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Meet the Presenter…

On the topic:
Auditing for E/M Documentation

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Faculty
Practice Management Institute
AUDITING FOR E/M DOCUMENTATION

Presented by:

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Faculty, Practice Management Institute

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Overview

- Introduction
- Documentation Guidelines for Evaluation and Management (E/M Services)
- General Principles of Medical Record Documentation
  - Documentation of History
  - Documentation of Examination
  - Documentation of Complexity of Medical Decision Making
  - Selecting the Level of Decision-Making

Introduction

The medical record is a legal document that serves as a chronological record of pertinent facts and observations about a patient’s health.

Proper medical record documentation is the key to substantiating quality of care rendered, place of service, type of service, as well as diagnostic and procedure code selections for accurate reimbursement.

Appropriate documentation justifies medical necessity and can prevent penalties and refund requests if a provider’s records are reviewed or audited.
Introduction (cont’d)

A chart audit is an examination of medical records (electronic and/or hard copy) to determine how well a practice performs. Chart audits can serve many purposes, from compliance to administrative to clinical.

You can conduct a chart audit on virtually any aspect of care that is ordinarily documented in the medical record. A miscoded billing note can cost your practice a lot of money. Auditing medical charts is the first step and a critical part of any successful medical office operation.

Performing chart audits keeps your practice compliant with federal health care regulations by allowing you to identify and correct errors and omissions before the federal auditors discover them.

The audit serves to compare what the clinician documented in the medical record to the services billed on the claim form. It identifies coding and billing errors, failure to accurately complete claim information, and failure to adhere to specific third-party payer guidelines. Depending upon the type of audit, it can also determine adherence to administrative policies.

Although chart auditing may seem intimidating, new attention from the OIG, RACs, and other third-party auditors makes this self-check more important than ever.
Introduction (cont’d)

The Office of Inspector General (OIG) has initiated audit initiatives to determine whether Medicare is making erroneous payments.

Through computer matching, data mining, and analysis techniques, the OIG has identified a number of types of payments that it believes are at high risk of being billed and paid inconsistently with Medicare rules and regulations.

Introduction (cont’d)

Some risk areas that have been identified in physician practices include:

1) Billing for services not rendered.
2) Upcoding the level of service provided.
3) Billing for non-covered services as if covered
4) Unbundling (billing for each component of the service instead of billing or using an all-inclusive code).
5) Failure to properly use coding modifiers.
6) Services are not being rendered consistent with applicable coverage guidelines set out in applicable National and Local Coverage Determinations.
A baseline audit should be conducted to examine the claim development and submission process. Following the baseline audit, periodic audits should be conducted at least annually to ensure compliance with the practice’s policies and procedures.

A minimum of (5) records per physician or billing provider per Federal payer should be reviewed.

In this course, we will:

• Review the Documentation Guidelines for Evaluation and Management (E/M) coding from the Centers for Medicare and Medicaid Services (CMS), generally, and by organ system, comparing and contrasting the 1995 and 1997 versions.
• Outline the process for correctly selecting the level of medical decision-making required.
• Understand how to use this information to review documentation in the medical record to ensure correct assignment of E/M codes.
• Apply information learned in multiple case studies.
• Outline tips for avoiding carrier audits.
Tips for Avoiding (Carrier) Audits: An Overview

The threat of Medicare or other insurance carrier audits can be very intimidating to providers.

The first step to avoiding audits is often easier understood that implemented, which is to learn to use the CPT® and ICD-10-CM coding systems.

Providers should be the most knowledgeable individuals in the office about these vital communication tools. CPT® and ICD tell insurance carriers what was done for the patient.

CARE=CHART=CODE

CARE – that is delivered must be appropriate for the patient’s medical problem and documented in the

CHART – and the

CODE – submitted for payment must accurately describe that care.

There is only one way to show medical necessity on a claim form, and that is through the use of the diagnosis code; there must be a direct correlation between the procedural and diagnostic codes.
What Causes a Carrier Audit?

- Random audits
- Complaints from patients & employees
- Repeated billing problems from carrier
- Abnormal distribution of E/M levels of care
- Unusually high numbers of any single code
- Failure to follow non-par Medicare rules
- Failure to routinely collect deductibles and co-pays
- Medical record that does not support the CPT® code

What Can Your Healthcare Organization Do to Avoid Audits?

1. Ensure your practice has a WRITTEN compliance program. If your practice does not have one, review the OIG’s Model Compliance Plan: [http://oig.hhs.gov/authorities/docs/physician.pdf](http://oig.hhs.gov/authorities/docs/physician.pdf).

2. Ensure that your practice has a Billing Policy Manual which specifies how certain procedures and lab tests are to be billed. This manual should be updated as new information becomes available.
3. Ensure that your healthcare organization conducts periodic chart audits internally.

4. If available, attend education sessions for the entire office on a regular basis to facilitate compliance with the latest guidelines and regulations.

5. If your healthcare organization plans to employ a billing service, they should be investigated thoroughly prior to hiring.

6. Use only CURRENT ICD-10-CM and CPT® coding books.

7. Develop/Use forms and checklists to eliminate human error.

8. Train recent hires (providers and staff) on documentation guidelines, and review regularly.
Coding of E/M Services

• E/M services must be medically reasonable and necessary, in addition to meeting the individual requirements of the CPT® code that is used.

• It would not be medically necessary or appropriate to bill for a higher level or E/M service when a lower level of service is warranted.

• Physicians are responsible for ensuring that the claims they submit to Medicare accurately reflect the E/M services provided and billing levels corresponding to those services.

Medicare Consult Codes

• Effective January 1, 2010, Medicare does not pay for Consultation Codes 99241 – 99245 and 99251 – 99255. Providers will use Office or Other Outpatient Services 99201 – 99205 for new patients and 99212 -99215 for established patients.

• Codes should be selected by patient type and documentation guidelines.
New or Established Patient

- A new patient is one who has not received any face-to-face professional services from the physician or other qualified healthcare professional within the past three years.
- In group practices, a patient is considered “new” to a physician or other qualified healthcare professional if another member of the group who is in the exact same specialty and subspecialty in the last three years has not seen the patient. Always read the special guidelines or reporting instructions unique to that category. (These will precede each set of E/M Codes.)

E/M Key Components

- History
- Examination
- Medical Decision Making
E & M Codes Overview

**History**

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>{</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Problem Focused</td>
<td>{</td>
</tr>
<tr>
<td>• Expanded Focused</td>
<td>C.C. - Description of Symptoms</td>
</tr>
<tr>
<td>• Detailed</td>
<td>HPI - Location, Quality, Severity, Duration, Timing, Context, Mod. Factors, Assoc. Signs &amp; Symptoms</td>
</tr>
<tr>
<td>• Comprehensive</td>
<td>ROS - Constitutional, Eyes, (Ears, Nose, Mouth &amp; Throat), Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic-Lymphatic, Allergic-Immunologic</td>
</tr>
<tr>
<td></td>
<td>PFSH - Past/Personal-Illness, Operations, Injuries, Treatment</td>
</tr>
<tr>
<td></td>
<td>Family - Med Events, Hereditary Events</td>
</tr>
<tr>
<td></td>
<td>Social - -Past/Current Activities</td>
</tr>
</tbody>
</table>

**Examination**

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>{</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Problem Focused</td>
<td>BODY AREAS Head, Neck, Including Face</td>
</tr>
<tr>
<td>• Expanded Focused</td>
<td>Chest, Abdomen, Genitalia, Back, Each Extremity</td>
</tr>
<tr>
<td>• Detailed</td>
<td>Including</td>
</tr>
<tr>
<td>• Comprehensive</td>
<td>Including</td>
</tr>
<tr>
<td>ORGAN</td>
<td>Gastrointestinal, Genitourinary, Musculoskeletal, Skin, Neurologic, Psychiatric, Hematologic, Lymphatic, Immunologic</td>
</tr>
<tr>
<td>SYSTEMS</td>
<td>Eyes, Ears, Nose, Mouth, Throat</td>
</tr>
</tbody>
</table>
E & M Codes Overview

Medical Decision Making

<table>
<thead>
<tr>
<th>MEDICAL DECISION MAKING</th>
<th>• Straight Forward</th>
<th>• # Diagnoses/Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Low Complexity</td>
<td>• Amount and/or Complexity of Data</td>
</tr>
<tr>
<td></td>
<td>• Mod. Complexity</td>
<td>• Risk of Complication-Morbidity/Mortality</td>
</tr>
<tr>
<td></td>
<td>• High Complexity</td>
<td></td>
</tr>
</tbody>
</table>

AMA/CMS Documentation Guidelines for Evaluation & Management Services

What is Documentation and Why is it Important?

• Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes.

• The medical record chronologically documents the care of the patient and is an important element contributing to high quality care.

• The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.
Appropriately Documented Medical Record

- communication and continuity of care among physicians and other health care professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.
- reduction in many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

What Do Payers Want and Why?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.
General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient’s status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services:

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   - reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   - assessment, clinical impression or diagnosis;
   - plan for care;
   - date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient’s progress, response to and changes in treatment, as well as revision of diagnosis should be documented.

7. The CPT® and ICD-10 codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
Can a provider Use Both the 1995 and 1997 Documentation Guidelines for Evaluation?

- For billing Medicare, a provider may choose either version of the documentation guidelines, not a combination of the two, to document a patient encounter. However, beginning for services performed on or after September 10, 2013 physicians may use the 1997 documentation guidelines for an extended history of present illness along with other elements from the 1995 guidelines to document an evaluation and management service.

Documentation of E/M Services

The descriptors for the levels of E/M services recognized seven components that are used I defining the levels of E/M services. These components are:

- history
- examination
- medical decision making
- counseling
- coordination of care
- nature of presenting problem; and
- time
Documentation of History

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive.) Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

<table>
<thead>
<tr>
<th>Type of History</th>
<th>History of Present Illness</th>
<th>Review of Systems</th>
<th>Past, Family, and/or Social History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Brief (1-3)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Brief (1-3)</td>
<td>Problem Pertinent (1)</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed</td>
<td>Extended (4+)</td>
<td>Extended (2-9)</td>
<td>Pertinent (1 of 3)</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Extended (4+)</td>
<td>Complete (10)</td>
<td>Complete (2 or 3) *</td>
</tr>
</tbody>
</table>

*NOTE – a complete PFSH is a review of 2 or all 3 history areas; 2 of 3 for established patients; 3 of 3 for new patients.
Chief Complaint

**Chief complaint (CC)**

- The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s words.

- **DG:** The medical record should clearly reflect the chief complaint.

History of Present Illness

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location,
- quality,
- severity,
- duration,
- timing,
- context,
- modifying factors, and
- associated signs and symptoms.

- **Brief** and **extended** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).
A brief HPI consists of one to three elements of the HPI.

- **DG:** The medical record should describe one to three elements of the present illness (HPI).

An extended HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

- **DG:** The medical record should describe at least four or more elements of the present illness (HPI) or status of at least three chronic or inactive conditions.

### Review of Systems

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (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
• A **problem pertinent** ROS inquires about the system directly related to the problem(s) identified in the HPI.

  ● **DG:** The patient’s positive responses and pertinent negatives for the system related to the problem should be documented.

• An **extended** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

  ● **DG:** The patient's positive responses and pertinent negatives for two to nine systems should be documented.

• A **complete** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

  ● **DG:** At least 10 organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least 10 systems must be individually documented.
Past, Family and/or Social History (PFSH)

The PFSH consists of a review of three areas:

• past history (the patient’s past experiences with illnesses, operations, injuries and treatments);

• family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk);

• social history (an age-appropriate review of past and current activities).

A pertinent PFSH is of a review of the history area(s) directly related to the problem(s) identified in the HPI.

DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.
A **complete** PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

**DG:** At least one specific item from **two** of the three history areas must be documented for a complete PFSH for the following E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.

**DG:** At least one specific item from **each** of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office/other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.

---

**Past History**

A review of the patient's past experiences with illnesses, injuries, and treatments that include significant information about:

- prior major illnesses and injuries
- prior operations
- prior hospitalizations
- current medications
- allergies
- age appropriate immunizations
- age appropriate feeding/dietary status
Family History

A review of medical events in the patient's family that includes significant information about:

- the health status or cause of death of parents, siblings, and children
- specific diseases related to problems identified in the chief complaint or history of the present illness and/or review of systems
- diseases of family members which may be hereditary or place the patient at risk

Social History

An age-appropriate review of past and current activities which include significant information about:

- marital status and/or living arrangements
- current employment
- occupational history
- use of drugs, alcohol, and tobacco
- level of education
- sexual history
- other relevant social factors
Documentation of Examination

The levels of E/M services are based on four types of examination that are defined as follows:

- **Problem Focused** -- a limited examination of the affected body area or organ system.
- **Expanded Problem Focused** -- a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
- **Detailed** -- an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
- **Comprehensive** -- a general multi-system examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

Types of Examinations

These types of examinations have been defined for general multi-system and the following single organ systems:

- Cardiovascular
- Ears, Nose, Mouth and Throat
- Eyes
- Genitourinary (Female)
- Genitourinary (Male)
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurological*
- Psychiatric
- Respiratory
- Skin*
Examination

<table>
<thead>
<tr>
<th>Exam ‘95 (Organ/Body)</th>
<th>Level</th>
<th>Exam ‘97</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PF</td>
<td>1-5 elements</td>
</tr>
<tr>
<td>2-7</td>
<td>EPF</td>
<td>6-11 elements</td>
</tr>
<tr>
<td>2-7 (more detailed)</td>
<td>D</td>
<td>12 or more elements in 2 or more systems</td>
</tr>
<tr>
<td>8 or more body areas/organ systems</td>
<td>Comprehensive General Multi System</td>
<td>18 or more elements in 9 or more systems</td>
</tr>
<tr>
<td>Not defined, but see ‘97 for guidance</td>
<td>Comprehensive Single Organ</td>
<td>Complete a system exam</td>
</tr>
</tbody>
</table>

General Multi-System Examinations

A general multi-system examination or a single organ system examination may be performed by any physician regardless of specialty.

To qualify for a given level of multi-system examination, the following content and documentation requirements should be met:

- **Problem Focused Examination** – should include performance and documentation of one to five elements in one or more organ systems(s) or body area(s).
- **Expanded Problem Focused Examination** – should include performance and documentation of at least six elements in one or more related body area(s) or organ system(s).
- **Detailed Examination** – should include at least six organ systems or body areas with at least two elements, for a total of twelve elements.
- **Comprehensive** – should include at least nine organ system or body areas. For each area/system, documentation of at least two elements.
Medical Decision-Making

Medical Decision-Making (MDM) measured by:

- Number of diagnosis and/or management options
- Amount and/or complexity of data obtained or reviewed
- Risk of significant complications, morbidity and/or mortality

Number of Diagnoses or Management Options

- The number of possible diagnoses and/or number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

- DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.
Number of Diagnoses or Management Options (cont’d)

• **DG:** The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.

• **DG:** If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.

Amount and/or Complexity of Data to be Reviewed

• The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed.

• A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.
Amount and/or Complexity of Data to be Reviewed (cont’d)

- **DG:** If a diagnostic service (test or procedure) is ordered, planned, scheduled or performed at the time of the E/M encounter, the type of service, e.g., lab or x-ray, should be documented.

- **DG:** The review of lab, radiology and/or diagnostic tests should be documented.

- **DG:** A decision to obtain old records or a decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.

Risk of Significant Complications, Morbidity, and/or Mortality

- Co-morbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

- If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure should be documented.

- The following tables may be used to help determine whether the level of risk is: minimal, low, moderate or high. The highest level in any one category determines the overall risk.
### Medical Decision-Making

<table>
<thead>
<tr>
<th>Type of Decision Making*</th>
<th># of Diagnoses of Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Significant Complications, Morbidity, and/or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

*NOTE – to qualify for a type of medical decision making, 2 of 3 elements must either be met or exceeded.

### Table 1: Presenting Problems

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>• One self limited or minor problem, e.g. cold, insect bite</td>
<td>• Two or more self-limited or minor problems</td>
<td>• One or more chronic illness with mild exacerbation</td>
<td>• One or more chronic illnesses with severe exacerbation</td>
</tr>
<tr>
<td>• One stable chronic illness, e.g., well controlled hypertension or diabetes</td>
<td>• One or more chronic illnesses</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</td>
</tr>
<tr>
<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, rectal bleeding</td>
<td>• Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis</td>
<td>• Severe respiratory distress</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Acute complicated injury, e.g. head injury with brief loss of consciousness</td>
<td>• Progressive, severe rheumatoid arthritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Depression with suicidal ideation</td>
</tr>
</tbody>
</table>
Table 2: Diagnostic Procedures

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab 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</td>
<td>Cardiovascular imaging studies with identified risk factors</td>
</tr>
<tr>
<td>Chest X-rays</td>
<td>Non-cardiovascular imaging studies with contrast e.g. barium enema</td>
<td>Endoscopy with no identified risk factors</td>
<td>Cardiac electro physiological tests</td>
</tr>
<tr>
<td>EKG</td>
<td>Superficial needle biopsies</td>
<td>Deep needle or incisional biopsy</td>
<td>Endoscopies with identified risk factors</td>
</tr>
<tr>
<td>EEG</td>
<td>Clinical lab tests requiring arterial puncture</td>
<td>Cardiovascular imagining studies with contrast and no identified risk factors; e.g. arteriogram, cardiac catheterization</td>
<td></td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Ultrasound, e.g. echo-cardiography</td>
<td>Lumbar puncture</td>
<td></td>
</tr>
</tbody>
</table>

Table 3: Management Options

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest</td>
<td>Over the counter drugs</td>
<td>Minor surgery with identified risk factors</td>
<td>Elective major surgery with identified risk factors</td>
</tr>
<tr>
<td>Gargles</td>
<td>Minor surgery with no identified risk factors</td>
<td>Referral for or decision to perform elective major surgery with no identified risk factors</td>
<td>Referral for or decision to perform emergency major surgery</td>
</tr>
<tr>
<td>Elastic bandages</td>
<td>Physical Therapy</td>
<td>Simple prescription drug management</td>
<td>Parenteral controlled substances</td>
</tr>
<tr>
<td>Superficial dressings</td>
<td>Occupational therapy</td>
<td>Therapeutic nuclear medicine</td>
<td>Multiple drug therapy requiring intensive monitoring for toxicity</td>
</tr>
</tbody>
</table>
### Presenting problem(s) (table 1)

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
</table>

### Diagnostic procedures (table 2)

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
</table>

### Management options (table 3)

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
</table>

### Overall risk

<table>
<thead>
<tr>
<th>1 Minimal</th>
<th>2 Low</th>
<th>3 Moderate</th>
<th>4 High</th>
</tr>
</thead>
</table>

### Type of medical decision making

<table>
<thead>
<tr>
<th>Straightforward</th>
<th>Low complexity</th>
<th>Moderate complexity</th>
<th>High complexity</th>
</tr>
</thead>
</table>

### Step 1: Number of diagnoses or management options

| 1 | 2 | 3 | 4 |

### Step 2: Amount and complexity of data

<table>
<thead>
<tr>
<th>≤ 1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>≥ 4 Extensive</th>
</tr>
</thead>
</table>

### Step 3: Overall risk

<table>
<thead>
<tr>
<th>1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>4 High</th>
</tr>
</thead>
</table>

### Type of medical decision making

<table>
<thead>
<tr>
<th>Straightforward</th>
<th>Low complexity</th>
<th>Moderate complexity</th>
<th>High complexity</th>
</tr>
</thead>
</table>
Documentation of an Encounter Dominated by Counseling or Coordination of Care

• In the case where counseling and/or coordination of care dominates (more than 50%) of the physicians/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

• **DG: If a physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.**

SAMPLE AUDIT TOOL
### History

After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 5.

<table>
<thead>
<tr>
<th>HPI (history of present illness) elements:</th>
<th>Status of 1 chronic condition</th>
<th>Status of 2 chronic conditions</th>
<th>Status of 3 chronic conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Severity</td>
<td>Timing</td>
<td>Modifying factors</td>
</tr>
<tr>
<td>Quality</td>
<td>Duration</td>
<td>Contact</td>
<td>Associated signs and symptoms</td>
</tr>
<tr>
<td>ROS (review of systems):</td>
<td>Ears, nose,</td>
<td>GI</td>
<td>Endo (spleen, liver)</td>
</tr>
<tr>
<td></td>
<td>Eyes</td>
<td>Cardiovascular</td>
<td>Musculo</td>
</tr>
</tbody>
</table>

**Complete ROS:** 10 or more systems or the pertinent positives and/or negatives of some systems with a statement “all others negative.”

**Complete PFSH:** 2 history areas: a) Established Patients - Office (Outpatient) Care, b) Emergency Department.

3 history areas: a) New Patients - Office (Outpatient) Care, Domiciliary Care, Home Care; b) Initial Hospital Care; c) Initial Observation; d) Initial Nursing Facility Care.

NOTE: For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Please refer to procedure code descriptions.

### Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

<table>
<thead>
<tr>
<th>Limited to affected body area or organ system (one body area or system related to problem)</th>
<th>PROBLEM FOCUSED EXAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affected body area or organ system and other symptomatic or related organ system(s)</td>
<td>EXPANDED PROBLEM FOCUSED EXAM</td>
</tr>
<tr>
<td>Extended exam of affected area(s) and other symptomatic or related organ system(s)</td>
<td>DETAILED EXAM</td>
</tr>
<tr>
<td>General multi-system exam (8 or more systems) or complete exam of a single organ system</td>
<td>COMPREHENSIVE EXAM</td>
</tr>
</tbody>
</table>

**Exam**

Body areas:
- Head, including face
- Chest, including breasts and axillae
- Abdomen
- Neck
- Back, including spine
- Genitalia, groin, buttocks
- Each extremity

Organ systems:
- Constitutional
- Ears, nose, mouth, throat
- Resp
- Musculo
- Psych
- Hands/feet
- Cardiovascular

1 body area or system
- Up to 7 systems
- Up to 7 systems
- 8 or more systems

PROBLEM FOCUSED | EXPANDED | DETAILED | COMPREHENSIVE
### Table of Risk

<table>
<thead>
<tr>
<th>LEVEL OF RISK</th>
<th>PRESENTING PROBLEM(S)</th>
<th>DIAGNOSTIC PROCEDURE(S) ORDERED</th>
<th>MANAGEMENT OPTIONS SELECTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One self-limited or minor problem, e.g. cold, insect bite, lice corpora</td>
<td>Laboratory tests require venipuncture, Chest x-rays, EKG/EEG, Urinalysis, Ultrasound, e.g. echocardiography, KOH prep</td>
<td>Rest, Gargles, Elastic Bandages, Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems</td>
<td>Physiologic tests not under stress, e.g. pulmonary function tests</td>
<td>Over-the-counter drugs, Minor surgery with no identified risk factors, Physical therapy, Occupational therapy, IV fluids without additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Physiologic tests under stress, e.g. cardiovascular imaging studies with contrast and no identified risk factors, Skin biopsies, Clinical laboratory tests requiring arterial puncture</td>
<td>Minor surgery with identified risk factors, Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors, Prescription drug management, Therapeutic nuclear medicine, IV fluids with additives, Closed treatment of fracture of dislocation – without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>Cardiac electrophysiological tests, Cardiac endovascular or endoscopic procedures with identified risk factors</td>
<td>Elective major surgery (open, percutaneous or endoscopic) with identified risk factors, Emergency major surgery (open, percutaneous or endoscopic), Parenteral controlled substances, Drug therapy requiring intensive monitoring for toxicity, Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
Related OIG Work

• Study from 2001 to 2010, physicians increased their billing of higher level codes for E/M services in all visit types.

• 1,669 physicians consistently billed for the two highest level codes for E/M services in 2010.

• With adoption of EHR technology, 57% of physicians who provided E/M services in 2010 used an EHR system.
Findings…

- 55% of claims for E/M services were incorrectly coded and/or lacking documentation in 2010, resulting in 6.7% billion in improper Medicare payments
- 26% of claims for E/M services were upcoded.
- 15% of claims for E/M services were downcoded.
- 2% of claims for E/M services had other coding errors.
- 12% of claims for E/M services were insufficiently documented
- 7% of claims for E/M services were undocumented.

SAMPLE CASE REPORT AND ANSWER KEY
## Case Report

**Date:** March 1, 2016  
**VITALS:** BP 110/70  
**HR:** 80  
**RR:** 20  
**TEMP:** 98°  
**WT:** 103

**Chief Complaint:** Follow-up on multiple medical conditions.

**SUBJECTIVE:** Mrs. Black is here for follow-up on multiple medical conditions. Generally asymptomatic. Occasional aches and pains. The patient is stable. Not gaining or significantly losing weight. She still takes oxygen occasionally, but her P02 on room air back in November was 82, which means she has graduated from oxygen treatment. Still gets occasional nebulizer treatments. Denies having any shortness of breath, denies having any chest pains. Patient smoked cigarettes for 35 years, but stopped 3 years ago.

**OBJECTIVE:** Physical examination shows a fairly nourished, fairly developed female in no acute distress. Vital signs stable. HEENT: shows no thyromegaly, no carotid bruits. No cervical lymphadenopathy. No jugular venous distention. Chest is clear, generally with no murmur or rales. Heart sounds are regular, no clear murmur at this time. Abdomen is soft and benign. No organomegaly. No clubbing or cyanosis. Good peripheral pulses.

**ASSESSMENT:** Medical problems include that of: 1) Chronic obstructive pulmonary disease (COPD) without acute infection or exacerbation, 2) Hypertension (under control), and 3) Primary generalized osteoarthritis.

**PLAN:** Continue present medications. Will see her again in about two to three months.

---

## Case Report Answers

### HISTORY

- **CC:** Follow up visit
- **HPI:** Element (Brief) = Expanded Problem Focused  
  Assoc. Signs & Symptoms = occasional aches & pain
- **ROS:** 3 systems (Extended) = Detailed  
  Constitutional = not gaining or losing weight  
  Cardiovascular = denies having S/O chest pains  
  Respiratory = still takes oxygen
- **PFSH:** n/a = Expanded Problem Focused

You need 2 out of 3 elements to meet or exceed: Overall level = EPF

### MEDICAL DECISION MAKING

2 or more established problems. StableImproving  
COPD & hypertension2 points = Low Level

**HPI:** Element (Brief) = Expanded Problem Focused  
Assoc. Signs & Symptoms = occasional aches & pain

Amount of complexity of data = none0 points = Minimal Level

Overall Table of Risk with drug management = Moderate Level

You need 2 out of 3 elements: Overall level = Low Level

### EXAMINATION

- **Constitutional:** Vital signs report  
  Fairly nourished, developed
- **Ear, Nose:** No thyromegaly  
  No murmur or rales
- **Respiratory:** Heart sounds regular, no murmur
- **Cardiovascular:** No cyanosis
- **Gastro (Abdomen):** Soft & benign
- **Musculoskeletal:** No clubbing

You need 2 out of 3 elements for an established patient: Overall level of service =

- **CPT:** 99213
- **ICD-10:** COPD J44.9
- **Hypertension:** 110
- **Primary generalized (osteo)arthritis:** M15.0
- **History of tobacco use:** 287.891

10 Bullets counted = Expanded Problem Focused
Tips, Tools, and Techniques

• DOCUMENT, DOCUMENT, “tell an accurate patient story”
• Use “step by step” audit tools to determine appropriate E/M level reflected in documentation.
• Be consistent with either the 1995 and 1997 guidelines
• Be familiar with specific guidelines for each E/M section

Resources

• Current Procedural Terminology 2015 American Medical Association
  http://www.ama-assn.org/ama/home.page

• Evaluation and Management Services Guide, CMS, November 2014
Questions?

- Thank you for your attendance!

- Get your questions answered on PMI's Discussion Forum:
  http://www.pmidm.com/pmiForums/rules.asp

- Contact information: pjoslin@pmimd.com