It’s All About That E/M
No Treble

Presented by
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OIG Reports

- Coding Trends of Medicare Evaluation and Management Services ~ May 2012
- Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010 ~ May 2014
Highlights- OIG Report - Coding Trends

- Between 2001-2010 Medicare payments increased by 48% ($22.7 billion to $33.5 billion)
  - Due to increases in the number of services provided
  - Due to increase in the average payment rate for E/M
  - Due to physician increase in billing higher level E/M

<table>
<thead>
<tr>
<th>E/M Coding Group</th>
<th>Number of Physicians</th>
<th>Number of Beneficiaries</th>
<th>Number of E/M Services</th>
<th>Average Medicare Payment per E/M Service</th>
<th>Average Medicare Payment per Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians Who Consistently Billed Higher Level E/M Codes</td>
<td>1,669</td>
<td>76,132</td>
<td>828,646</td>
<td>$131.24</td>
<td>$426.56</td>
</tr>
<tr>
<td>Other Physicians</td>
<td>440,321</td>
<td>29,950,855</td>
<td>368,800,457</td>
<td>$88.25</td>
<td>$221.62</td>
</tr>
<tr>
<td>Total</td>
<td>441,990</td>
<td>30,026,987</td>
<td>369,629,103</td>
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</tr>
</tbody>
</table>

### Highlights- Coding Trends

**Top six specialties with higher levels of E/M codes**

<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>19.8%</td>
<td>18.1%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>12.2%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>9.9%</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>1.9%</td>
</tr>
<tr>
<td>Cardiovascular Disease, Cardiology</td>
<td>4.0%</td>
<td>4.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>54.6%</strong></td>
<td><strong>51.8%</strong></td>
</tr>
</tbody>
</table>

*The remaining specialties represented 45.4 percent of physicians who consistently billed higher level E/M codes and 48.2 percent of other physicians.


### Highlights- Coding Trends

- Largest amount of E/M Medicare payments for 2010
  - Established office visits (99213 billed most)
    - Increased billing of 99214 & 99215 by 17% from 2001 - 2010
Highlights - Coding Trends

• Second largest – subsequent inpatient visits


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Highlights - Coding Trends

Third largest – Emergency department visits

*Percentages do not sum to zero because of rounding.
OIG Recommendations- Coding Trends

• Educate providers on coding and documentation for E/M services

• Encourage contractors to review provider billing for E/M services

• Review providers who bill higher level E/M codes for appropriate action

CMS Response to OIG

• Educate providers on coding and documentation for E/M services

• CMS agreed and finding ways to educate providers on proper E/M billing
CMS Response to OIG

• Encourage contractors to review provider billing for E/M services

• CMS agreed to inform MACs, issue billing reports to 5,000 providers designed to help identify potential errors and make changes

CMS Response to OIG

• Review providers who bill higher level E/M codes for appropriate action

• CMS Partially agreed to send names of top 1,700 physicians to MACs and direct each MAC to focus on the top 10 providers in its jurisdiction

• CMS stated they would review cost/benefit of E/M reviews versus more costly Part B services
Overture

• Chief Complaint
  – Set the scene
  – Brief reason as to why the patient is presenting for care
  – Follow-up, new problems, “referred by”, screening, etc.

• 1995 Guidelines or 1997 Guidelines

Act I

• History
  – History of Present Illness
• Details!
  – Who, what, why, where, when, how long, how often and anything else. New or follow-up?
  – Paving the way for what comes next...

“Patient presents with 9 month history of back pain exacerbated by lifting heavy boxes earlier this week. No relief with OTC analgesics, frozen bag of peas, heating pad or massage – pain is constant and severe”
### Act I

- **History**
  - Review of Systems
- **No conflicts with HPI!**
- **Document all systems reviewed – positive or negative**
- **Update previous ROS**
- **Patient history intake form?**
- **All systems reviewed and are negative? Is this ok?**

### Act I

- **History**
  - Past, Family, Social History
- **Chronic diseases, pertinent past illnesses, vaccines**
- **Pediatric Past History?**
- **Family History - Non-contributory? Unremarkable?**
- **Social History - Smoker – opportunity for tobacco cessation counseling**
Act II – “The plot thickens”

- Examination
  - 1995 or 1997? Single Specialty?
- Document all work performed
- Cloned?
- Medically necessary?
- Detail with positive findings
- Severity, level, stage, size, color, abnormality

Act II

- Significant findings
  - Positive or negative
- Wound care
  - Healed, infected, needs debridement, etc. -- describe in detail!!
- Conflicts?
  - 300 pounds and WD/WN?
  - Patient presents for pink eye with itchy and watery eyes
    - Exam: conjunctivae clear OU
Finale

- Medical Decision Making
  - Assessment and Plan
- Status of Illness and chronic diseases
- Planned additional workup? Tests ordered?
- Rule out for tests ordered
- Rx management
  - Ordering new Rx, changing dose of current, decision to stop or decision to continue/refill

Finale

- Severity of condition or risk? From end of visit until the anticipated next encounter?
  - Chronic stable
  - Chronic mild exacerbation
  - New problem with symptomatology
  - Undiagnosed
  - Severe exacerbation
  - Imminent organ system failure
  - Abrupt neurologic change
Finale

• Risk of patient current illness at the end of physician assessment until the next expected physician assessment
• Co-morbidities and status that may affect current condition or treatment options
• Test results affecting risk and/or supporting severity of condition
• Referrals to specialists
• Parenteral controlled substances

Finale

• Train wreck or fender bender?
  – Assessment and plan:
    • Anemia
    • Type II Diabetes - uncontrolled
    • COPD
  – Assessment and plan:
    • Severe Anemia – Hgb 7.3 – will transfuse 3 units packed RBC’s
    • Type II Diabetes – HAIC 10.2– 15 units insulin given stat with q. 6 hour finger stick
    • COPD – monitor oxygen saturation, notify < 92%
Finale

• Signature of provider
  – Legible
  – Credentials

• Identified as deficiency by OIG report due to missing signature, illegible or unacceptable (typed name with no initials/signature, “electronically signed”)

Counseling/Coordination of Care

• TOTAL time spent face-to-face with patient
• Percent or total time spent in counseling (GREATER than 50%)
• Sufficient detail to describe the counseling (Identified as a deficiency with OIG report)
Curtain Call

• Determine the level of E/M service
• Tests performed in office
• Procedures performed in office during E/M visit – separately identifiable? (Identified as deficiency by OIG report)
• Injections – medical necessity, site, drug mg, patient response, may require lot # and expiration date of drug (Documentation of injections identified as deficiency by OIG report)

Curtain Call

• Incident-to? (Only identified by OIG report when new patient visit performed by NPP and billed under physician)
• Share visit?
• 99211 with no previous plan?
• Direct supervision vs general supervision?
Curtain Call

- Modifiers? High risk? (Modifier 25 identified as not supported by OIG report)
- Units
- Diagnoses and linkage
- Admit, D/C, RTC, PRN

Critics

“It ain’t over until the fat lady sings”
Highlights- OIG Report – Improper Payments

• OIG concluded:
  – Medicare improperly paid $6.7 billion for E/M services in 2010
  – 42% of E/M services in 2010 were incorrectly coded (this included up-coding and down-coding)
  – 19% of E/M services in 2010 lacked documentation
  – Claims from high coding physicians were more likely to be incorrectly coded or insufficient documentation than other physicians

Highlights – Improper Payments

• Review conducted by:
  – Random sample from 2010
  – Review by three (3) certified professional coder with experience reviewing claims for E/M services
  – Contracted with a registered nurse to assist with determination of whether documentation supported medical necessity and was consulted upon “as needed”
Observations

• Stratum, subset, subgrouping, point estimates
  — Secondary analysis by statistician as to validity of sample set?
  — Secondary analysis by statistician as to validity of findings
• Individual findings not detailed or submitted to providers to respond to with appeal/additional information
• Experience of certified professional coders
• Review of RN vs physician for medical necessity

OIG Recommendations- Improper Payments

• Educate physicians on coding and documentation requirements for E/M services

• Continue to encourage contractors to review E/M services billed for by high-coding physicians

• Follow-up on claims for E/M services that were paid for in error or lacking documentation to include over payments and under payments
CMS Response to OIG

- Educate physicians on coding and documentation requirements for E/M services
- CMS agrees and will continue to issue educational documents on E/M services

CMS Response to OIG

- Continue to encourage contractors to review E/M services billed for by high-coding physicians
- CMS did not concur. CMS did a review of claims that were previously referred by OIG in their first report which resulted in a negative return on investment. CMS will reassess the effectiveness of reviewing high coding physicians.
CMS Response to OIG

- Follow-up on claims for E/M services that were paid for in error or lacking documentation to include over payments and under payments

- CMS partially agreed. CMS will analyze each overpayment to determine which claims exceed its recovery threshold and can be collected

Questions

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