# Indian Health Service Productivity and Coding/Documentation Audits

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# Objectives

Discuss Coding Productivity

Discuss Coding and Documentation Audits

Discuss Communication of Audit findings

Discuss Clinical Documentation Improvement

# Definitions

| | |
|---|---|
| Productivity: | The rate at which goods are produced or work is completed |
| Efficiency: | The ability to produce something without wasting time, materials or energy |
| Effectiveness: | How accurate or inaccurate something is |
| Standard: | A level of quality or achievement that is considered |

# How many coders do we need?

# Steps to determining how many coders are needed

Determine approved hours per pay period (35, 37.5, 40, etc.)

- What is the locations definition of an FTE?

Calculate the non-productive time vs. productive time

- Productive time is what you will use to determine the FTE

Know the average time to code each record

- Do a Time Study:
  - Obtain actual times to review and complete a record over a 2 week period
  - Take an average of the time to review and complete a record and put it into the below formula

Look at your volume in regards to your coding time

- Look at each type of encounter and the average time it takes to code each visit

# Example – Experienced Coder

FTE Definition:

40 hrs x 52 weeks = 2080 Total

- Vacation = 80 hrs
- Holiday = 80 hrs
- Sick time = 16 hrs
- Education = 24 hrs
- Breaks = 120 hrs
- Dept. Meetings = 21 hrs
- Annual In-services = 2 hrs

Non-Productive Time = 343 hours

Productive Time = 1,737 hours

| Visit Type | FY 2022 Total Volume | Average Coding Time per Visit Type |
|---|---|---|
| Direct Outpatient | 15,000 | 15,000 X 5 min. = 75,000 |
| Dental | 170 | 170 X 5 min. = 850 |
| Total Min/Hrs | | 75,850 min. or 1,264 hrs |

Based on FTE Definition and time example, this location should have:

1,264/1,737 = 0.73 FTE to cover their medical coding

# Example – Non-Experienced Coder

FTE Definition:

40 hrs x 52 weeks = 2080 Total

- Vacation = 80 hrs
- Holiday = 80 hrs
- Sick time = 16 hrs
- Education = 24 hrs
- Breaks = 120 hrs
- Dept. Meetings = 21 hrs
- Annual In-services = 2 hrs

Non-Productive Time = 343 hours

Productive Time = 1,737 hours

| Visit Type | FY 2022 Total Volume | Average Coding Time per Visit Type |
|---|---|---|
| Direct Outpatient | 15,000 | 15,000 X 10 min. = 150,000 |
| Dental | 170 | 170 X 10 min. = 1,700 |
| Total Min/Hrs | | 151,700 min. or 2,528 hrs |

Based on FTE Definition and time example above, this location should have:

2,528/1,737 = 1.5 FTE to cover their medical coding

# Assessing Productivity

# Goals

Track effectiveness and accurate nature of staff work

Develop measures to track annual performance goals

Provide an avenue to address low performers

Identify staff capacity needs

Meet compliance requirements

# Benchmarks*

| Type of Record | Reported Expectation (highest percentage) |
|---|---|
| Inpatient | 3-3.5 records per hour |
| Ambulatory Surgery Center | 6-7 records per hour |
| Clinic Visits | > 23 records per hour |
| Emergency Department Records | 8-11 records per hour |
| Interventional Testing | 4-5 records per hour |
| Non-interventional Testing | > 37 records per hour |

* 2011 Coder Productivity Survery-HCPro

# Things to consider:

Work type

Work hours

Work location

Software functionality

“Other duties as assigned”

Coding credentials

# Work Type

Inpatient facility

Outpatient facility

Clinic visits

Professional Procedures/Surgery

Diagnostic Services

Interventional

# Work Hours

FTE Status

Shift

Extended hours

# Work Location

Office

Remote Office

Remote Home

# Software Functionality

Computer Assisted Coding

Ability to build payer specific edits

Speed

Streamlined processes

# “Other Duties As Assigned”

What else are you responsible for?

- Abstracting (CPT, ICD)
- Answering questions
- Providing analysis
- Working denials
- Querying providers/departments
- Non-Business Office items

# Coding Credentials

CPC (et al)

CCS, CCS-P

RHIT, RHIA

# Assessing Productivity

Track current production over several weeks

Ask for input

- Daily, weekly or monthly averages

Create an incentive plan

- Payment/Time Off
- Conferences
- Special Projects

Establish annual goals based on performance

Delay promotions and/or moves for under performers

Allow overtime only for those meeting minimum production standards

# Then what?

Monitor production levels for all staff over a pre-designated period of time

Sort work by work type (specialty, inpatient, outpatient, abstracting, etc)

Determine average (hourly, daily)

Throw out the highest and lowest numbers

Set performance standards

# Setting the Measures

Determine the average production you expect

Set performance standards

- Minimum
- Average
- High

Share measures and data with staff

# Industry Standards*

| Work Type | Minutes Per Chart | Charts per Day | Charts per Week |
|---|---|---|---|
| Inpatient | 30 | 15 | 75 |
| Same Day Surgery | 12 | 35 | 175 |
| Gastroenterology | 10 | 42 | 210 |
| Other Outpatient Charts | 4 | 105 | 525 |

*UNMH HIM Coding Productivity and Quality Standards

# Production Measures

Coding staff expectation:

| | |
|---|---|
| Exceeds: | Goal is met 90% or greater of the time |
| Average: | Goal is met 70-89% of the time |
| Minimum: | Goal is met 40-69% of the time |
| Not Meeting: | Goal is met < 40% of the time |

# Quality Measures

Coding staff is expected to meet quality expectations:

Meets:  Achieves 90% or more

Not Meeting:  All others

# The Audit Process

# The Audit Process
# Auditing the Medical Record

**Types of Audits**

Internal vs. External

Random vs. Focused

Prospective vs. Retrospective

**Steps in the Audit Process**

Understand the steps involved in the audit process

# Types of Audits

Internal vs. External Audits

An internal audit is one that is performed by members of the organization. Some large hospital systems have an internal audit department that is responsible for auditing all aspects of the healthcare system (not just the coding and billing).

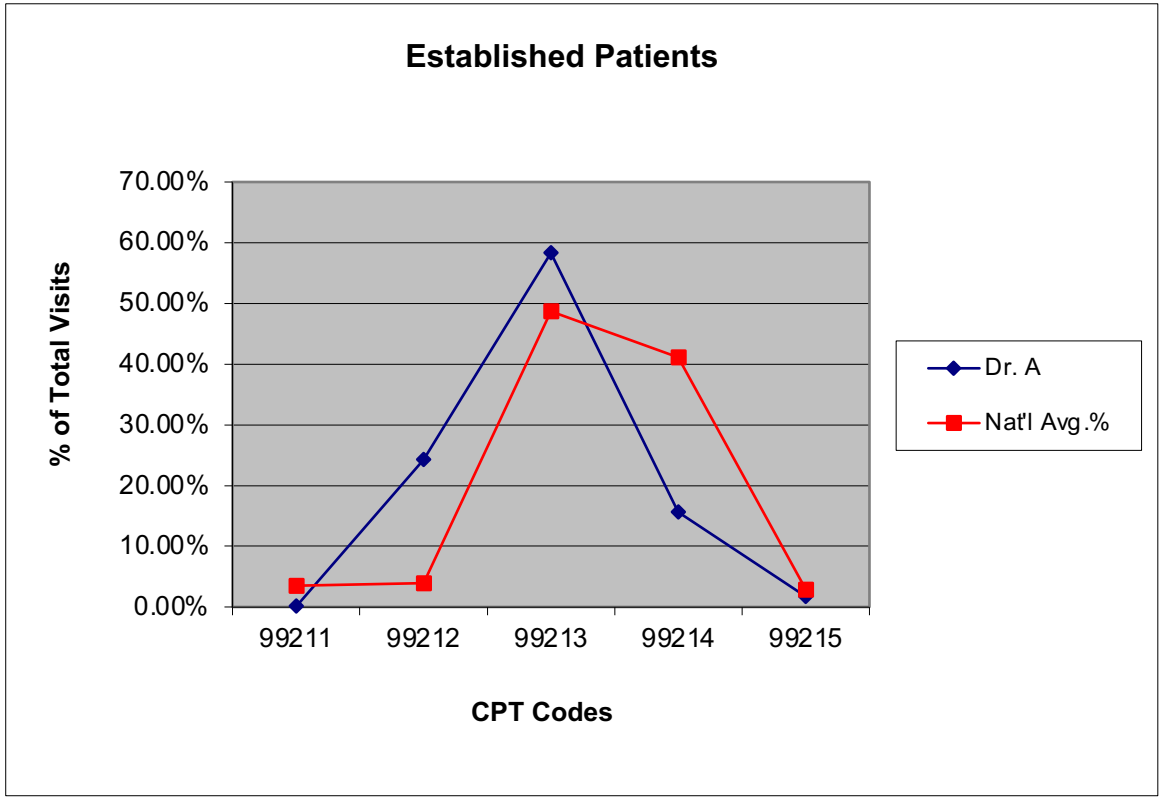
An external audit is one that is performed by an individual or group that is not a part of the organization or the practice.

# Types of Audits

Random vs. Focused Audits

Random audits – random selection of medical records to audit.

Focused audits – one item, one type of service, or one provider.



# Types of Audits

Prospective vs. Retrospective

Prospective audits – prior to claims submission

Retrospective audits – after claims submission and claims processing

# Types of Audits

Peer Review

Performed by another provider

Key when medical necessity is questioned

# Steps in the Audit Process

Determine the scope.

Determine the sample used for the final selection.

Consider what tools or resources will be required.

Gather the documentation and perform the audit.

Communicate results.

# Steps in the Audit Process

Determine the Scope

Type of Service

Office or Hospital

New vs. established patients

Consultation

Nursing home visits

Surgical Procedures

Patient Population

Government payers

Commercial payers

Self-pay

All Payers

A specific insurance carrier

Time Frame

Last quarter

Last year

One week

One day

# Steps in the Audit Process

Determine the sample used for the final selection

Identify measures

- Specific services (new patient visits, specific procedure, specific modifier, etc.)
- All services
- One provider vs all providers in the practice

Determine sample size

- 10-15 charts per provider
- All services performed on one day

# Steps in the Audit Process

CONSIDER WHAT TOOLS OR RESOURCES WILL BE REQUIRED

E/M Documentation Guidelines (1995 & 1997)

2023 Guidelines

Applicable Payer Guidelines & Contracts

Medical Policies

Bundling Edits

Office Policies

Additional Resources:

- CPT® Assistant references
- AHA Coding Clinic references
- Frequency reports by physician (utilization of levels of service obtained by the medical billing software)
- Utilization based on specialty (can be obtained by insurance carrier)
- Physician's fee schedule by insurance carrier
- Medical Dictionary
- Medical Terminology reference book
- OIG Work Plan
- Other coding references

# Steps in the Audit Process

Communicate results

Audit report

Communication with the audited provider/practice

Education and training

Ongoing audits

# Steps in the Audit Process

Gather the documentation and perform the audit

Onsite

Offsite

Who will gather the documentation

When will you receive the documenatation

Requesting additional information.

# Audit Communication Analysis and Report of Audit Findings

# The Audit Process
# Auditing the Medical Record

**The Audit Report**

The audit report is the primary method of communicating the results of an audit. We will explore the components of an audit report.

**Communicating Audit Results**

Communication usually occurs in two phases; written and oral. Here, we will discuss oral tips on communicating the results of an audit.

# The Audit Report

Components of an Audit Report

Background

Summary of audit findings

Standard of review

Issue-oriented findings

Discussion

Recommendations

Report attachments

# The Audit Report

Background

Dear Ms. Smith:

As instructed, I have analyzed the available clinical chart data for the claims selected by the Department of Justice ("**DOJ**") as reflected at Appendices B and C of this report. Specifically, you asked me to address Drs. XXXXX's and YYYYY's reporting of evaluation and management codes with modifier 25 in addition to minor surgical procedures on the same date. In the performance of this analysis, I have reviewed the materials indicated at Appendix A of this report in addition to the materials and references that are cited within this report. I have applied my nearly fifteen (15) years of experience as a healthcare compliance consultant and coding expert in formulating the opinions contained herein.

**A. SUMMARY OF EXPERTISE**

My complete Curriculum Vitae is attached at Appendix E of this report.

# The Audit Report

Summary of Audit Findings

B. SUMMARY OF FINDINGS

Both providers routinely reported an evaluation and management (“E/M”) service in addition to minor surgical procedures when performed on the same date.

In the case of Dr. XXXXX, 100 claims were audited. Some claims from the replacement pool were necessary due to the inability to obtain some records from the facility where the services were performed. Of the resulting 100 claims that were analyzed, only 6 cases were identified where the documentation did not support the use of modifier 25. Despite these 6 errors, significant coding at levels below those supported by the documentation were identified in the remaining 94 E/M services, which were appropriately reported as a significant and separately identifiable E/M services, resulting in a net underpayment of $600.92. The financial error rate for the sample as a whole was -14.41%.

In the case of Dr. YYYYY, the DOJ identified a primary sample of thirty (30) claims and provided a replacement pool of an additional fifteen (15) claims. The practice was unable to obtain many of the records but did locate fourteen (14) of the forty-five (45) primary and replacement claims. The audit of these 14 claims revealed that modifier 25 was appropriately reported in each case. One instance of coding below the CPT® level that was supported by the documentation was identified resulting in a net underpayment of $20.00 and a financial error rate of -3.00% for the claims audited.

# The Audit Report

Summary of Audit Findings (continued)

While routine reporting of an E/M service in addition to a surgical procedure such as debridement raises justifiable concern, the clinical facts evident in the cases reviewed supported the billing of Drs. XXXXX and YYYYY in nearly every case. While some error was evident, the majority of error was detrimental to the provider.

As is immediately self-evident through the records reviewed (and supported based on discussion with the practice), Drs. XXXXX and YYYYY work primarily with complex wound cases. The patients they manage have a number of co-morbid conditions and often have multiple wound sites. While the management of the co-morbid conditions such as peripheral vascular disease/venous insufficiency, lymphedema, cellulitis, and others has an indirect impact on how well a particular wound will heal, the conditions are not directly related to the wound (they exist and respond to treatment independent of each other) and therefore the evaluation and management of these conditions qualifies for separate reporting, especially where the express definition of modifier 25 provided by the American Medical Association ("AMA") Current Procedural Terminology Manual, 4th Edition ("CPT-4") is applied.

The specific clinical facts evidencing the separate E/M work of the providers and the basis for the level of service determinations is disclosed in the claim-specific audit results contained at Appendix B (for Dr. XXXXX) and Appendix C (for Dr. YYYYY). The clinical charts reviewed have been scanned electronically and are provided on a CD (Appendix D).

# The Audit Report

Standard of Review

C. STANDARD OF REVIEW

SEPARATE REPORTING OF THE E/M SERVICE:

Consistent with the MPIM guidance to analyze correct coding based on the coding guidance contained in the "Current Procedural Terminology-4 (CPT-4)…and any coding requirements listed in CMS manuals or MAC articles", the analysis of whether use of modifier 25 was appropriate must begin with the definition of the modifier as contained in the CPT® Manual as follows.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT® code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59. (Emphasis Added)

# The Audit Report

Issue-oriented  Findings

Doctor Name

Clinic Name

Date of Review 1/10/2023

Number of services Reviewed:  10

Audit Findings

- The E/M sample includes 10 dates of service yielding an accuracy rate of 90%.
- The CPT®/HCPCS II sample includes codes yielding an accuracy rate of 64%.
- The ICD-10-CM sample includes 32 codes yielding an accuracy rate of 91%.
- Coding errors associated with CPT® resulted in missed revenue opportunities for two dates of service where the documentation supported adding codes.
- One date of service in which the documentation either did not support the reported CPT® code or supported a different CPT® code.
- Only report diagnosis codes for conditions that are documented in the patient's medical record for the encounter.  Chronic conditions that do not affect the care being provided or conditions that are no longer present should not be reported as though they are active.
- Review diagnosis coding to be sure codes are reported at the highest level of specificity supported in documentation as well as reporting signs and symptoms in the absence of a definitive diagnosis.  Review Guidelines regarding proper sequencing of diagnosis.

# The Audit Report

Discussion

D. ANALYSIS

Application of the standard of review described above is reflected at Appendix B and C. The conclusions represent the conservative approach taken with respect to evaluating the appropriateness of modifier 25 as well as the level of E/M service that could be separately reported. Specifically, the documentation was reviewed for evidence of either: 1) E/M work associated with a diagnosis other than the ulcer that was surgically treated, or 2) E/M work associated with one or more ulcers that were not surgically treated (debridement, cauterization). Where such E/M work was identified, only the portions of the E/M service either associated with the diagnoses other than the ulcer/wound or the E/M work associated with an ulcer/wound that was not surgically treated, was considered when scoring the appropriate level of the E/M service.

# The Audit Report

Recommendations

E. CONCLUSION

Drs. XXXXX and YYYYY have, for the most part, reported their services accurately. To the extent there was error (as identified at Appendix B and C of this report), the error was detrimental to the provider overall. Under the express requirements of the CPT® Code Book as well as CMS guidance, no expression of error with respect to the level of service is possible given the unresolved ambiguity in these standards. Therefore, only when guidance beyond the AMA CPT® Code Book and Medicare Publications is applied, can we perform a quasi-objective analysis of the issues and adopt a scoring approach. Even under this most conservative but well-accepted E/M scoring approach, the audit result reveals a net underpayment for each provider. With respect to the use of modifier 25, only limited error was evident. Even where error was found, the cause of the error was most likely deficient documentation (the provider failed to record all of the work performed relative to the co-morbid conditions evident elsewhere in the record) rather than actual non-performance of the work represented by the CPT® code reported.

# The Audit Report Attachments

Attachments

Example List of Attachments:

- Appendix A – Standards/Documents Reviewed
- Appendix B – Claim-by-Claim Analysis – Dr. XXXXX
- Appendix C – Claim-by-Claim Analysis – Dr. YYYYY
- Appendix D – Chart Data (CD)
- Appendix E -- Curriculum Vitae

# The Audit Report

Example: Resources/Reference List

## Appendix A –Standards/References/Documents Reviewed

- Records of the Claims Identified in the Sample.
- 45 C.F.R. §§162.1000-1102
- American Medical Association, Current Procedural Terminology, (4th ed., Version in Effect).
- CMS, Medicare Claims Processing Manual, IOM Pub 100-4, Ch. 12, § 30.6.6.B.
- CMS, Medicare Program Integrity Manual, IOM Pub 100-8, Ch. 3, §3.6.2.4
- HHS OIG, Fraud and Abuse Work Plan (2002).
- AMA/HCFA (now CMS), Documentation Guidelines for Evaluation and Management Services, (1995) (accessed https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf)
- AMA/HCFA (now CMS), Documentation Guidelines for Evaluation and Management Services, (1997) (accessed https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf)
- E/M Scoring Worksheets Implementing Marshfield Scoring Criteria, https://www.acep.org/administration/reimbursement/reimbursement-faqs/medical-decision-making-and-the-marshfield-clinic-scoring-tool-faq/
- CMS, National Correct Coding Policy Manual, Version in Effect (accessed https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

# The Audit Report

Example: Service-Specific Results

| # | Patient | DOS | Reported | Documented | * EM Level | MDM or Time | ICD Reported | ICD Documented | Comments |
|---|---|---|---|---|---|---|---|---|---|
| 1 | XX | 10/15/20XX | 99213-25<br>11200 | 99213-25<br>11200<br>17000 | Correct | Low | E78.0<br>Q81.0<br>L57.0 | E78.0<br>Q81.0<br>L57.0 | Medical record documentation supports the reported E/M code.<br>Medical record documentation supports adding CPT® 17000.<br>Medical record documentation supports diagnosis code reported. |
| 2 | XX | 10/19/20XX | 99213-25<br>G0438 | 99213-25<br>G0438 | Correct | Low | Z00.01<br>E55.9<br>I10<br>M54.2 | Z00.00<br>E55.9<br>I10<br>M54.2 | Medical record documentation supports the reported E/M code.<br>Documentation supports a more specific diagnosis code. |
| 3 | XX | 11/3/20XX | 99214<br>36416 | 99214<br>No code | Correct | Moderate | E46<br>K31.84<br>R21<br>K13.79 | E46<br>K31.84<br>R21<br>K13.79 | Medical record documentation supports the reported E/M code.<br>Medical record documentation does not support CPT® 36415.<br>Medical record documentation supports diagnosis code reported. |

# Communicating Audit Results

Written communication

Audit report

- Educational tool
- Roadmap of achieving compliance

Writing style

- Persuasive
- Understandable

# Communicating Audit Results

Oral Communications

LISTEN

Do not be defensive or combative

Avoid pointing fingers

# Clinical Documentation Improvement

# Good Documentation

Medical record should be complete and legible

Documentation should include:

- Reason for the encounter (chief complaint)
- Relevant history (related to why the patient is here)
- Physical Examination (findings, observations)
- Test ordered and their results
- Assessment (clinical impression or diagnosis)
- Plan of care
- Date and signature of provider

# Additional Items

Rationale for ordering diagnostic or ancillary services should be documented or easily inferred

Past and present diagnoses available for review

Health risk factors should be identified

Documentation should support charges submitted on claim form

Medical record should be:

- Complete
- Concise
- Legible
- Timely

# Department of Health and Human Services (DHHS) Documentation Guidelines

Documentation:

Timely, accurate and complete

Appropriate for diagnoses and treatment

Medical Record Documentation:

Site of service

Appropriateness of service

Accuracy of billing

Identification of service provider

# Documentation Improvement in Physician Practice

Education

Documentation Improvement Programs

Physician Queries

Follow-up, Repetition, and Persistence

# Should the Medical Record be Addended?

Medical coders CANNOT add or change documentation in the medical record

Physicians must add additional information or missing information

Internal addendum policy should include:

- Process for changing, correcting or modifying medical record documentation

# A query should be considered when…

"Guidelines for Achieving a Compliant Query Practice" (AHIMA, 2016 Update)

Consider the following:

Conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent?

Description or associated clinical indicator without a definitive relationship to an underlying diagnosis?

Clinical indicator, diagnostic evaluation and/or treatment not related to a specific condition or procedure?

Provides a diagnoses without underlying clinical validation

Is unclear for present on admission indicator assignment

# A query should be considered when…

Remember:

Do not lead

Do not question the clinical judgment of the provider

Do not indicate the financial impact

Include clinical indicators

# Query Formats

Acceptable query formats:

- Open-ended
- Multiple Choice
- Yes/No

# Timelines for Queries

Medicare = No specific timeline for queries

General Rules to follow:

- Only attending physician can correct the medical record
- Corrections should be made within 30 days of the initial documentation and substantial reasoning must be provided for the change
- Amendment should be based on an observation of the patient on the date of service and signed by the observing physician

# Bottom Line for Physician Offices

Queries should be related to information or action taken during the specific date of service being queried.

Examples:

Results of lab, imaging, etc.

Diagnoses of active problem without documentation

Clinical indicators documented in the visit note without an accompanying diagnosis

Diagnoses coded/billed without indicating it was addressed/assessed

Contradictory information in the visit note

# Bottom Line for Physician Offices

Query to:

Add the appropriate diagnoses

Remove resolved diagnoses inappropriately coded

# Make it work

Work with your physicians

Engage physicians in the process

Develop a policy

Utilize secure methods of messaging and responding

# Clinical Documentation: Key Items

# Common Errors

Upcoding

Unbundling

Lack of medical necessity

Mismatched treatment/diagnosis codes

Typos in note

Not listing start and end times

Not listing where the patient and provider are located for telemedicine encounters

# General things we are looking for:

Chief Complaint

Medically appropriate history and exam

Medical Decision Making related to Medical Necessity

Start and End time for time-based codes

Age and Sex specific codes matching the patient

Signed Note

# Evaluation and Management (E/M)

Inspection and observation

Palpation- examination by touch

Auscultation-listening to body sounds

Percussion-Creating sounds from tapping on body areas

# New vs. Established Patient

New: has not received any face-to-face professional services from the physician/qualified health care professional, or a physician/qualified health care professional of the exact same specialty/subspecialty within the group practice, within the last 3 years

Established: has received face-to-face services in the last 3 years

# Common E/M services

Nurse Visits

Preventive Care Services

Telephone Services

Office and Other Outpatient services

# Nurse visits

99211 ONLY E/M code nurse can use

Patient must be established

It must be a face-to-face encounter

E/M service should be provided

Should NOT be reported when

- Purpose of visit is to pick up medication
- Purpose of visit is to administer injection or vaccine
- Vitals on the same day patient seeing provider
- BP Check not scheduled by provider
- Lab Draw

# Scenarios of 99211 Services

An established patient comes to the office with complaints of urinary burning and frequency.  The nurse takes a focused history, reviews the health record, discusses the situation with the physician and orders a urinalysis. The nurse then presents the findings to the physician, who writes a prescription for an antibiotic. The nurse communicates the instructions to the patient and documents the encounter in the health record.

# Scenarios of 99211 Services

An established patient comes to the office with complaints of urinary burning and frequency. The nurse takes a focused history, reviews the health record, discusses the situation with the physician and orders a urinalysis. The nurse then presents the findings to the physician, who writes a prescription for an antibiotic. The nurse communicates the instructions to the patient and documents the encounter in the health record.

**99211 and the appropriate laboratory code for the urinalysis should be reported because the E/M service is distinct from the lab service and appropriate for the evaluation of the patient's complaint.**

# Scenarios of 99211 Services

A patient comes to the office for a blood-pressure check.

# Scenarios of 99211 Services

A patient comes to the office for a blood-pressure check.

**If the visit was scheduled at the request of the physician, 99211 should be reported.**

**If the visit was prompted by the patient, the use of 99211 depends on whether there are clinical indications for the visit.**

**For example, 99211 should not be reported for the stable patient who decides to come in for a blood-pressure check while in the area, because the physician did not order the service and there were no clinical indications to validate the need for the visit. However, if the patient was experiencing problems (e.g., dizziness or headache) and the nurse took additional history, checked the patient's blood pressure and talked with the physician, 99211 would be appropriate since clinical indications prompted the intervention.**

# Preventive Medicine Services

Annual Physical Exam

Divided by new and established patient and by patient's age

If abnormality is encountered and is significant to require additional work

- Appropriate code from 99201-99215 reported with modifier 25 appended to the office/outpatient code

# Telephone services

## PHYSICIAN OR QHCP

- Codes 99441-99443
- Must be provided by a physician or other qualified health care professional
- Based on amount of time documented
- Patient must be established

- QHCP = Other Qualified Healthcare Professionals

## NON-PHYSICIAN OR NON-QHCP

Codes 98966-98968

Based on amount of time documented

# Medical Necessity

Becomes more prominent in code selection

Thought process in which a provider determines a diagnosis and treatment

One of two options in selection of a level of E/M service for Office and other outpatient services or one of the key elements for other categories of E/M

Supports the need to provide the service

# Definitions and Calculations of Time

Total time on the date of the encounter

Key take away items:

Face-to-face and non-face-to-face time = Total time

Time by the physician or QHCP – NOT time spent by clinical staff

All time on the DATE OF SERVICE – NOT the day before or the next day

No need to document > 50% of time spent

No need to document any phrasing relating to “counseling or coordination of care”

# What constitutes time?

Preparing to see the patient (eg, review of tests)

Obtaining and/or reviewing separately obtained history

Performing medically appropriate exam and/or evaluation

Counseling and educating the patient/family/caregiver

Ordering medications, tests, or procedures

Referring and communicating with other health care processionals (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

Coordination of Care

# Provider Documentation

Must be clear as to how the time was spent

- Activities performed needs to be clear!
- Documentation of how the time was spent needs to be clear!
  - If only total time is listed, you will likely get a query from the coder
- If two providers were seeing the patient, it needs to be clear!

# New Patient Requirements for E/M Codes on time

| Code | History/Exam | MDM | Total Minutes |
|---|---|---|---|
| 99202 | Medically Appropriate history and/or exam | Straightforward | 15-29 |
| 99203 | | Low | 30-44 |
| 99204 | | Moderate | 45-59 |
| 99205 | | High | 60-74 |

# Established Patient Requirements for E/M Codes on time

| Code | History/Exam | MDM | Total Minutes |
|---|---|---|---|
| 99212 | Medically appropriate history and/or examination | Straightforward | 10-19 |
| 99213 | | Low | 20-29 |
| 99214 | | Moderate | 30-39 |
| 99215 | | High | 40-54 |

# Bottom line for Time

It is Date Of Service Time

Must be a face-to-face

Only reporting provider time

Total time

# History and Exam

Medically appropriate history

Medically appropriate exam

- Determined by the Physician/Healthcare provider

Not counted in the level for office and other outpatient

E/M level are selected based on MDM or Total Time

# Medical Decision Making

Number and Complexity of Problems Addressed

- Self limited or minor
- Acute, uncomplicated
- Chronic, stable
- Chronic with exacerbation, progression or side effects from tx (acute on chronic)

Amount and Complexity of Data to be Reviewed and Analyzed

- Tests
- External records, communications or tests (from external physician or other qualified healthcare professional)
- Independent historian(s)
- Independent Interpretation

Risk

# Medical Necessity: Number and Complexity of Problems Addressed

Self-limited or minor problem:

A problem that runs a definite and prescribed course

Is transient in nature

Is not likely to permanently alter health status

If not treated, it would likely clear up on its own

# Medical Necessity: Number and Complexity of Problems Addressed

Acute, uncomplicated illness or injury:

A recent or new short-term problem with low risk of morbidity for which treatment is considered

There is little to no risk of mortality with treatment and full recovery without functional impairment is expected

A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course

Examples: Cystitis, allergic rhinitis or a simple sprain

# Medical Necessity: Number and Complexity of Problems Addressed

Stable, chronic illness:

A problem with an expected duration of at least a year or until the death of the patient

Conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes area single chronic condition)

“stable” is defined by the specific treatment goals for an individual patient

- Patient not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function

# Medical Necessity: Number and Complexity of Problems Addressed

Chronic illness with exacerbation, progression, or side effects of treatment:

A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care

Severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care

# Medical Necessity: Amount and Complexity of Data to be Reviewed and Analyzed

Tests: Imaging, laboratory, psychometric or psychometric data.

External: External records, communications and/or tests results from external physician, other qualified health care professional, facility or healthcare organization.

External physician or other qualified healthcare professional: Individual who is not in the same group practice or is a different specialty or subspecialty. Includes licensed professionals that are practicing independently, may also be facility or organizational provider such as hospital, nursing facility or home health care agency

# Medical Necessity: Amount and Complexity of Data to be Reviewed and Analyzed

Independent Historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to development stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.

Independent Interpretation: Interpretation of a test for which there is a CPT code and an interpretation or report is customary. A form of interpretation should be documented.

# Medical Necessity: Risk

Definition:

The probability and/or consequence of an event.

For Medical Decision Making:

Level of risk is based on consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forgo further testing, treatment and/or hospitalization.

# Medical Necessity: Risk

Key take away concepts:

... Consequences of the problems(s) addressed at the encounter when appropriately treated.

…Includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

Risk is based on consequences from appropriate treatment of conditions.

# How does this impact Medical Providers?

Reduces documentation overload

- History and Physical exam are no longer elements for code selection, but still need to be documented!
- Documentation based on MDM or total time
- Changing MDM criteria to focus on tasks that affect the management of the patients condition

Provide more time with patients

Removing ambiguity

Goal of Consistency

# Summary for Medical Providers

99211 will still be there, but there must be documentation of the reason for the encounter and any MDM by the reporting provider

Documentation for well visit and sick visit remains the same, just level the sick visit using the new guidelines

Documentation:

- An appropriate history and exam needed
- Needs to show complexity and treatment plans made that day
- Should indicate why the patient presented for care
- Medical necessity should be clear
- For time:
  - It is DOS Time
  - Must have a face-to-face
  - Only reporting provider time
  - Total time

# General Information for Coders

Ensure the documentation on the encounter matches the codes used

- If they don't query the provider
- If something is documented, but there is no code you can add the code to match the documentation

If documentation supports a code, but it's not billable

- LEAVE IT IN THE MEDICAL RECORD
- Billing should be removing these items from the claim, not coding staff from the medical record

If the patient comes in for a service, but there is no code or the CPT code used isn't billable

- Service Category should be ambulatory since they came in for services, NOT chart review

# Resources


AAPC, ICD-10-CM Clinical Documentation Improvement, 2014

AAPC, Healthcare Business Monthly, March 2017. “Query Physicians to Improve Documentation and DX Coding”

AHIMA, “Guidelines for Achieving a Compliant Query Practice” (2016 Update): http://acdis.org/system/files/resources/compliant-query-practice-2016.pdf

Medicare risk adjustment information: www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

Noridian, Jurisdiction E – Medicare Part B, Documentation Guidelines for Amended Medical Records, last updated on July 16, 2015: http://med.noridianmedicare.com/web/jeb/cert-reviews/mr/documentation-guidelines-for-amended-record

Medicare Program Integrity Manual, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf

AHIMA, “Managing an Effective Query Process,” August 2011

2004 Risk Adjustment Regional Training for Medicare Advantage Organizations Questions & Answers section

# Conclusion

Assess Productivity

Audit Communication

Audit report

Communicating audit results

Work with providers on clinical documentation improvement

# Questions?

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