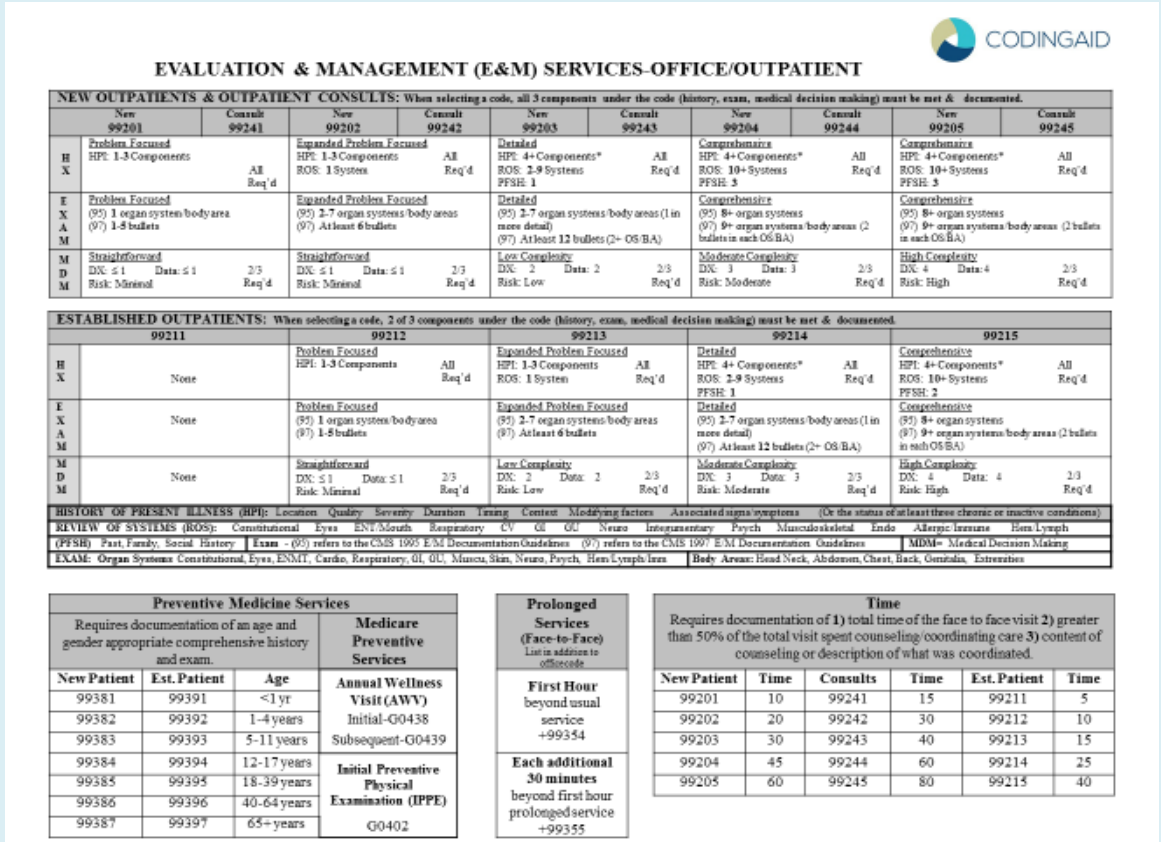
CODINGAID

AAPC CEU APPROVED

The Basics & Beyond

E & M Summit Part I

Presented by, **Lynn Handy**
(CPC, CPC-I, COC, CCS-P, LPN)



CODINGAID

EVALUATION & MANAGEMENT (E&M) SERVICES-OFFICE/OUTPATIENT

NEW OUTPATIENTS & OUTPATIENT CONSULTS: When selecting a code, all 3 components under the code (history, exam, medical decision making) must be met & documented.

	New 99201	Consult 99241	New 99202	Consult 99242	New 99203	Consult 99243	New 99204	Consult 99244	New 99205	Consult 99245
HX	Problem Focused HPI: 1-3 Components All Req'd		Expanded Problem Focused HPI: 1-3 Components ROS: 1 System All Req'd		Detailed HPI: 4+ Components* ROS: 2-9 Systems PFSH: 1 All Req'd		Comprehensive HPI: 4+ Components* ROS: 10+ Systems PFSH: 3 All Req'd		Comprehensive HPI: 4+ Components* ROS: 10+ Systems PFSH: 3 All Req'd	
EXAM	Problem Focused (95) 1 organ system/body area (97) 1-5 bullets		Expanded Problem Focused (95) 2-7 organ systems/body areas (97) At least 6 bullets		Detailed (95) 2-7 organ systems/body areas (1 in more detail) (97) At least 12 bullets (2+ OS/BA)		Comprehensive (95) 8+ organ systems (97) 9+ organ systems/body areas (2 bullets in each OS/BA)		Comprehensive (95) 8+ organ systems (97) 9+ organ systems/body areas (2 bullets in each OS/BA)	
MDM	Straightforward DX: ≤ 1 Data: ≤ 1 Risk: Minimal 2/3 Req'd		Straightforward DX: ≤ 1 Data: ≤ 1 Risk: Minimal 2/3 Req'd		Low Complexity DX: 2 Data: 2 Risk: Low 2/3 Req'd		Moderate Complexity DX: 3 Data: 3 Risk: Moderate 2/3 Req'd		High Complexity DX: 4 Data: 4 Risk: High 2/3 Req'd	

ESTABLISHED OUTPATIENTS: When selecting a code, 2 of 3 components under the code (history, exam, medical decision making) must be met & documented.

	99211	99212	99213	99214	99215
HX	None	Problem Focused HPI: 1-3 Components All Req'd	Expanded Problem Focused HPI: 1-3 Components ROS: 1 System All Req'd	Detailed HPI: 4+ Components* ROS: 2-9 Systems PFSH: 1 All Req'd	Comprehensive HPI: 4+ Components* ROS: 10+ Systems PFSH: 2 All Req'd
EXAM	None	Problem Focused (95) 1 organ system/body area (97) 1-5 bullets	Expanded Problem Focused (95) 2-7 organ systems/body areas (97) At least 6 bullets	Detailed (95) 2-7 organ systems/body areas (1 in more detail) (97) At least 12 bullets (2+ OS/BA)	Comprehensive (95) 8+ organ systems (97) 9+ organ systems/body areas (2 bullets in each OS/BA)
MDM	None	Straightforward DX: ≤ 1 Data: ≤ 1 Risk: Minimal 2/3 Req'd	Low Complexity DX: 2 Data: 2 Risk: Low 2/3 Req'd	Moderate Complexity DX: 3 Data: 3 Risk: Moderate 2/3 Req'd	High Complexity DX: 4 Data: 4 Risk: High 2/3 Req'd

HISTORY OF PRESENT ILLNESS (HPI): Location Quality Severity Duration Timing Context Modifying factors Associated signs/symptoms (Or the status of at least three chronic or inactive conditions)
REVIEW OF SYSTEMS (ROS): Constitutional Eyes ENT/Mouth Respiratory CV GI GU Neuro Integumentary Psych Musculoskeletal Endo Allergic/Immune Hem/Lymph
(PFSH) Past, Family, Social History | **Exam** - (95) refers to the CMS 1995 E/M Documentation Guidelines (97) refers to the CMS 1997 E/M Documentation Guidelines | **MDM=** Medical Decision Making
EXAM: Organ Systems: Constitutional, Eyes, ENMT, Cardio, Respiratory, GI, GU, Musculo, Skin, Neuro, Psych, Hem/Lymph/Imm | **Body Areas:** Head/Neck, Abdomen, Chest, Back, Genitalia, Extremities

Preventive Medicine Services			
Requires documentation of an age and gender appropriate comprehensive history and exam.			**Medicare Preventive Services**
New Patient	**Est. Patient**	**Age**	
99381	99391	<1 yr	**Annual Wellness Visit (AWV)**
99382	99392	1-4 years	Initial-G0438
99383	99393	5-11 years	Subsequent-G0439
99384	99394	12-17 years	
99385	99395	18-39 years	**Initial Preventive Physical Examination (IPPE)**
99386	99396	40-64 years	G0402
99387	99397	65+ years	

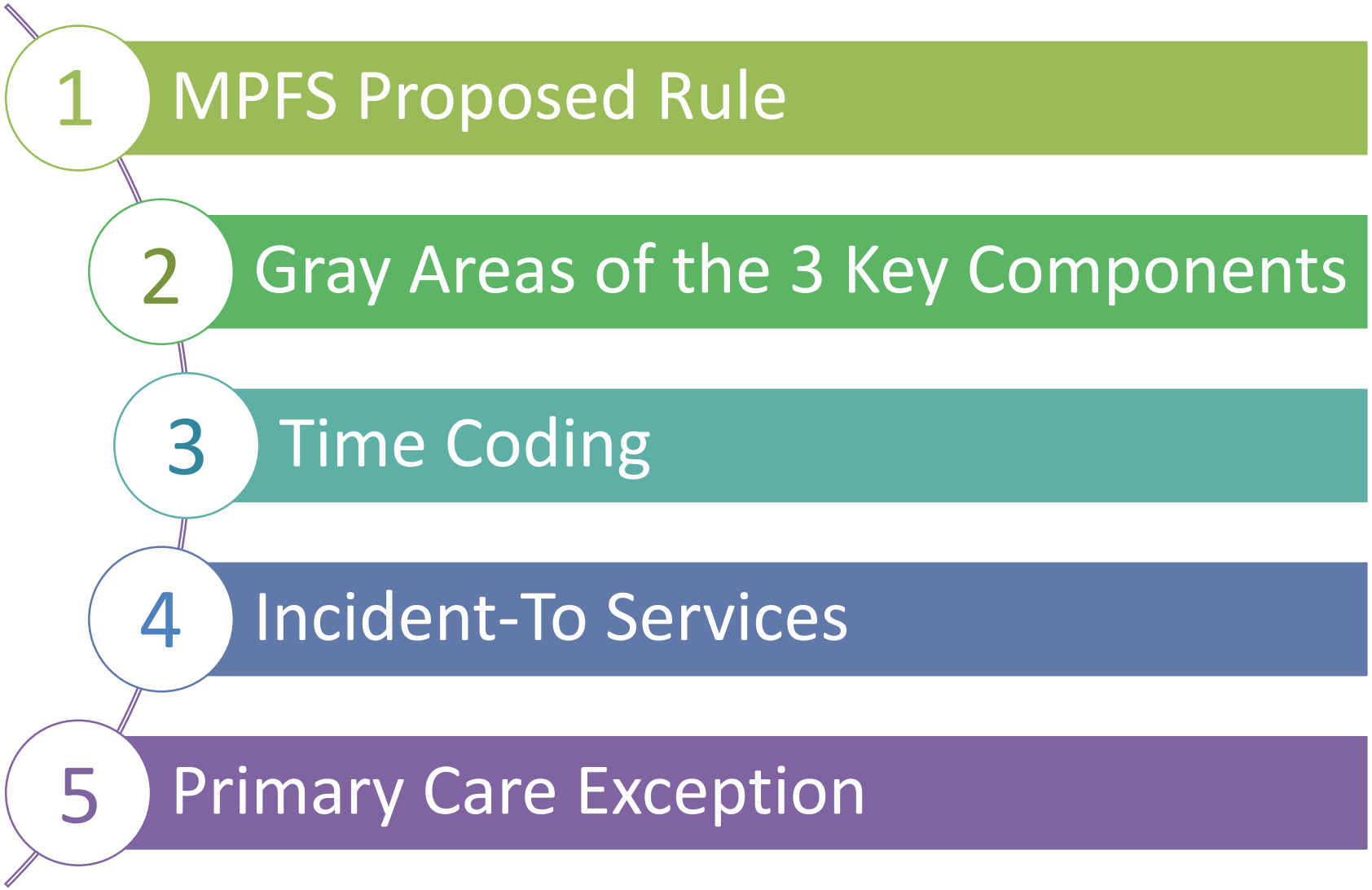
Prolonged Services (Face-to-Face) List in addition to office code
First Hour beyond usual service +99354
Each additional 30 minutes beyond first hour prolonged service +99355

Time					
Requires documentation of **1)** total time of the face to face visit **2)** greater than 50% of the total visit spent counseling/coordinating care **3)** content of counseling or description of what was coordinated.					
New Patient	**Time**	**Consults**	**Time**	**Est. Patient**	**Time**
99201	10	99241	15	99211	5
99202	20	99242	30	99212	10
99203	30	99243	40	99213	15
99204	45	99244	60	99214	25
99205	60	99245	80	99215	40

Your Presenter

Lynn Handy
CPC, CPC-I, COC, CCS-P, LPN

Agenda


1
MPFS Proposed Rule
2
Gray Areas of the 3 Key Components
3
Time Coding
4
Incident-To Services
5
Primary Care Exception

What's New

- **Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019**
  - On July 12, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that includes proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2019.

Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden

- Responding to stakeholder concerns, several provisions in the proposed CY 2019 Physician Fee Schedule would help to free EHRs to be powerful tools that would actually support efficient care while giving physicians more time to spend with their patients, especially those with complex needs, rather than on paperwork. Specifically, this proposal would:
  - Simplify, streamline and offer flexibility in documentation requirements for Evaluation and Management office visits — which make up about 20 percent of allowed charges under the Physician Fee Schedule and consume much of clinicians' time;
  - Reduce unnecessary physician supervision of radiologist assistants for diagnostic tests; and
  - Remove burdensome and overly complex functional status reporting requirements for outpatient therapy.

Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden

- CMS is proposing:
- Physicians would be allowed to choose one of the following methods of documentation:
  1. 1995 or 1997 E&M guidelines for history, physical exam and medical decision making (current framework for documentation);
  2. Medical decision making only; or
  3. Physician time spent face-to-face with patients.

Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden

- CMS would only require documentation to support the medical necessity of the visit and to support a level 2 CPT visit code. CMS assumes that physicians may continue to document according to the five levels of codes for clinical, legal, operational and other purposes.
- In addition, physicians would no longer be required to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated.
  - CMS would eliminate re-entry of information regarding chief complaint and history that is already recorded by ancillary staff or the beneficiary. The practitioner would only document that they reviewed and verified the information.

Payment Provisions

- To improve payment accuracy and simplify documentation,
  - We propose new, single blended payment rates for new and established patients for office/outpatient E/M level 2 through 5 visits and a series of add-on codes to reflect resources involved in furnishing primary care and non-procedural specialty generally recognized services.
  - We propose to apply a minimum documentation standard where Medicare would require information to support a level 2 CPT visit code for history, exam and/or medical decision-making in cases where practitioners choose to use the current framework, or, as proposed, medical decision-making to document E/M level 2 through 5 visits.
    - **Create a minimum documentation standard so clinicians would only need to meet requirements currently associated with a level 2 visit for history, exam, and medical-decision making (except when using time to document the service).**
  - In cases where practitioners choose to use time to document E/M visits, we propose to require practitioners to document the medical necessity of the visit and show the total amount of time spent by the billing practitioner face-to-face with the patient.

Proposed E & M Payment Rate

New patient office visits	CY 2018 Non-facility payment rate	Proposed CY 2019 Non-facility payment rate
99201	$45	$44
99202	$76	$135
99203	$110	
99204	$167	
99205	$211	

Established patient office visits	CY 2018 Non-facility payment rate	Proposed CY 2019 Non-facility payment rate
99211	$22	$24
99212	$45	$93
99213	$74	
99214	$109	
99215	$148	

Payment Provisions

- New Add on Codes
  - CMS Create an add-on payment of about $5 (0.15 RVUs) for primary care office visits via a new code GPC1X, *visit complexity inherent to evaluation and management associated with primary medical care services.*
  - CMS Create an add-on payment of about $12 (0.33 RVUs) for office visits performed by certain specialties via a new code GCG0X, *visit complexity inherent to evaluation and management associated with: Allergy/Immunology, Cardiology, Endocrinology, Hematology/Oncology, Interventional Pain Management-Centered Care, Neurology, Obstetrics/Gynecology, Otolaryngology, Rheumatology, or Urology*

- To recognize efficiencies that are realized when E/M visits are furnished in conjunction with other procedures, we propose a multiple procedure payment adjustment that would apply in those circumstances.
  - Reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E&M visit.

Payment Provisions

- We also propose new coding to recognize podiatry E/M visits that would more specifically identify and value these services.
- We propose a new prolonged face-to-face E/M code, as well as a technical modification to the practice expense methodology.
  - CMS would also add a new prolonged service code as an add-on to any office visit lasting more than 30 minutes beyond the office visit (i.e., hour-long visits in total). The code GPRO1, *prolonged evaluation and management or psychotherapy services(s) (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service),* would have a payment rate of approximately $67 (1.85 RVUs).

Other Proposed Changes

- We propose to eliminate the requirement to justify the medical necessity of a home visit in lieu of an office visit, and
- We will solicit public comment on potentially eliminating a policy that prevents payment for same-day E/M visits by multiple practitioners in the same specialty within a group practice.
- For E/M visits furnished by teaching physicians, we also propose to eliminate potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

- We are proposing to pay separately for two newly defined physicians' services furnished using communication technology:
  - **Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVCI1)**
  - Remote Evaluation of Recorded Video and/or Images Submitted by the Patient (HCPCS code GRAS1)

OIG Findings

- Two Examples of EHR documentation practices that could be used to commit Fraud:
  - Copy-Pasting
  - Overdocumentation

- Audit Logs are unique to EHR's and provide a tool to verify if a provider had changed anything in the medical record after the date of care or to validate authenticity of entries made in the medical records.

Medical Necessity

- **Medical necessity** of a service is the **overarching criterion** for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.
- CMS Manual System - CMS.gov
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/.../r178cp.pdf

Noridian

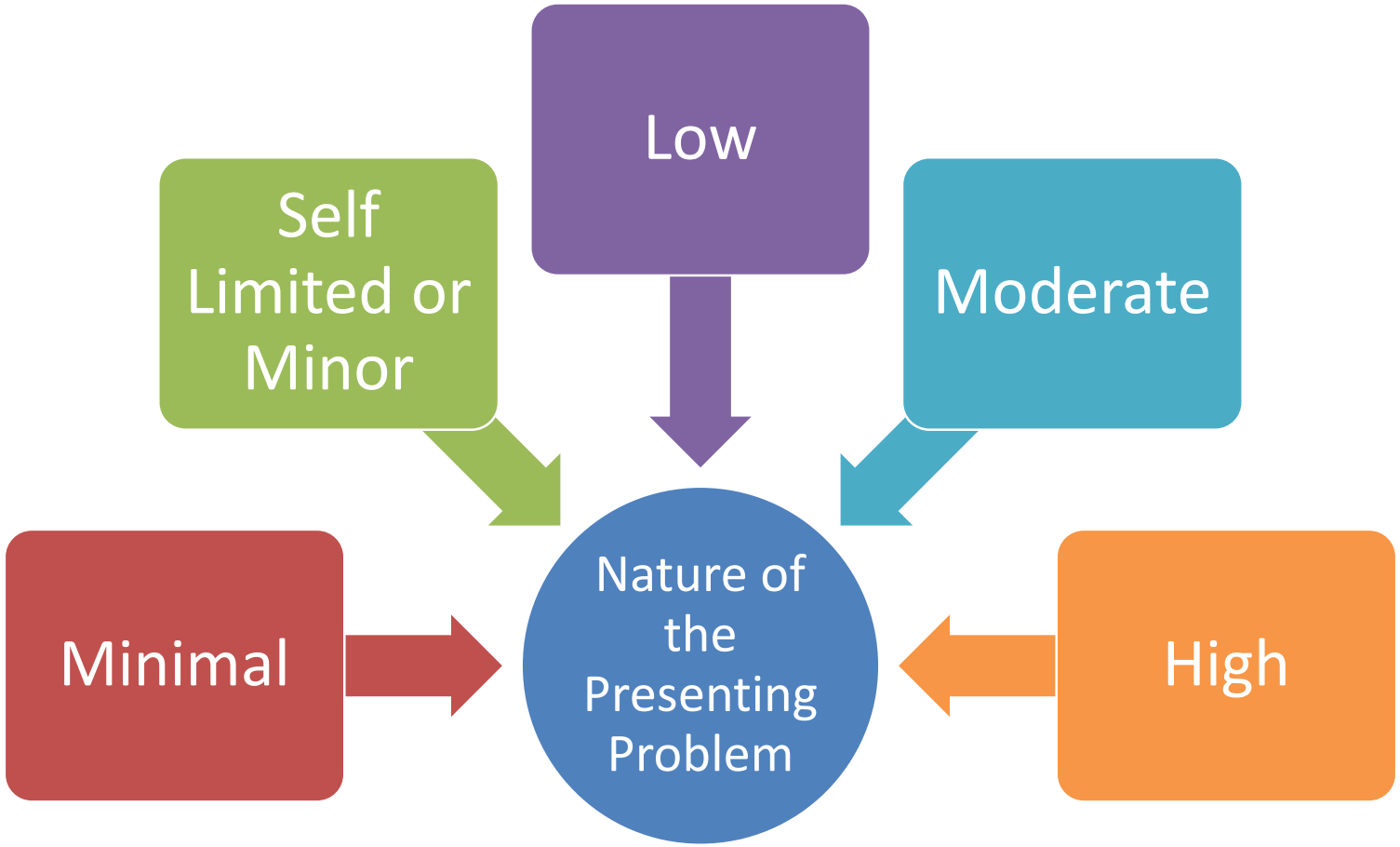
- The Noridian Part B Medical Review (MR) Department has noticed, during prepayment medical review, the provider community is using a quantification method to code their claims. The amount of data contained in the medical record should not be the controlling factor for determining the level of service (LOS). It is neither acceptable nor appropriate to include additional information in the medical record for the sole purpose of meeting the billing requirements for a specific Current Procedural Terminology (CPT) ® code. Providers may include any and all data that they deem appropriate in their patient's notes. However, per Medicare regulations, providers are required to bill only for the elements that are medically reasonable and necessary for the treatment of the patient.

CPT Defines an E/M services

- 7 Elements:
  - History
  - Exam
  - MDM
  - Time
  - Counseling/Coordination of Care
  - **Nature of the Presenting Problem**

- Presenting Problems
  - Minimal
  - Self Limited or Minor
  - Low
  - Moderate
  - High
- CPT assigns a type of presenting problem to each level of service

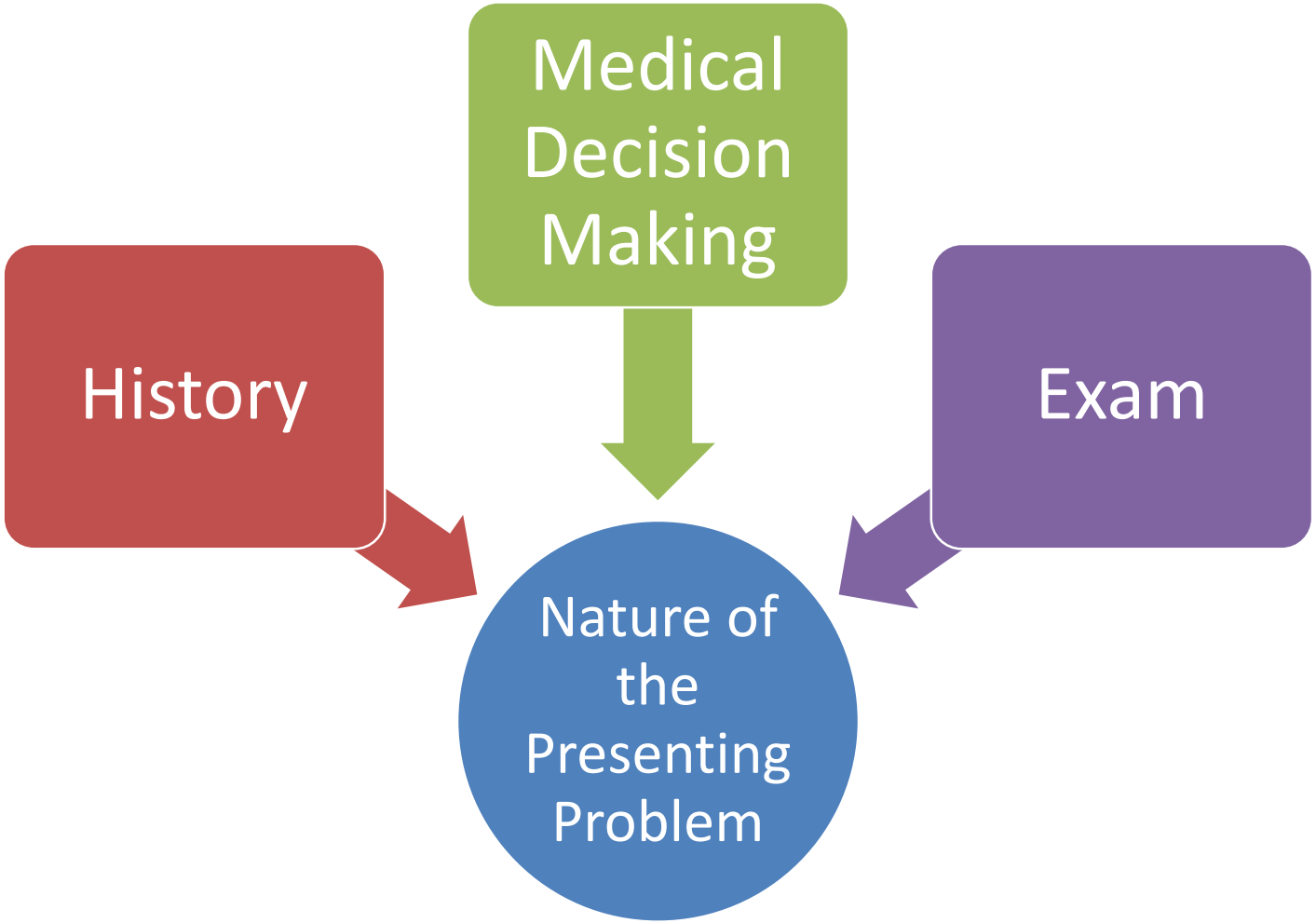
Types of Presenting Problems



Guideline Differences Between 1995 and 1997

E/M Components	History: History of Present Illness	History: Review of Systems	History: Past, Family and Social	Exam	Decision Making
1995	No Difference - An extended History of Present Illness may consist of status of three chronic/inactive conditions for either set of guidelines (1995 or 1997) for services performed on/after 09/10/13.	No Difference	No Difference	Body areas, body systems or complete single organ system	No Difference
1997				General multi-system or single organ system	

Evaluation & Management



"Time/Counseling" are considered contributory factors

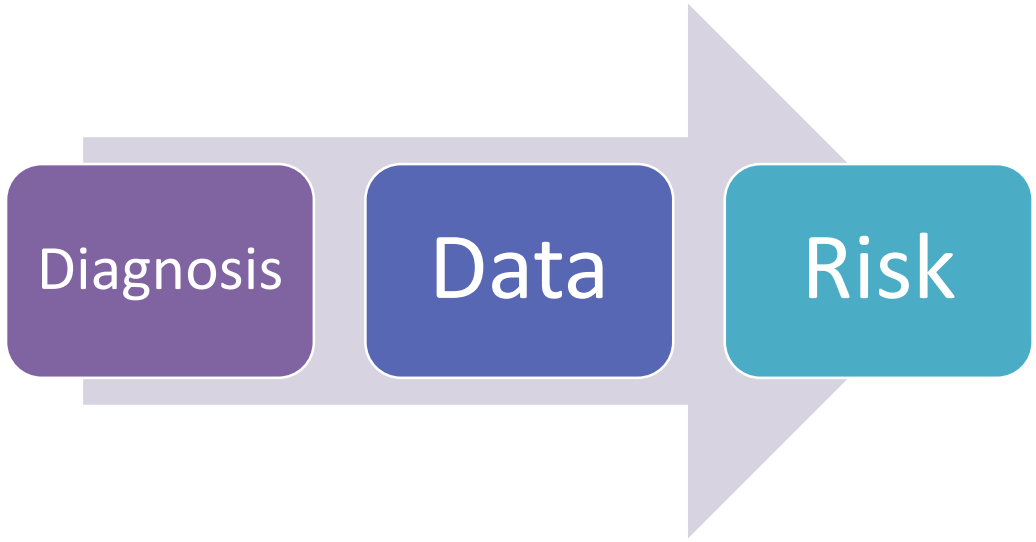
Complexity of Medical Decision Making

Medical Necessity is Not the same as Medical Decision Making

Medical Decision Making

- Start with medical decision making and work “backward” from the presenting problem(s).
- This is arguably the most important of the three key components because the Medical Decision-Making (MDM) reflects the intensity of the cognitive labor performed by the physician.
- Medical decision making drives medical necessity and, therefore, should be one of the two components that drives the level of service for established patient services and the basis for leveling any E/M service.
- More so than history or exam, medical decision making represents the actual value of a physician’s work.

Complexity of Medical Decision Making



Number of Diagnoses/Management Options

Table A. Number of Diagnoses or Management Options			
A	**B x C = D**		
Problem(s) Status	*Number*	*Points*	*Result*
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Established problem (to examiner); stable, improved		1	
Established problem (to examiner); worsening		2	
New problem (to examiner); no additional work-up planned	Max = 1	3	
New problem (to examiner); additional work-up planned		4	
		TOTAL	

Number of Diagnoses/Management Options

- **Self-Limiting Problem:**
  - If patient's condition would have resolved completely without necessitating a visit to the doctor's office (e.g., cold, insect bite); the course of treatment would have been the same with or without provider intervention.

- **Established Problem**
  - An established or chronic illness or problem, that may be stable or may be worsening, that will likely alter the patient's health status.
    - Worsening, failing to respond, etc.
    - "Failing to improve as expected"
    - "Patient condition unchanged"
      - We would refer to what is stated in the HPI.
      - Is it stable and unchanged or has it not improved and unchanged?

Number of Diagnoses/Management Options

- A new/established problem is defined as “new to the provider” or “established to the provider”
- New Problem –additional work-up planned
  - The term “work-up” is meant as any additional testing services that may be performed (during a future visit) that will assist the physician in determining a condition or extent of a condition that would help him effectively manage the patient.
    - Labs, Radiology, etc.
    - Consultation (requesting advise/opinion of another physician) is considered additional work-up
    - Decision for surgery/procedure:

      Diagnostic → work-up

      Therapeutic → not a work-up

- Palmetto GBA states “Additional Work-up” consists of any diagnostic testing, lab testing etc. and may be performed at the time of the visit.

  http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/JM-Part-B~94UJSG3310

Amount and/or Complexity of Data Reviewed

- Refers to information gathered from sources other than the history and physical exam.
- The point values assigned in the documentation guidelines are for types of data (e.g., lab tests, review of old records etc.), not for quantities of data.
- Data:
  - Review and order of diagnostic studies.
  - Discussions with other physicians.
  - Interpretations of films or tracing brought in by the patient from an outside source (independent visualization).
  - Review of old records (summary of findings must be documented).

Amount and/or Complexity of Data Reviewed

Table B. Amount and/or Complexity of Data Reviewed

Reviewed Data	*Points*
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
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	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

Table of Risk

Table C. Level of Risk

	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
MINIMAL	• One self-limited or minor problem, eg, cold, insect bite, tinea corporis	• Lab tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, eg, echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW	• Two or more self-limited or minor problems • One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, eg, pulmonary function tests • Non-cardiovascular imaging studies with contrast, eg, barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
MODERATE	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, eg, lump in breast • Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis • Acute complicated injury, eg, head injury with brief loss of consciousness	• Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization • Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
HIGH	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, 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 • Abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic Endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Moderate Risk Examples

- Presenting Problem
- One or more chronic illnesses with mild exacerbation (Moderate Risk). Examples:
  - “Patient with COPD comes in with Shortness of Breath”
  - “Hypertension with slight elevation of BP and change in medication”
  - “Diabetes with increased blood sugar”
- Undiagnosed New Problem (Moderate Risk). Examples:
  - “Chest pain, work up in progress”
  - “S.O.B.”

High Risk Examples

- **One or more chronic illnesses with severe exacerbation (High Risk). Examples:**
  - "Patient with COPD comes in with Respiratory Failure"
  - "Patient with Asthma comes in with Severe Exacerbation"
  - "CAD with severe dehydration and disoriented"
- **Acute or Chronic illness or injury that may pose a threat to life or bodily function (High Risk). Examples**:
  - "Organ System Failure (ESRD)"
  - "Diabetic Ketoacidosis"
  - "CVA with Altered Mental Status"

Identified Risk Factors?

- **Elective Major surgery**
  - With no identified risk factors (Moderate risk)
  - With identified risk factors (High risk)
    - These risk factors are above and beyond the risk of the procedure/surgery
    - Physician must mention the additional factor as a heightened risk
      - i.e. Diabetes, COPD/Emphysema, etc
      - Patient has increased risk due to diabetes and COPD

Table of Risk: Prescription Drug Management or OTC?

PRESCRIPTION DRUG MANAGEMENT (MODERATE RISK)	WHEN DETERMINING RX MANAGEMENT WITH DRUGS THAT ARE OTC (LOW RISK) VERSUS PRESCRIPTION (MODERATE RISK)
New prescriptions and Management of current medications	The dosage of the medication must be considered (Prescription drug strength may be Moderate Risk) risk to the patient must be considered
Documentation of management must be clear (i.e. “patient’s chronic back pain is stable on the current medication”)	Physician documentation stating increased risk of OTC must be considered

Drug Therapy requiring intensive monitoring for toxicity (High Risk)

DRUG LEVEL MONITORING MAY NOT BE REQUIRED	DRUG LEVEL MONITORING MAY BE REQUIRED
For drugs with a well-defined clinical response and a high therapeutic index (i.e., low toxicity), intensive therapeutic drug monitoring is not necessary	Administration of cytotoxic chemotherapy is always considered high risk under management options when monitoring of blood cell counts is used as a surrogate for toxicity.
For acute or short-term drug therapy, there is no advantage to monitoring drug levels	Drugs that have a narrow therapeutic window and a low therapeutic index may exhibit toxicity at concentrations close to the upper limit of the therapeutic range and may require intensive clinical monitoring.
For treatment of chronic disorders such as antihypertensive therapy, if the desired response can be readily assessed by a noninvasive technique, such as blood pressure monitoring, serial drug level monitoring is not medically necessary	

Drug Therapy requiring intensive monitoring for toxicity (High Risk)

Documentation needs to show monitoring:

- Monitor labs; either reviewing past labs or ordering new labs to monitor for toxicities of a high risk drug.
- Provider may monitor toxicity through examination (rather than labs). The provider must document in the exam what specifically they are looking for to evaluate for toxicity.

The route of medication will determine if drugs are high risk (po vs. IV):

- PO Vanco is not high risk vs. IV Vanco is high risk
- IV Heparin is high risk
- Fentanyl IV is high risk
- IV Dilaudid is high risk
- SQ Heparin is not high risk

The table below lists examples of drugs that may need to have drug levels monitored for toxicity

DRUG CATEGORY	DRUGS IN THE CATEGORY	TREATMENT USE
Cardiac drugs	Digoxin, digitoxin, quinidine, procainamide and amiodarone	Congestive heart failure, angina and arrhythmias
Antibiotics	Aminoglycosides (gentamicin, tobramycin, amikacin) Vancomycin and Chloramphenicol	Infections with bacteria that are resistant to less toxic antibiotics
Antiepileptics	Phenobarbital, phenytoin, valproic acid, carbamazepine, ethosuximide, sometimes gabapentin and lamotrigine	Epilepsy, prevention of seizures and sometimes to stabilize moods
Bronchodilators	Theophylline and caffeine	Asthma, Chronic obstructive pulmonary disorder (COPD) and neonatal apnea
Immunosuppressants	Cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil and azathioprine	Prevent rejection of transplanted organs and autoimmune disorders
Anti-cancer drugs	All cytotoxic agents	Multiple malignancies
Psychiatric drugs	Lithium, valproic acid and some antidepressants such as imipramine, amitriptyline, nortriptyline, doxepin and desipramine	Bipolar disorder (manic depression) and depression
Protease inhibitors	Indinavir, ritonavir, lopinavir, saquinavir, atazanavir and nelfinavir	HIV/AIDS

Complexity of Medical Decision Making

Figure 2. Determining Medical Decision Making Level

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

Table A	Number of Diagnoses or Management Options	<1 Minimal	2 Limited	3 Multiple	> 4 Extensive
Table B	Amount & Complexity of Data	<1 Minimal or Low	2 Limited	3 Multiple	> 4 Extensive
Table C	Highest Risk	Minimal	Low	Moderate	High
Type of Decision Making		Straight-forward	Low Complexity	Moderate Complexity	High Complexity

Low Risk Note

- CC: Follow up: BPH
- Impression: Patient is a 55 year old male with prostate hypertrophy. He has not had any recent urinary retention.
- Plan: Return as needed

TABLE 2 Medical decision making (MDM)

	MDM	Problem points	Data points	Risk
99212	Straightforward	1	1	Minimal
99213	Low	2	2	Low
99214	Moderate	3	3	Moderate
99215	High	4	4	High

From Department of Health and Human Services. Centers for Medicare and Medicaid Services.[6]

Moderate Risk Note

- CC: Follow up for Asthma

Assessment:
11 yo with asthma (persistent), poorly controlled. Still requiring rescue inhaler at least 2x per day for symptoms with exertion. Also having issues with school not allowing him to carry his albuterol prior to gym class. Will step up therapy at this time.

- Sleep disturbance continues, mainly insomnia.

TABLE 2 Medical decision making (MDM)

	MDM	Problem points	Data points	Risk
99212	Straightforward	1	1	Minimal
99213	Low	2	2	Low
99214	Moderate	3	3	Moderate
99215	High	4	4	High

From Department of Health and Human Services. Centers for Medicare and Medicaid Services.[6]

Plan:

We discussed the following:

1. Medication: symbicort 160mg 2 puffs BID, claritin 10mg QD, albuterol PRN
2. Discontinue: flovent
3. Influenza vaccination: recommended annually
4. Adherence: Discussed the importance of taking medication and following medical advice
5. Teaching: done during this clinic visit; asthma action plan updated & reviewed
6. School note for albuterol/spacer prior to gym
7. Discussed results of PSG, sleep (insomnia) remains an issue, discussed appropriate sleep hygiene practices & use of melatonin (5 mg, increase to 10 mg if ineffective)
8. Follow up in 2 months

High Risk Note

- 67 year old Caucasian/White female who is self-referred. She has a history of DM, HTN, PVD, hyperlipidemia, tobacco abuse, and COPD. She presents to the office today for a follow up visit after recent stress testing, echo and carotids. Carotids are 50-69% bilaterally, echo reveals nonnal EF, stress was benign. She reports she continues to have chest pain and shoulder blade pain, she reports the isosorbide did help. Her shortness of breath is about the same. She continues to smoke.
- She reports bilateral lower extremity edema, chest discomfort, dypspnea on exertion, dyspnea, fatigue, lightheadedness, palpitations, and paroxysmal nocturnal dyspnea. The swelling in her lower extremities is mild. The patient has been having frequent episodes of moderate chest pain. It has a pressure-like quality, which is localized to the left anterior chest. The patient states the chest discomfort is triggered by exertion. The chest pain is relieved by rest. She describes slowly worsening moderate dyspnea. The shortness of breath occurs with minimal levels of exertion. The episodes of mild lightheadedness and have been occurring frequently. The paroxysmal nocturnal dyspnea occurs frequently. The palpitations have been frequent. The patient denies focal neurological symptoms and syncope.

- The patient will be scheduled for a cardiac catheterization.
- CAD Presentation and Unstable angina Anginal
- CARDIOVASCULAR RISK FACTORS: Risk factors include: carotid artery disease, diabetes, family history of CAD, hyperlipidemia, hypertension, peripheral vascular disease, and tobacco use
- **Assessment**
- **Unstable angina 411.1/120.0**
- Essential hypertension with goal blood pressure less than 140/90 401.9/110
- PVD (peripheral vascular disease) 443.9/173.9
- Bilateral carotid artery stenosis
- Occlusion and stenosis of bilateral carotid arteries 433.10/165.23
- Tobacco abuse 305.l/Z72.0
- Shortness of breath 786.05/R06.02

TABLE 2 Medical decision making (MDM)

	MDM	Problem points	Data points	Risk
99212	Straightforward	1	1	Minimal
99213	Low	2	2	Low
99214	Moderate	3	3	Moderate
99215	High	4	4	High

From Department of Health and Human Services. Centers for Medicare and Medicaid Services.[8]

EPIC Note

MDM

- Number of Diagnoses or Management Options
  - Burn: new and does not require workup
  - Motor vehicle accident, initial encounter: new and does not require workup
  - Neck pain, musculoskeletal: new and does not require workup
- Amount and/or Complexity of Data Reviewed
  - Tests in the radiology section of CPT®: ordered and reviewed
- Risk of Complications. Morbidity. and/or Mortality
  - Presenting problems: moderate
  - Diagnostic procedures: moderate
  - Management options: low
- Patient Progress
  - Patient progress: stable

History Hot Topics

Chief Complaint

- A chief complaint is a required element for all E/M services.
- A trend noted by Part B MR (Noridian)
  - The MDM does not correlate to the **chief complaint**. One such example would be the HPI supports a follow-up visit for renal functions tests, hypertension, and reflux. The medical management of that patient is then a Physical Therapy referral for low back pain, with no mention of medical management of the issues that brought the patient to the clinic. The documentation did not support complaints of low back pain.
  - Part B MR has also noted that the plan of care simply lists the medical diagnoses of the patient, with no mention of changes to the plan of care if any, or continuation of current treatment regimens. It is difficult to determine the medical necessity of a visit when the documentation lacks important information, or when the documentation does not support medical management of the patient's **chief complaint**.

Chief Complaint

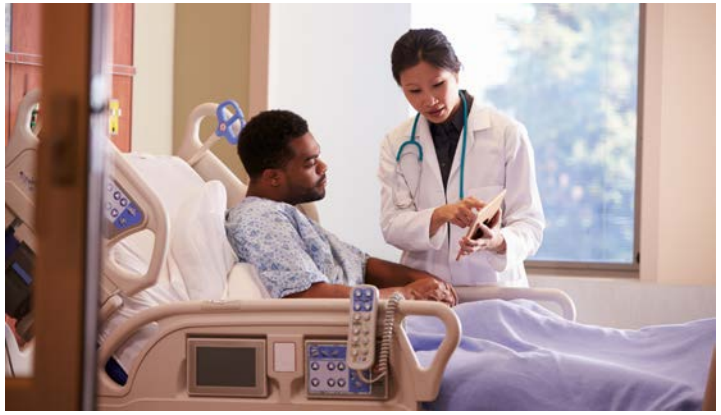
- If the CC is not clearly stated, the reason for the visit must be easily inferred from the notes.
  - Example: "patient complaining of headache, productive cough and drainage".

- *Question*: Can the CC be used as part of the History of Present Illness (HPI)?
  - *Answer*: Any descriptive statements made within the chief complaint can be used as part of the HPI.

- Question: Is a simple statement of "follow-up" or "Here for follow-up" considered as an appropriate CC?
  - *Answer*: No. "Follow-up" requires documentation in the note that easily infers to the CC. When the CC is listed as a "follow-up" for a chronic or previously existing condition(s), the condition(s) must also be indicated (e.g. diabetes).

History of Present Illness (HPI)

- Chronological description of the development of the patient's presenting illness from the first sign and/or symptom or from the previous encounter to the present.
- Described by using one or more of eight dimensions.



- Referring to Nurses/MA notes for HPI
  - The provider/physician must document the HPI, Only ROS and PFSH may be taken from the nurses/MA notes.
  - The ROS and/ or PFSH may be recorded by ancillary staff but to document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

History of Present Illness (HPI)

Location

- Area of the body where the problem, pain or injury is located
- Where does it hurt?

Quality

- Characteristics of grade of illness.
- What is the patient feeling?
- Stabbing, throbbing, dull, sharp

Severity

- How hard is it to endure?
- Level or magnitude of presenting problem.
- Scale of 1 to 10.

Duration

- Describing when the symptoms first occurred or duration of the condition.
- Hours? Weeks? Days?

Timing

- When does the problem occur?
- Morning? Night? Intermittent?

Context

- “Big Picture”.
- Circumstances in which a particular event occurs.

Modifying Factors

- What has the patient done to relieve the discomfort?
- What makes it better? What makes it worse?

Signs/Symptoms

- Other complaints the patient may have that are related to the chief complaint.

HPI

- Noridian Part B MR has noted that some Electronic Medical Record (EMR) software programs auto-populate certain aspects of the medical record with information that is not patient specific.
- This issue is more profound in the HPI when discussing the context of a certain illness and/or co-morbidity. Documentation to support services rendered needs to be patient specific and date of service specific.
- These auto-populated paragraphs provide useful information such as the etiology, standards of practice, and general goals of a particular diagnosis. However, they are generalizations and do not support medically necessary information that correlates to the management of the particular patient. Part B MR is seeing the same auto-populated paragraphs in the HPI's of different patients.
- ***Credit cannot be granted for information that is not patient specific and date of service specific.***

HPI

- **Location**: If the documentation includes a body system and the location can be easily inferred you may use it as the location HPI.
  - *Example:* Follow-up visit for pneumonia: inferred to the lungs as location (use this as location only if needed for the 4th HPI or it's the only HPI)
- **Associated Signs and Symptoms**: Although Associated Signs and Symptoms HPI is generally positive findings, a pertinent negative finding may also be used.
  - *Example*: Patient presents with Chest pain with no shortness of breath
- **Modifying Factors**: The negative or positive impact of the modifying factor must also be documented.
  - *Example:* Shoulder pain "relieved" after taking Motrin.

HPI versus ROS

- Can you use the same element or statement for both HPI and ROS. Although some carriers may allow this practice, many carriers do not.
  - **Novitas:**
    - “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.”
  - **WPS:**
    - “A clearly documented medical record would prevent the need to "double-dip" for HPI and ROS, but WPS Medicare, in rare circumstances, could accept counting one statement in both areas if necessary.”

History of Present Illness (HPI)

- Brief
  - **1 to 3 Elements**
- Extended
  - **4 or more Elements**
  - **The status of 3 or more chronic or inactive conditions**
    - Migraine Headaches(stable, worsening etc.)
    - Allergic Rhinitis (stable, worsening etc.)
    - GERD (stable, worsening etc.)

Review of Systems Examples

Constitutional:	Fever, weight loss, weight gain
Eyes:	Visual difficulties/changes
Ears, Nose, Mouth, Throat:	Tender gums, sensitive tongue, dry mouth
Cardiovascular:	Palpitations, edema, chest pain
Respiratory:	Wheezing, shortness of breath, orthopnea
Gastrointestinal:	Nausea, abdominal pain, vomiting
Genitourinary:	Frequent urination, hematuria
Musculoskeletal:	Joint pain, swollen joint, difficulty walking
Integumentary:	Skin irritation, blemishes, redness in skin
Neurological:	Loss of consciousness, seizures, numbness
Psychiatric:	Anxiety, sadness
Endocrine:	Polydipsia, hot or cold intolerance
Hematologic / Lymphatic:	Tender lymph nodes, easy bruising
Allergic / Immunologic:	Seasonal allergies with itchy eyes, frequent infections

Review of System

- **What can and cannot be used in ROS (Diabetes, HTN, etc)?**
  - The ROS should not be documentation of actual or historical diagnosis (e.g. Diabetes, HTN). That would be Past History information.
- **Allergies: Depending on documentation, allergies can fall under different categories:**
  - "She's allergic to medical latex & gets a rash -→ should fall under ROS (sign and/or symptom is documented)
  - "She's allergic to medical latex" -→ should fall under Past Medical History (No sign and/or symptom is documented)
  - Be aware of ROS statements being subjective
    - Patient is teary eyed, is an objective statement (exam)

Referring to previous ROS or PFSH

- When referring to a previous ROS and/or a PFSH there must be evidence that the physician reviewed and updated the previous information.
- This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record.
- The date of the previous record must be included!
  - "See admitting doctor's ROS" too vague for credit
    - "See H&P dated 6/1/10 for ROS. Agree, no changes
    - History Form completed on _____reviewed and revised. Provider Initials
      - This will only get you credit for the ROS that the H&P or history form addresses

- **Novitas:**
  - **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, the physician must include the sheet with all documentation for that date of service if he/she gets a request for medical records. Otherwise, the physician will not get credit for the information on the check-off sheet."

Complete ROS

- The E/M documentation guidelines state that “for a complete ROS those systems with positive or pertinent negatives responses must be individually documented. For the remaining systems, a notation such as “all other systems were reviewed and are negative” is permissible. Variations of language may also be acceptable if they clearly imply the same.”
  - In the absence of such a notation at least ten systems must be individually documented
  - The following are examples of allowed statements:
    - All other systems are negative
    - A complete ROS is negative
- **Palmetto GBA**: It is acceptable to use the statement 'All others Negative' and 'No other complaints' as long as the pertinent systems/symptoms/problems were addressed and documented.
- **Novitas, Noridian, WPS, NGS, Cahaba, First Coast Service Options** all accept “All others Negative” if the pertinent positive and negatives are documented.

Non Contributory (ROS)

- **Examples of phrases/documentation that are generally *not* allowed:**
  - "Other ROS non-contributory"
  - "All ROS negative" (without documenting the pertinent positive and/or negative responses related to the presenting problem)
  - "The rest of the ROS is negative"
  - "No other complaints"
- Who allows "Non Contributory"
  - **Novitas**: 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.
  - **Noridian and Palmetto GBA** do NOT accept the use of "non contributory"

Non Contributory (PFSH)

- Use of “non-contributory” as the sole notation in regards to all or part of PFSH (e.g., “Family History – non-contributory”) should not be credited. If the PFSH or a portion of the PFSH is reviewed by the physician and deemed non-contributory, a statement is required in the documentation to qualify it for a complete or partial PFSH.
  - Example: “Reviewed PFSH, non-contributory to current condition” (or a similar statement indicating that the history was in fact reviewed)
  - Example: “Family History non-contributory to heart disease”
- **Do not allow the following statements:**
  - Family History: “reviewed and non-contributory” without mention of the current condition
  - “Family History reviewed and negative”
  - “Family History none”

History Caveat

- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining the history
- If the patient's condition or other circumstance is clearly documented in the medical record, and the physician notes what elements of the history are unobtainable, the coder may give the provider credit for a Comprehensive History if the severity of the nature of the presenting problem warrants a comprehensive history. The physician must still document all elements, but he/she can simply note "unobtainable due to patient being intubated."
  - Example: "PFSH and ROS are unobtainable as patient presents in a coma"

History

DETAILED (99203/99214)	COMPREHENSIVE (99204/99205/99215)
4 HPI	4 HPI
2 Review of Systems	10+ Review of Systems
Past, Family & Social History • Only 1 required	Past, Family & Social History • All 3 required

Exam Hot Topics
95 or 97 Guidelines?

General Multi System Exam

95 Exam

Problem Focused

- Defined as “a limited examination of the affected body area or organ system.”

Expanded Problem Focused

- Defined as “a limited examination of the affected body area or organ system and other symptomatic of related organ system(s)” (2-7 BA/OS)

Detailed

- Defined as “an extended examination of the affected body area or organ system and other symptomatic or related organ system(s)” (2-7 BA/OS)

Comprehensive

- Defined as general multi-system examination or complete examination of a single organ system. (8+ OS)

97 Exam

Problem Focused

- One to five elements identified by a bullet

Expanded Problem Focused

- At least 6 elements/bullets

Detailed

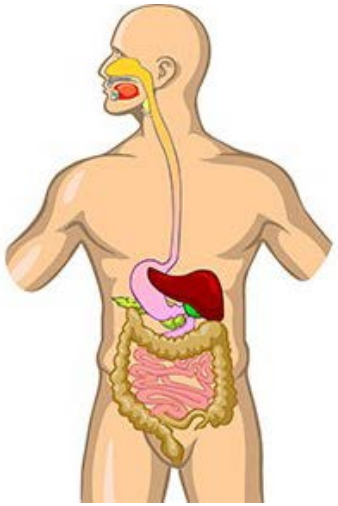
- At least 12 elements in two or more organ systems or body areas (or at least 2 elements in 6 or more body areas/organ systems

Comprehensive

- At least 9 organ systems or body areas. All elements of the exam identified by a bullet (for each area/system, documentation of at least 2 elements identified by a bullet is expected.

1995 Exam Guidelines: Body Areas & Organ Systems

- Body Areas
  - Head, including the face
  - Neck
  - Chest, including breasts & axillae
  - Abdomen
  - Genitalia, groin, buttocks
  - Back, including spine
  - Each extremity



- Organ Systems
  - Constitutional
  - Eyes
  - Ears, nose, mouth & throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Skin
  - Neurologic
  - Psychiatric
  - Hem/Lymph/Immune

Can you combine Body Areas & Organ Systems

CAN BE COMBINED	CANNOT BE COMBINED FOR ANY LEVEL OF EXAM
WPS (J5 and J8)	Palmetto GBA (JM and Railroad)
NGS (JK)	Noridian (JE and JF)
	Cahaba (JJ)
	Novitas

- **Counting Body Areas or Organ Systems in the 95 Exam Guidelines**
  - Comprehensive exam requires that only organ systems are counted (8+)

Body Areas

- **Exam statements counted in “Body Areas”**
  - “Neck Supple” is counted under Body Area (Neck)
  - “Abdomen benign or Abdomen obese” is counted under Body Area (Abdomen)
  - Extremities
    - you may give credit for the musculoskeletal system when components such as (joints, ROM, gait, instability…etc.) are listed under the extremity section of the exam

Organ Systems

- **Exam statements counted in "Organ Systems"**
  - Jaundice will default to the GI.
  - Sclera is icteric default to GI.
  - Cyanosis generally default to either Cardiovascular or Respiratory.
  - Cyanosis due to an injury would default to Musculoskeletal.
  - Edema default to Cardiovascular (even if documented under the extremity section) unless the cause of the edema is stated as a Musculoskeletal problem.
  - Clubbing default to Cardiovascular or Respiratory.
  - Alert and Oriented X3 default to Psych or Neuro depending on the presenting problem.
  - Alert and Oriented default to Psych.
  - Alert default to Constitutional.
  - No acute distress (NAD) default to Constitutional.
  - No JVD is counted in cardiovascular

95 Exam: What is a Detailed Exam?

- **Criteria to determine Expanded Problem Focused Exam (EPF) vs. Detailed exam for 1995 E&M Guidelines.**
  - Expanded Problem Focused Exam is defined as “A limited examination of the affected body area or organ system and other symptomatic or related organ system(s)”
  - Detailed Exam is defined as “An extended examination of the affected body area or organ system and other symptomatic or related organ system(s)”

Detailed Exam: 95 Guidelines

- Since the 1995 Documentation Guidelines does not clearly define what an extended exam of the affected body area includes, it may be necessary to develop internal coding guidelines to create consistency with all your providers and coders.
- For Example:
  - Documentation of 2-7 Body areas (BA) or Organ systems (OS), with a minimum of 3 elements from the affected body area(s) or organ system(s) is necessary to get to the Detailed level.
- There are some examples that may not be a detailed exam under the above guidelines and some discretion by the coder is needed.
  - For example: The patient is being seen for URI symptoms and the exam shows "ENT normal". Although this satisfies the minimum 3 body areas (ears, nose and throat), this would not be considered a detailed exam
  - This would meet the detailed guidelines: Follow up for hypertension: "Lungs –clear, heart-regular, extremities-no edema, pedal pulses normal."

Medicare Carriers 95 Exam Guidelines

Palmetto GBA

- More detail' refers to the extent of the exam. The level of detail involved in an exam is a clinical judgment based on the documentation for each individual medical record. There is an expectation that the exam will be more involved, and therefore more documentation would be submitted for a detailed exam.
- The documentation for a detailed exam would consist of at least two findings for at least two body areas or two organ systems.
- https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Railroad%20Medicare~Resources~FAQs~EM%20Help%20Center~8EELQD7181

CGS

- More detail consists of at least 2 findings for at least 2 “body areas” or “organ system’s”

Novitas Solutions (JH and JL)

- Follows the 4x4 rule (4 elements examined in 4 body areas or 4 organ systems) for determining if the exam is detailed in a 1995 exam. There is an additional caveat that states clinical judgment can be used in lieu of the 4 x 4 exam in determining a detailed exam.
- https://www.novitas-solutions.com/webcenter/portal/MedicareJH/page/pagebyid?contentId=00005056&_adf.ctrl-state=3zdgp109t_33&_afrLoop=155077528943224#!

Some Carriers

- 2-4 (Expanded) and 5-7 (Detailed)

NGS

- Suggesting 2-5 (Expanded) and 6-7 (Detailed)

1997 Single Organ System Exam Guidelines

Single Organ System Exam

- **Problem Focused Exam**
  - One to five elements identified by a bullet.
- **Expanded Problem Focused Exam**
  - At least 6 elements/bullets.
- **Detailed Exam**
  - At least 12 elements in two or more organ systems or body areas (or at least 2 elements in 6 or more body areas/organ systems). (9 bullets for Eye & Psych)
- **Comprehensive Exam**
  - All elements in a shaded area and at least one element in unshaded areas.

Exam Documentation Reminders

- Document specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s). A notation of “abnormal” without elaboration is not sufficient.
- Describe abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s).
- It is sufficient to provide a brief statement or notation indicating “negative” or “normal” to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

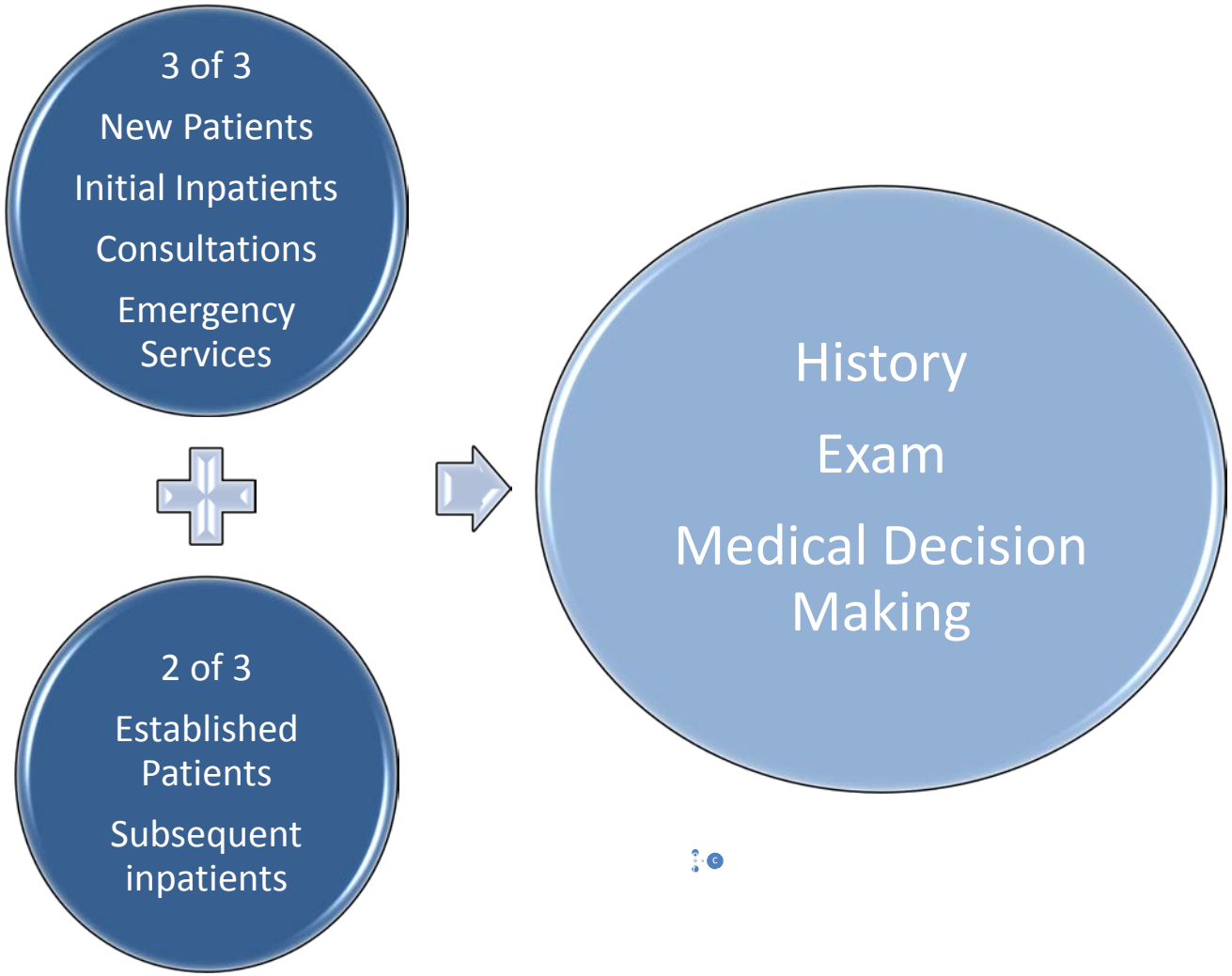
CC: HbSS and Wrist Pain

- **Exam:** General Appearance: active and alert. Level of Distress: no acute distress. Attentiveness: attentive.
- **HEENT:** Head: normocephalic, atraumatic, and no microcephaly, macrocephaly , no dolicocephaly. Eyes: round, non-injected, equal size, reactive to light, and no exudates; **scleral icterus noted**. Ears: tympanic membranes pearly w/ good landmarks and pinnae well-formed. Nose: no crusts/sores or nasal discharge and patent. Tonsils: no erythema or exudate and not enlarged. Oropharynx: normal dentition and mucous membranes.
- **Neck:** Neck: supple and no lymphadenopathy. Thyroid no enlargement, tenderness, nodules, thyromegaly, or bruit.
- **Cardiovascular System:** Heart Sounds: normal S1 and S2, no rub or murmur (**Grade 2/6 flow murmur**), and regular rate and rhythm.
- **Lungs:** Auscultation: no wheezing, rales/crackles, rhonchi, tachypnea, or retractions and clear to auscultation.
- **Abdomen:** Auscultation: normal bowel sounds. Palpation: no tenderness or masses. Liver: no hepatomegaly. Spleen: no splenomegaly.
- **Skin:** General: no cyanosis, good turgor, and generalized warmth. Moisture: dry. Lesions: no petechiae or rash.
- **Musculoskeletal System:** Hips: normal active motion. Extremities: normal active motion. Joints **joint swelling** and Full range of motion; **She has full range of motion of right wrist and arm, although hesitant to move wrist due to pain. Strong hand grisp with right hand. Mild swelling of right wrist noted.**.

CC: Eczema

- **General Appearance:** General: awake and alert and active. Temperature: extremities warm and well perfused.
- **Head:** Shape: normal shape.
- **Neck:** Cervical Spine: supple and full range of motion.
- **Lymph Nodes:** Lymph Nodes: no cervical lymphadenopathy.
- **Cardiovascular System:** Heart Sounds: normal S1 and S2 and regular rate and rhythm and no murmur.
- **Lungs:** Auscultation: clear to auscultation.
- **Skin:** General Appearance no rash; **has areas in the intertriginous folds, BUE and LLE with mild erythema, no cracking, minimal flaking, no thickening skin on shoulder and thighs softer than previously and no excoriations, no new lesions**.

E/M Key Components Requirement (3 year rule)



New Patient visits: Office or other Outpatient

3 of the 3 criteria (Hx, Exam, MDM) must be met for that level

3 of 3	History	Exam	MDM	Presenting Problem	Typical Time
99201	**Problem Focused** HPI: 1-3 ROS: none PFSH: none	**Problem Focused** 95: 1 BA/OS	**Straight Forward** Dx/Tx options: min 1 Amt/Complex data: min 1 Risk: minimal 1	Self limited or minor	10 min
99202	**Expanded Problem Focused** HPI: 1-3 ROS: 1 PFSH: none	**Expanded Problem Focused** 2-5 OS or BA limited	**Straight Forward** Dx/Tx options: min 1 Amt/Complex data: min 1 Risk: minimal 1	Low to moderate severity	20 min
99203	**Detailed** HPI: 4+ ROS: 2-9 PFSH: 1	**Detailed** 6-7 OS or BA extended	**Low Complexity** Dx/Tx options: limited 2 Amt/Complex data: limited 2 Risk: low 2	Moderate severity	30 min
99204	**Comprehensive** HPI: 4+ ROS: 10+ PFSH: 3	**Comprehensive** >8 organ systems	**Moderate Complexity** Dx/Tx options: Multiple 3 Amt/Complex data: Multiple 3 Risk: Moderate 3	Moderate to high severity	45 Min
99205	**Comprehensive** HPI: 4+ ROS: 10+ PFSH: 3	**Comprehensive** >8 organ systems	**High Complexity** Dx/Tx options: Extensive 4 Amt/Complex data: Extensive 4 Risk: High 4	Moderate to high severity	60 min

Established Patient visits: Office or other Outpatient

2 of the 3 criteria (Hx, Exam, MDM) must be met for that level

2 of 3	History	Exam	MDM	Presenting Problem	Typical Time
99211	**Minimal**			Minimal	5 min
99212	**Problem Focused** HPI: 1-3 ROS: none PFSH: none	**Problem Focused** 1 BA/OS	**Straight Forward** Dx/Tx options: min 1 Amt/Complex data: min 1 Risk: minimal 1	Self limited or minor	10 min
99213	**Expanded Problem Focused** HPI: 1-3 ROS: 1 PFSH: none	**Expanded Problem Focused** 2-5 OS or BA limited	**Low Complexity** Dx/Tx options: limited 2 Amt/Complex data: limited 2 Risk: low 2	Low to moderate severity	15 min
99214	**Detailed** HPI: 4+ ROS: 2-9 PFSH: 1	**Detailed** 6-7 OS or BA extended	**Moderate Complexity** Dx/Tx options: Multiple 3 Amt/Complex data: Multiple 3 Risk: Moderate 3	Moderate to high severity	25 Min
99215	**Comprehensive** HPI: 4+ ROS: 10+ PFSH: 3	**Comprehensive** >8 organ systems	**High Complexity** Dx/Tx options: Extensive 4 Amt/Complex data: Extensive 4 Risk: High 4	Moderate to high severity	40 min

Coding by Time

Time Based Services

- While some CPT codes allow the LOS to be time based, it is not acceptable to simply state "35 minutes spent with patient discussing treatment." When counseling and/or coordination of care is the key factor is determining LOS, documentation needs to support the amount of time spent in discussion and detail the context of the conversation and any decisions made or actions that will result based on this counseling.
- Per CPT, time can be used as the controlling factor for LOS when the counseling and/or coordination consume at least 50% of the total office visit. Refer to the article titled "Evaluation and Management: Time" located in CPT Assistant Volume 10, Issue 12, December 2000. This article has extensive information regarding the elements required when billing based on time.

Counseling & Coding by Time

- Counseling includes:
  - Diagnostic results, impressions, and/or recommended diagnostic studies.
  - Prognosis.
  - Risks and benefits of treatment options.
  - Instructions for treatment and/or follow-up.
  - Importance of compliance with chosen treatment options.
  - Risk factor reduction.
  - Patient and family education.

Documenting Time and Content of Counseling

- When counseling makes up more than 50% of the total time spent with the patient during an encounter, time can be used as the key factor in choosing a level of service.
- **Documentation must include:**
  - Total time spent.
  - % of time spent in counseling.
  - What was discussed in counseling. No canned or pre-set template statement when this appears to be cloned.
- **Can be coded by time:**
  - I spent 25 minutes with the patient, greater than 50% of the time was spent discussing her new diagnosis, conservative treatment options and reassurance.
- **Cannot be coded by time:**
  - A long discussion was held with the patient as to his underlying diagnosis. Course of treatment plan from conservative management to lesion excision was discussed with the patient & parents.

- DO NOT PUT A TIME STATEMENT ON ALL OF YOUR NOTES!!!

Good Example of Coding by Time

- I discussed with the patient the results of her ultrasound there was a 5cm cyst on her right ovary. We discuss the surgical option of excision. Patient would like to hold off for now. Will return in 1 month.

I spent 20 minutes of a 30 minute visit with counseling.

Rounding the Time

Sequential Time Coding

- The physician spends 21 minutes counseling a patient in the office and the discussion is more than 50% of the total encounter
- 99213 is for 15 minutes and 99214 is for 25 minutes
- You would code 99214 since it is closest to the actual time

Minimum Documentation Guidelines Not Met

- CPT code 99499 is never to be used to interpolate between two levels of E&M service within a category. Rather the next lower code for which all criteria are met is the appropriate choice. Reporting CPT code 99499 requires submission of medical records and contractor manual medical review of the service prior to payment, and CMS expects reporting of this E/M code to be unusual.
- Example:
  - New patient (Office or Outpatient): Only History and MDM is documented, code to the appropriate established patient services category (another common example is no HPI documented because it was done by the MA/nurse)
  - Initial in-patient Services: Detailed History or Exam is not documented, code to the subsequent in-patient services codes

NPP Billing Guidelines

- Key Factors to consider when working with Non Physician Practitioners (NPP's)

- What Place of Service are they working?
  - **Office (POS 11)**
  - **Outpatient Clinic (POS 19 or 22)**
  - **In-Patient (POS 21)**

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POS 11: Incident to Services

- Incident to a physician's professional services means that the services are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness
  - NPP may ONLY see established patient for established conditions
  - NPP may not see:
    - New Patients
    - Consultations
    - New Problems
  - Supervising physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.
  - Physician has performed initial service & subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment.

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Incident to Examples

- NPP sees patients in the office with the supervising physician in the same office suite, immediately available to render assistance, incident-to requirements are met and services are billed as if the physician had performed the service
- NPP sees patients in the office while the supervising physician is providing inpatient services at the hospital, - Incident to criteria is NOT met and the service must be reported under the NPP.

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Scribe Services

- The scribe is functioning as a “living recorder,” recording in real time the actions and words of the physician as they are done. If this is done in any other way, it is inappropriate. This should be clearly documented as noted, by both the scribe and the physician. Failure to comply with these instructions may result in denial of claims.
- It is inappropriate for an employee of the physician to round at one time and make entries in the record, and then for the physician to round several hours later and note "agree with above," unless the employee is a licensed, certified provider (PA, NP, CNS) billing Medicare for services under his/her own name and number.

CMS Scribe Policy (2017 Upate)

- *Scribes are not providers of items or services. When a scribe is used by a provider in documenting medical record entries (e.g. progress notes), CMS does not require the scribe to sign/date the documentation. The treating physician's/non-physician practitioner's (NPP's) signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided.*
- *Reviewers are only required to look for the signature (and date) of the treating physician/non-physician practitioner on the note. Reviewers shall not deny claims for items or services because a scribe has not signed/dated a note.*

Scribe Services

- The Centers for Medicare and Medicaid Services (CMS) offers the following guidance to contractors when reviewing evaluation and management services documented by scribes in the medical record.
  - If ancillary staff is present while the provider is gathering further information related to the patients visit (i.e. the three key components), he/she may document (scribe) what is dictated and performed by the physician or NPP.
  - The provider needs to review the information as it is written, documented, recorded or scribed ~~and write a notation after reviewing the documentation for accuracy, add to it if supplemental information is needed~~, and sign their name.
  - The name of the scribe must be identified in the medical records (The scribe is not required to sign the note).
  - Ancillary staff does not need to be employed by the physician (e.g., hospital employee) in order to scribe.

The Joint Commission defines a scribe as:

- "A scribe is an unlicensed person hired to enter information into the Electronic Medical Record (EMR) or chart at the direction of a physician or practitioner (Licensed Independent Practitioner, Advanced Practice Registered Nurse or Physician Assistant). It is the Joint Commission's stand that the scribe does not and may not act independently but can document the previously determined physician's or practitioner's dictation and/or activities.
- "Scribes also assist the practitioners listed above in navigating the EMR and in locating information such as test results and lab results. They can support work flow and documentation for medical record coding.“
- A scribe may be a staff member that accompanies a provider into the room when seeing a patient and they document what they see, hear, and observe.. they document what they see, hear, and observe .A scribe should not add anything additional to the documentation and may not perform any of the work of the encounter, outside of the ROS and PFSH as permitted through 1995 and 1997 Documentation Guidelines.

Scribes May Not:

- Independently document details of an encounter outside the exam room
- Populate exam elements prior to the provider interacting with the patient
- Cannot act independently to pre-populate information from a prior encounter
- Any action that falls outside the definition of a scribe as earlier defined

Novitas

- **Scribe Services**
- Scribed services are those in which the physician utilizes the services of ancillary personnel to document/record the work performed by that physician, in either an office, or a facility setting. The scribe does not act independently, but simply documents the physician's dictation and/or activities during the visit in the patients chart or Electronic Health Record (EHR).
- Documentation is considered scribed when the NPP writes notes into the medical record while the physician is personally performing the service.

Documentation of a scribed service must clearly indicate:

- Who performed the service
- Signed and dated by the treating physician or non-physician practitioner (NPP) affirming the note adequately documents the care provided
  - I agree with the above documentation' or 'I agree the documentation is accurate and complete' *
- If an NPP is utilized and acting as a scribe for the physician, the medical record should clearly indicate the NPP is acting as a scribe. This applies to all scribed encounters, whether scribing was performed by licensed clinical staff or other ancillary staff.
- **Examples***
  - Billing provider's note: '_____, acted as scribe for this encounter on _____",
  - Billing provider's note: "_____(scribes name) scribing for _____(physician/non physician provider name)
- It is recommended to include the identity of the scribe within the medical record documentation as the recorder of the service performed. It is expected that the use of a scribe to be clinically appropriate for each situation and in accordance with applicable state and federal laws governing the relevant professional practice, hospital bylaws and any other relevant regulations.
- **Reference**
- Centers for Medicare & Medicaid Services, Change Request 10076: Scribe Services Signature Requirements

Palmetto GBA

- A scribe can be a non-physician practitioner (NPP), nurse or other appropriate personnel designated by the physician/NPP to document or dictate on their behalf. A scribe does not have to be an employee of the physician/NPP.

- Scribes are not providers of items or services. When a scribe is used by a provider in documenting medical record entries (e.g. progress notes), the Centers for Medicare & Medicaid Services (CMS) does not require the scribe to sign/date the documentation. The treating physician's/NPP's signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided.

- The Medicare Administrative Contractor (MAC) is only required to look for the signature (and date) of the treating physician/NPP on the note. Services shall not be denied for items or services because a scribe has not signed/dated a note.

- Reference: CMS Change Request (CR) 10076/Transmittal 713 external link (PDF, 79 KB)

CGS

- Increasingly, CGS is seeing components of evaluation and management services completed or evaluation and management services completed or updated by nursing or other medical staff in the EMR. For example: In the Past Medical or Family/Social History sections, there is an electronic note stating "updated by Nancy Jones, Medical Technician" or an electronic statement of "medication list updated by Mary Smith RN." If the physician does not review and address these components as well; and the only documentation relating to these components is the entry from the nurse or a medical technician, then these components may not be used in determining the level of E&M service provided as they do not reflect the work of the physician.

References

- IOM Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6: E&M Services Codes located at http://www.cms.gov/manuals/downloads/clm104c12.pdf This link takes you to an external website. on the CMS website.
- Evaluation and Management Services Guide located at http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf This link takes you to an external website. on the CMS website.
- Other publications to assist with coding and determining the level of service are
  - Current Procedural Terminology® (CPT)
  - National Correct Coding Initiative (NCCI)

Thank You!

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