



The Health Care Financing Administration's new examination documentation criteria: Minimum auditing standards for the neurologic examination to be used by Medicare and other payors

Report from the American Academy of Neurology Medical Economics and Management Subcommittee

Marc R. Nuwer, MD, PhD, and Bruce Sigsbee, MD

Article abstract—Medicare recently announced the adoption of *minimum* documentation criteria for the neurologic examination. These criteria are added to existing standards for the history and medical decision-making. These criteria will be used in compliance audits by Medicare and other payors. Given the current federal initiative to eliminate fraud in the Medicare program, all neurologists need to comply with these standards. These criteria are for documentation only. Neurologic standards of care require a more complex and diverse examination pertinent to the problem(s) under consideration. Further guidance as to the content of a neurologic evaluation is outlined in the article "Practice guidelines: Neurologic evaluation" (*Neurology* 1990;40:871). The level of history and examination required for specific services is defined in the American Medical Association current procedural terminology book. Documentation standards for examination of children are not yet defined.

The Current Procedural Terminology (CPT) Editorial Panel of the American Medical Association (AMA) and the Health Care Financing Administration (HCFA) recently published definitions for 10 single system examinations (SSEs). Each of these examinations fulfills the physical examination requirements of CPT evaluation and management (E&M) procedure coding. Requirements for the new neurologic SSEs (Neuro-SSEs) are set forth here. Beginning July 1, 1998, these definitions will be used by compliance auditors to determine the level of examination services for E&M procedures. The criteria are for

documentation purposes only. The standards of neurologic practice, such as those outlined in the guideline for the neurologic evaluation of the American Academy of Neurology (AAN),¹ require an examination that characterizes the problem(s) under consideration and as such may or may not meet the documentation standards.

In 1991, the AMA developed new CPT codes for E&M services in an attempt to define more rigorously the different levels of these services. The E&M codes were based on specific levels of the history, examination, and decision-making. The HCFdA

See also page 326

From the UCLA Department of Neurology (Dr. Nuwer), Los Angeles, CA, and Physicians of Cape Cod (Dr. Sigsbee), Hyannis, MA.

Received September 25, 1997. Accepted in final form October 6, 1997.

Address correspondence and reprint requests to Dr. Marc R. Nuwer, UCLA, Clinical Neurophysiology, Reed Neurological Research Center, 710 Westwood Plaza, Room 1-194, Los Angeles, CA 90024-6987.

adopted the new codes and their accompanying definitions as the basis for Medicare physician services effective January 1, 1992. The HCFA in cooperation with the AMA and national specialty societies worked toward documentation criteria for these E&M services. The documentation criteria were intended to establish that sufficient work was performed to justify the level of coding. These criteria are intended to be used for the adult neurologic examination. No criteria are defined for children for whom an adult-type examination cannot be performed.

The HCFA had been given a legislative mandate to also develop criteria for SSEs, such as a neurologic examination, that were the work-equivalent of a general multi-system medical examination. The new SSE documentation standards resulting from this process attempt to balance the amount of physician work done in physical examinations across the various organ systems and specialties. Physicians representing multiple specialties, not just neurology, developed the criteria for the Neuro-SSE as well as all other SSEs. Some flexibility in examination elements was sacrificed to achieve both a reasonable simplicity and a similar outline or approach across different specialty examinations.

The AAN intervened on behalf of the specialty throughout this process. Without this involvement, the Neuro-SSE would have required examination of the abdomen, the entire skin, the thyroid gland, and cranial nerve one (smell) in every comprehensive examination. The AAN strove to maintain an emphasis on the elements that are typically part of a comprehensive neurologic examination. Acceptance by the HCFA, however, was contingent upon inclusion of a few elements that may not reflect neurologic practice or the type of examination as alluded to in the AAN's guideline.¹

The outcome was a set of documentation criteria that generally reflects neurologic practice. However, a competent neurologist evaluating a complex patient generally would have omitted some of the examination elements in this required documentation. That same neurologist typically would have included many observations not required by the documentation criteria. Compliance does not require extensive additional work, just the knowledge and the inclusion of the requirements.

The federal government is in the midst of a major Medicare anti-fraud campaign. One of the factors identified as a source of the imputed billions of dollars of fraud and abuse is coding of services without proper documentation (with the assumption that the coding was too high, not that the documentation did not adequately reflect the service actually performed). The Health Insurance Portability and Accountability Act of 1996 established onerous penalties for medical fraud and abuse, which could include a failure to meet the new documentation guidelines. In the past, competent neurologists may have reasonably excluded some of the elements

listed in the Neuro-SSE in their examination of many very complex patients. The Neuro-SSE criteria will be used by chart auditors from the medical fraud and abuse unit of the HCFA and the Department of Justice (FBI). Neurologists must now ensure that they provide documentation for these additional elements or face the risk of penalties. Academic institutions are presently under scrutiny. All neurologists will be at risk.

The number of E&M services provided by neurologists is extensive. The reader is referred to the AMA's CPT book² for the necessary levels of history and examination required for specific services. The list is too long to duplicate here. For level 4 and 5 consults, the bulk of neurologic work, both a complex history and complex examination are required.

The neurologic single system examination.

The elements of the Neuro-SSE are set forth in table 1. The examination is divided into 25 elements identified by bullets (●). For a comprehensive examination, all elements must be documented, except cardiovascular elements, for which only 1 of 3 needs to be documented. The cranial nerves serve as an example. Each cranial nerve except the first and tenth must be documented by at least one observation. The parentheses following each cranial nerve provide some examples of observations that meet HCFA guidelines. The list is not exclusive. Many techniques exist for characterizing neurologic function. The SSE criteria do not establish which techniques or maneuvers are qualifying. For the third, fourth, and sixth cranial nerves, a note about either pupils or eye movements qualify. For cranial nerve VII, the force of eyelid closure might qualify, although the observation is not specifically listed. The organization or sequence of the documentation is not specified, and the items do not have to be specifically labeled. One does not have to list the individual cranial nerves even though appropriate observations need to be written.

A brief statement or notation of "negative" or "normal" is sufficient to document normal findings in unaffected elements in the examination. But the brief statement "abnormal" is usually not sufficient, as abnormalities need to be described. Bulleted items cannot be grouped. It is *not* sufficient to state "Cranial nerves are normal."

All 23 required elements must be documented for every comprehensive Neuro-SSE (two of the three cardiovascular elements may be left undocumented). For elements with multiple components such as "examination of gait and station," each component of the element needs to be examined or performed even though only one component needs be documented. There are 37 Neuro-SSE examination components (to be performed) among the 23 elements (to be documented).

Documentation requirements for the problem focused, expanded problem focused, detailed, and comprehensive examinations are set forth in table 2.

Table 1 Neurologic single system examinationConstitutional

- Measurement of **any three of the following seven** vital signs: (1) sitting or standing blood pressure, (2) supine blood pressure, (3) pulse rate and regularity, (4) respiration, (5) temperature, (6) height, (7) weight (may be measured and recorded by ancillary staff)
- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Eyes

- Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) *and* posterior segments (e.g., vessel changes, exudates, hemorrhages)

Cardiovascular (Documentation of only one of the following three elements is required for a comprehensive examination.)

- Examination of carotid arteries (e.g., pulse amplitude, bruits)
- Auscultation of heart with notation of abnormal sounds and murmurs
- Examination of peripheral vascular system by observation (e.g., swelling, varicosities) *and* palpation (e.g., pulses, temperature, edema, tenderness)

Musculoskeletal

- Examination of gait *and* station

Assessment of motor function including:

- Muscle strength in upper *and* lower extremities
- Muscle tone in upper *and* lower extremities (e.g., flaccid, cog-wheel, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation, tardive dyskinesia)

Neurologic

Evaluation of higher integrative functions, including:

- Orientation to time, place, *and* person
- Recent *and* remote memory
- Attention span *and* concentration
- Language (e.g., naming objects, repeating phrases, spontaneous speech)
- Fund of knowledge (e.g., awareness of current events, past history, vocabulary)

Test the following cranial nerves:

- Second cranial nerve (e.g., visual acuity, visual fields, fundi)
- Third, fourth, *and* sixth cranial nerves (e.g., pupils, eye movements)
- Fifth cranial nerve (e.g., facial sensation, corneal reflexes)
- Seventh cranial nerve (e.g., facial symmetry, strength)
- Eighth cranial nerve (e.g., hearing with tuning fork, whispered voice, *and/or* finger rub)
- Ninth cranial nerve (e.g., spontaneous or reflex palate movement)
- Eleventh cranial nerve (e.g., shoulder shrug strength)
- Twelfth cranial nerve (e.g., tongue protrusion)

Test sensation, reflexes and coordination:

- Examination of sensation (e.g., by touch, pin, vibration, proprioception)
- Examination of deep tendon reflexes in upper *and* lower extremities with notation of pathologic reflexes (e.g., Babinski)
- Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

Note: Each *element* of the examination is noted above by a bullet (•). The word “*and*” is used for elements that include more than one examination component.

Again, these are the required minimum numbers of elements for audit purposes; many individual patients should receive evaluation of more signs or others not listed here.

There is a renewed interest in expecting legibility of entries. Auditors have been instructed to disallow illegible entries. Furthermore, a list of approved abbreviations exists at most institutions. Auditors may disallow abbreviations not on those lists.

SSEs have been adopted for other single organ systems also, including cardiovascular, ENT, eye, genitourinary, hematologic-lymphatic-immunologic, musculoskeletal, psychiatric, respiratory, and skin. The elements for each have been published in the

Table 2 Content and documentation requirements

Level of examination	Perform and document
Problem focused	1 to 5 elements identified by a bullet.
Expanded problem focused	At least 6 elements identified by a bullet.
Detailed	At least 12 elements identified by a bullet.
Comprehensive	Perform and document all elements identified by a bullet, except for the 3 cardiovascular elements. All 3 cardiovascular elements must be performed, but only 1 element need be documented.

Table 3 Example of minimal documentation for a comprehensive neurologic single system examination

This examination is for an adult patient with no abnormal physical findings. The notes here are deliberately limited to provide an example of what might constitute a *minimal* satisfactory documentation. Neurologic standard of care typically requires a much more complex examination.

Healthy male.

VS: 120/85, HR 72, RR 16

HEENT: Fundi ok, no carotid bruit.

MS: Awake, oriented, attentive; speech, knowledge, recent and remote memory, concentration normal.

CN: Visual fields and EOMs full; facial sensation and power normal; hears normally; palate/tongue midline; sternocleidomastoid normal.

Sense: Normal pin all four extremities.

Motor: Normal power/tone/DTRs × four extremities; toes down; finger to nose, gait normal.

AMA's *CPT Assistant* and are available on the HCFA's web site or through the AAN. Revised documentation requirements for the general multi-system examination are also published. Any physician may choose to use any of these examinations for any patient. For example, a neurologist might choose to use the musculoskeletal SSE or the general multi-system examination for certain patients. Likewise, physicians in any specialty might use the Neuro-SSE for certain patients presenting with neurologic problems.

Table 3 presents an example that we believe meets the comprehensive Neuro-SSE minimum documentation standards. Note how some signs are not necessarily included. For example, only one of the three cardiovascular elements (bruit) is mentioned. The sensory examination is documented for only one test modality, fewer than the usual neurologic examination community standards. Elements with two components examined (e.g., gait *and* station) only need documentation for one of those components.

Compliance and education. A recent audit of a private practice in which the members were aware of these criteria determined that approximately three-quarters of the consults did not have all the required documentation criteria to satisfy a comprehensive examination (Bruce Sigsbee, MD, personal communi-

cation). Neurology departments and practices will need to establish a formal compliance program to avoid potential fraud and abuse penalties. That program can take many forms. One method is to develop a macro for the word processing software that prompts for all of the required elements. A second would be to perform periodic compliance audits. A third program would be to develop a hand-held laminated card as a reminder for the elements and an aid while writing or dictating a report. Academic departments may need to consider several approaches because they are potentially at greatest risk. Simple education as to the required elements is necessary but not sufficient to assure compliance.

Summary. Minimum documentation criteria are now established for the Neuro-SSE. These criteria compliment already established criteria for the history and medical decision-making components of E&M services. The HCFA, and likely other third-party payors, will use these criteria to audit charts and establish compliance with reimbursement policies. Given the escalating interest in Medicare and Medicaid fraud, the number and scope of audits will increase.

The criteria are not ideal. Although more reasonable than initially proposed, the required elements do not necessarily reflect standard neurologic practice or the AAN's recommendations for a neurologic evaluation.¹ Neurologists who do a competent evaluation in a complex patient often do not fully include all the required elements of documentation. Furthermore, these criteria represent the *minimal* documentation criteria and are not intended to reflect the only requirements of neurologic practice.

It is strongly suggested that some formal method of assuring compliance with these criteria be adopted. Techniques such as a macro in the word processing software, periodic audits, or even reminder cards that are carried by the physician can, and should, be implemented.

References

1. Quality Standards Subcommittee of the American Academy of Neurology. Practice guidelines: neurologic evaluation. *Neurology* 1990;40:871.
2. American Medical Association. Physicians' Current Procedural Terminology: CPT '98. Chicago, IL: American Medical Association, 1998.