Evaluation and Management Services
Sticking to the Basics to Avoid Unnecessary Audits

October 30, 2014
Disclaimer

The purpose of this publication is to accompany a lecture prepared and presented by GILL COMPLIANCE SOLUTIONS, LLC. It is supplemental and is not a substitute for the CPT® or the ICD-9-CM coding manuals. There is no guarantee that the use of this presentation will prevent differences of opinion with providers or carriers in reimbursement disputes.

There is no implied or expressed warranty regarding the content of this publication or presentation due to the constant changing regulations, laws and policies. It is further noted that any and all liability arising from the use of materials or information in this publication and/or presentation is the sole responsibility of the participant and their respective employers, who by his or her purchase of this publication and/or attendance at a presentation evidences agreement to hold harmless the aforementioned party.

This publication is intended to be used as a teaching tool accompanying the oral presentation only.
Today’s Agenda

- Evaluation and management criteria for new, established, admission and subsequent visits.
- Uses of 1995 to 1997 exam guidelines and impact on EMR code checks or encoders.
- Ancillary staff and scribing.
- Time based services for E/M outpatient & inpatient application.
- Basics of “incident to” and shared services with consideration to regulatory constraints based on place of service.
- Questions?
Authentication Rules

**CMS on Signatures:**

- Notes should clearly identify authorship and should provide clarity as to who provided what elements of service.
- All notes should contain an official electronic authentication from provider and should be done before billing is performed. Notes as “incomplete”, “unsigned” or “un-reviewed” are not considered complete and authenticated.
- For electronic records; Pending, Revised does not qualify as “authenticated” as per CMS.
- Handwritten signature must be legible as per CMS guidelines.
Chief Complaint / Reason for Visit

Every visit should clearly indicate a “reason for visit” or “chief complaint”:

- CMS: A CC is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient’s own words. For example, patient complains of upset stomach, aching joints, and fatigue. The medical record should clearly reflect the CC/reason for visit. CMS AUDIT FOCUS!

- Noridian POE 4/2011: Medical records must be complete, legible and include the following information:
  - Reason for encounter, relevant history, findings, test results and date of service
  - Assessment and impression of diagnosis
  - A clear, concise reflection of patients condition
  - Plan of care with date and legible identity of observer
New and Established IP/OP Visits

**New Patient and Initial Hospital Criteria:**

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

  OR

- May satisfy criteria by documentation of time when counseling and/or coordination of care is greater than 50% of the total time taken.

**Definition of a “New Patient”:**

- CMS Definition:
  - One who has not received a face-to-face evaluation and management service or procedure from a physician, or colleague of the same specialty (or subspecialty; AMA 2012) who belongs to the same group practice within the past 3 years. Does not apply to admission, critical care services or ER.

- Based on Payor credentialing

- Mid-levels are non-designated (specialty) in most states (check your MAC)

**Established or Subsequent Patients:**

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

  OR

- May satisfy criteria by documentation of time when counseling and/or coordination of care is greater than 50% of the total time taken.
History Components

History Components:
- Made of three sub-sections:
  - HPI (history of present illness)
  - ROS (review of systems)
  - PFSH (past, family and social history)

History of Present Illness:
- Combination of ELEMENTS or summary of 3 chronic conditions relevant to chief complaint or reason for follow up.

September CMS Changes:
E/M services health care professionals may use either version of the 1995 or 1997 documentation guidelines, not a combination of the two, for a patient encounter. A FAQ on 1995 & 1997 Documentation Guidelines for Evaluation & Management Services can be accessed in the Downloads Section below. It provides information about using the 1997 documentation guidelines for an extended history of present illness along with other elements from the 1995 guidelines to document an E/M service performed on or after September 10, 2013.

History Components—HPI

- **Location**: Where is the problem located?
- **Quality**: Description of pain or problem (stabbing, tingling pain etc.)
- **Severity**: Problem is getting better, worsening, scale from 1–10 for pain etc.
- **Duration**: How long has the problem been present?
- **Timing**: At what point is the problem most/least active? (at night, during activity etc.)
- **Context**: How did the problem occur? (fell off a curb etc.)
- **Modifying factors**: What has been done to ease the pain or problem (bracing, OTC, Rx’s, hot/cold packs etc.)
- **Associated signs and symptoms**: Other symptoms exacerbating condition (nausea w/vomiting)
  **OR** status of 3 or more chronic conditions.
History Components—HPI

**HPI Tips for Each Visit:**

- HPI should clearly show development of problem since last visit
- If new problem should be clearly identifiable as a new issue
- Conditions and diagnoses the patient presents at a given appointment should correlate throughout the note starting with HPI, physical exam (if applicable), assessment & plan

**Noridian E/M Workshop August 2014:**

**Q** An RN or NP obtained the HPI and documents it. The physician then goes over the information with the patient to verify it, can the MD say, "I verified the HPI with the patient. Please see RN/NP documentation above?"

**A** If that scenario takes place, the information will not be accepted if reviewed. *The MD must gather and document the HPI themselves.* The ROS and PFSH can be recorded by other staff and the physician then reviews and confirms the information.
History Components—ROS

**Definition of Review of Systems:**
- An oral account (by patient or guardian) of signs and symptoms the patient is or has experienced

**Review of Systems:**
- There are three levels of ROS recognized by the E/M guidelines:
  - **Problem Pertinent ROS:** Requires review of ONE system related to current problem(s)
  - **Extended ROS:** Requires review of TWO to NINE systems
  - **Complete ROS:** Requires review of at least 10 systems (CMS suggests 14)

**Review of system noncontributory or all others negative:**
- **CMS DG:** If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance which precludes obtaining a history
History Components—ROS

Review of Systems:

- **CMS DG**: ROS and/or PFSH 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.

- **CMS DG**: ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

- **CMS DG**: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance which precludes obtaining a history.

- **14 PT inventory recommended for high level visits – payor specific.**
D. Use of Highest Levels of Evaluation and Management Codes
Contractors must advise physicians that to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet CPT’s definition of a comprehensive history). The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit. In the case of an established patient, it is acceptable for a physician to review the existing record and update it to reflect only changes in the patient’s medical, family, and social history from the last encounter, but the physician must review the entire history for it to be considered a comprehensive history.

History Components—PFSH

PFSH Components:

- **Past history**: Medications and/or patient’s past experiences with illnesses, operations, injuries and treatments
- **Family history**: A review of medical events in the patient’s family, including diseases that are hereditary or presents a risk factor for the patient.
- **Social history**: An age appropriate review of past and current activities

Past, Family, and Social History:

- Documentation in all three history areas is required in comprehensive levels of service for new outpatient encounters, initial hospital encounters, and initial skilled nursing facility encounters.
- History areas given as unremarkable or non-contributory can be considered insufficient information by many payors. CMS recommends giving greater clarity as to the information reviewed, with pertinence to the patient’s conditions or complaint, and found to be negative.
History Components—PFSH

Noridian E/M Workshop 6/8/11:

Q Is it appropriate to indicate “non-contributory” when completing the family history (FH) if the information obtained is not germane to the clinical problems at hand?

A Something specific should be provided in the FH. When it is not relevant to the chief complaint, it can be limited to the first-degree relatives (mother, father, sister, brother).

Q For an established patient visit, physician reads the patient’s PFSH to refresh his memory without verifying the PFSH with the patient; He asks "Anything new?" to which the patient responds, "No." If the MD references the prior note with PFSH, may we count PFSH for the review of systems (ROS)?

A The PFSH may be counted if it is relevant to the reason for the visit and yes, reporting " unchanged" is appropriate, if medically necessary for the issue being treated/reason for visit. If notes are requested, send the records with the old PFSH.
Summary—History Criteria
(must meet all three criteria)

<table>
<thead>
<tr>
<th>Level of History</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed (level 3 new/4 established)</th>
<th>Comprehensive (level 4/5 new, 5 established)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI</td>
<td>Brief (1)</td>
<td>Brief (2–3)</td>
<td>4 or more elements</td>
<td>4 or more elements</td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Pertinent 1 system</td>
<td>Extended 2–9 systems</td>
<td>Complete 10+ or some systems with statement “All others negative” (14 for CMS)</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>Pertinent 1 history area</td>
<td>Complete 2 (estab) or 3 (new) history areas</td>
</tr>
</tbody>
</table>
## Examination 1995 Guidelines

<table>
<thead>
<tr>
<th>Exam Level</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body Areas</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head, including face</td>
<td>1 body area or system</td>
<td>2-4 body areas or systems</td>
<td>5-7 body area or system</td>
<td>8+ organ systems</td>
</tr>
<tr>
<td>Genitalia, groin, buttocks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back, Including spine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest (axillae/breast), Each extremity, Abdomen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organ systems</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constitutional, Musculoskeletal, Eyes, Skin, ENMT, Neuro, Cardiovascular, Psych, Respiratory, GI, Hem/lymph/imm, GU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Examination 1997 Guidelines

## Psychiatric Single Organ System Exams Content and Documentation Requirements

<table>
<thead>
<tr>
<th>Problem Focused</th>
<th>Expanded PF</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 Elements by bullet</td>
<td>6-8 elements by bullet</td>
<td>At least 9 by bullet</td>
<td>Perform all elements by bullet; document every element with bold-type and at least 1 element without bold-type</td>
</tr>
<tr>
<td>99212, 99201</td>
<td>99213, 99202</td>
<td>99214, 99203</td>
<td>99215, 99204, 99205</td>
</tr>
</tbody>
</table>

**Constitutional**
- Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (may be measured and recorded by ancillary staff)
- General appearance of patient e.g. development, nutrition, body habitus, deformities, attention to grooming

**Musculoskeletal**
- Assessment of muscle strength and tone e.g. flaccid, cog wheel, spastic with notation of any atrophy and abnormal movements
- Examination of gait and station

**Psychiatric**
- Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities e.g. preservation, paucity of language
- Description of thought processes including: rate of thoughts; content of thoughts e.g. logical vs. illogical, tangential; abstract reasoning; and computation
- Description of associations e.g. loose, tangential, circumstantial, intact
- Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions
- Description of the patient’s judgment e.g. concerning everyday activities and social situations and insight e.g. concerning psychiatric condition
- Complete mental status examination including:
  - Orientation to time, place and person
  - Recent and remote memory
  - Attention span and concentration
  - Language e.g. naming objects, repeating phrases
  - Fund of knowledge e.g. awareness of current events, past history, vocabulary
  - Mood and affect e.g. depression, anxiety, agitation, hypomania, lability
## Complexity Point System

### A. Number of Diagnoses or Treatment Options

<table>
<thead>
<tr>
<th>Problem to Exam</th>
<th>Number x points =</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self limiting or minor; (Stable, improving or worsening)</td>
<td>__ x 1</td>
<td>=</td>
</tr>
<tr>
<td>Established problem (to examiner); Stable, improving</td>
<td>__ x 1</td>
<td>=</td>
</tr>
<tr>
<td>Established problem (to examiner); worsening</td>
<td>__ x 2</td>
<td>=</td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>__ x 3</td>
<td>=</td>
</tr>
<tr>
<td>New problem (to examiner); additional workup planned</td>
<td>__ x 4</td>
<td>=</td>
</tr>
</tbody>
</table>
## Complexity Point System

### B. Amount and Complexity of Data to be Reviewed

<table>
<thead>
<tr>
<th>Activity</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order clinical lab test(s)</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order tests in radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order tests in medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarize old records and/or obtain hx from someone other than patient and/or discuss case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
</tbody>
</table>

**Total Points =**
## Table of Risk  C. Risk of Complications and Mortality

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting Problem</td>
<td>• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis</td>
<td>• Two or more self-limited or minor problems</td>
<td>• One or more chronic illnesses with mild exacerbation, progression or side effects of treatment</td>
<td>• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
</tr>
<tr>
<td></td>
<td>• One stable chronic illness, e.g., well controlled HTN or NIDDM, cataract, BPH</td>
<td>• One stable chronic illness, e.g., well controlled HTN or NIDDM, cataract, BPH</td>
<td>• Two or more stable chronic illnesses</td>
<td>• Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g. multiple trauma, acute MI, pulmonary embolus, severe rheumatoid arthritis, psychiatric illness with potential threat to self/others, peritonitis, acute renal failure</td>
</tr>
<tr>
<td></td>
<td>• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>• An abrupt change in neurologic status, e.g., seizures, TIA, weakness, or sensory loss</td>
</tr>
<tr>
<td></td>
<td>• Cardiovascular imaging studies with contrast with identified risk factors</td>
<td>• Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization</td>
<td>• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis</td>
<td>• Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
</tr>
<tr>
<td></td>
<td>• Ultrasound, e.g., echocardiography</td>
<td>• Ultrasound, e.g., echocardiography</td>
<td>• Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>• Cardiovascular imaging studies with contrast with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• KOH Prep</td>
<td>• KOH Prep</td>
<td>• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test</td>
<td>• Cardiovascular imaging studies with contrast and identified risk factors</td>
</tr>
<tr>
<td>Diagnostic Procedures Ordered</td>
<td>• Laboratory tests requiring venipuncture</td>
<td>• Physiologic tests not under stress, e.g., pulmonary function tests</td>
<td>• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test</td>
<td>• Diagnostic endoscopies with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Chest X-rays</td>
<td>• Non-cardiovascular imaging studies w/ contrast, e.g., barium enema</td>
<td>• Diagnostic endoscopies with no identified risk factors</td>
<td>• Deep needle or incisional bx</td>
</tr>
<tr>
<td></td>
<td>• EKG/EEG</td>
<td>• Superficial needle</td>
<td>• Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization</td>
<td>• Cardiovascular imaging studies with contrast with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Urinalysis</td>
<td>• Clinical laboratory tests requiring arterial puncture</td>
<td>• Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>• Diagnostic endoscopies with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Ultrasound, e.g., echocardiography</td>
<td>• Skin biopsies</td>
<td>• Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors</td>
<td>• Discography</td>
</tr>
<tr>
<td></td>
<td>• KOH Prep</td>
<td>• Clinical laboratory tests requiring arterial puncture</td>
<td>• Minor surgery with identified risk factors</td>
<td>• Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors</td>
</tr>
<tr>
<td>Management Options</td>
<td>• Rest</td>
<td>• Skin biopsies</td>
<td>• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</td>
<td>• Emergency major surgery (open, percutaneous or endoscopic)</td>
</tr>
<tr>
<td></td>
<td>• Gargles</td>
<td>• Clinical laboratory tests requiring arterial puncture</td>
<td>• Prescription drug management</td>
<td>• Parenteral controlled substances</td>
</tr>
<tr>
<td></td>
<td>• Elastic Bandages</td>
<td>• Skin biopsies</td>
<td>• Therapeutic nuclear medicine</td>
<td>• Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td>• Superficial dressings</td>
<td>• Clinical laboratory tests requiring arterial puncture</td>
<td>• IV fluids with additives</td>
<td>• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
<tr>
<td></td>
<td>• Over-the-counter drugs</td>
<td>• Clinical laboratory tests requiring arterial puncture</td>
<td>• Closed treatment of fracture or dislocation without manipulation</td>
<td>•</td>
</tr>
<tr>
<td></td>
<td>• Minor surgery with no identified risk factors</td>
<td>• Clinical laboratory tests requiring arterial puncture</td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>
Complexity Table

Must have 2 of the 3 components to satisfy any given level of complexity

<table>
<thead>
<tr>
<th>Type of Decision</th>
<th>Straight-Forward</th>
<th>Low Complex</th>
<th>Moderate Complex</th>
<th>High Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Number of diagnoses or treatment options</td>
<td>1</td>
<td>2</td>
<td><strong>3</strong></td>
<td>4</td>
</tr>
<tr>
<td>B Amount and complexity of data</td>
<td><strong>1</strong></td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>C Highest risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td><strong>High</strong></td>
</tr>
</tbody>
</table>
Assessment/Plan—CMS Publication

Documenting the Number of Diagnoses and Management Options:

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

- For presenting problem(s) without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as “possible,” “probable,” or “rule out;” in which case the ICD-9-CM codes for billing would be reflective of signs/symptoms

The initiation of, or changes in treatment should be documented. Treatment may include a wide range of management options including, but not limited to: patient instructions, nursing instructions, therapies, and medications.

Problems that are improving or resolving are less complex than those problems that are worsening or failing to change as expected.

# Summary of Criteria—New Patient

<table>
<thead>
<tr>
<th>New Patient CPT Codes (3 of 3)</th>
<th>History</th>
<th>Exam</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>1-3 HPI</td>
<td>1 body area or organ systems</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99202</td>
<td>1-3 HPI, 1 ROS</td>
<td>2-4 body area or organ systems</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203</td>
<td>4 or more elements; 2-9 ROS, 1 PFSH</td>
<td>5-7 Body areas or organ systems</td>
<td>Low</td>
</tr>
<tr>
<td>99204</td>
<td>4+ or status of 3 chronic conditions; 10/14 ROS, 3 PFSH</td>
<td>8 organ systems</td>
<td>Moderate</td>
</tr>
<tr>
<td>99205</td>
<td>4+ or status of 3 chronic conditions 10/14 ROS, 3 PFSH</td>
<td>8 organ systems</td>
<td>High</td>
</tr>
</tbody>
</table>
## Summary of Criteria—Established Patient

<table>
<thead>
<tr>
<th>Established CPT Code (2 of 3)</th>
<th>History</th>
<th>Exam</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Nurse visit; minimal</td>
<td>minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99212</td>
<td>1-3 HPI</td>
<td>1 body area or organ systems</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99213</td>
<td>1-3 HPI 1 ROS</td>
<td>2-4 Body areas or organ systems</td>
<td>Low</td>
</tr>
<tr>
<td>99214</td>
<td>4 or more elements 2-9 ROS 1 PFSH</td>
<td>5-7 body areas or organ systems</td>
<td>Moderate</td>
</tr>
<tr>
<td>99215</td>
<td>4 or more elements 10 ROS 3 PFSH</td>
<td>8 organ systems</td>
<td>High</td>
</tr>
</tbody>
</table>
99211

**Appropriate Use:**
- Carrier specific code
- Must have MD orders to validate service (e.g. MD must document “medical necessity” for hypertensive patient to come in for BP check)
- Nurse should document: date of visit, reason for visit (as per doctors orders), necessary vitals and updated condition
- Code requires patient presence

**Misuse:**
- Doctor giving patient orders over the phone
- Calls for Rx refills
- Calls to reschedule patients
- Faxing medical records
- Recording lab results or relaying results over the phone
## Initial Hospital/OBS Service

<table>
<thead>
<tr>
<th>Initial Hospital Observation Require 3 of 3</th>
<th>99221 (30)</th>
<th>99222 (50)</th>
<th>99223 (70)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99218 (30)</td>
<td>99219 (50)</td>
<td>99220 (70)</td>
</tr>
<tr>
<td></td>
<td>99234 (40)</td>
<td>99235 (50)</td>
<td>992236 (55)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History</th>
<th>Detailed 4 + HPI or status of 3 chronic conditions 2-9 ROS 1 PFSH</th>
<th>Comprehensive 4 + HPI or status of 3 chronic conditions 10/14 ROS 3 PFSH</th>
<th>Comprehensive 4+ HPI or status of 3 chronic conditions 10/14 ROS 3 PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Detailed 5-7 Body areas or organ systems</td>
<td>Comprehensive 8 organ systems</td>
<td>Comprehensive 8 organ systems</td>
</tr>
<tr>
<td>Medical Decision</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>
### Subsequent Hospital/OBS Service

<table>
<thead>
<tr>
<th>Sub Hospital/ Sub Observation Requires 2 of 3</th>
<th>99231 (15)</th>
<th>99232 (25)</th>
<th>99233 (35)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99224 (15)</td>
<td>99225 (25)</td>
<td>99226 (35)</td>
</tr>
</tbody>
</table>

#### History
- **Problem Focused**
  - 1-3 HPI
- **Expanded Problem Focused**
  - 1-3 HPI
  - 1 ROS
- **Detailed**
  - 4+ or 3 chronic condition
  - 2-9 ROS
  - 1 PFSH

#### Exam
- **Problem Focused**
  - 1 body area or organ system
- **Expanded Problem Focused**
  - 2-4 body area or organ systems
- **Detailed**
  - 5-7 body area or organ systems

#### Medical Decision
- **Straightforward/Low**
- **Moderate**
- **High**
CMS on Follow-up Hospital

- CPT code 99231 usually requires documentation to support that the patient is stable, recovering or improving

- CPT code 99232 usually requires documentation to support that the patient is responding inadequately to therapy or has developed a minor complication. Such minor complications might include careful monitoring of co-morbid conditions requiring continuous active management.

- CPT code 99233 usually requires documentation to support that the patient is unstable or has a significant new problem or complication.
MLN ICN # 006347 December 2010:

• Any contribution and participation of a student to the performance of a billable service must be in the physical presence of the teaching physician (or other qualified health care individual)

• The teaching physician (or other qualified health care individual) may not reference any part of the note with the exception of the ROS and PFSH as a part of the billable service

• If a student documents an E/M service, the teaching physician (or other qualified health care individual) must document a stand alone note and re-document the HPI, PE and medical decision making portion of the note

MLN Fact Sheet: Guidelines for Teaching Physicians, Interns, and Residents

Ancillary Staff Documentation

CMS clearly defines what history sections within the patient record that may be completed by someone other than the provider:

“The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the Physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.”

Per CMS, only the physician or non-physician practitioner (NPP) who is conducting the evaluation and management (E&M) visit can perform the history of present illness (HPI) and chief complaint (CC). This is physician work and shall not be relegated to ancillary staff.

- Noridian Healthcare Solutions reminds providers that E&M codes are valued as including all elements of work to be performed by the physician or non-physician practitioner when “physician” criteria are met. Although ancillary staff may question the patient regarding the CC, that does not meet criteria for documentation of the HPI. The information gathered by ancillary staff (i.e. Registered Nurse, Licensed Practical Nurse, Medical Assistant) may be used as preliminary information but needs to be confirmed and completed by the physician.

- Reviewing information obtained by ancillary staff and writing a declarative sentence does not suffice for the history of present illness (HPI). An example of unacceptable HPI documentation would be “I have reviewed the HPI and agree with above.”

https://www.noridianmedicare.com/partb/train/education_center/evaluation_and_management_clarification.html
Scribe Documentation Requirements

**Documentation should include:**
- Who performed the service and who recorded the service

**Scribe’s documentation should include:**
- Name, title and signature of the scribe
- Name of the practitioner providing the service

**Practitioner’s documentation should include:**
- Affirmation the practitioner personally performed the services documented
- Confirmation he/she reviewed and confirmed the accuracy of the information in the medical record
- Acceptable practitioner signature

*Per CMS, the evaluation and management encounter is a face-to-face service; therefore there must be evidence that the practitioner personally saw the patient, reviewed and confirmed any documentation transcribed by the scribe.*

http://www.acep.org/Physician-Resources/Practice-Resources/Administration/Financial-Issues-/Reimbursement/Scribe-FAQ/
Time-Based Billing

Counseling/Coordination of Care:

- Documentation should reflect the following three components:
  - Total time
  - Counseling time
  - Content of counseling or coordination of care

- The note must specify the nature of the counseling in order for the level of service to be based on time. Phrases such as "counseled patient on the following topics" or "we discussed..." are recommended when documenting by time and to meet CMS criteria.

- When time based coding for level of service, counseling/coordination of care must dominate more than 50% of the total encounter time. Time statement variable.

Prolonged Services:

- Prolonged services codes may be possible when extra time does not = counseling or coordination of care.

- Documentation of face-to-face time (outpatient) +99354-99355 Office or Outpatient Prolonged Service
Counseling and Coordination of Care

Established Patient Times:

- 99211 = 5
- 99212 = 10
- 99213 = 15
- 99214 = 25
- 99215 = 40

Example of C&CC

- Patient returns for MRI results and discussion of treatment regarding her breast cancer. We discussed the role of chemotherapy and benefits of the current clinical trials. Patient understands side effects and consents to start treatment next week. Spent a total of 20 minutes with the patient, over half of which was counseling on treatment options.

- 99213 based on time.
Outpatient Prolonged Services Example

Patient presents for F/U visit for seizure disorder and requires a translator for communication. Provider documents level 4 visit with a detailed history and moderate decision (average time 25 minutes). Due to communication difficulties, patient visit took 60 face-to-face minutes. This was clearly documented in the record.

- 99214 time = 25 minutes
- Excess of 35 minutes spent with the patient
  \[ (60 - 25 \times 99214) = 35 \] additional minutes
- May bill 99214 and 99354 to account for additional face-to-face time
Inpatient Prolonged Services Example

Hospitalist #1 rounds on patient Adams in the am; shift changes at 6pm and due to patient deterioration, hospitalist #2 rounds again before midnight. Hospitalist 1 codes 99233 (comp exam/high MDM) with time statement that face-to-face time was 35 minutes. Hospitalist 2 documents a second note and time statement of 45 minutes face-to-face.

• 99233 time = 35 minutes + additional 45 minutes spent by 2nd provider
• Excess of 45 minutes spent with the patient
  (80 – 35 (99233) = 45 additional minutes
• May bill both 99233 and 99356 to account for additional face-to-face time
Discharge Services

**Discharge Services:**

- 99238 Discharge Day Management under 30 minutes
- 99239 Discharge Day Management over 30 minutes
- Time MUST be included in the medical record to justify 99239
- Face-to-face care must be documented in the discharges summary for the date the discharge service is billed

**CMS Discharge Q&A:**

**Q** What information does the physician need to show in the medical record to support a face-to-face visit for the discharge management? Several of our physicians indicate "stable," "stable and improved," "no vomiting, tolerating diet." Would these statements show a face-to-face service?

**A** No, the statements listed could have been obtained from a nursing note or chart. They do not support a face-to-face service. The medical record should show notations on an exam if one was performed, or other observations that could have only been obtained if the physician were present. Some examples could include, "patient is stable and states they are feeling well and want to go home," or "reviewed plan with patient and he had no questions."
Same DOS/Provider Office Visit and Exam

Per Medicare Policy Manual Chapter 12, Section 30.6.9.1.A:
When the patient is admitted to the hospital via another site of service (e.g., hospital emergency department, physician's office, nursing facility), all services provided by the physician in conjunction with that admission are considered part of the initial hospital care when performed.

Per CPT:
All [E/M] services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission.

Tips:
• When patient seen in the office by provider, on same date that provider admits patient to the hospital as an inpatient service, then the provider is the admitting provider and should bill hospital initial day codes 99221-99223 with an -AI modifier.
• Both Office Visit note and Hospital H&P can be combined to code service.
Incident-to Services

For POS 11 (clinic), billing incident-to services are payable if all of the 3 conditions are met:

1. Services must be provided by a caregiver whom you directly supervise, and who represents a direct financial expense to you (such as a “W-2” or leased employee, or an independent contractor).

2. Services must be provided under “direct” supervision meaning you must be present in the immediate office suite to render assistance if needed. If you are a solo practitioner, you must directly supervise the care. If you are in a group, any physician member of the group may be present in the office to supervise.

3. Diagnosis must be established by the provider (or group) with active involvement. If diagnosis is new, the service should be billed under the NPP’s NPI, not the physician.

Reimbursement:

• Services billed “incident-to” a physician are paid at 100% vs. 85% of the PFS fee schedule

• Incident-to is NOT applicable for POS 22 (check with your MAC!)
Shared/Split Visits with Mid-levels

CMS Regulation on SPLIT/SHARED E/M SERVICE

• **Medically Necessary Encounter**

• A split/shared E/M visit is defined as a medically necessary encounter with a patient where the physician and a qualified non-physician practitioner (NPP) each personally perform a **substantive portion** of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer.

• The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital, office and non facility clinic visits (incident-to), and prolonged visits associated with these E/M visit codes).

• The split/shared E/M policy does not apply to critical care services, or procedures. A split/shared E/M visit cannot be reported in the SNF/NF settings.

• *Due to consultation codes no longer being accepted by CMS, they are no longer a part of the SS exclusions.. even if a consultation is performed and billed under the 99221-99223 CPT codes.*
Industry News and Trends
Physicians: Incident-to Services

We will review physician billing for “incident-to” services to determine whether payment for such services had a higher error rate than that for non-incident-to services. We will also assess CMS’s ability to monitor services billed as “incident-to.” Medicare Part B pays for certain services billed by physicians that are performed by non-physicians incident to a physician office visit. A 2009 OIG review found that when Medicare allowed physicians’ billings for more than 24 hours of services in a day, half of the services were not performed by a physician. We also found that unqualified non-physicians performed 21 percent of the services that physicians did not perform personally. Incident-to services represent a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. They may also be vulnerable to overutilization and expose Medicare beneficiaries to care that does not meet professional standards of quality.
Physician: Claims Trending

Evaluation and Management Services: Trends in Coding of Claims

- Identify providers that exhibited questionable billing for E/M services in 2009. (OEI; 04-10-00180; expected issue date: FY 2012; work in progress)

Evaluation and Management Services: Potentially Inappropriate Payments

- Assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations.
- Review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. (CMS’s Medicare Claims Processing Manual, Pub. No. 100-04)
Documentation Guidelines for Medicare Services

By law, Medicare contractors (carriers and MACs) can review any information, including medical records, pertaining to a Medicare claim.

Medical records should be complete, legible, and include the following information:

• Reason for the encounter, relevant history, findings, test results, and date of service.

• Assessment and impression of diagnosis.

• Plan of care with date and legible identity of the observer.

• Documentation that supports that the rendering/billing provider indicated on the claim is the healthcare professional providing the service.

• Records should not only substantiate the service performed, but also the required level of care.

• If the physician uses a scribe, the scribe needs to fully sign the note, with their own credentials, followed by the physician’s signature and credentials.
Documentation Guidelines for Medicare Services (cont’d)

Providers billing Medicare for their services must act in accordance with the following conditions:

• Document in appropriate office records and/or hospital records each time a covered Medicare service is provided.

• When providing concurrent care for hospital or custodial care facility patients, physicians should identify their specialty in order to help support the necessity.

• Write medical information legibly and sign each entry with a legible signature, or ensure that the provider's/author's/observer's identity is present and legible.

• Medical information should be clear, concise, and reflect the patient's condition.

• Sign progress notes for hospital and custodial care facility patients with all entries dated and signed by the healthcare provider who actually examined the patient.

• Provide sufficient detail to support diagnostic tests that were furnished and the level of care billed.

• Not use statements such as "same as above" or ditto marks ("). This is not acceptable documentation that the service was provided on that date.

Palmetto Jurisdiction 11 Quality Review

Medical Record Cloning November 6, 2012

The word 'cloning' refers to documentation that is worded exactly like previous entries. This may also be referred to as 'cut and paste' or 'carried forward.' Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter. Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.
Noridian (CMS) Quality Review

Medical Necessity May 2011:

• Per the Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1 states:

• "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."

• Furthermore, all services must be sufficiently documented so the medical necessity is clearly evident.
Noridian (CMS) Quality Review

Medical Necessity May 2011:

- Another trend noted by Part B MR is the MDM does not correlate to the chief complaint. One such example would be the HPI supports a follow-up visit for renal functions tests, hypertension, and reflux. The medical management of that patient is then a Physical Therapy referral for low back pain, with no mention of medical management of the issues that brought the patient to the clinic. The documentation did not support complaints of low back pain.

- Part B MR has also noted that the plan of care simply lists the medical diagnoses of the patient, with no mention of changes to the plan of care if any, or continuation of current treatment regimens. It is difficult to determine the medical necessity of a visit when the documentation lacks important information, or when the documentation does not support medical management of the patient's chief complaint.
**Noridian (CMS) Quality Review**

**NAS Templated Documentation:**

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

• CMS is looking for an evaluation of each diagnosis on the Progress Note, not just the listing of chronic conditions, i.e. DM w/Neuropathy—meds adjusted, CHF—compensated, COPD—test ordered, HTN—uncontrolled, Hyperlipidemia—stable on meds. CMS considers diagnoses listed on the Progress Note without an evaluation or assessment as a “problem list”, which is unacceptable for encounter data submission.

• Each Progress Note must be able to “stand alone”. Do not refer to diagnoses from a prior Progress Note, problem list, etc.
Staying Low Doesn’t Keep You Below Radar

- If you believe that reporting lower level E/M codes can help you fend off an audit, remember this: Reporting all low-level codes will also get a payer’s attention, because reviewers will wonder why your physician never offers high-level examinations.
- When claims reviewers review “bell curves” to ascertain if a practice is coding inappropriately, they don’t just focus on upcoding, but see the trends across the board. In simpler words all 99212s and 99213s can get you in trouble, because almost every practice sees more complex patients requiring high level E/Ms at least occasionally. If auditors see that you’re deliberately downcoding claims, they’ll conclude that you’ve been coding improperly and this may prompt them to look at other aspects of your coding and billing. This has been a focus of the Office of Inspector General (OIG) in the past.

Under-coding Also Carries Compliance Implications

- Deliberately undercoding Medicare or Medicaid claims means infringement of the False Claims Act since that boils down to submitting a false claim intentionally.
- “The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government”.
  
- Even if the payment is lower than the actual services provided, it is still false. Any false record that is submitted to get payment would be considered fraudulent.
  
  http://news.aapc.com/index.php/2014/04/undercoding-is-no-better-than-overcoding/