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

Highlights- Coding Trends

- Approximately 1,700 physicians billed higher level E/M codes in 2010 at least 95% of the time
  - ✓Three top states – California, New York and Florida

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

Source: OIG analysis of 2010 NCH Carrier file.

Highlights- Coding Trends

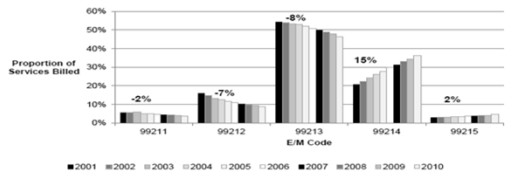
Top six specialties with higher levels of E/M codes

Specialty	Physicians Who Consistently Billed Higher Level E/M Codes	Other Physicians
Internal Medicine	19.8%	18.1%
Family Practice	12.2%	14.7%
Emergency Medicine	9.9%	7.1%
Nurse Practitioner	4.4%	5.2%
Obstetrics and Gynecology	4.3%	1.9%
Cardiovascular Disease, Cardiology	4.0%	4.8%
Total*	**54.6%**	**51.8%**

*The remaining specialties represented 45.4 percent of physicians who consistently billed higher level E/M codes and 48.2 percent of other physicians.
Source: OIG analysis of 2010 NCH Carrier file.

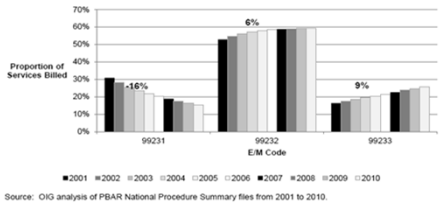
Highlights- Coding Trends

- 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

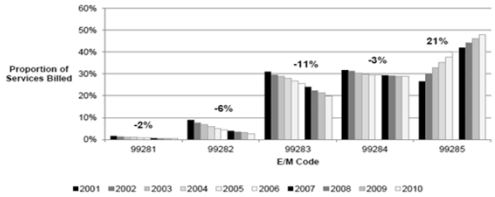
- Second largest – subsequent inpatient visits



Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Highlights- Coding Trends

Third largest – Emergency department visits



*Percentages do not sum to zero because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

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 repot)
- 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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