Pain Management Coding Alert

Compliance: New Study Shows Staggering Amount of Miscoded 99215s

Practices were overreporting these E/Ms more than half the time.

Check out what a recent National Government Services (NGS) prepayment review revealed about claims coders submitted for evaluation and management (E/M) code 99215 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity ...).

The lowdown: The review resulted in the Medicare payer reducing or denying more than 55 percent of claims in January, February, and March.

There are a few common errors that can lead to an E/M miscode. Avoid these errors by following these tips.

Check for Clear Documentation

Error 1: You submitted illegible documentation.

When referring to illegible notes in the past, this often meant you couldn't read the physician's handwriting, but in this age of electronic records, illegible documentation has taken on a new meaning, says **Marcella Bucknam, CPC, CCS-P, COC, CCS, CPC-P, CPC-I, CCC, COBGC**, manager of clinical compliance with PeaceHealth in Vancouver, Washington.

Transcription errors, blanks left in transcribed notes the physician never fills in, poorly used templates that create incomprehensible sentences, and using speech recognition software (e.g., Dragon) that creates nonsense are all factors that contribute to incomplete, incorrect, and illegible notes, according to Bucknam.

"Coders who work with the same doctor or doctors over the years get to know their style or what they 'really mean' and go ahead and code as though the documentation was correct," Bucknam says. "Then a payer asks for a copy of the record, and someone who doesn't already know what's going on can't figure out why the patient was seen or what care was provided."

Jodi Dibble, CPC, medical record coder II of physician services at the Florida Hospital New Smyrna in New Smyrna Beach, Florida agrees that electronic medical records (EMRs) have created many new issues with documentation errors like cloning, cut and paste, and over-documentation.

Tip: Work with your physician to ensure the documentation is legible.

Bucknam shares how coders can collaborate with their physicians to sustain legible documentation.

"Medicare states that when a physician signs his note, he is stating that the information in the note is correct and complete," Bucknam says. "But when you read the note later, you know that the doctor never read through it. It was signed without reading, and it's not a good record for billing or for patient care."

Reviewing the medical record before it goes out the door is the key to avoiding this error, according to Bucknam.

"If there is a referral or a test result or something that needs to be included, be sure it is there," Bucknam says. "If the note is unsigned, get it signed before you send it," **Suzan Hauptman, CPC, CEMC, CEDC, AAPC Fellow**, principal at Ace Med Group in Pittsburgh, Pennsylvania, adds to this advice.

"Physicians have gotten used to having an attestation about typos or Dragon miscues, but these will not excuse a note

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away," Hauptman says. "If the note has typos that make it difficult to understand or perhaps contradictory, the errors should be corrected before authenticating/signing."

Check for Complete Documentation

Error 2: Your claim contained missing and/or incomplete documentation (i.e., no exam or history, no content of counseling).

When the physician signs a note he created using a voice recognition system or the note was transcribed without reading through it, the true picture of the patient's condition could be lost, according to Hauptman.

"If there is contradictory information (i.e. chief complaint of back pain, review of system illustrating no back pain) the note could lose integrity," Hauptman says. "It could cause problems with patient care in the future. If another doctor (or the author) uses this note to understand the patient's condition, there could be confusion which could result in incomplete care or repeated tests."

Hauptman offers this example to illustrate her point: A note identifies that the physician is treating the patient for depression, but further into the note, it states that the patient has never had depression.

Pronouns can also get mixed up, Hauptman adds.

In our example, the patient is a male, however, without the text of the note, the pronoun of "she" is used, which brings into question if the information is describing the current patient or another patient. The information could have been copied and pasted from another note or dictated on the wrong patient.

Tip: Review all details in the documentation before the provider signs the note.

Bonus tip: For examples of details you should make sure to include in the medical documentation, look to the following examples from CMS's Evaluation and Management Services Guide:

- Reason for the encounter and relevant history, physical exam findings, and previous diagnostic test results
- Assessment, clinical impression, or diagnosis
- Medical plan of care
- Date and the observer's legible identity
- The physician's rationale for ordering diagnostic and other ancillary services.
- The treating and/or consulting physician should have access to the patient's past and present diagnoses.
- Appropriate health risk factors should be identified.
- The patient's progress, response to, and changes in treatment, including any diagnosis revisions.

Check for Provider's Signature

Error 3: Your documentation contained a missing or illegible provider signature.

Tip: Check with your providers and confirm that they understand Medicare's signature requirements. They also need to make certain they are signing their own notes and not mistakenly signing another physician's notes.

According to the Medicare Program Integrity Manual Chapter 3.3.2.4, for medical review purposes, the author must authenticate any services he provides or orders. The manual identifies either a handwritten or electronic signature as appropriate methods of authentication.

Note: You cannot use a stamped signature as an acceptable form of authentication, according to the Medicare Program Integrity Manual Chapter 3.3.2.4.

Handwritten signatures: "A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance, or obligation," according to the Medicare Program Integrity Manual Chapter 3.3.2.4. In certain situations, signature logs and signature attestation statements may be deemed acceptable.

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Electronic signatures: The Medicare Program Integrity Manual Chapter 3.3.2.4 recognizes that providers who use electronic systems should be aware that alternative signature methods could lead to abuse. To be safe, physicians should always check with their attorneys and malpractice insurers about using alternative signature methods.

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