DEFENDING AUDITS BEFORE THEY HAPPEN: A PRACTICAL GUIDE TO DOCUMENTING E/M CODES

Perhaps one of the greatest potential risks to a provider's practice is an overpayment audit. Refund demands, threat of provider contract termination, and the likelihood of lack of insurance coverage for this type of claim may place a provider at great financial risk.

This article is designed to help health care providers avoid audits and receive fair reimbursement for professional services. The article focuses on Evaluation and Management (E/M) Codes, which are used by a broad spectrum of providers; however, readers are cautioned that audits may be triggered by any number of CPT codes.

Understanding Billing Codes Requirement is the Best Audit Defense

Audits are typically triggered by either a patient complaint or billing practices that are outside of statistical norms. Most providers know that consistently billing the highest E/M Codes may trigger an audit. However, routinely choosing even low to middle E/M codes may also attract attention. It is important to properly document in order to support the E/M services coded.

Providers can document E/M services in two ways: "Key Components" or "Contributory Factors." Key components include specific parameters related to various levels of complexity for History, Examination, Medical Decision Making. On the other hand, Contributory Factors are billed according to time spent with the patient.

Key Component—Documenting History and Review of Symptoms

Medical history documentation is categorized as follows:

> **Problem focused**: Chief complaint; "brief" history of present illness or problem.
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> **Expanded problem focused**: Chief complaint; "brief" history of present illness; "pertinent" system review.
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> **Detailed**: Chief complaint; "extended" history of present illness; "problem pertinent" system review extended to include a review of a number of additional systems; pertinent past, family and/or social history related to the problem.
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> **Comprehensive**: Chief complaint; "extended" history of present illness; review of systems directly related to the identified problem, plus a review of all additional body systems; complete past, family and social history.

Thus, there is a need to understand the difference between a brief history and an extended history to properly categorize this element of the patient encounter. An "extended" history refers to three or more chronic or inactive conditions or four or more of the following symptom elements of the

HPI: 1) location; 2) quality; 3) severity; 4) duration; 5) timing; 6) context; 7) modifying factors; and 8) associated signs and symptoms. In contrast, a "brief" history only documents one to three of the above-listed HPI elements.

Sometimes the difference between brief and extended may be simply a word or two. For example, a chart which reads "Patient has had mild [severity], dull [quality], headache since yesterday [duration]" can be properly billed at a higher level than "Patient presents with a history of headache starting overnight." Thus, adding descriptors can change a "brief" history to an "extended" one.

Similarly, a "problem-pertinent" Review of Systems is distinguished from a more comprehensive ROS. The problem-focused ROS need only document the system that is directly related to the presenting problem. However, an extended ROS requires inquiry for two to nine systems, only one of which needs to be directly related to the presenting problem. Thus, providers coding a "comprehensive" ROS should document review of at least 10 organ systems, including the system of the presenting problem. Notably, the key word in this context is "review." While the HPI must be performed by a physician, the guidelines note that both the ROS and family/social history may be recorded by staff or may be completed by the patient on a form. Documentation of pertinent findings recorded by staff coupled with notations that "all other systems negative" may be sufficient to sustain a challenge.

Key Components—Documenting the Physical Exam

Guidelines for documenting the physical exam were provided in 1995 and in 1997. Unfortunately, neither set of guidelines is perfect. The original 1995 guidelines were deemed overly vague and the 1997 revisions went too far in the opposite direction.

In a very general sense, to qualify for a given level of reimbursement, there must be examination and documentation of certain specific elements of the following organ systems: 1) Eyes; 2) Ears, Nose, Mouth and Throat (Note that auditors consider that an HEENT exam applies to two organ systems, i.e. eyes and ears; nose, mouth and throat); 3) Cardiovascular; 4) Respiratory; 5) Gastrointestinal; 6) Genitourinary; 7) Musculoskeletal; 8) Skin; 9) Neurologic; 10) Psychiatric; and 11) Hematologic/lymphatic/immunologic. The number of systems included in the physical exam will determine the level of the applicable E/M code:

> **Problem Focused**: A limited examination of the affected body area or organ system (Exam should include 1-5 physical exam elements from one or more organ system or body area.).
>
> **Expanded problem focused**: A limited examination of the affected body area or organ system and other symptomatic or related organ system(s) (Exam should include at least 6 specific elements from one or more organ systems or specified body area.).

Detailed: An extended examination of the affected body area and other symptomatic or related organ system (Exam should include at least 12 elements within at least two different systems or areas.).

Comprehensive: A general multisystem examination or a complete examination of a single organ system (Exam should include all elements and documentation of at least 2 elements from each of at least nine systems or areas.).

Since the problem focused exam only requires exam of one element, a provider could meet the "problem focused" exam with documentation of basic vital signs. It is less clear how to differentiate between expanded, detailed and comprehensive physical exams. We anticipate auditors could look for various exam findings to determine which level of physical exam is appropriately coded. For example, in order to meet the 12 elements to qualify for a "detailed" physical exam, a provider might include the following in the PE: 1) vital signs; 2) general appearance; 3) examination of the neck; 4) auscultation of the lungs; 5) auscultation of the heart; 6) assessment of the carotid arteries, i.e. "normal carotid upstroke and amplitude"; 7) examination of abdomen; 8) examination of liver and spleen, i.e. "No HMS, no masses"; 9) examination of extremities for edema; 10) palpation of digits and nails; 11) inspection of skin; 12) mental status, i.e. "alert/orientated."

Key Components—Medical Decision-Making

Unlike the more specific and technical requirements for history and physical documentation, the decision-making component of E/M services leaves more room for interpretation. There are four levels of recognized medical decision-making: 1) Straightforward; 2) Low Complexity; 3) Moderate Complexity; and 4) High Complexity. Qualifying for a given type of decision-making is based on two of the following three factors:

The number of possible diagnoses and possible management options being considered;

The amount and complexity of data involved;

The risk to the patient either by the presenting problem or planned intervention.

Again, distinguishing between the middle levels of decision-making can pose challenges. There is no clear statement within the guidelines differentiating between these levels. Thus, clinicians should perform their own comparative analysis based on the patient encounter. For instance, established patients who need frequent medication changes may raise the level of complexity. Likewise, when a new issue arises, providers might look to the differential diagnoses in analyzing the level of complexity. Documenting the thought process behind the coding in the record may assist in defending against criticism in this area.

Time-Based Billing Entries

Regardless of the level of complexity, providers will have some visits that consist predominately of counseling and/or coordination of care. For these visits, E/M guidelines use the time spent with the patient as the controlling factor for reimbursement.

In order to sustain the scrutiny of an audit, there are specific requirements that providers must keep in mind when billing time-based entries. First, the time concerns face-to-face time spent with the patient or the patient representative. This may include the time associated with any history, exam, or medical decision-making performed. For the inpatient setting, the total time spent may also include discussions with nursing staff or other consultants and review of records for inpatient services.

Next, most of the total time (greater than 50%) must be used for "counseling and coordination of care." Providers should document the amount of time involved in the service and then write "more than half of the encounter involved counseling and coordination of care." This language makes it clear that the code was selected based on time. Vague statements such as "extensive discussion" or "discussed at length" are not likely to be sufficient. It is also strongly advisable to document the general nature of the discussion to give a potential auditor context.

Providers should familiarize themselves with the specific time period for various levels of services. For an established patient in the outpatient setting, there are five separate E/M levels with times ranging from 5 to 40 minutes. Providers should be mindful not to make a mistake by documenting a specific amount of minutes spent counseling that would be less than 50% of the billed level. For example, indicating "15 minutes in counseling and coordination of care" would be less than 50% of a 40-minute encounter and thus coding at this level would not be justified.

Conclusion

Both governmental contractors working on behalf of CMS and large private insurance companies have found the audit process to be an effective tool in recovering funds. The Government Accountability Office (GAO) estimates that nearly $60 billion in overpayments were paid to Medicare providers in 2014 alone. Be mindful the regulations to guard against an audit. If you are faced with an audit, enlist help. Contact an attorney right away. It also may be advisable to contact your insurance risk carrier.