Coding and Documentation
How to Avoid Common Coding Mistakes

Linda Gates-Striby CCS-P, ACS-CA

- Linda Gates-Striby has worked in the medical field for over 30 years. She has specialized in cardiology for the past 15 years.
- Linda is the Director of Corporate Compliance for St. Vincent Medical Group.
- Her clinical experience includes work in the heart stations and coronary intensive care units as well as serving as an EMT for a Level I trauma center.
- Linda serves as the non-physician member of the AHA coding subcommittee.
- Linda is the non-physician member of the American College of Cardiology's coding subcommittee.
- Linda is a sought-after speaker by many organizations such as Decision Health, HCPro, Wolter's Kluwer, MGMA etc., as well as numerous ACC Chapter offices.
- Linda has served as an IRO auditor for OIG Corporate Integrity Agreements, and as an expert witness on behalf of cardiology practices.

Debra Mariani, CPC, CGSC

- Debra Mariani has been in the medical field for over 30 years. She has worked with ACC as a Senior Specialist for Coding and Reimbursement for 3 years.
- Serves as the President of the Frederick, MD, Local Chapter of the AAPC (American Academy of Professional Coders).
- Serves as the staff liaison for ACC's CPT Advisor to the AMA CPT Editorial Panel.
- Staffs the American College of Cardiology's Coding Task Force.
Objectives for Today’s Webinar

- Ability to download informational PP slides as a reference
- Touch on common errors found on Office notes
- Tips on correct E/M coding
- Recap some of the activity we are now seeing involving the increased scrutiny of E/M services
- Review top 12 Definitions associated with E/M coding and documentation guidelines
- What often “tops the list” of E/M errors for Cardiology?
- Review various MAC Comments on E/M “gray” zones

Regulatory Focus

August 2013
Linda Gates-Stibby CCS-P, ACS-CA

Data Analysis

Question: Who is looking at your claims data?
Answer: Pretty much every payor

- Diagnosis data reviewed for severity, cost and quality programs, etc.
- CPT data – hunting for aberrant billing patterns, improper code combinations, comparisons to peers, etc.
Setting The Stage?

HIPAA Transaction Codes  NPI Numbers  CERT Program  MAC Conversions  Data Centers  RAC Program  Private Contractors

CMS.GOV/RAC

• **Recovery Audit Program**
• **Mission** - The Recovery Audit Program’s mission is to identify and reduce Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.

Where Did it Start?

What Was The Return?

Initial Demonstration Project
• The RAC program: achieved a respectable return on investment of 318 percent
• $4.60: $1 benefit: cost ratio
• CMS spent only 22 cents for each dollar collected
RAC Reviews

1) Automated Review
- Use OIG and GAO reports to help identify vulnerable areas
- Use claims data and “proprietary techniques”
- Required to “post” CMS approved list of projects/locations
- Must follow guidelines established by local MAC and/or CMS Nat'l when available
- Free to apply their own criteria if other guidelines are not available

2) Complex Review

FY11 Report To Congress

- The full report is available at CMS.gov/RAC
  - FY 2011 – identified and corrected $939 million in improper payments

RAC Appeal Levels

- Redetermination – must be submitted within 120 days of the initial determination
- Reconsideration – performed by QICs, and must be filed within 180 days of redetermination
- Administrative Law Judge (ALJ) – minimum amount of $1,300 must be filed within 60 days of reconsideration notice
- Appeals Council Review – must be filed within 60 days of ALJ decision
- Final Judicial Review (Federal District Court Review) – minimum amount $1,300 must be filed within 60 days
A Change In Approach?

- Most of the current CMS efforts involve a “post payment” review
- The “new” approach is a shift to “pre-payment” reviews
  - 7 states with high fraud and error prone providers: FL, CA, TX, MI, NY, LA, Ill
  - 4 states with high volume of short stays: PA, OH, NC, MO

First Coast – Prepay Edit 99215

- The Office of the Inspector General (OIG) recently reviewed current coding trends and discovered a growing frequency of Medicare providers billing higher level evaluation and management (E/M) codes. From 2001 to 2010, providers increased their billing for Current Procedural Terminology (CPT) codes 99214 and 99215 by 17 percent. The Centers for Medicare & Medicaid Services (CMS) concurred with the OIG recommendations that Medicare administrative contractors (MACs) continue to educate physicians on proper billing for E/M services and to review physicians’ billing for these services.
- Following these recommendations, First Coast Service Options, Inc. (First Coast) completed an analysis that indicates there is a high risk of improper claim payment for certain specialties billing E/M code 99215 in Florida. Therefore, a 100 percent prepayment review of code 99215 will be applied to claims submitted on or after January 18, 2013, for the following provider specialties in the Florida segment of First Coast’s jurisdiction:
  - GP, Optometry, Osteopathic, pediatric, podiatry
More To Come?

- CMS and DHHS present current efforts to the Committee 4-12
- Senate Finance Committee releases solicitation letter 5-2-12
- Committee accepts white papers 6-12
- Summary released 1-13

Where Eagles Fly…

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General
Washington, D.C. 20001

January 31, 2011
CBR From CMS

- **CBR Services Overview**
  - The Centers for Medicare & Medicaid Services (CMS) awarded the Comparative Billing Report (CBR) contract to SafeGuard Services LLC (SGS). A Comparative Billing Report or CBR is a documented analysis that shows a provider's billing pattern for various procedures or services and compares that billing to their peers.
  - CMS has authorized SGS to begin producing nationwide CBRs beginning in 2010. SGS, as the CBR Producer, has begun to develop an inventory of potential topics for study. CBRs will be produced using national data from Medicare A, B, and DME. Once each study has been completed, the CBR will be mailed or faxed to the providers that were selected under the topic criteria. A maximum of 5,000 providers will be selected per CBR topic. The CBR, approximately 4 pages in length will also be distributed to each provider in a PDF format. If, after reviewing the document the provider has any questions, they would then be able to call into the SGS CBR support team, whose contact information will be provided on each CBR.
  - The CBR is not intended to be punitive or sent as an indication of fraud. Rather it is intended to be a proactive statement that will help the provider identify potential errors in their billing practice. A CBR contains peer comparisons which can be used to provide helpful insights into their coding and billing practices. The information provided is designed to help the provider prevent improper billing and payment.

Sample Comparative Report – Testing
Commercial Payors

- Don’t forget the commercial payors are also conducting data review along with auditing and monitoring.
- The AMA’s E/M guidelines apply to all payors, and most payors do have additional educational resources they make available to providers.
- You will also want to be aware of any “cost & quality” data they are making available to you.
MAC Sample On Coding Patterns

- The nature of the patient’s presenting problem will vary, so will the amount of work necessary to address the problem. Providers must choose procedure codes based on the service they provided to the patient on that day. Medicare considers the claim in error when the service is either over or under-coded.
- “I’m a specialist”, “People send their sicker and needier patients to me”. -- Choose codes based only on the services provided to the patient on that day. Documentation must support both the service billed and the medical necessity of that service.

In Case You Are Wondering….

This is NOT the correct response

7 Fundamental Elements of an Effective Compliance Program

1. Conduct internal monitoring and auditing
2. Implement compliance and practice standards through development of written policies and procedures
3. Designate a compliance officer or contact to monitor and enforce standards
4. Conduct appropriate training and education
5. Respond appropriately to detected violations and implement corrective actions
6. Develop open lines of communication
7. Enforce disciplinary standards
OIG Work Plan Issues To Review

1) “Incident to”
2) Visits in a global period
3) E/M Errors - We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services.

Debra Mariani
coding@acc.org

ACC E/M Coding and Documentation Tips

Common Errors

Insufficient documentation:

• Procedure/service billed
• Missing or illegible documentation and/or physician signature
• No valid physician’s order
• No treatment plan
• No valid physician’s order
Incorrect coding errors:

- Evaluation and Management (E/M) codes
- Critical care and discharge day management
- Units of medication/infusion services
- Laboratory services

Complete Medical Documentation

The medical record should be complete and legible.

The 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; and
- Date and legible identity of the observer.

Additional Documentation **Tips**

- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
- The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
Key Components

Review of

- History
- Exam
- Medical Decision Making

Contributory Component

- Time
- Coordination of Care
- Counseling
- Nature of Presenting Problem

History
The History portion of your E/M service has to consist of the Chief Complaint and these three elements

1. History of Present Illness
2. Review of Symptoms
3. Past, Family, and Social History
Chief Complaint (CC) *Tips*

The CC is a concise statement describing the reason for the encounter. The CC should be clearly reflected in the medical record for each encounter and is usually stated in the patient’s words. The CC can be included in the description of the history of the present illness or as a separate statement in the medical record.

**Question # 1**

Who can document the History of Present Illness?

1. Patient
2. Ancillary Staff
3. Physician
4. All of the above

**History of the Present Illness (HPI)**

The HPI is a description of the development of the patient’s present illness.

- *Tip* - The HPI must be documented by the provider.
- *Tip* - There are only two types of HPI – Brief and Extended.

The HPI should include some or all of the following elements.
• Location – What is the location of the pain?
• Quality – Include a description of the quality of the symptom ex: sharp pain
• Severity – Degree of pain can be described on a scale of 1 - 10
• Duration – How long have you had the pain
• Timing - Describe when you have pain, for example; pain with exertion or pain in evening
• Context – What is the patient doing when the pain begins
• Modifying factors – What makes the pain better or worse for example; aspirin helps
• Associated signs and symptoms – physician, based on assessment, may ask about other sensations or feelings for example – do you experience pain while exercising

Review of Systems (ROS)
The ROS is an inventory of the body systems that is obtained through a series of questions in order to identify signs and/or symptoms which the patient may be experiencing.

Tip – The ROS may be taken in any format, such as a direct patient intake or questionnaire form.

CMS recognizes 14 systems for your ROS:
• Constitutional symptoms (e.g., fever, weight loss, vital signs)
• Eyes
• Ears, Nose, Mouth, Throat
• Cardiovascular
• Respiratory
• Gastrointestinal
• Genitourinary
• Musculoskeletal
• Integumentary
• Neurological
• Psychiatric
• Endocrine
• Hematologic/Lymphatic
• Allergic/Immunologic
ROS Guidelines to Keep in Mind

There are a couple of document guidelines for the ROS that you should be aware of when it comes to your patient’s medical record. *A ROS obtained during an earlier encounter does not have to be documented again if there is evidence that the physician reviewed and updated the previous information. The review and update may be documented by describing any new ROS or noting there has been no change in the information. The physician will also have to document the date and location of the earlier ROS in the present encounter. Another guideline is that a staff member may document the ROS in the medical record as long as there is evidence that the provider reviewed their documentation.

Three Levels for the ROS

- **A problem pertinent** ROS inquires about the system directly related to the problem(s) identified in the HPI. Documentation needs to include the positive responses and pertinent negatives for the system related problem.
- **An extended** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. Documentation needs to include the positive responses and pertinent negatives for two to nine systems.
- **A complete** ROS inquires about the system directly related to the problem(s) identified in the HPI plus all additional body systems. At least ten systems need to be reviewed. Those systems with positive responses and pertinent negatives must be individually documented. For the remaining systems, a notation indicating all other systems are negative is allowed.

Review of Systems (ROS) inquiries are questions concerning the system(s) directly related to the problem(s) identified in the History of Present Illness.
Past, Family and Social History (PFSH)

There are three areas to review in the PFSH:

- **Past History** – the patient’s past illnesses, operations, injuries, medications, allergies and/or treatments etc.
- **Family History** – the review of patient’s family and their medical events including diseases which may be hereditary or place the patient at risk
- **Social History** – age appropriate review of past and current activities e.g., job, marriage, exercise, marital status etc.

A pertinent PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI. At least one specific item from any of the three history areas must be documented for a pertinent PFSH.

A complete PFSH is a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services. At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.

Important PFSH Tips to Remember

- The PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.
- A PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:
  - describing any new PFSH information or noting there has been no change in the information; and
  - noting the date and location of the earlier PFSH.
- The PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance which precludes obtaining a history.
Additional Elements

- **Timing** - Describes when the symptom/pain occurs (intermittent, fluctuating, constant)
- **Context** - What created the symptom/pain
- **Modifying Factors** - What is done to make the symptom/pain worse or better
- **Associated Signs and Symptoms** - Describes what does or does not happen at the same time of the symptom/pain

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**Question #2**

A ROS obtained during an earlier encounter does not have to be documented again if there is evidence that the physician reviewed and updated the previous information.

True  
False
Exam

Guidelines

• Two sets of official E/M guidelines are available: “1995 Documentation Guidelines for Evaluation and Management Services” and “1997 Documentation Guidelines for Evaluation and Management Services.”

The 97 guidelines provide more specific documentation requirements and have two types of exams to follow:
• 1) General Multi-System Examination or
• 2) Single Organ System

Here are some comments regarding the two set of guidelines for your Exam

A physician or practitioner may use either set of guidelines to determine the appropriate level of code for the E/M service provided.

• For each separate E/M service, you must use only one set of E/M guidelines throughout the code determination process.

• Mixing or combining of the two sets of guidelines for a single E/M encounter is not acceptable.

• The “1997 Documentation Guidelines for Evaluation and Management Services” provide more detail on the examination component and the expected/recommended types of examination that should be completed for the respective levels. For example, these guidelines distinguish between a general multi-system exam and a single organ system exam.

The 1997 documentation guidelines are significantly different from the 1995 Documentation Guidelines for the exam portion of the E/M. Either set of guidelines can be performed by any physician, regardless of specialty. When documenting these examinations each element must satisfy any numeric requirements (such as “Measurement of any three of the following seven”) included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as “Examination of liver and spleen”) require documentation of at least one component. Documentation beyond the required elements should be documented with findings related to the additional systems and/or areas.
Levels of Service for the Exam

The levels of E/M services recognize four types of examination:

- Problem focused
- Expanded problem focused
- Detailed
- Comprehensive

<table>
<thead>
<tr>
<th>Problem Focused Exam</th>
<th>Expanded Problem Focused Exam</th>
<th>Detailed Exam</th>
<th>Comprehensive Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams of affected area(s) and other symptomatic or related organ system(s)</td>
<td>Exam of affected area(s) and other symptomatic or related organ system(s)</td>
<td>Exam of a single organ system or complete exam of a single organ system</td>
<td>Exam of multiple organ systems or complete exam of multiple organ systems</td>
</tr>
</tbody>
</table>

97 Guidelines for Multi-System Exam

<table>
<thead>
<tr>
<th>Specialty Exam: General Multi-System</th>
<th>Performed and Documented</th>
<th>Level of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to five bullets</td>
<td>Problem Focused</td>
<td></td>
</tr>
<tr>
<td>At least six bullets</td>
<td>Expanded Problem Focused</td>
<td></td>
</tr>
<tr>
<td>At least two bullets from each of six body systems/areas</td>
<td>Detailed</td>
<td></td>
</tr>
<tr>
<td>At least two bullets from each of nine body systems/areas</td>
<td>Comprehensive</td>
<td></td>
</tr>
</tbody>
</table>
### A Single Organ System

Examination level of service is described in detail according to the chart below:

<table>
<thead>
<tr>
<th>Level of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Should include performance and documentation of one to five elements identified by a bullet (●), whether in a box with a shaded or unshaded border.</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Should include performance and documentation of at least six elements identified by a bullet (●), whether in a box with a shaded or unshaded border.</td>
</tr>
<tr>
<td>Detailed</td>
<td>Examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet (●), whether in box with a shaded or unshaded border.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Should include performance of all elements identified by a bullet (●), whether in box with a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in each box with an unshaded border is expected.</td>
</tr>
</tbody>
</table>

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### Medical Decision Making

Medical Decision Making is the third key component for choosing your Evaluation and Management code. The levels of E/M services recognize four types of medical decision making.

The chart on the next slide shows the progression of the elements required for each level of medical decision making.

To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

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<table>
<thead>
<tr>
<th>Number of Diagnosis or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Complications and/or Morbidity and Mortality</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straight</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extreme</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
**Medical Decision Making**

Medical Decision Making is broken up into three categories:

1. Number of Diagnosis and Treatment Options
2. Amount and Complexity of Data Reviewed
3. Risk of Complications, and/or Morbidity or Mortality

**Number of Diagnosis or Treatment Options**

The number of possible diagnoses and/or the number of management options that must be considered is based on:

- The number and types of problems addressed during the encounter;
- The complexity of establishing a diagnosis; and
- The management decisions that are made by the physician.

- For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.
- For a presenting problem with an established diagnosis, the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or b) inadequately controlled, worsening, or failing to change as expected.
- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnosis or as “possible,” “probable,” or “rule out” (R/O) diagnoses.
- The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.
- If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.
### Problems and Points

<table>
<thead>
<tr>
<th>Problems</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (maximum of 2)</td>
<td>1</td>
</tr>
<tr>
<td>Established problem, stable or improving</td>
<td>1</td>
</tr>
<tr>
<td>Established problem, worsening</td>
<td>2</td>
</tr>
<tr>
<td>New problem, with no additional work-up planned (maximum of 1)</td>
<td>3</td>
</tr>
<tr>
<td>New problem, with additional work-up planned</td>
<td>4</td>
</tr>
</tbody>
</table>

### Amount and/or Complexity of Data to be Reviewed

The amount and/or complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. Indications of the amount and/or complexity of data being reviewed include:

- **A decision to obtain and review old medical records and/or obtain history from sources other than the patient** (increases the amount and complexity of data to be reviewed);
- **Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test** (indicates the complexity of data to be reviewed); and
- **The physician who ordered a test personally reviews the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation** (indicates the complexity of data to be reviewed).

- **If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray should be documented.**
- **The review of lab, radiology and/or other diagnostic tests should be documented.** An entry in a progress note such as “WBC elevated” or “chest x-ray unremarkable” is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.
- **A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.**
• Relevant finding from the review of old records, and/or the receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of “Old records reviewed” or “additional history obtained from family” without elaboration is insufficient.

• The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented. The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.

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**Data Reviewed**

<table>
<thead>
<tr>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review or order clinical lab tests</td>
</tr>
<tr>
<td>Review or order radiology test (except heart catheterization or echo)</td>
</tr>
<tr>
<td>Review or order medicine test (PFTs, EKGs, cardiac echo or catheterization)</td>
</tr>
<tr>
<td>Discuss test with performing physician</td>
</tr>
<tr>
<td>Independent review of image, tracing, or specimen</td>
</tr>
<tr>
<td>Decision to obtain old records</td>
</tr>
<tr>
<td>Review and summation of old records</td>
</tr>
</tbody>
</table>

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**Risk of Significant Complications, Morbidity, and/or Mortality**

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

• Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

• If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure eg, laparoscopy, should be documented.

• If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.

• The referral for or a decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.
The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

**TABLE OF RISK**

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s)</th>
<th>Management Options</th>
<th>Required Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Low</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Moderate</td>
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</tr>
<tr>
<td>High</td>
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</tbody>
</table>

*Keep in mind that medical necessity will have to support the code you choose.*
CPT Code | History | Exam | MDM | Nature of Problem | Average Time
---|---|---|---|---|---
99211 | Problem Focused | Problem Focused | Straightforward | Self-limiting or minor | 10
99212 | Expanded Problem Focused | Expanded Problem Focused | Straightforward | Low to moderate severity | 20
99213 | Detailed | Detailed | Low Complexity | Moderate Severity | 30
99214 | Comprehensive | Comprehensive | Moderate Complexity | Moderate Severity | 45
99215 | Comprehensive | Comprehensive | High Complexity | Moderate to high severity | 60

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E/M Coding & Documentation

August 2013
Linda Gates-Striby CCS-P, ACS-CA

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“Unofficial” Top 10 E/M Errors
From This Auditor’s Perspective

1) Less than 10 systems in a ROS when a comprehensive history is required
2) Missing a family or social history when a comprehensive history is required
3) Billing at a high level of medical decision making when the code is better as a moderate
4) Not having the required exam elements on a hospital level 3 follow-up visit
5) Problems with “incident to” (office setting) documentation
6) Problems with “split/shared” visit documentation in the hospital setting
7) Visit does not clearly identify a “significant and separate” condition on the day of a procedure or within a global period
8) Not clearly documenting the consultation requested when the consult code is billed
9) Conflicting information in the HPI versus the ROS with electronic medical records
10) Not clearly documenting the patient’s “new pt” status
### Sample Information

- The following information was obtained from MAC websites.
- It is not all inclusive, but a representative sample designed to illustrate the differences in documentation expectations.
- All Contractors have information on E/M services – i.e. links to CMS info, Articles, Educational Web sessions, FAQ, Provider workshops, audit forms, CERT error reports, etc.
  - You need to be familiar with payor expectations when they have made the information available to you.

### Caution

- The E/M guidelines were NOT designed to encourage recording unnecessary information to meet documentation requirements of a higher level service when the nature of the presenting problem related to the visit dictates a lower level service to be medically appropriate.
- The level of service should be chosen based on the clinical circumstances of the encounter – and the documentation must be present to support that level, and any other services billed.

### Medically Necessary Services

- All expenses paid by CMS and other payors must be “medically reasonable & necessary”.
- E/M services generally express the medical necessity in two ways: Frequency of services and intensity of services (CPT code level).
- In an audit your service could be denied or down coded when in the judgment of the auditor the service exceed the patient’s documented needs.
- Make sure your documentation clearly represents the patient’s condition(s).
WPS – General Comments For E/M Documentation

- Documentation records: pertinent facts, findings, and observations. The record should show clear evidence that the service was actually performed.
- Documentation should be complete, clear, and legible.
- Each of the following must be easily discernible to the reviewer: patient name, date of service, who performed the service, what service was performed, reason why the service was performed.
- Use standard and acceptable medical abbreviations. A “key” can be included if need be for specialty specific abbreviations i.e. CVA – costovertebral angle vs cerebrovascular accident.

Speaking Of Abbreviations…

Can I Bill Based on Time?

Yes, time can be considered and billed when:
- The time spent in counseling and/or the coordination of care is greater than 50% of the time spent face to face, physician to patient, on a patient encounter.
- Do not count your staff’s time.

Phrases such as:
- “Discussed at length”
- “Spent a long time”
- “Considerable time was spent…” Does Not Count.

Counseling is a discussion with a patient concerning one or more of the following areas:
- Diagnostic results, impressions, or recommended studies.
- Prognosis.
- Risks and benefits of management options.
- Instructions for management or follow up.
- Importance of compliance with chosen management.
- Risk factor reduction and or patient education.

“Evaluation and Management: Time” located in CPT Assistant Volume 10, Issue 12, December 2000. This article has extensive information regarding the elements required when billing based on time.
Comments on Documenting Time

- **Noridian** – It is not acceptable to simply state “35 minutes spent with patient discussing treatment.” Documentation needs to support the amount of time spent in discussion, and detail the context of the conversation and any decisions made or actions that will result.
- **Cahaba** – Time must be documented along with the nature of the counseling or coordination – Who, what, when, where, why and how long.
- **Palmetto** – The extent of the counseling and or coordination of care must be documented.
- **Novitas** – A number of factors must be documented. The total length of time of the E/M visit, evidence that more than half of the total length of time was spent, the content of the counseling and coordination of care provided during the E/M visit.

Chief Complaint

- All visits require a chief complaint – Do not limit the CC to “follow up” without elaborating and identifying the problem(s) that are being followed.
- Reminder - only the provider can document the chief complaint. The same is true for HPI.
- Consider the fact that many patients will provide minimal information to ancillary staff, and provide additional detail and or additional complaints when speaking with the provider.

Noridian On HPI

- Q29. An RN or NP obtained the HPI and documents it. The physician then goes over the info with the patient to verify it, can the MD say, “I verified the HPI with the pt. Please see RN/NP documentation above”?  
  A29. If that scenario takes place, the information will not be accepted if reviewed. The MD must gather and document the HPI themselves. The ROS and PFSH can be recorded by other staff and the physician then reviews and confirms the information.
Counting A Review Of Systems

- Only 1 system is needed for an expanded history (i.e. level 3 est pt)
- Any 2-9 systems for a detailed history
- Comprehensive ROS requires 10 systems
- Billing at a level that requires a comprehensive ROS – then not having 10 systems in the ROS is a very common problem
- Keep in mind that you are also held accountable to the fact that a 10 system ROS was medically indicated and necessary when billing in these levels

CMS Comments

- Stating “all others negative” or a similar statement will not always give you credit for having documented the patient’s pertinent negatives and may not meet requirements for a comprehensive history as the number of systems reviewed is unclear
- Guidelines require that all positive responses as well as all pertinent negatives be individually documented
- Do not note the system(s) related to the presenting problem as “negative” or “normal” – this comment without any further information should be limited to systems unrelated to the presenting problem
- Do not count physical observations as ROS (count them as physical examination).
- It is acceptable to reference a patient completed ROS, it is anticipated that there will be additional comments by the provider and at a minimum an initial and date by the provider to show their review.

WPS on ROS

- WPS – The statement “all other systems are negative” is acceptable. A comprehensive ROS the physician must document the review of at least 10 organ systems. The physician must document both the positive and problem pertinent negative responses relating to the chief complaint. Indicating the individual systems leaves no room for doubt as to the number of systems reviewed.
- WPS – A provider must notate his/her review of information obtained by staff or patient. Additions to the file confirming notations substantiate the provider’s review.
- WPS – “A notation of abnormal without elaboration is insufficient”.

Noridian & 1st Coast on ROS

Noridian on ROS
- Q13 A 10 pt ROS is negative except as in HPI. Is this an acceptable statement for a comprehensive ROS even though we do not know which systems were reviewed?
  A13. Does the chief complaint warrant a complete 10pt review of systems? Generally speaking a full ROS is not medically necessary; however the details are always in the documentation your statement would be appropriate if a full ROS is medically necessary.

1st Coast on ROS
- Q. Can I document the most clinically relevant systems and then say “all other systems reviewed are negative” in order to qualify for a complete (10 system) ROS?
  A. This would be allowed if all other systems were, indeed, reviewed and are negative, and if a complete ROS is medically necessary.

Missing A Family or Social History

- Another common error is the absence of a family or social history when a comprehensive history is needed
- When the patient presents with an acute condition, it is very easy to overlook a family or social history
- If you say a family history is “non-contributory”, does that count?

Comments on Using “Noncontributory”

Palmetto
- Is it acceptable to use “noncontributory, unremarkable or negative” when reporting past, family or social history?
  Answer: No, because the statement “noncontributory, unremarkable or negative” does not indicate what was addressed. Did the nurse or physician ask specific conditions (i.e., any family history of coronary artery disease)? If for some reason you cannot obtain the family history, the documentation must support the reason why (e.g., the patient was adopted).

Noridian
- Q12. Would it be acceptable for a provider to simply state the family history is “non-contributory”?
  A12. If the family history is not pertinent to the reason for the visit it would be acceptable.

CGS
- CGS: Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services.
  – Don’t use the term “non-contributory”.

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What If You Can Not Obtain The Patient’s History?

• When the patient is unconscious, sedated, confused etc. attempts should be made to obtain information from family, caregivers, past records etc.
• Noting the attempt and why the patient could not participate is generally accepted by auditors and the provider is not penalized for not having the information

Palmetto On Unobtainable History

• Does a physician have to document the reason why the history of present illness (HPI), review of systems (ROS) and past/family/social history (PFSH) were unobtainable or can it be inferred by other documentation within the history of present illness (HPI) (e.g., patient had severe dementia)?
• Answer:
The documentation must clearly reflect:
  – Why the HPI, ROS, and PFSH was unobtainable (severely demented, sedated on a vent, etc.). If they use ‘poor’ historian the documentation must support why (severely demented).
  – No family members were present to provide information
  – Unable to obtain information from medical record (chart, ambulance run sheet, etc.)
• If patient or family can provide information at a later time, the provider may add an addendum containing information

Can You Reference A Previous Document?

• At a minimum you need to name it very specifically – i.e. For patient’s past medical history please see my H & P from June 1, 2013.
  – Add a comment today that it is unchanged, initial and date.
  – Most payors want to see evidence that the previous information was reviewed
**FAQ – Documenting a review of Record Elements**

- A review and update of a medical record is considered to have occurred when: there is a description of new ROS and/or PFSH information or noting that there has been no change in the information.
- A ROS and/or PFSH may be recorded by ancillary staff or a patient completed form – there must be a notation by the provider supplementing or confirming the information obtained. This is best done with a brief statement, and at a minimum initials and date.

**MAC Comments - “Expanded vs Detailed” Exam**

- One of the differences expected to distinguish an “expanded” exam from a “detailed” exam is the detail in which the examined systems are described. It is anticipated that there will be more extended comments on the impacted area or system.
- “It is anticipated that the use of “normal”, “negative” or “WNL” notations will be limited to describing unaffected or asymptomatic organ systems.”
- “A notation of abnormal without elaboration is insufficient.”

**Counting Exam Elements**

Examples for HEENT

- HEENT – Normal (credit for 1)
- HEENT – PERL, no sinus tenderness (2)
- HEENT – normocephalic, PERL, good oral hygiene (Credit for 3)

- How do you count each of the statements above?
  - This varies from auditor to auditor
CGS On Exam

- Understand the difference between “Expanded Problem-Focused (EPF)” and “Limited” examination under 1995 guidelines.
  - The difference is not the number of systems examined. Two to seven systems are required for both examinations.
  - The difference is the detail in which the examined systems are described.
- Always examine the system(s) related to the presenting problem and do not describe it as “normal” or “negative.”
- Use “Normal,” “negative” and “WNL” notations only to describe unaffected or asymptomatic organ systems.

Medical Decision Making

To qualify for a level of MDM, you need to meet 2 of the 3 elements:
1. Diagnosis and management options
2. The amount or complexity of data to review
3. Risk (Must meet 2 of 3 on the risk table)

WPS On Multiple Conditions

FAQ – To get credit for multiple or inactive conditions, do I have to do more than mention the conditions?
- “The documentation should show what actions the physician is taking concerning these conditions and how they affected the chief complaint.”
- Sounds like the answer is “Yes”
Data Reviewed

- Attempts to assign a value to the various types of data reviewed
- Labs, X-rays, EKG, old records, etc.
- Credit for discussion with performing MD
- Credit for personal review of image versus review of report – i.e. EKG interp
- There is no credit for multiples of the same type – i.e. review 5 labs – get 1 point

A score of "4" is the max

Novitas – On “Visualization”

- If a provider is billing for the professional component of a test in the radiology and/or medicine section of the Current Procedural Terminology (CPT) Manual and an Evaluation & Management (E/M) procedure code on the same date of service, should that physician receive credit under the Independent Visualization of an image, specimen or tracing component in the Amount and/or Complexity of Data Reviewed Section of the Medical Decision Making key component of an E/M?

- If the provider is billing separately for the interpretation of a test in the radiology and/or medicine section of the CPT, then that same physician should not take credit for the independent visualization of that test in the Amount and/or Complexity of Data Reviewed Section of the Medical Decision Making key component of an E/M.

Novitas – Visualization Continued

- The 1995 E/M Documentation Guidelines address this issue on page 13 and state that, “The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.”
- If the provider is not billing separately for the interpretation of the test or the test was performed by another provider and that physician is independently visualizing the test, then the provider may take credit for the independent visualization of that test in the Amount and/or Complexity of Data Reviewed Section of the Medical Decision Making key component of an E/M.
Prescription Management

- **Noridian** Q. Can you specify what exactly “prescription drug management” consists of? For example, if a provider prescribes Motrin 800mg or a course of antibiotics, would this be considered “prescription drug management” within the MDM?

  A5. Prescription drug management is for managing the drug regimen. This would not be for just listing the patient’s medications. It would be for new drugs prescribed, evaluation and raise or lower drug dosages, etc.

- **First Coast** Q. What is required to get credit for prescription drug management? Do I have to stop, start or change a medication dosage, or can I get credit for making the decision to continue a specific medication?

  A. Credit is given as long as the documentation clearly indicates that decision-making took place in regard to the medication(s).

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Palmetto On Medical Decision Making

- Does Palmetto GBA consider Coumadin or Heparin a drug requiring intensive monitoring for toxicity?

  **Answer:**

  Coumadin (any setting) and Heparin (hospital setting only) are considered ‘high risk’ (Drug Therapy Requiring Intensive Monitoring for Toxicity).

- If a physician talks with a patient about a do not resuscitate (DNR) order and documents his or her discussion, would this be a high-level risk management option under medical decision making even though their prognosis may not be poor?

  **Answer:**

  No. A high level of risk would only be indicated if the documentation states that the patient has a poor prognosis, or it can be inferred there is a poor prognosis from the content of the note.

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A Word On Documentation

- Medicare Carrier’s Manual section 15501A “…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 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….”
Noridian Comments

- Medical Review Level of Service Findings
  - The NAS Part B Medical Review (MR) Department has noticed, during prepayment medical review, the provider community is using a quantification method to code their claims. The amount of data contained in the medical record should not be the controlling factor for determining the level of service (LOS). It is neither acceptable nor appropriate to include additional information in the medical record for the sole purpose of meeting the billing requirements for a specific Current Procedural Terminology (CPT)® code. Providers may include any and all data that they deem appropriate in their patient’s notes. However, per Medicare regulations, providers are required to bill only for the elements that are medically reasonable and necessary for the treatment of the patient.

CGS – On Medical Necessity

- E/M Coding: Volume of Documentation versus Medical Necessity
  - The Social Security Act, Section 1862 (a)(1)(A) states: “No payment will be made ... for items or services ... not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member.” This medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare.
  - During repeated reviews, we have observed the tendency to “over document” and consequently to select and bill for a higher level E/M code than medically reasonable and necessary. Word processing software, the electronic medical record, and formatted note systems facilitate the “carry over” and repetitive “fill in” of stored information. Even if a “complete” note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service. Information that has no pertinence to the patient’s situation at that specific time cannot be counted.

Consultation Code Reminder

Definition – Service provided by a physician whose opinion or advice regarding a specific problem is requested by another physician.

- There are not categories for “new” and “established” consults
- CMS no longer accepts the consult code, but most commercial payors do
- The guidelines for consultation services are very specific and there are key elements that absolutely must be documented in order to support the consultation service
- The consult requirements could be covered in one sentence – but you’d be amazed how often that sentence is missing
The Rule of 3 “R”s

- **Request** – Note the request for the consultation, physician, and condition
- **Render** – Provide the evaluation necessary to render your advice or opinion about the condition
- **Report** – Provide your written report to the requesting provider

This 87 year old female was evaluated at the request of Dr. Requesting due to her history of SVT and CVA in the setting of a recent GI Bleed.

Was evaluated for potential ______ at the request of Dr. ______

I was asked to see Ms. ______ by Dr. for assessment of her CHF

Entertaining To An Auditor?

Yes, My Favorites. But…….

- “Thank you for asking me to see Mrs. Patient… I have no idea what has happened to her either.”
- “I see you are now attempting to treat Mr. Patient… I’ve not had the pleasure for a few years, but thank you for providing me with an opportunity to remember how difficult he can be to manage.”
- “Welcome to the committee who attempts to take care of Mr. Patient. Congratulations, we have appointed you as his new traffic officer.”
- “I can see why you’ve asked us to see Mrs. Patient – she is certainly a challenge and I don’t believe I have anything new to offer you in the way of any suggestions that she might actually follow.”

Noridian – “Nonsensical”

- **Medical Review Documentation Findings**
  - NAS Part B MR has noticed that many patient records submitted for review contains nonsensical and/or incomplete documentation, suggesting that they have not been reviewed by the provider at the time of preparation or prior to submission upon the contractor’s request. Medical notes must be comprehensible and legible. The primary purpose of medical documentation is to ensure that the patient’s treatment is recorded for the continuity of appropriate treatment by the attending provider(s). It is also important for colleagues, consultants, and office staff as well as other third parties that the notes are written legibly or are typed. Nonsensical and/or incomplete documentation increases the potential of legal implications for a provider.
Noridian – “Nonsensical” Continued

- Credit for services rendered cannot be granted if the medical record is incomplete. Additionally, the use of some software programs produces office notes that are nonsensical. Below are some examples of office notes submitted for medical review containing incomplete and/or nonsensical documentation.
- 1. Excerpt from exam portion of E&M: “His liver alert and oriented x3 shows a deficit of cognitive function are thought physical psychosomatic eye pupils equal and rectal exams are normal her eczema with inflammation”.
- 2. Excerpt from HPI portion of E&M: “She states her back is doing much better she’s and Lipitor she has no hip or bone pain which has an infected tooth mesh for which she is on penicillin (Augmentin) as well as chlorhexidine mouth wash there thinking it may be due partially to the radio which she’s not had a shot for some time now”.

Modifier 24 – First Coast

- Documentation is required when billing modifier 24
- Based on three recent widespread probes of office evaluation and management (E/M) services, First Coast has discovered that the 24 modifier for E/M services, when billing within a global surgery period, has been billed incorrectly at least 60 percent of the time. Clinical review of documentation demonstrates that modifier 24 was either not supported for the encounter, or was improperly applied (i.e., a different modifier should have been submitted).
- To address this widespread improper billing, First Coast implemented a pre-payment edit on April 16, 2012, applicable to office visit E/M claims (codes 99201-99205 and 99212-99215) billed with the 24 modifier.
- Claims
- For claims containing modifier 24 received on or after April 16, First Coast began developing to the provider to provide supporting documentation that justifies the use of the 24 modifier. Providers must respond within the specified timeframe included in the development letter. Failure to submit the documentation timely may result in a claim denial.

WPS Examples – Would NOT Support A Split/Shared Service

- I have personally seen and examined the patient independently, reviewed the PA’s Hx, exam, and MDM and agree with the assessment and plan as written” signed by MD
- “Patient seen” signed by MD
- “Seen and examined” signed by MD
- “Seen and examined and agree with above (or agree with plan)” signed by MD
- “As above” signed by MD
- Documentation by the MLP stating “The patient was seen and examined by myself and Dr. X, who agrees with the plan” with co-sign of the note by Dr.
- No comment at all by the physician, or only a physician signature at the end of the note
You will find the 95 and 97 Guidelines on the CMS website at:

CMS bulletin regarding the use of Modifier 59:

General CMS website for physicians regarding manuals, HCPCS, ICD-9, ICD-10 etc.
https://www.cms.gov/Center/Provider-Type/Physician-Center.html

National Correct Coding Initiative:
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

Physician Fee Schedule and Place of Service Codes:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

Examples of Audit worksheets:
- Novitas Solutions E/M Audit Tool:
- First Coast:
- Highmark West Virginia