Get It Right the First Time: Appropriate Documentation of Office/Outpatient Services

April 19, 2011

Highmark Medicare Services
A CMS Contractor

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- Audio broadcast automatically starts when an attendee joins the event
- Attendees can play, pause or stop the broadcast
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- Handouts for today’s event are located on our Webinar page of our Training and Events Center

- Handout materials include the PowerPoint Presentation, and a copy of the Continuing Education Unit (CEUs) Certificate

- https://www.highmarkmedicareservices.com/calendar/partb/webinar/index.html

Question and Answer (Q&A) Panel

- The Q&A Panel can be used throughout the presentation
- We request that questions be relevant to the topic
- Enter your question and then hit send

Frequently Asked Questions

- Frequently Asked Questions relating to Evaluation And Management Services are available on our website

- Questions and answers from previous Webinars are reviewed and posted

- Visit
  - https://www.highmarkmedicareservices.com/faq/partb/index.html

Question and Answer Panel

- Responses presented in the question and answer panel considered written guidance of Medicare program requirements. They are intended to complement and not replace Medicare program requirements as set forth in statute, regulations and manual instructions. It is the responsibility of each healthcare professional/supplier submitting claims to Highmark Medicare Services to familiarize themselves with Medicare coverage requirements.

- Highmark Medicare Services makes efforts to ensure the information contained in the responses is accurate and current. However, because the Medicare program is constantly changing, it is the responsibility of each provider/supplier to remain abreast of the Medicare program requirements.

Disclaimer

- All Current Procedural Terminology (CPT) codes and descriptors used in this presentation are copyright© by the American Medical Association. All rights reserved.
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- This presentation is a general summary that explains certain aspects of the Medicare program, but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.
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Highmark Medicare Services

- Education specific to providers in Medicare Administrative Contractor (MAC) Jurisdiction 12 include: Delaware, Pennsylvania, Maryland, New Jersey and the District of Columbia District Metropolitan Area (DCMA)
- This education contains specific contractor guidance.
- If you are not a provider in Jurisdiction 12, please contact your Medicare contractor for specific guidance.

Objectives

- Discuss Comprehensive Error Rate Testing Errors
- Discuss Documentation of New Patient Visits
- Discuss Documentation of Established Patient Visits
- Provide Appropriate Documentation Tips

Comprehensive Error Rate Testing

Comprehensive Error Rate Testing (CERT)

- Administered by the Centers for Medicaid and Medicare Services (CMS)

- National Medicare Fee For Service Error Rate for November 2009 Reporting Period – 7.8%

- Error rate equates to $24.1 Billion

Common CERT Errors

- Errors across entire spectrum of E/M codes
- Incorrect Coding
  - Documentation did not support code billed
  - One or more of the key components
- Insufficient Documentation
  - Documentation did not contain a valid physician's signature
  - Missing records

CERT Information Center

- Comprehensive Information on the CERT Program
- Review Common CERT Errors
- Valuable References
- Bi Annual Reports
- Education
- Articles and Frequently Asked Questions
  - https://www.highmarkmedicareservices.com/cert/index.html

Common Errors – Office/Outpatient Services

- 99204 - Documentation supports a down code from 99204 to 99203 as billed with Detailed History, Detailed Exam, Moderate Complexity per 1995 E/M guidelines
- 99211 - Submitted documentation consists of record reflecting blood draw on 03/11/2010 and handwritten note, which reads, "Blood work drawn 03/10/10. Results to patient 03-11-10 by nurse." Insufficient documentation to support service as billed.

Common Errors – Office/Outpatient Services - Continued

- 99213 - Documentation submitted supports up code to 99214 with Problem Focused History, Comprehensive Exam, and Moderate Complexity per 1995 E/M guidelines.
- 99214 - Documentation supports code change from 99214/25 to 99213/25 with Expanded Problem Focused History, Expanded Problem Focused Exam and Moderate Complexity. Legibility poor due to handwriting.

Common Errors – Office/Outpatient Services - Continued

- 99215 - The office visit note for billed date of service 04/01/2010 is illegible and unsigned.
- 99215 - Documentation supports recode to 99213 with Problem Focused History, Expanded Problem Focused Exam, and Moderate Complexity per 1995 and 1997 E/M guidelines on billed date of service 04/01/2010. Presenting complaint of cough/bronchitis and a benign exam do not reach comprehensive level.

Signature Requirements

- Legible Identifier is IMPORTANT!
- CMS, Internet Only Manual (IOM), Publication 100-8, Chapter 3, Section 3.4.1.1 B:
  - Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes.

Examples of Acceptable Handwritten Signatures

- Legible full signature including first initial and last name
- Illegible signature over a typed or printed name
- Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signator.
- Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by a signature log, or an attestation statement
- Initials over a typed or printed name
- Initials NOT over a typed/printed name but accompanied by a signature log, or an attestation statement
- Unsigned handwritten note where other entries on the same page in the same handwriting are signed.

Resources

- Centers for Medicare and Medicaid Services Change Request (CR) 6698
  - http://www.cms.gov/MLNMattersArticles/downloads/MM6698.pdf
- Centers for Medicare and Medicaid Services Internet Only Manual Publication 100-8; Chapter 3, Section 3.4.1.1
  - http://www.cms.gov/manuals/downloads/pim83c03.pdf

Appropriate Documentation of New Patient Visits

New Patient Definition

- Patient has not had any professional face-to-face services from the practitioner or from a practitioner of the same specialty in the group within 3 previous years.
- Face-to-face includes surgical procedures.
- Face-to-face does not include professional services that do not have a face-to-face component.
- Non-physician practitioner visits count for face-to-face.

New Patient Visits – Basic Requirements

- Level of service determined by evaluating documentation of the three key components
  - History
  - Exam
  - Medical Decision Making
- All three must be used to determine level
- Lowest key component sets level of service
- Can be used in office and hospital outpatient places of service

New Patient Levels of Service

	99201	99202	99203	99204	99205
History	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
Exam	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
Medical Decision Making	Straightforward	Straightforward	Low	Moderate	High
Time (average)	10 Minutes	20 Minutes	30 Minutes	45 Minutes	60 Minutes

Appropriate Documentation Tips - History

- Level 4 and 5 require a comprehensive history
- Comprehensive history requires a complete review of systems and a complete past medical, family and social history
  - Complete review of systems
    - 10 or more systems reviewed or
    - Pertinent positive systems with clear "all others negative"
  - Complete past medical, family and social history
    - Requires documentation of all 3 categories
    - Family history is often missing
- Ancillary staff may document review of systems and past medical, family and social history but practitioner must show review of information

Appropriate Documentation Tips - Exam

- Level 4 and 5 require a comprehensive exam
- 1995 guidelines – 8 or more systems
- 1997 guidelines – vary by type of exam
- Documentation of “normal” sufficient
- Documentation of “abnormal” requires elaboration

Appropriate Documentation of Established Patient Visits

Established Patient Definition

- Patient has had a professional face-to-face service from the practitioner or from a practitioner of the same specialty in the group within 3 previous years.

Established Patient Visits – Basic Requirements

- Level of service determined by evaluating documentation of two of the three key components
  - History
  - Exam
  - Medical Decision Making
- Lowest key component can be ignored
- Can be used in office and hospital outpatient places of service

Established Patient Levels of Service

	99211	99212	99213	99214	99215
History	Minimal problem that may not require the presence of a physician	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Exam		Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Medical Decision Making		Straightforward	Low	Moderate	High
Time (average)	5 Minutes	10 Minutes	15 Minutes	25 Minutes	40 Minutes

Appropriate Documentation of Established Visits Tips

- Document first then determine level of service
- Previous review of systems and past medical, family and social history can be reviewed and updated
  - Make a specific reference to the date of the previous information or
  - Sign and date previous information
- Clinical circumstances determine level of exam
- Prescription drug management is a moderate level of risk

Appropriate Documentation of 99211

- Documentation must support a face to face
- Documentation must support evaluation and management of patient
- Requires direct physician supervision
- Cannot be paid with drug administration services

Appropriate Documentation of Established Office Visits and Minor Procedures

- Modifier -25 used for office visit on same day as minor procedure
- Documentation must support work over and above the typical pre and post work of the procedure
- If applies, documentation must support decision for surgery

Tips to Remember

- Comprehensive history requires a complete review of systems and a complete past medical, family and social history
- Higher level new patient services require comprehensive exams
- Previous review of systems and past medical, family and social history can be reviewed and updated
- Prescription drug management is a moderate level of risk
- 99211 requires documentation of face-to-face visit
- Modifier 25 requires documentation to support service is above typical pre and post work of a procedure

Summary

- Discussed Comprehensive Error Rate Testing Errors
- Discussed Documentation of New Patient Visits
- Discussed Documentation of Established Patient Visits
- Provided Appropriate Documentation Tips

References

- Highmark Medicare Services' Evaluation and Management Center Website
  - https://www.highmarkmedicareservices.com/em/index.html
- Centers for Medicare and Medicaid Services Internet Only Manual Publication 100-12, Chapter 12, Section 30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 - 99215)
  - http://www.cms.gov/manuals/downloads/clm104c12.pdf
- Centers for Medicare and Medicaid Services Internet Only Manual Publication 100-12, Chapter 12, Section 40 - Surgeons and Global Surgery
  - http://www.cms.gov/manuals/downloads/clm104c12.pdf
- Centers for Medicare and Medicaid Services Evaluation and Management Guide
  - http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

Self Service Options

Information Centers

Valuable information in one convenient location

- Evaluation and Management (E/M) Center
  - offers an array of educational resources which will assist you in coding E/M services.
    The E/M Center allows you to access information from one convenient location
- Training and Events Center
  - Lists upcoming educational events, podcasts, guides, online training materials and much more

Calendar of Events

- Our Training and Events Center offers a wide variety of Education.
- Join us for Workshops, Teleconferences, and Webinars.
- To view the most current Calendar of Events, visit
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  - 1-877- 235-8073
  - https://www.highmarkmedicareservices.com/selfservice/index.html
- Patient / Medicare Beneficiary
  - 1-800-MEDICARE (1-800-633-4227)
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Index # ____________

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