Documenting Evaluation and Management Services

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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Identify the differences between professional (physician) billing and hospital (facility) billing
  – Identify the overarching criteria for documenting evaluation and management (E/M) services
  – Discuss guidelines for chief complaint (CC), history of present illness (HPI), exam, and medical decision-making (MDM)
  – Provide documentation tips for professional billing

Disclaimer: This presentation was developed for educational purposes only. It represents my personal work and does not directly represent current processes/reviews/practices at the University of Kentucky. The information provided is current and accurate at the time of preparation.
Physician (Professional) Coding vs. Facility (Hospital) Coding

Before accurate comparisons of professional and facility claims can be made, you must understand the definition of both:

- **Professional coding:** Represents the skills and knowledge of highly trained healthcare professionals
- **Facility coding:** Represents resource utilization
## Let’s Compare

<table>
<thead>
<tr>
<th>Physician/Outpatient Coding</th>
<th>Facility/Inpatient Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilizes ICD-10-CM for diagnosis coding</td>
<td>Utilizes ICD-10-CM for diagnosis coding</td>
</tr>
<tr>
<td>Coding for “probable,” “suspected,” or “rule-out” is <strong>NOT</strong> allowed</td>
<td>Coding for “probable,” “suspected,” or “rule-out” conditions <strong>IS</strong> allowed</td>
</tr>
<tr>
<td>Utilizes CPT® and HCPCS Level II for medical/surgical procedures</td>
<td>Utilizes ICD-10-PCS for medical/surgical procedures</td>
</tr>
<tr>
<td>Reimbursement primarily based on physician fee schedule, insurance contracted rates</td>
<td>Reimbursement primarily based on the diagnosis-related group (DRG)</td>
</tr>
<tr>
<td>No hospital stay required</td>
<td>Requires a hospital stay</td>
</tr>
<tr>
<td>Code assignment is based on the individual encounter/visit</td>
<td>Code assignment is based on the entire admission (length of stay)</td>
</tr>
<tr>
<td>Services are billed on CMS-1500 form</td>
<td>Services are billed on UB-04 form</td>
</tr>
</tbody>
</table>
Basic Principles of E/M Documentation

• Complete and legible (spelling counts!)
• Include chief complaint (CC), reason for encounter (HPI), exam, assessment, plan of care, date, identity of observer
• Indicate rationale for ordering diagnostic and/or ancillary services
• Indicate past *and* present diagnosis(es)
• Indicate appropriate health risk factors
• Show patient progress or lack thereof
• Support service/procedure and diagnosis
Medical Necessity

Social Security Act 1862 (a)(1)(A):

“No payment may be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

CMS guidelines:

“Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT code.”

CMS Medicare Claims Processing Manual, Chapter 12, Section 30.6.1
Key Components of E/M Services

• History
  – Chief complaint
  – History of present illness (HPI)
  – Review of systems (ROS)
  – Past medical, family, social history (PFSH)

• Physical examination

• Medical decision-making (MDM)
  – Number of diagnoses or management options
  – Amount and/or complexity of data reviewed or ordered
  – Risk of complications and/or morbidity or mortality
Case Study – Let’s Follow a Case Through the Process

• Sally Sue is a 20-day-old female transferred to our facility from an outside hospital for respiratory distress
• The attending provider from Peds Critical Care has requested that ENT Surgery see her due to difficulty obtaining an airway and continued respiratory distress
• Final diagnosis was acute laryngeal edema due to multiple prior intubation attempts
Chief Complaint

• Traditionally the reason for the visit, usually stated in the patient’s own words, briefly describing his/her symptom, problem, or condition
• Required for all E/M codes
Sally Sue’s Case – Chief Complaint

HPI: This is a 20-day-old otherwise healthy full-term female presenting with respiratory distress. Per outside report, patient has been having “cyanotic episodes” and was diagnosed with “tracheomalacia” and RSV at the ED in Somerset a few days ago. Today, the episodes became worse and she again presented to the ED in Somerset. There, 7 attempts at intubation were made by the ED and the PICU transport team. They were unable to intubate and sent her to our facility with an LMA. PICU was having difficulty ventilating with the LMA, but patient mask ventilated well. Anesthesia was unable to intubate on first attempt in the PICU, and ENT was called. Anesthesia finally obtained the airway with a bougie and “extreme cricoid pressure.” Cords were never visualized, and the airway appeared like there were “many orifices.” The patient’s tongue also seemed large/edematous. Unclear if patient had been experiencing stridor, or what her symptoms may have been prior to presentation at the OSH.

In this instance, we can pull the CC from the first sentence of the HPI
History of Present Illness (HPI)

- A timeline describing the patient’s current illness from the first symptom(s) to the present, usually in the patient’s own words
- Should clearly show development (or lack thereof) of problem since last visit
- If there is a new problem, it should be clearly identifiable as a new issue
- Conditions and diagnoses the patient presents with should correlate throughout the note
- There are eight elements included in the HPI
## Elements of the HPI

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Site of problem (e.g., back pain)</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>Length of time problem exists (e.g., one week)</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td>Regularity of occurrence (e.g., onset, continuous, intermittent)</td>
</tr>
<tr>
<td><strong>Severity</strong></td>
<td>Intensity of degree (e.g., scale of 1–10, mild, severe)</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Description of characteristic (e.g., sharp, dull, stabbing)</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td>Events surrounding occurrence; what patient was doing at onset (e.g., running)</td>
</tr>
<tr>
<td><strong>Modifying Factors</strong></td>
<td>Effect on symptom(s); what relieves/exacerbates symptom(s) (e.g., medicine, ice)</td>
</tr>
<tr>
<td><strong>Associated Signs &amp; Symptoms</strong></td>
<td>Anything significant that is related to the presenting problem (e.g., numbness, tingling)</td>
</tr>
</tbody>
</table>
Sally Sue’s Case – HPI

**HPI:** This is a 20-day-old otherwise healthy full-term female presenting with respiratory distress (Chief Complaint). Per outside report, patient has been having “cyanotic episodes” and was diagnosed with “tracheomalacia” and RSV (Location) at the ED in Somerset a few days ago (Context). Today (Duration), the episodes became worse (Quality) and she again presented to the ED in Somerset. There, 7 attempts at intubation were made by the ED and the PICU transport team. They were unable to intubate and sent her to our facility with an LMA. PICU was having difficulty ventilating with the LMA, but patient mask ventilated well (Modifying Factor). Anesthesia was unable to intubate on first attempt in the PICU, and ENT was called. Anesthesia finally obtained the airway with a bougie and “extreme cricoid pressure.” Cords were never visualized, and the airway appeared like there were “many orifices.” The patient’s tongue also seemed large/edematous. Unclear if patient had been experiencing stridor, or what her symptoms may have been prior to presentation at the OSH.

- Since we have four or more HPI elements, this is an Extended HPI
Review of Systems (ROS)

- A series of questions and answers related to the patient’s complaints as stated in the chief complaint and history of present illness
- May be recorded by ancillary staff or the patient, as long as it is referenced in the chart note by the physician
- For ROS purposes, there are 14 organ systems
Review of Systems (cont.)

- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary

- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immune
Review of Systems (cont.)

- Three types of ROS:
  - Problem pertinent: Inquires about the system directly related to the problem(s) identified in the HPI (1 system)
  - Extended: Adds a limited number of additional systems (2–9 systems)
  - Complete: Inquires about the system directly related to the problem(s) identified in the HPI plus all additional pertinent organ systems (10+ systems)
Documentation Tips for ROS

- Document pertinent positive and/or negative findings.
- Any negative findings must be documented individually.
- “Noncontributory” is NOT acceptable.
- For a complete ROS, at least 10 organ systems must be reviewed. 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 10 systems must be individually documented.
- If the provider 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 a history.
- An ROS obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This is done by:
  - Describing any new ROS elements, or noting there has been no change in the information
  - Noting the date and location of the earlier ROS
Sally Sue’s Case – ROS

Review of systems: Unable to obtain, as patient is sedated and intubated.

• Since the provider tells us:
  – Unable to obtain; AND
  – Reason why (sedated and intubated)

We can give credit for Complete ROS.
Past, Family, Social History (PFSH)

**Past history**
- Prior major illnesses and injuries
- Prior operations and/or hospitalizations
- Current medications
- Allergies
- Age-appropriate immunizations
- Diet

**Family history**
- Health status or cause of death of parents, siblings, and children
- Specific diseases related to problems identified in CC, HPI, and/or ROS
- Hereditary diseases of family members that may affect patient

**Social history**
- Marital status and/or living arrangements
- Current employment
- Occupational history
- Use of drugs, alcohol, and tobacco
- Level of education
- Sexual history
- Other relevant social factors
- Military status
PF SH Documentation Tips

• A PF SH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This is done by:
  - Describing any new PF SH elements, or noting there has been no change in the information
  - Noting the date and location of the earlier PF SH
Sally Sue’s Case – PFSH

**Past medical history:** Born full-term, otherwise unknown (also includes medication list and allergies)

**Past surgical history:** Unknown

**Social history:** Lives with family, currently on their way but not at bedside

**Family history:** Reviewed and noncontributory

All elements present = Complete PFSH
Physical Examination

• The extent of the exam is dependent on clinical judgment and the nature of the presenting problem

• There are four levels of examination services:
  – Problem focused
  – Expanded problem focused
  – Detailed
  – Comprehensive
Physical Examination (cont.)

• **Problem focused:** A limited examination of the affected body area or organ system (1 body area/organ system)

• **Expanded problem focused:** A limited examination of the affected body area or organ system and other symptomatic or related body system (2–7 body areas/organ systems)

• **Detailed:** An extended examination of the affected body area(s) and other symptomatic or related organ system(s) (2–7 body areas/organ systems)

• **Comprehensive:** A general multisystem examination or a complete examination on an organ system (8 or more organ systems)
## Exam Level Selection

<table>
<thead>
<tr>
<th>Exam</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>1 body area/organ system</td>
<td>Up to 7 body areas/organ systems</td>
<td>2–7 organ systems; 1 in detail</td>
<td>8 or more organ systems</td>
</tr>
<tr>
<td>1997</td>
<td>1–5 bullets</td>
<td>6–11 bullets</td>
<td>12–17 bullets</td>
<td>18+ bullets (2 bullets in 9 organ systems)</td>
</tr>
</tbody>
</table>
## Physical Exam – Body Areas & Organ Systems

### Organ systems
- Eyes
- ENMT (ears, nose, mouth, throat)
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic
- Immunologic

### Body areas
- Head, including face
- Neck
- Chest, including breasts/axillae
- Abdomen
- Genitalia, groin, buttock
- Back
- Each extremity
Exam Documentation Tips

• Specific abnormal and relevant negative findings should be documented

• Abnormal or unexpected findings of the exam of any asymptomatic body areas or organ systems should be described

• A brief statement indicating “negative” or “normal” is sufficient to document normal findings related to unaffected or asymptomatic systems or areas
Sally Sue’s Case – Physical Exam

Exam:
VITALS: None recorded in last 24 hours.
GENERAL: Patient is sedated, intubated, well developed, and non-toxic appearing. (Constitutional OS)
HEAD/FACE: Normocephalic and atraumatic. (Head BA) Salivary glands exhibit no swelling or tenderness. (ENT OS)
EYES: The sclerae and conjunctivae are normal. No ptosis appreciated. (Eyes OS)
EARS: The pinnae are well formed. External auditory canals clear. TMs intact. (ENT OS)
NOSE: Nasal dorsum without scar or deformity. Nasal airways appear patent. (ENT OS)
ORAL CAVITY: Lips and gums appear normal. No mucosal masses or lesions are appreciated of the oral mucosa. Tongue slightly enlarged. (ENT OS)
NECK: The neck is soft (Neck BA) and supple. (Musculoskeletal OS)
RESPIRATORY: Intubated and sedated. 3.5 ETT in place. (Respiratory OS)
HEART: Rhythm regular. Bilateral upper extremities have 2+ peripheral pulses. No peripheral cyanosis appreciated. (Cardiovascular OS)
LYMPHATIC: No appreciable cervical lymphadenopathy present on palpation. (Lymphatic OS)
NEUROLOGIC: Sedated. (Cannot use)
PSYCHIATRIC: Sedated. (Cannot use)
❖ Total of 7 organ systems, one or more in detail = Detailed Examination

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Medical Decision-Making (MDM)

- Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option
  - Number of possible diagnoses and/or the number of management options
  - Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
  - Risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient’s presenting problems, diagnostic procedures, and/or possible management options
## Number of Diagnoses/Management Options

<table>
<thead>
<tr>
<th>NUMBER OF DIAGNOSES OR TREATMENT OPTIONS</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor; stable, improving, worsening</td>
<td>1</td>
</tr>
<tr>
<td>Established problem to examiner; stable, improved</td>
<td>1</td>
</tr>
<tr>
<td>Established problem to examiner; worsening, not stable</td>
<td>2</td>
</tr>
<tr>
<td>New problem to examiner; no workup planned</td>
<td>3</td>
</tr>
<tr>
<td>New problem to examiner; additional workup planned</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL DIAGNOSES/MANAGEMENT OPTIONS</strong></td>
<td></td>
</tr>
</tbody>
</table>
Sally Sue’s Case – Number of Diagnoses/Management Options

**Assessment/plan:** A 20-day-old female presenting with difficult airway and respiratory distress. She does have intermittent witnessed apneas and at least three confirmed cyanotic episodes per mother.

- Recommend IV dex 0.5 mg/kg q.8 hours x24 hours.
- Recommend having mask and LMA at bedside at all times.
- Will discuss with Dr. Azbell. May require airway eval in the OR.

New problems to examiner, no additional workup planned = 3 points
# Amount and/or Complexity of Data

<table>
<thead>
<tr>
<th>DATA TO BE REVIEWED</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab test</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 provider</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or history from someone other than the patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than the patient, and discussion of the case with another healthcare provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of the report)</td>
<td>2</td>
</tr>
</tbody>
</table>
Sally Sue’s Case – Amount/Complexity of Data

**Diagnostics:** No labs/diagnostic tests in the last 48 hours

No diagnostic data reviewed and no additional testing ordered = 0 points
Risk of Complications, Morbidity, and/or Mortality

- A combination of the risks related to the patient’s presenting problem and the risks associated with the performance of any diagnostic procedure and treatment/interventions

- The overall risk is ranked as minimal, low, moderate, or high using a specific table (see next slide)

- *The highest level of risk in any one category* (presenting problem, diagnostic procedure, or management option) determines the overall risk

- The determination of risk is complex and not readily quantifiable; the table includes common clinical examples, rather than absolute measure of risk
<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure Ordered</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One self-limited or minor problem, e.g., cold, insect bite, tinea corporis</td>
<td>Laboratory tests requiring: Venipuncture Chest x-ray EKG-EEG Urinalysis Ultrasound Echo Koh prep</td>
<td>Rest Gargles Elastic bandages Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>Physiologic tests not under stress, e.g., pulmonary function tests Non-cardiovascular imaging studies with contrast, e.g., barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies</td>
<td>Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effect of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g., lump in breast Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonia, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>Physiologic test under stress, e.g., 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, e.g., arteriogram, cardiac catheterization Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdoncentesis</td>
<td>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</td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment <strong>Acute or chronic illnesses 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</strong></td>
<td>Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological test Diagnostic endoscopies with identified risk factors Discography</td>
<td>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</td>
</tr>
</tbody>
</table>
Sally Sue’s Case – Table of Risk

**Assessment/plan:** A 20-day-old female presenting with difficult airway and respiratory distress. She does have intermittent witnessed apneas and at least three confirmed cyanotic episodes per mother.

- Recommend IV dex 0.5 mg/kg q.8 hours x24 hours.
- Recommend having mask and LMA at bedside at all times.
- Will discuss with Dr. Azbell. May require airway eval in the OR.

Acute respiratory distress and patient being intubated = High risk
Overall Level of MDM

Once all of the elements have been determined, the type of medical decision-making can be figured using the table below. To qualify for a given type of medical decision-making, two of the three elements in the table must be met or exceeded.

<table>
<thead>
<tr>
<th>Number of Diagnoses</th>
<th>Amount of Data</th>
<th>Risk</th>
<th>Overall MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>
Sally Sue’s Case – Overall Level of MDM

Assessment/plan: A 20-day-old female presenting with difficult airway and respiratory distress. She does have intermittent witnessed apneas and at least three confirmed cyanotic episodes per mother.

- Recommend IV dex 0.5 mg/kg q.8 hours x24 hours.
- Recommend having mask and LMA at bedside at all times.
- Will discuss with Dr. Azbell. May require airway eval in the OR.

BREAKDOWN OF MDM

- Number of dx/tx options = New problem with no additional workup (3)
- Amount/complexity of data = None reviewed/ordered (0)
- Risk = Acute illness that may pose a threat to life/bodily function (High risk)

OVERALL MODERATE LEVEL OF MEDICAL DECISION-MAKING
Documentation Tips for MDM

• When documenting the number of diagnosis/treatment options, an assessment, clinical impression, or diagnosis should be documented for each encounter. The decision should be clearly documented.

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

• The review of lab, 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 containing the test results.

• The review of old records must be documented and findings or lack of findings should be stated in the record.

• Document comorbidities and/or underlying diseases that increase risk of presenting illness (those that do not significantly increase complexity of MDM should not be considered).
Add MEAT to Your Documentation

**M** – Monitor: Signs, symptoms, disease progression, and disease regression

**E** – Evaluate: Test results, medication effectiveness, and response to treatment

**A** – Assess/address: Ordering tests, discussion, review of records, and counseling

**T** – Treatment: Medications, therapies, and other modalities
Counseling and Coordination of Care

- An exception to the 3 key components rule exists when the visit consists predominantly of counseling and coordination of care, such as when more than 50% of the visit is spent face-to-face with the patient for counseling.

- Time then becomes the controlling factor.
Counseling and Coordination of Care (cont.)

- Counseling, as it relates to E/M coding, is defined as a discussion with a patient and/or family concerning one or more of the following areas:
  - Diagnostic results, impressions, and/or recommended studies
  - Prognosis
  - Risks and benefits of management or treatment options
  - Instructions and/or follow-up
  - Importance of compliance with chosen treatment or management options
  - Risk factor reduction
  - Patient and family education
Documenting on Time

• CMS states, “When counseling and/or coordination of care dominates (more than 50 percent of) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital, or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services. If the level of service is reported based on counseling and/or coordination of care, the total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care.”

EXAMPLES

“I spent 20 of 35 minutes counseling patient on ____________.”

“Total visit time was 35 minutes with greater than 50% of time spent counseling patient on ______________.”

Medicare Claims Processing Manual, Chapter 12, 30.6.1 Section C
Querying in the Outpatient World

• The rules do not change based on the setting (inpatient vs. outpatient)
• Determine the best CDI review timing (concurrent, retrospective, prospective)
• One critical difference: In the outpatient setting, “probable,” “suspected,” “rule out,” etc. diagnoses are not reportable
• Open-ended, multiple-choice, and “yes/no” formats acceptable
• Section IV of the FY 2019 ICD-10-CM *Official Guidelines for Coding and Reporting*, states that “chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).”
Query Example #1 (Concurrent)

**Context:** Patient seen in ED for complaints of lower back discomfort, being returned to SNF.

**Opportunity:** Concurrently clarify conflicting documentation related to patient’s possible wound during the ED encounter.

**Physician ROS:** Skin – warm and dry, no rashes or lesions.

**Nurse documentation:** Stage 3 sacral pressure ulcer requiring wet-to-dry dressing changes.

**Query:** Dr. Jones, I see that in your ED assessment note it was documented that the patient has skin that is warm and dry with no rashes or lesions; however, nursing documentation describes a “stage 3 sacral pressure ulcer” requiring wet-to-dry dressing changes. Please clarify the diagnosis undergoing treatment in the ED assessment note.
Query Example #2 (Prospective)

**Context:** Patient is on the schedule for colonoscopy at outpatient GI clinic.

**Opportunity:** Clarify whether this is a screening or diagnostic colonoscopy.

**Record review:** PCP referred for colonoscopy, but does not state if it is for screening or diagnostic purposes. Review of the records from PCP reveals no GI symptoms that would indicate the need for a diagnostic study; however, the patient has a family history (father) of colon cancer.

**Query:** When this patient is seen, please clarify whether this is a screening colonoscopy or diagnostic colonoscopy, if known. It is noted only that the patient is referred for colonoscopy. She has no documented GI symptoms and has a family history of colon cancer.
Putting It All Together

• If it isn’t documented, it hasn’t been done—but, if it isn’t done, don’t document it
• The medical record should be complete and legible
• The documentation of each patient encounter should include:
  — Reason for encounter
  — Assessment, clinical impression, or diagnosis
  — Plan of care
  — Legibly identify the observer along with the date of the signature
• If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
• Past and present diagnoses should be accessible to the treating and/or consulting provider
• Appropriate health risk factors should be identified
• Patient progress, response to and changes in treatment, and revision of diagnosis should be documented
• The information in the medical documentation should support the CPT and ICD-10 codes billed
CMS E/M Changes

Beginning January 1, 2019, CMS adopted the following E/M documentation changes:

- For E/M visits, providers are not required to re-enter information about the patient’s chief complaint and history that a staff member has already entered. Instead, the provider can indicate in the medical record that the information has been “reviewed and verified.”

- For established office visits, providers can focus their documentation on changes since the last visit and “need not re-record the defined list of required elements if there is evidence” that the provider has already done so.

- For home visits, providers are no longer required to prove explicit medical necessity when reporting the range of codes 99341–99350.
CMS Proposed E/M Changes

In 2021, CMS plans to implement a series of major revisions to E/M coding, payments, and documentation requirements:

- Providers will be able to opt for medical decision-making or time as the key documentation requirement when reporting E/M office codes

- CMS plans to adopt a minimum documentation standard for the “middle of the pack,” levels 2 through 4 codes
  - History and exam only needs to be documented to level 2 criteria
  - MDM and/or time will be the driving factor for code choice
CMS Proposed Single-Rate Payments

- Will not apply to 99215 or 99205
- “Extended visit” add-on code will be available for use on high-duration encounters that correspond to levels 2 through 4 visits
- Pay rates will bundle levels 2 through 4 codes into a “to be determined” payment amount
  - 99202–99204 reimbursement: $130 (subject to change)
  - 99205 reimbursement: $211 (subject to change)
  - 99212–99214 reimbursement: $90 (subject to change)
  - 99215 reimbursement: $145
Resources

- CGS Education website. [www.cgsmedicare.com](http://www.cgsmedicare.com)
Thank you. Questions?

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.