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On the topic:

E/M Audit Issues
Brought on by EHR Templates

Aimee Wilcox,
CPMA, CCS-P, CST, MA, MT
Find-A-Code
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Evaluation and Management Audit Issues Brought on by EHR Templates

Presented By
Aimee Wilcox, CPMA, CCS-P, CST, MA, MT
Director of Content
Find-A-Code

"You must first investigate and then educate."

Objectives
- Review an EHR record
  - Provider scored
  - Auditor scored
- Review component-specific guidelines
- Documentation and EHR issues

Understanding Documentation Methods Facilitates Provider Education
Chief Complaint:
- Sinus infection
- Medication Refill

History of Present Illness:
The patient is a 55 year old Caucasian/White female established patient who presents for evaluation of moderate (severity) nasal (location) congestion that began 3 days ago (duration). The congestion involves the sinuses bilaterally. The onset of symptoms was gradual and may have been associated with an upper respiratory tract infection (context). The patient had an upper respiratory tract infection 3 days ago, which has not yet resolved. She reports the condition is uniformly present throughout the day (timing). The patient states the symptoms are alleviated by nose blowing. The patient states that the symptoms are aggravated by reclining (modifying factors). The patient also reports headache, nasal discharge and postnasal drip (associated signs/symptoms). The patient describes a bilateral thin (quality) nasal discharge that has been present for 3 days. The patient denies additional symptoms. The patient’s past medical history is noncontributory (PMH). The patient’s history of medication usage is noncontributory. The patient’s social and environmental history is noncontributory (SH). The patient has not received any prior treatment for this condition. Patient is here for medication refills. Patient needs her Norco and Tramadol refilled for her chronic pain. Patient needs a flu shot.
**Chief Complaint**
Per the 1995 & 1997 EM Guidelines a chief complaint is always required. The CC is a concise statement describing the symptom(s), problem(s), condition(s), diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s words.

**History of Present Illness (HPI)**
A chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present, scored on the presence of 8 elements documented in the medical record.

<table>
<thead>
<tr>
<th>8 Elements of HPI</th>
<th>Scoring:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>♦ Brief: Consists of 1-3 elements</td>
</tr>
<tr>
<td>Quality</td>
<td>♦ Extended:</td>
</tr>
<tr>
<td>Severity</td>
<td>♦ Consists of 4+ elements OR</td>
</tr>
<tr>
<td>Duration</td>
<td>♦ Status of three chronic conditions*</td>
</tr>
<tr>
<td>Timing</td>
<td></td>
</tr>
<tr>
<td>Context</td>
<td></td>
</tr>
<tr>
<td>Modifying factors</td>
<td></td>
</tr>
<tr>
<td>Associated signs/symptoms</td>
<td></td>
</tr>
</tbody>
</table>

**Chief Complaint:**
- Sinus infection
- Medication Refill

**History of Present Illness:**
The patient is a 55 year old Caucasian/White female established patient who presents for evaluation of moderate (severity) nasal (location) congestion that began 3 days ago (duration). The congestion involves the sinuses bilaterally. The onset of symptoms was gradual and may have been associated with an upper respiratory tract infection (context). The patient had an upper respiratory tract infection 3 days ago, which has not yet resolved. She reports the condition is uniformly present throughout the day (timing). The patient states the symptoms are alleviated by nose blowing. The patient states that the symptoms are aggravated by reclining (modifying factors). The patient also reports headache, nasal discharge and postnasal drip (associated signs/symptoms). The patient describes a bilateral thin (quality) nasal discharge that has been present for 3 days. The patient denies additional symptoms. The patient’s past medical history is noncontributory. The patient’s history of medication usage is noncontributory. The patient denies any prior treatment for this condition. The patient’s social and environmental history is noncontributory. The patient has not received any prior treatment for this condition. The patient is here for medication refills. The patient needs her Norco and Tramadol refilled for her chronic pain. The patient needs a flu shot.
**Chief Complaint**

**History of Present Illness**

**EHR Issues**

**CC/HPI EHR issues**

1. Note appears to have two authors when looking at the HPI.
   - Providers are adept at an organized HI (medical school)
   - Ancillary staff tend to perform patient intake and prepare patients for providers to streamline office time.
2. Who can document the CC?
3. Where can we find those guidelines?
4. Who can document the HPI?*  
   - Individual MACs post their rules on who can/can’t document the HPI.
5. Does the EHR system properly track entries by username?
6. Are providers allowing ancillary staff access to usernames/passwords?

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**Review of Systems (ROS)**

**Review of Systems:**

**Constitutional:** Denies: night sweats, weight loss, difficulty sleeping

**Eyes:** Denies: eye pain, impaired vision, dryness, dry eyes, discharge from eye

**HENT:** Denies: nasal obstruction, nasal congestion, postnasal drip, dental problems, snoring, oral ulcers

**Cardiovascular:** Denies: chest pain, irregular heartbeats, rapid heart rate, syncope

**Respiratory:** Admits: abnormal sputum production. Denies: wheezing, additional symptoms, except as noted in the HPI

**Gastrointestinal:** Denies: nausea, vomiting, diarrhea, constipation, blood in stools

**Skin:** Denies: rash, itching, new skin lesions, changes to existing skin lesions or moles

**Musculoskeletal:** Denies: joint pain, joint swelling

**Endocrine:** Denies: polyuria, polydipsia, cold intolerance, heat intolerance

**Hem-Lymph:** Denies: easy bleeding, easy bruising, lymph node enlargement or tenderness

**All Others Negative**

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**Provider Scored:**  
**Complete (10+OS)= 99215**
Defined:
An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

Purpose:
To aid the provider in identifying the actual condition, illness, disease, or injury the patient suffers from.

- Inquires about the system(s) directly related to the problem(s) identified in the HPI and others that may also be affected.

14 Organ Systems

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Eyes</th>
<th>Ears, Nose, Mouth, Throat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>Respiratory</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Musculoskeletal</td>
<td>Integumentary (skin/breast)</td>
</tr>
<tr>
<td>Neurological</td>
<td>Psychiatric</td>
<td>Endocrine</td>
</tr>
<tr>
<td>Hematologic/Lymphatic</td>
<td>Allergic/Immunologic</td>
<td></td>
</tr>
</tbody>
</table>

- "You must individually document those systems with positive or pertinent negative responses. For the remaining systems a notation indicating all other systems are negative is permissible."

Who can document the ROS?

CMS DG:
Comprehensive: "You must individually document those systems with positive or pertinent negative responses. For the remaining systems a notation indicating all other systems are negative is permissible." (Always check your MAC)
ROS EHR Issues

1. Templates (regular, prepopulated (macro), check boxes)
   - Who should be involved in setting these up and reviewing EHRs?*
2. Cloning or copy/paste*
   - Address this with compliance officer, provider, or practice manager.
   - Opens up a provider for a full audit when cloning is suspected.
3. Contradiction between CC/HPI and ROS*
4. Undocumented positives or pertinent negatives
5. Over documentation still not addressing affected OS

*Some EHR systems use templates that complete forms by checking a box, macros that fill in information by typing a key word, or auto-population of text when it is not entered. Problems can occur if the structure of the note is not a good clinical fit and does not accurately reflect the patient's condition and services. These features may encourage over-documentation to meet reimbursement requirements even when services are not medically necessary or are never delivered.*

- Is a complete ROS?
  - Allow for provider to get a pulse on patient health
    - Listen for key phrases of ("All I need for a higher level is...")
    - Frequency (what is reasonable?)
  - Disallow when...
    - Doesn’t hit positives/pertinent negatives from CC/HPI
    - Contradicts CC/HPI
    - Being done to hit higher code level

Past Medical, Family, & Social History (PFSH)

HPI Paragraph Contains PFSH Information
The patient's past medical history is noncontributory. The patient’s history of medication usage is noncontributory. The patient's social and environmental history is noncontributory. The patient has not received any prior treatment for this condition.

Past Medical History: Reviewed None Changed.
Past Surgical History: Reviewed None Changed.
Medication List: Reviewed None Changed.
Allergy List: Reviewed None Changed.
Family Medical History: Reviewed None Changed.
Genetic Screening: Reviewed None Changed.
Reproductive History: Reviewed None Changed.
Social History: Reviewed None Changed.
Immunizations: Reviewed None Changed.

Provider Scored:
PMH = 1, SH = 1, FH = 1
3 of 3 = Complete or 99215

“Non-contributory” & “Reviewed none changed” means the information wasn’t pertinent to the CC/HPI?

Rather, document the answer to the question asked.

(Not needed but still noted.)
**PFSH Guidelines**

**Past Medical History:** Experiences with illnesses, operations, injuries, and treatments.

**Family History:** A review of medical events, diseases, and hereditary conditions that may place the patient at risk.

**Social History:** An age-appropriate review of past and current activities.

**Scoring**

**Pertinent: (1/3)**
A review of the history areas directly related to the problem(s) identified in the HPI.

**Complete: (2/3 or 3/3)**
A review of two or all three of the history areas for services, that by their nature, include a comprehensive assessment or reassessment of the patient.

- What is the purpose of documenting a PFSH?
- Who can document PFSH?
- Do you use a questionnaire?
  - Paper
  - Electronic (part of MR)
- Do you know how to identify the information that pertains to each history area? (tobacco use, appendectomy, sister with breast cancer, still living)
- Was the information documented pertinent to the problem(s) identified in the HPI?

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**Past Medical, Family, and Social History (PFSH)**

**HPI Paragraph Contains PFSH Information**

“The patient’s past medical history is noncontributory. The patient’s history of medication usage is noncontributory. The patient’s social and environmental history is noncontributory. The patient has not received any prior treatment for this condition. Patient is here for medication refills. Patient needs her Norco and Tramadol refilled for her chronic pain. Patient needs a flu shot.”

**Template PFSH Section**

- **Past Medical History:** Reviewed None Changed.
- **Past Surgical History:** Reviewed None Changed.
- **Medication List:** Reviewed None Changed.
- **Allergy List:** Reviewed None Changed.
- **Family Medical History:** Reviewed None Changed.
- **Genetic Screening:** Reviewed None Changed.
- **Reproductive History:** Reviewed None Changed.
- **Social History:** Reviewed None Changed.
- **Immunizations:** Reviewed None Changed.

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**Remember CC/HPI**

- Nasal discharge
- URI
- Headache
- Postnasal drip
- Chronic pain
- Meds refill
- Flu shot

**Auditor Scored:**

- **PMH = 0, SH = 0, FH = 0**
- **None = 99213**

- Duplicity (HPI and PFSH) that contradict each other.
- No date reference for “reviewed none changed”
- “Noncontributory” = not needed?
- What was the provider looking for or is this a result of pulling information forward?
- Is the patient taking any medications or does he have any allergies the provider should be aware of before prescribing today?
- What is the current dosage of current meds that need refilled and last refill dates?
**PFSH HER Issues**

- **HER?** Did you mean EHR? Edit, edit, edit!
  - When not done – the integrity of the note is compromised.
- Copy/Paste, Pull forward, Bulletin board holding area.
  - Who updates/edits?
- Ancillary staff and provider both documenting can look disorganized.
- Can the provider edit the EHR to include/discard items?
- “Unchanged” from a prior DOS? What DOS?
- “Noncontributory” do your payers accept that phrase?
- Provider’s signature makes this a legal document.
  - What’s their comfort level in front of a judge?
- Contact the EHR vendor about things that don’t work.

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**Overall History Level**

**Provider:**
- CC: Present
- HPI: Extended 99215
- ROS: Complete 99215
- PFSH: Complete 99215
  
**Auditor:**
- CC: Present
- HPI: Extended 99215
- ROS: None 99212
- PFSH: None 99213
  
**Overall History:** 99215

**Rule:**
The lowest score in any of the subcomponents of history is the overall history score.
### Physical Examination: (page 1 of 2)

**Constitutional:**
- Appearance: Well developed, well nourished, obese, alert, male in no acute distress, seated upright.
- **Vitals:**
  - Time: 02:21 pm; BP: 138/73 sitting; HR: 96-R; RR: 18; temp (F): 97.7; WT: 196 lbs 6 oz; HT: 5' 2''; BMI kg/m²: 35.92; BSA m²: 1.97; O2 sats: 93%.

**Head/Face:**
- **Eyes:**

**ENT:**
- **Ears:** External ears: appearance within normal limits, no lesions present. Otoscopic examination: Tympanic membranes appearance within normal limits bilaterally without perforations, mobility normal.
- **Nose:** Appearance normal. Intranasal exam: Mucosa within normal limits, vestibules normal, no intranasal lesions present, septum midline.

### Physical Examination: (page 2 of 2)

**Neck:**
- Inspection/Palpation: Normal appearance, no masses or tenderness, trachea midline. Range of Motion: Cervical range of motion within normal limits.
- **Thyroid:** gland size normal, nontender, no nodules or masses present on palpation, trachea midline.

**Respiratory:**
- Respiratory Effort: breathing unlabored. Auscultation of Lungs: Normal breath sounds.

**Cardiovascular:**
- **Heart:** Auscultation of Heart: Regular rate and rhythm, no murmurs present. Peripheral Vascular System: Extremities: no edema or cyanosis.

**Lymphatic:**
- **Neck:** no lymphadenopathy present.

**Skin:**
- Inspection: no rashes present, no lesions present, no areas of discoloration present. Palpation: no abnormalities on palpation, no masses present on palpation, no tenderness to palpation.

**Psychiatric:**
- Mood and Affect: mood normal, affect appropriate.
Double Dipping You Say?

Double dipping has been misconstrued since the CMS 1997 Train the Trainer Conference with HCFA director, Bart McCann, MD, where his comment and coinining the term “double dipping” came about.

This comment
“cannot use one statement to count as two elements”

had to be clarified (over and over again) to reiterate his true meaning of

“cannot use a single statement to count as two elements within the same component.”

Attached copies of documentation supporting these claims is available.

1995 PE Guidelines

<table>
<thead>
<tr>
<th>1995 Guidelines</th>
<th>Body Areas</th>
<th>Organ Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prob Focused</strong></td>
<td>Head</td>
<td>Constitutional</td>
</tr>
<tr>
<td>1 BA or OS</td>
<td>Neck</td>
<td>Eyes</td>
</tr>
<tr>
<td><strong>ExpPF</strong></td>
<td>Chest (breasts/axillae)</td>
<td>Ears, Nose, Mouth, Throat</td>
</tr>
<tr>
<td>2-7 BA or OS</td>
<td>Abdomen</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>No OS in detail</td>
<td>Back including spine</td>
<td>Respiratory</td>
</tr>
<tr>
<td><strong>Detailed</strong></td>
<td>Genitalia/Groin/Buttocks</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>2-7 BA or OS</td>
<td>Each extremity</td>
<td>Genitourinary</td>
</tr>
<tr>
<td>w/affected OS detailed</td>
<td></td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td><strong>Comp</strong></td>
<td></td>
<td>Skin</td>
</tr>
<tr>
<td>8+ OS</td>
<td></td>
<td>Neurologic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychiatric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hem/Lymph/Immunologic</td>
</tr>
</tbody>
</table>

- Document specific abnormal and relevant negative findings in affected/symptomatic BA/OS. Abnormal without elaboration is insufficient
- Abnormal/Unexpected findings in unaffected BA/OS should be documented
- Count body areas and organ systems separately. (not a combined total)
- What’s the difference between ExpPF and Detailed?
  - Some MACs have defined as 4x4
- Put the right info in the right BA or OS for credit
- No specific bullet points so anything counts if it pertains to the BA or OS
Physical Examination: (page 1 of 2)

Constitutional: ❖
   Appearance: Well developed, well nourished, obese, alert, male in no acute distress, seated upright. **Vitals:** Time: 02:21 pm; BP: 138/73 Sitting; HR: 96-R; RR: 18; Temp (F): 97.7; WT: 196 lbs 6 oz; HT: 5’2”; BMI kg/m²: 35.92; BSA m²: 1.97; O₂ sats: 93%.

Head/Face: ❖
   Head: inspection: normocephalic, atraumatic. Face: inspection: No facial lesions. Palpation: no sinus tenderness on palpation

Eyes: ❖
   Conjunctivae: Conjunctivae normal (inspection). Sclera: Sclera are white (inspection). Pupils/Irises: PERRLA bilaterally. Eyelids/Ocular Adnexa:
   Eyelid appearance normal, no exudates present, eye moisture level normal.

ENT: ❖

Physical Examination: (page 2 of 2)

Neck: ❖
   Inspection/Palpation: Normal appearance, no masses or tenderness, trachea midline. Range of Motion: Cervical range of motion within normal limits. Thyroid: gland size normal, nontender, no nodules or masses present on palpation, trachea midline.

Respiratory: ❖
   Respiratory Effort: breathing unlabored. Auscultation of Lungs: Normal breath sounds.

Cardiovascular: ❖
   Heart: Auscultation of Heart: Regular rate and rhythm, no murmurs present. Peripheral Vascular System: Extremities: no edema or cyanosis

Lymphatic: ❖
   Neck: no lymphadenopathy present.

Skin:
   Inspection: no rashes present, no lesions present, no areas of discoloration present. Palpation: no abnormalities on palpation, no masses present on palpation, no tenderness to palpation.

Psychiatric:
   Mood and Affect: mood normal, affect appropriate.

❖ Were specific abnormal and relevant negative findings in affected/symptomatic BA/OS documented? **YES**

Auditor Score: 1995 Guidelines

Organ Systems:
Constitutional Eyes ENT (affected detailed)

Body Areas
Head/Face

Page 1
3 OS with ENT in detail
1 BA

❖ ENT is the affected OS and it has more detail than the other OS
❖ It’s possible for affected OS to be normal on exam
❖ Note: Patient had a normal temp on vitals. It happens

Remember CC/HPI
- Nasal discharge
- URI
- Headache
- Postnasal drip
- Chronic pain
- Meds refill
- Flu shot
Physical Examination: (page 1 of 2)

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Head/Face:
Head: inspection: normocephalic, atraumatic. Face: inspection: No facial lesions. Palpation: no sinus tenderness on palpation

Eyes:

ENT:

*scores on next page*

Physical Examination: (page 2 of 2)

Neck:
Inspection/Palpation: Normal appearance, no masses or tenderness, trachea midline. Range of Motion: Cervical range of motion within normal limits (MSL). Thyroid: gland size normal, nontender, no nodules or masses present on palpation, trachea midline.

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Respiratory Effort: breathing unlabored. Auscultation of Lungs: Normal breath sounds.

Cardiovascular:
Heart: Auscultation of Heart: Regular rate and rhythm, no murmurs present. Peripheral Vascular System: Extremities: no edema or cyanosis (skin)

Lymphatic:
Neck: no lymphadenopathy present. **(requires 2 areas to qualify)**

Skin:
Inspection: no rashes present, no lesions present, no areas of discoloration present. Palpation: no abnormalities on palpation, no masses present on palpation, no tenderness to palpation.

Psychiatric:
Mood and Affect: mood normal, affect appropriate.

**Provider Scored 1997 GMS Guidelines**

Constitutional (2)
- VS x 3
- General appearance

Head/Face (1)
- Inspection of head/face

Eyes (3)
- Inspection conjun/lids
- Exam pupils/irises

ENT (5)
- Ex inspection ear/nose
- Otoscopic exam
- Inspection intranasal
- Insp teeth, lips, gums
- Inspection oropharynx

Neck (2)
- Exam neck
- Exam of thyroid

Respiratory (2)
- Effort
- Auscultation

Cardiovascular (2)
- Auscultation
- Extremities: no edema

Lymphatic (1)
- Neck-no lymphad

Skin (2)
- Palpation
- Inspection

Psychiatric (1)
- Mood/Affect

21 bullet points in 10 BA/OS = 99215
Physical Examination: (page 1 of 2)

Constitutional:
Appearance: Well developed, well nourished, obese, alert, male in no acute distress, seated upright. **Vitals:** Time: 02:21 pm; BP: 138/73 sitting; HR: 96-R; RR: 18; temp (F): 97.7; WT: 196 lbs 6 oz; HT: 5' 2"; BMI kg/m²: 35.92; BSA m²: 1.97; O2 sats: 93%.

Head/Face:
Head: inspection: normocephalic, atraumatic (MS). Face: inspection: No facial lesions (skin). Palpation: no sinus tenderness on palpation

Eyes:

ENT:

### Physical Examination: (page 2 of 2)

**Neck:**
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**Lymphatic:**
- Neck: no lymphadenopathy present. *(requires 2 areas to qualify)*

**Skin:**
- Inspection: no rashes present, no lesions present, no areas of discoloration present. Palpation: no abnormalities on palpation, no masses present on palpation, no tenderness to palpation. *(doesn't state where on body so only two points for inspection (general) and palpation (general))*

**Psychiatric:**
- Mood and Affect: mood normal, affect appropriate.

---

### Auditor Scored

**Using 1997 Guidelines**

<table>
<thead>
<tr>
<th>Neck (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam neck</td>
</tr>
<tr>
<td>Exam of thyroid</td>
</tr>
<tr>
<td>MS (head/neck) (2)</td>
</tr>
<tr>
<td>Head: Inspection*</td>
</tr>
<tr>
<td>Neck: Range of Motion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effort</td>
</tr>
<tr>
<td>Auscultation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiovascular (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auscultation</td>
</tr>
<tr>
<td>Exam: no edema</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lymphatic (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No points (0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin (2) (face included)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palpation</td>
</tr>
<tr>
<td>Inspection</td>
</tr>
<tr>
<td>Psychiatric (1)</td>
</tr>
<tr>
<td>Mood/Affect</td>
</tr>
</tbody>
</table>

2 bullet points in 1 BA OR 21 bullet points in 9 OS

**Selected organ systems**

- Comprehensive or 99215

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### Physical Examination EHR Issues

- Templates can create opportunities for upcoding*
  - Do most of the provider’s notes look the same?
  - Exact wording is the same?
  - Provider exam habits and documentation constants.
  - What do your providers always check?

- Prepopulated macro templates
  - Editing errors
  - Contradictions

- Some exams are normal, even when the patient is symptomatic.
  - Discuss oddities with provider if possible (internal auditor).
  - Benefit of the doubt to provider (external auditor)

- Was more done than needed to be?
  - Psychiatric: Possible upcoding? Without it the 95 exam is detailed
  - Skin: Rash is common with URIs but w/o it the 95 exam is detailed

- Which areas of the EM service tend to have pre-populated templates?
**Overall PE Level**

<table>
<thead>
<tr>
<th>Provider:</th>
<th>1995</th>
<th>Comprehensive 99215</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1997</td>
<td>Comprehensive 99215</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Auditor</th>
<th>1995</th>
<th>Comprehensive 99215</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1997</td>
<td>Comprehensive 99215</td>
</tr>
</tbody>
</table>

**Rule:**
Best score takes the cake.

## Medical Decision Making (MDM)

### Assessment:
1. Sinusitis, Acute (461.9/J01.90)
2. Migraine without status migrainosus, not intractable, unspecified migraine type (346.90/G43.090)
3. Low back pain without sciatica, unspecified back pain laterality (724.2/M54.5)

### Plan:
1. Administer immunization today for flu vaccine 3 above (Quad) given (90688).AW
2. Refill on following medications:
   3. Norco 10-325 mg oral tablet. Take 1 tablet by oral route every 6 hours as needed for pain for 30 days, #90 tablets with 0 refills.
   4. Tramadol 50 mg oral tablet. Take 1 tablet (50mg) by oral route every 6 hours as needed #60 tablets with 2 refills.
   5. Zithromax 500 mg oral tablet. Take 1 tablet (500 mg) by oral route once daily for 3 days #3 tablets with 0 refills.
6. Return to office as needed. Call or return if symptoms worsen.

### Provider Scored Diagnoses:
- Acute sinusitis (new, 3 points)
- Migraine (new, 3 points)
- Low back pain (estab, stable, 2 points)

Total 8 points

### Data:
- None ordered and None reviewed
- Minimal or 99212

### Risk:
- Prescription management
- Moderate or 99214

Overall: 99214
MDM Guidelines

The complexity of establishing a diagnosis and/or selecting a management option as measured by:

- **Diagnoses**: Number of possible diagnoses and/or the number of management options that must be considered.
- **Data**: Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
- **Risk**: The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

**Marshfield Clinic Scoring Tool**

This tool was created by auditors at the Marshfield Clinic, where the EM Guidelines were tested, because auditors realized the rules governing MDM calculation were too vague. Most of the Medicare carriers use this tool to calculate the MDM, with the exception of TrailBlazer, who has their own tool. Unless the payer recommends a specific MDM calculation tool, you can use this one.

<table>
<thead>
<tr>
<th>Level of Complexity</th>
<th>Diagnoses</th>
<th>Data</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal (1)</td>
<td>Minimal (1)</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Low (2)</td>
<td>Low (2)</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Moderate (3)</td>
<td>Moderate (3)</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>High (4+)</td>
<td>High (4)</td>
<td>High</td>
</tr>
</tbody>
</table>
### Medical Decision Making

**Assessment:**
1. Sinusitis, Acute (461.9/J01.90)
2. Migraine without status migrainosus, not intractable, unspecified migraine type (346.90/G43.090)
3. Low back pain without sciatica, unspecified back pain laterality (724.2/M54.5)

**Plan:**
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   5. Zithromax 500 mg oral tablet. Take 1 tablet (500 mg) by oral route once daily for 3 days #3 tablets with 0 refills.
6. Return to office as needed. Call or return if symptoms worsen.

### Auditor Scored

**Diagnoses:**
- Acute sinusitis (new, 3 points) (Max = 1)
- Migraine (new, 0 points)
- Low back pain (0 points)

**Total 3 points**

**Moderate complexity = 99214**

**Data:**
- None ordered and None reviewed

**Total = 0 points**

**Minimal = 99212**

**Risk:**
- Prescription management
  - Prescription meds filled (moderate)
  - Flu shot (moderate)

**Moderate or 99214**

Drop the lowest and highest scores.

**Overall MDM score: 99214**

### MDM EHR Issues

- **Diagnoses**
  - Random diagnoses show up in the assessment but weren’t in the CC/HPI, ROS, or checked out on the PE.
  - Providers tend to forget to document the status of the diagnoses listed in the Assessment.
  - Document well a differential diagnosis (“probable”, “possible”, “rule out”)
  - Providers who put their thought process in the assessment and not just a “diagnosis and code” will have a better chance at passing an audit and identifying medical necessity.
MDM EHR Issues

Data
- Results in random locations.
- Lists of data that are not relevant to the current encounter brought into the note with copy/paste or pull forward.
- Forgetting to document within the body of the note, orders and findings.
- Data documented but the reader cannot tell if the service was performed/billed by the provider or just ordered/reviewed.
- Summarization of medical records reviewed documented.
- One point per type of data (Clinical tests, Radiology Section, Medicine Section, etc.)
- Documenting provider discussions with performing providers.

MDM EHR Issues

Risk
- The Table of Risk is not a comprehensive list. (immunizations?)
- The highest level of risk from any of the three columns = the overall Risk for the encounter.
- Providers who identify the status of any diagnosis allow a better level of risk to be assigned and upheld in an audit.
- Providers are forgetting to put their train of thought in the note. EHRs make it more generic and less individual.
- Risk is individual. Surgery on a healthy 21 year-old vs. the same surgery on a 55 year-old with chronic conditions.
- Risk of death due to anesthesia isn’t the concern, but how it differs for each patient is. Some people are denied surgical intervention due to the risk being too high for them to go under a general anesthetic.
- Consider including providers, compliance officers, coders, and internal auditors in the process of setting up EHR templates.
Overall EM Code Selection

Provider selected:
- History: 99215
- PE: 99215
- MDM: 99214
- OVERALL: 99215

Auditor selected:
- History: 99212
- PE: 99215
- MDM: 99214
- OVERALL: 99214

This EM service was upcoded by one level. This is a COMMON error. In 2010, CMS reported that 55% of EM services were incorrectly coded and/or lacking documentation with 79% of miscoded claims upcoded or downcoded by just one level.*

Questions

- What would you do differently?
- How does your organization handle the gray areas of auditing?
- Are you satisfied with your EHRs performance?

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