Who is coming for you?

- Medicare Administrative Contractors (MACs)
- Recovery Audit Contractors (RACs)
- Medicaid Recovery Audit Contractors (MACs)
- Comprehensive Error Rate Testing (CERT)
- Health Care Fraud Prevention & Enforcement (HEAT)
- Private Payors
- Auto Insurance

Be on alert

- Know who your local MAC, RAC, ZPIC, CERT, Etc… contractors are
  - Billing staff should know how to recognize records requests and inquiries from local contractors.

What do to

- Respond as directed ASAP!!
- Review the documentation and coding and prepare a rebuttal in the event of a negative outcome.
- Appeal downcoding with supporting documentation and justification of coding.

Know the rules

- Know the coding guidelines and policies for your payers.
- Some payers have unique rules for E&M components.
  - ROS
  - Exam
  - MDM
- Review the payer websites regularly for updates to policies.

Allergies as ROS

- "No known drug allergies or allergies in general are not considered part of the ROS. AMA/CPT publications have always indicated that these are elements of PFSH."

Allergies as ROS

- **Q 14. Can an allergy be part of the ROS rather than the past history? For example, patient has allergy to penicillin; it causes hives?**

- A 14. No, questions and responses concerning any past allergies and the resulting reactions are part of the Past, Family, and Social History (PFSH). They are not part of the Review of Systems (ROS).

WPS GOVERNMENT HEALTH ADMINISTRATORS

WPS ROS

- **Q9. The 1995 and 1997 DGs indicate "all other systems are negative" is acceptable for a comprehensive level of the Review of Systems. Does WPS accept this?**

- A9. Yes. For a comprehensive ROS, the physician must document the review of at least 10 organ systems. The physician must document both the positive and the problem pertinent negative responses relating to the chief complaint. Indicating the individual systems leaves no room for doubt as to the number of systems reviewed, but "all other systems negative" is acceptable.

PMH as ROS

- Question: If the past medical section states a chronic or current illness (that the provider is not treating), can it be used in the Review of Systems (ROS)? If the past medical section lists several conditions and there is no mention of controlled or uncontrolled, could this be used in the ROS?

- Answer: No, per both the 1995 and 1997 Evaluation and Management (E & M) Documentation Guidelines, "a Review of Systems is an inventory of body systems obtained through a series of questions seeking to identify signs or symptoms that the patient may be experiencing or has experienced."

  A past medical history would not contain a patient's pertinent positive and/or negative responses as related to the problems identified in the patient's history of the present illness.

PFS Hx

- When a Past, Family and/or Social History documentation has the terms "Non-contributory" or "negative", these are not considered appropriate documentation.
- Documentation of PFSH must include social and/or family history information, such as alcohol consumption, smoking history, occupation, or familial hereditary conditions

-WPS

Exam	1995 E&M DG	Numerical Interpretation
Problem Focused	• a limited examination of the affected body area or organ system	• 1 Body Area or Organ System
Expanded Problem Focused	• a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).	• 2-4 Body areas or systems
Detailed	• an extended examination of the affected body area(s) and other symptomatic or related organ system(s).	• 5-7 Body areas or systems
Comprehensive	• a general multi-system examination or complete examination of a single organ system. - The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.	• 8 or more Organ systems

Examination

- The 2-4, 5-7 breakdown originated with then HCFA Medical Director, Bart McCann at the CPT Editorial Panel Advisory Committee meeting in November of 1995.
- Indicated that a new version of the DGs were to be released in 1996 that would reflect the 2-4, 5-7 to more clearly refine the exam requirements.

Examination

- Many sources changed their version of the DGs to reflect the expected update that was never made official.
- Still sources, including many of the Medicare carriers, that use the numerical breakdown to assign a level to the exam.

NHIC Examination

	Affected Body Areas (BA)	Organ Systems (OS)		1995 Guidelines			
EXAM	☐ Head/Face	☐ Constitutional	☐ Skin	1 (BA) or (OS)	2-4 (OS) and/or (BA)	5-7 (OS) and/or (BA)	8 or more (OS)
	☐ Neck	☐ Eyes	☐ Neuro	(Limited exam of affected BA or OS)	(Limited exam of affected BA or OS and other symptomatic or related OS(s))	(Extended exam of affected BA(s) and other or related OS(s))	(A general multisystem exam or complete exam of a single organ system)
	☐ Abdomen	☐ Ears, nose, mouth, throat	☐ Psych				
	☐ Chest + breast / axillae	☐ Cardiovascular	☐ Hem/Lymph/Immune				
	☐ Genital/groin/buttocks	☐ Respiratory					
	☐ Back, include spine	☐ GI					
	☐ Extremity/(ies) L / R Upper	☐ GU					
	L / R Lower	☐ Musculo		PF	EPF	D	C

CIGNA E&M Tips

- Understand the difference between "Expanded Problem-Focused (EPF)" and "Limited" examination under 1995 guidelines.
  - The difference is not the number of systems examined. Two to seven systems are required for both examinations.
  - The difference is the detail in which the examined systems are described.

Novitas 4x4 Rule

- Under the 1995 guidelines both the expanded problem focused examination and the detailed examination provide for the examination of "up to 7 systems" or 7 body areas.
- This has led to variability in reviews utilizing the '95 guidelines, and required an interpretation for proper and consistent implementation of the E/M guidelines.

Novitas 4x4 Rule

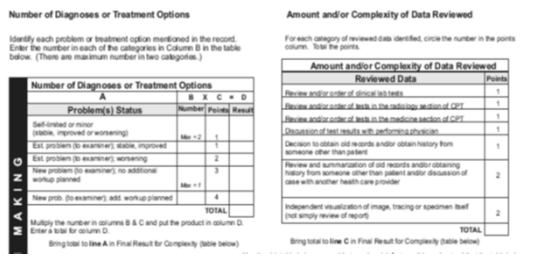
- By providing a tool (4 elements examined in 4 body areas or 4 organ systems satisfies a detailed examination) our reviewers and the physicians have a clinically derived tool to assist in implementing the E/M guidelines and decreasing one area of ambiguity.
- This is a tool that is consistent with the way medicine is practiced, as confirmed in Documentation Coding & Billing by Laxmaiah Manchikanti, M .D, and A Guide to Physical Examination by Barbara Bates, M D. And, it is a tool to reduce reviewer variability.

MDM Controversies

- Additional work-up planned
- 2 Points for interps and/or 93010
- Check box for “Old records reviewed”
- Discussion w/ another “health care provider”

MDM variables

- Marshfield MDM scoring



Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.)

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

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.

Bring total to **line A** in Final Result for Complexity (table below)

Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the points column. Total the points.

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

Bring total to **line C** in Final Result for Complexity (table below)

Marshfield Scoring- Number of Diagnoses / Treatment Options

New Problem, no add'l work-up planned 3 points

New Problem, add'l work-up planned 4 points

2 common definitions

A. Additional diagnostic work-up after the current E&M service is completed.

B. Diagnostic work-up during the current E&M service.

Additional work-up planned

Per Noridian:

- Q3. Please clarify if "new problem to provider, additional workup" means that the additional workup must be done beyond that encounter at that time.
- For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision making. Or, does additional work-up consist of any diagnostic testing, laboratory testing, etc. that can be performed during the visit.
- A3. There is no specific indication that "further workup needed" must be completed at a future date.

Additional work-up planned

Definitions	
Additional Work-up Planned	Any testing/consultation/referral that is being done beyond that Encounter to assist the provider in medical decision making.

UnitedHealthcare MEDICARE & RETIREMENT

Additional work-up planned

- An example of Additional Work-up Planned, is if the physician schedules testing him/herself or communicates directly with the patient's primary physician or representative the need for testing *which is to be done after discharge from the ED*, and the appropriate documentation has been recorded. Credit for "Additional Work-up" Planned is granted (4 points assigned).
- Credit is not given for the work up if it occurs during the ER Encounter.
- Patients admitted to the hospital under the care of a physician other than the ER physician may have testing done as part of the admitting physician's care for that patient. The ER physician will not receive credit for the Additional Work-up Planned done under the care of the admitting physician.

Novitas Add'l W/U

- Is the physician doing additional workup?
- Additional workup will require the physician to review the results/make decisions on a day other than the day of the patient encounter.

Novitas Add'l W/U

- What constitutes additional workup in the Amount and Complexity of Data grid for Medical Decision Making?
- Additional workup is anything done beyond that encounter at that time. For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision-making.

WPS MDM

Q6. My question centers on the number of diagnosis or management options in the MDM of the E/M service. When coding an Emergency department encounter, would all presenting problems fall under the "new problem" category (either with or without additional workup)?

WPS MDM

A6. The 1995 and the 1997 DGs have a table the provider can use in determining the level of MDM. There is no specific "new problem" category.

The number of possible diagnosis and/or the number of management options your provider considers 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. The highest level of risk in any one category determines the overall risk.

WPS MDM

- **Q2. Define self-limited or minor problem in the medical decision making grid under minimal level of risk. At times, it is difficult to determine whether a problem is self-limited or minor or whether it is a new problem with no additional work-up planned.**

- A2. The 1995 and 1997 DGs indicate the determination of risk is complex and not readily quantifiable and includes some examples in each of the categories. The DGs do not address a new problem with no additional work up planned. Therefore, you can use the examples provided in the DGs to determine the level of the presenting problem.

Noridian MDM

Medical necessity cannot be quantified using a points system. Determining the medically necessary level of service (LOS) involves many factors and is not the same from patient to p patient and day to day. Medical necessity is determined through a culmination of vital factors, including, but not limited to:

- Clinical judgment
- Standards of practice
- Why the patient needs to be seen (chief complaint),
- Any acute exacerbations/onsets of medical conditions or injuries,
- The stability/acuity of the patient,
- Multiple medical co-morbidities,
- And the management of the patient for that specific DOS.

MDM Controversies

Low	> Two or more self limited or minor problems > One stable chronic condition illness (e.g. HTN, DM, Cataracts, BPH) > Acute uncomplicated illness or injury (e.g. sprain, cystitis, rhinitis)	>Physiological test not under stress (PFT) >Non-cardiovascular imaging studies with contrast (barium enema, CT) > **Sleep studies** >Superficial needle biopsy arterial puncture >**Skin biopsy**	>Over the counter drugs >Minor surgery with identified risk factor **(0-10 days global period)** >PT-OT-ST >IV fluids without additives >**Prescription drug management – maintenance phase**
Risk Level	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Options Selected**
	treatment >Two or more stable chronic conditions >Undiagnosed new problem with uncertain prognosis (e.g. lump in breast) >Acute illness with systemic symptoms (e.g. pneumonitis, colitis, pyelonephritis) >Acute complicated injury (e.g. head injury with brief loss of consciousness)	>Diagnostic endoscopies with no identified risk factors > Deep needle or incisional biopsy >Cardiovascular imaging studies with contrast and no identified risk factors (ex arteriogram, cardiac catheterization) >Obtain fluids from body cavity (ex L.P), thorancentesis	(open, percutaneous, or endoscopic, davinci) with no risk identified risk factors >Prescription drug management **(new medication for patient)** >Therapeutic nuclear medicine >IV fluids with additives >Closed treatment of fracture or dislocation without manipulation

EMR MDM

Medical Decision Making

Discussion of test results with the performing providers: yes

Decide to obtain previous medical records: yes

Obtain history from someone other than the patient: no

Review and summarize previous medical records: yes

Discuss the patient with another provider: yes

Independent visualization of image, tracing, or specimen: yes

Auditor response

- "*These statements provide no clinical insight as to what happened in the ED or how these steps impacted the diagnosis or treatment of the patient. Documentation that is aimed to meet the guidelines for payment but is clinically irrelevant to the patient presenting problem will not increase the level assigned to that visit.*"

EKG Pay vs Points

WPS GOVERNMENT HEALTH ADMINISTRATORS

- The ordering of the EKG would be part of the Medical Decision Making (MDM) under the Risk category under Diagnostic Procedures Ordered.
- The interpretation of the ordered EKG is considered part of the EKG reimbursement, and as such is not part of the Amount and/or Complexity of Data to be Reviewed category under the MDM portion of the E/M service.
- Counting both a review of the ordered EKG and billing for the interpretation and report of the same EKG is incorrect.

Independent visualization of image, tracing or specimen itself

- If I personally review a film, e.g. x-ray, electrocardiogram (EKG) in my office, will I receive 2 points on the E/M score sheet?
- Yes, you may get two points for independent visualization of an image, tracing or specimen on the E/M score sheet in the Amount and/or Complexity of Data Reviewed section under the Medical Decision Making key component.
- The medical record documentation must clearly indicate that the physician/qualified NPP personally (independently) visualized and performed the interpretation of the image; tracing or specimen and that he/she did not simply read/review a report from another physician/qualified NPP.

CC Time

- **Q5. Can I use a check box indicating 30-74 minutes instead of saying I spent 51 minutes in critical care?**
- A5. Document the total time spent each time you visit the patient. CMS IOM Publication 100-04, Chapter 12, Section 30.6.12.E states, "Critical care is a time-based service, and for each date and encounter entry, the physician's progress note(s) shall document the total time that critical care services were provided."

Automated Down coding

ER level of care	December 1, 2016	CPT code 99285 is used to indicate medical conditions that are of high severity, are potentially life threatening, and require the immediate attention of a physician. Services for constipation, earaches and colds, for example, should not be billed using CPT code 99285. When a hospital or physician bills a level 5 emergency room service (CPT 99285) with a designated minor diagnosis code, we will down code 99285 to a level 4 emergency room service (CPT 99284).

Aetna OfficeLink Updates | September 2016 3

Automated Down coding

In September, we communicated that when CPT code 99285 is billed with a minor diagnosis, we will recode to 99284. This policy will not be implemented. The following review program will be implemented in its place.

CPT code 99285 is used to indicate medical conditions that are of high severity, are potentially life threatening, and require the immediate attention of a physician. Services for constipation, earaches and colds, for example, should not be billed using CPT code 99285. When a hospital or physician bills a level five emergency room service (CPT 99285) with a designated minor diagnosis code, we will request documentation/medical records. If the documentation/medical records support the level five service it will be paid per Aetna Standard Guidelines. If records do not indicate a level five is warranted, the service will be recoded.

Automated Down coding

illinicare health

Visit **https://www.illinicare.com/providers/resources/clinical-payment-policies.html** to find these policies. The effective date for the below policies is **October 8, 2017**.

Number	Policy Name	Policy Description	Product
CC.PP.053	Non-Emergent ER Services	The purpose of this policy is to define payment criteria for non-emergent emergency room services to be used in making payment decisions and administering benefits. When a hospital, free-standing emergency center or physician bills a level 4 (99284) or level 5 (99285) emergency room service, with a non-emergent diagnosis, IlliniCare Health will reimburse the provider at a level 3 (99283) contracted reimbursement rate.	Medicaid Medicare Ambetter

CENTENE Corporation

Automated Down coding

- Centene (operates in 26 states, include Medicaid MCO plans, exchange plans and Medicare/Medicaid plans)

Policy Overview

- To encourage providers to direct patients to more appropriate care settings, the health plan has adopted a payment strategy that will provide lower levels of reimbursement for services indicating lower levels of complexity or severity rendered in the emergency room.
- The purpose of this policy is to define payment criteria for emergency room services to be used in making payment decisions and administering benefits.