

Electronic Health Records, Autocoding, and Ewe: Don't Be a Sheep!

Daniel M. Siegel, MD, MS

PRACTICE POINTS

- Know when to bill for evaluation and management (E&M) services performed on the same visit as a dermatologic procedure.
- Consult documentation guidelines from the Centers for Medicare & Medicaid Services when making coding decisions about E&M services.
- Watch that your electronic health record program is not overcoding.

Sheep are thought of as nervous animals, a good target for predators. You do not want to be a sheep. Unfortunately, many electronic health record (EHR) programs make you a target for audits and requests for the return of payments for a variety of reasons. Although you likely are aware of the uses of modifier -25, it is the abuses—either intentional or accidental—that can bring an audit your way. The use of modifier -25 was previously reviewed in *Cutis*.¹ Despite the availability of this excellent review, I have found that there is still great confusion about both the use of modifier -25 and the selection of the correct evaluation and management (E&M) code when used.

When to Bill for E&M

Based on recent discussions with colleagues in the New York area who have been audited, an easy way to bring on a request for medical records is to report an E&M 100% of the time with a procedure. In these instances, every single E&M was performed on the same visit as a dermatologic procedure, most commonly biopsies (*Current Procedural Terminology* [CPT] code 11100,

11101) and premalignant destructions (CPT code 17000, 17003, 17004), which is in contrast with typical practitioners who perform an E&M approximately 70% of the time (RUC rationale; American Medical Association RBRVS Data Manager; May 12, 2016). One circumstance involved the reporting of E&M services 100% of the time when performed during the same visit as Mohs micrographic surgery (CPT code 17311–17315), a surprising frequency considering that the typical same day use of a code for this procedure with an E&M in the Medicare population is less than 25%.

According to the *National Correct Coding Initiative Policy Manual for Medicare Services*, procedures with a global period of 90 days are defined as major surgical procedures,² which only include adjacent tissue transfers and grafts for dermatology. If an E&M is performed on the same date of service as one of these procedures to decide whether to perform the procedure, the E&M can be reported separately using modifier -57. Other preoperative E&M services provided on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not reported separately.²

All other procedures dermatologists perform generally are considered minor, which are defined as having a global period of 0 or 10 days. Because the decision to perform a minor procedure is included in the payment for the procedure, E&M services should not be reported separately from the minor procedure.

From the Department of Dermatology, SUNY Downstate Medical Center, Brooklyn.

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Correspondence not available.

However, “a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply.”²

Documentation Guidelines

These guidelines seem straightforward, but as with so much else where the government is involved, the devil is in the details. When making coding decisions, you may consult the documentation guidelines from either 1995³ or 1997,⁴ which are available for download on the Centers for Medicare & Medicaid Services (CMS) website (<https://www.cms.gov/outreach-and-education/medicare-learning-network-MLN/MLNedwebguide/emdoc.html>). The 1995 guidelines are less empiric and offer more flexibility, while the 1997 guidelines rely on number of “bullets” as examination elements.

1995 Guidelines—According to the 1995 documentation guidelines, the levels of E&M services are based on 4 types of examination that are defined as follows: (1) problem focused, a *limited* examination of the affected body area or organ system; (2) expanded problem focused, a *limited* examination of the affected body area or organ system *and* other symptomatic or related organ system(s); (3) detailed, an *extended* examination of the affected body area(s) *and* other symptomatic or related organ system(s); and (4) comprehensive, a *general multi-system examination* or *complete examination of a single organ system*.³ Detailed history is the fuzziest part of the coding universe. Some insurers take an approach that you need to examine 2 to 7 organ systems and 4 distinct lesions in 4 body areas, which is discussed in audit tools available from some Medicare intermediaries (Advancing the Business of Healthcare forum; April 10, 2014). As a result, the 12-bullet examination from the 1997 documentation guidelines may be more suitable for a new level 3 or established level 4 visit. For a comprehensive examination, the 1995 criteria allow for a complete examination of a single organ system such as the full-body skin examination with the patient completely undressed, which is medically necessary in our melanoma patients.

For purposes of examination, 9 body areas are recognized in the 1995 guidelines,³ along with more than a dozen organ systems of which the skin is of most interest to dermatologists.

According to the 1995 guidelines,³ the extent of examinations performed and documented is dependent upon clinical judgment and the nature of the

presenting problem(s) and range from focused examinations of single body areas to general multisystem or complete single organ system examinations. Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. Although a notation of normal is sufficient, abnormal without elaboration is insufficient, and abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described. The medical record for a general multisystem examination should include findings involving approximately 8 or more of the 12 organ systems.

An expanded problem focused examination under the 1995 guidelines could be as simple as “Scar on cancer excision site on left cheek soft and supple. No cervical adenopathy.” There is some confusion regarding detailed examinations, and one consultant went as far as calling the guidelines “vague,”⁵ while others such as a Medicare intermediary make a quantum leap that if a comprehensive general system examination includes 8 to 12 organ systems, one step below should include 2 to 7 organ systems.⁶ In essence, the payer makes the rules here.

1997 Guidelines—According to the 1997 documentation guidelines, count bullets that are examination elements, which can be either general or single organ system.⁴ (A table showing the bullets for the examination elements is available from the CMS.⁴) For each type of examination, apply the following: problem focused examination requires 1 to 5 elements identified by a bullet, expanded problem focused examination needs at least 6, detailed examination requires at least 12, and comprehensive examination requires all elements identified by a bullet with documentation of every element in each box with a shaded border and at least 1 element in each box with an unshaded border.⁴ Although you may do more writing when using the 1997 guidelines, you can easily count up bullets and these guidelines are amenable to template examinations on paper and obviously easily coded into EHR software that will do the bullet counting for you.

Unfortunately, this is where a ewe becomes a sheep, ripe for hunting for a number of reasons. First, just because you documented an E&M service does not mean it is medically necessary. Do you really need vital signs for every visit? If you are a meaningful EHR user working on penalty avoidance, you may capture examination data for meaningful use that is not medically necessary but cannot be parsed out by the autocoder in your EHR. As a result, simply do a quick manual audit of your notes to see if you are overcoding, which becomes second nature if you do it often.

The second trap, which brings us back to modifier -25, is when you perform a procedure the same day as your E&M or vice versa. Every procedure we do within the Resource-Based Relative Value Scale contains preservice time, which includes review of materials relevant to the procedure, examination of the area, and all preparation (eg, marking, time out, anesthesia, scrub and drape) before the surgery begins. The detailed vignettes are available to those involved in the Relative Value Scale Update Committee process and to the rest of the world in a subscription product called the RBRVS DataManager Online, which is produced by the American Medical Association. Unfortunately, the American Medical Association is not accepting new subscriptions to this product, as it has decided to outsource most of its coding resources to Optum360, one of the many arms of UnitedHealth Group, and will not have a replacement product until after June 30, 2016.⁷

In essence, if you (and your EHR) are counting bullets and then treating the body area in question, you are double-dipping, as the examination of the area is included in the procedure. So if you are heading toward a CPT 99213-25 with 6 bullets, one of which is on the left arm, and you perform a 0- or 10-day global procedure on that arm, you are down to 5 bullets, which drops your level of examination to problem focused. Remember, you need only 2 of 3—history, examination, and decision making—to be at or above that need for that particular level of reporting. If only one of your history or decision making is at or above the needed level for a 99213, the loss of a single bullet drops you down to a 99212! An audit where a handful of medical records are pulled and a request for money back on the universe of payments the insurer has paid is always unpleasant and you should, if you get a request for same, follow all the rules and timelines outlined by the payer. If you knowingly behaved in a risky fashion, consult a good attorney.

Of course, you may argue that the effort needed for the E&M work for the procedure was above and beyond what is typical for the service, which can be a hard standard to meet. Although the CMS requires a “significant and separately identifiable

E&M service” as noted above and a separate diagnosis is not needed, the onus is on you to prove it. It is much easier to have a separate diagnosis that stands on its own, which will probably make an audit less common (unless you do it too often).

Final Thoughts

In summary, document what you do, do what you document, and report what is medically necessary. Keep watch over your EHR to be sure it is not overcoding for you. You do not want to be a ewe!

REFERENCES

1. Alam M. Modifier -25 use in dermatology. *Cutis*. 2015;95:76-77.
2. *National Correct Coding Initiative Policy Manual for Medicare Services*. Baltimore, MD: Centers for Medicare & Medicaid Services; 2016. <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/2016-NCCI-Policy-Manual.zip>. Accessed May 6, 2016.
3. *1995 Documentation Guidelines for Evaluation and Management Services*. Baltimore, MD: Centers for Medicare & Medicaid Services; 1995. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuideDownloads/95Docguidelines.pdf>. Accessed May 6, 2016.
4. *1997 Documentation Guidelines for Evaluation and Management Services*. Baltimore, MD: Centers for Medicare & Medicaid Services; 1997. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf>. Accessed May 6, 2016.
5. E/M FAQ #19. E/M University website. <http://www.emuniversity.com/FAQ/EMFAQ19.html>. Accessed May 4, 2016.
6. In the E/M documentation guidelines, what does “more detail” regarding the exam mean, and what is the difference between an expanded problem-focused exam and detailed exam? Palmetto GBA website. <http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Railroad%20Medicare~Resources~FAQs~EM%20Help%20Center~8EELQD7181?open&navmenu=%7C%7C>. Updated March 2, 2016. Accessed May 4, 2016.
7. AMA website. <http://info.commerce.ama-assn.org/online-coding-home>. Accessed May 4, 2016.