namas national alliance of medical auditing specialists

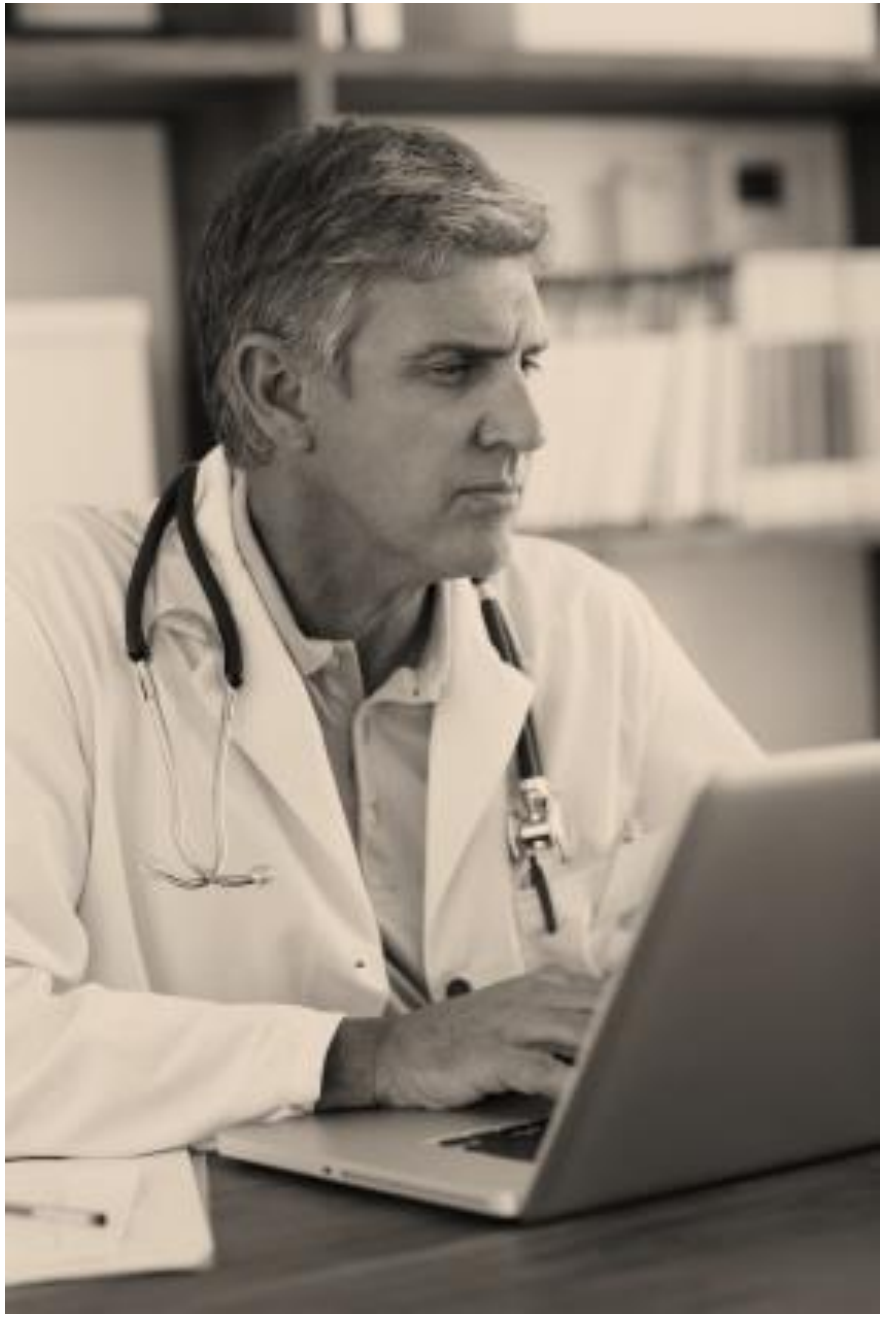
PERFORM REGULAR AUDITS
You provide routine maintenance for your car- but what about your documentation?

CODING vs AUDITING

Does it all boil down to Medical Necessity?

EDUCATE WISELY
Be sure and discern the difference between someone's opinion and the actual rules!

SHANNON O. DeCONDA
CPC, CPC-I, CPMA, CEMC, CMPM, CMSCS
PRESIDENT OF NAMAS
PARTNER IN DOCTORSMANAGEMENT



WE KNOW HOW TO HELP YOU

DOCUMENTATION PITFALLS

EMR costs so much money, and by your recent audit findings it appears your documentation is no better- how can that be?

MEDICAL NECESSITY

What are carriers looking for when it comes to medical necessity, and what concerns should you have over who is reviewing it?

COMPLEXITY OF CARE IN YOUR DOCUMENTATION

Small changes that can make a HUGE difference in your average everyday office notes

CONSIDER THESE NEXT…

Making changes to other areas of your documentation and billing practices may be necessary too. We will consider these topics and potential concerns

Defensive Coding Skills

What exposed risk does your documentation have?

Malpractice, misconduct, negligence, AND fraud & abuse

What is the risk?	$73.00 per encounter
At 32 PPD:	$2,336.00 per day
Risk?	Put all others aside and access fraud & abuse

False Claims Act

Triple the claim amount
Penalties up to $11,000 per claim
$25,000 penalty
5 years in jail

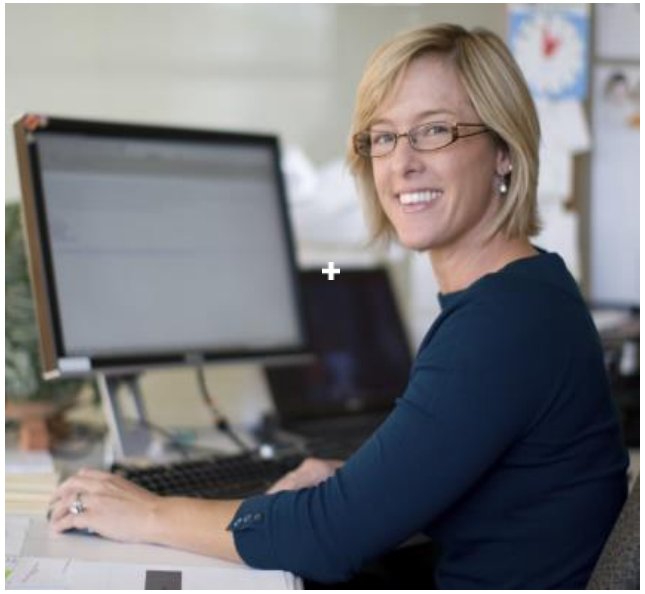
FCA Liability?	$40,258.00 (plus potential jail)

Why is Defensive Coding Needed?

three variations of the documentation

THE PHYSICIAN
work involved

Value is emphasized in the “work” involved with the patient encounter



THE CODER
documentation content

Value is emphasized on documentation content alone

THE AUDITOR
complexity of care documented

Assessment of the work and the documentation combined

Complications with
medical necessity arrive when providers insist that it should be “assumed” that a test “should have been ordered”

Auditors are NOT
allowed to assume or interpret.

Provider of care
Is tasked with connecting the dots between the documentation requirements and complexity of care to meet the medical necessity

Medicare even
says the provider should “paint a portrait” of the patient through their documentation

DOES
THIS MAKE SENSE?

Well with the forced adaptation of EMR, it is reasonable

Yes, it stinks that CMS has FORCED providers to use EMR, and now that providers can actually meet all of the documentation bullets …. They try to change the focus of the documentation…. OR DID THEY?

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

May 26, 2003

Table of Contents

30.6.1 - Selection of Level of Evaluation and Management Service

(Rev.)

Physicians must select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for noninpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection A below.

The physician must have provided all the services necessary to meet the CPT description of the level of service billed. A claim for a service must reflect the service actually performed. A physician may submit a claim for CPT code 99499, "Unlisted evaluation and management service", with a detailed report stating why the visit was medically necessary and describing what service(s) was performed. The carrier has the discretion in valuing the service when the service does not meet the terms of the CPT description (e.g., only a history is performed). CPT modifier -52 (reduced services) must not be used with an evaluation and management service. Medicare does not recognize modifier -52 for this purpose.

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents
(Rev. 3476, 03-11-16)

30.6.1 - Selection of Level of Evaluation and Management Service
(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

A. Use of CPT Codes

Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

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

CONSIDERING MEDICAL NECESSITY

DOCUMENTATION GUIDELINES

Unfortunately, they are 20 years old and medical necessity was not as pertinent 20 years ago

CODING/BILLING TRAINING

As we have discussed, no guidelines address medical necessity, therefore most trainings do not address this topic as well

CMS DOCUMENTATION GUIDELINES

Does not address medical necessity because essentially it is 1995 and 1997 regurgitated

MEDICAL AUDITING

Medical necessity became the backbone of E&M code selection with the on slot of EMR in the industry

AMA CPT GUIDANCE

Focus is on the key components, NOT on medical necessity

NON-CLINICIAN REVIEW

Carriers do not commonly use peer-to-peer review! Documentation is more commonly reviewed by a non-clinician- NOT specialty trained

EMR & MEDICAL NECESSITY

What is the TRUE purpose of an EMR?

- Commercialization
- Will we ever get there?

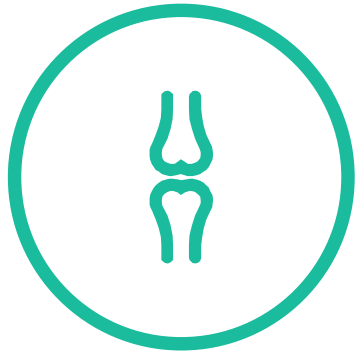
Purpose

Who designed the EMR?

Think back to selecting your EMR–

- Selling points
- What sold you
- What regrets do you have?

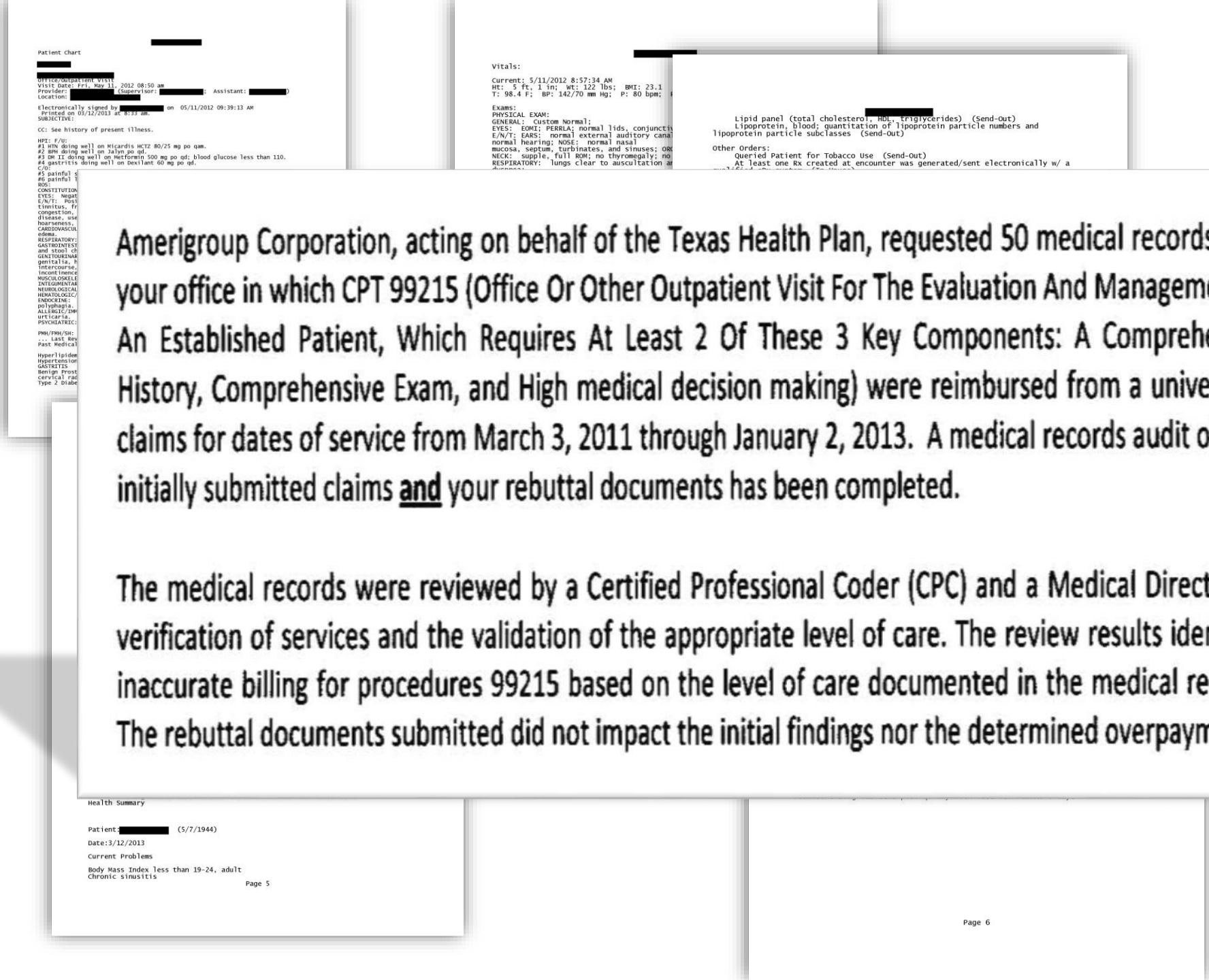
Design



Internal design and template formation:

- Who designed your templates?
- Did you have an auditor review them?
- Any coding evaluation at all?

Keyword



Amerigroup Corporation, acting on behalf of the Texas Health Plan, requested 50 medical records from your office in which CPT 99215 (Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient, Which Requires At Least 2 Of These 3 Key Components: A Comprehensive History, Comprehensive Exam, and High medical decision making) were reimbursed from a universe of claims for dates of service from March 3, 2011 through January 2, 2013. A medical records audit of your initially submitted claims **and** your rebuttal documents has been completed.

The medical records were reviewed by a Certified Professional Coder (CPC) and a Medical Director for verification of services and the validation of the appropriate level of care. The review results identified inaccurate billing for procedures 99215 based on the level of care documented in the medical records. The rebuttal documents submitted did not impact the initial findings nor the determined overpayment.

Non-Clinician Review

WHY?

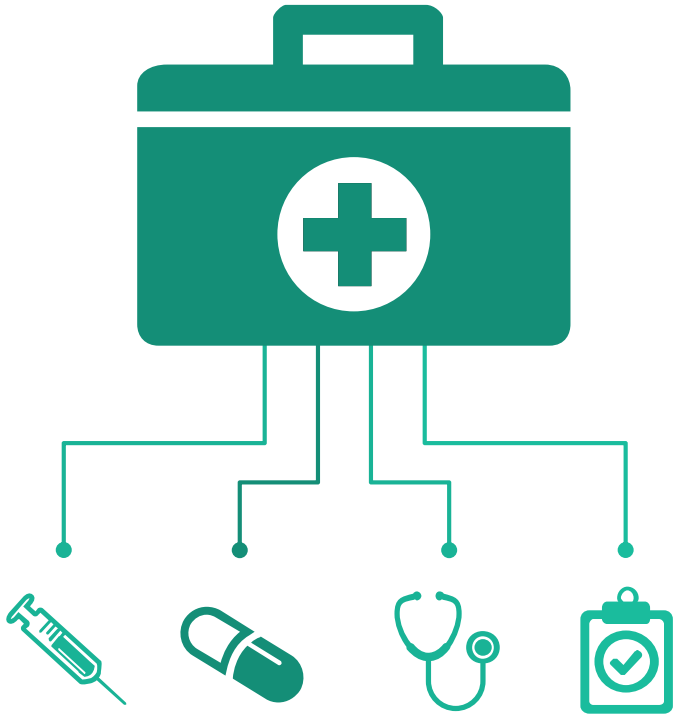
WHAT IS

MEDICAL NECESSITY?

Complexity of Care

NOT based on medical care

Medical Necessity Defined Outpatient/Clinic



HOW DOES CMS DEFINE MEDICAL NECESSITY?

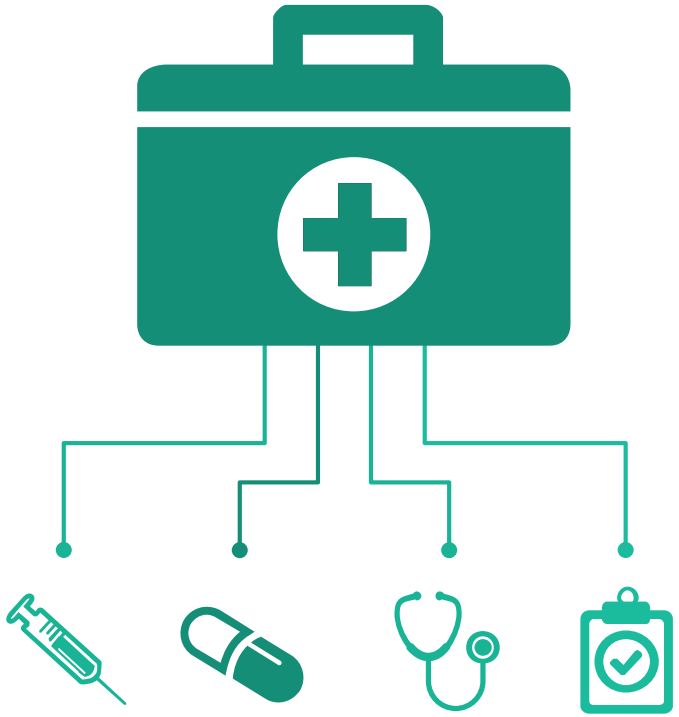
NOVITAS MEDICARE:
Medical necessity cannot be quantified using a points system. Determining the medically necessary level of service (LOS) involves many factors and is not the same from patient to patient and day to day. Medical necessity is determined through a culmination of vital factors, including, but not limited to: Clinical judgment, Standards of practice, Why the patient needs to be seen (chief complaint), Any acute exacerbations/onsets of medical conditions or injuries, The stability/acuity of the patient, Multiple medical co-morbidities, And the management of the patient for that specific DOS.

STILL THERE IS NO “YARD STICK” METHOD

99202 99212	99203 99213	99204 99214	99205 99215
DISCHARGE	CHRONIC STABLE OR ACUTE UNCOMPLICATED	CHRONIC EXACERBATED OR ACUTE COMPLICATED	CHRONIC SEVERLY EXACERBATED OR THREAT TO LIFE OR BODILY FUNCTION

THIS IS THE STATUS OF THE PATIENT TODAY…
DURING TODAY’S ENCOUNTER!

Medical Necessity Defined Inpatient



HOW DOES CMS DEFINE MEDICAL NECESSITY?

Inpatient services follow the same idea when it comes to accessing the complexity of care of the patient.

REMEMBER we cannot evaluate what you did in the room…. We weren't there!

The review of the complexity is all based on what you documented in the notes of the patient encounter

99231
99221

Stable state

99232
99222

Minor tweaking is required to help get the patient to a stable state

99233
99223

Major tweaking to try and get the patient to a manageable condition

THIS IS THE STATUS OF THE PATIENT TODAY… DURING TODAY'S ENCOUNTER!

CODING vs. AUDITING

How can it be that coding and auditing both evaluate the code choice and the documentation and they are so similar- yet the findings can be far from the same?

TRAINING

MARK THE BOX TEACHING

ON-THE-JOB-TRAINING

TRYING TO MAKE SENSE OF “PROPER CODING”

LET'S PUT THIS IDEA TO THE TEST

Let's identify each area of the E&M Encounter…

and identify the difference in opinion and variation between auditor and coder given the relevance of medical necessity.

Consider The Documentation

KEEP IN MIND

auditing of the medical record, unless clearly identified is NOT for the purposes of critiquing your medical care or medical reasoning of services. It's all centered around meeting the guidelines, and defining the complexity of care of the encounter.

TYPES OF DOCUMENTATION

Dictation, Handwritten, Templates, and EMR

COPY-PASTING TECHNIQUES

I said it before, why do I need to say it again?

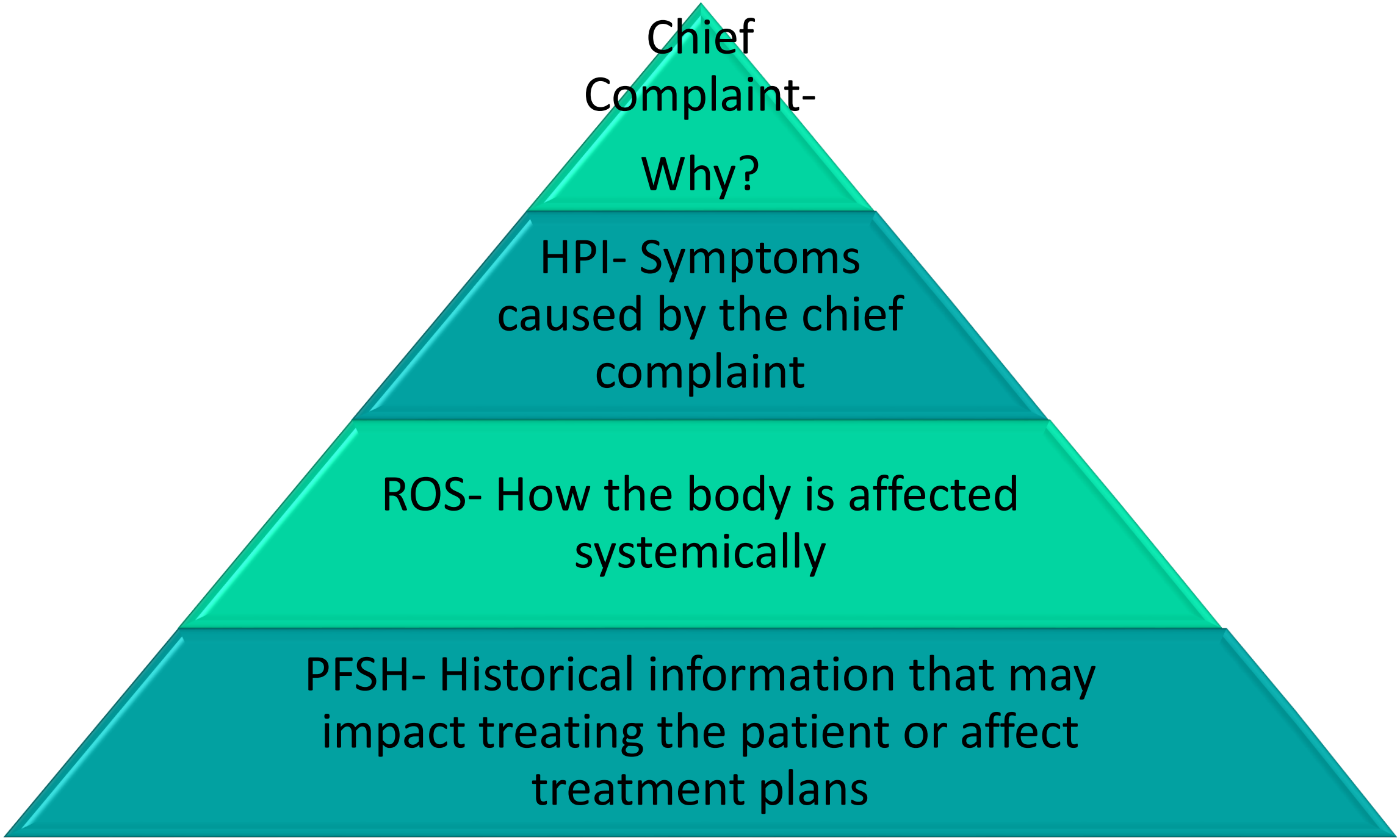
OVER-DOCUMENTING THE ENCOUNTER

There is NOTHING wrong with it, but it certainly detracts from the complexity of care

MAKING IT ALL RELEVANT

Remember S-O-A-P notes?
Find the "A" in your documentation

LET'S WORK THROUGH E&M REQUIREMENTS TO SHOW HOW THIS WORKS


Chief Complaint-
Why?
HPI- Symptoms caused by the chief complaint
ROS- How the body is affected systemically
PFSH- Historical information that may impact treating the patient or affect treatment plans

1995/1997 DOCUMENTATION GUIDELINES
CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

!DG: The medical record should clearly reflect the chief complaint.

WHAT IS THE CHIEF COMPLAINT?
The reason you entered the room to visit with the patient on that given date of service

DOCUMENTATION OF THE CHIEF COMPLAINT
In the patient's own words- do NOT diagnosis in the CC

AFFECTS OF THE CHIEF COMPLAINT
Sets the "tone" of complexity for the encounter. It is NOT a "scored" portion of the documentation

VALID CHIEF COMPLAINT
Follow-up is technically a valid chief complaint, but does it best tell the complexity of the encounter?

MISSING CHIEF COMPLAINT
Documentation guidelines indicate that the chief complaint "should" be documented on each encounter. Why wouldn't you include it?

CONSIDER YOUR INPATIENT ENCOUNTERS
Even if you see the patient inpatient everyday for 30 days, you need a chief complaint

Defining the Difference of Opinion

WHAT DO YOU SEE AS THE CHIEF COMPLAINT?

Patient returns today for 6 month follow up. The patient is doing well with her diabetes and reports no sugar spikes lasting greater than 1 hour since her last visit.

PHYSICIAN'S INTERPRETATION
6 month follow up

CODER'S INTERPRETATION
No valid chief complaint documented

AUDITORS'S INTERPRETATION
Diabetes

History of Present Illness (HPI)

What is HPI?

HPI should expand the chief complaint by telling the symptoms the patient is having due to their chief complaint.

The history should be working to tell the severity of the patient according to the patient.

TWO FORMS OF DOCUMENTATION

HPI ELEMENTS

Document problem specific elements about the condition. These should be POSITIVE problems the patient is experiencing. Negative problems are review of systems. Maximum 4 elements

3 CHRONIC OR INACTIVE

You must be managing the chronic/inactive problem and you must tell the problem AND give a status update.

QUALITY

Descriptive terms regarding the presenting cough OR improving/stable/ worsening

MODIFYING FACTOR

Anything the patient has tried to make their problem better or what makes it worse

CONTEXT

What the patient was doing when the problem began

TIMING

When the problem affects the patient the most

SEVERITY

How severe is the patient's problem and/or the pain scale

ASSOCIATED S&S

Other problems the patient is having because of the chief complaint

DURATION

How long has the patient had the problem

LOCATION

Site of the patient's chief complaint. Cannot be implied

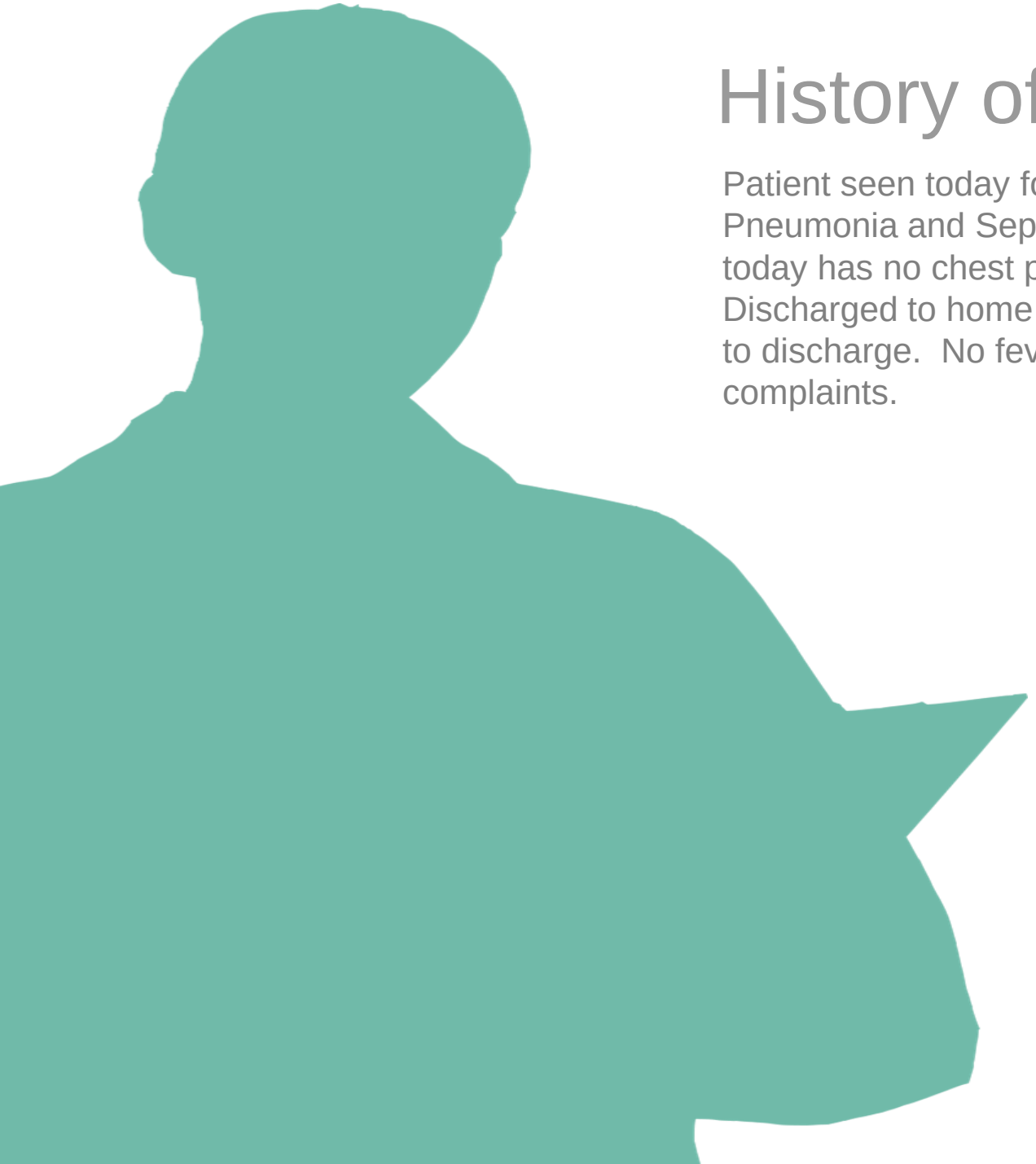
History of Present Illness (HPI)

Patient seen today for hospital stay follow up. She was admitted for 7 days for Pneumonia and Sepsis. She was Discharged to home with no further complications as the problem resolved prior to discharge. No fever to report.

PHYSICIAN'S INTERPRETATION
Complete HPI, gives me all the information I need to treat the patient

CODER'S INTERPRETATION
Complete HPI (Location-Lungs, Duration-7 days, Quality-No further problems, S&S-No fever)

AUDITOR'S INTERPRETATION
No qualifying HPI, and due to lack of defining presenting problem- it becomes harder to abstract any details



History of Present Illness (HPI)

Patient seen today for hospital stay follow up. She was admitted for 7 days for Pneumonia and Sepsis. She has been battling pneumonia now for 10 days, and today has no chest pain. She says she is improving overall. She was Discharged to home with no further complications as the problem resolved prior to discharge. No fever to report. She is still taking her antibiotics with no complaints.

CHANGES MADE NOW HELP TO MEET 4 HPI

LOCATION: CHEST
QUALITY: IMPROVING
DURATION: 10 DAYS
M. FACTOR: ANTIBIOTIC

COMPLETE HPI DOCUMENTED

COMPLEXITY OF CARE

what is the complexity of care according to the documentation?

Carrier	GUIDANCE REGARDING WHO MAY DOCUMENT THE HISTORY OF PRESENT ILLNESS (HPI)
Cahaba	It is expected that the HPI will be performed by the provider billing the service, and not by ancillary personnel
WPS	WPS Medicare will allow the CC when recorded by ancillary staff. However, the physician must validate the CC in the documentation. The 1995 and the 1997 Documentation guidelines indicate ancillary staff may obtain the ROS and PFSH but they do not indicate the ancillary staff can obtain the History of Present illness.
First Coast Services	No additional guidance other than pointing to 1995 and 1997 Guidelines allowing ancillary staff to record the ROS and PFSH
Noridian	Although ancillary staff may question the patient regarding the CC, that does not meet criteria for documentation of the HPI. The information gathered by ancillary staff (i.e. Registered Nurse, Licensed Practical Nurse, Medical Assistant) may be used as preliminary information but needs to be confirmed and completed by the physician. The ancillary staff may write down the HPI as the physician dictates and performs it. The physician shall review the information as documented, recorded or scribed and writes a notation that he/she reviewed it for accuracy, did perform it, adding to it if necessary and signing his/her name. Reviewing information obtained by ancillary staff and writing a declarative sentence does not suffice for the history of present illness (HPI). An example of unacceptable HPI documentation would be “I have reviewed the HPI and agree with above.”
Novitas	Novitas only refers to the allowance of the ancillary staff to record the ROS and PFSH of an encounter as noted in 1995 and 1997 Documentation Guidelines
Palmetto	Only the physician or NPP that is conduction the E/M service can perform the history of present illness (HPI). In certain instances, an office or emergency room triage nurse may document pertinent information regarding the chief complaint (CC)/HPI, but this information should be treated as preliminary information. The physician providing this E/M service must consider this information preliminary and needs to document that he or she explored the HPI in more detail.
NGS	The provider is responsible for eliciting and documenting the History of the Present Illness (HPI), since this requires defined clinical skill. That said, the provider may utilize the services of a Scribe in documenting the HPI, as with any other element of an E/M service.
CGS	No information other than references made to 1995 and 1997 documentation Guidelines regarding the ROS & PFSH

Review of Systems (ROS)

Laundry List

No rules to exclude the information

All Others Negative

Most affective form of documenting the ROS

Required Number

Only 99204 99205 and 99215 require a complete ROS

Pertinent to CC

Makes the BEST complexity of care, BUT not required

Define through the ROS how the patient's entire body is being affected by their presenting problem

Review of Systems (ROS)

While there are varying opinions, these do not breakdown into abstracting the findings, but rather applying the true rules.

PHYSICIAN'S INTERPRETATION
"The patient is doing well with no complaints at this time.

CODER'S INTERPRETATION
I cannot count a ROS that is not pertinent to the CC
There was no need for the provider to do that ROS

AUDITOR'S INTERPRETATION
Auditors will allow credit for documented ROS because in the end complexity of care will decide the LOS

MAKING THE PFSH COUNT

Again, there is no rule that states that all 3 areas of the PFSH MUST be relevant to the presenting problem. Only in instances with only one element.

PAST MEDICAL HISTORY

While negative diabetes is relevant to patient care in any specialty, chose something that you as the medical provider consider about their past that could impact this problem by making it more complex and then include negative of positive

FAMILY HISTORY

A review of medical events, diseases of the patient's family. Again, make this as relevant as possible.

SOCIAL HISTORY

Age appropriate review of past and current activities. While smoking and drinking may be applicable, consider other events that may be more applicable to showing the complexity of the patient's problem.

Objective Exam

INFORMATION

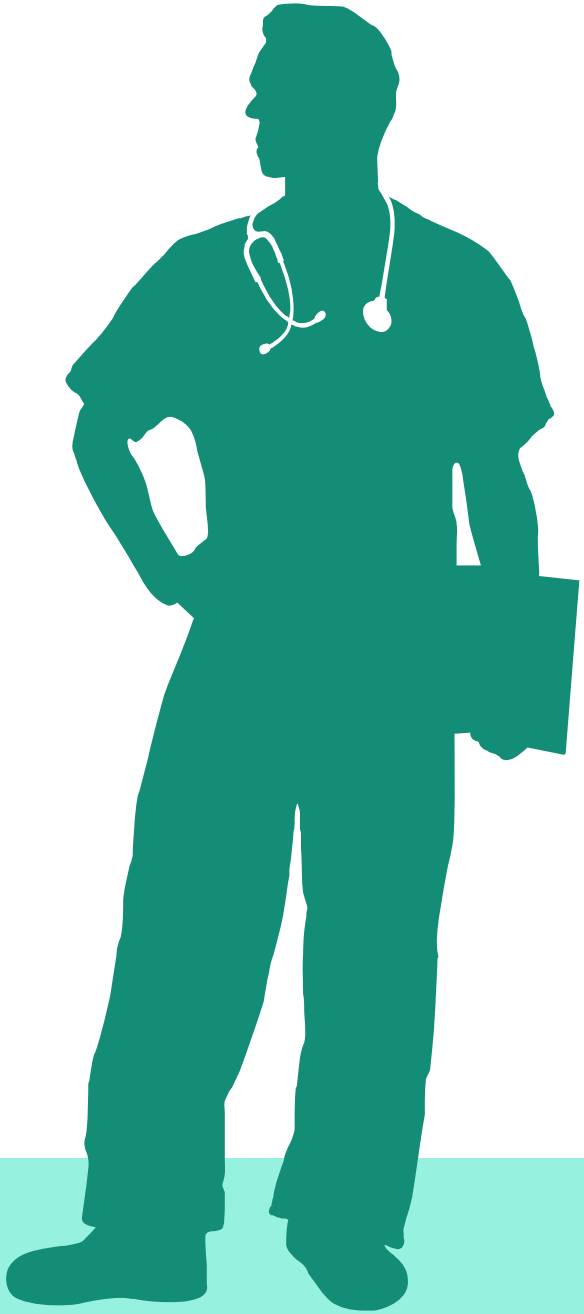
The documentation and the point of the objective session the provider has with the patient.

- **What is needed?**
- **What is not needed?**
- **How could the exam documentation been more appropriate?**

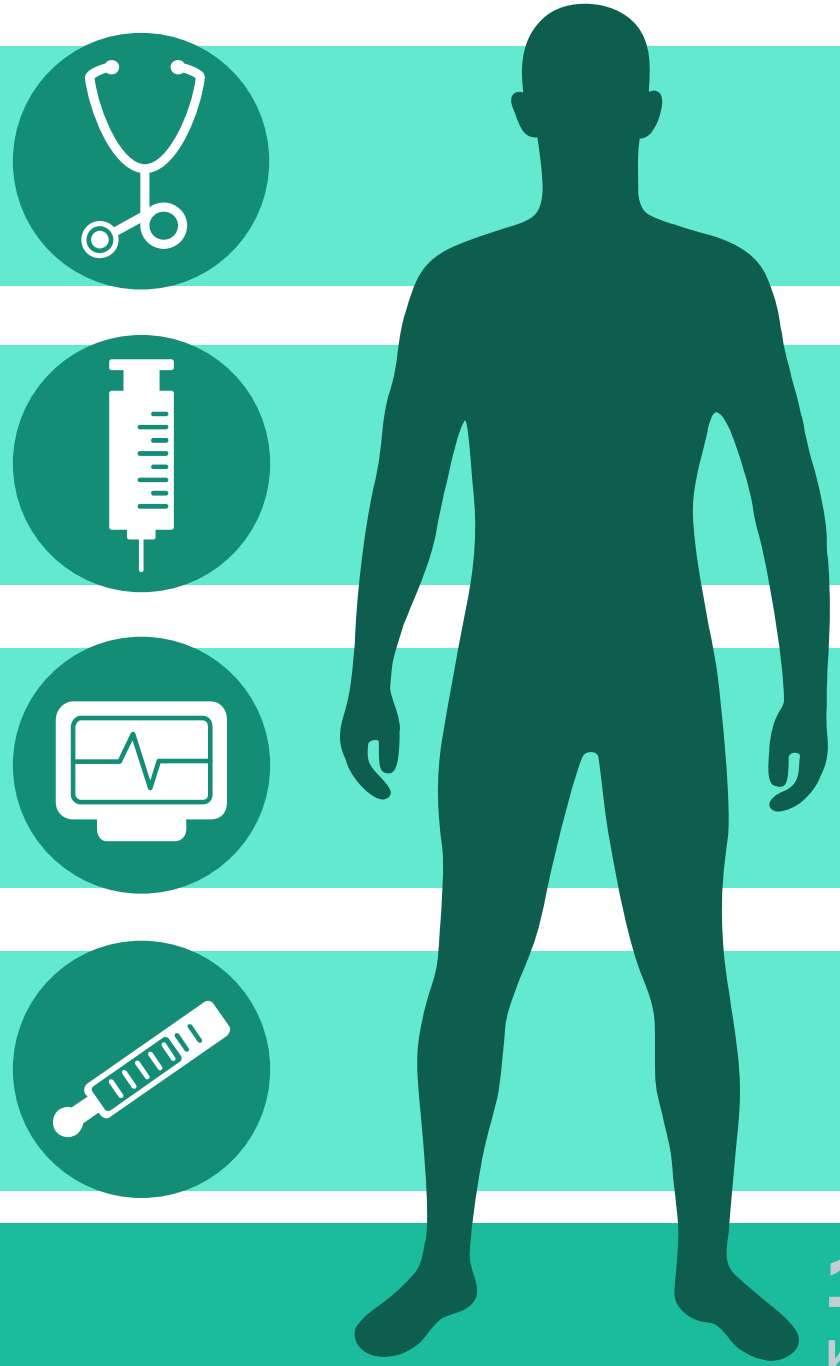
What is your most commonly billed E&M Office visit?

- **99213: 2 organ systems**
- **99214: 2 organ systems with affected one in detail**

8 organ systems is only needed when billing a 99204 99205 or 99215



EXAM FINDINGS



Organ Systems vs. Body Area

Body areas are ONLY counted when they are the source of the chief complaint

Fit the body area into the organ system

Documentation Requirements for 1995 Exam

Negative/Normal is sufficient

Specific negatives are not required, only specific positives

Diagnostic Findings

If a scope is performed during the exam process (scope is separately reimbursed) findings may NOT be used

Document other portions of the exam you performed

Accounting Organ Systems Properly

To create awareness- not all coders and auditors are proficient at assigning body areas to organ systems

1995 Exam Documentation

Knowing the ins and the outs

The Confusion of the 1995 Exam

Knowing the confusion may help your documentation

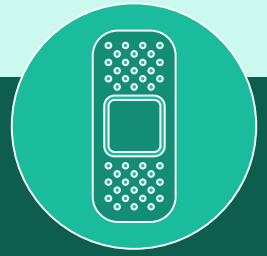
Constitutional

Double documentation by many providers:

General statement of the patient's well being

OR

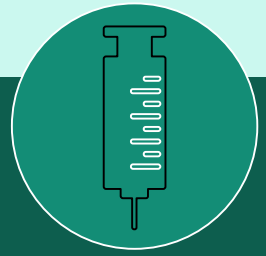
3 Vital signs
- BP
- Weight
- Temp
- Pulse
- RR



Extremities

Organ systems that *could be* part of this exam:
Cardiovascular
Muscular
Neurologic
Integumentary

Consider adding some clarity to your documentation to better point to the organ system involved



Combinations

While you as a provider mean one thing with the abbreviations and exam findings, what does the documentation clearly address?

HEENT: Normal
HEENT: Runny nose

HEENT:
- Eyes
- ENT
- Head: does it matter?

Abdomen

Does the documentation more demonstrate an exam of the body area or the GI system?

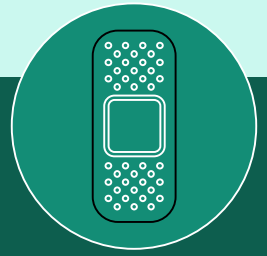
Soft non-tender
No HSM
Bowel Sounds
Extended
Gassy

The Confusion of the 1995 Exam

Knowing the confusion may help your documentation

Neuro

Technically according to documentation guidelines a neuro exam could even quantify as alert and oriented, but also may be more extensive to include specific nerve findings



Psych

Affect and well-being of the patient as well as more specific mental health information based on the patient complaint

Some confusion suggests among auditors/coders not wanting to counting 2 organ systems for alert/oriented (neuro) & NAD

Neck

Very tricky as this body area may include several organ systems, but must have the specificity to support.

Bruits
Musculoskeletal
Lymphatics

But it could also include integumentary although not a common finding

Overall Take Away

Document organ systems

No need to document all of the negatives findings

Objective findings from that given date of service- NO carry over and no referring to a previous exam

Cardiovascular Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	• Inspection of conjunctivae and lids (eg, xanthelasma)
Ears, Nose, Mouth and Throat	• Inspection of teeth, gums and palate • Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	• Examination of jugular veins (eg, distension; a, v or cannon a waves) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Palpation of heart (eg, location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) • Auscultation of heart including sounds, abnormal sounds and murmurs • Measurement of blood pressure in two or more extremities when indicated (eg, aortic dissection, coarctation) Examination of: • Carotid arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay) • Abdominal aorta (eg, size, bruits) • Femoral arteries (eg, pulse amplitude, bruits) • Pedal pulses (eg, pulse amplitude) • Extremities for peripheral edema and/or varicosities
Chest (Breasts)	
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
Genitourinary (Abdomen)	
Lymphatic	
Musculoskeletal	• Examination of the back with notation of kyphosis or scoliosis • Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, stasis dermatitis, ulcers, scars, xanthomas)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person, • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

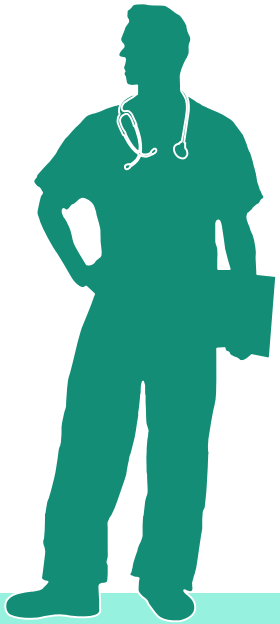
Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Specialty Specific

Organ specific exam with relevant findings

Other Systems

Other organ systems examined should be documented and will help add to complexity



Exam Findings

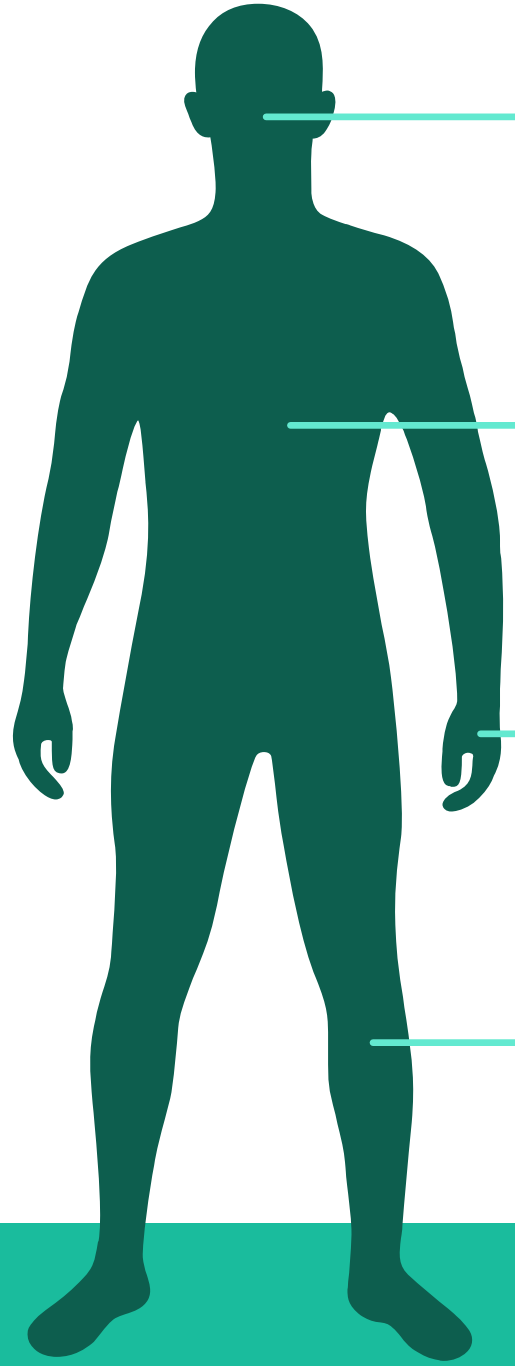
Be specific
In contrary to 1995, you must be specific as to what the specific exam findings are

Extent of Exam

It's more about how much of each exam and related organ systems to the chief complaint you performed and documented

Content and Documentation Requirements

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



Musculoskeletal

Constitutional, cardio, lymphatics, musculoskeletal, skin, neuro, and psych

Neurologic

Constitutional, Eyes, Muscle, Neuro

Respiratory

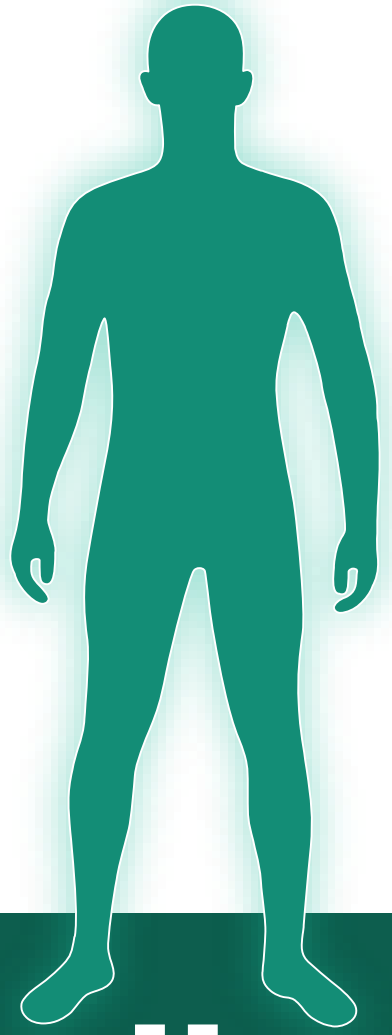
Constitutional, ENT, Respiratory, Neck, Cardiology, Gastro, other systems may be contributory but not “pertinent”

Integumentary

Constitutional, ENT, Skin, other systems may be contributory but not “pertinent:

1997 Documentation Specifications

Examples of what is counted on specific exams



Medical Decision Making

Number of Diagnosis

Myths and misconceptions regarding the number of diagnoses documented and

Number of Diagnosis

- ✓ Only those made relevant in the documentation
- ✓ Confusion surrounds regarding if the problem is new to the patient or the provider
- ✓ Confusion surrounding if the new problem requires additional workup or not.

Dat…er

Maki… docu… are can t… get all the credit you deserve

…evaluated to ensure your documentation is representative of the work and "risk" of the encounter

3 ELEMENTS IN THE MDM

Lab testing that was ordered and/or reviewed

Radiology services ordered and/or reviewed

Medical testing ordered and/or reviewed

Discussion of results with another provider

Decision to obtain records or obtain history from someone other than patient.

Review AND summarization of old records OR discussion with another healthcare provider

Independent Visualization of image or tracing

Review AND Summarization

Add Total of Data

If properly documented all areas will be combined to give a total point value in this area of documentation

Data & Complexity of Review

How much work did you do— no did you document you did?

Myths & Misconceptions

PRESCRIPTION DRUGS

Prescription drug management does NOT automatically qualify a note for a level 4 encounter

DRUGS FOR TOXICITY

This allow will NOT qualify for high complexity services

RISK FACTORS

Risk factors for surgery, such as comorbidities may not be considered risk, unless you define

DIAGNOSIS CREDIT

Only credit is given to what was actually relevant to the patient encounter according to the documentation

OTC MEDICATIONS VS RX

Define the difference to avoid being erroneously down-coded

MUTLIPLE PROBLEMS

While greater than one chronic problem can raise the level of service, this does NOT hold true for acute problems.

IT’S ALL UP
TO THE PROVIDER!

We know they did the work, but does the documentation show the same complexity of what you actually did in the room?

Other Considerations

What Is The Provider Managing?

- ✓ We can only count what is made relevant
- ✓ Especially relevant in the inpatient setting
- ✓ If the provider is managing a problem that is related to another specialty, it should be addressed thoroughly enough to identify this

WHAT IS BEING MANAGED

Confusion of carry forwards make it hard to tell who is responsible for what– create your relevance!

Complexity of Care in Other Areas

NOT JUST IN THE CLINIC!

The complexity of care does not just pertain to treating patients in the clinic, nor does it just pertain to E&M. All services must have medical necessity in order to perform and bill them to the carrier, and this includes the following:

INPATIENT SETTING
Scale of complexity does exist in the IP.

CRITICAL CARE
CC is NOT following a patient that has organ failure alone

CONSULT SERVICES
Why were you (as a specialist) called in to see this patient at this time?

PREVENTIVE CARE
Vaccinations, testing, and referrals that are generated

Other Considerations

Preventive with Sick Encounter

- ✓ Absolutely acceptable
- ✓ Use 25 modifier
- ✓ Must be for more than a minimal complaint- example- diaper rash is not suitable unless RX given and complexity shown

PREVENTIVE WITH SICK VISIT

It is allowed, but documentation is CRITICAL!

Other Considerations

TIME BASED BILLING

Meeting the MDM and time of the same level of service?

Time Based Visits

- ✓ Allowed and works best for encounters in which lab or testing results are discussed.
- ✓ Little known fact- Program Integrity Manual states… MDM must demonstrate the same level as the time
- ✓ Therefore, you MUST define complexity in your documentation

CMS CLAIMS PROCESSING MANUAL 30.6.1 c

C - Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling

Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

EXAMPLE

A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

Incident-To Services

ANCILLARY STAFF

Anyone in your office that you feel comfortable performing the service being delivered

NPP PROVIDERS

Nurse Practitioner, Physician Assistant, Clinical Social Worker, Clinical Nurse Midwife

WHAT IS IT? WHY USE IT?

Billing someone under a supervising physicians information to Medicare

- Ancillary staff
- Non-physician providers: Nurse practitioner, Physicians Assistants

Reimbursement varies: NPP billing under physician 100% fee schedule and billing under their own billing information is 85%

Modifier 25

NO

Decision to perform the procedure alone is the reason for billing the E&M encounter.

NO

There is NO additional reimbursement as Medicare considers this as part of the overall reimbursement

NO

Patient is a new patient- this criteria alone is NOT enough

YES

2 SEPARATE PROBLEMS

Patient is treated for more than 1 problem and you have adequately addressed both throughout your encounter

YES

EXTENSIVE WORKUP

Over and above- use your “A” to explain why, or it may NOT be covered

YES

PAYOR CONSIDERATIONS

Medicare rules, but most commercial carriers follow Medicare guidance

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