Things Not Often Known About Documentation and Coding

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Senior Consultant, Rose & Associates

Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.

Scope of Course

• Frequently Asked Questions
  – During Courses
  – Post-Audit Conferences
  – List Serves
• Frequently Found Errors
  – During Audits
  – Reported From 3rd Party Audits

E&M - Exam Codes

• Evaluation & Management Codes (E&M)
  – 99201-99205 (NP) 99211 – 99215 (EP)
  • History
    – History of Present Illness (HPI)
    – Review of Systems (ROS)
    – Personal Family Social History (PFSH)
  • Exam
    – 12 Elements Plus Mental Status
  • Medical Decision Making
    – Diagnoses & Management Options
    – Data to Be Reviewed
    – Risk of Complications

E&M - HPI

• 1995 & 1997 Guidelines
  – State who can obtain ROS, PFSH
  • CMS states only the Provider/NPP can obtain the HPI
    – Not enough to “Confirm,” “Verify,” “Review”
    – Can be dictated to scribe
  • Sources Mixed on Who can Obtain the CC
    – Required for both Eye Codes and E&M
    – Is the basis of the HPI
    – Provider/NPP must Verify

E&M - Exam Codes

• Physician Required Work
  – HPI
  – Mental Status
  – Most of The Exam
  – Assessment & Plan
• Technicians Work
  – ROS & PFSH
  – Work-up – VA, CVF, IOP
E&M - HPI

• Paper Chart or EHR
  – Entry Specific to HPI
    • “HPI Obtained by I.C. Well, MD” in the provider handwriting
    • “HPI Dictated by I.C. Well, MD and Scribed by I. Wrote, COA”
  – Cannot be simply the signature at the bottom of the encounter

E&M - HPI

• EHRs Without Entry Specific to HPI
  – Work with vendors to have that changed
  – Be sure the provider is logged in when the HPI is obtained
    • Electronic Audit will Verify who obtained the HPI
  • EHR Pick-Lists
    – Make sure the Pick-Lists are accurate for the provider to use
    – Negatives only count if they are pertinent

E&M – Review of Systems

• Review of Systems (ROS)
  – 14 Possible Body Systems
    • 10 are the most ever needed, but include all
    • Positives and Pertinent Negatives
      – Like “All Other Systems” Carefully
  – Inventory of Signs and/or Symptoms
    • “As it is directly related to the problem(s) identified in the HPI.”
    – Must be signed, referenced and updated to be counted

E&M - Mental Status

• Physician Must Assess
  – Notation should state as such
    • “Mental Status Evaluated by I.C. Well, MD – Oriented to Person, Place and Time. Mood and Affect Appropriate” - in provider handwriting
    • “Mental Status Evaluated by I.C. Well, MD – Oriented to Person, Place and Time. Mood and Affect Appropriate” - Dictated to and scribed by: I. Wrote, COA”
  – Can only be the last Exam Element

E&M - MDM

• Medical Decision Making - 3 Elements
  – Diagnoses and Management Options
  – Data to be Reviewed
  – Risk of Complications
    • Must meet or exceed 2 of 3 for level

Medical Decision Making

<table>
<thead>
<tr>
<th>Number of Diagnoses and/or Management Options</th>
<th>Data to be Reviewed</th>
<th>Risk of Complications</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal (Suggest 1-2)</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Straight Forward (99201, 99202, 99212)</td>
</tr>
<tr>
<td>Limited (Suggest 3-4)</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity (99203, 99213)</td>
</tr>
<tr>
<td>Multiple (Suggest 5-6)</td>
<td>Moderate</td>
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<tr>
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Note: 2 of the 3 components of Medical Decision Making must be met or exceeded for each level. Drop the lowest component and bill the lowest of the remaining components.
TABLE OF RISK (Unofficial)

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Processing Problems</th>
<th>Diagnostic Tests/Fields</th>
<th>Management Options/Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Low Complexity</td>
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<td>Minimal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reduced</td>
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Choosing the Level of Service

- CC/HPI Dictates the Level of ROS & PSFH
  - Comprehensive History Not Always Necessary
- The History Creates the Foundation for the Extent of the Exam
  - CC/HPI + ROS + PFSH
  - All Exam Elements Not Always Necessary
- Combine History & Exam for Assessment
- All of the Above Determines the Plan

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Determining a New Patient E&M

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New Patient: The lowest of the three components determines the overall code Low Complexity determines the code 99203.

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Downcoding

- Some Physicians Downcode
  - It is not a Protection Strategy
    - Believe it will avoid a utilization audit
    - Billing the same code makes an outlier
  - Easier than learning proper coding
  - Lowers Practice Revenues
  - Does not alleviate need for proper documentation

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### Downcoding

- Physicians Should Learn Requirements for Exam Codes
  - E&M (99 codes)
  - Eye (92 codes)
    - Safer and provides more accurate coding
    - Also enhances revenue
  - Lessens chance for Medicare scrutiny
    - Avoids hassles for entire practice

### Off-Cycle Visits

- Patient Return Not Planned
  - Early
    - May be an acute problem
      - History should reflect as “new” problem
    - May be a scheduling error
      - Lost to follow-up
        - Non-compliant
        - Other illness or issue
  - Late
    - History should reflect as “new” problem

### Quality of Care

- CMS Future
  - Pay based on Quality Care
  - Documentation will need to reflect this
    - Requires participation for support staff
  - Physician reimbursement based on what is documented not what was done
    - Initial claim will be paid
      - Will it hold up in post-payment review

### Diagnostic Tests

- Three Elements of Required Documentation
  - Physician Order
    - Indication for test
    - Ordering physician utilizes results
  - The test results themselves
    - Interpretation and report
      - What was found
        - Disease progression or improvement
        - How will the results impact treatment
    - Initial claim will be paid
      - Will it hold up in post-payment review

### Dry Eye Patients

- Clinical Findings
  - Tear film
  - Lids – MGD, Malposition
  - Cornea – SPK, PEE
- Tear Osmolarity – CPT 83860
  - Results meaning
- Meibography – CPT 92285
  - Infra-red? Retro-illumination?
Dry Eye Patients

- Meibomian Evacuation
  - LipFlow CPT 0207T
- Tear Interferometry
  - LipiView® CPT 0330T Punctal Occlusion
    - By closure (cautery, laser) CPT 68760
    - By plug CPT 68761
- Test indication and timing
  - Results and impact on treatment
- Assessment
  - Reason for treatment choice

Axial Length Measurement

- Test Specific Order
  - A-Scan – 76519 and 76519-26
  - IOL-Master – 92136 and 92136-26
    - Make sure the scan is stored
- Measurement Order
  - Axial length measurement
  - Biometry for IOL Calculation
- Order Should Be From Provider Using Results

Pachymetry

- Indicated For:
  - Glaucome – “Once in a Lifetime”
  - Corneal Disease - As Medically Necessary
    - Causes Edema/Thickening – e.g., Fuchs’s
    - Causes Ectasia/Thinning – e.g., Keratoconus
- If Performed With:
  - Ultrasound: CPT 76519
  - Ocular Coherence Tomography: CPT 92132
  - Optical: CPT 92499

SCODI & Visual Fields

- Glaucoma
  - SCODI expected early to moderate stage
    - Detects loss of NFL prior to visual field loss
  - Visual Field expected moderate to late stage
    - Defects appear once significant NFL loss occurs
    - Not expected on the same day
      - Baseline may be acceptable

Newer Glaucoma Tests

- For Early to Moderate Glaucome
- Should Not Bill if Confirming What Other Tests Already Revealed
  - Visual Evoked Potential – VEP CPT 95930
    - Objectively measures the neurological responses of the entire visual pathway
  - Electroretinography – ERG CPT 92275
    - Measures loss of retinal function and distinguishing retinal from optic nerve lesions

Major & Minor Procedures

- All Codes from 65091 – 68999 Considered Surgeries
  - Including: Epilation, Punctal Plugs, etc.
- Need Appropriate Documentation
  - Patient Complaint and/or Adjacent Damage
  - Consent?
  - Procedure Note with Details
Minor Procedures

• Minor Procedures are Defined by a 0 or 10 day Global Period
  – Typically done in the office
• Major Procedures are Defined by a 90 Day Global Period
  – Typically done in the OR/ASC
    • Two charts
    • Two log-ins
    • Two sets of documents

Medical Necessity

• Minor Surgery May Be Based On
  – Patient Discomfort
    • Irritation, Scratchiness
  – Clinical Findings - if Left Alone Could Lead to Possible Loss of Function
    • Adjacent Tissue Damage
    • Suspicious appearance with a history of related malignancy

Medical Necessity

• If Patient Unable to Present With Complaint
  – Document the circumstances that lead to the decision for the procedure
  – The History can be obtained from another
    • A caregiver might have noticed a change
  – The patient’s cornea is neurotrophic
  – The damage to the eye is justification

Shaving

• “Shaving is the sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full-thickness dermal excision. This includes local anesthesia, chemical or electrocauterization of the wound. The wound does not require suture closure.”

Biopsy

• Obtaining Tissue for Pathology
  – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure unless otherwise listed)
    • 11100 – single lesion
    • +11101 – each separate/additional lesion (list separately in addition to code for primary procedure)
      – Add-on codes are not subject to multiple procedure reduction

Biopsy

• Lesions Sent to Pathology Following Shaving, Excision, Destruction
  – NOT reported separately as Biopsies
• Biopsies followed by Lesion Removal Once Pathology Results Known
  – ARE reported separately
• If Moh’s Procedures Use Codes 1731x
### Destruction

- Means the ablation of benign, premalignant or malignant tissues by any method, with or without curettement, including local anesthesia, and not usually requiring closure.

### Excision

- “Excision is defined as full-thickness (through the dermis) removal of a lesion, including margins and includes simple (non-layered) closure is performed”
  - Size is the excision size not the lesion size
  - Code per lesion if multiple excised in the same session

### Code Descriptions

- CPT Codes 67800 - 67850
  - Codes for the removal of lesion include more than skin (i.e., involving lid margin, tarsus, and/or palpebral conjunctiva)
  - For removal of lesion, involving mainly skin of the eyelid, see 11310 – 11313, 11440 – 11446, 11640 – 11646, 17000-17004

### Removal of Eyelid Lesion

- CPT Code 67840
  - Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure
- CPT Code 67850
  - Destruction of lesion of lid margin (up to 1cm)
  - Margin of eyelid is between the anterior & posterior edges

### Benign Lesions

- CPT Code 11310 – 11313 (0 Global)
  - “Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane;”
- CPT Code 11440 – 11446 (10 Day Global)
  - “Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips mucous membrane;”
  - Size of Excision not lesion determines code

### Excision – Benign Lesions

- Subjective – CC or HPI
  - Patient is significantly bothered by the lesions
  - NOT the appearance of the lesions
  - Cosmetic Procedure Charge is Patient Responsibility
- Objective – Examination
  - External Exam – Size of lesion
  - Clinical Signs Supporting Patient Complaint
- Operative Note – Details
  - Location, Instrumentation, Size & Closure
Excision – Malignant Lesions

- CPT Code 11640 – 11646 (10 Day Global)
- Objective – Examination
  - External Exam – Size of lesion
  - Clinical Signs Supporting Working Diagnosis
  - May include Patient Medical History
- Operative Note – Details
  - Location, Instrumentation, Size & Closure

Lesion Characteristic

- When do you know the lesion is benign or malignant?
  - Don’t give the patient a disease they don’t have
- When should the procedure be coded?
  - Size of Excision not lesion determines code

Wound Closure

- Certain Codes Stipulate Method of Closure
  - Sum of wounds in centimeters
  - “The closure of defects created by incision, excision, or trauma may require intermediate or complex closure.”
    - Simple - 12011 - 12018
    - Intermediate - 12051 - 12057
    - Complex - 13150 - 13153

Intermediate Closure

- Intermediate
  - Require layered closure of one or more deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure
  - Single layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter
    - CPT Codes 12051 - 12057

Complex Closure

- Complex
  - More than layered closure
  - Scar revision, debridement extensive undermining, stents or retention sutures
  - Multiple Closures
    - Report total lengths of each
    - Choose corresponding closure code
    - Sum lengths
    - Submit primary method first
    - Secondary methods with -59
      - CPT Codes 13150 - 13153
Complex Cataract Surgery

- Complex NOT Complicated
- Beware of Canned Operative notes
  - Lack specifics to a given surgery
    - Requirements for code 66982
  - Are not in chronological order
- Clinic record should show anticipation of possible complex cataract surgery
  - Hazy view, Poor dilation, History of Flomax

Legibility

- Or Lack Thereof
  - Paper charts
  - Documents hand-written & scanned
  - Significant issue for Medicare
    - If is can’t be read, will be ignored
      - Will result in refund request
    - Use scribes if EHR not an option

Physician Signature

- Serves as Authentication
  - Attests the billed services were performed
- Signatures Often Do Not Resemble Name
  - Must be identified
    - Typed name below signature line
    - Signature log
      - Include with external audits

Assignment of Medicare Benefits

- Once in a Lifetime Authorization
  - Allows payment directly to practice/ASC
    - Can include both entities on one form
    - Document must appear in both charts
  - Includes language on Medigap/secondary
    - Name of secondary insurance
    - Coordination of benefits
  - Release of information
    - Purpose of claims payment

Questions

- Include
  - Patient’s printed name
  - HIC Number
  - Patient’s signature
    - POA must have associated legal documents
    - Date of signature
  - Avoid Listing Individual Providers
    - The list may change

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