The Key to E/M Documentation…
(and Reimbursement)?

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COGNITIVE VS. PROCEDURAL SERVICES

- **Cognitive Services**
  - Performed with your mind, your mouth, and a pen
  - Evaluation and Management ("E/M") Services

- **Procedural Services**
  - Debridement, “surgery”, injections, x-rays, casts
  - “hands on”
Some visits entail *only* procedural services

Some visits entail *only* cognitive services

Many visits entail *both*
“There is a certain (minimal?) component of E/M in any procedural service”

It has been argued that “there is a certain procedural component in any E/M service”

(I’m not so sure…)
E/M MODIFIER “-25”

- Significant, separately identifiable Evaluation and Management Service performed on the same date as a (billable) procedural service

- Separates the billable procedural services from the billable E/M services, when both are payable

- To be appended to E/M code, not procedural code

- Do not use if no procedural service performed and billed
MAJOR items of investigation and audit:

- E/M services with procedures (Modifier 25)
- Multiple procedures (Modifier 59)
Standards of medical documentation for E/M services are confusing (for Providers and Reviewers)

But if you focus on the single most common code, and understand IT well, it all becomes far more understandable

Enhances quality of documentation, and supports appropriate reimbursement
THERE IS A FUNDAMENTAL DIFFERENCE BETWEEN “MEDICALLY NECESSARY” AND “COVERED BENEFIT”

- Services can be Medically Necessary, but not Covered
- Services can be Covered, but not Medically Necessary
Payers will not reimburse services which are not:

- “Medically Necessary”
- Documented
- And they have the legal / contractual right to ask for money back
“The…key components (history, examination, and medical decision-making) must be met and documented in the medical record to report a particular level of service”

(American Medical Association, Introduction to Appendix C: Clinical Examples, CPT 2014)
E/M SERVICES

- A target for audit?
- Certainly considered a source of potential abuse
- Newer “easier-to-use” guidelines a line item in proposed federal budget
- E/M documentation “a key finding in CMS’s CFO audit error rate”
- Newly-proposed Internet-based guidelines
SITUATIONS THAT CLEARLY SUPPORT USE OF E/M SERVICES
(assuming adequate documentation)

- New Problem
- Relevant interval change in medical history
- Situation not responding (unchanged)
  - Situation getting worse
  - Need for new plan of care
  - Need to (re)evaluate and manage new or changed circumstances
"CLINICALLY RELEVANT"

- Adj. *Closely connected or appropriate to the matter at hand*
- ORIGIN early 16\textsuperscript{th} cent. (a Scottish legal term meaning “legally pertinent”)
3 KEY COMPONENTS

History
Examination
Medical Decision-making

- For a NEW patient, all three components must be met
- For an ESTABLISHED patient, (any) two of the three components must be met
NEW VS ESTABLISHED PATIENT

“New PATIENT”

- Not seen by the provider, or any same-specialty provider in the same group, within the past three years
BMAD DATA

- Medicare Part B utilization data
- Permits comparison of use of all CPT codes (E/M and procedural services) across states and professions
CRITERIA FOR CPT 99213 (or any established patient visit)

- History and Examination, with NO Decision making
- History and Decision making, with NO Examination
- Examination and Decision making, with NO History
PUBLISHED GUIDELINES
(1995, 1997 and subsequent/various versions)

- “Bullets”
- Still being revised and contested
- Future Internet-published guidelines
- 1997 version may be the easiest for provider to defend in case of audit
HISTORY - Components

- Chief Complaint, or Reason for the Encounter
- History of the Present Illness (HPI)
- Review of Systems (ROS)
- Past, family, and/or social history (PFSH)
THE CHIEF COMPLAINT (OR REASON FOR THE ENCOUNTER) IS REQUIRED ON ALL VISITS

- It must be stated, or “easily inferred”
- “Physician-directed return” is a valid reason
VALID REASONS TO NOT OBTAIN A HISTORY
(but they must be documented)

- Urgent/emergent condition
- Patient at very high risk; immediate action necessary
- Patient unable to communicate
- Lack of interpreter
- No medical record available
- No family/significant other or legal guardian available in person or via telephone
In the event of documentation of a valid reason to not obtain a History, the provider is given credit for having obtained a “Comprehensive” History
HISTORY OF PRESENT ILLNESS

Components

- Location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms, and related functional status

- Include positive, and clinically-pertinent negative statements
HOW BULLETS ADD UP IN HPI

- Pain in the heel (1)
- Pain in the left heel (2)
- Pain in the left heel of 3 weeks duration (3)
- …constant, but variable in intensity (4)
- …worse with first weightbearing (5)
- …no numbness (6)
- …limping, can’t exercise (7)
- …but you don’t need more than 4 at any level!
REVIEW OF SYSTEMS

Components

- (Abbreviated) Systems: Constitutional (fever, weight loss), Allergic, Endocrine, Gastrointestinal, Integumentary, Musculoskeletal, Neurological

- Any new information should be documented, or the lack of change (“no change”) from a documented prior date of review (“no change from visit of April 3, 2014”)
PAST MEDICAL, FAMILY, AND/OR SOCIAL HISTORY

Components

- **Past History:**
  - Medications, Allergies, Operations, Injuries/Trauma, Past Illnesses, Functional Status, Treatment/medication compliance

- **Family History:**
  - Relevant (Diabetes, Cancer, Vascular disease)

- **Social History:**
  - Smoking, Alcohol or drug use, Occupation, Diet, Exercise patterns
Use of Checklist, Template, or Preprinted Forms

- Acceptable, with qualifications
- Elements not actually performed should be crossed out (or otherwise indicated)
- Statement of “negative” or “normal” is sufficient
- Statement of “abnormal” is NOT sufficient
- Statement of “unchanged” is sufficient (with applicable prior date of reference)
“MUSCULOSKELETAL EXAMINATION”

- See handouts
MEDICAL DECISION MAKING

Components

- Scope of the presenting problem(s), number of diagnoses considered, and/or risk of complications, morbidity or mortality
- Diagnostic procedures/tests ordered and/or amount of data to be obtained or reviewed
- Management options considered
- The highest level of any one of these will determine the overall level
- Any Rx
COUNSELING / COORDINATION OF CARE

- When more than half of the face-to-face time is spent with the patient in discussion …
- CPT 99213…”typically 15 minutes”
- Relevant history, exam, and medical decision making, if performed, should also be documented
ANTICIPATED TIME INTERVALS FOR VARIOUS E/M

NEW
- 99201 – 10 minutes
- 99202 – 20 minutes
- 99203 – 30 minutes
- 99204 – 45 minutes
- 99205 – 60 minutes (cannot really achieve)

ESTABLISHED
- 99211 – 5 minutes
  - (does not require presence of physician)
- 99212 – 10 minutes
- 99213 – 15 minutes
- 99214 – 25 minutes
- 99215 – 40 minutes
80 y/o female to evaluate medical management of arthritis

9 y/o with dyshidrosis

Symptomatic pigmented nodule on dorsal foot

58 y/o female w/ painful unilateral bunion

45 y/o female with osteoarthritis and painful swollen joint

Psoriasis, with involvement of elbows, scalp, and nails
IF YOU PROVIDE (OR DOCUMENT) LESS THAN A CPT 99213...

- No E/M available/billable
- CPT 99211
  - Does not require presence of physician
- CPT 99212
IF YOU PROVIDE (AND DOCUMENT) MORE THAN A CPT 99213…

- CPT 99214
- CPT 99215
  - Unlikely, but possible
NURSING FACILITY E/M

- CPT 99304-99306 (formerly 99301-99301)
  - Reflect initial comprehensive assessment by physician with *primary admission* responsibility
  - Virtually *no* specialists should use this code
    - (But approx 30% are billed as such…)

- CPT 99307-10 (formerly 99311-99313)
  - New or Established Nursing Facility Assessment
  - *THIS* is the correct code for specialists
IN CONCLUSION…

- Understanding the component services and documentation associated with CPT 99213 may be the simplest and most effective way to better understand all levels of E/M coding and documentation.