Best Practices of Successful E/M Auditing

Kitchi Goodwin, CPC, CPMA
February 2014

Why We Are Here

- OIG Report (OEI-04-10-00180)
- Coding Trends of Medicare Evaluation and Management Services - May 2012

Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

Figure 1: Percentage of E/M Codes Billed for Established Patient Office Visits From 2001 to 2010
Figure 3: Percentage of E/M Codes Billed for Emergency Department Visits From 2001 to 2010

Table 2: Specialties With the Largest Percentage of Physicians by E/M Coding Group in 2010

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Physicians Who Consistently Billed Higher Level E/M Codes</th>
<th>Other Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>10.5%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>12.2%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>9.0%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>4.4%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Obstetrics and Gynecology</td>
<td>4.3%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Cardiovascular Disease, Cardiology</td>
<td>4.0%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Total*</td>
<td>54.4%</td>
<td>61.6%</td>
</tr>
</tbody>
</table>

*The meaning of a code represents 5% of physicians who consistently billed higher level E/M codes and 82.2% of other physicians.

Objectives

- Compare your practice to your peers
- 20 most common coding and documentation errors & how to avoid them
- The “Grey Areas”
- EHR pitfalls and what to look for in your audit
- Strategies for improving documentation and coding
- How to conduct an effective audit

Where does your practice fit?

<table>
<thead>
<tr>
<th>All Specialties</th>
<th>Total Supported</th>
<th>Compliance Risk (Over coding)</th>
<th>Revenue Opportunity (Under coding)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>72%</td>
<td>21%</td>
<td>7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PC vs. Specialist</th>
<th>Total Supported</th>
<th>Compliance Risk (Over coding)</th>
<th>Revenue Opportunity (Under coding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>74%</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Specialists</td>
<td>60%</td>
<td>25%</td>
<td>7%</td>
</tr>
</tbody>
</table>
Room for improvement

<table>
<thead>
<tr>
<th>Top 3 Specialties</th>
<th>Total Supported</th>
<th>Compliance Risk (Over coding)</th>
<th>Revenue Opportunity (Under coding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>77%</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>75%</td>
<td>19%</td>
<td>7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>73%</td>
<td>19%</td>
<td>8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Worst 3 Specialties</th>
<th>Total Supported</th>
<th>Compliance Risk (Over coding)</th>
<th>Revenue Opportunity (Under coding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Oncology</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>40%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>10%</td>
<td>80%</td>
<td>10%</td>
</tr>
</tbody>
</table>

The 20 most common coding and documentation errors

History Common Mistakes
- Chief Complaint
- History of Present Illness
- Chronic Conditions
- Review of Systems
- Language
Exam Common Mistakes

- Documentation
- Mixing
- Check boxes
- Understanding

Assessment and Plan (MDM) Common Mistakes

- Severity and number
- Time based
- Orders
- Diagnosis

General Documentation Mistakes

- Inconsistent documentation
- Abbreviations
- Counting elements
- Office procedures
- Misunderstanding of preventive services
- Authentication
- Timely
Coding & Data Entry Mistakes

- Modifier misuse
- NCCI and LCD edits
- Diagnosis coding
- Chronic conditions

The “Grey Areas”

Chief Complaint in HPI

- Fact or Fiction – The CC can be pulled from the HPI.
Status of 3 Chronic Conditions

- Fact or Fiction – Status of 3 chronic conditions can be used to support an extended level of history with the ’95 guidelines

Unobtainable History

- Fact or Fiction – If the history is unobtainable or noncontributory you can automatically bill a comprehensive history

HPI Taken By Nurse

- Fact or Fiction - If the nurse takes the HPI the physician can then state, "HPI as above by the nurse" or “Have read and agree with the HPI"
Double Dipping

- Fact or Fiction – A provider can count a single history item in both the HPI and ROS

Single Organ System Exam

- Fact or Fiction – It’s acceptable to use the ‘97 Specialty specific exams for the comprehensive exam of a single organ system in ‘95

Detailed Exam

- Fact or Fiction – CMS defined the requirements of the Detailed Exam for the ‘95 Guidelines
EHR - Good or Bad

Electronic Health Record Adoption
EHR Adoption by Office-based Providers

Office-Based Provider Adoption of Basic EHRs (Percent)
EHR Issue #1
• The copy and paste

EHR Issue #2
• Over documentation

EHR Issue #3
• Missing documentation
EHR Issue #4

- Auto coding E/M

EHR Issue #5

- Favorites lists

EHR Issue #6

- Updates
EHR Issue #7

• Who did it

EHR Issue #8

• Signature authentication

EHR Issue #9

• Incomplete notes
EHR Issue #10

- Coding edits

Strategies for improving documentation & coding

- Educate providers
- Coders involvement with template design
- Perform gap assessment of new templates/EHR
- Coders shadow providers
- Perform regular audits
- Re-educate providers

How to Conduct an Effective Audit

- Knowledge of
  - Carrier interpretations of E/M Guidelines
  - Carrier policies for CPT®, ICD-9 and HCPCS
  - OIG Work Plan
  - RAC, CERT and other audit focus areas
  - Internal documentation and coding policies
  - How to effectively and professionally communicate and educate
Tips and Tools

Conducting an Internal Audit

Coding Compliance Program

• Coding accuracy goal
• Reduction in billing/claim errors
• 100% participation
• Turnaround time to complete audits
• Staff certification and education

Focus

• What is the focus of the audit?
  – Focused
  – New employment
  – Chronic problem
  – Targeted code(s)
Be Prepared

• No surprises
• Focus
• Timeline

Auditors

• Specialized auditors
• Specialty credentials

• How do you ensure the quality of the audit?

Auditor’s Role

• Advocate
  – To the provider
  – To the coder
• Attitude
  – Educator
  – Trainer
  – Enforcer
Standards

- Define grey areas
- ‘95 or ‘97 guidelines?
- “HEENT: negative”
- Prescription drug management
- Additional work up
- Medical necessity

Documentation

MAC

- Know your MAC carrier guidelines

- Review website often and attend trainings
Gather

- Provider signature logs
- Supervising physicians
- Abbreviations
- Tools

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Signature</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe</td>
<td>12/17</td>
<td>John Doe</td>
<td>Complete</td>
</tr>
<tr>
<td>Alice Smith</td>
<td>11/11</td>
<td>Alice Smith</td>
<td>75%</td>
</tr>
<tr>
<td>Mike Jones</td>
<td>10/10</td>
<td>Mike Jones</td>
<td>80%</td>
</tr>
</tbody>
</table>

Training

- Individual?
- Group?
- Provider?
- Coder?
- Provider and coder?
- Follow-up

Report and Follow-up

- Summary
- Action Plan
- Follow-up
Recommended Resources

- Current ICD-9-CM code book
- Current CPT® code book
- Current HCPCS Level II Coding Procedures code book
- Specialty specific coding reference from a credible source

Knowledge

“Any fool can know. The point is to understand.”
~ Albert Einstein

AAPC Client Services can assist you with:

- Coding and documentation audits
- ICD-10-CM assessment readiness audits
- Compliance risk assessments
- Compliance program implementation
- Training and education

Visit us at: www.aapc.com or Call: 888.200.4157
Questions?

kitchi.goodwin@aapc.com
866.200.4157 ext 307

OIG

CMS and Its Contractors Have Adopted Few Program Integrity Practices To Address Vulnerabilities in EHRs

http://oig.hhs.gov/oei/reports/oei-01-11-00571.asp