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Pam Joslin,
MM, CMC, CMIS, CMOM

On the topic:

E/M Auditing - Telling an Accurate Patient Story
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E/M Auditing: Telling an Accurate Patient Story

Brought to you by
Pam Joslin, MM, CMC, CMIS,
CMOM, CMCO, CEMA
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Introduction

• The Medical record is a legal document that serves as a chronological record of pertinent facts and observations about a patient’s health.

• A chart audit is an examination of medical records to determine how well a practice performs.

• The Office of Inspector General (OIG) has initiated audit initiatives to determine whether Medicare is making erroneous payments.

• A baseline audit should be conducted to examine the claim development and submission process.

What Causes a Carrier Audit?

• Random audits
• Complaints from patients and employees
• Repeated billing problems from carrier
• Abnormal distribution of E/M levels of care
• Unusually high numbers of any single code
• Failure to follow non-par Medicare rules
• Failure to routinely collect deductibles and co-pays
• Medical record that does not support the CPT® code
Improper Payments for E/M Services Cost Medicare Billions

- Medicare paid $32.3 billion for E/M services in 2010, representing nearly 30 percent of Part B payments that year. E/M services are divided into broad categories that reflect the type of service, the place of service, and the patient’s status.
- In 2012, OIG reported that from 2001 to 2010, physicians increased their billing of higher level codes for E/M services in all visit types. Additionally, OIG identified 1,669 physicians who consistently billed for the two highest level codes for E/M services in 2010.

E/M services must be medically reasonable and necessary, in addition to meeting the individual requirements of the CPT® code that is used on the claim. According to CMS, “[I]t would not be medically necessary or appropriate to bill [for] a higher level of [E/M] service when a lower level of service is warranted.”
- Physicians are responsible for ensuring that the claims they submit to Medicare accurately reflect the E/M services provided and the billing levels corresponding to those services.
Audit Surveillance Increasing

• The Office of the Inspector General is increasing its audit surveillance.

• New attention from the OIG, RACs, ZPICs, PSCs are resulting in medical offices losing thousands of dollars annually.

Types of Audits

• There are many types of medical record audits:
  – Internal audits
  – Preliminary audits
  – Comprehensive audits
  – Retrospective audits
  – Pre-payment audits
  – Compliance audits
  – External audits
Percentage of E/M Claims and Type of Error

<table>
<thead>
<tr>
<th>Type of Error</th>
<th>Percentage of Claims for E/M Services</th>
<th>Medicare Payments (in billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrectly Coded</td>
<td>51.3%</td>
<td>$7.9</td>
</tr>
<tr>
<td>- Miscoded</td>
<td>(0.7%)</td>
<td>(51.0%)</td>
</tr>
<tr>
<td>- Upcoded</td>
<td>0.7%</td>
<td>$0.1</td>
</tr>
<tr>
<td>- Downcoded</td>
<td>20.2%</td>
<td>$2.8</td>
</tr>
<tr>
<td>- Other Coding Error (e.g., Wrong Code, Unbundling)</td>
<td>14.5%</td>
<td>$4.6</td>
</tr>
<tr>
<td>- Lacking Documentation</td>
<td>2.0%</td>
<td>$0.5*</td>
</tr>
<tr>
<td>- Insufficiently Documented</td>
<td>10.0%</td>
<td>$2.6</td>
</tr>
<tr>
<td>Overall Gross**</td>
<td>51.3%</td>
<td>$7.9</td>
</tr>
<tr>
<td>Overall Net**</td>
<td>54.6%</td>
<td>$6.7</td>
</tr>
</tbody>
</table>

*The 95-percent confidence interval for this point estimate was $80,378,029 to $820,370,881. Because few sampled claims for E/M services in 2010 fell into the category of “other coding error,” the confidence interval for this estimate was wide.

**The column sum of certain percentages and dollar figures does not equal the overall gross or net totals because of rounding. Source: OIG analysis of 2010 E/M medical records, 2014.

Source: https://oig.hhs.gov/oei/reports/oei-04-10-00181.pdf

Percentage of Upcoded & Downcoded Claims for E/M

Additionally, claims for E/M services billed for by high-coding physicians were more likely to be insufficiently documented than those billed for by other physicians. Twenty percent of claims for E/M services billed for by high-coding physicians were insufficiently documented compared to 12 percent of those billed for by other physicians. The difference in error rates for undocumented claims by stratum was not statistically significant at the 95-percent confidence level.

Audit Findings

- 55% of claims for E/M services were incorrectly coded and/or lacking documentation
- 26% were upcoded
- 15% were downcoded
- 12% were insufficiently documented
- 7% were undocumented
- 2% had other coding errors

Claims for E/M services billed for by high-coding physicians were more likely to be incorrectly coded or insufficiently documented than those billed for by other physicians.

What Can Your Healthcare Organization Do to Avoid Audits?

1. Ensure your practice has a WRITTEN compliance program.
2. Ensure that your practice has a Billing Policy Manual.
3. Ensure that your healthcare organization conducts periodic chart audits internally.
4. Attend education sessions for the entire office on a regular basis.
5. A billing service should be investigated thoroughly prior to hiring.
6. Use only CURRENT ICD-10 and CPT® coding books.
7. Develop/Use forms and checklists to eliminate human error.
8. New providers hired should be trained on documentation guidelines.
DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES

General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient’s status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services:

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:
   – reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   – assessment, clinical impression or diagnosis;
   – plan for care;
   – date and legible identity of the observer.
General Principles of Medical Record Documentation

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient's progress, response to and changes in treatment, as well as revision of diagnosis should be documented.

7. The CPT® and ICD-10 codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Documentation of E/M Services

The descriptors for the levels of E/M services recognized seven components that are used in defining the levels of E/M services. These components are:

- history
- examination
- medical decision making
- counseling
- coordination of care
- nature of presenting problem; and
- time
• The first three of these components - history, examination, and medical decision making) - are the key components in selecting the level of E/M services.
• Because the level of E/M service is dependent on all three key components, performance, and documentation of one component at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.
• These documentation guidelines for E/M services reflect the needs of the typical adult population.

Documentation of E/M Services

Documentation of History

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

• Chief complaint (CC);
• History of present illness (HPI);
• Review of systems (ROS); and
• Past, family and/or social history (PFSH).

The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).
# Capsulization of History Documentation Requirements

<table>
<thead>
<tr>
<th>Chief Complaint</th>
<th>History of Present Illness</th>
<th>Review of Systems</th>
<th>Past, Family and/or Social History</th>
<th>Type of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>V</td>
<td>Brief (1-3)</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>V</td>
<td>Brief (1-3)</td>
<td>Problem Pertinent</td>
<td>N/A</td>
<td>Extended Problem Focused</td>
</tr>
<tr>
<td>V</td>
<td>Extended (4+)*</td>
<td>Extended (2-9)</td>
<td>Pertinent (1 of 3)</td>
<td>Detailed</td>
</tr>
<tr>
<td>V</td>
<td>Extended (4+)*</td>
<td>Complete (10+)</td>
<td>Complete (2 of 3) or (3 of 3)**</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

*Status of 3 chronic of inactive conditions
**2 of 3 is for an established patient; 3 of 3 is for a new patient

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

**DG:** A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. The review and update may be documented by:

- Describing any new ROS and/or PFSH information or noting there has been no change in the information; and
- Noting the date and location of the earlier ROS and/or PFSH.
• **DG:** The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. There must be a notation supplementing or confirming the information recorded by others.

• **DG:** If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance which precludes obtaining a history.

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**Chief Complaint**

**Chief complaint (CC)**

• The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s words.

• **DG:** The medical record should clearly reflect the chief complaint.
History of Present Illness (HPI)

- The HPI is 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. It includes the following elements:
  - location,
  - quality,
  - severity,
  - duration,
  - timing,
  - context,
  - modifying factors, and
  - associated signs and symptoms.

- Brief and extended HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

- A brief HPI consists of one to three elements of the HPI.
  - **DG**: The medical record should describe one to three elements of the present illness (HPI).

- An extended HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.
  - **DG**: The medical record should describe at least four or more elements of the present illness (HPI) or status of at least three chronic or inactive conditions.
Review of Systems (ROS)

A ROS is 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. For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Problem Pertinent ROS

- A problem pertinent ROS inquires about the system directly related to the problem(s) identified in the HPI.
  
  ● **DG:** The patient’s positive responses and pertinent negatives for the system related to the problem should be documented.

- An extended ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

  ● **DG:** The patient's positive responses and pertinent negatives for two to nine systems should be documented.
Complete ROS

- A **complete** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

  **DG:** At least 10 organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least 10 systems must be individually documented.

Past, Family and/or Social History (PFSH)

The PFSH consists of a review of three areas:

- past history (the patient’s past experiences with illnesses, operations, 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 PFSH

A *pertinent* PFSH is of a review of the history area(s) directly related to the problem(s) identified in the HPI.

*DG*: *At least one specific item from any of the three history areas must be documented for a pertinent PFSH*

Complete PFSH

A *complete* PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

*DG*: *At least one specific item from two of the three history areas must be documented for a complete PFSH for the following E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.*
**Past History**

A review of the patient's past experiences with illnesses, injuries, and treatments that include significant information about:

- prior major illnesses and injuries
- prior operations
- prior hospitalizations
- current medications
- allergies
- age appropriate immunizations
- age appropriate feeding/dietary status

**Family History**

A review of medical events in the patient's family that includes significant information about:

- the health status or cause of death of parents, siblings, and children
- specific diseases related to problems identified in the chief complaint or history of the present illness and/or review of systems
- diseases of family members which may be hereditary or place the patient at risk
Social History

An age-appropriate review of past and current activities which include significant information about:

- marital status and/or living arrangements
- current employment
- occupational history
- use of drugs, alcohol, and tobacco
- level of education
- sexual history
- other relevant social factors

Documentation of Examination

The levels of E/M services are based on four types of examination that are defined as follows:

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

These types of examinations have been defined for general multi-system and the following single organ systems:

- Cardiovascular
- Ears, Nose, Mouth and Throat
- Eyes
- Genitourinary (Female)
- Genitourinary (Male)
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurological*
- Psychiatric
- Respiratory
- Skin*

*dependent on a demonstration that the physician work is equivalent to that of a general multi-system examination

General Multi-System Examinations

A general multi-system examination or a single organ system examination may be performed by any physician regardless of specialty.

To qualify for a given level of multi-system examination, the following content and documentation requirements should be met:

- **Problem Focused Examination** – should include performance and documentation of one to five elements in one or more organ systems(s) or body area(s).
- **Expanded Problem Focused Examination** – should include performance and documentation of at least six elements in one or more related body area(s) or organ system(s).
- **Detailed Examination** – should include at least six organ systems or body areas with a least two elements, for a total of twelve elements.
- **Comprehensive** – should include at least nine organ system or body areas. For each area/system, documentation of at least two elements.
### General Multi-System Exam

| • Constitutional | • Gastrointestinal |
| • Eyes | • Genitourinary |
| • Ears, Nose, Mouth, and Throat | • Lymphatic |
| • Neck | • Musculoskeletal |
| • Respiratory | • Skin |
| • Cardiovascular | • Neurologic |
| • Chest (Breasts) | • Psychiatric |

### Content and Documentation Requirements

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem Focused</strong></td>
<td>One to five elements identified by a bullet.</td>
</tr>
<tr>
<td><strong>Expanded Problem Focused</strong></td>
<td>At least six elements identified by a bullet.</td>
</tr>
<tr>
<td><strong>Detailed</strong></td>
<td>At least two elements identified by a bullet from each of six areas/systems OR at least twelve elements identified by a bullet in two or more areas/systems.</td>
</tr>
<tr>
<td><strong>Comprehensive</strong></td>
<td>Perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine area/systems.</td>
</tr>
</tbody>
</table>
Documentation of the Complexity of Medical Decision Making

- Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:
  - The number of possible diagnoses and/or the number of management options that must be considered.
  - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
  - The risk of significant complications, morbidity, and/or mortality, as well as co-morbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Medical Decision-Making

<table>
<thead>
<tr>
<th>Number of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Significant Complications, Morbidity, and/or Mortality</th>
<th>Type of Decision Making*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

* NOTE – to qualify for a type of medical decision making, 2 of 3 elements must either be met or exceeded.
Number of Diagnoses or Management Options

- The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.
  
  - **DG:** For each encounter as assessment, clinical impression, or diagnosis should be documented.
  - **DG:** The initiation of, or changes in, treatment should be documented.
  - **DG:** If referrals are made, consultations requested or advice

Amount and/or Complexity of Data to be Reviewed

- Based on the types of diagnostic testing ordered or reviewed.
  
  - **DG:** If a diagnostic service is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service should be documented.
  - **DG:** The review of lab, radiology, and/or other diagnostic tests should be documented.
  - **DG:** A decision to obtain old records or additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented.
  - **DG:** Relevant findings from the review of old records, and/or the receipt of additional history of family, caretaker, or other source should be documented.
Amount and/or Complexity of Data to be Reviewed

- **DG:** The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.

- **DG:** The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.

Risk of Significant Complications, Morbidity, and/or Mortality

- Based on the risks associated with the presenting problem(s), the diagnostic procedures(s), and the possible management options.

  - **DG:** Co-morbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

  - **DG:** If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure should be documented.

  - **DG:** If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.
Risk of Significant Complications, Morbidity, and/or Mortality

• **DG:** The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

<table>
<thead>
<tr>
<th>Table 1 – PRESENTING PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
</tr>
<tr>
<td>One self limited or minor problem, e.g. cold, insect bite</td>
</tr>
<tr>
<td>One stable, e.g. well controlled hypertension or diabetes</td>
</tr>
<tr>
<td>Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
### Table 2 – DIAGNOSTIC PROCEDURES

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lab tests requiring venipuncture</td>
<td>• Physiologic tests not under stress, e.g. pulmonary function tests</td>
<td>• Physiologic tests under stress, e.g. cardiac stress test</td>
<td>• Cardiovascular imaging studies with identified risk factors</td>
</tr>
<tr>
<td>• Chest X-rays</td>
<td>• Non-cardiovascular imagine studies with contrast e.g. barium enema</td>
<td>• Endoscopies with no identified risk factors</td>
<td>• Cardiac electro physiological tests</td>
</tr>
<tr>
<td>• EKG</td>
<td>• Superficial needle biopsies</td>
<td>• Deep needle or incisional biopsy</td>
<td>• Endoscopies with identified risk factors</td>
</tr>
<tr>
<td>• EEG</td>
<td>• Clinical lab tests requiring arterial puncture</td>
<td>• Cardiovascular imagining studies with contrast and no identified risk factors; e.g. arteriogram, cardiac catheterization</td>
<td>• Superficial needle biopsies</td>
</tr>
<tr>
<td>• Urinalysis</td>
<td></td>
<td>• Lumbar puncture</td>
<td></td>
</tr>
<tr>
<td>• Ultrasound, e.g. echocardiography</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Table 3 – MANAGEMENT OPTIONS

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Rest</td>
<td>• Over the counter drugs</td>
<td>• Minor surgery with identified risk factors</td>
<td>• Elective major surgery with identified risk factors</td>
</tr>
<tr>
<td>• Gargles</td>
<td>• Minor surgery with no identified risk factors</td>
<td>• Referral for or decision to perform elective major surgery with no identified risk factors</td>
<td>• Referral for or decision to perform emergency major surgery</td>
</tr>
<tr>
<td>• Elastic bandages</td>
<td>• Physical Therapy</td>
<td>• Simple prescription drug management</td>
<td>• Parenteral controlled substances</td>
</tr>
<tr>
<td>• Superficial dressings</td>
<td>• Occupational therapy</td>
<td>• Therapeutic nuclear medicine</td>
<td>• Multiple drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Summary

Table 4 – In the table below, find the circle(s) farthest to the right. Draw a line down that column to the bottom row and circle to overall risk.

<table>
<thead>
<tr>
<th>Presenting Problem(s) (Table 1)</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Procedures (Table 2)</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Management Options (Table 3)</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

Overall Risk

1 Minimal 2 Low 3 Moderate 4 High
Medical Necessity

According to Medicare.gov, “medically necessary” is defined as “health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.”

For a service to be considered medically necessary, it must be reasonable and necessary to diagnose or treat a patient’s medical condition.

When submitting claims for payment, the diagnosis codes reported with the service tells the payer "why" a service was performed. The diagnosis reported helps support the medical necessity of the procedure.

Example

- **For example**, a patient presents to the office with chest pain and the physician orders an electrocardiogram (ECG).
- A 12-lead ECG performed in the office and interpreted by a physician is reported with CPT® code 93000.
- The **reason** the physician orders the ECG is because the patient is complaining of chest pain. The diagnosis code for unspecified chest pain is R07.9.
• In this case, the provider should be queried why the chest X-ray was ordered so the proper diagnosis can be reported.

• The provider may have wanted a knee X-ray and made a mistake when writing his orders. By asking the provider for clarification, you have prevented the performance of an unnecessary test because the provider really intended to order a knee X-ray.

• In this case, the knee pain would support the order of the knee X-ray. If the provider intended to order a chest X-ray, by asking for clarification you can report the service with a more appropriate ICD-10-CM code and eliminate a claim denial.

• The provider must document the diagnosis for all procedures that are performed. The provider also must include the diagnosis for each diagnostic test ordered.

• A common error seen when reviewing medical documentation is that the provider will document a diagnosis and indicate tests ordered, but it is unclear that all the tests ordered are for the diagnosis documented in the assessment.

• For example, the patient presents with right knee pain and the physician performs an arthrocentesis. He also orders a chest X-ray. The only diagnosis documented is knee pain. The knee pain supports the medical necessity for performing the arthrocentesis, but it does not support the medical necessity for the chest X-ray.
Case Study

- **CC:** Seeking a new primary physician
- **HPI:** The patient is a pleasant 65 year old female who presents to establish care with a local primary physician after moving to this area recently, to be near her daughter. She has a history of hypertension and type II diabetes, both controlled with medications. She also has a history of coronary artery disease, which has been asymptomatic for the last three years following PTCA deploying 2 stents. She has no spontaneous current complaints.
- **ROS:** Complete ROS was performed and documented and was positive for intermittent lower extremity edema and easy bruising. For more details, please refer to the ROS questionnaire with today’s date located in the chart.
- **Medications:** Atenolol 25 mg PO QD. Glyburide 5 mg PO BID. Lisinopril 10 mg PO BID. Atorvastatin 20 mg PO QD.
- **PMH:** In addition to the HPI, she has osteoarthritis.
- **SH:** The patient has been widowed for 5 years. She denies tobacco or alcohol abuse.

Exam:

- **Vitals:** 116/70, 80, 97.9
- **General Appearance:** NAD, well conversant
- **Eyes:** Anicteric sclerae, moist conjunctiva; no lid-lag; PERRLA.
- **HEENT:** AT/NC; oropharynx clear with MMM and no mucosal ulcerations; auditory canals patent with pearly TM.
- **Neck:** Trachea midline; FROM, supple, no thyromegaly or lymphadenopathy.
- **Lungs:** CTA, with normal respiratory effort and no intercostal retractions.
- **CV:** RRR, no MRGs
- **Abdomen:** Soft, non-tender; no masses or HSM.
- **Extremities:** No peripheral edema or extremity lymphadenopathy.
- **Skin:** Normal temperature, turgor and texture; no rash, ulcers or nodules.
- **Psych:** Appropriate affect, alert and oriented to person, place and time.
- **Labs:** HGBA1c 6.8; BUN 25, creatinine 0.8; LDL 86, HGB 12
Assessment:
1. Well controlled essential hypertension
2. Optimally controlled NIDDM
3. Stable CAD

Plan:
1. Continue current medications unchanged
2. Return visit in two months
3. Will repeat HGBA1c, CBC, and renal profile
4. Will repeat LFTs since patient is on statin medication
5. Will re-check microalbumin/creatinine
Rationale

Examination – Comprehensive (20 Bullets)

- Constitutional – Bullet #1, Bullet #2
- Eyes – Bullet #1, Bullet #2
- Ears, nose, mouth, & throat – Bullet #1, Bullet #6
- Neck – Bullet #1, Bullet #2
- Respiratory – Bullet #1, Bullet #4
- Cardiovascular – Bullet #2, Bullet #7
- Gastrointestinal – Bullet #1, Bullet #2
- Lymphatic – Bullet #1, Bullet #4
- Skin – Bullet #1, Bullet #2
- Psychiatric – Bullet #2, Bullet #3
Rationale

Medical Decision Making – Moderate Complexity

- #Dx – Multiple (3 established and stable problems: hypertension, diabetes, and CAD)
- Data – Minimal
- Risk – Moderate
Number of Diagnoses or Treatment Options

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max = 2</td>
<td>1</td>
<td></td>
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<tr>
<td>Est. problem (to examiner); stable, improved</td>
<td>3</td>
<td>1</td>
<td>3</td>
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<tr>
<td>Est. problem (to examiner); worsening</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max = 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New prob. (to examiner); add. workup planned</td>
<td>4</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

Amount and/or Complexity of Data Reviewed

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1</td>
</tr>
<tr>
<td>Level of Risk</td>
<td>Presenting Problem(s)</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Minimal</td>
<td>• One with limited or minor problem, e.g., cold, mild burn, local injury</td>
</tr>
<tr>
<td>low</td>
<td>• Two or more self-limited or minor problems</td>
</tr>
<tr>
<td>Moderate</td>
<td>• One serious chronic illness, e.g., stable or controlled hypertension or non-cardiac or non-thoracic disease, including diabetes, obesity, HIV/AIDS</td>
</tr>
<tr>
<td>High</td>
<td>• One or more serious illnesses with cerebrovascular, cardiovascular, or cardiac involvement, including pneumonia, sepsis, diabetes, malignancies, trauma, burns, or severe trauma</td>
</tr>
</tbody>
</table>

**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.
Tips, Tools & Techniques

- Have a written compliance plan in place
- Conduct audits on a regularly scheduled basis and provide feedback
- Track and train in areas of deficiency to maximize results and be “audit-proof”
Questions?

• Thank you for your attendance!

• Get your questions answered on PMI’s Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp