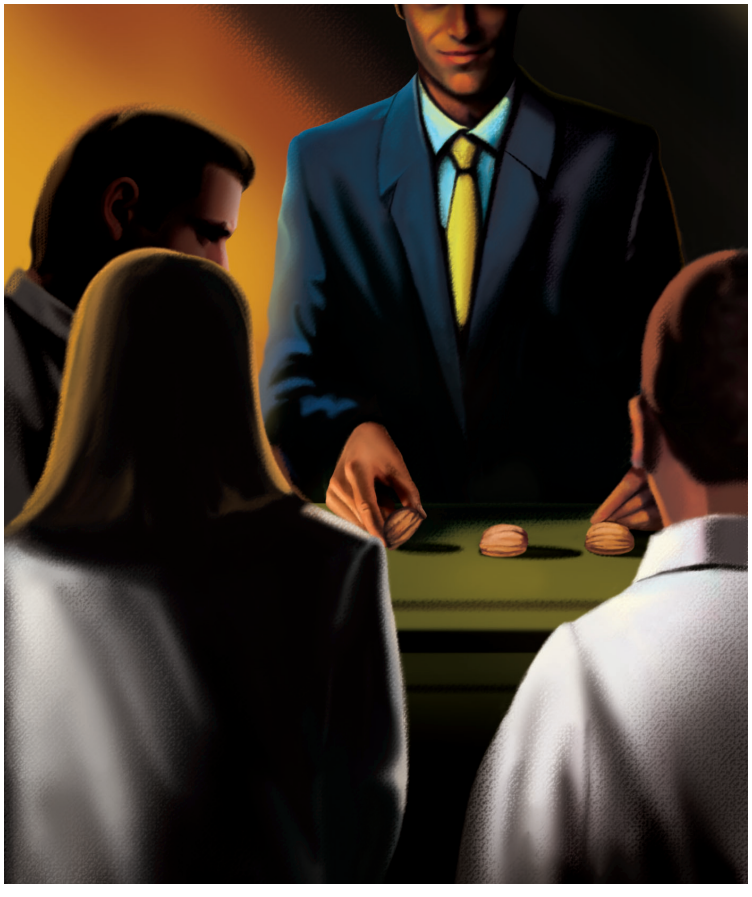
Don't let varying interpretations of the evaluation and management guidelines keep you from getting paid.

Is Your Medicare Payer Playing by the Rules?

Cindy Hughes, CPC

Medicare claims for evaluation and management (E/M) services have high error rates. This is probably not news to you; most physicians understand that this is the result of the complicated rules laid out in *Current Procedural Terminology* and Medicare's *Documentation Guidelines for Evaluation and Management Services.* What you may not know is that the Centers for Medicare & Medicaid Services (CMS) has allowed the individual Medicare administrative contractors (MACs) that process Medicare claims to interpret the guidelines as they see fit and that, as a result, well-meaning physicians who rely on the nationally recognized guidelines are at risk of being denied payment.



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This phenomenon became apparent several years ago when one aptly named MAC, TrailBlazer Health Enterprises, changed its documentation requirements to prohibit the use of "all others negative" when documenting a full review of systems, and it adopted a new method for determining the level of medical decision making. Today TrailBlazer is not alone in developing its own "interpretations" of the guidelines. After days of Internet searching for guidance on E/M documentation, I discovered widespread differences among MAC policies. Some provide clear, consistent information to physicians based on historical understandings of the documentation guidelines, while others have added restrictions and provide inconsistent and sometimes unclear interpretations. Others offer little to no direction at all.

To be fair, portions of the documentation guidelines are so vague that using them practically requires some interpretation. The most notable example is in the medical decision making section, where the guidelines include a table helpful for assessing risk and relating it to the four levels of decision making but offer no similar tool for assessing diagnosis and management options and data, the other two elements of medical decision making. (See "Thinking on Paper," page 10, to brush up on documenting decision making.) To help fill this gap, many contractors use score sheets that assign points

for documentation of various diagnoses and management options and types of data review and relate these to the overall level of medical decision making. Responding to a similar lack of clarity in the exam section of the 1995 version of Medicare's documentation guidelines, Highmark Medicare Services developed what it calls a "4x4 tool" to help determine if an exam should be scored as expanded problem focused or detailed. Other ambiguities in the guidelines have spawned frequently asked questions from physicians and others.

The table on page 30, part of a larger table that is available online, gives several examples of the welter of interpretations that have grown out of all of this uncertainty. It compares Medicare's documentation guidelines with Medicare contractors' guidelines where the latter were available. In addition, several important questions that the documentation guidelines don't address are listed below.

CMS developed the Comprehensive Error Rate Testing program to determine how accurately MACs pay claims, and CMS says the results consistently demonstrate the need for increased documentation review and provider education for certain E/M services. So before CMS requests your records and your practice receives a hard lesson in documentation and coding, learn the rules the MAC for your state is playing by (see "Who's the MAC in my state?" on page 29). Contact the Provider Outreach and Education Department of your MAC, and let the issues raised on page 30 guide your questions. The following are just a few examples of interpretations that could affect your practice.

CMS allows individual Medicare contractors to interpret the evaluation and management guidelines as they see fit.

This puts physicians who rely on the nationally recognized guidelines at risk of being denied payment.

Physicians should identify their Medicare contractor using the map on page 29.

History of the present illness

In its *Evaluation and Management Services Guide,* CMS has stated that documenting the status of at least three chronic or inactive conditions is acceptable support for an *extended* history of the present illness (HPI) under both the 1995 and 1997 versions of its *Documentation Guidelines for Evaluation and Management Services*.[1] However, the 1995 version of the guidelines available on the CMS web site includes a narrower definition – four or more elements of the HPI (location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms). Confused? It appears the MACs are too.

The E/M documentation worksheet for First Coast Service Options reflects the differing definitions, with the status of at least three chronic or inactive conditions constituting an extended HPI only when the 1997 guidelines are used. Palmetto GBA doesn't recognize the status of three chronic conditions under the 1995 guidelines either. But Wisconsin Physicians Service and National Heritage Insurance Corporation (NHIC) accept the broader HPI definition for both versions of the guidelines.

You may wonder if this really matters. After all, HPI is only one of the three documentation elements of a patient history. As Kent Moore wrote in an article about history documentation in the March/April 2010 issue of *FPM*, the 1995 definition "tends to undervalue the HPI for follow-up visits with patients who have multiple chronic problems. If the

MORE QUESTIONS TO ASK YOUR PAYERS

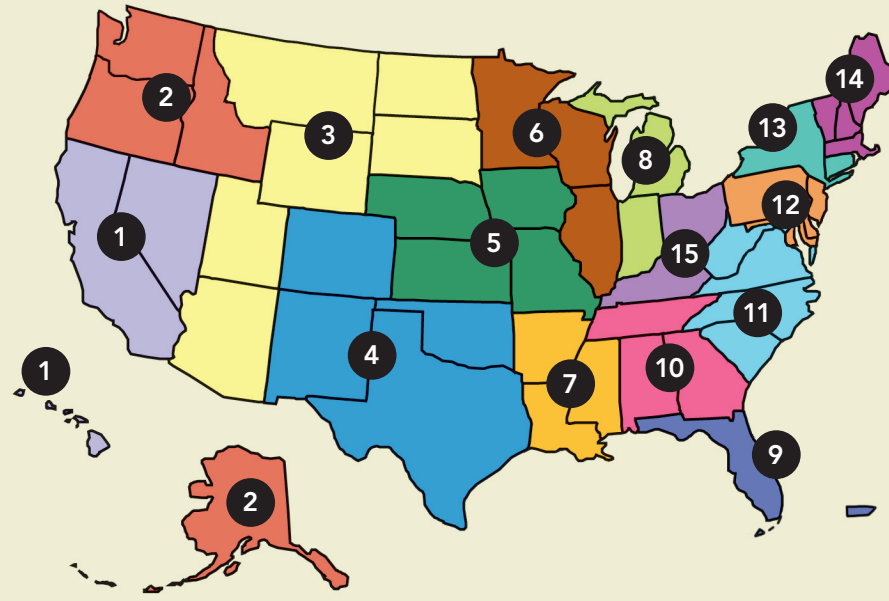
Medicare's *Documentation Guidelines for Evaluation and Management Services* doesn't address the following issues, but your Medicare contractor's answers to these questions may significantly influence how your practice would fair in an audit. Why not ask them now?

- Is it necessary to use either the 1995 or 1997 guidelines in their entirety, or is it acceptable to use portions of each, e.g., the 1995 guidelines for exam and medical decision making with the 1997 guidelines for history?
- Do you use score sheets to quantify diagnosis and management options and data review related to medical decision making documentation? If so, can these be shared with physicians?
- What constitutes an "interval history," as required for documenting subsequent hospital care?

Article Web Address: http://www.aafp.org/fpm/2010/0700/p27

WHO'S THE MAC IN MY STATE?

Turnover is high among Medicare administrative contractors, and this can confound practices' efforts to stay in compliance with any unique rules the contractors may have. To keep up with the changes in contractors and jurisdictions, visit the contractors' web sites (listed below) or the CMS Medicare Contracting Reform web page at https://www.cms.gov/MedicareContractingReform/02_Spotlight.asp#TopOfPage.



Jurisdiction 1 covered by Palmetto GBA (http://www.palmettogba.com/medicare): American Samoa, California, Guam, Hawaii, Nevada and Northern Mariana Islands

Jurisdiction 2 contract currently under protest: Alaska, Idaho, Oregon and Washington

Jurisdiction 3 covered by Noridian Administrative Services (http://www.noridianmedicare.com): Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming

Jurisdiction 4 covered by TrailBlazer Health Enterprises (http://www.trailblazerhealth.com): Colorado, New Mexico, Oklahoma and Texas

Jurisdiction 5 covered by Wisconsin Physicians Service (http://www.wpsmedicare.com): Iowa, Kansas, Missouri and Nebraska

Jurisdiction 6 contract currently under protest: Illinois, Minnesota and Wisconsin

Jurisdiction 7 contract currently under protest: Arkansas, Louisiana and Mississippi

Jurisdiction 8 contract currently under protest: Indiana and Michigan

Jurisdiction 9 covered by First Coast Service Options (http://www.fcso.com): Florida, Puerto Rico and U.S. Virgin Islands

Jurisdiction 10 covered by Cahaba Government Benefit Administrators (http://www.cahabagba.com): Alabama, Georgia and Tennessee

Jurisdiction 11[1] covered by Palmetto GBA (http://www.palmettogba.com/medicare): North Carolina, South Carolina, Virginia and West Virginia

Jurisdiction 12[2] covered by Highmark Medicare Services (http://www.highmarkmedicareservices.com): Delaware, District of Columbia, Maryland, New Jersey and Pennsylvania

Jurisdiction 13 covered by National Government Services[1] (http://www.ngsmedicare.com): Connecticut and New York

Jurisdiction 14 covered by National Heritage Insurance Corporation (http://www.medicarenhic.com): Maine, Massachusetts, New Hampshire, Rhode Island and Vermont

Jurisdiction 15 contract currently under protest: Kentucky and Ohio

1. For Part-B services, the counties of Arlington and Fairfax and the city of Alexandria in Virginia are excluded. Services for these areas of Virginia will be covered under jurisdiction 12.

2. For Part-B services, the counties of Arlington and Fairfax and the city of Alexandria in Virginia are included. Services for the rest of the state of Virginia will be covered under jurisdiction 11.

EVALUATION AND MANAGEMENT SERVICES Q&A: HOW DOES YOUR MAC INTERPRET THE GUIDELINES?

The following questions and answers were found on Medicare administrative contractors' (MACs) web sites. Table cells were left blank if the answer could not be found. Certain contractors are not included in the table because of a lack of information on

	Medicare's Documentation Guidelines for Evaluation and Management Services	Cahaba Government Benefit Administrators	First Coast Service Options	Highmark Medicare Services
Does documenting "the status of at least three chronic or inactive conditions" meet the requirement for an extended HPI when using the 1995 version of Medicare's documentation guidelines?	The 1997 version defines an extended HPI as four or more elements of the HPI or the status of three or more chronic or inactive conditions. This definition has not been incorporated into the 1995 version of the guidelines published on the CMS web site, although Medicare's *Evaluation and Management Services Guide* indicates that this definition is part of the 1995 guidelines.	Yes.	No.	
Is it acceptable to document the status of chronic or inactive conditions to meet the requirements for a brief HPI (1-2, since 3 or more has been deemed acceptable for documenting an extended HPI)?		No.	No.	Yes. "The status of one to two chronic conditions qualifies for an expanded problem-focused HPI." *Editor's note: Since there's technically no such thing as an expanded problem focused HPI, we think the payer means a brief HPI.*
Is it acceptable to use summary statements when documenting review of systems (ROS) findings?	Yes. "To correctly document a complete ROS, you must show that you have reviewed at least 10 organ systems, one of which is the system directly related to the problem identified in the HPI. However, you do not have to individually document all the systems reviewed; you only have to document those with a positive or pertinent negative response if you document a review of the remaining systems with a notation like 'all others negative.'"	Yes.		
Can a single item count toward both the HPI and ROS? For example, could "shortness of breath" count as an associated sign and symptom in the HPI and respiratory system in the ROS?				Yes. ROS inquiries are questions concerning the system(s) directly related to the problem(s) identified in the HPI. Therefore, it is not considered "double dipping" to use the system(s) addressed in the HPI for ROS credit.

their web sites. See page 29 to identify the MAC for your state. (This table includes a portion of my findings; the full results are included in the table that appears with the online version of this article at http://www.aafp.org/fpm/2010/0700/p27.html.)

National Heritage Insurance Corporation	Palmetto GBA	Pinnacle Business Solutions	TrailBlazer Health Enterprises	Wisconsin Physicians Service
Yes.	No.			Yes. According to the WPS web site, WPS received clarification from CMS indicating this statement applies to both the 1995 and 1997 versions of the guidelines.
Yes. "There is no distinction that states that the status of one or two chronic or inactive conditions would qualify for a brief HPI. However, identifying a problem/condition is sufficient to meet the brief HPI. This qualifies for both the 1995 and 1997 guidelines."	No.	Yes.		
Yes.	Yes, if the statement makes it clear which systems were found to be negative. "In the CPT manual you will see that there are 14 systems listed, so in this situation stay clear of using '10 other systems negative' etc., because it's not telling us precisely which system. We would look for things like 'all others negative,' 'no other complaint,' etc."	Yes.	Yes, if the statement makes it clear which systems were found to be negative. "When using 'negative' notation, always identify which systems were queried and found to be 'negative.'"	Yes.
		Yes. "According to the E/M guidelines an item cannot be used twice within the same section of the history (either HPI, ROS or PFSH), but a single item may be used in two separate historical sections. According to CMS documentation guidelines, the use of a single historical item in both HPI and ROS is recognized as an acceptable practice." *Editor's note: We were unable to verify this in Medicare's documentation guidelines.*		Yes, "in rare circumstances." "A clearly documented medical record would prevent the need to "double-dip" for HPI and ROS, but WPS Medicare, in rare circumstances, could accept counting one statement in both areas if necessary."

CMS has allowed the individual contractors that process Medicare claims to interpret the guidelines as they see fit.

problems are well-controlled – enough for the patient to be asymptomatic – even the most careful and thorough HPI might not be able to turn up four or more of the specified elements. (How do you give the duration of a symptom that isn't there?) As a result, this definition of the HPI tends to put a ceiling on the level of the visit: A brief HPI limits the level of history to problem focused or expanded problem focused, and that limits the level of a follow-up visit to 99213 unless both the exam and the medical decision making are involved enough to justify a higher level without reference to the history."[2]

To further confuse HPI documentation, Pinnacle Business Solutions, NHIC and Highmark Medicare Services accept the status of *one to two chronic or inactive conditions* to meet the requirement for a *brief HPI.* This seems like a logical extension of the extended HPI definition, but Medicare's documentation guidelines don't address it. First Coast Service Options states that a brief HPI requires one to three elements of the HPI, not one to two chronic or inactive conditions. Note, however, that First Coast Service Options' guidance doesn't actually prevent the status of one to two chronic conditions from counting as a brief HPI. For example, if you state that the patient has hypertension that is well controlled with current medications, you have documented a brief HPI in compliance with either definition – noting the status of one chronic condition or two elements of the HPI (quality and one modifying factor).

Medical decision making

Although Medicare's guidelines place no greater emphasis on medical decision making than on history or exam in determining a level of service, some auditors and payers argue that for established patient services that require only two of three key components, medical decision making must be one of the two components.

The results of my research on this issue were confusing. For example, Pinnacle indicates on its web site that any two of the three key components can be used to determine the code selection, but then elsewhere says, "Medical review places the most significant emphasis on the level of MDM [medical decision making] documented and required by the condition of the patient. For example, if 99223 is billed with a comprehensive history, comprehensive examination and moderate level of MDM, this would be recoded to 99222 to reflect the level of decision making ... ."

NHIC also gives contradictory information, explaining that medical decision making does not have to be one of the components used for code selection and elsewhere requiring it. NHIC goes as far as to say that if the level of medical decision making is lower than what is required for that code, the service may be downcoded – even if the history or exam component meets or exceeds the level required.

Stay informed

These examples illustrate why it is important to monitor the information provided by your payers, and especially your MAC. Periodically comparing your supporting documentation to payers' requirements and making adjustments as needed will help keep your claims from being denied. Don't let the MAC or its review contractors find an "educational opportunity" in your practice. FPM

Send comments to **fpmedit@aafp.org.**

- Be aware of how your contractor interprets the medical decision making guidelines.
- The table on page 30 highlights common questions and answers from individual Medicare payers.
- Keep up with jurisdiction changes by consulting CMS and contractors' web sites.

About the Author
Cindy Hughes is the coding and compliance specialist for the AAFP and is a contributing editor to *Family Practice Management.* Author disclosure: nothing to disclose.

1. Centers for Medicare & Medicaid Services. *Evaluation & Management Services Guide.* July 2009. http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf.

2. Moore KJ. Documenting history in compliance with Medicare's guidelines. *Fam Pract Manag.* 2010 Mar-Apr; 17(2):22-27. http://www.aafp.org/fpm/2010/0300/p22.html.