

Evaluation and Management 101

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Program Notes for CDI Outpatient Workshop Series

- Workshop materials and recordings
 - Copies of the slides for all programs in this workshop series can be downloaded at the link below. The workshop recordings will be posted to the same location on a rolling basis within a few days of a program:
 - <https://acdis.org/2017-outpatient-cdi-workshop>
- Continuing education information
 - Please note: In order to receive your continuing education certificate(s) for this workshop series, you must complete the online evaluation, which can be found in the CE instructions file on the download page. The evaluation will open after the last event in the *entire* series on November 17, 2017.

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
 - Explain the importance of the encounter flow as it relates to evaluation and management (E/M)
 - Discuss how the nature of the presenting problem and medical decision making relate to the E/M level
 - Describe the role medical necessity plays in E/M coding
 - Compare example remote and on-site CDI E/M processes

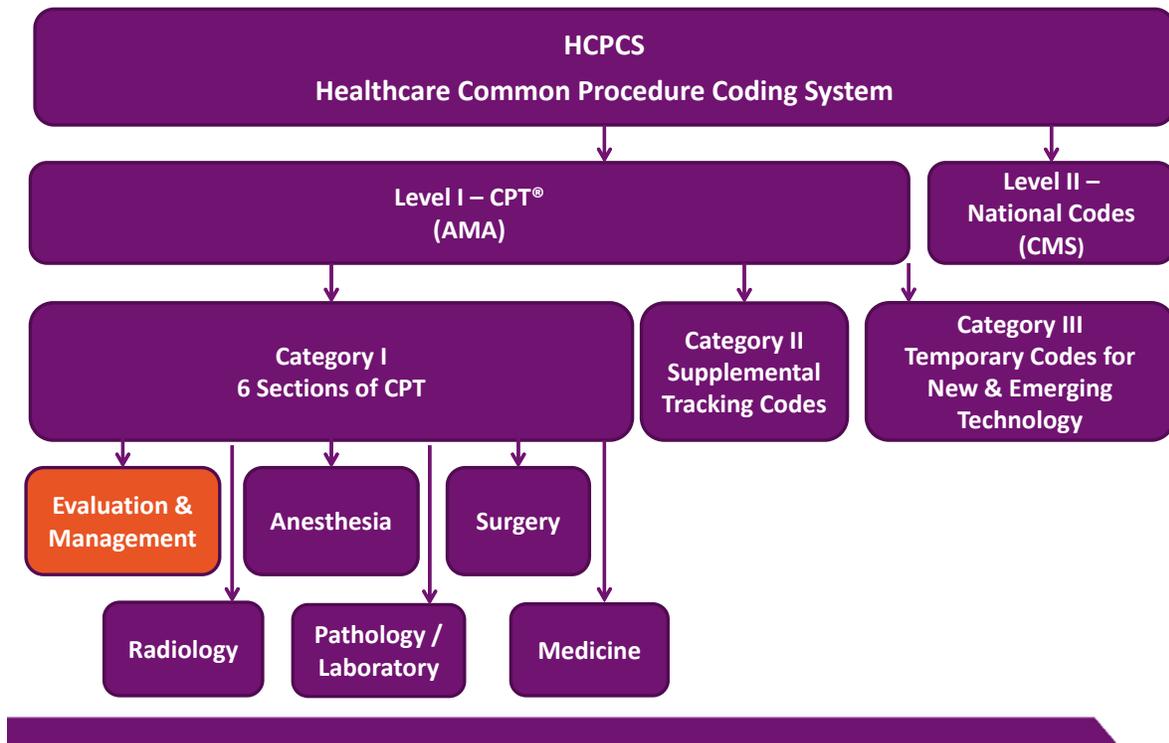
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Why E/M for the CDI Professional?

- 922.6 million physician office visits; 296.7 visits per 100 persons (CDC.gov/NCHS – 2013 data)
- E/M is used by the majority of providers.
- E/M is the dominant source of revenue for most providers.
- Most providers assign own codes and may not be up to date on the latest guidelines, verbiage, etc.
- E/M is focused on establishing a diagnosis and supporting that diagnosis based on the components with documentation outlining the cognitive work of the provider.
- The medical decision making component of E/M is closely related to the critical thinking a CDI professional utilizes in their record review.

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HCPCS



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What Is Evaluation & Management (E/M)?

- Professional services

Face-to-face services rendered by physicians and other qualified healthcare professionals who may report evaluation and management services reported by a specific CPT code(s)

- 99xxx
- First in *CPT Manual*

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Guidance

- *Official Guidelines for Coding and Reporting, Section IV*
- *Current Procedural Terminology (CPT)*
- *Documentation Guidelines for Evaluation and Management (DG)*
- *Uniform Ambulatory Care Data Set (UACDS)*
- Medicare Administrative Contractor (MAC)
- Scoring tools



E/M Components

E/M Components

- History
 - Examination
 - Medical decision making
- ← ← ←
- Key Components**
-
- Counseling
 - Coordination of care
 - Nature of presenting problem
 - Time
- ← ← ← ← ←
- Contributory Components**

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Encounter Flow

- CPT manual and CMS

“An understanding of the encounter flow is helpful as we move into these components”

- Medical decision making begins with the presenting problem

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Components

- History
 - Examination
 - **Medical decision making**
- ← ← ←
- Key Components**
-
- Counseling
 - Coordination of care
 - **Nature of presenting problem**
 - Time
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Nature of Presenting Problem

Overview

Nature of Presenting Problem

- Relationship to medical necessity
- CPT manual and DG

The extent of history, as well as the extent of the exam is “dependent upon clinical judgment and the nature of the presenting problem(s)”

- “Nature” = intrinsic characteristic(s) or behavior(s)

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Presenting Problem Type & Definition

Type	Definition
Minimal	A problem that may not require the presence of the physician or other qualified healthcare professional, but service is provided under the physician’s or other healthcare professional’s supervision.
Self-limiting or minor	A problem that runs a definite and prescribed course, is transient, and is not likely to permanently alter the patient’s health status OR has a good prognosis with management/compliance.
Low severity	A problem where the risk of mortality without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
Moderate severity	A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment, uncertain prognosis, OR increased probability of prolonged functional impairment.
High severity	A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

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Medical Decision Making

Overview



Medical Decision Making Elements

- Elements to consider:
 - The number of **diagnoses or management options**
 - The amount and/or complexity of **data** to be reviewed
 - The risk of complications, and/or morbidity or mortality



MDM Element

Number of diagnoses or management options



Key Points

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

1995 and 1997 Documentation Guidelines for Evaluation and Management

Key Points

- 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**” (R/O) 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.

1995 and 1997 Documentation Guidelines for Evaluation and Management

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Table I: Diagnosis/Management Options

Marshfield Clinic Scoring Tool (beta site '95 DG; not endorsed by CMS or AMA)

Problem and Course	Number	X Points
Self-limiting or minor; stable, improved, or worsening	0–2	1
Established problem (to examiner); stable, improved	Any #	1
Established problem (to examiner); worsening	Any #	2
New problem (to examiner); no additional workup planned	0–1	3
New problem (to examiner); additional workup planned	Any #	4

1 point = Minimal

3 points = Multiple

2 points = Limited

≥ 4 points = Extensive

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Case Scenario – Ms. Jones (Diagnosis/Management Options Element)

Ms. Jones is a 27-year-old woman with a history of prior ectopic pregnancy who presents with acute RLQ pain concerning for ectopic pregnancy, PID, ovarian torsions, appendicitis, or other acute ovarian or abdominal pathology.

What level of diagnosis and management options would you assign?

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MDM Element

Amount/complexity of data reviewed

Key Points

- If not documented, the rationale for ordering diagnostic and other ancillary services should be **easily inferred**
- The direct visualization and independent **interpretation** of an image, tracing, or specimen previously or subsequently interpreted by another physician should be **documented**

1995 and 1997 Documentation Guidelines for Evaluation and Management

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Key Points

- A **decision** to obtain old records or **decision** to obtain additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented
- **Relevant** findings from the review of old records and/or the receipt of history from the family, caretaker, or other source to supplement that obtained from the patient should be **documented**

1995 and 1997 Documentation Guidelines for Evaluation and Management

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Case Scenario – Ms. Jones (Data Element)

CBC, BMP, urinalysis w/urine HCG ordered. Add serum HCG and US if urine +. If HCG neg, order abd CT. Encounter w/ Dr. Gyn 6 wks ago reviewed – neg UPT, gonorrhea, and chlamydia, benign exam, and unremarkable wet prep. IV morphine – pain, Zofran – nausea ordered.

On re-eval, Ms. Jones’ pain and nausea significantly improved, resting comfortably. Cont to have RLQ rebound tenderness. Labs reviewed – WBC elevated, nl HCT and plt. Lytes and renal function nl. UA – no infection. uHCG neg, ectopic unlikely. CT abd ordered after d/w pt.

CT reviewed – distended appendix w/surrounding fat stranding, concerning for appendicitis w/o perf. Dr. Jen Surgeon consulted – she will admit, and requested IV Cefoxitin pre-op. Ms. Jones informed of CT results and consult and agrees to plan for admission and likely appendectomy. Will keep NPO.

What data points do you see here?

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Table II: Amount/Complexity of Data

Marshfield Clinic Scoring Tool (beta site ‘95 DG; not endorsed by CMS or AMA)

Data Reviewed	Points
Clinical lab tests	1
Radiology (except cardiac cath and echo)	1
Medical tests (PFTs, ECG, cath, and echo)	1
Discuss tests with performing physician	1
Decision to obtain old records	1
Review and summation of old records	2
Independent review of image, tracing, specimen itself	2

1 point = Minimal or none
3 points = Moderate

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MDM Element

Risk of complications and/or morbidity or mortality

Key Points

- 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 (e.g., laparoscopy) should be **documented**
- The referral for or decision to perform a surgical or invasive diagnostic procedure on an **urgent** basis should be **documented or implied**

1995 and 1997 Documentation Guidelines for Evaluation and Management

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Risk Table Simplified – Areas of Focus

Highest level of risk in any one category determines overall risk

Risk	Presenting Problem (w/examples)	Diagnostics	Examples of Management Options
Minimal	- <i>Self-limited/minor</i> : insect bite, cold (1 problem at most)	Labs requiring venipuncture; XR; ECG; US	Rest; bandage; gargles
Low	- <i>One stable, chronic illness</i> : HTN, DM - <i>Acute, uncomplicated</i> : simple sprain, cystitis - <i>2 or more self-limited or minor problems</i>	Imaging w/contrast; ABG	Minor surgery; IVF w/o additives; OTC meds ; PT/OT
Moderate	- <i>Undiagnosed new problem w/uncertain prognosis</i> : breast mass - <i>Acute w/systemic symptoms</i> : pyelonephritis, pneumonia, colitis - <i>Two or more stable chronic illnesses</i> - <i>Chronic w/exacerbation</i> : COPD, CHF	Lumbar puncture; thora /paracentesis stress tests	Prescription drug management ; reduction/splinting; IVF w/additives
High	- <i>Threat to life or bodily function</i> : MI, PE, severe resp distress - <i>Chronic illness w/severe exacerbation</i> - <i>Abrupt change in neuro status</i>	CV imaging w/contrast w/risk factors; EPS	IV controlled substance; drug therapy monitoring; DNR decision

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Case Scenario – Ms. Jones (Risk Element)

- Differentials include causes at each level of risk
 - If workup limited to cystitis and ovarian cysts > *minimal to low risk*
 - If considered PID or other serious infection > *moderate risk*
 - Concern for appendicitis, peritonitis, and ovarian torsion > *high risk*
- Noninvasive testing (labs and radiology) > *low risk*
- IV opioids to treat pain > *high risk*

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Case Scenario – Mr. Smith (Risk Element)

Mr. Smith is a 55-yo male established patient who returns today for follow-up of HTN. Has done well since last visit w/o Sx consistent w/angina or CHF. His only complaint is increased fatigue w/o DOE or other constitutional Sx. Current meds include Nadolol 20 mg qd, HCTZ 25 mg qd.

Assessment: 1. Stable HTN 2. Fatigue most likely secondary to hypertensive meds – rule out electrolyte abnormality.

Plan: Continue Nadolol 20 mg qd. Discontinue HCTZ and monitor BP and Sx. Consider changing Nadolol if fatigue persists. CBC/Chem panel today. Return for follow-up in 3–4 weeks.

What would Mr. Smith's level of risk be for the presenting problem, diagnostics, and management options?

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Risk Table Simplified

Highest level of risk in any one category determines overall risk

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Moderate	-Undiagnosed new problem w/uncertain prognosis: breast mass -Acute w/systemic symptoms: pyelonephritis, pneumonia, colitis -Two or more stable chronic illnesses Chronic w/exacerbation: COPD, CHF	Lumbar puncture; thora /paracentesis stress tests	Prescription drug management; reduction/splinting; IVF w/additives
High	-Threat to life or bodily function: MI, PE, severe resp distress -Chronic illness w/severe exacerbation -Abrupt change in neuro status	CV imaging w/contrast w/risk factors; EPS	IV controlled substance; drug therapy monitoring; DNR decision

Overall level of risk: **Moderate risk**



Medical Decision Making

Quantifying the elements

Final Table: Type of Decision Making

2 of 3 elements must be met or exceeded

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low complexity
Multiple	Moderate	Moderate	Moderate complexity
Extensive	Extensive	High	High complexity

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Consider This Common Scenario ...

- Patient presents with new undiagnosed problem ...
 - What is the diagnosis and/or management option?
 - What is the risk of complications, morbidity, and/or mortality?

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High	-Threat to life or bodily function: MI, PE, severe resp distress -Chronic illness w/severe exacerbation -Abrupt change in neuro status	CV imaging w/contrast w/risk factors; EPS	IV controlled substance; drug therapy monitoring; DNR decision

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Final Table: Type of Decision Making

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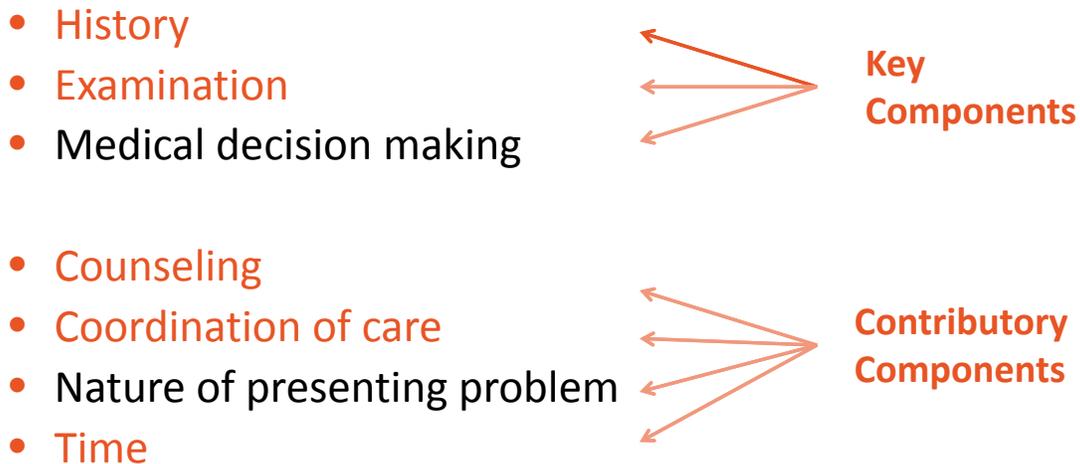
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CDI E/M Process

- Dependent on setting
- Possible models
 - Remote:
 - Retrospective
 - Audit, education
 - Best for providers who have a firm grasp of CDI
 - On-site:
 - Concurrent
 - Review, query
 - Best for providers new to CDI
 - Blended

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Only the Beginning ...



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Pearls

- Documentation in the medical record must support the level of service provided.
- The nature of the presenting problem will greatly influence the complexity of medical decision making, which influences the extent of the history and the exam, and can be viewed as the “driver” of the encounter.
- Medical decision making documentation supports medical necessity, which is reflected in the presenting problem.
- 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.
- Risk simplified pearl: any visit that involves documented prescription management is at least a moderate risk visit, which can simplify the process of establishing a risk level.
- Risk simplified pearl: a patient who presents with an undiagnosed new problem is at a moderate complexity of MDM by both the diagnoses/management element and the risk element.

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Table of Risk—Minimal

Highest level of risk in any one category determines overall risk

Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Option(s) Selected
One self-limited or minor problem; cold, insect bite	Laboratory tests requiring venipuncture	Rest
	Chest X-rays	Gargles
	EKG/EEG	Elastic bandages
	Urinalysis	Superficial dressings
	Ultrasound, e.g., echo	
	KOH prep	

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Table of Risk—Low

Highest level of risk in any one category determines overall risk

Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Option(s) Selected
Two or more self-limited or minor problems	Physiological tests not under stress; e.g., pulmonary function tests	Over-the-counter drugs
One stable chronic illness; e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH	Non-cardiovascular imaging studies with contrast; e.g., barium enema	Minor surgery with no identified risk factors
Acute uncomplicated illness or injury; e.g., cystitis, allergic rhinitis, simple sprain	Superficial needle biopsies	Physical therapy
	Clinical laboratory tests requiring arterial puncture	Occupational therapy
	Skin biopsies	IV fluids without additives

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Table of Risk—Moderate

Highest level of risk in any one category determines overall risk



Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Option(s) Selected
One or more chronic illnesses w/mild exacerbation, progression, or side effects of treatments	Physiologic tests under stress; e.g., cardiac stress test, fetal contraction stress test	Minor surgery w/identified risk factors
Two or more stable chronic illnesses	Diagnostic endoscopies w/no identified risk factors	Elective major surgery (open, percutaneous, or endoscopic) w/no identified risk factors
Undiagnosed new problem w/ uncertain prognosis; e.g., lump in breast	Deep needle or incisional biopsy	Prescription drug management
Acute illness w/systemic symptoms; e.g., pyelonephritis, pneumonitis, colitis	Cardiovascular imaging studies w/contrast and no identified risk factors; e.g., arteriogram, cardiac catheterization	Therapeutic nuclear medicine
Acute complicated injury; e.g., head injury w/brief loss of consciousness	Obtain fluid from body cavity; e.g., lumbar puncture, thoracentesis, culdocentesis	Closed treatment of fracture or dislocation w/o manipulation
		IV fluids with additives

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Table of Risk—High

Highest level of risk in any one category determines overall risk



Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Option(s) Selected
One or more chronic illnesses w/severe exacerbation, progression, or side effects of treatment	Cardiovascular imaging studies w/contrast w/identified risk factors	Elective major surgery (open, percutaneous, endoscopic) w/identified risk factors
Acute or chronic illnesses or injuries that pose threat to life or bodily function; e.g., multiple trauma, AMI, pulm embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, ARF	Cardiac electrophysiological tests	Emergency major surgery (open, percutaneous, endoscopic)
An abrupt change in neurologic status; e.g., seizure, TIA, weakness, or sensory loss	Diagnostic endoscopies w/identified risk factors	Parenteral controlled substances
	Discography	Drug therapy requiring intensive monitoring for toxicity
		Decision not to resuscitate or to de-escalate care because of poor prognosis

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Thank you. Questions?

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To submit a question, go to the questions window located on the right side of your screen. Type your question into the box at the bottom then click the "Send" button.

Conclusion

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Thank You!

The next program in the
Outpatient CDI Workshop series,

HCCs and Pay for Performance,

will be broadcast live on Friday, October 20 at 1 p.m. ET.

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