Evaluation and Management

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Objectives

- ✓ Define Evaluation and Management (E&M) services
- ✓ Understand the components of an E&M visit
- ✓ Determine the components required for each type of service, each level of service
- ✓ Understand the options available for assessment (1995 Guidelines or 1997 Guidelines)
- ✓ Identify types of E&M services, and the leveling components required
- ✓ Assign proper E&M level

OIG Report Published May 29, 2014

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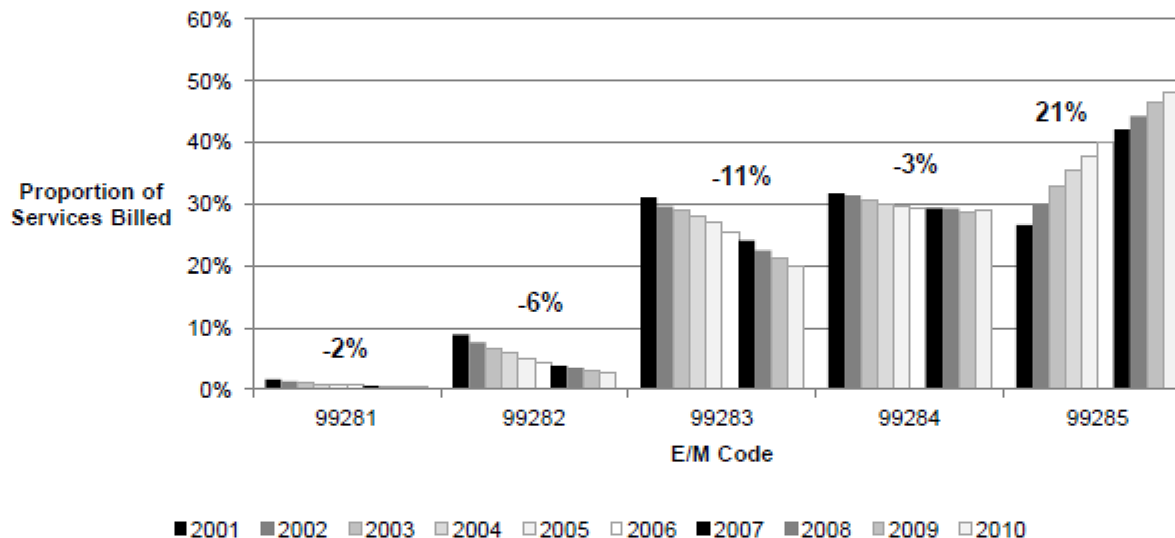
"Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010"



Report Findings

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- Medicare inappropriately paid $6.7 billion for claims for E/M services in 2010
- Represents 21%of the E/M payments in 2010
- 42% incorrectly coded (upcoded and downcoded)
- 19% lacking documentation
- The OIG recommended that the Centers for Medicare & Medicaid Services (CMS) do the following:
  - Educate physicians on coding and documentation requirements for E/M services;
  - Continue to encourage contractors to review E/M services billed by high-coding physicians; and
  - Follow up on E/M services that were paid in error.

Evaluation and Management Service: Definition

Physician/patient encounter of a medical nature, in which the chief complaints are identified and examined. Services represented by E&M codes include evaluating symptoms, disease process or chronic condition, and managing condition to affect cure or minimize impact on quality of life.

Three Key Components of E&M Level

1. History

- 4 components
- Multiple requirements to satisfy to determine the proper level

2. Physical Exam

- 1 of 4 levels assigned

3. Medical Decision Making

- 1 of 4 levels assigned

Components of History

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1. Chief Complaint

- Also called reason for visit
- CC must be recorded in the medical record to qualify for reimbursement

2. History of Present Illness

- Eight elements eligible to determine one of two levels assigned
- Performed only by physician

3. Review of Systems

- Twelve systems to determine 4 available levels
- Can be obtained by ancillary staff
- Must be reviewed and notated by the physician

4. Past Medical, Family, Social History

- Seventeen criteria available to determine one of three possible levels
- Can be obtained by ancillary staff
- Must be reviewed and notated by the physician

Physical Exam

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- Fifteen Affected Body Areas/ Organ systems

Constitutional	Ears, nose, mouth, throat	Respiratory	Genitourinary (female)
Chest (breasts)	Lymphatic	Eyes	Genitourinary (male)
Neck	Cardiovascular	Psychiatric	Musculoskeletal
Skin	Neurologic	Gastrointestinal (abdomen)	

- Each system has up to 12 bullet points to review
- Points assigned from physical exam of systems determine levels

Score History

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- Circle the entry farthest to the right for each history area
- Draw a line down from the circle farthest to the left

Chief Complaint: ______ **Bene Initials:** ______ **D.O.S.** ______

HISTORY

HPI (history of present illness) elements:

☐ **Location** Where is problem?	☐ **Duration** Onset of .symptoms to present.	☐ **Modifying Factors** What have you done to alleviate or worsen symptoms?	**Brief** 1-3 HPI elements	**Extended** ≥4 HPI elements or status of ≥ 3 chronic or inactive conditions
☐ **Severity** How bad on a scale 1/10	☐ **Timing** When/how often	☐ **Associated Signs/Symptoms** What else is bothering you?		
☐ **Quality** Sharp/dull/ hot/dry	☐ **Context** What are you doing when sxs occurs?			

ROS (Review of Systems)

☐ Constitutional ☐ Card/Vasc ☐ Musculo ☐ Psych X ☐ "All Others Negative"

☐ Eyes ☐ Respiratory ☐ Integument ☐ Endo

☐ Ears, Nose Mouth, Throat ☐ GI ☐ GU ☐ Hem/Lymph

☐ Neuro ☐ Allerg/Imm.

None	ROS	Extended 2-9 ROS	Complete ≥ 10 ROS or some systems + statement "all others negative"

No PFSH is required: Subsequent Hospital and Subsequent Nursing Facility Care services require an interval history only.

☐ **Past History** (the pt's past experiences w/illnesses, operations, injuries, treatments, medications & allergies)

☐ **Family History** (review of medical events in the pt's family including diseases which are hereditary or put the pt at risk)

☐ **Social History** (an age appropriate review of past and current activities)

Established/ Subsequent *E.D.	None	1 PFSH	2 PFSH
New or Initial	None	1-2 PFSH	3 PFSH

Circle the entry farthest to the right for each history area. To determine history level, draw a line down the column with the circle **farthest to the left**.

Important Note: Allow a comprehensive history if the physician is ***unable* to obtain a history** from the patient **or other source**. The **record should describe** the patient's condition or circumstance that precludes obtaining history.

***99281-99285**: No distinction is made between **new & established** patients in the **E.D.**

PROB. FOCUSED	EXP. PROB. FOCUSED	DETAILED	COMPRE-HENSIVE
PF	EPF	D	C

Physical Exam 1995

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Body Area	Organ Systems	
Head/face	Constitutional	Musculoskeletal
Neck	Eyes	Skin
Chest/breast/axillae	Ears, Nose Throat, Mouth	Neurologic
Abdomen	Cardiovascular	Psychiatric
Genitalia/groin/buttocks	Respiratory	Hem-lymphatic
Back/spine	Gastrointestinal	
Each extremity	Genital-Urinary	

Discrepancies

- Neck and Chest, Breast Axillae are considered Body Areas
- Palpation of 2 or more lymph nodes considered Lymphatic
- Musculoskeletal includes examination of the joints, bones, and muscles of one or more of the following six areas
  - ✓ Head and neck
  - ✓ Spine
  - ✓ Right upper extremity
  - ✓ Left upper extremity
  - ✓ Right lower extremity
  - ✓ Left lower extremity

- Examination of external genitalia considered Body Area and Genital-Urinary
- How should these be assigned?

Physical Exam Categories

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	1995 Guidelines	1997 Guidelines
Problem focused	Limited exam of affected body part or organ	1-5 bullets from one or more organ systems
Expanded problem focused	Limited exam of affected body part or organ and **limited exam** of 2-7 other symptomatic or related organs	At least 6 bullets from any organ systems
Detailed	**Extended exam** of 2-7 affected body areas and other related organ systems	At least 2 bullets each from 6 organ systems, or 12 bullets total from 2 or more systems
Comprehensive	General multisystem exam, or complete exam of a single organ system	2 bullets each from 9 systems

July 2017 MAC Specific Guidance

- Per 1995 Documentation Guidelines for Evaluation and Management (E/M) Services, 2-7 body parts and/or organ systems are analyzed for both the expanded problem-focused visit as well as detailed physical exam visit
- These contradictory guidelines create more confusion than assistance
- NGS has made a small but significant change to the documentation requirement for physical examination
- Effective from 1st July 2017 for claims submitted to NGS
  - Physical Examination of 6-7 body parts or organ systems would be considered ‘Detailed’
  - Physical Examination of 2-5 body parts or organ systems would be considered ‘Expanded Problem Focused’
- Other MACs hopefully would follow suit

1997 Guidelines for Specialty Leveling

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- Specialty Leveling criteria has been established for 11 specialties

Cardiovascular	Dermatology	Ophthalmology	Genitourinary (female)
Ear, nose, throat	Orthopedics	Neurology	Genitourinary (male)
Psychiatry	Pulmonary	Hematology Oncology	

- Leveling process is the same, but the systems and exam criteria is more specifically geared toward the specialty than are the general criteria

https://emuniversity.com/SpecialtyExams.html

Score Exam

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- Check with your MAC to define Limited vs. Extended
- Create a P&P to define Limited vs. Extended for all payors

EXAM

1997 Guidelines - **General Multi System**	1997 Guidelines - **Single Organ System**	**Exam Level**
1-5 elements identified by •	**1-5** elements identified by •	**PROBLEM FOCUSED (PF)**
≥ **6** elements identified by •	≥ **6** elements identified by •	**EXPANDED PF (EPF)**
≥ **2** elements identified by • from any **6** areas/systems OR ≥**12** elements identified by • from **≥2** areas/systems	≥ **12** elements identified by • EXCEPT ≥ **9** elements identified by • for eye & psych exams	**DETAILED (D)**
≥ **2** elements identified by • from **9** areas/systems	Document **all** elements in bolded outlined system boxes and ≥ **1** element in unbolded system boxes	**COMPREHENSIVE (C)**

Affected Body Areas (BA)	**Organ Systems (OS)**		**1995 Guidelines**			
☐ Head/Face	☐ Constitutional	☐ Skin	**1** (BA) or (OS)	**2-7** (OS) and/or (BA)	**2-7** (OS) and/or (BA)	**8** or more (OS)
☐ Neck	☐ Eyes	☐ Neuro				
☐ Abdomen	☐ Ears, nose, mouth, throat	☐ Psych	(**Limited** exam of **affected BA** or OS)	(**Limited** exam of **affected BA** or OS and other symptomatic or related OS(s))	(**Extended** exam of **affected BA(s)** and other or related OS(s))	(A **general multisystem** exam or **complete exam of a single** organ system)
☐ Chest + breast / axillae	☐ Cardiovascular	☐ Hem/Lymph/Immune				
☐ Genital/groin/buttocks	☐ Respiratory					
☐ Back, include spine	☐ GI					
☐ Extremity/(ies) **L** / **R** Upper	☐ GU					
L / **R** Lower	☐ Musculo		**PF**	**EPF**	**D**	**C**

Medical Decision Making (MDM)

- Pertains to the cognitive labor performed by the practitioner
- Three levels determine the overall level of complexity:
  - The nature and number of clinical problems
  - The amount and complexity of the data reviewed by the physician
  - The risk of morbidity and mortality to the patient
- 1995 and 1997 guidelines are identical for MDM

Marshfield Scoring System

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- 600 physician practice chosen to “Beta Test” the E/M Leveling guidelines
- Developed a scoring worksheet to evaluate MDM
- Never made it into the official guidelines, but are commonly used for evaluation of MDM

A	B	C	B X C
Number of Diagnoses or Treatment Options	**Number**	**Points**	**Results**
Problems to Examining Physician	Max = 2	1	
Self-limited or Minor			
(stable, improved or worsening)		1	
Established Problem (to examiner) stable, improved		2	
Established Problem (to examiner) worsening	Max = 1	3	
New Problem (to examiner) **no additional work-up planned**		4	
New Problem (to examiner) **additional work-up planned**		Total	

Diagnoses or Treatment Options

How should "additional workup planned" be scored?

Planned for future visits?

Planned and performed in the same visit?

Per ACEP interpretation "the Marshfield Clinic Scoring Tool is that additional work-up was "planned," <u>not</u> whether it was performed on the same day or a later date."

Amount/Complexity of Data Reviewed

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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 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	

Tables of Risk: High

Risk Level	Presenting Problems	Diagnostic Procedures	Management Options Selected
HIGH Requires ONE of these elements in ANY of the three categories listed	• One or more chronic illness with severe exacerbation or progression • Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others, peritonitis, ARG • An abrupt change in neurological status, e.g. seizure, TIA, weakness, sensory loss	• Cardiovascular imaging studies, with contrast, with identified risk factors • Cardiac EP studies • Diagnostic endoscopies, with identified risk factors • Discography	• Elective major surgery (open, percutaneous, orendoscopic), with identified risk factors • Emergency major surgery (open, percutaneous, endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate, or to de-escalate care because of poor prognosis

Tables of Risk: Moderate

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Risk Level	Presenting Problems	Diagnostic Procedures	Management Options Selected
MODERATE Requires ONE of these elements in ANY of the three categories listed	• Two stable chronic illnesses • One chronic illness with mild exacerbation or progression • Undiagnosed new problem with uncertain prognosis (e.g., lump in breast) • Acute uncomplicated injury or illness, e.g., cystitis, allergic rhinitis, sprain	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies, with no identified risk factors • Deep needle, or incisional biopsies • Cardiovascular imaging studies, with contrast, with no identified risk factors, e.g., arteriogram, cardiac catheterization • Obtain fluid from body cavity, e.g., LP/thoracentesis	• 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

Tables of Risk: Minimal and Low

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Risk Level	Presenting Problems	Diagnostic Procedures	Management Options Selected
MINIMAL Requires ONE of the elements in ANY of the three categories listed	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Lab tests • Chest X-rays • EKG/EEG • Urinalysis • Ultrasound / Echocardiogram • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW Requires ONE of these elements in ANY of the three categories listed	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled HTN, DM2, cataract • Acute uncomplicated injury or illness, e.g., cystitis, allergic rhinitis, sprain	• Physiological tests not under stress, e.g., PFTs • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsy	• Over the counter drugs • Minor surgery, with no identified risk factors • Physical therapy

Score MDM

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MDM Score					
A	Circle the Total number in section A	≤ 1 Minimal	2 Limited	3 Multiple	≤ 4 Extensive
B	Circle the Total number in section B	≤ 1 Minimal or None	2 Limited	3 Multiple	≤ 4 Extensive
C	Circle the Level in section C	Minimal	Low	Moderate M	High H
	Final MDM Score	**Straightforward**	**Low L**	**Moderate M**	**High H**
Complexity Level of Medical Decision Making (MDM)					
Draw a line down the column with 2 or 3 circles and circle decision making level OR Draw a line down the column with the center circle = level of MDM					

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.

“The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”

Time Based Code Selection

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- Provider has the option to define visit according to time spent, *except* in ER visits
- Time includes Face-to-face time in the office or other outpatient setting, or floor/unit time in the hospital or nursing facility
- Time spent with the patient and family, and/or spent in care of the patient on the floor (includes discussions with nurses, ordering follow up services, etc..) must be clearly indicated
- NO time can be counted once provider leaves the floor, even if additional follow up is required
- For Office based services, provider must certify that more than 50% of time spent was spent on counseling
- Time-based dictation determines the level if present

Scoring by Time

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- Must document face to face time, and greater than 50% of time spent counseling for office based services
- Must document Inpatient and Observation time, and more than 50% of time spent
  - On the unit in dedicated coordination of care of the patient, including supportive documentation as to how time was spent, or
  - More than 50% of the time spent counseling
- Once time is documented STOP and code according to time

<table>
<tr><th colspan="4">TIME</th></tr>
<tr><td colspan="4">If the physician documents total time and suggests that counseling or coordinating care dominates (greater than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, and/or risk reduction.</td></tr>
<tr><td>Does documentation reveal total time? Time: Face-to-face outpatient setting
Unit/floor in inpatient setting</td><td>☐ Yes</td><td>☐ No</td><td rowspan="2">If both answers are yes, select the level based on time</td></tr>
<tr><td>Does documentation describe the content of counseling or coordinating care?</td><td>☐ Yes</td><td>☐ No</td></tr>
</table>

Time Based Code Assignment

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New Office / Outpatient Visits & Office / Inpatient Consultations				
99201-10	99202-20	99203-30	99204-45	99205-60
99241-15	99242-30	99243-40	99244-60	99245-80
99251-20	99252-40	99253-55	99254-80	99255-110

Established Patient Office / Outpatient Visits				
99211-5	99212-10	99213-15	99214-25	99215-40

Initial Hospital Visits / Observation Care				
99221-30		99222-50		99223-70
99218		99219		99220
99234		99235		99236

Subsequent Hospital				
99231-15		99232-25		99233-35

Initial Nursing Facility Care				
99304-25		99305-35		99306-45

Subsequent Nursing Facility Care				
99307-10	99308-15	99309-25	99310-35	

New Patient Home / Domiciliary / Custodial / Rest Home / etc.				
99341-20	99342-30	99343-45	99344-60	99345-75
99324-20	99325-30	99326-45	99327-60	99328-75

Estalished Home / Domiciliary / Custodial / Rest Home / etc.				
99347-15	99348-25	99349-40	99350-60	
99334-15	99335-25	99336-40	99337-60	

Out Patient New Vs. Established

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New Patient

- An individual who did not receive any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous 3 years

Established Patient

- An individual who received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

Inpatient

- Same specialty during the current Inpatient stay

Observation

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- Initial observation care (99218-99220) represents all of the care rendered by the ordering physician on the date the patient's observation services began
- For stays lasting less than eight hours, report only the initial observation, no discharge
- Subsequent observation care (99224-99226) represents all the care rendered by the physician of record on the day(s) other than the initial or discharge date
- All other physicians who furnish consultations or additional evaluations or services must bill the appropriate outpatient (99201-99215) service codes

Observation Admit and Discharge Same Day

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For stays lasting more than 8 hours, and discharged on the same day, use code range Observation or Inpatient care, including admission and discharge on the same day

99234-99236

If a patient is admitted to inpatient following observation, the treating physician reports only the initial hospital visit code for the date.

99221-99223

No observation service or discharge can be reported.

Observation Discharge 99217 Should be reported to represent all discharge services provided by he physician of record if the date of discharge is not the initial date of observation, or the date transferred to inpatient

Inpatient

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- Initial Hospital Care and Subsequent Hospital Care codes are “per diem” services
- Report only once per day by the same physician or physicians of the same specialty from the same group practice
- All physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221-99223)
- The physician of record should append modifier AI
- Other specialist should be managing concurrent issues not managed by the physician of record
- Report subsequent codes (99231-99233) for follow-up visits by all physicians

Inpatient Discharge

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- Only the attending physician of record may report discharge day management service
- Report discharge visits on the actual date of the visit, even if the patient is discharged from the facility on a different calendar date
- Represents services performed by clinician during final steps of discharge
  - Last exam
  - Discussing hospital stay
  - Instructions for ongoing care
  - Preparing discharge records
  - Prescriptions
  - Referrals

Inpatient Discharge

Time based Codes

Time does not need to be concurrent

99238 - Hospital discharge day management; 30 minutes or less

99239 - Hospital discharge day management; more than 30 minutes

Bring It All Together

- Most Auditors start with Chief Complaint
- No chief complaint, no E/M
- Next, review MDM
  - MDM should support the need for relevant documentation
  - If MDM does not support the level, then all of the documentation in the world will not make a visit high level
- Determine type of visit
- New/Established/Consult outpatient
  - ER or OBS
  - Inpatient initial, subsequent or consult
  - Is time-based dictation present for service other than ER?
  - Yes, STOP and code
  - No, continue assessment
- Determine how many components must be satisfied for leveling
- Evaluate level components
- Assign final level

Outpatient Visits

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New Office/Outpatient Visits & Office/Inpatient Consultations					
Level	**Draw a line down the column which has a key component identified which is the farthest to the left (leveled by the lowest)**				
HX	PF	EPF	D	C	C
EX	PF	EPF	D	C	C
MDM	SF	SF	L	M	H
CPT Code	**99201-10** **99241-15** **99251-20**	**99202-20** **99242-30** **99252-40**	**99203-30** **99243-40** **99253-55**	**99204-45** **99244-60** **99254-80**	**99205-60** **99245-80** **99255-110**

Established Patient Office/Outpatient Visits				
If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code				
Minimal problem that may not require presence of MD/DO	PF	EPF	C	C
	PF	EPF	C	C
	SF	L	M	H
99211-5	**99212-10**	**99213-15**	**99214-25**	**99215-40**

Emergency Room

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- Emergency services cannot consider time-based guidelines

EMERGENCY CARE SERVICES					
Level	**Draw a line down the column which has a key component identified which is the farthest to the left (leveled by the lowest)**				
HX	PF	EPF	EPF	D	C
EX	PF	EPF	EPF	D	C
MDM	SF	SF	M	M	H
CPT Code	**99281**	**99282**	**99283**	**99284**	**99285**

Inpatient and Observation

Initial Hosp. Visits & Observation Care			
Level	**Draw a line down the column which has a key component identified which is the farthest to the left (leveled by the lowest). These are PER DAY CODES.**		
HX	D OR C	C	C
EX	D OR C	C	C
MDM	SF/L	M	H
CPT Code	**99221-30 99218 99234**	**99222-50 99219 99235**	**99223-70 99220 99236**

Subsequent Hosp.		
If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code. This is a PER DAY CODE.		
PF interval	EPF interval	D interval
PF	EPF	D
SF/L	M	H
99231-15	**99232-25**	**99233-35**

Questions?

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SCIENCE FACT: If you took all of the veins from your body and laid them end to end, you would die.

Resources

- https://www.acep.org/Clinical---Practice-Management/Medical-Decision-Making-And-The-Marshfield-Clinic-Scoring-Tool-FAQ/#sm.0000m8839m10hgea8x1g6d44btnsi
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/referenceII.pdf
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