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In This Issue

Defending Audits Before They Happen: A Practical Guide to Documenting to Sustain A Challenge to E/M Codes

By: Thomas O'Carroll

Although many believe malpractice suits to be the primary risk-management issue facing healthcare providers, an increasing number of caregivers have learned that the greatest potential risk to the provider's practice is an overpayment audit. This is especially true when there is a risk of terminating a provider agreement of the caregiver's largest payor.

The cases often involve a practitioner who is lulled into the belief that a billing practice was appropriate based on years of payment without contention. Eventually, that provider may open the mail one day to find that the third party payor is suddenly demanding a large refund. The sticker shock of these demands, coupled with the threat of termination of the provider contract, and the likelihood that the caregiver is without coverage for these claims can put a provider at a far greater risk of bankruptcy than even a substantial medical malpractice claim. To make matters worse, in certain cases, providers may face threats of criminal proceedings.

The high reimbursement cost of an audit is due to extrapolation. Third party payors typically take the percentage of claims they feel should have been denied from a sample set of patients and then carry that over to the total number of claims through a given time period. Depending on state law, that time period may extend over several years.

We've designed this article to help you as a provider avoid audits and get fair payments for professional services. We focus on Evaluation and Management (E/M) Codes as they cover a broad spectrum of providers. However, you should be aware that audits may be triggered by any number of CPT codes.

Understanding Billing Codes Requirement Is the Best Audit Defense

Audits are typically triggered by either a patient complaint or from a flag of certain billing practices that are outside of the statistical norms. Most providers should already know that consistently billing under the highest E/M Codes will likely result in an audit. However, many are surprised to learn that routinely choosing even low to middle E/M codes will also attract attention of the computers designed to look for outliers in billing practices.

While CPT codes tend to frustrate most providers, those caregivers who fail to provide support for their choice of codes in their medical record generally do so to their detriment. A thorough understanding of these codes will allow a provider to overcome fears of an audit and likely result in the caregiver to be **reimbursed at higher levels**. In a 2012 review of 60,000 audits, the American Academy of Professional Coders found that 37% of records were either under-coded or under-documented resulting in an average loss of revenue of $64,000 per physician.

A provider can document support for E/M services two ways: "Key components" or by "contributory factors." Key components include specific requirements to sustain the certain levels of complexity for: 1) History; 2) Examination; and 3) Medical Decision Making. The contributory factors are billed according to time spent with the patient.

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Rockford partners **Greg Snyder** and **Jennifer Johnson** recently obtained a defense verdict in a jury trial in Winnebago County. The case arose from an intraoperative injury during laparoscopic gynecological surgery. The defendant physician was using a power morcellator (a device that has since been removed from the market) to evacuate uterine fibroids from the patient's abdomen when it inadvertently came into contact with the patient's small bowel causing a perforation. This required the patient to undergo an open repair surgery and a later rehospitalization for an ileus. The patient claimed ongoing problems with constipation, incisional pain and increased anxiety as a result of the surgical complication. Our expert witness explained how the injury occurred despite the use of proper technique and disputed the connection between the plaintiff's ongoing issues and our surgery.

Partners **Madelyn Lamb** and **Jeff Glass** in Belleville obtained summary judgment in favor of their client, an emergency department staffing and management company, in two wrongful death actions premised on medical malpractice pending in St. Clair County, Illinois. In both cases, the plaintiffs sought to impose vicarious liability against the staffing company for the allegedly negligent acts of the emergency room physicians whom plaintiffs claimed were its agents and employees.

Although St. Clair County is well known as a plaintiff-oriented venue, we persuaded the court that there was no genuine issue as to any material fact and the defendant staffing company was entitled to judgment as a matter of law because the emergency physicians were independent contractors. Plaintiff's attorneys routinely add the staffing company as a party defendant in cases involving emergency care in local hospitals and, in fact, there are a number of pending actions against our client. The successful result in these two lead cases will have a positive impact on the defense of those outstanding actions.

Key Component—Documenting History and Review of Symptoms

Documenting medical history to sustain a given E/M code is categorized as follows:

- **Problem focused**: Chief complaint; "brief" history of present illness or problem.
- **Expanded problem focused:** Chief complaint; "brief" history of present illness; "pertinent" system review.
- **Detailed**: Chief complaint; "extended" history of present illness; "problem pertinent" system review extended to include a review of a number of additional systems; pertinent past, family and/or social history related to the problem.
- **Comprehensive:** Chief complaint; "extended" history of present illness; review of systems directly related to the identified problem, plus a review of all additional body systems; complete past, family and social history.

The term "extended" history refers to three or more chronic or inactive conditions **or** four or more of the following symptom elements of the HPI: 1) location; 2) quality; 3) severity; 4) duration; 5) timing; 6) context; 7) modifying factors; and 8) associated signs and symptoms. A "brief" history only documents one to three of above listed HPI elements.

Thus, the only difference between one level and the next may be no more than a word or two. For example, a chart which reads "Patient has had mild [*severity*], dull [*quality*], headache since yesterday [*duration*]" can be properly billed at a higher level than "Patient presents with a history of headache starting overnight." Simply adding these descriptive elements into the record would promote a "brief" history into an "expended" because it added three descriptive elements.

There is a similar difference between a "problem-pertinent" Review of Systems and an "extended" ROS. For a "problem-focused" ROS, you only need to document the system that is directly related to the presenting problem. However, an "extended" ROS includes an inquiry into two to nine systems, only one of which needs to be directly related to the problem. If one was to document a "complete" ROS, you need to show that you have reviewed at least 10 organ systems, including the system of the presenting problem.

The key word in this context is "review." While the HPI must be performed by a physician, the guidelines note that both the ROS and past family and social history may be recorded by staff or may be completed by the patient on a form. The provider who documents the pertinent findings from the form and notes "all others negative" may have already greatly helped his own efforts in sustaining a challenge against an audit.

Key Components—Documenting the Physical Exam

The requirements of documenting the physical exam can be defined in more than one way. Unfortunately, both of them are difficult. The original 1995 guidelines were deemed overly vague and the 1997 revisions went too far in the opposite direction.

In a very general sense, to qualify for a given level, there must be performance and documentation of certain specific elements of the following organ systems: 1) Eyes; 2) Ears, Nose, Mouth and Throat (Note that auditors consider that a HEENT exam only documents two organ systems *i.e.* eyes and ears, nose mouth and throat); 3) Cardiovascular; 4) Respiratory; 5) Gastrointestinal; 6) Genitourinary; 7) Musculoskeletal; 8) Skin; 9) Neurologic; 10) Psychiatric; and 11) Hematologic/lymphatic/immunologic. The number of systems included in the physical exam will determine the level of the E/M code to use.

- **Problem Focused**: A limited examination of the affected boy area or organ system (Exam should include 1-5 physical exam elements from one or more organ system or body area.)
- **Expanded problem focused:** A limited examination of the affected boy area or organ system and other symptomatic or related organ system(s) (Exam should include at least 6 specific elements from one or more organ systems or specified body area.)
- **Detailed:** An extended examination of the affected body area and other symptomatic or related organ system (Exam should include at least 12 elements within at least two different systems or areas.)
- **Comprehensive:** A general multisystem examination or a complete examination of a single organ system (Exam should include all elements and documentation of at least 2 elements from each of at least nine systems or areas.)

Since the problem focused exam only requires one element, a provider could meet the "problem focused" exam with documentation of basic vital signs. It is less clear how to differentiate between an expanded, detailed and comprehensive physical exam and it will basically come down to a point system checking off various elements of exam findings.

For example, in order to meet the 12 elements to qualify for a "detailed" physical exam, a provider could include the following: 1) vital signs; 2) general appearance; 3) examination of the neck; 4) auscultation of the lungs; 5) auscultation of the heart; 6) assessment of the carotid arteries *i.e.* "normal carotid upstroke and amplitude"; 7) examination of abdomen; 8) examination of liver and spleen *i.e.* "No HMS, no masses"; 9) examination of extremities for edema; 10) palpation of digits and nails; 11) inspection of skin; 12) mental status *i.e.* "alert/orientated."

Key Components—Medical Decision Making

Unlike the specific and technical requirements of the history and physical documentation, the decision making component of E/M services leaves room for interpretation. There are four levels of recognized medical decision making: 1) Straightforward; 2) Low Complexity; 3) Moderate Complexity; and 4) High Complexity. Qualifying for a given type is based on two of the following three factors:

- The number of possible diagnosis and possible management options being considered;
- The amount and complexity of data involved;
- The risk to the patient either by the presenting problem or planned intervention.

Again, distinguishing between the middle levels of decision making can be ambiguous. There is no clear statement within the guidelines which conditions or tests are considered minimal or complex. Thus, clinicians are left to perform their own comparative analysis based on the patient encounter.

For instance, established patients who need frequent medication changes may raise the level of complexity. Likewise, when a new issue arises, providers should look to the extent of the differential diagnosis in analyzing the level of complexity. Keep in mind that while not every patient will qualify for the highest level of complexity, it should also follow that providers should give themselves credit for the complexity of making a diagnosis or managing patients with various other conditions so that they are not shortchanging themselves.

Time Based Billing Entries

Regardless of the level of complexity, providers will have some visits that consist predominately of counseling and/or coordination of care. For these visits, E/M guidelines allow providers to use the time spent with the patient as the controlling factor to qualify for a particular level of services. This model is a separate analysis than the documentation requirements for the key components (history, physical exam, and medical decision making) outlined above. Here, time alone can be used to select the level of care.

In order to sustain the scrutiny of an audit, there are specific requirements that providers must know.

- First, the time only includes face-to-face time spent with the patient or the patient representative. This would include the time associated with any history, exam, or medical decision making you performed. In the inpatient setting, the total time spent may include discussions with nursing staff or other consultants and review of records for inpatient services.
- Next, **most (greater than 50%) of the total time** must be used for "counseling and coordination of care." Providers should document the amount of time involved in the service and then write "more than half of the encounter involved counseling and coordination of care." This language makes it clear that the code was selected based on time being the determining factor. Vague statements such as "extensive discussion" or "discussed at length" are not likely to be sufficient. It is also strongly advisable to document the general nature of the discussion to give a potential auditor context even if it may seem obvious.

Milwaukee partners **Mike Malone** and **Jill Munson** obtained a defense verdict for a pediatric surgeon in a two-and-a-half-week trial in Milwaukee County. The plaintiff claimed the surgeon, two residents and nursing staff were negligent because they did not provide sufficient fluids and glucose following surgery to remove a malignant tumor, resulting in hypovolemic shock and hypoglycemia. The defendants produced expert testimony that the care provided – including a plan to provide fluids – was reasonable, and that no one would have anticipated hypoglycemia. The residents and nursing staff also obtained defense verdicts.

In Chicago, partner **Diane Webster**, partner **Tom Mulroy** and associate **Whitney Goldin** secured a not guilty verdict for a gastroenterologist and his group in a three-and-a-half week wrongful death trial of a 64 year old woman. Plaintiff alleged defendants misdiagnosed the patient with gall bladder disease. They allege defendants further failed to timely diagnose and treat a paraesophageal hernia by failing to order a CT scan after the patient presented to the emergency department with persistent abdominal pain and subsequent testing had ruled out the gall bladder as the etiology of her pain. Plaintiff contended a CT scan would have timely made the diagnosis and would have avoided subsequent strangulation, rupture, cardiac arrest and death. The defense argued plaintiff presented with the classic signs of a gall bladder attack which later showed signs of improvement allowing the defense to wait to order further testing. When the patient's condition deteriorated the following day, appropriate testing had been ordered, an EGD, which would have diagnosed a hernia, but the plaintiff refused to undergo the testing allegedly due to excruciating pain. Shortly thereafter, the patient arrested, coded, and was taken to emergency surgery, dying four days later. Plaintiff asked for $3.65 million, and the jury returned a not guilty verdict after 2.5 hours.

- Finally, providers should familiarize themselves with the specific time period for various levels of services. For an established patient in the outpatient setting, there are five separate E/M levels with times ranging from 5 to 40 minutes. Providers should be mindful not to make a mistake by documenting time spent counseling that would be less than 50% of the billed level. For example, a statement that 15 minutes was spent in counseling and coordination of care would be less than 50% of the average 40 minutes to justify the highest E/M level.

Conclusion

Audits are becoming more and more frequent. Both governmental contractors working on behalf of CMS and large private insurance companies have found the audit process to be an effective tool in recovering funds. The Government Accountability Office (GAO) estimates that nearly $60 billion in overpayments were paid to Medicare providers in 2014 alone.

If you are faced with an audit, contact an attorney right away. It also may be advisable to contact your insurance risk carrier. More and more malpractice carriers are offering coverage for these claims. But most importantly, the best defense is audit prevention and the best way to avoid an audit is to understand and utilize the coding rules to your advantage.

Recent Illinois Appellate Court Case Clarifies Petrillo Doctrine

By: Jason Winslow

In *McChristian*, the Appellate Court determined an issue of first impression as to how the Petrillo doctrine, which typically prohibits communications between defense counsel and Plaintiff's subsequent treating physicians, applies when Plaintiff continues to treat with other physicians in the same group as the Defendant-physician. In this case, Jacqueline McChristian underwent podiatric surgery performed by the Defendant-podiatrist, Dale S. Brink, D.P.M., after which she developed complications associated with an infection. Plaintiff eventually underwent a revisionary surgery performed by the Defendant-podiatrist and his partner, Timothy Krygsheld, D.P.M., with whom Plaintiff continued to treat following the second surgery. Plaintiff filed suit against Dr. Brink and the Performance Foot and Ankle Center, L.L.C. (LLC), of which he was a managing member, but did not name Dr. Krygsheld as a Defendant in the suit. Defense counsel, who represented both Dr. Brink and the LLC, sought permission from the Court to communicate *ex parte* with the Dr. Krygsheld, who was a managing member, decision-maker, and "control group" member of the LLC. The trial court granted the motion for *ex parte* communication and this appeal followed.

On appeal, the *McChristian* Court recognized tension between the Petrillo doctrine and the attorney-client privilege, which typically protects communications between corporate counsel and members considered to be within the "control group" of the corporation. The *McChristian* Court noted that Plaintiff sought medical care from a different doctor within the same medical group, which created a conflict of interest that "was worsened when she filed suit against the corporation of which both her legal adversary and her current treating doctor were managing members." 2016 IL App (1st) 152674, ¶ 26. Because the unnamed partner-podiatrist, as a managing member of the LLC, was privy to the information of his own corporation, the Court determined that he was not a third-party to whom otherwise doctor-patient privileged information should remain undisclosed. The appellate court concluded that the Defendant-podiatrist, as well as the unnamed members of the control group of the LLC, would be severely hampered in their ability to defend themselves if not allowed to consult with counsel for the corporation. Therefore, the *McChristian* Court declined to extend Petrillo and the physician-patient privilege to prohibit *ex parte* communications with their lawyers in this context, holding "Petrillo does not preclude *ex parte* communications with the individuals who serve as the corporate heads and who are decision makers of the accused medical or podiatry corporation." Id. ¶ 27.

Because the Plaintiff had previously disclosed the unnamed partner-podiatrist as an expert witness as to the nature and extent of Plaintiff's injuries, however, the *McChristian* Court issued a sua sponte discovery order prohibiting any *ex parte* communications between the unnamed partner-podiatrist and defense counsel from taking place on remand until after Plaintiff was given an opportunity to depose the unnamed partner-podiatrist on those issues relating to damages. After that deposition, Defense counsel would be free to consult *ex parte* with the unnamed partner-podiatrist on the issues of liability and causation.

This decision clarifies that Petrillo does not necessarily prohibit any and all communications between defense counsel and subsequent treating physicians. In the limited instance where the subsequent treating physician also serves as a corporate leader and decision maker (i.e., within the "control group") of the Defendant medical corporation, Petrillo is not an automatic bar to *ex parte* communication.