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April 2010

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MEDICAL PRACTICE CONSULTANTS, INC.

E/M DOCUMENTATION CODING HEADACHES

Physicians and Medicare alike have struggled for many years with correct coding, documentation and reimbursement of E/M services. For over a decade the government, its Medicare contractors, private industry coding experts, health care organization compliance staff, physician organizations and others have lectured and written about correct E/M coding for services reported to Medicare. Among them, TrailBlazer has dedicated significant educational and medical review resources over the past several years to correcting E/M Comprehensive Error Rate Testing (CERT) errors. Despite all of the attention given to E/M coding, the errors continue for many reasons.

E/M services, by their nature, are a diverse set of cognitive procedures. The American Medical Association's complex CPT E/M code set describes the various physician work and expense scenarios encompassed within the procedures. Medicare is required by federal law to pay only for services that are medically reasonable and necessary. For E/M services, medical necessity applies to both the frequency and the intensity of paid E/M services. Add to these the conflicting information available about work-based coding and the relative lack of medical necessity-based coding instruction (not to mention the myriad issues that arise simply from the technical variability of physician and practitioner record-keeping), and it's easy to understand the current conundrum of recalcitrant E/M CERT error rates.

Medicare's definition of medical necessity requires that paid services meet but not exceed the patient's medical needs and be provided in accordance with accepted standards of medical practice. Accordingly, TrailBlazer believes that the patient's condition (severity, acuity, number of medical problems, etc.) is the key determinant for the frequency and intensity of E/M services for which Medicare pays. Coding E/M services first on the basis of medical necessity followed by verification of documentation of required key work components for the selected code allows coders and clinicians to avoid several common pitfalls of E/M documentation and coding. The CPT E/M codes, their CPT section preamble, and the CPT clinical examples (Appendix C) contain material that is useful for classifying severity of illness usually associated with the various E/M services. TrailBlazer uses the CPT definitions in its medical necessity determinations of E/M services and recommends that clinicians and coders do so as well.

Given this framework for E/M coding, the TrailBlazer medical director offered the following highly simplified "bottom-line" E/M coding advice.

"Regardless of how much history, physical examination and/or medical decision-making related to an E/M encounter are recorded:

- Do not consider reporting the highest two codes of any code family:
  - ◊ When fewer than three distinct medical conditions/complaints were evaluated and managed during the encounter.

  Or,
  - ◊ No problem evaluated and managed, without appropriate intervention, conferred at least a 50/50 likelihood of worsening, disability or death between the time of the current encounter and the next physician encounter.
- Do not consider reporting the highest codes of any code family:
  - ◊ When fewer than four distinct medical conditions/complaints were evaluated and managed during the encounter.

  Or,
  - ◊ No problem evaluated and managed, without appropriate intervention, conferred at least a 50/50 likelihood of worsening, disability or death between the time of that encounter and the next physician encounter."

Although this approach simplifies coding E/M services by eliminating from consideration the highest level codes for reporting services, in our opinion, it goes against the interpretation of the E/M guidelines by the majority of experts.

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Where man sees but withered leaves, God sees sweet flowers growing.

~ Albert Laighton

Although there is disagreement with the comments made by TrailBlazer regarding the highest two E/M levels, it is important to note when using the number of conditions for selecting a CPT E/M code, the medical record must demonstrate clearly that the conditions were significant and distinct, and the physician evaluated and managed those conditions in a manner consistent with accepted standards of care. It is insufficient to simply count the patient's conditions or problems if documented physician work to evaluate and manage those conditions or problems is absent from the record. Also, key component work elements required by the CPT code definition and CMS' E/M Documentation Guidelines absolutely must have been performed, must have been clinically reasonable and necessary, and must be properly documented in the patient's record.

The TrailBlazers medical director's "bottom-line" advice addresses the most common source of known Medicare E/M coding errors: failure of medical records to demonstrate the work of and/or medical necessity of higher level E/M services reported for payment. Adopting this coding approach will likely reduce the level of and payment for E/M services reported by some physicians and practitioners. But it does so by reducing inappropriate Medicare resource utilization. This approach can provide the tangible payoff of substantially reducing the burden and risk associated with unnecessarily documenting and coding clinically irrelevant key component work.

Other Payers

Equally confusing is the documentation requirements for CMS as compared to other Payers. According to the American College of Emergency Physicians the guidelines to follow include:

When coding for a claim that will be submitted to Medicaid (depending upon the state) and/or Medicare, you must use the CMS Documentation Guidelines for Evaluation and Management services. Some groups choose to follow CMS' guidelines across the board for all payers. Others follow CMS guidelines for Medicare and other governmental payers and apply CPT rules for all other patients. Keep in mind that for other payers, which guidelines you use will most likely depend upon whether or not you participate with the payer. If you participate, you must use the payer's designated guidelines and comply with associated payer policies. If you do not participate with a payer, then usually the CPT guidelines pertain.

EHRs

During the last several years, a significant number of articles have pointed out compliance problems intrinsic to the majority of current EHR systems. Chief among these relate to coding engines that fail to consider medical necessity, and certain types of data-entry functionality that result in "cloned documentation," in which the records of every visit read almost word-for-word the same except for minor variations confined almost exclusively to the chief complaint.

According to Medicare, *"Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made."*

Consultations

Effective for dates of services on or after January 1, 2010, CMS abolished Medicare's use of consultation CPT codes, 99241–99255. CMS has instructed physicians and other providers to use other applicable Evaluation and Management (E/M) CPT codes to report the services that formerly were coded as consultations.

Two options exist for coding services that do not meet the work and/or medical necessity requirements of 99221–99223. One option is to report the services using CPT code 99499© (unlisted evaluation and management service). Reporting 99499 requires submission of medical records and contractor manual medical review of the services prior to payment. The second option is to report a subsequent hospital care code that appropriately reflects physician work and medical necessity for the service. Reporting a subsequent care code avoids mandatory medical record submission and manual medical review.

CMS recognizes provider reluctance to "miscode" initial hospital care as subsequent hospital care. However, doing so is preferable in that it allows Medicare to process and pay the claims much more efficiently. For those concerned about miscoding these services, please understand that CMS will not find fault with providers who choose this option when records appropriately demonstrate the work and medical necessity of the subsequent code chosen.

Renee Brown will be one of the featured speakers during the up-coming OKMGMA Spring Conference in Tulsa, April 22nd—23rd, 2010.

If you are interested in attending, please go online for additional information.