

Tips for Effective Documentation Compliance

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Webinars

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About the Speaker

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About the Speaker



Sonal has served as a multi-specialty healthcare coding, auditing, and compliance professional in the industry for over 13 years. She began her second career as a medical biller and continued to advance into a renowned cancer hospital's patient business services' department armed with her CMC®, CPC®, and CPMA® credentials. She has had the honor of directly working with and supporting healthcare attorneys in defense of their clients' myriad of reimbursement issues for almost six years.

Sonal has utilized her creative strengths while working in the business side of healthcare. She serves as the creator and host of her Paint The Medical Picture Podcast series which is currently in its third year. She has provided rich, thought-leadership content on LinkedIn since 2012. Sonal is also a published author in numerous industry publications, including the Health Care Compliance Association's (HCCA®), 2021 edition of the Complete Healthcare Compliance Manual. She finds herself often collaborating with her colleagues and trusted

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About the Speaker



resources on podcasts, white papers, and so much more. Sonal provides young coders, newly certified coders, or those thinking of entering the niche world of medical coding with advice and encouragement.

Sonal proudly holds certifications as a Certified Professional Coder (CPC®) and Certified Professional Medical Auditor (CPMA®) from the AAPC®, the world's largest credentialing body for the business of medicine. She is also proudly certified from the Practice Management Institute® (PMI®) as a Certified Medical Coder (CMC®). She is highly proficient in ICD-10-CM and stands ready to master ICD-11-CM when it becomes a reality in the United States.

Sonal is an active member with the AAPC®, the American Medical Billing Association (AMBA®), HCCA®, the National Alliance of Medical Auditing Specialists (NAMAS®), and PMI®.

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Agenda

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Agenda



- Documentation challenges in MDM – history and physical exam
- Documentation challenges in MDM – problems addressed
- Documentation challenges in MDM – data analyzed
- Documentation challenges in MDM – risk to patient management
- Documentation challenges – time
- Avoid risk with effective documentation compliance
- Final Thoughts

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MDM – History & Exam

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MDM – History & Exam

History

- Clinically **relevant** history for the patient encounter
- Documentation **must** contain history in order to report 99202-99215

Exam

- **Medically appropriate** physical examination for the patient encounter
- Eliminate outdated EMR templates and formatting from 1995 and 1997 guidelines for general multi-system and single organ system physical exams
- Documentation **must** contain an exam in order to report 99202-99215

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MDM – History & Exam

History

- Disconnect early in 2021 for simply not including it based on misunderstanding
- Patients Over Paperwork Initiative in 2020 was meant to alleviate administrative burden, and the why behind the 2021 overhaul
- Internal audits reflect this
- Simply a removal of history and exam as 2 of 3 key components used to select E/M in CPT® code definition, **not the removal of history completely!**
- Post-payment audits have started for 2021

Exam

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MDM – Problems Addressed

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MDM – Problems Addressed



Straightforward

- 1 self-limited or minor problem.
 - Example: Cough
 - Example: Dermatitis

Low

- 2 or more self-limited or minor problems
 - Example: Cough and low fever
 - Example: Seborrheic dermatitis (scalp) and atopic dermatitis (eczema)
- 1 stable chronic illness
 - Example: Well-controlled hypertension
 - Example: Well-controlled diabetes
- 1 acute, uncomplicated illness or injury
 - Example: Simple wrist sprain
 - Example: Allergic rhinitis
- 1 stable, acute illness
 - Example: Improving wrist sprain
 - Example: Improving allergic rhinitis
- 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
 - Example: Acute dehydration requiring IV fluids to rehydrate

NOTE: These are examples only. Examples may fit into more than one category.

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MDM – Problems Addressed

Moderate

- 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment
 - Example: Osteoarthritis with pain
 - Example: Hypertension with continued elevated blood pressure
- 2 or more stable chronic illnesses
 - Example: Well-controlled osteoarthritis
 - Example: Well-controlled hypertension
- 1 undiagnosed new problem with uncertain prognosis
 - Example: Suspicious skin lesion
 - Example: Breast lump
- 1 acute illness with systemic symptoms
 - Example: Colitis
 - Example: Pyelonephritis
- 1 acute, complicated injury
 - Example: Head injury with brief loss of consciousness

NOTE: These are examples only. Examples may fit into more than one category.

High

- 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
 - Example: Asthma in status asthmaticus
 - Example: Hypertensive crisis
- 1 acute or chronic illness or injury that poses a threat to life or bodily function
 - Example: Acute myocardial infarction
 - Example: Psychiatric illness with potential threat to others or self

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MDM – Data Analyzed

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MDM – Data Analyzed

Tests, Images, and Documents
Category 1 – Must meet 2 out of 3 for Low MDM

- 1. Review of prior **external note(s)** from each **unique** source:
 - All hospital notes from 1 stay are counted 1x (each note cannot be counted separately)
 - Documentation should clearly state the notes are from an **external source** (i.e., ACME ACS, ACME Hospital, Dr. ACME)
- 2. Review of the result(s) of each **unique** test:
 - If practice ordered the labs, cannot count again for reviewing
 - Documentation should clearly state number of tests and types (i.e., eliminate vague “labs reviewed”)

Tests, Images, and Documents
Category 1 – Must meet 2 out of 3 for Low MDM

- 3. Ordering of each unique test:
 - Documentation should clearly state number of tests and types (i.e., eliminate vague “labs ordered”)
 - Includes tests considered but not executed
 - Pulse oximetry is **not** considered a test for purposes of data ordered, nor is considered a test for purposes of data reviewed/analyzed

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MDM – Data Analyzed

Assessment Requiring Independent Historian

- Independent historian can be parent, guardian, surrogate, spouse, witness
 - Patient has to be unable to provide a complete or reliable history (e.g., pediatric patient and elderly patient with Parkinson’s)
 - The independent history does not need to be taken in person but DOES need to be obtained directly from the historian providing the independent information
 - Documentation should clearly state: “History provided by mother...”;
 - Or “Father provided confirmation of...”;
 - Or “Due to patient’s dementia, the daughter provided a complete history...”
 - Translators providing translation services are not counted as independent historians

Assessment Requiring Independent Historian

- Can meet Low MDM as Category 2 alone
- Can meet Moderate MDM with any combination of 3 elements in Category 1
- Can meet High MDM, but only if 2 out of 3 Categories are met

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MDM – Data Analyzed

Independent Interpretation of Tests

- Used when there is a CPT code for a test where an interpretation or report is customary.
- A form of interpretation should be documented but does not have to conform to the usual standards of a complete report.
- This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient.
- "A test that is ordered and independently interpreted may count as both a test ordered and interpreted" – March 2023 AMA CPT® Errata and Technical Corrections

Independent Interpretation of Tests

- Can meet Moderate MDM as Category 2 alone
- Can meet High MDM as Category 2 alone, in addition to if 2 out of 3 Categories are met

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MDM – Data Analyzed

Discussion of management or test interpretation

- Discussion with **another** physician or QHP or appropriate source
- Discussion requires an **interactive** exchange
 - Exchange must be direct (not through clinical staff, trainees, etc.)
 - Just sending chart notes or written exchanges in the progress note does not meet criteria for discussion
 - Does not have to be on the date of the encounter
 - Can only be counted once and only when it is used in the decision-making process for the encounter
 - Does not need to be in person
 - Must be initiated and completed in a short period of time (within a day or two)

Discussion of management or test interpretation

- Can meet Moderate MDM as Category 3 alone
- Can meet High MDM as Category 3 alone, in addition to if 2 out of 3 Categories are met

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MDM – Risk to Patient Management

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MDM – Risk to Patient Management



- One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.
- Risk - The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

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MDM – Risk to Patient Management



- Effective documentation includes decisions made at the encounter associated with diagnostic procedure(s) and treatment(s).
- Effective documentation includes possible management options selected and those considered but not selected after shared decision making with the patient/family.
- Effective documentation includes shared decision-making involving patient/family preferences, patient/family education, and explaining risks and benefits of management options.

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MDM – Risk to Patient Management



Minimal

- No examples in MDM Table
 - Rest
 - Saltwater gargle
 - Gauze, bandages
 - Superficial dressing (Band-Aids with Neosporin)
 - Diet and exercise

Low

- No official in MDM Table
 - Over the counter medications (e.g., Tylenol, Advil)
 - X-Rays
 - CT/MRI without contrast
 - Physical/Occupational therapy
 - DME
 - Minor surgery with no identified patient or procedure risk factors

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MDM – Risk to Patient Management



Moderate

- Examples in MDM Table
 - Prescription drug management
 - Decision regarding minor surgery **with** identified patient or procedure risk factors
 - Decision regarding elective major surgery **without** identified patient or procedure risk factors
 - Diagnosis or treatment significantly limited by social determinants of health (SDOH)

High

- Examples in MDM Table
 - Drug therapy requiring intensive monitoring for toxicity
 - Decision regarding elective major surgery **with** identified patient or procedure risk factors
 - Decision regarding emergency major surgery
 - Decision regarding hospitalization or escalation of hospital-level care
 - Decision not to resuscitate or to deescalate care because of poor prognosis

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MDM – Risk to Patient Management



- Effective documentation includes prescription drugs that are **managed** at the encounter – increased dose, decreased dose, starting meds, stopping meds
- Effective documentation includes eliminating the outdated Consolidated Drug List
- Effective documentation for Surgery includes adding simple improvements like “the procedure poses no significant risk to the patient” and “the procedure is serious and can cause”
 - The classification of surgery into minor or major is based on the **common meaning** of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.

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MDM - Selection

• To score by MDM, 2 of the 3 columns for that level must be met or exceeded

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release



Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i>	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited (Must meet the requirements of at least 1 of the 2 categories) Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate (Must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	High • 3 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

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Time

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Time

Time You Can Count

- Preparing to see the patient (eg, review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Time You Cannot Include

- Activities performed by clinical staff
- Performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

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Time

- Effective documentation includes documenting exact times versus old verbiage “approximately spent” since CPT® definitions have more succinct verbiage of “30 minutes must be met or exceeded to report 99213”
 - Effective January 1, 2024 all time thresholds are eliminated from CPT® coding definitions for office and other outpatient settings to better align with all other E/M code sets since 2023
- Effective documentation for supporting medical necessity is always the driving factor so ensure a 99215 for 50 minutes is supported for a stomachache / indigestion (i.e., how much time for clinically relevant history and exam, how much time it took to order an EGD, independently interpret an external barium swallow film and discuss with parent need to order EGD, how much time it took to take information from parent as additional historian, how much time it took to communicate with other physicians, etc.)

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Avoid Risk

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Avoid Risk



- Front and center - CMS defines medically necessary services as, “Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.”
- Front and center - The post-payment audits have started on 2021 E/M claims
- Front and center – 5 Fraud and Abuse Laws that could be triggered
 - False Claims Act (FCA) - 31 U.S.C. §§ 3729–3733
 - Anti-Kickback Statute (AKS) - 42 U.S.C. § 1320a-7b(b)
 - Stark Law - 42 U.S.C. § 1395nn
 - Exclusion Statute - 42 U.S.C. § 1320a-7
 - Civil Monetary Penalties - 42 U.S.C. § 1320a-7a

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Final Thoughts

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Final Thoughts



- Avoid rolling out the red carpet to risk
- Work with EMR / EHR vendors to update outdated 1995, 1997 templates
- For MDM, take each column separately to make documentation improvements
- For time, include exact time with all allowable activities
- Perform small sample self-audits per month

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Resources

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Resources



2021, 2023 CPT® Coding Manual

<https://www.ama-assn.org/system/files/2023-cpt-corrections-errata.pdf>

https://oig.hhs.gov/documents/physicians-resources/947/roadmap_web_version.pdf

<https://www.cms.gov/glossary?page=57>

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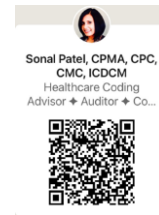
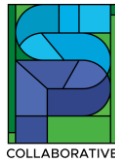
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Thank You

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