

CPT AUDIT TOOL INSTRUCTIONS

The Nursing Consultants from the Public Health Nursing and Professional Development Unit based on multiple Evaluation & Management audits across the state have developed these tips and recommendations for maximizing the effective use of CPT/ICD coding. The list also includes some general information from 1995 & 1997 Documentation Guidelines that may help staff understand the process better. Although either may be used, the 1995 Documentation Guidelines are generally more beneficial for health department use.

General Principles of Coding

- Medical records should be complete and legible.
- Documentation of each patient encounter should include:
 - reason for the encounter and relevant history, physical examination findings and prior and current diagnostic test results;
 - assessment, clinical impression or diagnosis;
 - plan for care; and
 - date and legible identity of the observer.

Forms designed to collect this information will help staff collect all pertinent information.

- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred. This includes routine labs for all patients in a particular clinic performed according to protocol.
- The CPT and ICD codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
- ICD codes on billing form are to justify the CPT codes. You need to be able to link the ICD code to the respective CPT code. Other ICD codes on billing form are used only if you need them to track diagnosis types or for other data collection purposes.

Chief Complaint: CC is indicated at all levels.

- Providers should make sure the chief complaint is listed in some portion of the note for that visit. If providers use a standard SOAP note format, then chief complaint may be listed in the subjective portion of the note. The chief complaint should be specific enough to indicate why (symptom, problem, condition or diagnosis) the patient is being seen. For a child coming in following treatment of an ear infection; “primary care visit” is not specific enough, instead use “re-check of ears”.

Key Components in selecting the level of E/M service are History, Examination, and Medical Decision-Making

History includes three components: HPI, ROS and PFSH

- The chief complaint, HPI, ROS and PFSH may be listed separately or may be included in a description of the HPI.
- A ROS and/or PFSH obtained during an earlier encounter, does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. If there was no new information to add, then a note indicating “no change in ROS/PFSH information from ____ date noted.”
- The HPI, ROS and PFSH may be recorded by ancillary staff or on a form recorded by the patient. Provider reviewing the information needs to make a notation that the information has been reviewed, such as “see above note” or “see HPI/ROS/PFSH dated _____” or co-sign and date the note made by ancillary staff. The provider should write "HPI as above, plus..." and write another comment or two.

History of Present Illness (HPI)

- Assess for HPI by using the elements defined below:
 - Location: where is the problem located (i.e., body system or organ);
 - Quality: in the case of pain, is it dull or sharp;
 - Severity: on a scale of 1 - 10 where does the level of pain fall;
 - Duration: how long does it last, how long has it been going on;
 - Timing: has/does anything trigger it, how frequently does it occur;
 - Context: does it occur in relation to anything else (i.e., exercise, eating, sleeping, etc.)
 - Modifying factors: does anything make it worse or better;
 - Associated signs/symptoms: what other problems are associated with patient symptoms.

HPI should focus on the reason for the visit, or chief complaint, and include information on the above elements.

Review of Systems (ROS)

- The ROS is an inventory of body systems through a series of questions seeking to identify signs and/or symptoms, which the patient may be experiencing or has experienced.
- The patient’s positive responses and pertinent negatives for the system related to the problem should be documented.
- If the documentation is used in determining the extent (level) of the HPI, it may not be used again in the ROS. This also pertains to the use of the same documentation in more than one system. If you count one documented element in more than one component this can be considered “double

dipping”. For example, HPI: patient complaining of sore throat x 4 weeks without fever includes four elements; location-throat, quality-sore, duration-4 weeks, associated signs/symptoms-without fever. You would not be able to use HPI sore throat as throat ROS or without fever as constitutional ROS. The system used for the HPI must have an expanded narrative to also satisfy the ROS criteria when taking a patient’s history.

Past, Family and Social History (PFSH)

As a general rule for PFSH, document that an area(s) was either assessed or updated. If no change was noted then, state, “no change in PFSH since last visit.” If any part of the PFSH was performed by another provider, either on the same day or different day, document that you reviewed that provider’s PFSH note. You may document by dating and co-signing that provider’s note or noting that you reviewed that information in your progress note.

- Past History - review of the patient’s past experiences with illnesses, operations, injuries and treatments, current medications (e.g., maternity patients taking prenatal vitamins or type of contraception for family planning patients), allergies, age appropriate immunization status.
- Family History - review of medical events in the patient’s family including diseases, which may be hereditary or place the patient at risk for disease (e.g., any one in family with same symptoms).
- Social History - an age appropriate review of past and current activities, marital status, current employment, sexual history, school attendance, etc.

Documentation of Examination

- You may use the 1995 or the 1997 Documentation guidelines but you cannot use both in coding the same visit. The information regarding the History and Complexity of Medical Decision-Making is consistent between the two versions of the guidelines; only the physical exam requirements are different.
- Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.
- Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.
- A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).
- If a form is used and blanks are provided, the form or an agency policy should include the meaning of the symbol(s) and/or abbreviation(s) used.

- Using the 1997 Documentation Guidelines, an examination may be a general multi-system examination or a single organ system examination. See pages 11 and 12 in the 1997 Documentation Guidelines for qualifying requirements of each examination type. When using the 1995 Documentation Guidelines the examination is based on organ systems or body areas, see pages 4 and 5 in the 1995 Guidelines.

Determining the Complexity of Medical Decision-Making

Remember, no one other than a physician or mid-level provider may decide a level of complexity. The 1995 E & M Documentation Guidelines state that “for each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.”

Part A: Number of Diagnoses or Treatment Options

This section deals with numbers of possible diagnoses and/or management options. A patient is considered to have a new problem if the provider has not seen the patient for the presenting problem. A patient is considered to have an established problem if the provider has seen the patient for the problem in the past (see below for further explanation). If the encounter is for an established problem, the record should reflect whether the problem is stable, improving or worsening. “**Additional Work-up**” includes referrals that are made, consultations requested, or advice sought. The record should indicate to whom or where the referral or consultation is made or from whom the advice is requested. Document and date all problems on the problem list.

For example:

New Problem to the Provider: No Additional Work-up Planned = First time the provider has treated this patient for this problem/diagnosis of Otitis media (although the patient may have had other earaches in the past, they resolved and this is a new episode) patient treated and to return PRN.

New Problem to the Provider: Additional Work-up Planned = First time the provider has treated this patient for this diagnosis of Otis Media and a referral is made or consultation with specialist is requested.

Established Problem to the Provider = The provider has seen this patient with this problem/diagnosis of Otis Media and this is the recheck appointment. The record should reflect whether the problem is: improved, well-controlled, resolving or resolved; or inadequately controlled, worsening, or failing to improve as expected.

Self-limited or Minor = Problems are very simple such as colds, insect bites, tinea corporis.

Part B: Risk of Complications and/or Morbidity and Mortality

Remember, you only need one bulleted item in the highest possible risk level to receive that level of risk. All prenatal patients are considered “**Moderate**” risk because they have one or more chronic illnesses with mild exacerbation, progression, or side effects of treatment. A prenatal patient with diabetes and hypertension MAY fall into the “**High**” risk level because of the risk these conditions may pose to life or bodily function.

If you score “**Moderate**” for level of risk because of prescription drug management, make sure the medications ordered are prescription.

Part C: Amount and/or Complexity of Data to be Reviewed

Document under “Plan,” all clinical, radiological or medical tests ordered.

Clinical Labs = cultures, blood work, urine dips/C&S, fern tests, KOH, dark-fields
Includes CPT Codes: 80048 – 89356

Radiological Tests = CXR, ultrasounds
Includes CPT Codes: 70010 – 79999

Medical Tests = non-stress tests
Includes CPT Codes: 90281 – 99199

Discussion of test results with performing physician = if you as the provider calls the performing physician to discuss test results (i.e., ultra-sound performed off-site, EEG, discuss suspicious or inconclusive results of a mammogram)

Decision to obtain old records and/or obtain history from someone other than the patient = score for situations like, getting a release for old records, or getting paternal family history from the father of the baby.

Review AND summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider = reviewing old records AND writing a summarization note; **obtaining a history from someone other than the patient** = means the patient is not able to give the history such as with an unconscious patient (more critical and involved than the above definition); and **discussion of the case with another health care provider** = means discussing findings with a physician who does not make face to face contact with the patient such as in the case of nurse practitioner discussing worsening elevated blood sugars in a pregnant patient with the back-up physician or with another physician as in the case of a referral.

Independent visualization of image, tracing or specimen itself (not simply review of report) = is when the examining provider looks at the image, tracing or specimen that has been or will be interpreted by another provider who is billing for the complete procedure. If you are performing the test and billing it, you would not score this element as it would be considered “double dipping” to bill the same test in two different ways.

Scoring the Tally Blocks

The **History** and **New patient** blocks (under level of service) use the farthest to the left rule or score the weakest area. The **Complexity** and **Established patient** blocks (under the level of service) use the two or more in a column or the one in the middle rule.

New versus Established Patient

A new patient is one who has not been seen in your agency within the last three years, for a billable service that includes some level of evaluation and management service (preventive, evaluation & management or HCPCS codes). WIC, immunizations, CSC, MCC, MOW, pregnancy tests or interpretation of a diagnostic test do not affect the designation of a new patient. A patient can be new to a program and established to the agency, thus billed as established.

Due to new edits/audits in MMIS related to the national Correct Coding Initiative, the practice of billing a 99211 and then billing a NEW visit code will be eliminated. Many local health departments have been billing a 99211 (usually an RN only visit) the first time they see a patient and then 2 weeks to up to 3 years later bill a 99201 – 99205 or 99381-99387 (New Visit). Examples may include: billing the 99211 for pregnancy test counseling or head lice check by RN and then a new visit when the patient comes in for their first prenatal, Family Planning or Child Health visit. Now that the new edits have been implemented all of those “new” visits will deny because the LHD will have told the system (via billing a 99211) that the patient is “established”.

Time

Time may determine the level of the visit only where counseling and/or coordination of care dominates (more than 50%) the face-to-face time between the physician/patient and/or family. If you use time you must document total visit time, describe the content of counseling or coordinating care, and actual time spent in counseling or coordinating care.

Miscellaneous Information

When codes are provided, such as N=no Y=yes on the flow sheets, staff need to use those codes not X's or O's. If a code is not provided, symbols need to be clearly documented, easily understood and included in agency policies.

Good practice for providers is to do a self-audit and to look at other providers in their agency each month for educational purposes. This helps to keeps the level of billing consistent between providers, helping to assure that the same type of service is billed at the same level.

Modifiers need to be used occasionally. The modifier 25 needs to be used if a separately identifiable evaluation and management (E/M) service by the same provider is done on the same day as a procedure

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or other service. The modifier 25 is attached to the E/M code, not the procedure code. The modifier 51 is used if, more than one procedure is done the same day by the same provider. Code the primary procedure first and add 51 to the 2nd and other subsequent procedures.

Provider's signatures should reflect credentials for the level of position and license for which they are hired.

Agencies can bill Medicaid for Expanded Role Nurses who perform exams covered by the preventive medicine codes (99383-99386 and 99393-99396). Check with other 3rd party payors for possible reimbursement as Medicare and some insurance companies have been reimbursing for these.

Make sure all services provided are marked on the encounter form either for billing or reporting.