Coding E/M Services Based on Medical Necessity

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E/M Coding

- Identify common misconceptions related to E/M coding & Medical Necessity
- Problem solve to determine solutions for those misconceptions:
  - Determining correct E/M coding level
  - Importance of proper documentation
  - Over-coding or under-coding based on Medical Necessity
  - Regulations that impact E/M documentation
  - Learn the top things coders can do to help code consistently and accurately for E/M services

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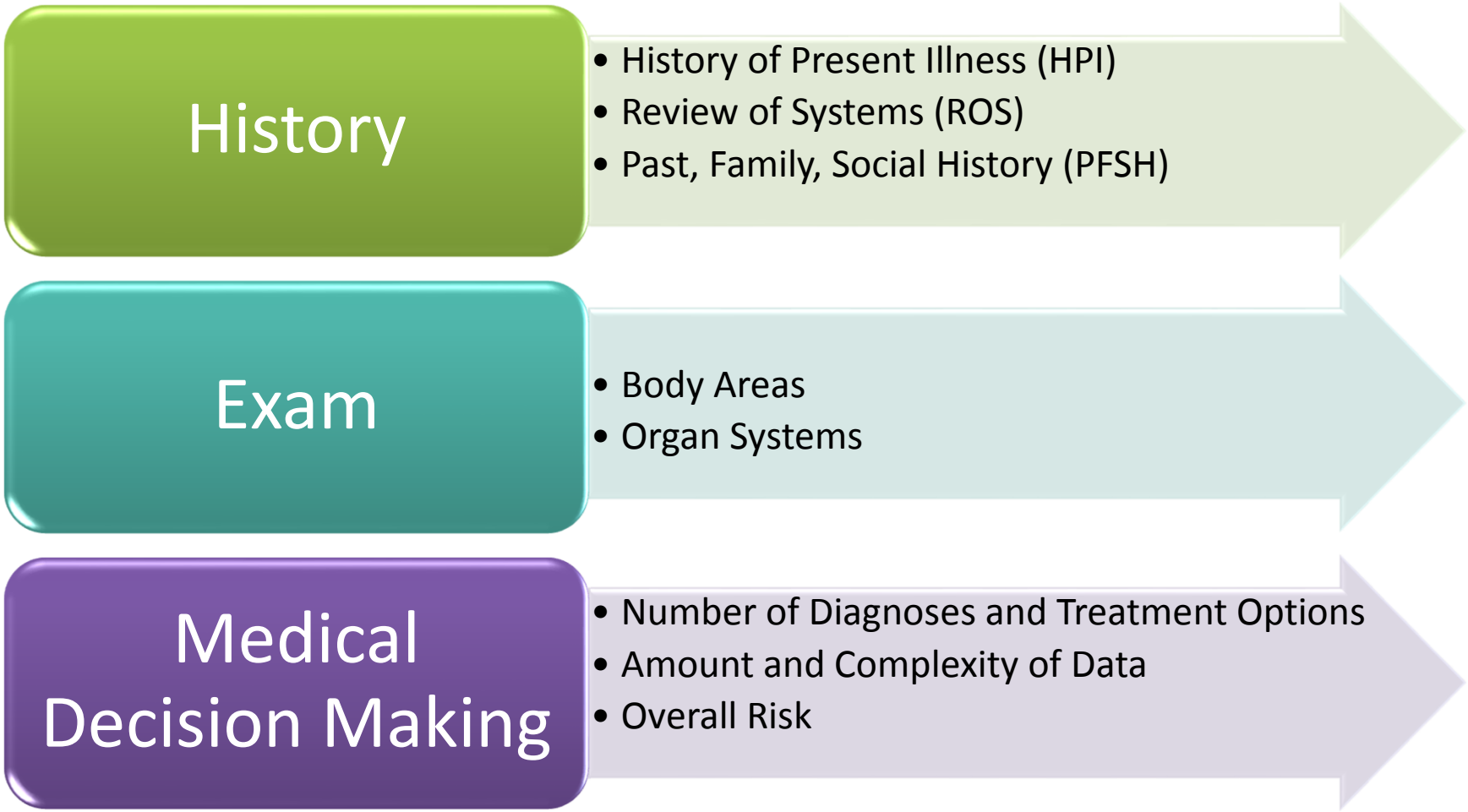
E/M Coding Guidance

- Federal Register
- OIG Compliance Guidance
- ICD-10-CM Official Guidelines
- CPT Guidelines
- CMS 1995 and 1997 DGs for E/M
- CMS Internet Only Manuals (IOMs)
  - Chapter 9 – Medicare Claims Processing Manual
  - Chapter 13 – Medicare Benefits Policy Manual
- HIPAA Guidance
- National Correct Coding Initiative (NCCI)
- False Claims Act; Qui Tam
- Social Security Act – Medical Necessity
- Physician Quality Reporting System (PQRS)
- Valued Based Modifier program
- Meaningful Use

Coding the Key Components of E/M



Time may be used if >50% of the encounter is spent on counseling or coordination of care.

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History

HPI

- Patient's stated reason for the visit:
- Location
- Context
- Duration
- Quality
- Modifying Factors
- Severity
- Timing
- Associated Signs and Symptoms
- Chronic Conditions

ROS

- Patient query:
- ROS may be obtained in an format – separate patient intake or questionnaire form within HPI
- Positive and negative responses to signs/symptoms
- ROS should be medically necessary

PFSH

- Past: The patient's past experience with illnesses, operations, injuries and treatments, and medications
- Family: A review of medical events in a patient's family including possible hereditary diseases
- Social: Age-appropriate review or past and current activities

Exam (1995)

Organ Systems

- [ ] Constitutional
- [ ] Eyes
- [ ] ENMT
- [ ] Cardiovascular
- [ ] Respiratory
- [ ] Gastrointestinal
- [ ] Genitourinary
- [ ] Musculoskeletal
- [ ] Skin
- [ ] Neurologic
- [ ] Psychiatric
- [ ] Hematologic/lymphatic/immunologic

Body Areas

- [ ] Head/Face
- [ ] Neck
- [ ] Back
- [ ] Abdomen
- [ ] Genitalia
- [ ] Chest/axillae/breast

Medical Necessity ≠ Medical Decision Making

Medical Necessity

- The diagnosis documented merits the level of investigation and treatment administered to the patient.

Medical Decision Making

- Utilized to describe the amount of effort the physician must exert to decide how to treat the patient.

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Example

- **Patient Name:** John Doe
- **Date of Service:** 01/01/2015
- **Date of Birth:** 01/01/1935
- **Chief Complaint:** “Osteoarthritis”
- **History of Present Illness (HPI):**
  75-year-old male with a history of osteoarthritis.

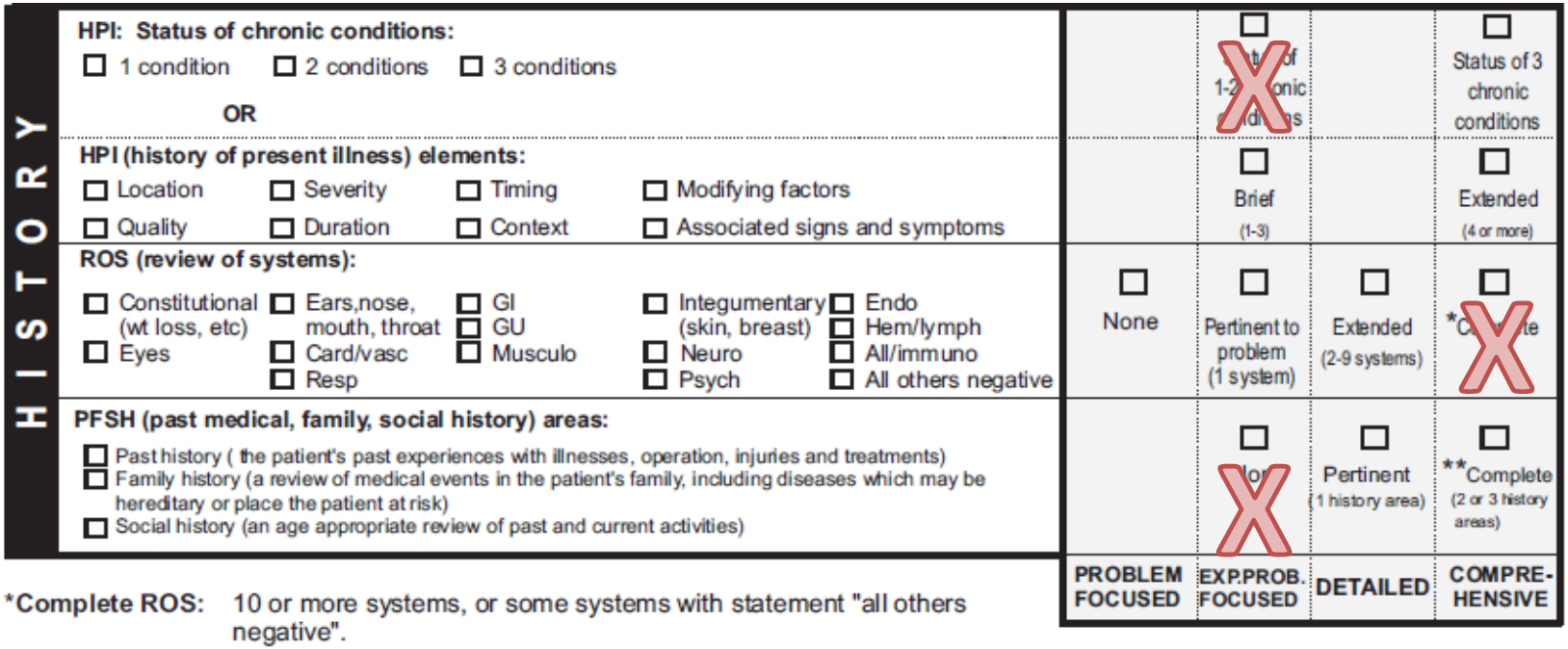
Example

- **Review of Systems (ROS):**
  Constitutional symptoms — No fever, no loss of appetite.
  Cardiovascular — Negative for chest pain.
  Respiratory — No shortness of breath.
  Gastrointestinal — No nausea or vomiting.
  Genitourinary — No difficulty urinating.
  Musculoskeletal — Pain in joints intermittently.
  Integumentary — No rash.
  Neurological — Denies disorientation.
  Endocrine — No cold intolerance.
  Allergic/Immunologic — Positive for seasonal hay fever.

Example

- **Past, Family, Social History (PFSH):**
  See visit record for date of service 1/1/2010.

History



HISTORY				
HPI: Status of chronic conditions: ☐ 1 condition ☐ 2 conditions ☐ 3 conditions OR		☐ Status of 1-2 chronic conditions		☐ Status of 3 chronic conditions
HPI (history of present illness) elements: ☐ Location ☐ Severity ☐ Timing ☐ Modifying factors ☐ Quality ☐ Duration ☐ Context ☐ Associated signs and symptoms		☐ Brief (1-3)		☐ Extended (4 or more)
ROS (review of systems): ☐ Constitutional (wt loss, etc) ☐ Ears,nose, mouth, throat ☐ GI ☐ Integumentary (skin, breast) ☐ Endo ☐ Eyes ☐ Card/vasc ☐ GU ☐ Hem/lymph ☐ Resp ☐ Musculo ☐ Neuro ☐ All/immuno ☐ Psych ☐ All others negative	☐ None	☐ Pertinent to problem (1 system)	☐ Extended (2-9 systems)	☐ *Complete
PFSH (past medical, family, social history) areas: ☐ Past history (the patient's past experiences with illnesses, operation, injuries and treatments) ☐ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) ☐ Social history (an age appropriate review of past and current activities)		☐ Pertinent (1 history area)		☐ **Complete (2 or 3 history areas)
	PROBLEM FOCUSED	**EXP.PROB. FOCUSED**	**DETAILED**	**COMPRE-HENSIVE**

*Complete ROS: 10 or more systems, or some systems with statement "all others negative".

**Complete PFSH: 2 history areas: a) Established patients - office (outpatient) care; b) Emergency department.

3 history areas: a) New patients - office (outpatient) care, domiciliary care, home care; b) Consultations; c) Initial hospital care; d) Hospital observation; e) Initial Nursing Facility Care.

NOTE: For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Please refer to procedure code descriptions.

Example

- **Physical exam:**
  Vital signs — T 98.7, P 76, R 20, BP 130/80.
  Head, Ears, Eyes, Nose, Throat — Oropharynx clear, no mucosal ulcerations and auditory canals clear.
  PERRLA.
  Neck — Trachea midline, supple.
  Lungs — Clear to auscultation bilaterally.
  Cardiovascular — Regular rhythm and rate.
  Abdomen — Soft, nontender.
  Extremities — Normal.
  Musculoskeletal — Bilateral knees with normal range of motion, crepitus on motion, pain with ambulation rated 3 out of 10 and tenderness upon palpation.
  Neurologic — Oriented to time, place and person.
  Hematologic/Lymphatic/Immunologic — No bruising, no lymphatic swelling.
  Skin — Normal temperature, turgor and texture. No rash.
  Psychiatric — Appropriate mood and affect.

Examination

Limited to affected body area or organ system (one body area or system related to problem)	**PROBLEM FOCUSED EXAM**
Affected body area or organ system and other symptomatic or related organ system(s) (additional systems up to total of 7)	**EXPANDED PROBLEM FOCUSED EXAM**
Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 or more depth than above)	**DETAILED EXAM**
General multi-system exam (8 or more systems) or complete exam of a single organ system (complete single exam not defined in these instructions)	**COMPREHENSIVE EXAM**

EXAM

Body areas:

☐ Head, including face ☐ Chest, including breasts and axillae ☐ Abdomen ☐ Neck

☐ Back, including spine ☐ Genitalia, groin, buttocks ☐ Each extremity

Organ systems:

☐ Constitutional (e.g., vitals, gen app) ☐ Eyes ☐ Ears,nose, mouth, throat ☐ Cardiovascular ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Skin ☐ Neuro ☐ Psych ☐ Hem/lymph/imm

☐ 1 body area or system	☐ Up to 7 systems	☐ Up to 7 systems	☐ 8 or more systems X
PROBLEM FOCUSED	**EXP.PROB. FOCUSED**	**DETAILED**	**COMPRE-HENSIVE**

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Example

- **Assessment:**
  Occasional joint pain.

  Plan:
  1. Continue same treatment.
  2. Return to office in three months.

Medical Decision Making

Number of Diagnoses or Treatment Options					
A	B	X	C	=	D
Problem(s) Status	Number		Points		Result
Self-limited or minor (stable, improved or worsening)	Max = 2		1		
Est. problem (to examiner); stable, improved			1		
Est. problem (to examiner); worsening			2		
New problem (to examiner); no additional workup planned	Max = 1		3		
New prob. (to examiner); add. workup planned			4		
			TOTAL		1

Amount and/or Complexity of Data Reviewed	
Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	0

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Medical Decision Making

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
X **Low**	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
X **Moderate**	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic with identified risk factors) • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Scoring - Medical Decision Making

Final Result for Complexity

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

Final Result for Complexity					
A	Number diagnoses or treatment options	≤ 1 Minimal X	2 Limited	3 Multiple	≥ 4 Extensive
B	Highest Risk	Minimal	Low	Moderate X	High
C	Amount and complexity of data	≤ 1 Minimal or low X	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making		STRAIGHT-FORWARD	LOW COMPLEX.	MODERATE COMPLEX.	HIGH COMPLEX.

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Scoring the Visit

Established Office Requires 2 components within shaded area				
Minimal problem	PF	EPF	D	C
that may not require presence of	PF	EPF	D	X
physician	SF	L	M	H
5 (99211)	10 (99212)	15 (99213)	25 (99214)	40 (99215)
I	II	III	IV	V

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Example

“The patient presented with a single, chronic, well-controlled problem. Unfortunately, the practitioner’s explanation of the nature of this patient’s problem is too vague to get even a sense of whether this service is at all medically necessary. Osteoarthritis is a chronic problem that appears to be stable in this patient. Is a three-month follow-up reasonable and necessary for stable osteoarthritis? Why or why not? Those are the questions the information in the record should address for Medicare payment to be determined appropriate.

Example

"If one assumes this was a medically reasonable and necessary visit, what level of service is needed for a follow-up visit with a patient who has one stable problem (for which the likelihood of death or disability before the next visit is very unlikely)? The answer is that this visit would appropriately be paid as a low-level E&M service, probably code 99212. Consequently, while the very brief HPI and medical decision-making could be appropriate for the care of this patient's osteoarthritis, the comprehensive ROS and examination exceeded the level of care needed for the patient's presenting condition."

Medical Necessity Concerns with EMR

- Documentation
  - Check boxes do not allow to document “story”
  - Exploding or pull forward
  - Review of systems query
  - Past, Family, Social History
  - Saved examination templates
  - Missing orders

The Medical Necessity Problem

- Incorrect E/M coding can result in significant overpayments
- 20% of initial hospital visits & 13.6% of new patient office visits are incorrectly coded

99233 = error rate of 58%
99214 = error rate of 14.5%
99232 = error rate of 16.5%

- Medical Necessity errors are twice as common as coding errors
- CMS 1995 and 1997 Coding Documentation Guidelines are just that…**guidelines – not definitive statutes.**
  - Medical necessity of a service is the authoritative factor
- Medicare may deny payment for services which they believe to be not reasonable or necessary, even if a physician believes it is clinically appropriate

Medicare – Medical Necessity

- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirement of a CPT code.
- Factors to assist in determining medical necessity:
  - Clinical judgement
  - Standards of practice
  - Chief Complaint
  - Exacerbations/onset of injuries/medical conditions
  - Co-morbidities

Documentation

- Complete and legible
- Documentation for each encounter should include
  - Reason for encounter
  - Relevant history, exam and prior diagnostic test results
  - Assessment, clinical impression
  - Plan of care

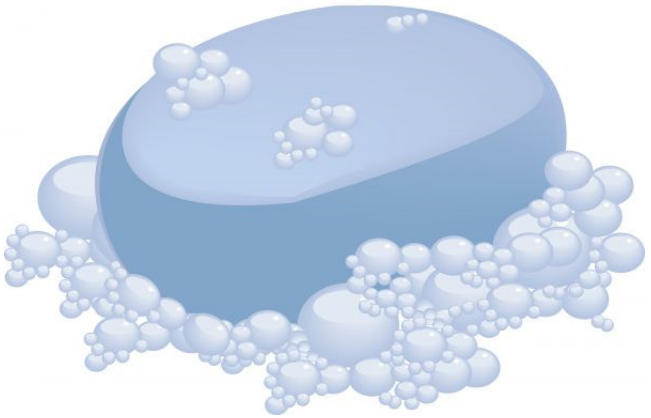
Lather up!

Subjective = Opinion

Objective = Fact

Assessment = Judgement

Plan = Strategy



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Subjective = Opinion

- Medical Necessity is…
  - An action that is clinically required;
  - The reason for a patient visit;
  - Validation for the provision of a particular service;

Staff asking all ROS questions for a sore throat?

- Provider request
- Was “told” to collect during training

Objective = Fact

- Medical Decision Making is a *measurable* element of E/M coding
  - Defined by 1995 and 1997 documentation guidelines
  - Not just a guess – mathematical formula resulting from all documented components or the service:
    - "Data driven outcome of a patient visit and not a substitute for determining the appropriateness of the services rendered or the Medical Necessity."

Diagnoses + Data + Risk = Medical Decision Making

Assessment = Judgement

- These judgements are a culmination of several factors:
  - Clinical judgement
  - Standards of practice
  - Acute exacerbations or onsets of medical conditions
  - Acuity of the patient
  - Medical co-morbidities
  - Management of specific diagnoses…

AAPC: *"The best way to stay compliant with Medical Necessity related laws is to think of each element of the patient's history and physical exam as a separate procedure that should be performed only if there is a clear medical reason to do so."*

Plan = Strategy

- Common mistake: assuming that Medical Necessity is the same this as Medical Decision Making
  - Leads to overpayments or underpayments
- Solution: Bridge the gap!

Clinical Knowledge of Providers Documenting the Service

Coding Knowledge of Coders who are Billing for the Service

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Medical Necessity Defined

- Government definition:
  - Per the Social Security Act 42 U.S.C. § 1395y(a)(1)(A), "SSA" – Medicare only pays for medical items and services that are *"reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning or a malformed body member",* unless there is another statutory authorization for payment.
  - National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) – Section 522 of the Benefits Improvement and Protection Act (BIPA) defines and LCD as *"a decision by a Medicare carrier whether to cover a particular service in accordance with SSA".*

5 Things to Remember…

1. • **No tool can substitute for a Physician** in Medical Necessity determinations
2. • Understand **why** the topic of payment is a source of frustration for Physicians
3. • The key to communicating with Physicians about coding is to **be concise** and **use terms they can relate to**
4. • Master the art of asking the **right questions**
5. • Create **Best Practices** for your coding staff as well as your documenting Providers

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Questions ????

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