How to Use the "Level Only" Audit Tool



Dermatology E/M 2021 Leveling Audit Tool

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 $START \rightarrow$

"Level Only" Audits

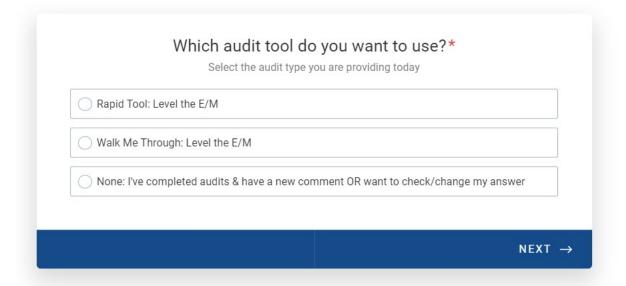
Auditor reviews documentation and an E/M code as provided

- A retrospective audit of 10 randomly selected office visit services is conducted remotely by certified coding professionals. Medical notes, orders, medication lists, and other clinical documentation associated with each office visit was compared with the E/M code selected by the physician or provider.
- Only the E/M code is audited. Modifiers and other services (except prolonged visits, if applicable) are not audited



The Audit Tools

- "Rapid tool" is for experts that want no help with code calculations
- "Walk me through" will make coding suggestions based on your inputs
- "None" is when you want to alert your
 - If think you might have made a mistake in a previous submit
 - If you have observed a pattern after multiple audits of a provider and you want that included on the provider's report, just let us know by using the bottom option.





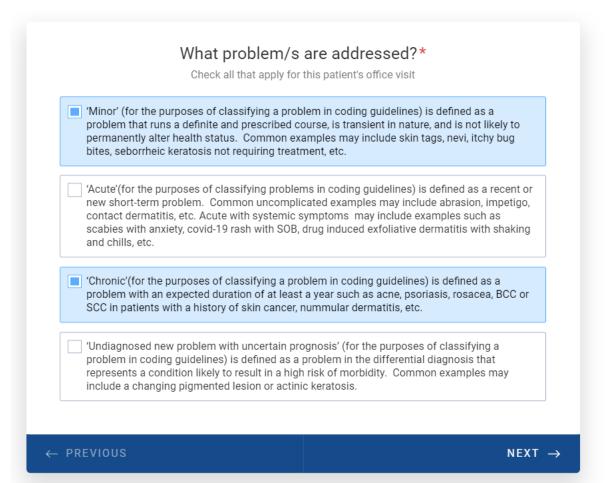
Quick Caution on "Walk me Through"

Which audit tool do you want to use?*

- This tool is a "jot form" and uses your inputs to hide slides you don't need to see
- Your inputs calculate coding suggestions when you use the "walk me through" tool. Use caution when skipping back and forth to change your inputs. Changing inputs can cause errors because your new inputs will 1) unhide slides you didn't see before and 2) hide slides you did see before. This means you can't "erase" your answers on hidden slides and the tool still uses the hidden information. Refresh your browser and start again if you think this has happened.

Use 2021 CPT® definitions to pick the problems addressed

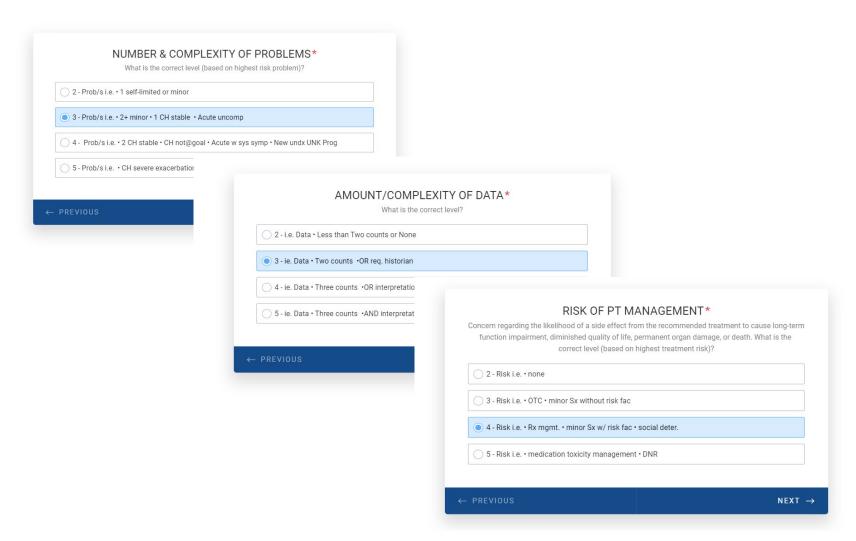
- Check all that apply to the problem as it is documented.
- The tool gives clinical examples and is not all inclusive –just suggested hints





Rapid Tool Does Not Make Suggestions

 The Auditor selects the level of service that correlates with the documentation





But it displays what you enter...

 To help you visualize the correct level of service

Put it together:

Unless coding on time, to qualify for a particular level of medical decision making, two of the three elements for that level of medical decision making must be met or exceeded. You selected:

- 3 Prob/s i.e. 2+ minor 1 CH stable Acute uncomp
- 3 ie. Data Two counts •OR req. historian
- 4 Risk i.e. Rx mgmt. minor Sx w/ risk fac social deter.



← PREVIOUS

 $NEXT \rightarrow$

List your audit result when prompted.

• Do not enter modifiers –this audit is for the level only. If no separately identified E/M code is documented enter N/A

	PT 2021 E/M Code * Nothing supported = "N/A"
99214	
Enter only one code: the primary E/M code without the modifier	
← PREVIOUS	NEXT →



Level only audits also include Prolonged Services (if documented)

 Say "yes" to enter your audit result ONLY if there is a prolonged E/M service secondary to the primary E/M code documented

We	ere Prolonged S	ervices Supported*	
	YES	NO/NA	
← PREVIOUS			NEXT →



Overall Result

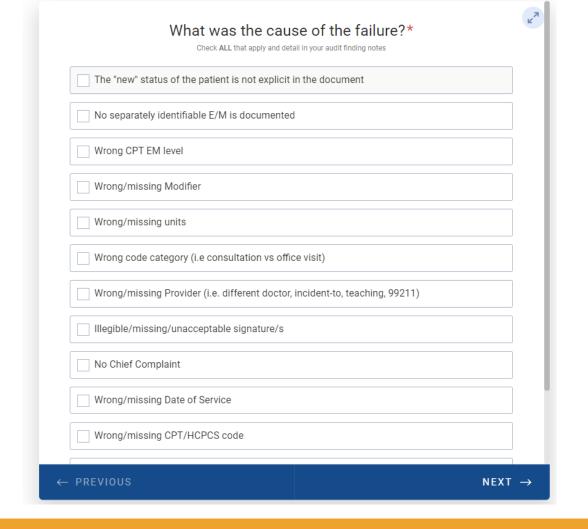
- If the E/M code was billed correctly enter "pass"
- If a likely over payment or underpayment would occur based on coding errors the provider made, enter "fail"

AUDITOR FINDING:	Payment Accuracy*
Pass	Fail
← PREVIOUS	NEXT →



Enter the cause of any failure

 Click the boxes that correlate with provider coding errors





Give us your audit reference

- Select from the drop-down box
- If your reference is not there, include in auditor note section

DECODING DOCTOR

Primary reference that supports audit findings:*

Which reference should be included on your report?

1995 and 1997 CMS Documentation Guidelines for Evaluation and Management Services and Medicare Claim: 🕶

GENERAL

MEDICAL NECESSITY: Section 1862(a) (1) (A) of the Social Security Act directs the following: "No payment ma AMA 2021 CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged § 1995 and 1997 CMS Documentation Guidelines for Evaluation and Management Services and Medicare Claims SIGNATURE/DATE: CMS Medicare Program Integrity Manual Chapter 3 Section 3 3 2 4

TIME G2212 HCPCS: Prolonged office or other outpatient evaluation and management service(s) beyond the m

E/M FROM MCM

TEACHING PHYSICIANS: Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practition
"INCIDENT TO": Medicare Claims and Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 3
PREVENTIVE WITH SICK: Medicare Claims and Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners
NEW VS EST PT: Medicare Claims and Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners
SAME GROUP: Medicare Claims and Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 30

MODIFIER

MODIFIER 24: Medicare Claims and Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 30 MODIFIER 25: Medicare Claims and Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 30 MODIFIER 51 - Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40.6 - MODIFIER 59 XE XS XP XU - Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 LT RT- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 40 MODIFIER 50 MODIFIER 5

OTHER

SURGERY ASSSITANT: Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioner ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 – UPDATED January 1 2021

- PREVIOUS NEXT →

Enter any Educational Information

 Use the tool to select commonly appropriate information to share



Educational Opportunities/Information

Check all that apply and detail in your audit finding notes

SUBJECTIVE DETERMINIATIONS - This auditor allowed implied elements where another might request additional documentation (detailed in Audit Findings.) Concise documentation is recommended to avoid payer audit findings that require peer review, appeal, additional time, and/or cost.
UNCERTAIN VERSUS UNSPECIFIED - This auditor made an observation with the documented use of D48.5 Neoplasm of "uncertain" behavior of skin. Uncertain has a specific meaning in ICD-10. It means that the specimen has been examined by the pathologist and it can't be determined if the neoplasm is benign or malignant. An uncertain neoplasm is reported after

SEPARATELY IDENTIFIABLE: This auditor assumes that the lab/s ordered are not also being separately billed by the same provider. If the provider bills for the test, the provider does not get credit in MDM for the order or reviewing the results.

the pathologist's report, not when sending the specimen for biopsy. D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin is what this auditor expected to see listed.

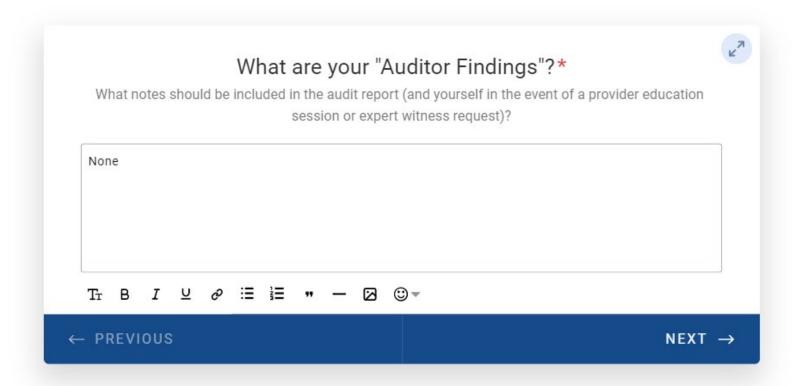
MEDICATION TOXICITY MONITORING - If the provider documents that the patient is at high riskregarding the likelihood of side effects from medication to cause long-termfunction impairment, diminished quality of life, permanent organ damage, ordeath, the provider will qualify for a "high" level of risk under the componentof "Risk of Complications and/or Morbidity or Mortality of Patient Management". However, toxicity monitoring is only one oftwo required aspects under Medical Decision Making and two are required for alevel 5.

STABLE VERSUS NOT AT GOAL - This auditor recommends updating EHR terms and using specific language regarding problems that are "Stable": STABLE for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. A stable



PREVIOUS NEXT →

Enter any findings not addressed





Review

• The last side lets you review your work to determine if you want to change your audit results or findings. In this example the time actually supported a higher level than the auditor selected, and this gives the auditor the chance to spot their mistake.

This is what you picked with the Rapid Tool:

Visit #	Provider Coded	Result
3	99215	Fail

You said the correct code is:99214

- 4 Prob/s i.e. 2 CH stable CH not@goal Acute w sys symp New undx UNK Prog
- . 2 Data i.e. · Less than Two counts or None
- 4 Risk i.e. Rx mgmt. minor Sx w/ risk fac social deter.
- Problem/s: 'Acute' (for the purposes of classifying problems in coding guidelines) is defined as a recent or new short-term problem. Common UNCOMPLICATED examples may include abrasion, impetigo, contact dermatitis, AK requiring treatment, etc. Acute with SYSTEMIC symptoms may include examples such as scabies with anxiety, covid-19 rash with SOB, drug induced exfoliative dermatitis with shaking and chills, etc.,'Chronic' (for the purposes of classifying a problem in coding guidelines) is defined as a problem with an expected duration of at least a year such as acne, psoriasis, rosacea, BCC or SCC in patients with a history of skin cancer, nummular dermatitis, etc. STABLE conditions are "at goal".

Time - Est: Level 5 New:N/A

You said the added comments should include:

Incorrect code: Wrong E/M level



THANKYOU!

Contact Stephanie Cecchini 801-664-3639 with any questions