Objectives

- Discuss good “basic” audit techniques
- Review the role of Medical Necessity in auditing
- Understand the three key components in E&M auditing “DG – Documentation Guidelines”
- Review the use of “time” coding and required documentation
- Recognizing the EMR challenge for the auditor – Unintended consequences

Audit

- Start with the benchmarks
  - CMS MEDPAR by specialty
- Get a CPT distribution for provider and compare
- Decide on appropriate scope of audit
  - Don’t review 99212 if compared to benchmark, provider is billing 50% more 99215’s then his/her peers
- Utilize RAT-STATS for unbiased selection process
Audit

- Make sure the use of new patient vs. establish patient codes are utilized correctly
- Watch code selection relative to place of service
  - i.e. provider bills hospital codes for hospital services, Outpatient vs. Inpatient.
- Always utilize trustworthy resources.
  - CMS 1995 or 1997 guidelines
  - Specific MAC references
  - CPT and ICD9 code books
  - OIG website when needed

Audit

- Don’t forget to review the record for more then just appropriate level assignment
  1. All records require a chief complaint
  2. All records require a signature
     1. Use your local MAC as reference – MM6698
  3. All records should be legible
  4. Ancillary staff and/or patient may ONLY document ROS & PFSH
     • Provider must reference appropriately
     • Specifically watch this in EHR

Documentation Guidelines

- Chief Complaint
  - DG – The medical record should clearly reflect the chief complaint
- Signature
  - The documentation of each patient encounter should include:
    • Date and legible identity of the observer
- Legibility
  - The medical record should be complete and legible
Documentation Guidelines

- ROS/PFSH
  - DG – from earlier encounter. “The review and update may be documented by noting the date and location of the earlier ROS and/or PFSH”.
  - DG – to document the provider reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
  - DG – if unable to obtain a history the record should clearly describe the circumstance that precludes obtaining a history.

Medical Necessity

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.

Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1
Medical Necessity

• E/M guidelines are complex and subjective
  – This has introduced the use of templates
  – Influences provider to document in pattern that may make every visit look the same
  – Typically providers forget to document their medical thinking which is crucial to support medical necessity
  – Easily inferred may not mean the same to a provider
    • Explain and educate provider on this fact

Medical Necessity

• Medical necessity cannot be quantified using a point system
• Differs from patient to patient with the following factors
  – Clinical Judgment - Co-morbidities
  – Standards of practice - Management for
  – Chief complaint  the specific DOS
  – Acute exacerbations
  – Stability/acute of patient

Medical Necessity

• Novitas – (Formally Highmark)
  "medical necessity is the first consideration in reviewing all services”.
• CGS Administrators–
  – "generally expressed as intensity of service"
  – "Medicare will deny or down code E/M services that, in its judgment, exceed the patient's documented needs".
Key Components

Let’s work our way backwards!
• Medical Decision Making
  – Recognized levels
    • Straightforward
    • Low
    • Moderate
    • High
  – Refers to complexity of establishing a diagnosis and selecting a management option

Medical Decision Making
• Three areas of documentation for MDM
  – Diagnosis: number and status of diagnoses treated
  – Complexity: tests and procedures performed or ordered
  – Risk: level of risk assigned to diagnoses treated
    • Probably the most difficult for non-clinical auditors

Medical Decision Making
• Diagnosis
  – Is this new or established to the provider?
  – Is it improving, worsening, or stable?
  – Does it require additional workup?
• Documentation Guideline Moment:
  – DG – Diagnosis may be explicitly stated or implied in documented decisions regarding management plans or further evaluation.
  – DG – An established diagnosis should reflect whether the problem is improved or worsened.
Medical Decision Making

- Complexity of data
  - Diagnostic Testing
    - Credit is given for number of tests performed, ordered, or reviewed.
    - The type of testing lends more toward complexity rather than number of testing.
  - Medical Records
    - Points given for reviewing and summarizing old records as well as making a decision for obtaining records from another provider.

- Documentation Guideline Moment
  - DG - A notation of old records reviewed or additional history obtained from family without elaboration is insufficient.

Medical Decision Making

- Independent Visualization
  - Provider can receive 2 points for interpreting the test by direct visualization.

- Documentation Guidelines Moment
  - DG - the direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.
Medical Decision Making

Risk
- Takes the categories already looked at within the decision making into consideration for level of risk determination
- Three components:
  - Presenting Problem
  - Diagnostic procedure(s) ordered
  - Management Options
- The risk of significant complications is based on all the risks associated with the presenting problem(s), the diagnostic procedure(s), and the management options

The table on the next slide is used to help quantify the four levels of risk. They are:

- Minimal
- Low
- Moderate
- High

- Documentation Guideline Moment
  - DG - Co-morbidities/underlying diseases or other factors that increase the complexity of MDM by increasing risk of complications should be documented
  - DG - If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the TYPE of procedure (e.g., Laparoscopy) should be documented
Exam

- Area of documentation that is easily converted to a template.
- There are two versions:
  - 1995 (body areas or organ systems)
  - 1997 Bulleted
- You may audit using whichever is beneficial to the provider
- Cannot mix on one record
Exam Component 1995

**Body Areas:**
- Head
- Neck
- Chest
- Abdomen
- Back/Spine
- Genitalia/Groin/Buttocks
- Left upper extremity
- Right upper extremity
- Right lower extremity
- Left Lower extremity

**Organ Systems:**
- Constitutional
- Eyes
- Ears, Nose, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Integumentary
- Musculoskeletal
- Neurological
- Psychiatric
- Hematologic/Lymphatic/Immunologic

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**Exam 1995**

- **Problem Focused** - limited exam of affected body area OR organ system
- **Expanded Problem Focused** - limited exam of the affected body area OR organ system and other symptomatic or related organ system(s)
- **Detailed** - an extended exam of the affected body area(s) and other symptomatic or related organ system(s)
- **Comprehensive** - a general multi-system exam or complete exam of a single organ system

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**Exam 1995**

- **Documentation Guideline Moment**
  - DG – specific abnormal and relevant negative findings should be documented. A notation of abnormal without elaboration is insufficient.
  - DG – The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems
- **Audit tip:** The extent of the exam performed and documented is dependent on the clinical judgment of the provider and the nature of the presenting problem.
Exam

1997

- Designed as a “bullet system” encompassing most specialties.
- Auditing process is counting bullets (AKA elements) based on documentation in the record.
- Documentation for each element must satisfy the requirement of that element:
  - i.e., measurement of any 3 of 7 vitals listed is specific
- Elements with multiple components but no specific numeric requirement require documentation of at least one component

1997

- May use a general multi-system exam or a single organ system (i.e., Neurological) to document in the record.
- Each level of exam, problem focused, expanded problem focused, and comprehensive have documentation guidelines that apply for general multi-system or single organ system.
- Refer to the following CMS E/M guide on page 52 for specific guidance on number of elements:


General Multi-System Examination

<table>
<thead>
<tr>
<th>Examination Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>Measurement of any three of the following items: weight, height, &amp; standing blood pressure</td>
</tr>
<tr>
<td>Labs</td>
<td>Inspection of pupils and iris; assessment of visual acuity and color discrimination.</td>
</tr>
<tr>
<td>Lungs, Chest, Heart and Vascular</td>
<td>Ophthalmoscopic examination of the eyes, size, G6 ratios, appearance and position of pupils.</td>
</tr>
<tr>
<td>Skin, nails, mouth and teeth</td>
<td>Examination of ears and nose, eye, mouth, and other appearance.</td>
</tr>
</tbody>
</table>

10
History

Last but not least…the history component

- There are three elements within history component:
  - HPI – History of present illness
  - ROS – review of systems
  - PFSH – past medical, family, & social history

Documentation Guideline:
- DG – The CC, ROS, PFSH may be listed as separate elements of history, or they may be included in the description of the history of present illness.

History

- HPI
  - Location
  - Quality
  - Severity
  - Duration
  - Timing

There are two kinds of HPI’s:
Brief = one to three elements (1-3)
Extended = four or more (4+) or the status of at least three (3) chronic or inactive conditions

History

- Review of Systems (ROS)
  - ROS is a series of questions that provider and/or ancillary staff asked the patient based upon the history of the present illness or complaint.
  - Constitutional (e.g., fever, weight loss)
  - Eyes
  - Ears, nose, mouth, throat
  - Cardiovascular
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Integumentary (skin and/or breast)
  - Neurological
  - Psychiatric (e.g., mood swings)
  - Hematologic/Lymphatic
  - Endocrine
  - Allergic/immunologic
History

There are two types of PFSH:

- Pertinent: review of the history area(s) directly related to the problem(s) identified in the HPI.
- Complete: review of two or all three of the PFSH history areas depending on the category of E/M.

- 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.
- For certain categories of E/M services that include only an interval history, it is not necessary to record a PFSH.

- I.e. subsequent hospital/subsequent nursing facility.

Putting it all together...

<table>
<thead>
<tr>
<th>Type of History</th>
<th>Chief Complaint</th>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past Medical, Family, and Social History (PFSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Required</td>
<td>Brief (1.5)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Externally Focused</td>
<td>Required</td>
<td>Brief (1.5)</td>
<td>Problem Pertinent (Exclude 1)</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed</td>
<td>Required</td>
<td>Extended (3-9 months)</td>
<td>Extended (2-5)</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Required</td>
<td>Extended (1 year and 6 months)</td>
<td>Complete (interventions)</td>
<td>Complete</td>
</tr>
</tbody>
</table>
Time

- A level may be achieved by time.
- Documentation should reflect in the record appropriately.
- More than 50% of the encounter spent in counseling or coordination of care indicates that the time spent is the controlling factor.

DG - If provider elects to report level of service based on time, the total length of time of the encounter should be documented and the record should describe the counseling and/or the activities to coordinate care.

Time on audit sheet
Typical Times

- 99201 - 10
- 99202 - 20
- 99203 - 30
- 99204 - 45
- 99205 - 60
- 99211 - 5
- 99212 - 10
- 99213 - 15
- 99214 - 25
- 99215 - 40

EMR

- A new audit era
- No longer “not documented; not done” now its “documented and not done”
- It’s the integrity of the record that is in question
- Cloning was “near” impossible when records were on paper. Now it is common place
- One good thing…legibility is no longer an issue

Common issues

- Cut and paste
- Cloning
- Signature authentication
- Macros (unedited)
- Default templates (unedited)
- Who documented what
Excerpt from the letter from Kathleen Sebelius, Secretary HHS
September 24, 2012

http://www.modernhealthcare.com/Assets/pdf/CH82990924.PDF

EMR
Auditor Response

• Now you may need to see “pre-canned” templates to verify cloning.
• You may need to see policies and procedures surrounding documentation in the EMR.
• You know have to know the EMR process flow to figure out who did what.

EMR
Remember:

• Nothing has changed in the guidelines just because we adopted the use of EMR.
• You must verify when you have a question about the author of the documentation.
• You need to “call out” cloning and educate your providers.
• You need to ASK when you need to in regard to exam elements in question.
The End

“Good Luck in your Auditing endeavors and keep staying true to the guidelines and MAC direction! You are the expert and should share your knowledge through education with all the providers you touch through an audit process”.

S K CPC CPMA CPPM CPCI