

## Documentation of The Top Ten CPT Codes, Part 1

Attention to detail will enable you to receive proper payment.

Kenneth F. Malkin, DPM

Dr. Malkin is a diplomate of the American Board of Quality Assurance and Utilization Review Physicians. He is immediate past president of the American College of Podiatric Medical Review and the Medicare Physicians Carrier Advisory Committee representative for New Jersey.

Fear of Medicare audits and malpractice suits often drives physicians to write textbook chapters for each and every patient encounter. Unfortunately, writing a longer note does not guarantee that the required elements for an audit will be documented.

Where are the rules the auditors use? There are four common reference sources that may be consulted to determine the requirements for the documentation of medical services. The least obvious is each state medical licensing board. Each physician should maintain a copy of the rules and regulations of his/her state licensing board. This manual will include the requirements for documentation of patient encounters. These sources are usually overly general, but are the law in your state. The other main sources would be the AMA/Center for Medicare/Medicaid (CMS) Guidelines on Evaluation and Management Coding (E/M) from 1995 or 1997, your local medical review policies (LMRP) promulgated by your Medicare carrier for commonly billed procedural codes, and commercial third-party payer guidelines.

Documentation is often related to coding but differs in its sources. Obviously the Gray's Anatomy of coding is the AMA CPT Manual. However, the guidelines contained in the manual are sparse.

Table 1 lists the top ten CPT codes billed to Medicare by podiatrists in 2000 listed in order of frequency. This information is supplied courtesy of the American Podiatric Medical Association. Since these ten codes represent 64% of all codes billed by DPM's to Medicare, it follows that knowing the rules for these codes brings you two thirds of the way towards perfection. Seven of the services are surgical procedures and three are Evaluation and Management (E/M) services.

Table 1

Top 10 CPT Code By Frequency Billed To Medicare in 2000

1
11721
6
11719
2
99212
7
11056
3
99213
8

11730  
4  
11720  
9  
99202  
5  
11040  
10  
G0127

#### General Guidelines

1. Each page of the medical record must contain the patient's name and date of service.
2. The note must be legible. If your nurse cannot read your handwriting, you must buy a computerized charting program or utilize a dictation service.
3. Each day of service should be self-contained and support a medically necessary service.
4. If the service is an E/M service, the code level chosen must meet the guidelines of Center for Medicare/Medicaid Services (CMS) /American Medical Association (AMA) Guidelines for 1995 or 1997.
5. If the service is a procedure, and the procedure has a Medicare local medical review policy (LMRP), it must follow the guidelines in place at the time the service was performed. If the procedure is for a non-Medicare patient or there is no LMRP or third party payer policy for the procedure, the documentation must follow the standards set by peers in the community.

#### LMRP's

It follows that a prudent physician would either commit to memory or have available for ready reference the key points contained in local medical review policy (LMRP) for the services that are billed in the practice. LMRP's are published on the internet on each Medicare Carrier's web site and also published in written bulletins mailed to every physician at the address listed for receipt of their payments.

#### Top-Ranked Codes 1 and 4: CPT 11720 and 11721

These two codes are discussed together for obvious reasons. Requirements differ only by the number of nails treated (less than five for 11720 and six or more for 11721). Documentation requirements are variable for these codes and are based on the LMRP's maintained by each Medicare carrier. These codes are under severe scrutiny and the OIG recommends Focused Medical Reviews be conducted by carriers in the coming year. Using the SOAP format for all documentation is prudent, but not required.

#### Subjective

1. Describe the office or specific location in which the patient is being examined and treated.
2. Document any symptoms the patient may be experiencing or may have been experiencing. Some Medicare carriers require all patients billed with 11720 or

11721 to "experience pain that markedly limits ambulation" while other carriers require simply pain, and others require that no painful symptoms be documented - if the patient has a systemic disease that is severe enough it puts the patient " at risk."

3. Many states that require pain be present for eligible nail debridement also require that the specific nails, which are causing the patient pain, be documented.

4. There are no clear guidelines on documenting pain for patients who are unable to communicate verbally. A prudent physician would document any physical actions the patient demonstrates upon palpation of his/her nails.

#### Objective

1. Some states require clinical evidence of mycosis to be present, while others simply consider onychia or the thickening of a nail as eligibility for the nail debridement codes. It is required in most jurisdictions to describe the clinical appearance of at least one nail for 11720 and at least six nails for 11721. Some states have specific clinical descriptors that must be used to be eligible. Review your local medical review policy. Common clinical descriptors for onychomycosis include onycholysis, dystrophy, yellow white discoloration, odor, subungual debris. The use of the word "thickness" seems to be critical in many jurisdictions, as some carriers define nail debridement as being the "reduction of thickness or girth of a nail."

2. Some carriers allow debridement codes to be used in the absence of pain - if the patient suffers from a systemic disease that appears on a carrier's specific list - with other supporting information. If the diagnosis on the list carries an asterisk, most states require documentation that the patient is under the active care of an MD or DO. Active care is usually defined as seeing an MD or DO in the six months prior to treatment, but there are some exceptions. In most states, the diagnosis of vascular insufficiency (a diagnosis without an asterisk) may be made by a DPM, and in a few other states it requires an MD or DO. Usually the vascular insufficiency diagnoses do not require that the patient be under the active care of an MD or DO. In these cases, the treating DPM is considered the "referring doctor" for the purposes of claim submission.

3. In most cases, the systemic disease not only has to appear on the carrier's list, but also may have to be considered "severe enough." The severity is presumed when the patient meets "class-findings", which are generally elements of the vascular exam. If class findings are required for a patient, they should be documented and updated "periodically."

4. In about one half of the states, diabetes is covered without class findings and hence considered a "stand-alone" diagnosis. This means the patient does not have to meet class-findings, but does have to be under the active care of an MD or DO for diabetes and have documented in the medical record the loss of protective sensation or LOPS.

5. Lastly, there are some states that allow for nail debridement in the presence of a secondary infection resulting from a thickening of the nail plate, without requiring pain or a systemic disease.

\*If it is not obvious, you must be certain of all the requirements for nail debridement to be covered in your state .....

## Assessment

This would include onychomycosis or onychia (where eligible) and either pain that limits ambulation (if present and a qualifier) or a systemic disease on the list of the carrier (if a qualifier) or a secondary infection (again if considered a qualifier)

## Plan

This should be specific to the patient, the exam and the day of service - i.e., "debridement of nails 123 left and 13 right to patient's tolerance was performed." If any topical medication or oral therapy is prescribed, it should be documented.

One note: some states do not allow 11720 or 11721 for nail debridement in the absence of pain but do allow the use of G0127 (trimming of dystrophic nails) for mycotic nails that are debrided in the absence of pain but with systemic disease that puts a patient at risk.

Top Ranked Codes 2,3 and 9:CPT 99202, 99212, and 99213 - The E/M Codes

\* The SOAP (subjective, objective, assessment, and plan) format is the most commonly used method for these notes.

\* Every E/M code is calculated based on the extent of the key components that are documented (history, exam, and decision making) or the time of counseling/ coordinating care. For the purposes of the following discussion the time of counseling or coordinating care is not being considered in determining the level of CPT code.

\* All E/M visits for established patients in an office or other outpatient setting require that two of three of the key components meet or exceed the level of code which is chosen. Therefore, for example, if the level of history (problem- focused, expanded-problem focused, detailed, or complete) and level of decision-making (straightforward, low, moderate or high complexity) meet the level of code that is chosen, the level of exam component does not need to be considered.

\* All E/M encounters for new patients in an office or other outpatient setting require that three of three key components meet or exceed the level of CPT code which is chosen.

\* A CPT 99212 requires at least two of the following three be met: a problem-focused history, a problem-focused exam, and straightforward decision-making.

\* A CPT 99213 requires at least two of the following three be met: an expanded problem-focused history, an expanded problem-focused exam, and low-level decision-making

\* A CPT 99202 requires at least three of three of the following be met: an expanded problem-focused history, an expanded problem-focused exam, and straightforward decision-making.

## Subjective

The chief complaint:

All E/M codes above a 99211, which are coded using the history as a key component, require a chief complaint.

In what place of service is the patient being examined? This is important if one is billing for an E/M code because coding billing is based on the place of service (hospital, office, home, nursing home, assisted living, etc.)

Why is the patient being examined and managed? Is it for pain in the foot, a skin rash, diabetic foot care, etc? It is very surprising how often the reason a patient is being treated is not apparent in the medical record.

Is this a new patient or follow up? It is also surprising how many physicians do not document that the patient is "new" to their practice.

If this is an established patient encounter, is the visit "physician - directed" or is it patient-initiated? This is very important when one considers billing for both a procedure and an E/M visit at the same patient encounter. The medical necessity is often more apparent on follow up visits that are patient-initiated rather than those that are physician-directed.

Is the patient being seen in consultation from a physician or other appropriate source or is s/he simply self-referred to the office?

Example: Patient seen in XYZ nursing home for recommended diabetic foot care.

Example: Patient is seen in office as a new patient on consultation from Dr. Smith for evaluation of heel pain.

The history of present illness (HPI):

This is basically the NLDLOCAT (nature, location, duration, onset, course, aggravated by, past treatments). The intensity of history (problem-focused vs. detailed), in part, depend on whether 1-3 elements or 4 or more elements were documented in the HPI.

In the office setting, when using the history as one of the three key components, a 99212 and 99213 require that just one item be documented in the HPI! For new patient visits, a CPT 99201 and 99202 require only one item of the HPI, while a 99203 or higher-level visit require that four or more elements of the HPI be documented.

For a 99202, or 99212 or 99213 if using the history as a key component:

Example: Patient is 50% improved since last visit.

Example: Post static dyskinesia lasts 10 min. in the morning.

Example: Pain, right plantar heel.

Example: Pain, right hallux nail.

Review of Systems:

Recall that the review of systems is defined as an "inventory of body systems obtained through a series of questions seeking to identify signs and or/symptoms which the patient may be experiencing or has experienced." It may be related to the chief complaint or management options. The ROS may be completed

by the patient or staff member as long as it is reviewed and countersigned. Any positives and pertinent negatives should be documented according to the CMS/AMA Guidelines.

The following are the recognized systems:

- \* Constitutional symptoms (fever, weight loss)
- \* Eyes
- \* Ears, Nose, Mouth, and Throat
- \* Cardiovascular
- \* Respiratory
- \* Gastrointestinal
- \* Genitourinary
- \* Musculoskeletal
- \* Integumentary (skin or breast)
- \* Neurological
- \* Psychiatric
- \* Endocrine
- \* Hematologic/Lymphatic
- \* Allergic/Immunologic

One system always needs to be reviewed for 99202, and if the history is considered a key component, 99213 also requires one system to be reviewed. Even when the history is considered a key component, 99212 does not require a review of systems.

The systems which are most commonly reviewed, depending on the nature of the podiatric complaint or treatment plan, are:

- \* Constitutional (anorexia, syncope, fever, weight loss, weakness)
- \* Musculoskeletal (other joint aches or pains, stiffness, weakness, low back pain, knee or hip pain)
- \* Gastrointestinal (constipation, diarrhea, dyspepsia, nausea, vomiting, melena)
- \* Cardiovascular (claudication, night cramps)
- \* Integumentary (xerosis, dryness, rash, scaling)
- \* Neurological (numbness, tingling, paresthesia, hyperesthesia)

EXAM:

Paraphrasing the 1995 E/M Guidelines we find the following:

Problem-focused exam = limited exam of one extremity.  
Expanded problem-focused exam = limited exam of affected extremity and other symptomatic or related extremities.

The 1997 Guidelines define exams as follows:

Problem-focused exam = documentation of 1-5 bulleted items  
Expanded problem-focused exam = documentation of 6-11 bulleted items

A few key points:

- \* Either 1995 or 1997 criteria can be used, whichever benefits the physician.
- \* Upon examining a patient with a single complaint involving an established problem that is resolving as expected which encompasses only one extremity ( i.e., left heel pain, paronychia, right hallux), a problem-focused exam is all

that is usually medically necessary. For example, a patient whose only concern is heel pain requires little more physical exam than palpation of the medial tubercle at the first follow-up visit, provided he or she is improving.

Assessment: document each complaint as being better, stable, or worse.

Plan:

Decision-making for these three common codes (CPT 99212, 99213, or 99202) is either straightforward or low-level. There is no level of decision-making that is lower than straightforward and therefore, it has no requirements. A 99202 is automatic, as long as the history and exam are at least expanded problem-focused. A 99212 is also automatic, as long as there is either a chief complaint, and one item of the HPI or one item examined. The most common scenario for a 99213, assuming there is only one complaint (the exam is problem focused), is with low-level decision-making and an expanded problem-focused history. So what is the difference between straightforward and low-level decision-making?

Decision-Making

The level of decision-making is determined by the highest level of two of three of the following components.

1. The number of diagnosis or treatment options, which may be either minimal, limited, moderate, or extensive.
2. The quantity of data and medical records reviewed, which may be minimal, limited, moderate, or extensive.
3. The level of risk associated with a problem, diagnostic procedure, or management option, which may be minimal, low, moderate or high-risk.

To calculate the level of decision-making, one drops the lowest of the above three items. (This is a two-of-three matrix just like established patient visits and the key components). There are accepted tables for each of these three components which may be found in my E/M Coding Book and in other sources.

To reach low-level decision-making with one established problem that is stable or improved one must do the following:

- \* Order and review a radiology report or
- \* Review an actual radiology film or
- \* Order blood work and a radiology test or
- \* Review a radiology or lab report and discuss the report with the physician that actually performed the study or
- \* Discuss the case with another healthcare provider

AND

- \* Recommend an OTC drug or prescribe an Rx medication or
- \* Perform minor surgery on a patient with or without risk factors or
- \* Perform physical therapy or
- \* Treat a closed fracture with or without manipulation.

To reach low-level decision making with one established problem that is getting worse one must do one of the following:

- \* Order and review a radiology report or
- \* Review an actual radiology film or
- \* Order blood work and a radiology test or
- \* Review a radiology or lab report and discuss the report with the physician that actually performed the study or
- \* Discuss the case with another healthcare provider
- \* Recommend an OTC drug or prescribe an Rx medication or
- \* Perform minor surgery on a patient with or without risk factors or
- \* Perform physical therapy or
- \* Treat a closed fracture with or without manipulation.

Here are some low-level decision-making examples:

- \* Patient with two or more concurrent problems that are being treated (regardless of whether they are stable, worse, or improved) that has minor surgery performed.
- \* Patient with heel pain and ingrown nail problems, who has a nail avulsion performed.
- \* Patient with two or more concurrent problems that are being treated (regardless of whether they are stable, worse, or improved) that has blood work ordered or reviewed and also has a radiological test ordered or reviewed.
- \* Patient with ingrown nail and heel pain that has x-rays ordered and blood work reviewed.
- \* Patient with one problem that is worsening and has minor surgery performed.
- \* Heel pain that is worse and is either strapped or injected.
- \* Patient with one problem that is worsening and is using an OTC drug.
- \* Heel pain is worse and Advil recommended.

Other important points to be included in the plan:

1. What exactly was performed today? Complete avulsion medial border, left hallux nail, under 3 cc, 2 % Xylocaine plain, using freer 62 blade, and stat. Cleanse and dress with Betadine solution and DSD.
2. Why was this procedure done? If the reasons are clear - no further explanation is needed (such as a nail avulsion of tibial right hallux nail because under the exam, an infected tibial right hallux nail border was clearly described.)
3. What was not done? Such as: treatments (po antibiotics) or cultures were considered, but not indicated - provided this condition does not resolve, will institute same at next visit.
4. What is the plan for the future? May need P and A if recurs.
5. What was the patient told regarding his/her current condition and what is his/her home care? Written and oral instruction provided, including dilute Betadine soaks and topical Betadine.



6. When are they to come back? 3 days, 1 week, PRN.

CPT 11040

Some states have LMRP's for the use of the code, while others do not. This code is explicitly allowed by some Medicare carriers for the debridement of painful tylomas and helomas, but explicitly disallowed for this purpose by still others. CPT 11040 must be documented as debridement that is performed "partial thickness." That means the debridement must occur through the level of the stratum corneum, the outermost layer of epidermis. Once debridement is fully through the epidermis and into portions of the dermis, CPT 11041 (skin, full-thickness) is appropriate. In my opinion, and also of an administrative law judge in New Jersey, in circumstances where dermatological lesions need to be enucleated, and are clearly not in the realm of patient care, such as pre-ulcerative lesions and painful intractable plantar keratoses, these codes may be used. For patients with chronic conditions requiring this service, I recommend the use of photographs to be left in the chart at the outset of treatment to demonstrate the nature and severity of the pathology. These would be very helpful in the event of an audit.

A Typical Note

S: Patient presents c/c severe pain under first met left foot x 3 weeks duration. Reports cannot walk without pain.

O: Exam reveals a deep lesion under first head, left foot, approx. 3-4 mm, which is approx. 6 mm in diameter with bleeding under it and severe pain on exam.

A: Grade 0 ulcer, left foot

P: Using ethyl chloride the lesion is enucleated with a 64 blade through the stratum corneum. Areas of bleeding cauterized with silver nitrate and the lesion dressed with Bacitracin and U pad. Leave on three days. PRN pain.

Next month we will continue with the next five most commonly billed CPT codes.

Disclaimer:

The opinions and facts contained herein are not the official position of any organization including, but not limited to, the American College of Podiatric Medical Review, the American Podiatric Medical Association, the New Jersey Podiatric Medical Society, or Podiatry Management magazine. Coding and documentation rules are not simply black and white, and are subject to many interpretations. The various Medicare carriers differ in their medical policies for coding and documentation of the identical patient encounter. Unfortunately, there are many private insurers that maintain unique coding and documentation requirements that are in conflict with the AMA CPT Manual. The reader is urged to contact his or her local insurance carrier to discuss any statements made in this article considered controversial. In cases where variability exists, the physician must conform to the rules promulgated by the local carrier.