Evaluation and Management Coding Basics

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Why Should I Learn This Stuff?

- If you have anything to do with providing services which are billed to a payer, documentation, coding, or billing, you have a responsibility to understand the rules.

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Office of Inspector General on FRAUD

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* * * * * * * *

Should know or should have known means that a person, with respect to information—

1. Acts in deliberate ignorance of the truth or falsity of the information; or
2. Acts in reckless disregard of the truth or falsity of the information. For purposes of this definition, no proof of specific intent to defraud is required.

* * * * * * * *
E & M – *Office* Visits
New Vs Established

**E&M CODE DECISION TREE**

- **RECEIVED PROFESSIONAL FACE-TO-FACE MEDICAL CARE FROM PHYSICIAN WITHIN LAST 3 YEARS**
  - **YES**
    - EXACT SAME SPECIALTY?
      - **YES**
        - ESTABLISHED PATIENT (99211-99215, 99391-99397)
      - **NO**
        - NEW PATIENT (99201-99205, 99381-99387)
  - **NO**
    - NEW PATIENT (99201-99215, 99381-99387)
Auditing E & M

- CPT guidelines
  - KEY components in selecting the level of service
    1. History
    2. Examination
    3. Medical Decision-making

- Also consider....
  - **TIME** - Counseling and coordination of care
Time Based Coding

- Often the best choice when dealing with cancer patients & treatment decisions
- From the CMS E&M Scoresheet:

<table>
<thead>
<tr>
<th>4. Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the physician documents total time <em>and</em> suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does documentation reveal total time?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time: Face-to-face in outpatient setting Unit/floor in inpatient setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does documentation describe the content of counseling or coordinating care?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does documentation reveal that more than half of the time was counseling or coordinating care?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If all answers are "yes", select level based on time.
A patient presents for an office visit after preliminary work-up. The physician sees the patient in his office and discusses the treatment options and subsequent lifestyle effects of the treatment for 40 minutes. The physician did not complete a history or physical exam.

What level of service can the physician bill?

1. Level 1 – 99211
2. Level 3 – 99213
3. Level 4 – 99214
4. Level 5 – 99215
5. The physician cannot bill for this service
<table>
<thead>
<tr>
<th>New Patient Visit Time</th>
<th>Established Patient Visit Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>99211</td>
</tr>
<tr>
<td>10 minutes</td>
<td>5 minutes</td>
</tr>
<tr>
<td>99202</td>
<td>99212</td>
</tr>
<tr>
<td>20 minutes</td>
<td>10 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>99213</td>
</tr>
<tr>
<td>30 minutes</td>
<td>15 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>99214</td>
</tr>
<tr>
<td>45 minutes</td>
<td>25 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>99215</td>
</tr>
<tr>
<td>60 minutes</td>
<td>40 minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Hospital Care Time</th>
<th>Subsequent Hospital Care Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>99231</td>
</tr>
<tr>
<td>30 minutes</td>
<td>15 minutes</td>
</tr>
<tr>
<td>99222</td>
<td>99232</td>
</tr>
<tr>
<td>50 minutes</td>
<td>25 minutes</td>
</tr>
<tr>
<td>99223</td>
<td>99233</td>
</tr>
<tr>
<td>70 minutes</td>
<td>35 minutes</td>
</tr>
</tbody>
</table>
Billing using time…..

Physician is face to face with an established patient in the office for 35 minutes, counseling and coordinating care. Which code would you bill?

1. 99214 (25 min)
2. 99215 (40 min)
3. Beats the heck out of me!
E & M - Basics

- Billing using time.....

- CPT Assistant, August 2004 / Volume 14, Issue 8, page 3
  - "In selecting time, the physician must have spent a time closest to the code selected.
  - For example, 99214 has a typical time of 25 minutes and 99213 has a typical time of 15 minutes. If the face-to-face office time is 21 minutes, code 99214 would be selected as it is more than half of the time difference."

CPT and CPT Assistant available on the AMA site: www.ama-assn.org
Billing using time...

- What % of time must the counseling and coordination of care dominate?
  1. At least 50%
  2. More than 50%
  3. 75%
  4. 100%
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Billing using time....

In the office setting, which component below cannot be included when determining time?

1. Time spent face to face with the patient counseling the patient
2. Time spent examining the patient
3. Time spent answering questions from the patient’s family with the patient in the same room
4. Time spent after the visit coordinating care with another physician
5. None of the above
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Billing using time...

- In the hospital setting, which component below cannot be included when determining time?
  1. Time down the hall from the patient’s room communicating with the patient’s family
  2. Time spent in pathology department, different floor, reviewing patient’s findings
  3. Time at the bedside discussing test results
  4. Time at the bedside reviewing chart
  5. Time at the nurses’ station (same floor) ordering additional tests
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Billing based on time –
- Documentation required components
  - Total face to face/floor time
  - More than 50% spent counseling and coordinating care
  - Summary counseling topics and/or how time was spent coordinating the patient’s care

If the components of time are documented, it will “trump” other documentation and will be used to determine the level.
E & M - Basics

If a physician has established the code based on time but spends a long time with the patient, medically necessary, can you also consider billing the prolonged add-on code?

1. Yes
2. No
## E & M - Basics

### Prolonged Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time for Code</th>
<th>Threshold Time to Bill Code 99354</th>
<th>Threshold Time to Bill Codes 99354 and 99355</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>10</td>
<td>40</td>
<td>85</td>
</tr>
<tr>
<td>99213</td>
<td>15</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td>99214</td>
<td>25</td>
<td>55</td>
<td>100</td>
</tr>
<tr>
<td>99215</td>
<td>40</td>
<td>70</td>
<td>115</td>
</tr>
</tbody>
</table>
Prolonged Services
- Physician spends 60 minutes with a patient counseling and coordinating care;
- Which would you bill?
  1. 99214 (25) plus 99354 (>30)
  2. 99215 (40) plus 99354 (>30)
  3. 99215 (40) alone
  4. None of the above
**H. Prolonged Services Associated With Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based)**

- “When an evaluation and management service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the evaluation and management code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the evaluation and management code) and should not be “rounded” to the next higher level.”

- “In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.”

Prolonged Services -

What is the approximate Medicare reimbursement for the 99354 prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour

1. $25.00
2. $55.00
3. $95.00
4. $100.00
Prolonged Services

What is the approximate reimbursement for the 99355 prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; Additional 30 minutes

1. $25.00
2. $55.00
3. $98.00
4. $115.00
The Basics.....

**All E & M visits must have “Chief Complaint” (CC)**

“A chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient’s words.

- **WATCH OUT**: Patient is here for chemo.
- **WATCH OUT**: Medical Necessity

3 KEY components

- History
- Examination
- Medical Decision making

New or Initial = 3 Key Components
Established or Subsequent = 2 of 3 Key Components
E & M - Basics

- Documentation should show....
  - Reason for the encounter (chief complaint)
  - Relevant history
  - Physical exam and findings
  - Assessment
  - Clinical impression/diagnosis
  - Plan for care
  - Date & the legible signature of the provider
E & M Basics

- **History of Present Illness**
  - HPI is a chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present. HPI elements are:
    - Location (example: left leg);
    - Quality (example: aching, burning, radiating pain);
    - Severity (example: 10 on a scale of 1 to 10);
    - Duration (example: started three days ago);
    - Timing (example: constant or comes and goes);
    - Context (example: lifted large object at work);
    - Modifying factors (example: better when heat is applied); and
    - Associated signs and symptoms (example: numbness in toes).

- **Brief (1-3)  *Extended (4 or more)**
Review of Systems

ROS is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced. The following systems are recognized for ROS purposes:

- Constitutional Symptoms (e.g., fever, weight loss);
- Eyes;
- Ears, Nose, Mouth, Throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Integumentary (skin and/or breast);
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic; and
- Allergic/Immunologic.

Pertinent (1 system)
Extended (2-9 systems)
Complete (> 9 or all others neg)

“all other systems NEGATIVE” = extended
E & M Basics

- **Past, Family, and/or Social History**
  - PFSH consists of a review of three areas:
    - Past history including experiences with illnesses, operations, injuries, and treatments;
    - Family history including a review of medical events, diseases, and hereditary conditions that may place the patient at risk; and
    - Social history including an age appropriate review of past and current activities.
  - The two types of PFSH are: pertinent (1) and complete.
    - **2** history areas for established = complete
    - **3** history areas for new patient or initial hosp care

Noridian Website: PFSH could up the level of HPI – however to get credit the histories documented need to be pertinent to the date of service and applicable to the medical management of that particular patient on that particular day.
E & M Basics

- Score History
  - If one column Contains 3 circles – drawn line down and choose result
  - If no column with 3 circles – **pick column containing a circle farthest to the left!**

- Problem Focused
- Exp. Problem Focused
- Detailed
- Comprehensive

- The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
E & M Basics

- **Examination**
  - There are two versions of the documentation guidelines – the 1995 version and the 1997 version.
  
  - The most substantial differences between the two versions occur in the examination documentation section.
  
  - Either version of the documentation guidelines, not a combination of the two, may be used by the provider for a patient encounter.
E & M – Basics

- General multi-system -1997
  - Cardiovascular
  - Dermatology
  - Ears, nose and throat
  - Eyes
  - Genitourinary-female

- Genitourinary – male
- Hematologic/ Lymphatic/ Immunologic
- Musculoskeletal
- Neurology
- Psychiatry
- Respiratory

Comprehensive (Level 5): 9 systems/2 elements
Detailed (Level 3): 12 or more elements
Expanded Problem Focused (Level 2): 6-11 elements
Problem Focused (Level 1): 1-5 elements
E & M – Basics

1995 Physical Exam - *Organ Systems*

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic
E & M - Basics

- 1995 General Multi=System Exam*
  - Comprehensive
    - 8 systems
  - Detailed
    - 5-7 systems
  - Expanded Problem Focused
    - 2-4 systems
- Problem Focused
  - 1 system

Count only what is medically necessary
Exam Note:
- Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is not sufficient.

- Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.

- A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

SCORE EXAM......
Medical Decision Makin (MDM)

LEARN IT – UNDERSTAND IT – TEACH IT

NEVER the same

the KEY factor to determining the level of service and medical necessity

Established patient = 2 of 3

not required to use MDM but using it seems to keep the level chosen more accurate

Used to determine medical necessity of the visit

WHAT DID YOU DO FOR THIS PATIENT TODAY?

1. Number of diagnosis OR treatment options
2. Amount and/or complexity of data reviewed (and documented)
3. Risk of Complications and/or Morbidity or Mortality
Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
  - Noridian states – just listing the diagnosis or medications DOES NOT count towards your level of service!

- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed;

- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options.
E & M Basics

For each encounter, an assessment, clinical impression, or diagnosis should be documented which may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation:

- For a presenting problem with an established diagnosis, the record should reflect whether the problem is:
  - Improved, well controlled, resolving, or resolved; or
  - Inadequately controlled, worsening, or failing to change as expected.

- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a “possible,” “probable,” or “rule out” diagnosis.

- The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.

- If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom advice is requested.
Amount and/or Complexity of Data to be Reviewed

- The amount and/or complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. Indications of the amount and/or complexity of data being reviewed include:

  - A decision to obtain and review old medical records and/or obtain history from sources other than the patient (increases the amount and complexity of data to be reviewed);

  - Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test (indicates the complexity of data to be reviewed); and

  - The physician who ordered a test personally reviews the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation (indicates the complexity of data to be reviewed).
DATA Reminders…

- Some important points that should be kept in mind when documenting amount and/or complexity of data to be reviewed include:
  - If a diagnostic service is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service should be documented.
  - The review of laboratory, radiology, and/or other diagnostic tests should be documented. A simple notation such as “WBC elevated” or “Chest x-ray unremarkable” is acceptable. Alternatively, the review may be documented by initialing and dating the report that contains the test results.
  - A decision to obtain old records or obtain additional history from the family, caretaker, or other source to supplement information obtained from the patient should be documented.
  - Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement information obtained from the patient should be documented. If there is no relevant information beyond that already obtained, this fact should be documented. A notation of “Old records reviewed” or “Additional history obtained from family” without elaboration is not sufficient.
  - Discussion about results of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.
  - The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.
The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the following categories:

- Presenting problem(s);
- Diagnostic procedure(s); and
- Possible management options.

The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter.
Risk Reminders….

- Some important points that should be kept in mind when documenting level of risk are:
  - Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented;
  - If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure should be documented;
  - If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented; and
  - The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.
### Medical Decision Making – Let’s Score….

1. Number of Diagnosis or Treatment Options

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved, or worsening)</td>
<td>Max = 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); stable, improved</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); worsening</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max = 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New prob. (to examiner); add workup planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.
E & M

- Medical Decision Making

2. Amount and/or Complexity of Data Reviewed

For each category or reviewed data identified, circle the number in the points column. Total the points.

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
</tbody>
</table>

**TOTAL**
<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>• One self-limited or minor problem, e.g., cold insect bite, tinea corporis</td>
<td>• Laboratory tests requiring venipuncture</td>
<td>• Rest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Chest X-rays</td>
<td>• Gargles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• EKG/ ECG</td>
<td>• Elastic bandages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Urinalysis</td>
<td>• Superficial bandages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ultrasound, e.g., echo</td>
<td>• Superficial dressings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• KOH prep</td>
<td><strong>Low</strong></td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>• Two or more self-limited or minor problems</td>
<td>• Physiologic tests not under stress, e.g., pulmonary function tests</td>
<td>• Over-the-Counter drugs</td>
</tr>
<tr>
<td></td>
<td>• One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH</td>
<td>• Noncardiovascular imaging studies with contrast, e.g., barium enema</td>
<td>• Minor surgery with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>• Superficial needle biopsies</td>
<td>• Physical therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clinical laboratory tests requiring arterial puncture</td>
<td>• Occupational therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Skin biopsies</td>
<td>• IV fluids without additives</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>• One or more chronic illness with mild exacerbation, progression, or side effects of treatment</td>
<td>• Physiologic tests not under stress, e.g., cardiac stress test, fetal contraction stress test</td>
<td>• Minor surgery with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Two or more stable chronic illnesses</td>
<td>• Diagnostic endoscopies with no identified risk factors</td>
<td>• Elective major surgery (open, percutaneous or endoscopic with no identified risk factors)</td>
</tr>
<tr>
<td></td>
<td>• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>• Deep needle or incisional biopsy</td>
<td>• Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis</td>
<td>• Cardiovascular imaging studies with contrast and no identified risk factors, e.g., aortogram cardiac cath</td>
<td>• Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td>• Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>• Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>• IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Closed treatment of fracture or dislocation without manipulation</td>
<td><strong>High</strong></td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>• Cardiovascular imaging studies with contrast with identified risk factors</td>
<td>• Elective major surgery (open, percutaneous or endoscopic with identified risk factors)</td>
</tr>
<tr>
<td></td>
<td>• Acute of chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure</td>
<td>• Cardiac electrophysiological tests</td>
<td>• Emergency major surgery (open, percutaneous or endoscopic)</td>
</tr>
<tr>
<td></td>
<td>• An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss</td>
<td>• Diagnostic endoscopies with identified risk factors</td>
<td>• Parental controlled substances</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discography</td>
<td>• Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
Medical Decision Making – Final Result

**Final Result for Complexity**

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

<table>
<thead>
<tr>
<th>A</th>
<th>Number diagnoses or treatment options</th>
<th>≤1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>≥4 Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minimal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multiple</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extensive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Highest Risk</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Amount and Complexity of Data</td>
<td>≤1 Minimal or Low</td>
<td>2 Limited</td>
<td>3 Multiple</td>
<td>≥4 Extensive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of decision making</td>
<td>STRAIGHT FORWARD</td>
<td>LOW COMPLEX.</td>
<td>MODERATE COMPLEX.</td>
<td>HIGH COMPLEX.</td>
<td></td>
</tr>
</tbody>
</table>
## E & M – Final Results

### 5. Level of Service

**Outpatient, Consults (Outpatient, Inpatient) and ER**

<table>
<thead>
<tr>
<th>Level of Service</th>
<th>New Office/Consults/ER</th>
<th>Established Office</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requires 3 components within shaded area</strong></td>
<td></td>
<td><strong>Requires 2 components within shaded area</strong></td>
</tr>
<tr>
<td>History</td>
<td>PF (ER: PF)</td>
<td>EPF (ER: EPF)</td>
</tr>
<tr>
<td>Examination</td>
<td>PF (ER: PF)</td>
<td>EPF (ER: EPF)</td>
</tr>
<tr>
<td>Average time (minutes) (ER has no average time)</td>
<td>10 New (99201) 15 Outg. cases (99241) 20 Input cases (9925) ER (99283)</td>
<td>20 New (99242) 30 Outg. cases (99243) 40 Input cases (99244) ER (99283)</td>
</tr>
<tr>
<td>Level</td>
<td>I</td>
<td>II</td>
</tr>
</tbody>
</table>

**Inpatient**

<table>
<thead>
<tr>
<th>Initial Hospital/ Observation</th>
<th>Subsequent Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requires 3 components within shaded area</strong></td>
<td><strong>Requires 2 components within shaded area</strong></td>
</tr>
<tr>
<td>History</td>
<td>D/C</td>
</tr>
<tr>
<td>Examination</td>
<td>D/C</td>
</tr>
<tr>
<td>Complexity of medical decision</td>
<td>SF/L</td>
</tr>
<tr>
<td>Average time (minutes) (Observation care has no average time)</td>
<td>30 Init. hosp. (99221) Oberv care (99218)</td>
</tr>
<tr>
<td>Level</td>
<td>I</td>
</tr>
</tbody>
</table>

**Watch Out!**

**Medically Necessary!**

Level 3 or 5?

- **PF = Problem Focused**
- **EPF = Expanded Problem Focused**
- **D = Detailed**
- **C = Comprehensive**
Cloned Notes - CAUTION

- OIG Work Plan Item since 2011
  - (OEI; 0410100181; 0410100182; expected issue date: FY 2012; work in progress)

- “Medicare contractors have noted an increased frequency of medical records with identical documentation across services. We will also review multiple E&M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments.”
Cloned Notes - CAUTION

- Old paradigm: If it’s not documented it wasn’t done
- New: It’s documented…was it done? (OIG Inspector quote)

- Cloning notes: OIG will search for excessive use of copy/paste.
  - OIG acknowledges convenience but is it used in a way that is accurate?
  - OIG looking for identical documentation across services, especially consistent medical decision making notes
  - Similar but different? What makes a note different enough?
  - Current documentation rules are from 1995, but technology has moved forward
Is it ok to clone part of the visit?
1. Yes
2. No
3. Some portions
4. One portion

ONE PORTION
- HPI & ROS – should be from that day
- Past medical history – YES
  - Past medical, social and family history can be carried from previous note
    - The documentation guidelines state the history doesn’t have to be re-documentated, not that the work doesn’t need to be done.
    - May add – “Family history reviewed, unchanged”
    - BUT what if the family history was blank?

- Populating note with information from last visit?
  - Dangerous
  - One mistake and the whole note could be thrown out
    - Others too…..
MODIFIER 25

- Modifier -25 is defined as a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

- In the review of E/M services billed with the -25 modifier, first identify within the medical records the documentation specific to the procedure or service performed on that date of service.

  - Next, consider the additional documentation separate from the documentation specific to the procedure or service to determine:
    - If there is a significant, separately identifiable E/M service that was rendered and documented, and
    - If the required components of the E/M service are supported as "reasonable and necessary" per Social Security Act, Section 1862(a)(1)(A), and
    - What level of care is supported by the documentation?
E & M Basics - MEDICARE

- "Incident To" (bill w/supervising NPI)
  - Midlevel Provider
    - Following the direction of the ordering or supervising physician

- Not "Incident to" (bill w/own NPI)
  - Any component of the visit addressing a problem not known to the ordering/supervising physician, treatment changes (including doses)
Questions??

Contact:
Michelle Weiss
President, Weiss Consulting
Management and Reimbursement Consultant
www.weissconsulting.org
If the physician states same/unchanged from last visit, will he receive credit for reviewing the last visit information?

Credit may be taken only if the physician includes the documentation from the previous visit. Otherwise, the reviewer would not know what was the same or unchanged from the previous visit.
For the Review of Systems, can the physician reference a sheet that he has in the patient's chart where the physician checked off items?

- Yes. However, if medical records are requested, the sheet must be submitted with all of the other documentation for that date of service. Otherwise, no credit can be given for the information on the check-off sheet.
When scoring the review of systems (ROS), can you use the systems addressed in the history of present illness (HPI) elements or is that "double dipping"?

- ROS inquiries are questions concerning the system(s) directly related to the problem(s) identified in the HPI. Therefore, it is not considered "double dipping" to use the system(s) addressed in the HPI for ROS credit.
E & M FAQs

How do we get credit for a test under the Amount and/or Complexity of Data Reviewed section of the evaluation and management (E/M) score sheet?

- Credit is given in this section when the test (clinical lab test, test in the radiology section of the CPT, or test in the medicine section of the CPT) is documented as reviewed and/or ordered, and the service is medically indicated.
E & M FAQs

- If I personally review a film, e.g. x-ray, electrocardiogram (EKG) in my office, will I receive additional credit on the evaluation and management (E/M) score sheet?
  - Yes, two points may be given for independent visualization of an image, tracing or specimen on the E/M score sheet in the Amount and/or Complexity of Data Reviewed section under the Medical Decision Making key component. The medical record documentation must clearly indicate that the physician/qualified NPP personally (independently) visualized and performed the interpretation of the image, tracing or specimen and that he/she did not simply read/review a report from another physician/qualified NPP.
Can the Review of Systems (ROS) and/or Past, Family, Social History (PFSH) sections of the History component of an Evaluation and Management (E/M) be recorded by ancillary staff?

- Yes, according to the 1995 E/M Documentation Guidelines, the ROS and/or PFSH section of the history component of an E/M may be recorded by ancillary staff. There must be a notation supplementing or confirming the information that was recorded by the ancillary staff member by the physician.
E & M FAQs

- Under limited circumstances, could the term “noncontributory” be used as appropriate documentation to support the review of systems (ROS) and family history sections of the history component of an evaluation and management service (E/M)?
  - It is understood that there may be circumstances where the term "noncontributory" may be appropriate documentation when referring to the ROS and/or family history sections of the history component of an E/M service. Under the E&M documentation guidelines, it is noted that, "those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented." The use of the term "noncontributory" may be permissible documentation when referring to the remaining negative review of systems. The term "noncontributory" may also be appropriate documentation when referring to a patient's family history during an E/M visit, if the family history is not pertinent to the presenting problem.
How can we differentiate modifying factors versus associated signs and symptoms?

- A modifying factor is something that is being done to help or alleviate the problem. Associated signs and symptoms are signs and symptoms that are associated or could be related to the presenting problem.
Evaluation and Management Services Guide

More help……CMS 89 page E & M Guide