Can Your Practice Pass A CMS Audit?

In September 2012, CMS authorized Recovery Audit Contractors (RAC) to begin auditing E/M office visits for healthcare providers in Texas and several other states. The Recovery Audit Contractor Connolly, Inc. will begin auditing Medicare coding for CPT 99215 -evaluation and management of an established patient - *in physician offices.* The RAC auditor will conduct limited reviews using a statistical sampling to project how many physician claims used the E/M code 99215. The audits will include dates of service as far back as October 1, 2007.

Recovery Audit Contractors (The RAC)

Since the RACs are not required to have same specialty physicians review RAC determinations, the TMA, AMA and specialty organizations have expressed concern that the RAC auditors will not fully understand the variability or clinical relevance that generated a particular CPT code within a specific specialty. It has also been emphasized to CMS that an appropriate code designation is usually a subjective matter based on the complexity of the patient visit. While Connolly will be extrapolating its findings using statistical sampling claims submitted, there are questions as to whether this process is an accurate assessment of a physician's coding and documentation of Medical Decision Making (MDM). Physicians should also be aware that RAC auditors are paid on a contingency basis. The Connolly contingency fee will be 9% of collections. Thus, auditors are highly incentivized to find retrospective noncompliant E/M documentation within a patient's outpatient medical record.

E/M codes make up 1.6% of all procedure codes within the Physician Fee Schedule Database (PFSDB) but they account for approximately 20% of approved services and 43% of Medicare B payments. In an attempt to control health care spending, Federal (and Commercial) Insurance audits are becoming standard in the business operation of physician practices. While currently the higher level E/M CPT codes will be scrutinized by RAC, this does not mean that future audits of physician offices will not include across the board audits of documentation for all

E/M codes. Novitas Solutions Inc, which recently took over from TrailBlazer as the new Medicare carrier for Texas, has already emphasized that they will be looking for assurances that Texas doctors are coding properly.

Physician Billing for E/M Codes

The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) reported close to 370 million E/M services that were submitted to CMS by approximately to 442,000 physicians nationwide in 2010. During this time, the payments for Medicare E/M services increased from $22.7 to $33.5 billion. A study indicated that there were 1,669 physicians who consistently billed higher level E/M codes, such as the 99215, which resulted in increased costs to CMS by upwards of $100 million in the calendar year 2010. Texas (6.7%) was one of four states that appeared to have the largest number of outliers.

This pattern of higher levels of E/M services billed during the past decade has lead to a recent review of physician coding trends. The Health and Human Services Office and Department of Justice have indicated that many of the increases in E/M services (defined as "Upcoding") have occurred in tandem with the increased use of EHRs. This data has lead to a focused evaluation of EHR usage from a coding and auditing perspective. A common pattern that has emerged following EHR examination is the user's tendency to pull data from a prior visit into a current visit, a process defined as cloning. In addition, an almost unlimited amount of text can be entered into the medical record using macros, templates and prepopulated data. This often results in the unintentional recording of data that does not accurately represent the information obtained from the patient *during a particular encounter* or information that was placed in the note that is *not relevant for the specific visit*. According to CMS, cut and pasting from a prior visit or even a different medical record does not make a note truly unique for that patient visit and may not justify the level of E/M code charged for the *designated patient encounter*. CMS has indicated that office notes that contain little information other than bulleted lists do not convey the complexity of the provider's thought process and are not compliant with documentation of Medical

Decision Making. CMS has further emphasized that "intentional" improper billing is considered to be fraudulent activity by a provider.

Not all EHRs are created equal

To help avoid a CMS audit, Neurologists must recognize while EHRs have been characterized as a critical step in implementing interconnectivity of medical care and improve record keeping, quality, and cost control, the very goals of EHR could potentially jeopardize traditional safeguards. While EHRs often generate pages of information, it appears that some may be less efficient on recording the patient's actual medical data but more centered on justifying coding and billing payment requirements. This may be because health care insurers, led by Medicare, have been so focused on "compliant" documentation in support of a particular billing code, that some EHR reports are more characteristic of a reimbursement tool. While the accuracy of physician documentation has been scrutinized for years, the new focus seems to be on how physicians use EHR features to support their claims. The unintended consequence of EHR adaptation has been the increased rates at which practices bill costlier, higher-level services. While some say this is attributable to the enhanced capabilities provided by EHRs, CMS has expressed concern that the increased charges –intentional or not- may be more related to the enhanced billing capabilities provided by EHRs. This has also led to the post payment audits by CMS. The focus of the audits is documentation for the level of service charged. Because of the complexity of E/M documentation for Medical Decision Making, MDM would likely be one of the first areas studied by an auditor.

In 2011, the Dept. of Health and Human Services Office of the National Coordinator for Health Information Technology established EHR certification for meaningful use. However, to date, there is no certification or formal evaluation process for EHR E/M coding tools. Irrespective of what level of code is suggested by an EHR, the attending physician ultimately remains responsible for the code

submitted for reimbursement. While well designed EHRs can result in documentation that meets an extremely high level of coding accuracy, physician oversight will always be required as a fundamental tool for audit protection. This rule includes physician extenders (NPs and PAs) who work under the direction of the doctor. If an auditor identifies overcoding, the financial consequences that may be imposed upon the attending physician and the practice can be devastating.

The best way for a Neurologist to achieve EHR E/M audit protection is to satisfy the fundamental compliance principal of Medical Decision Making.

It has already been indicated that auditors frequently focus on MDM to help determine the level of service for a patient encounter. Notes that contain little information other than bulleted lists are at risk of being non-compliant in identifying the complexity of the visit. Bullets without transcript often do not define the physician's decision making thought process. If an auditor has difficulty inferring the complexity of the visit from cloned or template data and the computer lists of diagnoses and treatments are not supported by additional documentation, there is much exposure in a compliance audit. This is especially true if the level of complexity that was reimbursed is moderate or high. While Neurologists are especially proficient in detailed documentation of the History and Physical examination, the most prominent remaining challenge has resided with the subjective components of MDM. It is critical for Neurologists to understand that, depending on the EHR software, they may be exposed to increased audit risk if they completely rely on their EHR system to resolve the MDM compliance challenge.

How can a Neurologist be sure the EHR generated medical record is compliant with E/M Documentation Guidelines for MDM?

Traditionally the medical record provided documentation to understand the patient's symptoms, clinical findings, reasoning about the diagnosis and a

treatment plan. Now, however, health care insurers, led by Medicare, require specific elements of documentation which will justify individual billing codes for payment levels. The traditional documentation of *Diagnosis, Discussion*, *Recommendations, and Treatment Plan,* unless precisely designed to be compliant with E/M Documentation Guidelines for Medical Decision Making, often do not define the fundamental principles of MDM. MDM now asks us to rate the "*complexity"* of the decision making, plus rate the "*complexity"* of the diagnosis and therapeutic options. The "*amount"* and "*number"* of items must be documented. To meet MDM compliance there is also a need to address the "*risk"* associated with the diagnosis as well as the "*risk"* associated with necessary tests and management options selected. Remember, the majority of auditors are not physicians and in some settings may not recognize that the components of MDM may actually be integrated into the record but in an unfamiliar format. For this reason, it is advisable to design an EHR template which clearly addresses the requirements of MDM. It is also important to avoid generating simple bulleted lists of diagnosis and treatments that are not supported by additional documentation and narrative. Again, this is particularly true when the level of complexity is moderate or high.

Specifically, the fundamental principles of MDM are measured by the three following elements:

1. The number of possible diagnoses and/or the number of management options that must be considered
2. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed or analyzed
3. The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedures(s) and/or the possible management options

The E/M Documentation Guidelines recognize four levels for each of the three components listed above. The level of MDM for a given visit depends on the highest two out of these three elements.

An important part of MDM that is frequently misunderstood by physicians is the importance of documenting the subjective impressions about a relative problem, or *differential diagnosis.* For billing purposes the principal of recording a specific diagnosis primarily applies to the International Classification of Diseases (ICD) coding. When submitting a claim for reimbursements, we have all been taught that a "rule out" diagnoses or a "possible" diagnoses would not be acceptable and an ICD Diagnosis must be defined; even though there are still different interpretations regarding a "definitive" diagnosis and a "working" diagnosis.

Contrary to billing requirements, MDM does require recording the number of diagnosis to help identify the level of CPT coding. However, just listing a number of ICD diagnoses without documentation or narrative does not necessarily increase the potential for a higher CPT level of care. It is also important to recognize that while the ICD coding system is used to code signs, symptoms, injuries, diseases and conditions, it is the CPT coding system that describes the thought process and clinical indications for performing medical procedures and services. Therefore the ICD code describes the clinical condition of the patient to support the medical necessity of the CPT procedure or service.

When documenting the CPT component of MDM, quantifying the Number of Diagnosis or Management Options, including a differential diagnosis, is not only important, it is actually mandated. The rules defining this component of MDM are clearly stated in the E/M Documentation Guidelines: "…for a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as a 'possible', 'probable', or 'rule out (R/O) diagnoses". Basically, the MDM guidelines ask the physician to describe the differential diagnosis including alternative diagnoses. This may include descriptive adjectives such as "severe" and "refractory". Just listing ICD diagnoses or bulleted lists for the MDM Number of Diagnoses or Treatment Options does not permit any narrative related to the patient's clinical condition. In an audit this practice could be considered noncompliant with E/M Guidelines.

Another nontraditional element of MDM that auditors could focus on is the Risk of Complications and/or Morbidity or Mortality. This component considers the

level of risk to the patient within the decision-making process. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following the procedure or treatment. The E/M Guidelines also state: "The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk." The identification and documentation of the appropriate level of risk is based on explanations provided in the *Table of Risk* which can be found in the 1997 Documentation Guidelines.

The Table of Risk provides common clinical examples within the three categories of risk, all of which serve as a guideline to help measure the risk inherent in medical problems and procedures. The documentation of the risk for only one category meets compliance for determining the overall risk. If an EHR were to use the E/M Table of Risk as a reference, a graphic interface with a single check box next to each possible choice could be a compliant documentation tool that would allow a physician to record this part of MDM in seconds. While recording risk may also require some narrative, which will depend on the clinical situation, if the EHR basis the determination of risk on the Table of Risk (and subsequently the 1997 E/M Documentation Guidelines), simply listing the choices for the levels of risk with check boxes adjacent to each possible choice readily permits the physician to document this element of MDM. Ideally, the software for an EHR would also provide a pop-up window that shows the Table of Risk whenever the physician needs it as a reference while documenting MDM. It is reasonable to conclude that in an audit, if the physician were to demonstrate that the EHR software references the E/M Table of Risk in decision making, it would be more difficult for an auditor to find non-compliance with this element of the guidelines.

Conclusion

Because all responsibility for accurate documentation lies solely with the clinician, an accurate and compliant EHR medical record can be achieved if physicians remain thorough, meticulous, and conscientious in meeting all the documentation guidelines. Since each medical specialty has specific areas of need, an ideal

situation would be if all the EHR manufacturers collaborated with physician specialists and improved the design of programs; focusing on the goals of user friendly medical quality and medically appropriate documentation. Given the current aggressive competition among the leading EHR venders, it would be naïve to think that a cooperative venture and sharing of information would take place anytime soon.

Despite the fact that there are many dissatisfied physicians who would like to switch EHR venders or physicians who are antagonistic toward EHRs altogether, the majority would agree that the implementation of Electronic Health Records has been a remarkably useful technological tool in the advance of many important aspects in the delivery of medical care. However, while EHRs have been hailed as a critical step in the modernization and integration of healthcare, there is literature which suggests that the change to EHR has actually jeopardized the traditional record keeping process and safeguards. Some of the beneficial timesaving features of EHR, such as copying and pasting, using templates (which in some audits has led to misleading history and physical examinations), relying on prepopulated data, and substituting bullets and macros, have unintentionally resulted in record completing behaviors which could be noncompliant in meeting the E/M Documentation Guidelines; especially MDM obligations.

There also seems to have been a transformation for the reason of keeping medical records, from the traditional recording of a patient's medical history and data, to a new role of providing focused documentation to justify coding and subsequent reimbursements. While one might assume that justifying individual billing codes for payment levels would default to meeting CPT documentation guidelines, the EHR templates and formats designed to comprehensively document all the elements of reimbursable care are not always in compliance with how E/M documentation was designed. If an EHR is focused on a payer instigated process the data may actually tell very little about the medical aspects of the doctor/patient encounter.

Most physicians have seen EHR generated medical records where important patient information has inadvertently been transformed into repetitious data

based reports that are embedded in a computer design format. So have auditors! Focused comments from regulatory agencies conducting audits can be easily found when reviewing the literature. The basic themes include perceptions that:

Documented information in medical records is too much to review. Lengthy information not relevant to the specific visit is being imported.

Physical examination findings change but the documentation does not reflect that change.

A level 4 or 5 history and physical examination is recorded at each office visit but the time allocated to that particular visit does not support the length of time expected for a detailed or comprehensive evaluation.

Useful plans or recommendations are fragmented and hard to find. The care plan may be documented but does not comply with the E/M Medical Decision Making documentation guidelines

Copy forward has caused some significant documentation errors. Comments not relevant to the specific visit can be perpetuated in every office visit note

The longer the office note, the more likelihood of errors and redundancy

As discussed above, there has already been much evidence to indicate that auditors will focus on the assessment to determine the level of complexity of Medical Decision Making. Unless the EHR clearly documents "what the doctor was thinking" in a format that includes appropriate narrative and text; unless the medical record is in accordance with the 1995 or 1997 Evaluation and Management Documentation Guidelines; and unless MDM is recorded in a format that an auditor recognizes as compliant with those guidelines, the physician and practice could be fined based on the subjective determinations of the auditor.

While the Texas Medical Association, as well as a number of other important physician organizations, has expressed opposition to the expansion of E/M RAC audits of office visits, CMS has not rescinded its authorization for Connelly, Inc to begin auditing Medicare coding for CPT 99215. Although the audits will only be

conducted on limited reviews of the high level, established patient office visit, historically, once an auditing process for a particular service has begun, it is not difficult to expand the scope of what will be audited. The transition of RAC audits limited to hospitals to current authorization to audit physician practices is an example of extending the auditing boundaries. In addition, Neurologists are more likely to bill for higher level of E/M services because of the potential for increased frequency of complicated cases. An auditor not familiar with Neurology may suspect that the elevated frequency of high level E/M billing indicates a pattern of overcoding, which could result in a greater likelihood of being selected for a retrospective audit.

If an office practice EHR promotes noncompliance or false claims, the physician could face recoupment, false claims allegations and civil monetary penalties-even if the inadequate documentation and/or upcoding was without intent to commit fraud. The physician's benchmark for EHR design and functionality must confirm that another physician, an attorney or an auditor can read the clinical record and find it understandable, medically accurate, E/M compliant and appropriate for that specific patient visit.

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