What’s all the fuss about?

- Clinical, legal and economic implications
- Max reimbursement versus fraud
  - Large fines for fraud even if unintentional
  - Providers ‘overcode’ because of ambiguity/interpretation of guidelines/rules
  - Providers ‘undercode’ out of fear, poor training, poor understanding of guidelines/rules
- Financial loss to practice/provider

What payors look at – “Red Flags”

- Nearly every encounter coded at equal complexity (especially high complexity)
- Inadequate documentation to back up coding
- Coding for service never performed or duplicate coding
- Incorrect date or place of service on claim
- Hospital records not supporting necessity of hospitalization
- Lack of physician order for diagnostic test
- Lack of justification of clinical necessity of test/lab
- Meeting incident-to rules
Purpose of Documentation

• Running record of pt’s care
• Assist clinicians who follow in performing subsequent care
• Show that the service was medically necessary
• Justify billing the service at the level billed
• Demonstrate that the standard of care was met, if needed, to defend against an action for malpractice

Codes, Codes, Codes

• CPT (Current Procedural Terminology) Codes (established by AMA)
  – Identifies services rendered – “what I did”
• ICD-10 (International Classification of Diseases) Codes (Established by WHO)
  – Identifies diagnosis on claims – “why I did it”
• E/M (Evaluation/Management) Codes (established by Medicare/Congress)
  – Standard documentation guidelines for billing – “I can prove it”

ICD-10 Codes

• Introduced in 1994 and used all other the world (USA last country to adopt in Oct 2015)
• Used for reporting diagnoses, morbidity and other health data
  – ICD-10: 160,000 codes – alphanumeric (IDC-9 had only 17,000 – numeric only)
• Proper coding = less denials
ICD-10

- Code to highest level of specificity
  - Acuity
  - Severity
  - Stage or type
  - Site
  - Morphology (e.g., Neoplasm)
  - Etiology/underlying disease
  - Laterality
  - Associated diagnoses/conditions/sequela

- Avoid use of symptom as diagnosis
  - Link cause and effect

ICD-10 Examples of Specificity

- Cardiac:
  - Acute systolic HF, acute on chronic diastolic HF

- Pulmonary:
  - Acute hypoxic respiratory failure
  - PNA due to possible aspiration

- Neurologic:
  - Acute right middle cerebral artery CVA
  - Right-sided hemiplegia with right dominance

- Renal:
  - AKI on CKD Stage 3

- Orthopedics:
  - Non-displaced fx of right radial styloid process

Funny ICD codes
E/M Codes

- Subset of CPT codes
- Should reflect work that was done
- Be supported by documentation
  - Content, not volume
- Reflect care that is reasonable and necessary
  - Compliant with standards of good medical practice
- Medical necessity is the overarching determinant of what code is used

E/M Codes

- Determined by
  - Type of service
    - Initial visit, consultation, existing patient, etc
  - Site of service
    - Inpatient, outpatient, nursing home, etc
  - Level of service
    - Either: History, exam and medical decision making
      - Documenting ‘by elements’
    - Or: Time spent in counseling and coordination of care
      - Documenting ‘by time’

Three Key Components

- Level of service based on complexity of:
  - Extent of patient history
    - Problem-focused, expanded problem-focused, detailed, comprehensive
  - Extent of physical exam
    - Problem-focused, expanded problem-focused, detailed, comprehensive
  - Complexity of decision making
    - Straightforward, low complexity, moderate complexity, high complexity
Three Key Components

• Type of service determines how many components need to be included
  – For new patients, need all three components
  – For established patients, need only two components

• My recommendation:
  – *Medical decision-making* should always be one of the needed components

Evaluation/Management Coding

• E/M Codes: 99201–99499
  – (99201–99215) Office/other outpatient services (most commonly used)
  – (99217–99220) Hospital observation services
  – (99221–99239) Hospital inpatient services
  – (99241–99255) Emergency department services
  – (99291–99292) Critical care services
  – (99304–99318) Nursing facility services
  – (99341–99350) Home health services
  – (99374–99380) Care plan oversight services
  – (99381–99429) Preventive medicine services
  – (99441–99444) Non-face-to-face physician services
  – … (There are more) …

99201–99215
Office/other outpatient services

• 99201 – 99205
  – New pt office or other outpatient services
  – New: not seen by any provider within same practice for 3 years

• 99211 – 99215
  – Established pt office or other outpatient services

• 99214 most commonly billed code with 99213 being close second
2 Sets of Guidelines

- 1995 versus 1997
  - both still in used and you have a choice
- But – cannot ‘mix and match’ within same note
- They differ mainly in the exam
  - 1997 guidelines less ambiguous/more rigid
    - Modern EMR systems may help as templates can be adapted for which guideline a provider prefers
- They don’t dictate the format of your documentation, just the content

Documentation Format

- No prescribed format
  - Just need to have all elements required for coding level
  - Content over volume
- Still need to document to shows standard of care, no matter what E/M code rules require
  - In case of litigation or board investigation, your documentation will be best confirmation of ‘what happened’
  - “Audit yourself before someone else does”

99211 - 99215
Established Office Visits

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>History</th>
<th>Physical Exam</th>
<th>Medical Decision Making</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>None required</td>
<td>None required</td>
<td>None required</td>
<td>5 min</td>
</tr>
<tr>
<td>99212</td>
<td>Problem focused</td>
<td>Problem focused</td>
<td>Straight forward</td>
<td>10 min</td>
</tr>
<tr>
<td>99213</td>
<td>Expanded problem focused</td>
<td>Expanded problem focused</td>
<td>Low</td>
<td>15 min</td>
</tr>
<tr>
<td>99214</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
<td>25 min</td>
</tr>
<tr>
<td>99215</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
<td>40 min</td>
</tr>
</tbody>
</table>

only 2 of 3 elements are needed for established patients
A word about 99211

- Should NOT be used by physicians/PAs/NPs
  - 'nursing visit'
  - does not require presence of physician or any medical decision-making
  - presenting problems minimal
  - Require ‘supporting’ documentation but no specific requirements for Hx, PE, decision making
  - Used for things like
    - BP check, suture removal, dressing changes, allergy injections with observation by a nurse, peak flow meter instruction

Coding “Backwards”

- Instead of thinking
  - History -> Exam -> Medical Decision-making
- Think
  - Medical Decision-making -> history and/or exam
- Presenting problem -> logical beginning
  - Use as tentative code selection and mold your history/exam documentation based on presenting problem
  - Medical decision making permeates what you do and shapes visit and exam
Medical Decision-Making

- Type of Medical Decision Making
  - Options for Diagnosis or Management
  - Data Reviewed
  - Risk

<table>
<thead>
<tr>
<th>Type of Medical Decision Making</th>
<th>Options for Diagnosis or Management</th>
<th>Data Reviewed</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Multiple</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

*At least two of the three criteria in the row must be met or exceeded to qualify*

Think of this as “presenting problem”

- ‘Presenting Problem’
  - Number of possible diagnoses or management options to be considered
- Data
  - Amount and/or complexity of diagnostic tests, medical records and other info that must be obtained or analyzed to make a diagnosis
- Risk
  - Risk of complications and/or comorbidities associated with patient’s presenting problem and possible management options

Dx or Mgt Options – Presenting Problem(s)

- Diagnosis
  - Minor or self-limited, established or new
  - e.g. already-diagnosed problem improved/well-controlled/resolved versus new diagnosis with uncertain outcome/requiring further workup
- Document:
  - Number of problems you are dealing with
  - Uncertainty about diagnosis
  - Number of management options you have and why/what you ordered
How to determine level of management options

<table>
<thead>
<tr>
<th>Management Options</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>1</td>
</tr>
<tr>
<td>Fair</td>
<td>2</td>
</tr>
<tr>
<td>Good</td>
<td>3</td>
</tr>
<tr>
<td>Excellent</td>
<td>4</td>
</tr>
</tbody>
</table>

Table A. Number of Diagnoses or Management Options

<table>
<thead>
<tr>
<th>Problem or Status</th>
<th>Number</th>
<th>Points</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max = 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established problem (by examiner)</td>
<td>Stable, improved</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established problem (by examiner), worsening</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (to examine); no additional work-up planned</td>
<td>Max = 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New problem (to examine); additional work-up planned</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL

Data

- Information gathered from sources other than history and physical
  - Lab, imaging, other diagnostic studies, old records …
- Document:
  - Test/lab reviewed, summarize results
  - Decision to request outside/old records
  - Review of records and summarize findings
  - History obtained from persons other than patient
  - Personal/direct visualization or independent interpretation of tests

How to determine level of data

- Can only get points listed, no matter how many different labs or other tests you review
- But can get 2 points for independent visualization/interpretation
- MUST document that you did so and summarize
Risk

- Quantification of risks of complications, morbidity and mortality
  - Considers presenting problems, diagnostic procedures and management options selected
- Document
  - Comorbidities, underlying diseases, other factors that increase risk
  - Needed surgical/invasive interventions
  - Urgency of intervention

Medical Necessity

- Medical decision-making helps convey medical necessity
  - While only 2 of 3 elements (history, exam, decision-making) are needed for any established visit E/M code, don’t document high-level history and high-level exam for minor problem
  - Always use medical decision-making as one of your 3 elements and you lessen chances of denials or audits
How to determine level of Medical Decision-Making

Remember: Managing prescription meds → mod risk!

Elements of History

- History of Present Illness (HPI)
  - 9 elements: location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms
  - or can also comment on status of three or more chronic or inactive conditions (cannot with 1995 guidelines)
- Review of Systems (ROS)
  - 14 systems: Constitutional, Eyes, Ears/nose/mouth/throat, CV, Respiratory, GI, GU, MS, Integumentary, Neuro, Psych, Endocrine, Hem/Lymphatic, Allergic/Immunologic
- Past, family and social history (PFSH)
Elements of History

<table>
<thead>
<tr>
<th>History: Level of Service</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-focused</td>
<td>1-3 elements</td>
<td>Not required</td>
<td>Not required</td>
</tr>
<tr>
<td>Expanded problem-focused</td>
<td>1-3 elements</td>
<td>1 system</td>
<td>Not required</td>
</tr>
<tr>
<td>Detailed</td>
<td>4 or more elements</td>
<td>2-9 systems</td>
<td>1 area</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>4 or more elements</td>
<td>10 or more systems</td>
<td>2 or more areas</td>
</tr>
</tbody>
</table>

- Reviewing meds/allergies considered an element of Past Medical Hx
- Ok to list pertinent positives/negatives for ROS and then have following statement – “All other systems reviewed and are negative”

Elements of Exam

<table>
<thead>
<tr>
<th>Exam: Level of Service</th>
<th>Number of Body Areas/organ Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-focused</td>
<td>1-5 elements in one or more organ systems or body areas</td>
</tr>
<tr>
<td>Expanded problem-focused</td>
<td>At least 6 elements in one or more organ systems or body areas</td>
</tr>
<tr>
<td>Detailed</td>
<td>Includes at least 6 organ systems or body areas. For each area or system selected, documentation of at least two elements is expected. Alternatively, may include documentation of at least 12 elements within two organ systems or body areas.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Includes at least 6 organ systems or body areas. For each area or system selected, documentation of at least two elements is expected.</td>
</tr>
</tbody>
</table>

General multi-system exam versus Single organ system exam

Recognized Organ Systems under 1997 Guidelines
- Constitutional (three vital signs = 1 bullet), Eyes, Ears/Nose/Mouth/Throat, Neck, Respiratory, CV, Chest, GI, GU, Lymphatic, MS, Skin, Neurologic, Psych
Optimal Coder

- Step 1: Choose the levels of RISK and DIAGNOSES
- Step 2: Choose the level of complexity of Medical Decision Making (CMDM)
- Step 3: Choose the E/M CPT code
- Step 4: Document the History based on the requirements of the chosen E/M CPT code
- Step 5: Document the Physical Exam based on the requirements of the chosen E/M CPT code

www.optimalcoder.com
Relative Value Units (RVUs)

- Created by Medicare but used by many other healthcare organizations for reimbursement
  - determines $ amount of reimbursement
- Adjusted by geographic cost indices multiplied by a fixed ‘conversion factor’ to determine dollar amount of payment
- Composed of three factors
  - Physician work (54%)
  - Practice expense (41%)
  - Malpractice expense (5%)

99213 versus 99214

<table>
<thead>
<tr>
<th></th>
<th>99213</th>
<th>99214</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New Patient</td>
<td>Established Patient</td>
</tr>
<tr>
<td>Level 1</td>
<td>0.48</td>
<td>0.10</td>
</tr>
<tr>
<td>Level 2</td>
<td>0.93</td>
<td>0.46</td>
</tr>
<tr>
<td>Level 3</td>
<td>1.42</td>
<td>0.97</td>
</tr>
<tr>
<td>Level 4</td>
<td>2.43</td>
<td>1.5</td>
</tr>
<tr>
<td>Level 5</td>
<td>3.17</td>
<td>2.11</td>
</tr>
</tbody>
</table>
Coding based on Time

- If >50% of visit time is spent on “counseling and coordination”
- Must meet/exceed established time limits
- In office: face-to-face time
- Hospital/nursing home: floor or unit time
- Document total time spent and include description of the counseling/coordination of care activities
Example of Detailed Exam
• Template can be easily adapted

Vitals & Measurements:

- T: 96.6°F (Tympanic) TMIN: 96.6°F (Tympanic) TMAX: 97.6°F (Temporal) Artery: T: 97.3°F
- MAP: 101 (Cuff), Hg: 120-90% HR: 100.4 kg

General: well appearing, 77-year-old male in no acute distress at this time, breathing comfortably and moving complete sentences

HEENT: amanacatic eyes DUM
Nec: no carrot beat, no JVD
Respiratory: C/T bilateral, no crackle, rhonchi, wheezes, good respiratory effort
Cardiovascular: EKG, normal 51 and 52, no murmurs, trace bilateral lower leg edema
Abdomen: Soft, non-distended, normal bowel sounds
Gastrointestinal: Defecated
Racial: Normal
Musculoskeletal: moving all extremities without difficulty
Integumentary: warm, and dry, no rash
Horm/Lymph: no bruises
Neurologic: A/G: 3, grossly intact
Psychiatric: cooperative with normal mood, affect, and cognition

Example of ‘undercoding’
• Significant risk but documentation does not support higher level of coding

Incident-to Rules
• Frequently audited service
  - Documentation must clearly show NPPA service linked to physician service
    - Physician established plan, NPPA follows it
  - NPPA must be employed/contracted by same entity as physician
  - Service must be provided under general supervision
    - Physician must be on-site during incident-to service
      - Does not need to be physician who performed initial service
  - Can only be used in office/clinic setting
Shared Billing

- Applies to E/M services only
  - Cannot use in the office/clinic, SNF, for procedures, critical care services, consultations, home visits
  - Can use for hospital-based initial and subsequent visits, ER visits, observation and discharge services
  - Physician MUST personally provide some face-to-face time with patient and MUST document what portions of E/M services he provided
    - Simply co-signing NPPA note not sufficient

Consultation codes

- Never allowed for shared or incident-to billing
- Eliminated by Medicare in 2010, but may still be used by private payors
- Although use of consultation codes eliminated, rule re: shared billing was not
  - Previous guidelines still apply
    - i.e. ‘consultations’ under Medicare still cannot be shared
Critical Care Services

• Critical illness or injury
  – Acute impairment of one or more vital organ systems such as there is high probability of imminent or life threatening deterioration
  – Probability of death if interventions not done immediately
  – Can be used on multiple days
  – BUT just being in ICU does not institute critical care

Represents intensity of care > standard E/M codes

Critical Care Services

• No specific documentation requirements
  – Must convey critical nature of patient’s condition and what you did about it, must show involvement of highly complex decision making
• Use wording such as
  – “Time spent includes multiple re-examinations, speaking with family, discussions with other providers, overseeing administration of multiple medications, titrating drips”
• Time-base code
  – Must be one-on-one but necessarily face-to-face not, i.e. cannot take care of another pt during same period of time
  – 1st hour = minutes 31 – 74 of care

EMR Cloning

• “Clinical plagiarism”
  – copy and paste text from other physicians’ notes documenting work that you did not perform
• Medicare defines cloning as multiple entries in a patient chart that are identical or similar to other entries in the same chart
  – Has become specific target for auditors
  – Has lead to ‘upcoding’
  – Claims have been denied
EMR Cloning

- Always document HPI based on pt’s description that day
- Don’t copy/carry forward whole notes, carefully review and edit whatever you do copy
- Review auto-fill and edit
- Use templates with care, review and edit them thoroughly
- Remember that volume of info in note does not determine complexity for level of billing
“Chart-must-have” Recommendations

• Document reason of visit or procedure
• Document reason that pt need hospitalization that day
• Document aspects of medical work (for coding)
• State that previously documented problem has resolved, or if not, what is being done
• Note pt’s lack of progress, document change of plan or referral

Carolyn Buppert, NP, JD Medscape article 756954

Resources

• E/M University (www.emuniversity.com)
• AAPA (www.aapa.org)
• Family Practice management (www.aafp.org)
• www.codinginstitute.com
• medicaledconomics.modernmedicine.com
• www.optimalcoder.com