Part B Insider (Multispecialty) Coding Alert

Compliance: Consider These 3 Self-Audit FAQs As You Review Your Practice's Claims

Time can drive E/M level--if it's documented.

Most Part B practices routinely perform self-audits twice a year to ensure that their physicians are coding and billing correctly--but audits can bring up questions that might be tough to answer. Consider these three self-audit questions and answers that will get you on the right track.

Background: When you audit your practitioner's services, you can uncover incorrect coding patterns or compliance issues. You'll discover any problems before an outside auditor (such as a RAC or an OIG auditor) does, and you'll be on your way to collecting the exact reimbursement you should.

Get Into the Habit of Documenting Time Spent

Question 1: After completing our audit, we found several instances when the doctor billed 99214 and the documentation did not warrant it. However, in all of these cases, he spent 30 minutes with these patients (who had multiple chronic issues), almost all of which was spent counseling them and coordinating their care with family members. How can we rectify this?

Answer: If the physician did not document the time spent with the patient, the only way to rectify the past records is for the doctor to make an amendment/correction to the record--but only if he actually remembers the time spent with the patient, as well as the time spent counseling/coordinating care. He would have to add the information to the record, sign and date the amendment, and write the reason why he is adding the additional information.

Reality: Since most physicians see multiple patients per day, they would likely have trouble remembering exact times spent with individual patients that they saw in the past. The reality in this situation is that the doctor should adjust his documentation habits going forward to ensure that he documents time in the records when necessary, and can code based on time spent counseling/coordinating care when he meets the requirements.

Reminder: You should only code an E/M service based on time alone if at least 50 percent of the visit was spent on counseling or coordination of care, and this fact must be noted in the documentation. The documentation must contain the following three elements:

- Notation of the total time spent on the encounter
- Notation of the total time spent on counseling and/or coordination of care or the percentage of the visit spent on counseling/CoC
- The reason for/topic of the counseling/CoC

For example, the following statements would allow billing based on time alone: "45 minute office visit with 40 minutes spent on counseling about surgical options for recurrent tonsillitis" or "Total encounter: 55 minutes with 35 minutes spent on coordination of care for patient's increased dementia."

Tip: If your physician routinely sees patients with multiple chronic conditions requiring time-intensive counseling, you should educate him to record time spent in total as well as time spent counseling on all of his charts. Include a section on your E/M template where he can record this to avoid undercoded visits in the future.

You Must Meet Minimum History Requirement to Bill New Patient

Question 2: We found several instances where our physician saw a new patient but didn't document the minimum levels of history required (he either documented no chief complaint or no HPI) to bill any new patient office visit codes (99201-99205). What can we report in circumstances like this?

Answer: Review the brief HPI information the physician documented to determine if the statement contains both elements of a CC (chief complaint) and history of present illness (HPI). The doctor must document the HPI, exam (with the exception being vitals, which an ancillary staff member can document), and the medical decision making (MDM). You need documentation of all three key components (history, exam, and MDM) to support a new patient level E/M code.

If you truly have no HPI documentation, you cannot submit a claim with the new patient E/M codes (99201-99205). Help educate your physicians on the importance of clear E/M documentation. The HPI is a vital part of the patient record that documents the reason why the patient is seeking care and the circumstances surrounding the problem that led up to and includes the present status and any changes since the patient's last visit. If a physician routinely omits the HPI, you'll be hard pressed to establish medical necessity for many patient encounters.

Doctor Overdocuments History, Exam? You Can't Always Bill 99215

Question 3: Our physician bills a lot of high-level E/M codes (99214, 99215) and after auditing these claims, we found that the documentation warrants these codes because he records his history and exam so thoroughly. However, his medical-decision making is usually low. For instance, he reported a 99214 for a sinus infection because he reviewed so many systems and performed such a thorough exam. Should we just keep putting these claims through?

Answer: No. According to CMS, medical necessity should always be the overarching factor that your doctors use to select the E/M service level. Just because a physician completes a comprehensive history and examination doesn't mean he always should report a level-five code. Medical necessity should drive the components that he performs.

Watch out: Some practices believe that when billing E/M services for established patients, there is a loophole that allows level-five reporting regardless of the medical necessity of the encounter. This mindset is particularly worrisome with the implementation of EHR systems, which automatically code encounters without regard to medical necessity. It is very easy to document high levels of history and exams, particularly for established patients, which will result in level four and five services when the medical necessity may dictate only level two or three services. The history and exam that the physician performs should be relevant to the patient's condition.

Keep in mind: Comorbidities, the need for diagnostic testing, the plan of care, and so on, may complicate the encounter and increase medical decision making, and warrant additional history and exam as well.

Good idea: Ask your physician to list the patient's complicating factors. Unless the chart spells these out, you have no way of knowing that a comorbidity, chronic condition, or medication played a role in raising an office visit's MDM from straightforward or low to moderate or high complexity.