Conquering Coding’s Everest:
Compliant E/M Coding & Auditing for Electronic Health Records

Stephen R. Levinson, M.D., CHCA
www.PracticalEM.com
asallc@aol.com

Disclaimer
• This presentation is designed to provide accurate and authoritative information in regard to the subject matter covered. The information includes both reporting and interpretation of materials in various publications, as well as interpretation of policies of various organizations. This information is subject to individual interpretation and to changes over time
• Presenter has personal interests in consulting, presenting, writing about, and developing software in order to help physicians achieve compliant medical records and to help them facilitate quality patient care

Overview
• Proactive approach to EHRs
  – We need & want EHRs, but only high quality EHRs
  – Must be ‘operable as well as interoperable’
    • Usable, efficient, E/M compliant, trustworthy, and assist in promoting high quality patient care
• About a lot of things, but #1 is quality healthcare!
  – For us as patients
  – Care MDs should want to provide

Attendee Demographics
• EHRs with compliant E/M?
• EHRs with compliant coding engine?
• EHRs that actively consider medical necessity?
• Physicians’ response to their EHR?
  – Divorced
  – Living together in misery
  – Happy fast and non-compliant
  – Other

Surveying the Current EHR Landscape
The “Catch 22” Scenario

Electronic Health Records Needed To Benefit Health Care
(The marketing case)
• Interconnectivity *
• Interoperability *
• Clinical decision support
  – Preventive care services
  – Care protocols for diagnosed conditions
• Data mining
• PQRI reporting
• Health information exchange *
* = not yet standard with EHRs
• Access to patient info.
• Increased Patient Safety *
• Increased Quality Care *
• Eliminate duplicate tests and services *
• Cost savings to health system *
• No evidence to support & no valid testing
We Are Currently Engulfed in a Tsunami of Demand for EHRs

- HiTECH legislation
- ARRA / CMS incentives for Meaningful Use
  - $44,000 per MD over five years
  - (about $35 per day)
- CMS penalties for non-use
  - 1.2% reduction in Medicare payments starting in 2016 ($500/yr)

2011-2013 OIG Work Plans

- “We will review the extent of potentially inappropriate payments for E&M services…. Medicare contractors have noted an increased frequency of medical records with identical documentation across services.
- We will also review multiple E&M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments.”

“The Perfect Storm”
Federal Audits of Practices with EHRs

*Medical Economics*, April 09
- 4 practices audited after implementing EHRs and using them as instructed and intended
- Audit failures ranged from 20% to 95% of charts
- Fines ranged from $50,000 to $175,000+ per physician
- Non-compliant documentation is also a “canary in the coal mine” to report problems with usability, data integrity, quality of care, & liability protection

MU Certification Includes No Criteria for Software to be E/M Compliant

- May: OIG reports 48% for E/M code levels 2001-2010
  - Especially F/U office, F/U hospital, & E.D.
- 9/17, WSJ: “EHR savings little more than hype”
  - Software generally clunky, frustrating, user-unfriendly
- 9/17, Center for Public Integrity: upcoding by docs and hospitals
  - Getting worse “with proliferation of EMRs, which critics say can facilitate abuse”

Electronic Health Records Ups & Downs On the HOT SEAT!

- 9/21, NY Times: MC bills rise w Elect Records
  - OIG warned that E/M “vulnerable to fraud & abuse”
  - “move to elect records may billions in higher billing, whether or not they provide additional care”
- 9/25, NY Times: Abuse of EHRs
  - Obama admin warns against fraudulent use of EHRs to inflate billings to MC (Holder & Sibelius)
10/4: Lawmakers urge halt on MU payments
   – Hold payments until clearly define (and achieve) interoperability standards
9/25, NY Times: EHR Ups & Downs
   – A MAC (NGS) says will deny payment for treatments using “cloned documentation” (EHRs) rather than individualized notes…to show medical necessity”
   – “Dr. Monteith said electronic systems were ‘disrupting traditional medical records and, beyond that, how we think – the process of arriving at a diagnosis’

Electronic Health Records Ups & Downs
On the HOT SEAT!

Physicians Feel Trapped in a Vice
Decreasing net income
Decreasing time for care
No compl. training
Inadequate doc. tools
↑ reporting demands
↑ doc. requirement
↑ oversight
MACs, RACs, CERT, ZPICs
Non-funded mandates

Setting the Table
Sources of EHR Challenges

EHR Audit is an E/M Audit (already challenging enough) on Steroids

Starting the Climb 1: Why is the EHR Environment So Challenging?

Starting the Climb 2: Why is the EHR Environment So Challenging?

• Physicians and proponents of the benefits of EHRs expect and rely on EHR developers to create programs that meet published standards for compliant documentation and coding of E/M services
• It is well documented that currently this is not the case
• Yet presently there are no certification criteria mandating that EHR software programs meet these E/M compliance standards

• EHR vendors and proponents of the benefits of EHRs expect and rely on physicians to be effectively trained in the principles of E/M compliance and in the use of compliant medical record tools
• However, currently this is not the case
• Yet presently there are no standards established by the American Association of Medical Colleges (AAMC), residency training guidelines, or CMS mandating that physician training institutions meet these E/M compliance standards
Ascending the Mt. 1: Why is E/M So Challenging for Physicians?

- Absence of Compliance training during medical education
  - (it is therefore a “foreign language”)
- Absence of usable, efficient, compliant documentation forms that promote compliant care and documentation
  - (it is therefore not possible to complete the intended task in the time available)
- Loss of physician role models

Ascending the Mt. 2: Why is EHR Coding So Challenging for Coders?

- Most EHRs have incorporated the incomplete and non-compliant ‘scoring sheet’ as an automated coding engine
  - Facilitates ↑ code levels with ↑ volume of documentation
- Most programmers build their screens on fulfilling needs of coding engines, so screens guide incomplete & non-compliant documentation
- Most EHRs compound problems by providing data entry shortcuts for “fast” documentation (i.e., cloned)
- Most coders are using incomplete coding tools, making it difficult to identify EHR doc shortcomings

Transforming E/M Compliance from a Foe into a Friend

Where Does CPT’s E/M System Come From?

E/M is Based on the Reference Commonly Used to Set the Standard for Optimal Patient Care

- “Bates Guide to the H&P”
  - 7 Elements of the HPI: p. 3
    - 8th “timing” incl. “duration”
  - 16 ROS Systems: p. 5 - 8
  - PFSH: p. 4 - 5
  - Physical Exam: p. 9
  - MDM: p. 36 – 38
    - Data review, Dx, plans
  - NPP: p. 37
    - When to consider NPP: p. 36

  - 8 Elements of the HPI: p. 7
  - 14 Systems of the ROS: p. 8
    - Combines M&F GU, skin/breast
  - PFSH: p. 9
  - Physical Exam: p. 13 - 16
  - MDM: p. 43
    - Data review, Dx, plans, risks
  - NPP: CPT p. 2 – 3
    - When to consider NPP: Practical E/M, p. 119

Linking E/M Compliance With Quality Care/Data Integrity

- E/M is based on the standard reference text used to teach physicians the optimal approach to diagnosis & care
  - That is, the E/M system, when used correctly and efficiently, is a codification of the comprehensive H&P taught to student physicians as the ideal for high quality care
- Therefore E/M can be used as a blueprint to guide and facilitate quality patient care

ASA, LLC

ASA, LLC

ASA, LLC

ASA, LLC
High Quality H&P Presents a Three-Sided Benefit for Clinicians

- Fulfills Compliance Needs
- Promotes Quality Care
- Provides Liability Protection
- E/M Compliance is the key to unlocking this inter-relationship

Prioritize the 3 Groups of E/M Components that Can Set Level of Care

- Medical History
  - Chief Complaint, HPI, PFSH, ROS
- Physical Examination
- Medical Decision Making (MDM)
  - Data reviewed &/or ordered
  - # of diagnoses &/or treatment options
  - Risk of problems, tests, treatments

Medical Necessity: Foundation for Reliable & Authoritative E/M Coding and Auditing

- “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code”
- Medicare Claims Processing Manual, Chapter 12, section 30.6.1
- In accordance with the Social Security Law, Medicare will not pay for services that are not medically necessary (Sec. Sec. section 1862)

Necessity Differs from “Key Components”

**Medical Necessity for Evaluation and Management Services**

1. Patient not required that all services listed by the Medicare, including services, are medically necessary and reasonable.

   - Medical necessity of E/M services is generally expressed in the usual frequency of services and not specifically indicated.

2. Evaluation and management services are such that the diagnosis and management of each patient's problem(s) is indicated.

   - The most comprehensive evaluation and/or management of a problem set(s) of evaluation and management services to set the upper limit for level of care which is medically necessary (i.e., “warranted”)

3. Evaluation and management services are provided for the patient's presenting problem(s) or condition(s) that involves services that are related to the problem(s) set(s) of evaluation and management services.

   - In accordance with the Social Security Law, Medicare will not pay for services that are medically unnecessary (Sec. Sec. section 1862)

4. Evaluation and management services are provided for the patient's presenting problem(s) or condition(s) that involves services that are related to the problem(s) set(s) of evaluation and management services.

   - ‘Nature of the Presenting Problem’ is the key to correct coding (see Appendix C of CPT)

   - It sets the upper limit for level of care which is medically necessary (i.e., “warranted”)

   - It also RAISES the bar to the level of care that is medically indicated

**The Key Practical E/M Insight:**

- Nature of the Presenting Problem is the key to correct coding (see Appendix C of CPT)
  - It sets the upper limit for level of care which is medically necessary (i.e., “warranted”)
  - It also RAISES the bar to the level of care that is medically indicated
Re-Prioritize the 3 Groups of E/M Components that Can Set Level of Care

- Medical History
  - Chief Complaint; HPI; PFSH; ROS
- Physical Examination
- Medical Decision Making (MDM)
  - Data reviewed &/or ordered
  - # of diagnoses &/or treatment options
  - Risk of problems, tests, treatments
- Nature of the presenting problem (NPP)
- Counseling
- Coordination of Care
- Time

Prioritizing the E/M Components

- Therefore, while the overwhelming focus for physicians and for EHR programs has been on the three “key components,”
- The level of care determined by the key components is subordinate to
  - The level of care warranted by medical necessity
  - The level of care indicated by time of counseling and coordination of care, when circumstances are appropriately documented

The Paper Record Dog Chasing the EHR Tail

- Most EHR software replicates physicians’ non-compliant paper records and adds non-compliant data entry shortcuts
- Many physicians using paper records have now mimicked and adopted non-compliant EHR features to increase speed of documentation

Questions About Setting the Table, Role of Medical Necessity?

Selected Foundation Concepts for EHR

- The faster we get done, the more patients we see
- The more patients we see, the more the $$$
- The faster the EHR, the better the EHR!!
- WRONG!!! Speed is efficiency
- (vendors are selling speed but calling it “efficiency”)

Hooked on EHR Speed….
EHR Terminology

• Interface
  – Graphic (yes/no; normal/abnormal responses)
  – Narrative (descriptions & details)
• Personnel entry options (patient/staff/MD)
• Data entry modalities: Written / dictated / electronic / **hybrids
• Format: Data entry vs. Data storage/retrieval

The Critical Importance of Appropriate Use of a Narrative Interface

• Medical History
  – Tells a story of the patient’s problems (& specific details)
• Physical Examination
  – Paints a verbal picture of the patient’s abnormal findings
• MDM:
  – Impressions: creates a logic tree for diff. Diagnosis (precision, probability, severity, support)
  – Treatment options: creates a blueprint for future care

With Compliant Tools, MDs Must Remember only Three Basic Coding Rules

• If care was not documented in the medical record, it was not done
  (CMS Carriers’ Manual, section 703.101)
• In accordance with the Social Security Law, Medicare will not pay for services that are not medically necessary
  (Soc. Sec. section 1862)
• Automation is NOT documentation
  (“Practical EHR” 2008)
  • Practical E/M mobilizes the “flip side”

Examine “Automation” of Data Entry

• "The use of automated entry of clinical information conflicts with the requirements for proper documentation. Because the physician has not dictated or typed any of the canned information that the computer pastes into the record, he or she has not actually documented this data, the computer has.
• Combining this realization with... (the principle) ‘If care was not documented in the medical record, it wasn’t done,’ leads to the conclusion that portions of the record that have automated entry have not been adequately documented by the physician, and therefore no care can be credited in an audit of these sections. In summary, automation is not documentation.”

Software Programming Challenges

• Programmers work with zeroes and ones
  • This allows ease of working with quantitative concepts
  • But this also creates barriers in addressing qualitative features
Mapping Out EHR’s E/M Challenges

Primary Categories of EHR Compliance Challenges?

1) Coding engine problems
   • Including failure to consider Medical Necessity
2) Data entry screen design problems
   • Including failure to consider Medical Necessity
3) Data entry shortcuts

Primary Categories of EHR Compliance Challenges

• Most EHR coding engines are incomplete and non-compliant:
  – Lack active consideration of Medical Necessity (NPP)
  – Failure to consider qualitative E/M features
  – MDM problems (incomplete & non-compliant calculations)
• Data entry screens are built 1:1 on coding engine, leading to

Primary Categories of EHR Compliance Challenges

• Non-compliant screen designs, lacking ability to document:
  – Qualitative E/M features
  – Several elements of MDM
  – NPP (i.e., medical necessity)

Primary Categories of EHR Compliance Challenges

• Non-compliant data entry functionality
  – Resulting from programming effort to overcome keyboard and mouse challenges for data entry usability & efficiency
  – Leading to “cloned” documentation and imprecise “translation”

EHR & E/M Problem #3: Cloned (i.e., Automated) Data Entry

• This has drawn the most (if not the exclusive) attention from the press, MACs, the OIG, and compliance experts
• **Addressing this issue is necessary, but NOT sufficient
  – The other 2 major problem types are equally egregious
Attack of the Clones

- Automated and semi-automated documentation tools result in non-individualized records:
  - Generic pick lists
  - Documentation by exception
  - Copy forward
  - Copy / paste
    - Pre-loaded generic macros
    - Copy from other charts
  - Translation

Generic Pick Lists

- Originally offered by vendors as alternative to typing. Limited selection list of vocabulary words and phrases compiled by point and shoot into a pseudo-narrative
- Limited choices → near-identically worded charts in visit after visit and patient after patient
- Also fails to provide sufficient depth or breadth to encompass individual nuances and variations that are required to facilitate patient specific & visit specific medical narratives

Documentation by Exception

- Pre-filled (or single click) graphic forms, or descriptive narratives, that physician is required to erase (if not performed) or change (from negative to positive or from normal to abnormal)
- Note: it takes more time and effort to correctly document REAL CARE with this approach than to work from a blank template, free text dictation, or writing
  - **What is the problem this is trying to solve?**

Copy Forward

- Moving entire blocks of history, exam, and/or MDM forward from one visit to the next
- Sequential charts appear (mostly) word-for-word identical
- Conveys patient’s status from long ago, not what has transpired since last visit
- (Leads to “care by lab tests” rather than individualized patient specific and visit specific diagnosis and treatment)

Copy/Paste Functionality

- Moving entire blocks of history, exam, and/or MDM forward from one patient to the next, or from centrally stored macros
- Not reliable, individualized, or compliant for history or exam sections
  - Documentation almost always reveals all aspects of history and physical completely normal except for one area related to CC & HPI (how this is created)
  - That is, this results in problem focused care disguised to look like comprehensive care
  - MDM problems with copy/paste of entire (unmanaged) problem list, whether or not relevant to current encounter

Observations on Translation

- Clinical information is collected in a graphic format (e.g., pre-loaded questions with check box answers) that might pass an audit (if other factors met)
- However, this graphic format is automatically converted (by macros) to a pseudo-narrative format with identical wording in every case. It presents the exact appearance of a macro with documentation by exception
- This presentation commonly will not pass a high quality E/M audit
  - Unless practice can produce the original graphic format, demonstrating individualized documentation
Translation Type I

- Translation is indistinguishable from documentation by exception
  - Cannot determine if "no" responses actually asked and documented
- "Where’s Waldo" effect
- Loss of qualitative aspects of history – Why does this ROS fail compliance?
  - Impact on Compliance
  - Impact on Quality
  - Impact on Liability
- Would you want this care??

Translation Type II (i.e., “misrepresentation”)

- Combines abbreviated translation I with copy/paste of pre-loaded generic macros:
- ROS information collected by just checking a box labeled with an organ system; this is translated to an extensive list of questions and negative responses, with no documentation that they were asked:
  - E.g., Cardiovascular Yes  No → "no history of chest pain, palpitations, shortness of breath, dyspnea on exertion, or pedal edema"

Translation Type II (“misrepresentation”)

- Similar issues with established patient visits, for documenting an update of PFSH & ROS:
  - i.e., “no change in PFSH or ROS since last visit” → copy forward of the entire list of PFSH and ROS questions & answers from last visit,
  - Which was copied forward from the prior visit
  - Which was copied forward repeatedly, visit after visit, all the way back to the initial visit 2 years ago
- Fails to fulfill definition of update of PFSH/ROS

Translation Type II (“misrepresentation”)

- Similar issues for documenting normal exam components:
  - e.g., Lungs Normal Abnl → “normal respiratory effort & excursions, no suprasternal retractions, clear to percussion and auscultation, without rales, rhonchi, cracking, or wheezing”
  - Likelihood of all normal findings (other than related to HPI) in all areas in case after case??
  - Gym example
- Significant potential for False Claims allegations
  - The documentation does not accurately record the care that was actually performed

Copy Paste or Copy Forward for MDM: Problem Lists, Data Orders, Treatment Orders

- What is inside your bag of tricks??
- Why not use the old problem list and cut and paste it into my new note??
- Problems….???
- Solution….???(2 clicks)
- Similar approach for order sets for data & Rx

Copy-paste of generic macros, copy forward, & doc by exception: Just like MAGIC!!

- Documentation appears in the medical record that supports everything I do (or that I would like to get paid for).right?
- Resultant medical records (& the patients) lose their individuality!
  - The records are not patient specific and/or visit specific!
EHR Macros Create Ducks in a Row…

- Every patient looks the same…
- Every ROS reads the same…
  - All negative except for system related to HPI
  - What question(s) did the MD actually ask?
- Every exam reads the same…
  - All normal except for system related to HPI
- Every code level is the same for particular diagnoses

Dilbert’s Analysis of Copy & Paste

Quality Care & Liability
Dangers of Cloned Doc.

- Leads to approaching each patient identically to every other patient in a similar diagnostic category
- Cloned (limited) diagnoses
- Cloned evaluations
- Cloned treatments
- Changes how physicians approach their patients
- Linear thinking rather than global or holistic thinking
  - i.e., Problem focused care!
- Physician delegates decisions to the computer

Compliance Failure of Cloned Doc.

- 2007 HHS & ONCHIT white paper: “These tools [defaults, templates, copying] can be extremely helpful if used correctly; however, the tools can also open the EHR-S up to fraud or abuse.”
  - ONCHIT & HHS, “Recommended Requirements for Enhancing Data Quality in Electronic Health Record Systems,” 2007, page 46
- Note: this statement’s use of the term “templates” refers to our discussion of “MACROS”

EHRs, Cloned Documents, & Medical Necessity

- “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.”
  - Eugene J. Winter, M.D., Medical Director for First Coast Service Options, Inc.

EHRs, Cloned Documents, & Medical Necessity

- “Limited Space Templates (i.e., “macros”) … do NOT constitute sufficient documentation of a face-to-face visit and medical examination.”
- “Limited space templates (i.e., “macros”) often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.”
- “Templates (i.e., “macros”) designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met. This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria for the item/service are met.”
Effect of Automation on the Diagnostic Paradigm

- Optimal Paradigm: Good Medical History Guides Dx
- Automation Paradigm: Diagnosis creates the history
  - Tentative diagnosis (based on chief complaint) generates insertion of a pre-loaded non-specific history for that diagnosis, with a pre-determined work-up and outcome

Effect of Automation on the Diagnostic Paradigm

- As a result, the record for every patient with a given (presumed) diagnosis reads similar to every other patient with that disease (and 2nd visit reads same as the 1st)
  - In other words: “GIGO”
  - “Every chart reads vanilla”
- Non-specific history is insufficient for precise and reliable diagnoses

Impact of Automatic Documentation on the Diagnostic Paradigm

- Increased reliance on routine laboratory and radiographic testing
- Increased costs and decreased efficiency
  - Increased “shotgun” testing
  - Increased number follow-up visits
- Decreased quality of care
  - Loss of ability to recognize when test results don’t fit the history
  - Challenge when test results negative (no basis to explain symptoms or guide future care)

Impact of Patient Specific & Visit Specific Doc on Quality Care

- Osler: “It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has”
- Osler: “Variability is the law of life, and as no two faces are the same, so no two bodies are alike, and no two individuals react alike and behave alike under the abnormal conditions which we know as disease”
- Practical EHR: “It is often even more important to find and address the differences among patients with similar clinical manifestations than it is to recognize their similarities”
- Margaret Mead: “Always remember that you are absolutely unique. Just like everyone else”

Questions About Cloned Data Entry?

- Note: download PDF for a color-coded, complete & compliant E/M coding, auditing, & educational tool

EHR & E/M Problems #1 & #2: Non-Compl. Coding Engines & Screen Designs

- Failure to consider qualitative as well as quantitative features of E/M & Documentation Guidelines
- Failure to include all aspects of MDM
- Use of non-compliant coding engine shortcut for MDM
- Failure to incorporate consideration of Medical Necessity (NPP) into documentation & coding
Failure to Consider Qualitative Elements: ROS & PFSH for Initial Visit Types of Service

- Note: all 14 organ systems reviewed and documented this way
- Is this a problem pertinent, extended, or comprehensive ROS; or no ROS at all?
  - Why or why not?
- What is the critical qualitative ROS element that is missing
- (same issue w PFSH)

Failure to Consider Qualitative Elements: ROS & PFSH for Established Visits

- Do Not
  - repeat all the questions
- Do Not
  - State “I reviewed old history”
  - “Photocopy” old history (EHRs)
  - “copy forward”
  - Non-compliant & clinical problems
- Do
  - Update ROS = “no change since 1/1/2013, except…”
  - Effect on coding
  - Effect on quality of care

Failure to Consider Qualitative Elements: HPI

- History of present illness should tell the “story” of the course & details of the patient’s problem(s), not a quick fill-in-the-blank text that satisfies the HPI “elements”; e.g.,
  - CC: Chest Pain
    - Duration: 3 weeks
    - Timing: intermittent
    - Severity: mild to moderate
    - Location: chest
    - Associated signs and symptoms: no SOB
- Is this an HPI?
  - Does this tell the patient’s story?
  - Does this allow MD to determine a differential diagnosis?
- In fact, this is simply a somewhat elaborate chief complaint
- What is the critical qualitative HPI element that is missing?

Failure to Guide Prelim. Assessment of NPP

- At conclusion of a comprehensive medical history, physician should have high probability preliminary assessment of a differential diagnosis
- AND an excellent preliminary assessment of the probable risks of morbidity, mortality, and/or loss of function without intervention
  - i.e., the Nature of the Presenting Problem(s)
  - i.e., the level of Medical Necessity
- Per CPT descriptors, this assessment can be used to determine (and guide) the medically indicated extent of examination and MDM to be performed and documented

Failure to Consider Qualitative Elements: Physical Examination

- Simply listing areas examined and whether they are “normal” or “abnormal” is inadequate for compliance and for quality of care
- Documentation Guidelines (‘95 & ‘97) require:
  - “Specific abnormal and relevant negative findings of the affected or symptomatic body area(s) or organ system(s) should be documented.”
  - A notation of ‘abnormal’ without elaboration is insufficient”
Challenges of ‘95 Exam Guidelines: No Measure of the Qualitative Terms

- **Problem focused**: limited exam of affected body area or organ system
- **Expanded problem focused**: limited exam of affected body area or organ system and other symptomatic or related organ systems
- **Detailed**: extended exam of the affected body area(s) and other symptomatic or related organ system(s)
- **Comprehensive**: a general multi-system exam or complete exam of a single organ system

- Should this be a limited or extended exam of 8 or more organ systems?
- Shouldn’t a comprehensive exam be more thorough than a detailed exam?

Inherent Coding/Auditing Challenges of the ‘95 Exam Guidelines

- How to audit an extended (but < comprehensive) exam confined to a single affected organ system?
- Should exam be considered expanded if MD documents > 1 organ system, but does not document all the organ systems that are symptomatic or related to the presenting problem(s)?
- Frequently find charts coded for a “detailed exam” when there is an extended exam of the affected body area or organ system, but only limited exam of other symptomatic or related organ systems

MDM Hurdles in CPT & Doc Guidelines

- Subjective elements of E/M that call for objective measures:
  - **Number of diagnoses and/or treatment options**
  - **Amount of data ordered or reviewed**
- Elements not documented by physicians:
  - **Three types of risk**
  - **Separation of data ordered from treatment options**
  - **Complexity of data ordered or reviewed**
- Complex calculation (2 out of 3)

Failure to Consider Qualitative Elements: Medical Decision Making

- Contaminating MDM with billing codes!!
  - Selecting diagnoses from a pick list of ICD-9 codes (or ICD-10 codes to come)
  - In order to enter simultaneously practice management billing information
- Prohibits use of differential diagnoses, which is required for compliant E/M and for quality
- Precludes use of adjectives for probability of Dx
- Precludes use of adjectives for severity of Dx

Use of Non-Compliant MDM Calculation Shortcut Engines

- Many EHR coding engines incorporate the so-called “Marshfield Tool” to improperly “count” MDM
- Borrows a corrupted value from the Table of Risk to manufacture a non-sanctioned quantitative value for # of diagnoses
  - i.e., “one new problem” → moderate complexity MDM → supports level 4 care
  - i.e., “one new problem with further workup” → high complexity MDM → supports level 5 care

Failure to Consider Qualitative Elements: Medical Decision Making

- Multiple additional problems with use of automated “Marshfield Tool” to improperly “count” MDM
  - If 1 new problem = “multiple diagnoses,” how many diagnoses are “limited” or “minimal”?
  - Ignores # of treatment options
  - This approach permits significant overvaluation of relatively minor illnesses
  - For established visits, this approach may significantly undervalue relatively moderate/severe illnesses
- **This tool fails to incorporate consideration of Medical Necessity**
Marshfield & the EHR Slam Dunk Level 4

- Comprehensive history
  - New Pt: pre-loaded macro, doc by exception
  - Established Pt: copy forward old history
- Detailed or comprehensive exam
  - Copy/paste pre-loaded macro, doc by exception
  - Or copy forward old exam
- Marshfield MDM
  - 8 diagnoses: 1 new problem
  - Risks:
    - 1 new problem with uncertain prognosis
    - 2 stable chronic illnesses
    - Manage one prescription medication
  - Ignore NPP (medical necessity)
  - Time of visit & doc = 90 seconds!

Result: audit = “false claims”; liability = catastrophe; quality

Marshfield & the Slam Dunk Level 4

Failure to Document Qualitative Elements: NPP

- Medical Necessity of a service is the overarching criterion for payment
- Is it possible to have a compliant coding engine without consideration of medical necessity???
- Most EHR screens fail to provide ability to document the NPP (some have option but no guidance)
  - Including this opportunity requires related physician training for integrating NPP into workflow
  - Failure to document NPP permits an auditor to misinterpret severity of illness and Medical Necessity

Questions About Non-Compliant Screen Designs and Coding Engines?

Documentation Guidelines Postulate

- For compliance & quality, which E/M criteria should be dominant?
  - Quantitative
  - Qualitative
  - Bothitative

Conquering EHRs’ E/M Challenges (SRL Recommendations)
E/M Toolkit for EHR Compliance

- Retain and augment good EHR features
- Correct inadequate EHR design features
  - Missing features that should be present
- Eliminate intrinsically non-compliant features that obstruct compliance and/or optimal care
  - Existing features that should be removed

Positive EHR Features

- Information (data) storage
- Information retrieval
- Information processing
- Information sharing
  - “Interoperability” (if and when actually achieved)

Missing Features that Should be Added

- Practices expect EHR systems should solve the E/M challenge; this should be prioritized (including new certification criteria for compliance)
- Improved “usability”
  - Data entry designs should match optimal physician workflow & diagnostic process
  - Increased options for data entry (including dictation and legible handwriting)
- Ability to enter qualitative E/M features and incorporate these into compliant E/M coding engines
  - Add missing elements of history, exam, MDM, and NPP
  - Program coding engine measures for qualitative narrative information

EHR Features that Should be Removed

- Eliminate non-compliant coding engines
  - Need to include BOTH qualitative and quantitative elements
  - Eliminate non-compliant MDM calculations
  - Incorporate consideration of Medical Necessity
  - Incorporate NPP guidance for levels of care, documentation, & codes

EHR Features that Should be Removed

- Eliminate non-compliant data entry shortcuts
  - Medical history and physical exam sections should not permit copy forward, copy/paste, documentation by exception, or translation
  - Unmanaged problem lists & medication lists
  - MDM section should eliminate copy/paste of entire problem list without prior review
  - Contamination of MDM with billing processes

Summary of EHR Problem Resolutions

<table>
<thead>
<tr>
<th>Missing E/M features you would like to have added</th>
<th>EHR features you would like fixed or turned off</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Consideration of medical necessity for determining appropriate levels of care, documentation, &amp; coding</td>
<td>1) Automated data entry shortcuts that create “cloned” pseudo-documents</td>
</tr>
<tr>
<td>2) Documentation of qualitative E/M features as well as quantitative</td>
<td>2) Incomplete and non-compliant coding engines</td>
</tr>
<tr>
<td>Missing E/M features</td>
<td>2) Incomplete and non-compliant coding engines</td>
</tr>
<tr>
<td>1) Consideration of medical necessity for determining appropriate levels of care, documentation, &amp; coding</td>
<td>3) Billing codes used in MDM for indicating clinical diagnoses</td>
</tr>
</tbody>
</table>
Sci-Fi Observations on Software Designs

• Lazarus Long: “Do your respect good machinery”
  Ira Weatherill: “Yes. As much as I despise machinery that doesn’t do what it is putatively designed to do” (page 13)
  – Robert Heinlein, Time Enough for Love, Berkeley publishing group
• This was published in 1973 !!!!

Principles for Effective EHR Design

• “The EHR must supplement physicians’ knowledge and judgment, not supplant them through automatic insertion of programmed clinical information and/or automated decisions regarding patient care”
  – “Practical EHR,” Chapter 10
• “Our goal should NOT be to design EHRs that compel physicians to ‘think’ like computers. Our goal should be to design EHRs that help physicians think like physicians.”
  – SRL, 2011

CEU Code ORL513

AAPC’s May Workshop presents this topic in greater depth, with a chance for roundtable discussion with your colleagues

Stephen R. Levinson, M.D.
www.PracticalEM.com
ASALLC@aol.com

Thank you for your interest