\$764,748,051
24th	99203	5,220,132	51st	\$467,752,536
26th	99204	3,253,961	73 rd	\$446,072,558
75th	99211	9,352,557	26 th	\$182,532,090
77th	99205	1,044,246	Not ranked in top 200 by volume	\$180,998,259
103rd	99202	2,452,937	101 st	\$146,253,219
Not ranked in top 200 by charges	99201	Not available	Not ranked in top 200 by volume	Not available

2007 CMS Data – Hosp Svcs Ranking by Chg's & Volume

Ranking by Charges – Top 200 Services	E/M CPT Codes	Reported Volume in 2007	Ranking by Volume - Top 200 Services	CMS-Allowed Charges for Services
3 rd	99232	51,136,188	4 th	\$3,268,459,610
5 th	99233	19,622,911	11 th	\$1,802,195,665
10 th	99223	5,695,945	42 nd	\$985,665,624
21 st	99231	16,361,169	15 th	\$579,134,425
34 th	99238	5,656,185	44 th	\$367,492,023
36 th	99222	3,091,154	81 st	\$364,190,842
53 rd	99239	2,803,942	92 nd	\$265,391,361
Not ranked in top 200 by charges	99221	Not available	Not ranked in top 200 by volume	Not available

2007 CMS Data – Office Consult Svcs Ranking by Chg's & Vol

Ranking by Charges – Top 200 Services	E/M CPT Codes	Reported Volume in 2007	Ranking by Volume - Top 200 Services	CMS-Allowed Charges for Services
<u>Office</u>				
8 th	99244	6,108,417	38 th	\$1,080,175,045
19 th	99243	5,035,539	54 th	\$601,579,210
23 rd	99245	2,280,161	107 th	\$502,678,482
112 th	99242	1,538,504	155 th	\$131,791,447
Not ranked in top 200 by charges	99241	Not available	Not ranked in top 200 by volume	Not available

2007 CMS Data – Hosp Consult Svcs Ranking by Chg's & Vol

Ranking by Charges – Top 200 Services	E/M CPT Codes	Reported Volume in 2007	Ranking by Volume - Top 200 Services	CMS-Allowed Charges for Services
<u>Hospital</u>				
12 th	99254	6,108,417	40 th	\$918,976,626
22 nd	99255	2,898,269	86 th	\$575,378,459
38 th	99253	3,242,608	74 th	353,880,963
167 th	99252	988,037	Not ranked in top 200 by volume	\$72,583,415
Not ranked in top 200 by charges	99251	Not available	Not ranked in top 200 by volume	Not available

How Median Coding Comes to Light

Various Federal & State Audit Initiatives of Concern

Federal Auditing Findings

- At the local Medicare Carrier levels, efforts in monitoring providers who have entrenched median or habitual same-code billing patterns (via claims) will reveal these trends:
 - A more straight-lined (graph) utilization deviating from national and local norms
 - And it follows: a more horizontal payment history
 - Practices typically have a bell-curve with 99213 at the crest
- Same-code billing & median coding will trip Carrier audits when these patterns emerge, and will not prevent audits (as providers expect)
- No providers actually “fly under the radar” anymore, with all of the ongoing official auditing/monitoring efforts

Federal Auditing Initiatives

- **MAC Efforts (FI/Carrier Level)**
 - Focused Medical Reviews, ADRs and other pre-payment reviews
 - Specific provider post-payment reviews and other claim-level case-basis reviews (next slide)
- **CERT Efforts** – Imposed by CMS, all FIs/Carriers must perform comprehensive error rate testing (CERT) and HPMP audits via “improper Medicare FFS payments initiative” – 60/40 %
- **RAC Efforts** – Separate FFS program integrity initiative (via the Tax Relief and Health Care Act of 2006) to correct past improper payments (including underpayments) to providers and prevent future mis-payments
 - ‘Random’ RAC reviews ongoing now
 - E/M leveling audits and E/M focused medical reviews anticipated to be begin in 2010
 - Standardized leveling tool yet to be approved (AMA and CMS to decide)
 - Ongoing now: E/M NCCI edit type scenarios, e.g., duplicate claims and post-op E/M svcs without modifier -24 or other claim-based problems
- **OIG Efforts**
 - Annual OIG Work Plans (targeted areas, including E/M in various years) and targeted reviews (including “whistleblower’s”/qui tam cases)

Federal Auditing Initiatives

- **MAC – FI/Carrier claim-level case-basis audits**
 - Claims hit automated edits (NCCI & MUE, OCE/CCI for OP claims) – typically:
 - Duplicate services
 - E/M services during global sx periods
 - Modifier errors (E/M and other services)
 - Idiosyncratic errors, e.g., gender error for specific service
 - Claims hit LCD/NCD edits – typically:
 - Frequency of certain services
 - ICD-9-CM codes not supportive of medical necessity (either error codes or missing appropriate codes)

Federal Auditing Findings

- Documentation not submitted
 - Or, if auditor is on-site, documentation not found
- Services billed but not documented (or adequately documented)
 - Includes all svcs and I-9s reported
 - Includes provider orders for testing, consult requests
- Other documentation errors (more mundane)
- Over-coded encounters (mainly E/M)
- Mis-coded encounters (e.g., OVs vs. consults or preventive svcs billed as regular E/M visits)
- Medical necessity cases (via I-9s)

Federal Auditing Findings

- Incident-To Services are likewise targeted for audit under E/M services
 - Not fully 'understood' (i.e., they tend to not be readily identifiable on claims) by federal reviewers
 - Plans for tightening of rules and greater federal oversight
- OIG Report *09-06-00430* 8-1-09 found E/M services (performed Qtr 1 2007) were comprised of:
 - 23% of all allowed MC services ...
 - Out of which 81% performed by authorized providers (physicians and qualified NPPs) –and–
 - 19% performed incident-to, perhaps by “unauthorized, non-accredited” non-qualified NPPs and ancillary personnel

Federal Auditing Findings

- **OIG Report *09-06-00430*** 8-1-09 for Qtr 1 2007 services was concluded with these recommendations for CMS, possibly germane to future E/M services:
 - All svcs must be performed within incident-to guidelines – including supervision rules – and follow state laws
 - A special incident-to modifier may be developed & would be used on all claims, identifying incident-to services
 - CMS should take steps to identify services reported on claims not adherent to incident-to rules

State Auditing Findings

- Similar to CMS' CERT program, a CMS-based audit program for Medicaid payments called "PERM" or "payment error rate measurement" program is active and ongoing
- Likewise, another audit effort is the Medicaid Integrity Program (MIP) operated via the Medicaid Integrity Group and funded through 2010 with probable continuation
 - Funded by the Deficit Reduction Act of 2005
- State-agency specific "contract" auditing efforts, usually claim-based post-payment or, if tied to an automatic cross-over claim for a Medicare/Medicaid beneficiary, conducted in tandem with a Medicare MAC/Carrier claim-based audit including ADRs, focused medical reviews, etc.

\$Revenue\$ & Median Coding

Fiscal Impact of Median &
Inaccurate E/M Coding

Revenue Impact of Median Coding

- Revenue impact for median coding is obvious: again when graphed, the providers' utilization & payment history are straight-lined, therefore providers are:
 - Paid less for E/M services that should have been coded higher
 - Paid more for E/M services that should have been coded lower
 - These carry audit liability potentials for (a) recoupment by the Carrier, (b) fines and penalties, &/or (c) worse if FWA charges are levied

Revenue Impact of Median Coding

- Other basic areas of revenue impact:
 - Requested documentation not submitted (or not found if on-site audit) = **\$0/denial or recoupment**
 - Services billed but not documented (or adequately documented) = **\$0/denial or recoupment**
 - Services documented but not billed = **\$0 lost revenue**
 - Over-coded E/M encounters = **\$ recoupment/poss. fines**
 - Mis-coded encounters (e.g., OVs vs. consults) = **\$0 /denial, suspended revenue under appeal, recoupment**
 - Undercoded E/M encounters = **\$potential for payment to provider under RACs but at this time, not under MAC or CERT initiatives = basically, LOST revenue**

Revenue Impact of Median Coding

- **“Requested documentation not submitted”**
 - Providers not responding to requests for documentation or for additional documentation (ADR)
 - One of the most prevalent ‘findings’ under OIG, MAC, CERT and prospectively RAC audit initiatives
 - By default it is a prevailing reason for \$0 payments or full recoupment by requesting entities
 - No reasons usually given for ‘no documentation’ to the requesting entity
- Providers should have underlying structure in the office to support, track and verify ADRs and similar MR copy requests from federal/state entities

E/M Coding – A Return to the Basics ... Again

...And Divulging Areas in E/M
Coding that Flag CERT &
MAC Auditor Attention

E/M ‘Core’ Codes

- Office Visits
 - New patients 99201 – 99205
 - Established patients 99211 – 99215
- Hospital Inpatient Services
 - New patients 99221 – 99223
 - Established patients 99231 – 99233
- Consultations
 - Office-based 99241 – 99245
 - Hospital-based 99251 – 99255
 - New or Established patients

Reminder: E/M **Documentation Guidelines**

- Either '95/'97 guidelines remain acceptable
- The basic parameters, i.e., three key components for E/M services, remain same for both
 - Future: Collapsed physical exam model is expected in the future, among other changes from '97 version (which has one multi-specialty & 10 single-specialty exams templates)
 - Future: New guidelines are expected to be less quantitative (the major physician contention with the '97 guidelines)
- DGs (documentation guidelines) are embedded in both but more discernible under the bulleted style of the 1997 set

Reminder: E/M **Documentation Guidelines**

- Because – again - either '95/'97 guidelines remain acceptable, the practice should choose either/or and be consistent across the board
 - A practice can utilize both sets; however, the practice must be vigilant about disclosing which set is being used and for what scenarios
- For CDI (clinical documentation improvement) efforts, following the 1997 version's "DGs" assists in CDI endeavors
- Know your Medicare Carrier's DG standards for the medical record even outside of E/M services

Reminder: E/M **Documentation Guidelines**

- From CMS and Various Carriers:
 - *“When reviewing MRs the Review Staff utilizes the 1995 and 1997 E/M DGs to review your records. We evaluate and apply the DGs for BOTH to ascertain the most advantageous to the provider. The provider’s clinical judgment, the amount of work, the nature of the presenting problem, and then the MR documentation all go towards supporting the level of service coded and billed, which we are reviewing.”*

CPT E/M Coding Criteria

- Level of Service 3-Key Components:
 - history
 - physical examination
 - medical decision making
- 4-NonKey Components:
 - counseling/coordination of care
 - nature of presenting problem
 - time

CPT E/M Coding Criteria

● **3-Key components** needed for:

- New OVs; hosp. observation services (new/est.); initial hosp. care (new/est.); 1-day observation/IP care
- Consults: office (new/est.) & initial IP (new/est.)
- ED services; initial nursing facility (new/est.)
- New rest home (domiciliary) and new housecalls

CPT E/M Coding Criteria

● **2-Key components** needed for:

- Est. OVs; subsequent hospital care
- Subsequent nursing facility
- Rest home (domiciliary) for est. patients
- Housecalls for est. patients

Elements of History Documentation

General Information, Tips &
Specific Audit Findings

Elements of History Documentation

- Chief complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
 - **Weakest physician documentation area;**
severely limits level of service when not
adequately recorded
- Past Medical/Surgical History, Family
History & Social History (PFSH)

Elements of History **Documentation**

CC, HPI and PFSH – General Tips/Advice:

- CC is required for all levels of E/M work
 - Interval (F/U) visits should have concise statements such as “no change today” or “feels well”
- PFSH is required for detailed and higher levels
- CC & PFSH can be recorded by ancillary staff (intake staff, scribes, etc.)
- The HPI should be recorded by the treating provider; some Carriers do not allow any ancillary staff contributions to the HPI, e.g., *“Only the physician can perform the HPI.”*
[WPS Medicare]

Elements of History **Documentation**

CC, HPI and PFSH – General Tips/Advice:

- Provider for which the E/M service will be billed should acknowledge all ancillary staff notes by verifying/validating or initialing/dating (if on separate forms) as well as augmenting the info as is germane to the case
 - This action dovetails the ancillary staff intake data to the provider’s work, even if the notes are on separate documents such as ROS, PFSH and medication intake forms, etc.
- Scribes and ancillary staff must sign and date their contributions to the E/M notes. *[Incident-to teleconference guidelines, Highmark Medicare]*

Elements of History Documentation

● Chief Complaint CERT & MAC Audit Errors:

- CC counted as 'error' when written as "F/U" without the reason why follow up was being performed
 - If not fully documented, then inferring the reason for follow up from a CC statement should be achieved, e.g., "F/U flu – feels better"
 - **CAUTION:** Auditors become confused when "F/U" is documented but the follow up reason(s) do not match up with the previous visit, if those records are likewise reviewed, or
 - If F/U is the CC but the HPI expresses new complaints
 - **CAUTION:** Auditors may only look at a single DOS, not the entire MR and therefore the idiom "Every record must stand on its own" must be upheld

Elements of History Documentation

● HPI CERT & MAC audit errors:

- HPI should be written in such a way that the nature of the presenting problem is clear
 - Remember lower level and higher level services have different numbers of elements that must be documented
 - Brief: 1-3 elements for prob-focused, expanded prob-focused
 - Extended: 4 or more elements for detailed, comprehensive
 - (1997 DGs state "4 or more for acute conditions; 3 or more elements for chronic/inactive conditions)
 - Regardless of which set DGs followed, overall the "elements" are for the acute problem(s) and/or the chronic problem(s) being managed and related to the HPI
- "No change" is not sufficient HPI documentation – that is considered an interval CC statement
- Medical necessity for higher level E/M services begins to be adjudged via the documented HPI elements

Elements of History **Documentation**

- **PFSH CERT & MAC audit errors:**
 - 3-realms or areas to be considered: (a) past medical/surgical, (b) family and (c) social histories
 - Using the term “noncontributory” may be unacceptable – check with your local Carrier
 - Two levels of documentation for PFSH: problem-pertinent & complete
 - *Complete* PFSH is obtained in detailed and comprehensive visits and is appropriate for new pts, est. pts. w/new problems, consultations, IP hospital, comprehensive nursing home visits, and any clinically-appropriate pt. encounter

Elements of History **Documentation**

- **CC, HPI and PFSH audit findings within eHR (or eMR):**
 - Do not record unnecessary info solely to meet requirements of higher level E/M services when the nature of the presenting problem does not indicate a high level E/M service is medically necessary
 - Following *prompts* set up by eHR/eMR as well as “leveling tool” templates is considered over-documenting by simply fulfilling the logic of the templates, and not particularly medically appropriate for the patient encounter

Elements of History Documentation

ROS – General Tips/Advice:

- Can be obtained by ancillary staff (intake staff, scribes, etc.) and should be augmented as necessary & verified (with signature) by treating provider
 - Provider should add to the info as appropriate and then begin his/her notes
 - Like the PFSH, the ROS – if obtained during an earlier DOS – does not need to be re-documented but does need to be re-acknowledged as being reviewed and related to the current DOS
 - If ROS is obtained on a separate form, be sure to dovetail that document to the MR notes (clinic notes) by initialing the separate form – a statement in the visit note (history portion) to “see ROS intake form dtd 10/15/09” is appropriate
 - **CAUTION:** Auditors for MACs & CERT bodies have found instances when the separate intake forms were not supplied for review and therefore no ROS ‘credit’ was accorded the provider
 - Scribes and ancillary staff must sign and date their contributions to the these forms/notes

Elements of History Documentation

- **ROS CERT & MAC audit errors – again, weakest physician documentation area & therefore highly scrutinized by federal auditors**
 - Required by most levels of service (but not prob-focused)
 - From 14 systems available (including constitutional), record all “+” and germane “-” findings related to the presenting problem(s)
 - Never note systems as “-” if related to the current presenting problem (a common error)
 - If all systems are “-” what does this tell the Carrier? The ROS was marked but not actually obtained
 - Most Carriers allow “all others neg” or “ROS unremarkable” or “all other sys noncontributory” for ROS ‘credit’ ... however
 - Trailblazers & WPS do not; remarks must be dedicated positive or negative-pertinent points related to the HPI
 - Only systems/areas thusly documented will be counted as ‘credit’ in the documentation by these Carriers

Elements of History **Documentation**

- **ROS audit findings within eHR (or eMR) – echoed from CC, HPI & PFSH:**
 - Again, do not record unnecessary info solely to meet requirements of higher level E/M services when the nature of the presenting problem does not indicate a high level E/M service is medically necessary
 - Following *prompts* set up by eHR/eMR as well as “leveling tool” templates is considered over-documenting by simply fulfilling the logic of the templates, and not particularly medically appropriate for the patient encounter

Elements of History **Documentation**

- **ROS audit findings within eHR (or eMR):**
 - Medicare auditors can be confused by eMR systems which segregate data into discrete areas for the various portions of the History, such as ROS and PFSH.
 - Make sure the provider references this data in the HPI (main screen of the clinical encounter note) so that independent reviewers will be referred to other relevant areas of the eMR to dovetail all required elements into a single appropriate level of service
 - *“If the physician were not referencing previous material in the eMR, then the information would NOT be used in choosing the final level of E/M service.”*
[E/M FAQs 2009 WPS Medicare]

‘Double-Dipping’ – What’s This?

- What is Double-Dipping? Essentially, DD is counting data points from one area of the documentation and using those to fulfill the criteria for another area, especially seen to/from the ROS. What gave this practice its impetus?

...proceeding with caution....

- **DD is mentioned in the 1995 & 1997 E/M DGs:**
Though both sets of the E/M DGs (1995 pg. 4 & 1997 pg. 6) state a form of ‘double-dipping’ is valid ...
 - *“The CC, ROS and PFSH maybe listed as separate elements of history or they may be included in the description of the history of present illness.”*
- ... it is advised that one must make clear in the MR notes all data relationships by using discrete references (i.e., cross-references or ‘roadmaps’) to and between the required elements of the History, such as to/between the HPI and ROS, or to/between the ROS and PFSH, etc.

‘Double-Dipping’ – What’s This?

...proceeding with caution....

- DD between Key Components – Many local Carriers, including Trailblazers and WPS, state emphatically “do not double-count physical exam notations also as ROS (or other History) notations!”
 - That is, do not count **PE** notes also as **History** notes
- DD between Component Elements - Both Carriers are likewise opposed to using “one bit of information in two places” within the a key component such as in the History, e.g., in both the HPI & the ROS
- That said, those Carriers tend to be the exceptions; other Carriers (e.g., Highmark) reasonably state that specifically approved citations from *certain areas of the History* can be used to fulfill *other related History sections*

‘Double-Dipping’ – What’s This?

...proceeding with caution....

- To wit, Highmark states:
 - *“ROS inquiries are questions concerning the system(s) directly related to the problem(s) identified in the HPI. Therefore it is NOT considered “double-dipping” to use the system(s) addressed in the HPI for ROS credit.”*
- And that position parallels the E/M DGs. For example, ‘fever’ noted in the HPI can be used to fulfill a data point under the ROS (i.e., fever = constitutional data point) **... and CMS**

‘Double-Dipping’ – What’s This?

...proceeding with caution....

- *...and CMS* has publicly stated (but unfortunately only in CMS-to-Carrier fashion, not in nationally published guidelines), more or less, that if one HPI note is to be used as a second ROS point (or vice versa), there should be a reference to the relationship of this data recorded in the chart. For example:
 - The HPI states “abdominal pain for 24 hrs with associated nausea.” To be used twice, the ROS should have a notation next to the GI area some like “See HPI” in order to receive credit for this note in both of those History areas
- CMS states in the above case, it is important that the data which is provided “can be accurately inferred by a reviewer [between those elements] to determine the correct level of service...”

‘Double-Dipping’ – What’s This?

...proceeding with caution....

- In a related area but in an arguably unreasonable stance, Highmark has stated that *‘PFSH notations cannot be used to fulfill ROS or HPI criteria because the PFSH information is past history data, not current ROS or HPI data as related to the CC.’*
- Providers have argued that this perspective is in error; a PFSH point, e.g., date of last menses noted in the PMH - if related to the presenting prob such as amenorrhea - can be counted as a GU point for the ROS
- **CAUTION:** Be sure to have a data relationship between those points, and the credit can be argued for both areas

‘Double-Dipping’ – What’s This?

...proceeding with caution....

- **CAUTION:** It is best in most scenarios to have clear demarcations between the required elements of any E/M key component, e.g., between PFSH points and ROS points
 - “Roadmap’ or cross-reference clearly between the required elements if you plan to use notations more than once
- **CAUTION:** Always check with your local Carrier for these areas of ‘gray’ (e.g., check the Carrier’s FAQs) and make sure to keep those official statements from your local Carrier on-file
- **CAUTION:** Many times MACs and other auditing entities outsource the audit function so the expertise of the auditors can come into question when/if they are not aware of these local Carrier statements NOT typically found in the E/M DGs themselves

‘Double-Dipping’ – What’s This?

...proceeding with caution....

- **CAUTION:** Do not be confused by ‘urban legend’ double-dipping industry gossip, such as “it is approved to use one statement to fulfill two points *within the same key element*” such as (under History) one note counting for numerous areas of the ROS. For example,
 - Do not count a simple note of “chest pain” under the ROS within **BOTH** the CV as well as musculoskeletal areas; now, if this note were further developed such as ‘dull generalized chest pain at rest’ as well as ‘Left intercostal pain with inspiration’ then obviously these notes could be counted twice within the ROS (CV + Resp)
- Similarly, you cannot count “pain began yesterday” as a notation within the HPI for **BOTH** duration and timing

‘Double-Dipping’ – What’s This?

- In conclusion

...proceeding with caution....

- **CAUTION:** Err on the side of conservatism ... keep in mind that the direct relationships between History data (CC, HPI, ROS and PFSH) are clear to clinical personnel but not necessarily clear to nonclinical auditing staff or other Medicare reviewers
- Use well-demarcated areas within the notes to obtain, record and be credited with all of the patient data-work you are obtaining
- And, if using single data points to fulfill more than one element of the History, be sure there are clear documented relationships that cross-reference these points

Elements of History **Documentation**

"If I could make one suggestion to physicians about medical documentation, it would probably be documentation of the history component of the E/M service.

When we do our medical review of charts, we find that most times results in a lowering of the level of service on E/M is the documentation specifically **of the history**.

Many physicians focus on the medical management or medical decision making as the driver in their E/M service and as a physician I see why.

However, the documentation guidelines are as they are and **whenever there's an issue with an E/M being downcoded, it's unfortunately because of the history that's documented.**

So, my one word of advice would be focus on history."

- Dr. Andrew Bloschichak, VP and Contractor Medical Director, Highmark Medicare

Elements of **PE** **Documentation**

General Information, Tips &
Specific Audit Findings

Elements of PE Documentation

- Levels of PE include prob-focused, expanded prob-focused, detailed and comprehensive
 - Use 1995 or 1997 DGs, whichever are most advantageous for the encounter
- PE documentation requirements are segregated into body areas / organ systems
 - 6 body areas + each extremity (i.e., 6+4=10 max)
 - 12 organ systems (11+ “constitutional” =12)
- 1995 DGs proffer one general multi-system exam format; 1997 DGs include 10 specialty exams (single organ system exams) + 1 general multi-system exam
 - **Weakest physician documentation area tends to lie simply in the extent of documentation to satisfy a particular E/M level that has been coded/billed**

Elements of PE Documentation

- Both sets of DGs for the PE documentation state:
 - “Negative” and “WNL” notations are acceptable forms of documentation of normal findings for **unaffected or asymptomatic** body areas / organ systems
 - Those comments are not acceptable for **affected** areas (as related via the HPI), i.e., specific abnormal and clinically relevant negative findings must be fully documented
- Always check the patient’s History and ensure an informational relationship exists between the CC/ROS and the PE data (i.e., dovetail them)
 - **Common CERT/MAC audit example:** CC and scant History documentation stated “F/U arm fracture; no pain today” but the PE documentation pointed to an encounter for acute upper respiratory illness, such as for influenza
 - In this case there is no data relationship between the History elements and the PE

Elements of PE Documentation

General Tips/Advice:

- PE data (except for 'constitutional' info) cannot be obtained by ancillary staff (intake staff who are not qualified NPPs) but can be "scribed" per the provider's clinical operations
 - **If all notes are scribe-recorded, ensure the Provider AND Scribe sign/date every note for verification**
- DGs Choice: While providers can use both sets of DGs for the patient encounters, both sets cannot be mixed/matched *within a single encounter*
- It should be very clear which DGs are being utilized for any particular encounter if the practice uses both the 1995 & 1997 DGs

Elements of PE Documentation

- **PE CERT & MAC audit errors**
 - As stated a common error found by audit is when the PE data recorded does not dovetail or even refer to the info contained in the CC and/or HPI
 - Systems/areas related to the HPI should be recorded within the body of the PE data (if, in fact, one is done)
 - Summation notations like "Normal" or "Negative" which comprise the entire PE note (and without expounding upon the affected systems / areas) are not counted by auditors as valid and full PE documentation

Elements of PE Documentation

● PE CERT & MAC audit errors

- Another common auditor finding is when organ systems and body areas have been erroneously added together to achieve a higher level of PE work (under 1995 DGs), for example:
 - 8 systems or areas are req'd for a comprehensive exam
 - The provider billing a comprehensive exam noted 5 organ systems in the PE data as well as remarks about the skin of the 4 extremities, counting the individual PE notations as 9 recorded points, however ...
 - Organ systems and body areas in this case cannot be counted together; the skin notations count as 1 organ system and not 4 body areas (i.e., "each extremity")

Elements of PE Documentation

● PE CERT & MAC audit errors

- Many errors are found in the "detailed" level of PE reporting, e.g., E/M services requiring detailed PEs such as 99203 / 99214 (OVs), 99221 / 99233 (IP hospital), and 99243 and 99253 (consults)
 - This becomes especially important when the History for F/U OVs and IP hospital services cannot be used to achieve a level of service due to scanty info documented and the PE by default becomes the first key component that must be in evidence(continued)

Elements of PE Documentation

● *continuing*

- In the PE req's, confusion arises between the DG requirements for expanded prob-focused = "2 to 7 systems/areas" as well as detailed = "2 to 7 systems/areas" So which is which?
 - Detailed level requires more 'actual data detail' (i.e., an expansion of PE descriptions) than do the req's for expanded prob-focused:
 - **EPF: *limited*** exam of affected areas/systems + any other symptomatic/related areas/systems, up to 7
 - **Detailed: *extended*** exam of affected areas/systems + any other symptomatic/related areas/systems, up to 7
 - Detailed exam is more thorough and in-depth (*i.e., quality/quantity counts*)
[CMS E/M FAQs & Highmark Medicare Augmented DGs]

Elements of PE Documentation

● PE CERT & MAC audit errors

- Lastly, a common in-house (MAC/Carrier or CERT) auditor finding is when the PE simply states "unchanged from prior visit" or more specifically "unchanged from visit of 9/29/09;" however, no other DOS documentation is supplied to the auditing entity for review (seen often in F/U IP hospital, ex. 99232)
- "Credit" cannot be given for re-examining a patient and using prior recorded data if:
 - (a) specifics are not cited in the reference, such as "PE same as xx/xx/09" or "unchanged from prior visit; see PE detailed notes for xx/xx/09" **-and-**
 - (b) the referenced PE documentation is not supplied to the reviewer(s)
- **CAUTION:** Ensure office personnel charged with fulfilling ADRs review all materials prior to sending

Elements of PE Documentation

● PE audit findings within eHR (or eMR):

- Yet again, as emphasized by many Medicare Carriers, do not record unnecessary info solely to meet requirements of higher level E/M services when the nature of the presenting problem does not indicate a high level E/M service is medically necessary
- eHR/eMR exam 'e-prompts' (or templates on hardcopies) will easily lead a provider to comprehensively complete the PE fields when in fact a high level PE is not medically necessary for the pt. case

Elements of Medical Decision Making

General Information, Tips &
Specific Audit Findings

Medical Decision Making (MDM)

- Aspects of MDM include the following:
 - (1) Number of dx's or treatment options
 - (2) Amount and/or complexity of data to be reviewed (e.g., test results or under order [labs, radiology, medicine-based], discussion of said tests, past MR review, and more)
 - (3) Overall risk (reference the Risk Table)
- Final levels of MDM
 - Straightforward
 - Low
 - Moderate
 - High

Medical Decision Making (MDM)

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">● A. Straightforward<ul style="list-style-type: none">▪ Dx/mgmt options = 1/minimal▪ Amt/complexity data = 1/minimal▪ Risk = Minimal● B. Low<ul style="list-style-type: none">▪ Dx/mgmt options = 2/limited▪ Amt/complexity data = 2/limited▪ Risk = Low | <ul style="list-style-type: none">● C. Moderate<ul style="list-style-type: none">▪ Dx/mgmt options = 3/multiple▪ Amt/complexity data = 3/multiple▪ Risk = Moderate● D. High<ul style="list-style-type: none">▪ Dx/mgmt options = 4/extensive▪ Amt/complexity data = 4/extensive▪ Risk = High |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Medical Decision Making (MDM)

MDM General Tips/Advice:

- Remember when assessing final level of MDM, the final level is equal to 2 of 3 aspects “met or exceeded,” e.g., if the...
 - Number dx’s/tx options = 2/limited
 - Amt/complexity of data reviewed = 3/multiple
 - Risk = Low (which equals 2 points)
 - Final MDM level “met or exceeded” is 2 (not 3)
 - **Final MDM Level = LOW**

Medical Decision Making (MDM)

- **MDM CERT & MAC audit errors**
 - Many errors in the MDM portion are attributed to lack of documentation (surprise, surprise)
 - Record all relevant impressions, working or R/O dx’s, confirmed dx’s from previous visits germane to the ongoing treatment, therapies and planned changes in regimen, etc.
 - Do not carry forward unrelated dx’s or other old unrelated data (esp. seen in eMR where these fields contain cumulative data)
 - Orders/reasons for tests as well as consultation requests are found to be missing in many cases
 - For consultations, the requesting provider must have contained in his/her notes the request/reason for consultation (*More on Consultations later ...*)

Medical Decision Making (MDM)

● **MDM CERT & MAC audit errors**

- Often providers assess the final level of MDM not from all three aspects (as previously described) but only from the severity of the presenting problem
- The final MDM level, again, is all three aspects taken in a “2 out of 3” context for the final MDM level
- For eMR/eHR, remember some s/w programs or templates prompt the provider into comprehensively completing the information; in MDM this can occur by prompting the provider to review old MRs, carry forward unrelated old dx’s, etc.

E/M Coding – Special Cases

High Habitual Coding Error Rate Areas
& Unusual Areas

That

Flag CERT & MAC Auditor Attention

The Case for CPT Code '99211'

- “Office or other outpatient visit, est. pt., that may not require the presence of a physician (i.e., provider). Usually presenting probs are minimal; 5 minutes typically spent performing or supervising the service.” *[paraphrased]*
- CERT pronouncement for documentation:
 - 99211 needs two E/M elements present in the MR:
 - (1) clinically germane info is exchanged, i.e., an evaluation is done on some level, and
 - (2) management is provided, which is proven when the MR reflects an “influence” on pt. care, e.g., diet, ADLs, change in meds, pt. education provided and understood, etc.
[CERT Team, WPS Medicare]

The Case for CPT Code '99211'

- CERT audit findings:
 - Auto-coded/billed with lab order, such as for urine specimens, fecal occult and/or venipuncture
 - Auto-coded/billed with provision of lab results, even when given by phone
 - Auto-coded/billed with check of injection/immunization sites, e.g., TB Tine test, without additional supportive documentation to substantiate an E/M service
 - Coded/billed as a consultation service for ‘consult with the office nurse’ without supporting documentation (99211 is not a *consult* code)
 - Coded/billed with joint injections with modifier -25, e.g., Synovisc, without additional supportive documentation to substantiate a separate E/M service
[CERT Team, WPS Medicare]

The Case for Using Time for E/M Services

- Time can be used (for nonTime-based E/M codes) as the only Key Component when counseling and/or coordination of care (C/CoC) constitutes 50% or greater of the total face-to-face time the provider spends with the patient and/or family, provided:
 - Total face-to-face time is documented, e.g., in/out times
 - Total time spent in C/CoC is documented, e.g., 25 minutes
 - Content, germane facts and other related info is recorded in the body of the visit notes which otherwise summarize the service(s) provided to the patient
 - Non face-to-face time in C/CoC should not be included in calculating the 50% or greater threshold for outpatient services
 - Counseling with family members or legal guardians, when the patient is unable to understand the C/CoC intent, is allowed but should be well-documented
- **Major CERT Finding:** MR notes lacking in Time information

The Case for CPT Code ‘99499’

- “Unlisted evaluation & management service”
 - Case-by-case basis adjudged/valued per Carrier discretion – 99499 use is considered “rare”
 - The reason(s) why this code is reported/billed should be readily apparent in leading data (with description of the service) for the pt. case/encounter
 - Typically this is because one of the key components for an E/M service could not be obtained, e.g., history
 - Must be submitted to the Carrier with full array of supporting documentation including explanation for absent key component(s) of the E/M service
 - Possible reasons for reporting 99499: (a) unable to gather reliable hx from patient or pt. representative; (b) pt. unconscious and is unaccompanied; (c) unable to perform exam due to extenuating circumstances, etc.

The Case for CPT Code ‘99499’

- 99499 is commonly - but mistakenly - reported for an initial IP hospital service (99221-99223) when one or more of the key components cannot be obtained, for whatever reasons
 - If criteria for the lowest level initial IP hospital service, 99221, cannot be met but the service still meets the definition of ‘initial IP hospital service,’ then report from the subsequent code selections (99231-99233) as only 2 of the 3 key elements are needed
 - Carriers already recognize that this will not follow services provided in a chronological sequence, i.e., initial and then subsequent services
 - But, if the hospital services cannot meet the criteria for a F/U IP hospital visit, then 99499 can be reported with a full array of documentation explaining the unusual circumstances

The Case for CPT Consult Codes

- Highest area of E/M service errors (inappropriately paid to providers) by CERT audits
- Basic considerations for coding/billing consultation services in terms of DGs comprise the “3-R’s”:
 - Request (both MRs) (verbal or in writing)
 - Reason (both MRs: requestor/care plan; consultant/report)
 - Report (from consultant to requestor, both MRs)
- Other basic consideration is the intent of the request which must be made for only medical advice and/or opinion of the consultant ...
- ... and not requested when ‘transfer or referral of care’ is fully intended at the time of the consult request

[See “Sticking Points of Consultations” later in this program]

Clinical Scenario #1 - **Assessed**

- Dr. Smith, a family physician, evaluates a long-standing patient well known to him for DM and HTN, among other things. Assessing new complaints & changes in her DM and HTN, he spends time/attention focusing on these changes; he documents new points of her history as well as extending her ROS, and modifies the pt.'s medication regimen in light of these new changes. He initially encircles 99214 on the superbill but thinks it simply “looks too high” for a well-known, well-established pt. He then encircles and ultimately bills 99213.
√ ***Undercoding – Probably correct as 99214***

Clinical Scenario #2 - **Assessed**

- Dr. Jones briefly sees/treats a patient during a F/U office visit. The patient reports total abatement of his flu symptoms and feels well, as noted on the MR by the intake nurse. Dr. J quickly examines the patient, performs a cursory auscultation of key areas of the lungs, notes this as her sole PE documentation and tells the pt. to “finish your meds and RTC if your symptoms come back.” Dr. J checks off 99213 as a “typical follow up OV for my services” and does not consider the key elements of this level of service.
√ ***Overcoding – Probably correct as 99212***

Clinical Scenario #3 - Assessed

- A PA – based in a private practice with 5 GI physicians – is tasked with performing services in the hospital setting. Depending on info from the practice physicians, the PA either performs F/U hospital visits or IP consults. He documents scantily, & does not document in accordance with either set of E/M guidelines for the hospital visits or inpatient consultations, and none of the criteria for the consultations is ever considered. He summarily codes these visits as 99232 or 99254, regardless of work done or documentation entered. These services are also reported under the collaborating physician's NPI, who routinely co-signs the hospital charts later in the week.
 - √ ***Probable Overcoding and/or Mis-coding***
 - ▶ ***Requires Consult criteria to be met (i.e., 3-R's) and/or***
 - ▶ ***Requires E/M DGs to be evident in the hospital records if IP hospital services are rendered***
 - √ ***Mis-Application of the Incident-to Guidelines***
 - ▶ ***Incident-to services cannot be reported in the IP setting***
 - ▶ ***Qualified NPPs must report IP services under their individual NPI***

Sticking Points of Consultations

A Few Things to
Remember in Following
CMS' Criteria

E/M Coding Criteria: **Consultations**

- Level of Service – 3-Key Components:
 - History
 - Physical Examination
 - Medical Decision Making
- Required for **all** consults, whether new or established patient, initial or F/U consult
 - Required for all settings including office/other outpatient and IP hospital/SNF (“wherever”)
- All key elements must be adequately documented at the minimum documentation threshold of the selected consult code for consultation payment eligibility; otherwise, the service could be downcoded to the appropriate E/M service for the setting

E/M Coding Criteria: **Consultations**

- Official (legal) federal definition of a consultation service, per 42 C.F.R. Ch. IV Public Health, Section 411.351:
 - *Consultation* means a professional service furnished to a patient by a physician [*or authorized NPP*] if the following conditions are satisfied:
 - (1) The physician’s opinion or advice regarding evaluation or management or both of a specific medical problem is requested by another physician [*or other appropriate source*].
 - (2) The request and need [*i.e., reason*] for the consultation are documented in the patient’s medical record.
 - (3) After the consultation is provided, the physician prepares a written report of his or her findings, which is provided to the physician who requested the consultation.

[Italicized additions belong to author per CMS data]

E/M Coding Criteria: Consultations

- Going back to the “3-R’s” ... providers must ensure the following data is documented in the billing provider’s notes:
 - **Report** of consultative findings rendering the ‘medical opinion and/or advice’ as appropriate; tests and treatment initiated as appropriate should also be mentioned
(fulfills one “R” – Report)
 - A reference statement re: the ‘consult at the request of Dr. (or NPP) Doolittle for Supercalifragilistic-x-p-allidocious’ is in the report
(fulfills two “R’s” – Request & Reason)
 - Especially important in cases of verbal requests
 - Requesting provider’s Plan of Care should include:
 - **Request** for consult and **Reason** why it is being requested

This satisfies the consultation criteria, now

E/M Coding Criteria: Consultations

- **...now** the correct level of service (per the consult setting) must be selected based on the extent of the documented 3-Key Components:
 - History
 - Physical Examination
 - Medical Decision Making –or–
 - Time, if appropriate
- Again, remember in consultations all 3-Key Components are necessary in the documentation

E/M Coding Criteria: **Consultations**

- As with typical E/M services (e.g., OVs and IP hospital visits) most consults are downcoded by federal/state auditors for a dearth of recorded data in the:
 - History
 - ROS lacking in information
 - Physical Examination
 - Few systems/areas recorded in notes or report
 - Medical Decision Making
 - Planned studies, orders thereof, not recorded
 - Other MRs/data reviewed but not documented as done

E/M Coding Criteria: **Consultations**

- Providers using **'time'** as the single key component, by audit, have been downcoded for these reasons:
 - Time alluded to in the MR notes but no actual times were recorded (e.g., in/out times or total-to-C/CoC times)
 - Nature/content of C/CoC was not documented
 - Pertinent history and/or MDM not in evidence in report
 - Time spent in counseling replaces 'evaluation' or CoC replaces some of the MDM when used as the key criterion; however, a word of caution: these key components should still be developed in the MR notes/consult report to differentiate from other E/M services
 - Provider attempted to include non face-to-face time (outside of family &/or direct floor/unit for IP) in the final consult level chosen
 - Provider clearly demonstrated <50% face-to-face time was provided but still used 'time' as the key criterion for the final consult level

-continued-

E/M Coding Criteria: Consultations

-continued-

- Providers using 'time' ... downcoded for these reasons as well:
 - Provider neglected to provide a written report of findings, i.e., a single statement that counseling was provided constituted the full extent of the 'report'
 - Request was not found; reason for request was not documented
- Remember, all consult criteria (i.e., "3-R's") must still be in evidence for the consultation service to be eligible for federal payment when 'time' is the single service criterion

E/M Coding Criteria: Consultations

- Other useful consult coding/billing information (as per CERT and MAC audit findings) – In General:
 - 66% of all high level consultations conducted in 2007 were found to be in the median coding ranges, i.e., 99244 and 99254 as well as 99255, and were found to be in error for reasons on the previous and following slides, as well as one single erroneous assumption by specialty physicians:
 - ***"I am a specialist in my field; therefore, all new patient encounters are consultations."***
 - CMS' answer to this: ***"Wrong!"***

E/M Coding Criteria: **Consultations**

- Other useful consult coding/billing information (as per CERT and MAC audit findings) - NPPs:
 - Consultation services cannot be split/shared between an MD and a qualified NPP (as can be done with other select E/M services)
 - Consultations cannot be reported as 'incident-to' services when performed in the IP setting, e.g., IP consult performed by a PA or NP
 - Qualified NPPs must report these services under their own NPI, not the collaborating physician's NPI
 - Qualified NPPs must also follow both state laws and hospital/facility by-laws in these incidences

E/M Coding Criteria: **Consultations**

- Other useful consult coding/billing information (as per CERT and MAC audit findings) – F/U Services:
 - Once a pt. is being managed/treated after the initial consult, further services should be reported as subsequent (F/U) visits (per setting: office, IP, SNF, etc.) and NOT as subsequent consultations
 - If 'transfer of care' is in evidence *before* the initial consult is provided (e.g., "Pt. referred to Dr. XXX for care of cholecystitis,") no initial consult should be reported; instead report a new or est. pt. service appropriate for the setting

E/M Coding Criteria: Consultations

- Other useful consult coding/billing information (as per CERT and MAC audit findings) – IP Hospital Consults:
 - Initial inpatient consults can only be reported once **per consultant per pt. admission**; F/U services are reported as 'subsequent' services appropriate to the setting
 - Includes services to complete the initial consultation, monitor progress, discuss test results, finesse treatment previously initiated, etc.
 - The hospital record is a common document, shared among the treating/consulting providers
 - The consultant can choose to compose the 'report of findings' directly in his/her hospital progress notes ... no special outside report needs to be composed/sent
 - The hospital record must still contain the "3-R's" as well as the opinion/advice of the consultant

E/M Coding Criteria: Consultations

- Other useful consult coding/billing information (as per CERT and MAC audit findings) – Misc. Findings:
 - Pre-Op clearance is a justifiable reason for consultation; ensure all criteria are documented per usual (and the pre-op consultant is NOT also the surgeon)
 - Post-Op Consults at the request of the surgeon are likewise allowed provided care/management of the patient is not the reason the provider evaluates the patient; all other consult criteria must be met (i.e., "3-R's")
 - Same Group Practice Provider-to-Provider Consults can be done; ensure consulting provider has further or different knowledge/expertise in consult area the requesting provider does not. All consult criteria still must be met.
 - Most large practices have shared MRs similar to the hospital record; the consultant's report (as well as the request/reason) should all be documented within the shared record

E/M Coding Criteria: Consultations

- Other useful consult coding/billing information (as per CERT and MAC audit findings) – 2nd Opinions & Hospital By-Laws:
 - CMS does not pay for ‘mandated’ services (e.g., disability insurer 2nd opinions, IME’s for rehab/WC cases) by third party payors
 - Modifier -32 Mandated Services cannot be reported to Medicare
 - A second opinion at the request of the family for a facility-based pt., e.g., a SNF resident, arranged via the treating provider, can be coded/billed as Initial IP Consultation by the consulting provider as long as all other consult criteria are met
 - Consultations required by hospital by-laws and facility admitting regulations are likewise not eligible for federal payment as ‘consultations’
 - These services may meet medical necessity services for initial/subsequent IP hospital services, etc., as appropriate
 - Medical necessity must always be established in these cases

E/M Coding Criteria: Consultations

- Last note on consultation services: The MPFS, in the Proposed Rule (*Federal Register* 7-13-09), has proposed to delete all consultation codes (except telehealth) from payment eligibility as follows:
 - *Beginning **January 1, 2010**, we propose to budget neutrally eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our PE [“practice expense”] and malpractice RVU calculations.*
- Comments accepted until 8-31-09; Final Rule is expected 11-1-09

General Documentation Requirements

CERT & MAC Audit
Recommendations for
Physician MR Documentation

MR Documentation

MR Progress Notes, Forms, Reports & Addenda:

- Legibility
 - Transcribe if there is a problem in reading/deciphering the text
 - Carrier may ask for copy of original handwritten notes, as well
 - Transcribed notes may have two dates: DOS and DOT
- Each MR page patient-identified:
 - Patient name
 - DOS
 - MR number if appropriate
- All notes signed by ancillary personnel and/or scribes, if utilized, in appropriate areas of the MR documentation
- Each DOS should be signed/verified IAW physician signature requirements
 - Facsimile stamped signatures (for DOS 9/07 and afterwards) are no longer authorized forms of provider signatures for federal/state purposes (*exception*: hospice care)
 - E-signatures applied by MR systems via verified protocols are valid
 - If the provider's identity cannot be accurately discerned, the Carrier may deny the service altogether (not simply downcode it)

MR Documentation

Replying to External ADRs:

- In response to external CERT, MAC, RAC and/or OIG requests for additional DOS documentation for any particular patient, ensure:
 - Previous slide's MR doc standards are met
 - All documents pertaining to the DOS are included in the response; include separate forms, sheets, notes, orders, test results, etc., if they are germane to the case
 - ROS sheets, PFSH forms, etc., should be included
 - If eMR/eHR system is utilized, ensure print-out from all *relevant* screen fields (e.g., PFHS, ROS, medication and immunization lists,) are included in the submission package

MR Documentation

Replying to External ADRs continued:

- If tests/studies were ordered, ensure the order as well as the reason(s) for the studies are written and/or easily inferred from the clinical data
- For any/all ICD-9-CM diagnosis codes submitted on the original claim for the case in question, ensure all medical necessity (i.e., clinical diagnostic information) is clearly documented and/or easily inferred from the clinical notes, and included in the documents sent to the official reviewer
- Support of consultations rendered must always include the "3-R's" in the documents submitted

Concluding Remarks

Quick Checklist for the Program
&
Resources/References

In Conclusion ...

Median Coding:

- Provides false sense of equitable coding/billing for patients
- Negatively impacts practice revenue
- Creates artificial sense of audit impermeability and may expose practice providers to audit liability and Fraud-Waste-Abuse penalties
- Final code selection not typically supported by appropriate MR documentation

Appropriate Coding & MR Documentation:

- Select E/M codes based on face-to-face work done and work documented in the MR
- Ensure all E/M code category and level criteria are met
- For consultations, ensure "3-R's" are documented and accurate E/M service level is selected based on MR documentation
- Avoid eMR/eHR prompts for comprehensive service levels when not medically necessary
- Ensure accurate reporting and MR documentation for E/M service 99211
- Use caution when reporting 99499 Unlisted E/M Service
- Follow CMS' and local Carrier guidelines as appropriate

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- Medicare Claims Processing Manual, Ch.12 *Physicians and NPPs* & Ch. 23 *Fee Schedule Admin and Coding Requirements*, updated 2009 @ CMS' Internet-Only Manuals www.cms.gov
- CMS' CRs 5871, 5971 & 6100 Physician Signature Requirements, 3-4/08 & 8-9/08 release/effective dates; IOM 100-8 Ch. 3 §3.4.1.1 Facsimile Signature Requirements (i.e., invalidity of)

Official Carrier E/M Leveling Resource

A Useful Tool for Your
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References & Sources

E/M Leveling Tool:

- E/M Leveling Tool based on 1995 E/M Documentation Guidelines and reproduced with permission by Highmark Medicare Services (www.highmarkmedicare.com), found @ <http://www.highmarkmedicare.com/partb/reference/scoresheets.html>
 - Choose first option for 1995 E/M scorecard
 - For specialty exams, choose appropriate exam type