Evaluation and Management (E/M)

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OIG Report

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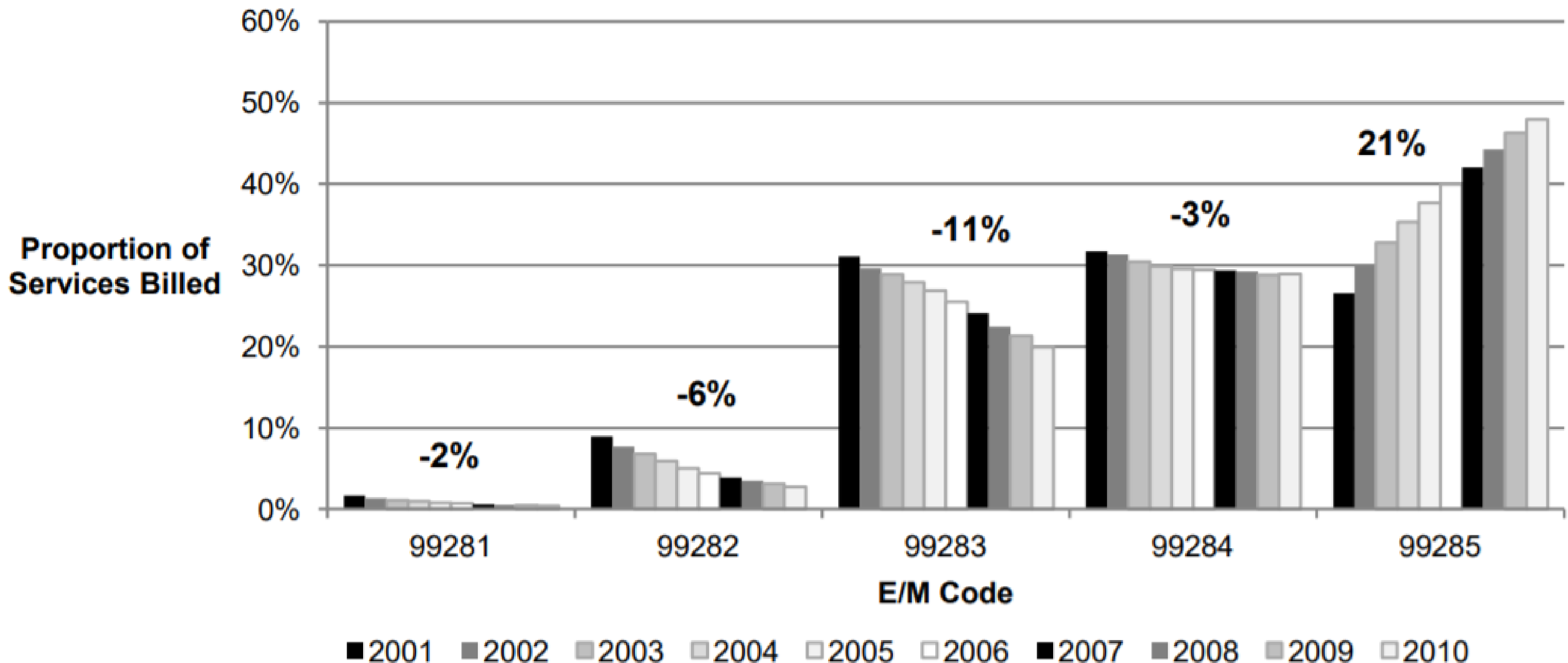
- Improper payments for evaluation and management services cost Medicare billions in 2010:



*Percentages do not sum to zero because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 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.

History

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Chief Complaint

History of Present Illness

Review of Systems

PFSH

- Ancillary staff or patient completion allowed for ROS and PFSH
- CMS allows ancillary staff to collect Chief Complaint and History

- Physician must add a notation supplementing or confirming the information recorded by others

HPI (History of Present Illness)

- 1995 HPI includes
  - Location
  - Quality
  - Severity
  - Duration
  - Timing
  - Context
  - Modifying factors
  - Associated signs and symptoms
- 1997 HPI includes
  - 1995 guidelines
  - Status of at least 3 chronic or inactive conditions
- Per CMS
  - 1997 guidelines for HPI may be combined with other elements of 1995 guidelines to document E/M

History of Present Illness

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Severity Quality Location

The patient reports excruciating piercing headaches for the first few hours

Timing

every morning, until her coffee kicks in.

Is this a modifying factor, or context?

- Location. Where is the site of the problem? ...
- Quality. What is the nature of the pain? ...
- Severity. ...
- Duration. ...
- Timing. ...
- Context. ...
- Modifying factors. ...
- Associated signs and symptoms.

Greater than 4 HPI scores extended

There's an App for That

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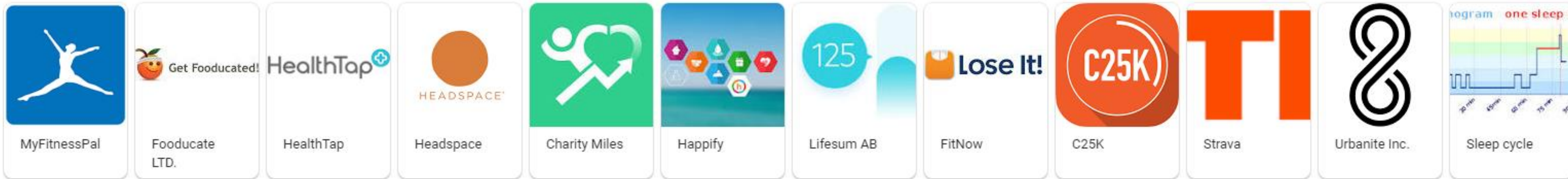

- Apps may help or may cloud issues and encourage capturing of data with cursory review
  - Identify elements of HPI
  - Health history questionnaires
  - Print copies for appointments

…say "I feel symptoms every day, especially after I work out," or "I only notice my symptoms occasionally, like every few days."

…if you're experiencing headaches, use descriptive words like sharp, dull, stabbing, or throbbing. You can use these kinds of terms to describe many physical symptoms

…if symptoms are connected to specific activities, injuries, times of day, food or beverages, and anything else that exacerbates them. Also note if they affect your life in any way

Review of Systems

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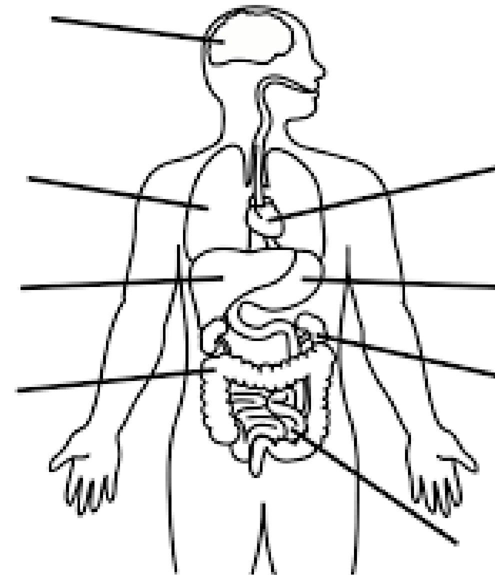
Categories	Score
• Constitutional (e.g., fever, weight loss) • Eyes • Ears, Nose, Mouth, Throat • Cardiovascular • Respiratory • Gastrointestinal • Genitourinary • Musculoskeletal • Integumentary (skin and/or breast) • Neurological • Psychiatric • Endocrine • Hematologic/Lymphatic • Allergic/Immunologic	• None • Extended: 2-9 • Complete: > 10 • All others negative



Past Family, Social, History

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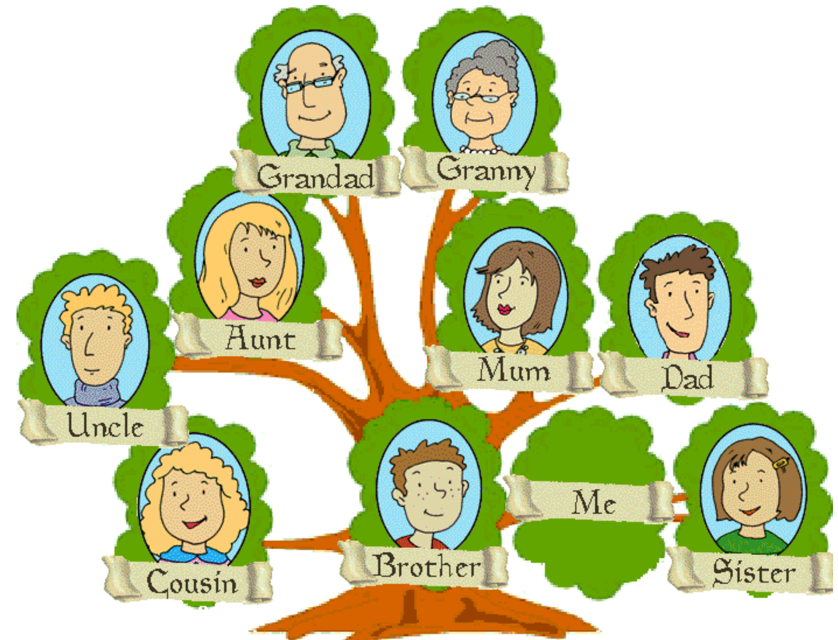
Categories	Score
• Past – Patient illness, injuries, operations, treatments, allergies • Family – Relevant history e.g. hereditary illnesses • Social – Patient social behavior particularly those that could impact health	• None • One in ED, otherwise 1-2 • Two in ED, otherwise 2-3



Noncontributory: Past Medical, Family, Social History

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- Palmetto GBA: *"noncontributory, unremarkable, or negative" does not indicate what was addressed. Did the nurse or physician ask specific conditions (e.g., any family history of coronary artery disease)? If for some reason you cannot obtain the family history, the documentation must support the reason why (e.g., the patient was adopted).“*
- 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.”*
- Other MACs Silent

Final History Score

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Lowest Score Rules

1 HPI, No ROS and 3 PFSH	Problem Focused (lowest score)
1 HPI, 1 ROS, 3 PFSH	Expanded problem focused
4 or more HPI, 2-9 ROS, 1 PFSH	Detailed
4 or more HPI, 10 ROS, 3 PFSH	Comprehensive

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:

- [X] **Location** Where is problem?
- [X] **Duration** Onset of .symptoms to present.
- [ ] **Modifying Factors** What have you done to alleviate or worsen symptoms?
- [ ] **Severity** How bad on a scale 1/10
- [ ] **Timing** When/how often
- [X] **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.

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)

	PROB. FOCUSED	EXP. PROB. FOCUSED	DETAILED	COMPRE-HENSIVE
HPI	Brief 1-3 HPI elements	Brief 1-3 HPI elements	Extended ≥4 HPI elements or status of ≥ 3 chronic or inactive conditions	Extended ≥4 HPI elements or status of ≥ 3 chronic or inactive conditions
ROS	None	1 ROS	Extended 2-9 ROS	Complete ≥ 10 ROS or some systems + statement "all others negative"
PFSH – Established/ Subsequent *E.D.	None	None	1 PFSH	2 PFSH
PFSH – New or Initial	None	None	1-2 PFSH	3 PFSH
	PF	EPF	D	C

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.**

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
Some MACs determine EPF or Detailed		
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

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- 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 2-5 body parts or organ systems would be considered 'Expanded Problem Focused'
  - Physical Examination of 6-7 body parts or organ systems would be considered 'Detailed'
- Other MACs are silent

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 are more specifically geared toward the specialty than are the general criteria
- Provider does not need to be specialist to use specialty criteria
- Must be relevant to reason for visit

https://emuniversity.com/SpecialtyExams.html

Medical Necessity

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"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."

Medical Decision Making

Nature of Clinical Problem

- New to provider
- Established, stable or worsening
- Additional work-up required

Data Reviewed

- Clinical labs
- Independent review of results
- Discuss with other provider
- Medicine tests
- Radiology
- Old records

Table of Risk

- Presenting problem
- Diagnostic procedures
- Management options selected

Medical Decision Making: Assessment & Plan

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- For each encounter, an assessment, clinical impression, and diagnosis should be documented
- Presenting problem(s) of an established diagnosis(es) should reflect whether the problem is:
  - Improved, well controlled, resolving, or resolved; or Inadequately controlled, worsening , or Failing to change as expected
  - "Possible," "probable," or "rule out;" acceptable in MDM, but coding should report ICD-10 CM codes for signs/symptoms
  - The initiation of, or changes in treatment should be documented. Can include patient instructions, nursing instructions, therapies, and medications
- If the visit MDM does not require detail required to meet a higher level CPT, a lower level code should be reported
- Do NOT include additional components for the purposes of achieving a higher level CPT

Medical Decision Making

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A **Presenting Problems to the Treating Provider** (# Diags Require Active Management **or Affect Treatment Options**)			
	Points = Result		
Self limited / minor (stable, improved or worse)	Max=2	1	
Est. problem (stable, improved)		1	
Est. problem (worsening)		2	
New problem (to Provider) (no add'l workup)	Max=1	3	
New problem (to Provider) (additional workup)		4	
Bring total to Line A in Final Result for Complexity		**TOTAL**	

B Amount **and/or** Complexity of Data to be Reviewed	**Pts.**
Review or order of clinical lab tests	1
Review or order of tests in the radiology section of CPT	1
Review or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decide **to obtain** old records or **to obtain** history from someone else	1
Review & summarize old records **or get Hx** from someone **or** talk with **other provider**	2
Independent visualization of image, tracing or specimen itself (not simply review of the paper copy report)	2
Bring total to Line B in Final Result for Complexity **TOTAL**	

Medical Decision Making

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C — Risk of Complications / Morbidity / Mortality: Check off all that apply. The **highest** level of risk in any one column determines the overall risk.

Level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
MINIMAL	• One self-limited or minor problem, *e.g., cold, insect bite, tinea corporis*	• Laboratory tests requiring venipuncture • Chest x-rays KOH prep or EKG/EEG • Urinalysis or Ultrasound e.g., echo • Potassium Dydroxide prep etc.	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW	• 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*	• Physiologic test not under stress e.g., *pulm. function tests* • Non-cardiovascular imaging studies with contrast *e.g., barium enema* • Superficial needle biopsies or Skin biopsies • Clinical laboratory tests requiring arterial puncture	• 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 e.g., lump in breast • Acute illness with systemic symptoms *e.g., pyelonephritis pneumonitis, colitis* • Acute complicated injury *e.g., head injury with brief loss of consciousness*	• 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 • Caridovascular imaging studies with contrast and no identified risk factors *e.g., arteriogram, cardiac cath* • Obrtain fluid from body *cavity e.g., 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 may pose a threat to life or bodily function *e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure* • An abrupt change in neurological status *e.g., seizure, TIA, weakness, sensory loss*	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electophysiological tests • Diagnostic endoscopies with **identified risk factors** • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factor • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or de-escalate care because of poor prognosis

Medical Decision Making

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- Patient follow-up for well controlled hypertension and hypercholesterolemia
- No reported issues
- Prescriptions refilled and follow-up scheduled
- Number of diagnoses (2 stable) = 2
- Amount of data reviewed = 0
- Table of risk - Prescription drug management = moderate

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	High
	Complexity Level of Medical Decision Making (Mdm)	STRAIGHTFORWARD **SF**	**LOW L**	**MODERATE M**	**HIGH H**

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**

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, other outpatient setting, 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

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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99234-99236	99221-99223	99217
• For stays lasting more than 8 hours, and discharged on the same day, use code range observation admission and discharge on the same day	• If a patient is admitted to inpatient following observation, the treating physician reports only the initial hospital visit code for the date. • No observation service or discharge can be reported.	• Observation discharge should be reported to represent all discharge services provided by the 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 NPPs 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

Initial Inpatient Codes

- Must have documentation in **all three** categories of history, exam, and medical decision making to meet level of service,

  OR

  Clear documentation of time when counseling and/or coordination of care is greater than 50% of the total visit

- Can be down coded if only 2 of three categories documented per CMS Transmittal 2282, August 26, 2011:

  > *"Medicare contractors shall not find fault with providers who report a subsequent hospital care code (99231 and 99232) in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay."*

Subsequent Visits

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- Must have documentation in **at least two categories** of history, exam and medical decision making

  OR

- PFSH not required
- Documentation of time when counseling and/or coordination of care is greater than 50% of the total time
- Modifier AI should not be reported in conjunction with subsequent codes, even for physician of record

Subsequent Inpatient

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- Patient is feeling much better
- Does not feel like going home today
- Would like to stay another day
- Admit to Inpatient

Subsequent Inpatient

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- Patient is a 56 year old insulin dependent diabetic with a continuous glucose monitor. She presented to the emergency department yesterday with chest pain and abdominal pain.
- The patient is a nurse, and states previous episodes of Atrial Fib. Afib was confirmed by the ED and the patient was admitted for observation.
- She had extensive vomiting overnight, and glucose levels above 380 mg/dl. Her hemoglobin result last night was 8 g/dl. Overnight, she was hydrated and received 2 units of blood. She is feeling much better. Afib is resolving, but H/H is still well below normal, as indicated in the most recent lab results. She has noted black stool, concerning for a GI bleed. Due to difficulties managing glucose levels, and concerns for a GI bleed.
- I expect to keep this patient at least 2 more midnights to further diagnose and stabilize her. If cardiac and glucose results remain stable, I will schedule an EGD for tomorrow.

Inpatient Discharge

- 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

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Time based coding

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

Critical Care Codes

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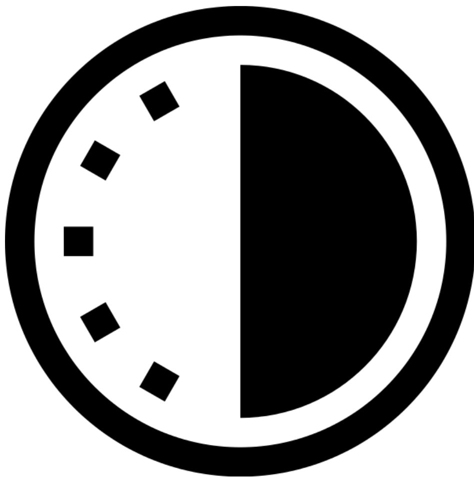
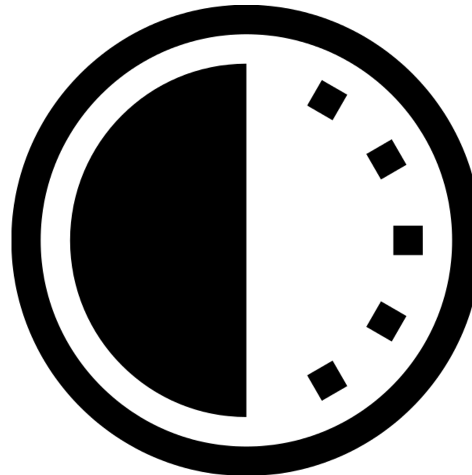
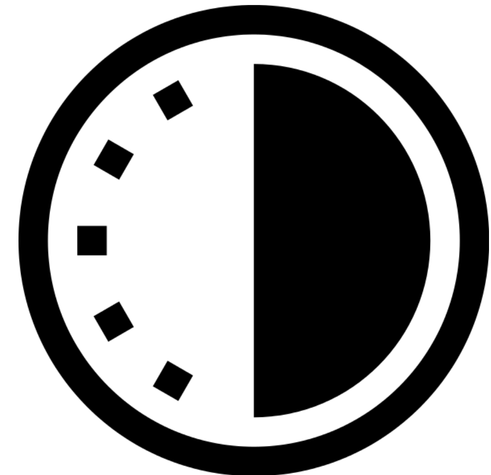
- 99291 Critical Care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
- 99292 Critical Care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes are listed separately in addition to code for primary service

Critical Care Evaluation and Management

- CPT defines Critical Care as an illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition.
- CMS adds, “the failure to initiate … interventions on an urgent basis would likely result in sudden, clinically significant or life-threatening deterioration in the patient's condition.”
- CMS ultimately defines, “Critical care involves high complexity decision making to assess, manipulate, and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient’s condition.”

Critical Care

- Treatment of a patient in a critical care unit, who does not meet the guidelines (vital organ failure *and* prevention of life threatening deterioration) must be reported using the appropriate subsequent hospital visit code 99231-99233
- CMS does not allow billing for emergency room visits on the same day as critical care services even if the services represent different blocks of time in the same day
- Multiple physicians may support vital systems, and may report critical care on the same DOS, but not in overlapping times

Bundled Services in Critical Care

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- The following services when performed on the day a physician bills for Critical Care are included in the Critical Care service and should **not** be reported separately
  - The interpretation of cardiac output measurements (CPT 93561, 93562)
  - Chest x-rays, professional component (CPT 71010, 71015, 71020)
  - Blood draw for specimen (CPT 36415)
  - Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data-CPT 99090)
  - Gastric intubation (CPT 43752, 91105)
  - Pulse oximetry (CPT 94760, 94761, 94762)
  - Temporary transcutaneous pacing (CPT 92953)
  - Ventilator management (CPT 94002 – 94004, 94660, 94662) and
  - Vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600)
- Check CCI edits for facility requirements

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

https://emuniversity.com/COW/NHIC.pdf

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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)**	
☐ Head/Face	☐ Constitutional	☐ Skin
☐ Neck	☐ Eyes	☐ Neuro
☐ Abdomen	☐ Ears, nose, mouth, throat	☐ Psych
☐ 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	

1995 Guidelines			
1 (BA) or (OS) (**Limited** exam of **affected BA** or OS)	**2-7** (OS) and/or (BA) (**Limited** exam of **affected BA** or OS and other symptomatic or related OS(s))	**2-7** (OS) and/or (BA) (**Extended** exam of **affected BA(s)** and other or related OS(s))	**8** or more (OS) (A **general multisystem** exam or **complete exam of a single** organ system)
PF	**EPF**	**D**	**C**

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DECISION MAKING

A **Presenting Problems to the Treating Provider**
(**#** Diags Require Active Management **or Affect Treatment Options**)

	Points = Result		
Self limited / minor (stable, improved or worse)	Max = 2	1	
Est. problem (stable, improved)	Max = 2	1	
Est. problem (worsening)	Max = 2	2	
New problem (to Provider) (no add'l workup)	Max=1	3	
New problem (to Provider) (additional workup)	Max=1	4	
Bring total to Line A in Final Result for Complexity		**TOTAL**	

B Amount **and/or** Complexity of Data to be Reviewed **Pts.**

Review or order of clinical lab tests	1
Review or order of tests in the radiology section of CPT	1
Review or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decide **to obtain** old records or **to obtain** history from someone else	1
Review & summarize old records **or get Hx** from someone **or** talk with **other provider**	2
Independent visualization of image, tracing or specimen itself (not simply review of the paper copy report)	2
Bring total to Line B in Final Result for Complexity **TOTAL**	

C Risk of Complications / Morbidity / Mortality: Check off all that apply. The **highest** level of risk in any one column determines the overall risk.

Level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
MINIMAL	• One self-limited or minor problem, e.g., *cold, insect bite, tinea corporis*	• Laboratory tests requiring venipuncture • Chest x-rays, KOH prep or EKG/EEG • Urinalysis or Ultrasound **e.g., echo** • Potassium Dydroxide prep etc.	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW	• 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*	• Physiologic test not under stress **e.g.,** *pulm function tests* • Non-cardiovascular imaging studies with contrast e.g., *barium enema* • Superficial needle biopsies or Skin biopsies • Clinical laboratory tests requiring arterial puncture	• 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 **e.g., lump in breast** • Acute illness with systemic symptoms e.g., *pyelonephritis pneumonitis, colitis* • Acute complicated injury e.g., *head injury with brief loss of consciousness*	• 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 • Caridovascular imaging studies with contrast and no identified risk factors e.g., *arteriogram, cardiac cath* • Obtain fluid from body *cavity e.g., 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 may pose a threat to life or bodily function e.g., *multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure* • An abrupt change in neurological status e.g., *seizure, TIA, weakness, sensory loss*	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electophysiological tests • Diagnostic endoscopies with **identified risk factors** • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factor • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or de-escalate care because of poor prognosis

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	High
Complexity Level of Medical Decision Making (Mdm)		STRAIGHTFORWARD SF	LOW L	MODERATE M	HIGH H

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**

TIME

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.

Does documentation reveal total time? Time: Face-to-face outpatient setting Unit/floor in inpatient setting	☐ Yes	☐ No	If both answers are "yes," you may select the level based on time.
Does documentation describe the content of counseling or coordinating care?	☐ Yes	☐ No	

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	New Office/Outpatient Visits & Office/Inpatient Consultations					Established Patient Office/Outpatient Visits				
Level	Draw a line down the column which has a key component identified which is the farthest to the left (leveled by the lowest)					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				
HX	PF	EPF	D	C	C	*Minimal problem that may not require presence of MD/DO*	PF	EPF	D	C
EX	PF	EPF	D	C	C		PF	EPF	D	C
MDM	SF	SF	L	M	H		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	99211-5	99212-10	99213-15	99214-25	99215-40

	Initial Hosp. Visits & Observation Care			Subsequent Hosp.		
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 <u>PER DAY CODES</u>			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 <u>PER DAY CODE</u>		
HX	D or C	C	C	PF interval	EPF interval	D interval
EX	D or C	C	C	PF	EPF	D
MDM	SF/L	M	H	SF/L	M	H
CPT Code	99221-30 99218 99234	99222-50 99219 99235	99223-70 99220 99236	99231-15	99232-25	99233-35

	EMERGENCY CARE SERVICES				
	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	L	M	M	H
CPT Code	99281	99282	99283	99284	99285

CMS Changes Effective 2019

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- Relevant data already in the record does not need to be restated each visit
- Provider must
  - Document what has changed
  - Document pertinent information that has not changed
  - Document evidence that prior data was reviewed and updated as necessary
- Does not need to restate chief complaint and history collected by ancillary staff
- Document information was reviewed and verified
- *CMS has not provided expectations for the way in which its new guidelines will be audited*

2020

- Elimination of requirement to document medical necessity of home visits in lieu of office visits
- Providers may document what has changed since the last visit or, pertinent items that have not changed. No longer need to rerecord the defined list of required elements
- Providers are not required to re-enter the patient’s chief complaint and history already entered by ancillary staff
- May indicate that the information has been reviewed
- Providers should remove potentially duplicate information entered or included by residents or other members of the medical team for E/M visits furnished by teaching physicians

Code Changes Effective 2021

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- Deletion of 99201
- New guidelines specific to 99202-99215
- Changes in component scoring for both new and established patient codes (99202-99215)
  - Time alone can select level. Counseling/coordination of care no longer necessary
  - Documentation of history and physical examination will still need to be medically appropriate
  - Amount of history or number of elements examined and documented will not factor into the scoring
- Changes to the medical decision-making table
  - Level based on MDM and time
- Changes to the typical times associated with each E/M code (99202-99215)

Time Calculation 2021

- Includes both the face-to-face and **non-face-to-face time** personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter
  - Preparing to see the patient (e.g., review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, tests, or procedures
  - Other services **not separately reported**
    - Referring and communicating with other health care professionals Documenting clinical information in the electronic or other health record
    - Independently interpreting results
    - Updates or discussions with Patient/family/caregiver
    - Care coordination

2021 History and Exam

- Report when performed
- Nature and extent of the history and/or physical examination is determined by the treating physician or other qualified NPP
- Care team may collect information and the patient or caregiver may supply information directly
- Extent of history and physical examination is not an element in selection of office or other outpatient services

2021 Medical Decision Making

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- Comorbidities are not considered in selecting a level of E/M services unless they are addressed *and t*heir presence increases:
    - The amount and/or complexity of data to be reviewed and analyzed *or*
    - The risk of complications and/or morbidity or mortality of patient management
- Final diagnosis for a condition does not in itself determine the complexity or risk
- Extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.
- Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

New vs. Established

- A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years
- Where a physician/qualified health care professional is on call for or covering for another physician/ qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available.
- When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician.

2021 Table of Risk

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM) Elements of Medical	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 **99213**	**Low**	**Low** • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** **• Any combination of 2 from the following**: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* **or Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**

Table of Risk 2021

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM) Elements of Medical Decision Making	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
99204 **99214**	**Moderate**	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** **• Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with	**Moderate risk of morbidity from additional diagnostic testing or treatment** Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 **99215**	**High**	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** (Must meet the requirements of at least 2 out of 3 categories) **Category 1: Tests, documents, or independent historian(s)** **• Any combination of 3 from the following**: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate	**High risk of morbidity from additional diagnostic testing or treatment** Examples only: : • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to deescalate care because of poor prognosis

2021 Evaluation and Management Training

- Begin notification early
- Provide education for code selection
- Update
  - Templates
  - Macros
  - EMR
- Audit frequently

Resources

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- http://www.emuniversity.com/Free/Guide.pdf
- https://emuniversity.com/Templates.html
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/referenceII.pdf
- https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00004966
- https://med.noridianmedicare.com/documents/10542/2840524/Common+E%26M+Errors+by+Cert+and+Medical+Review+Presentation
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Resources

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- https://emuniversity.com/COW/NHIC.pdf
- 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
- https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00004966