

SENT VIA EMAIL OR FAX ON
Mar/23/2009

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DATE OF REVIEW:
Mar/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Office Visit 99214 on 9/23/08 and 10/29/08

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Records from Dr. 8/5/08 thru 2/18/09
Approval Letters 7/9/08 and 1/9/09
Preop Visit 7/16/08
Records from Dr. 8/15/06 thru 10/14/08
Multicare Centers 11/11/08 and 5/8/07
MRI 12/3/07
CT Lumbar 6/17/08
EMG/NCS 7/21/06
Letter from 2/12/09
Record from Dr. 12/4/07
Lumbar Spine 3 Views 5/19/06

PATIENT CLINICAL HISTORY SUMMARY

He injured his back on xx/xx/xx and underwent back surgery on (L4-Sacrum) 9/28/06 and a revision of the fusion on 7/3/08. He has the diagnosis of failed back syndrome, lumbar disc displacement with radiculitis. There is adjustment disorder with anxiety and depression. Dr. used a checklist form for the two visits in question. The 9/23/08 note showed he was there for medication refill. The 10/29/08 visit for was the medication refill and the pain. He had the check list the required components of the EM code that is the complaint, history, ROS, Social history, examination, diagnosis and treatment. The additional material addressed therapy, functional levels and the surgery, x-rays and other physician reports.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

There are two issues. First, was the office visit necessary on each of the two dates? The second is whether or not the correct EM code of 99214 was chosen. There are two formats permitted, 1995 and 1997. There are differences regarding the “bullets” counted in the examination. The key issue, however, would appear to be the Medical Decision Making Process. There are several different guides for this. The Reviewer relied on the Publishing publication on EM coding based upon the AMA requirements. This includes the 1) multiple number of diagnoses or management options considered; 2) Moderate amount or complexity of data reviewed; and 3) Moderate risk of complications or morbidity or mortality. This appeared to be a mediation check up for refills. This is necessary for managing the pain medications. However, there was no acute change. This in turn limited the diagnostic options, and the amount of data reviewed. There was no change in the risk of complications. Further, as noted on the web site the Reviewer also enclosed from the AFP, a complex history would also suffice. Dr. chose to use multiple organ system examinations. However, there did not appear to be the medical complexity required for a 99214 code. The example provided showed that chronic conditions, which this man had, are at this code when medication adjustments are necessary. The visit was for medication management, but no changes apparently were made.

Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a “flag” to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of “virtual visits” compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy.

Coding 9921

CPT defines a 99214 or level-IV established patient visit as one involving a detailed history, detailed examination and medical decision making of moderate complexity. But wait! CPT also states that only two of the three key components are required for the selection of the level of service. This means that the coding can be based on the extent of the history and medical decision making only. In this instance, you don't have to worry about counting body systems or exam elements to justify the reported level of care, and coding 99214 visits suddenly becomes easier than you may have thought. Of course, in cases where the history isn't detailed or the medical decision making isn't moderate but you provided and documented a high-level exam, it would be well worth your trouble to count your findings. So let's review all three components of E/M coding for a 99214

History. The requirements for a detailed history are actually easy to remember. According to the documentation guidelines, a detailed history requires that you note at least four elements in the history of present illness (HPI) (or the status of at least three chronic or inactive conditions, as explained in the right-hand column), a review of two to nine organ systems (ROS), and either the patient's past history, family history or social history (PFSH). It might read something like this: "CC: stomach pain. Patient complains of intermittent, dull, epigastric pain that began two months ago. No N,V,D. No chest pain or dyspnea. Non-smoker." You might actually take a more extensive history, but this is all that's required for reporting the detailed history associated with a level-IV established patient visit

Coding can be based on the extent of the history and medical decision making only.

Not all presenting problems lend themselves to documenting a history of present illness in the fashion just described. For example, you'll also meet the HPI requirement when you see a patient with three or more chronic or inactive conditions (e.g., hypertension, diabetes and coronary artery disease) and document the status of each.² Likewise, you will meet the ROS requirements since you will question the patient about signs and symptoms since his or her last visit and note accordingly. And finally, because CPT considers the review of a patient's medications and responses to treatment to be a component of the patient's past history, you will also have met the requirement for assessing one aspect of the PFSH. You can see that many of your patient encounters routinely meet at least the PFSH component for documenting the detailed history that a level-IV visit requires

When you consider the thresholds for the components of the history, it is not really necessary to count anything to ensure that a detailed history has been performed. Documentation is the key! To meet the minimum requirements for a detailed history, you need only remember to do the following

- Document in some detail the circumstances or conditions that brought the patient to your office,
- Document responses to a review of the affected organ system and at least one other system,
- Document your medication review or mention some other aspect of the PFSH, such as smoking status.

Exam. The requirements for the detailed exam are a little more difficult to remember. In part, this is because a detailed exam can be defined in more than one way. It can be either an examination of at least five organ systems/body areas (according to the 1995 version of the documentation guidelines) or the performance and documentation of at least 12 specific exam findings (according to the 1997 version).² In most circumstances, it is easier to use the first definition since it requires documentation of less detailed information. You frequently perform this level of exam when managing patients with multiple chronic conditions

Here's an example of a detailed exam involving a common complaint: a patient presenting

with a fever, cough and chest discomfort. It might be documented as follows

- Vitals: temperature 101.5, BP 140/80;
- ENT: negative;
- Neck: supple;
- Chest: rales in both bases, pain on deep inspiration;
- CV: negative;
- Abd: benign.

Remember, in cases where your history and medical decision making are going to support the level of service, you don't need to spend time quantifying the extent of the examination you provided. Of course it is necessary to document any abnormal or unexpected exam findings, but details about normal findings related to organ systems outside the area of focus are not required for coding and documentation purposes

Medical decision making. Medical decision making of moderate complexity is based on two of three factors

- The number of diagnoses or management options being considered,
- The amount and complexity of data involved,
- The risk to the patient of either the presenting problem or the planned interventions.
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Although it is generally easy to identify straightforward or high-complexity encounters, low and moderate levels of decision making often feel more ambiguous. It may be useful to think of medical decision making as a type of comparative analysis. Throughout the day, you subconsciously judge patient encounters to be simple, difficult, complex or a myriad of other adjectives. These terms seldom refer to the performance of the history or physical exam but, rather, to your cognitive work. There is a difference in the way you think about the uncomplicated patient with well-controlled hypertension and the patient who requires frequent medication changes for a chronic condition and has additional medical problems. Likewise, formulating a treatment plan for a patient presenting with abdominal pain, nausea and vomiting when there is a viral gastroenteritis in the community requires fewer considerations than evaluating a patient with similar but unexplained symptoms

When determining the level of medical decision making, take into account the extent of your differential diagnosis or the seriousness of the problem. If you are dealing with multiple medical problems, have several data elements to review or your level of uncertainty is increased, then you should begin to think about your medical decision making as moderate. This might be a patient with three stable illnesses who is being managed on prescription drugs. It could also be a patient presenting with an acute problem with systemic symptoms.

www.aafp.org/fpm/20031000/31howt.http

Although nothing in CPT or the documentation guidelines requires that medical decision making be one of the two required components for a 99214, it seems logical that it serve as the foundation. It may be more difficult than documenting the history and exam, but documenting your medical decision making and letting it guide your selection will probably lead you to the appropriate code

HOW OFTEN DO YOU CODE 99214

Medicare data show family physicians billed 60 percent of established patient office visits at level-III and 16 percent at level IV during 1999. If family physicians undercode by 30 percent, as one recent study suggests, approximately 21 percent of the established patient office visits you provide may really be 99214s.¹

Source: Centers for Medicare & Medicaid Services

Family physicians see many patients with multiple medical problems and are often the first providers to evaluate new conditions or complications. The referral specialist is likely dealing with an established diagnosis affecting a limited number of organ systems. This doesn't mean that the work of the specialist is not valuable but, rather, that you may not be giving yourself credit for the complexity of your own medical decision making

Another way to define 99214

Because you spend a lot of time educating patients about their conditions, discussing compliance issues and treatment options and reviewing findings from diagnostic studies, you may occasionally have a patient encounter that doesn't meet the level-IV history and exam requirements but that can still be appropriately coded at that level. For example, say a patient returned to your practice to review the findings of diagnostic tests and to discuss the resulting management options. You obtained only an interval history and didn't perform a physical exam. You don't have to "downcode" the visit just because the history and exam are limited. If you spent at least 25 minutes with the patient and more than half of that time involved counseling or coordination of care, you can bill 99214 based on time

When billing based on time, you code according to the total time spent with the patient. Times are noted in the CPT descriptors for many, but not all, E/M services. These times are most often used for reference; they represent average or "typical" times associated with a range of services that vary according to the clinical circumstance. When your coding is based on meeting two of the three key components, you needn't worry about whether your service took less time than CPT says is typical. But when your coding is based on time, you must meet or exceed the times associated with the reported E/M code. In the office setting, time is measured based on the face-to-face encounter between the physician and the patient. It's measured as floor or unit time in a hospital or nursing care facility. In each case, face-to-face time includes the time in which the physician obtains a history, performs a physical exam and counsels the patient. Remember: You can use time as the determining factor for the level of care only if counseling or coordination of care activities account for more than 50 percent of the visit. Be sure to document the total time spent with the patient and include a description of the counseling or coordination of care activities.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)