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On the topic:

E/M Coding Strategies for Endocrinology

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E/M Coding Strategies
Helping Providers “Code by the Rules”

Developed & Presented by:
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Agenda

• Review coding trends of E/M services.
• Outline general principles of medical record documentation.
• Define medical necessity and how it relates to E/M services.
• Discuss the components of selecting the proper E/M code.
• Discuss key differences between the 1995 and 1997 E/M guidelines.
• Identify and discuss the components of an E/M service focusing on the three key components.
• Billing based on time.
• Review consultation services.
• Discuss Teaching Physician guidelines.
Coding Trends

- **Evaluation and Management (E/M) Services**
  - Refer to diagnostic/therapeutic management of the patient furnished by healthcare providers
  - Account for approximately
    - 1% of all procedure codes
    - 18% of frequency reported to Medicare
    - 28.4% of payments made by Medicare
  - In the 2017 National Physician Fee Schedule Database, there are
    - 14,489 unique procedure codes
    - 160 unique E/M codes
    - $29 billion of $102 billion in total payments

Coding Trends

- **Coding Trends of Medicare E/M Services**
  - Medicare payments for Part B services increased by 43%, from $77 billion to $110 billion.
  - The number of E/M services billed increased by 13%, from 346 million to 392 million.
  - Medicare payments for E/M services increased by 48%, from $22.7 billion to $33.5 billion
  - Physicians increased their billing of higher level E/M codes in all types of E/M services.
  - Authors of the report encouraged CMS to audit E/M codes because, they noted, “E/M services have been vulnerable to fraud and abuse ” and to educate physicians on proper billing for E/M services.

Source - OIG Report: May 2012 OEI-04-10-00180
Coding Trends

• Types of Audits
  – Additional Documentation Requests (ADRs)
  – Comprehensive Error Rate Testing (CERT)
  – Medicare Administrative Carriers (MACs)
  – Recovery Audit Program
  – Zone Program Integrity Contractors (ZPICs)
  – Private Payers
  – The Practice (YOU)

Coding Trends

• Common Medical Review Findings
  – Failure to meet the key component levels required for the code billed.
  – The documentation does not meet three of three key components for “new” patient or “initial visit services.
  – The documentation did not support the medical necessity for the level of service billed.
  – Lack of medical necessity for the frequency of stable, chronic conditions (monthly visits for the stable, chronic conditions; no new complaints).
  – Cloning.
  – Conflicting documentation within the note.
General Principles of Documentation

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; and
   – 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, and revision of diagnosis should be documented.
7. The CPT® and ICD-10-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Medical Record Documentation

• Documentation Tips
  – Providers and coders must work together to ensure coding accuracy.
  – Use of templates can facilitate documentation and remind providers of the requirements of each level of care.
  – Providers have to be specific in their patient encounter documentation to provide the best opportunity to choose the most correct codes to guarantee appropriate reimbursement.
  – 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; do not over document or under document.
Medical Record Documentation

• Common Provider Documentation Errors:
  – Inconsistent documentation
  – Incomplete progress notes
  – Undocumented care
  – Missing test results
  – Historical diagnosis documented as current
  – Chronic conditions not documented
  – Illegibility
  – Documentation not completed on time
  – Incorrectly coding the level of E/M

Medical Necessity

• Social Security Act 1862 (a)(1)(A):
  – “No payment may be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

• CMS Guidelines:
  – Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT code (CMS Medicare Claims Processing Manual, Ch. 12, section 30.6.1). 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.

• Federal False Claims Act
  – Billing CMS for services that are not medically necessary can result in being prosecuted for fraud by the OIG; violators may pay up to three times the amount of damages and face penalties of up to $21,916 for each service.
Medical Necessity

- Defined as accepted healthcare services and supplies provided by healthcare entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
- Must adhere to the standard of care that applies to the actual direct care and treatment of the patient.
- Services must be within the scope of practice for the relevant type of provider in the State in which they are furnished.
- For every service billed, you must indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.
- You are responsible for knowing up-to-date information on services covered by CMS or other third-party payers.

E/M Documentation Guidelines

- Evaluation and Management (E/M) Codes
  - Were developed by AMA and CMS to translate patient encounters into 5 digit numerated categories to facilitate billing
    - Initial Hospital Care
      - 99221
      - 99222
      - 99223
  - Two sets of guidelines were created to facilitate code selection
    - 1995 E/M Guidelines
    - 1997 E/M Guidelines
  - Providers are allowed to utilize either guidelines; not a combination of both. Exception – Use of the 1997 E/M Guidelines for an extended HPI along with other elements from the 1995 E/M Guidelines.
What Constitutes an E/M Code Assignment?

- The E/M code is selected based on medical necessity (i.e., how sick a patient is).

- Lower levels (1-2) are assigned for patients who present with minor problems and/or who are well controlled.

- Levels 3-5 are assigned for patients who are injured or “sick”.

E/M Documentation Guidelines

These steps should be taken when selecting an E/M code:

1. Patient Type
   - New
   - Established

2. Setting of Service
   - Office or Other OP Setting
   - Hospital IP, ED or NF

3. Select Appropriate Level of E/M Service Performed
   - Review CPT Code Descriptors
   - Review CPT Reporting Instructions
E/M Documentation Guidelines

The correct level of service is chosen based on the following:

**Key Components**
- History
- Examination
- Medical Decision Making

**Contributory Factors**
- Counseling
- Coordination of Care
- Nature of the Presenting Problem

**Time**
- Face to Face
- Floor/Unit in Hospital or NF
1995 and 1997 Guideline Similarities and Differences

**E/M Components**

<table>
<thead>
<tr>
<th>E/M Components</th>
<th>History of Present Illness</th>
<th>Review of Systems</th>
<th>Past, Family and Social History</th>
<th>Exam</th>
<th>Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1995</strong></td>
<td>No Difference</td>
<td>No Difference</td>
<td>No Difference</td>
<td>Body areas, body systems or complex single organ system</td>
<td>No Difference</td>
</tr>
<tr>
<td><strong>1997</strong></td>
<td>An extended History of Present Illness may consist of status of three chronic/inactive conditions for either set of guidelines (1995 or 1997).</td>
<td>No Difference</td>
<td>No Difference</td>
<td>General multi-system or single organ system</td>
<td>No Difference</td>
</tr>
</tbody>
</table>

Documentation of History (1995 or 1997 Guidelines)

- Based on four types of history
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - 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)
  - Past, family and/or social history (PFSH)

- All three elements in the table must be met
  - A chief complaint is indicated at all levels
Capsulization of History Documentation Requirements

<table>
<thead>
<tr>
<th>HPI Elements</th>
<th>ROF</th>
<th>PF</th>
<th>EPF</th>
<th>DET</th>
<th>COMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must be documented by the provider</td>
<td>Brief</td>
<td>1-3</td>
<td>2-2 Conditions</td>
<td>Complete</td>
<td>Extended</td>
</tr>
<tr>
<td>1 Condition</td>
<td>None</td>
<td>None</td>
<td>Pertinent (1 of 3)</td>
<td>Complete</td>
<td>Extended (4+ Conditions)</td>
</tr>
<tr>
<td>2 Conditions</td>
<td>None</td>
<td>None</td>
<td>Pertinent (1 of 3)</td>
<td>Complete</td>
<td>Extended (4+ Conditions)</td>
</tr>
<tr>
<td>3 Conditions OR Brief 1-3 2-2 Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In order to meet each level of history, you must meet or exceed that level of HPI, ROS and PFSH

Common History Documentation Errors

- Chief complaint: Not Documented
- HPI: Documented by non-provider
- 3+ Chronic Conditions: No Status
- ROS: Not Documented, “See HPI”, “All others negative” and nothing else, Double Dipping
- Language: “Non-contributory”, “none”, “not on file”
E/M Documentation Guidelines

• Points to Remember – The History
  
  – HPI
    • Must be documented by the provider
    • Status of chronic conditions
  
  – Review of Systems
    • Maybe documented by ancillary staff or patient
      – Provider must review and sign; and refer to ROS in note
    • Not required to re-record from a previous encounter
    • Record pertinent positives & negatives
    • Some systems (2-3) and “all others negative”
  
  • Double Dipping

E/M Documentation Guidelines

– Past, Family, Social History
  
  • Maybe documented by ancillary staff or patient
    – Provider must review and sign; and refer to PFSH in note
  
  • Not required to re-record from a previous encounter
  • Different requirements for complete
  • Record family history even if “non-contributory”

– Clinical History
  
  • Interval history is acceptable for subsequent hospital services
  • Unable to obtain clinical history from patient/family member or caregiver
    – Indicate reason & all attempts made
    – Example: patient unconscious, intubated, poor historian
• **HPI Clinical Vignettes**
  - 4 descriptors = Comprehensive
    - A patient with a longstanding history of Type II Diabetes Mellitus presents for diabetes management. The patient reports having extremely (severity) high blood sugars especially after dinner (context) for the past two weeks (duration). She has experienced some dizziness and nausea (associated sign or symptom) over the last 3 days. Her diabetes is currently managed with 100 unit/ML subcutaneous insulin (modifying factor). Her last hemoglobin A1c was 8.3%.
  - 3 Chronic Conditions = Comprehensive
    - Patient has fairly well controlled Type I DM without complications. Poorly controlled hypertension - B/P 165/80. Mixed hyperlipidemia stable; on statins.
  - Unable to Obtain History = Comprehensive
    - Provider documents patient has altered mental status. Obtains limited information from a family member but is unable to obtain the patient’s complete history. (Full-history credit because of impossibility to obtain more information)

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**Documentation of Examination**

• Based on Four Types of Examination
  - Problem Focused (PF)
  - Expanded Problem Focused (EPF)
  - Detailed (Det)
  - Comprehensive (Comp)

• Physical Exam Rules
  - All abnormal physical exam findings must be described
  - All "pertinent-negative physical exam findings" should be described (e.g.: no hepatosplenomegaly )

Note: Providers are allowed to use either the 1995 or the 1997 documentation guidelines
E/M Documentation Guidelines

Body Areas (BA):

- Head/Face
- Chest/Breast/Axillae
- Genitalia/Buttock/Groin
- Back/Spine
- Abdomen
- Neck
- Extremity

OR

Organ Systems (OS):

- Constitutional
- Respiratory
- Skin
- Eyes
- Gastrointestinal
- Neurological
- ENT/Mouth
- Genitourinary
- Psychiatric
- Cardiovascular
- Musculoskeletal
- Heme/Lymph/Imm

Exam 1995 Guidelines 1997 Guidelines

PF

1
Limited Exam of BA or OS

1-5
Bulleted elements in one or more OS

EPF

2 – 7
Limited Exam of Affected BA or OS & other symptomatic or related BA/OS

6-11
Bulleted elements in one or more OS

Detailed

2 – 7
Extended Exam of Affected BA or OS & other symptomatic or related BA/OS

12 ≥ bulleted elements in 2 or more OS or 2 bullets from 6 areas

Novitas “4 x 4 Rule”

Comp

8 or more OS
General multi-system exam

OR Complete single OS

18 ≥ bulleted elements (2 in 9 or more OS)
All items identified by a bullet; Every element in all shaded borders & at least 1 element in each unshaded border
• Novitas - “4 x 4” Rule
  – Defined by 4 bullet points in 4 ≥ body areas or organ systems

  – Example using the 4 X 4 Rule
    • Constitutional
      1) BP      2) Temp      3) Pulse      4) Respiration
    • Respiratory
      1) Chest clear to auscultation  2) Non-labored breathing  3) No Rales  4) No Rhonchi
    • Cardiovascular
      1) Regular Rate and  2) Rhythm  3) Normal S1 and  4) S2
    • Gastrointestinal
      1) Abdomen soft  2) Non-distended  3) No masses  4) No hernia
E/M Documentation Guidelines

Single Organ System Exam

• Common Examination Documentation Errors
  – Lack of documentation
  – Mixing of body areas and organ systems
  – Check boxes
    • Abnormal without findings
  – Lack of understanding 1997 Guidelines
• Points to Remember – The Exam

− Ancillary staff may only document the constitutional organ system
− Abnormal or unexpected findings should be described
− A notation of “abnormal” without elaboration is insufficient
− Do not combine the body areas & organ systems when scoring the exam
− A brief statement or notation indicating “negative” or “normal” is sufficient for findings within normal limits
  • Documentation of “noncontributory” is not sufficient to indicate a normal finding
− Under 1995 DGs, comprehensive PE must consist of evaluation of 8 or more of the 12 Organ Systems

E/M Documentation Guidelines

• Exam Example


E/M Documentation Guidelines


- 1995 Guidelines
  - Constitutional
  - Eyes
  - ENT
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Skin
  - Psychiatric
- Comprehensive (8 organ systems evaluated)

- 1997 Guidelines
  - Constitutional – 2 bullets
  - Eyes – 2 bullets
  - ENT – 3 bullets
  - Neck – 1 bullet
  - Respiratory – 1 bullet
  - Gastrointestinal – 1 bullet
  - Skin – 1 bullet
  - Psychiatric – 1 bullet

- Detailed (12 bullets documented)

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**Documentation of the Complexity of Medical Decision Making**

- The levels of E/M services recognize four types of medical decision making
  - Straight-forward
  - Low complexity
  - Moderate complexity
  - High complexity

- Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by
  - Number of possible diagnoses and/or management options
  - Amount and/or complexity of data reviewed
  - Risk of significant complications

  - To qualify for a given type of decision making, two of the three elements in the table must be either met or exceeded
## E/M Documentation Guidelines

**MEDICAL DECISION MAKING (requires 2 of 3 elements)**

<table>
<thead>
<tr>
<th>Level</th>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity or data to be reviewed</th>
<th>Risk of complications and/or morbidity or mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal or None (0-1)</td>
<td>Minimal or None (0-1)</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low</td>
<td>Limited (2)</td>
<td>Limited (2)</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple (3)</td>
<td>Moderate (3)</td>
<td>Moderate</td>
</tr>
<tr>
<td>High</td>
<td>Extensive (4+)</td>
<td>Extensive (4+)</td>
<td>High</td>
</tr>
</tbody>
</table>

To qualify for any specific level of decision making at least 2 of the 3 components must be met or exceeded.

<table>
<thead>
<tr>
<th>Level</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Self Limited or Minor; stable, improved, or worsening (Max of 2)</td>
</tr>
<tr>
<td></td>
<td>Established Problem*; stable, improved</td>
</tr>
<tr>
<td></td>
<td>Established Problem*; worsening</td>
</tr>
<tr>
<td></td>
<td>New Problem*; no workup planned (Max of 3)</td>
</tr>
<tr>
<td></td>
<td>New Problem*; addl. workup planned</td>
</tr>
</tbody>
</table>

**Total Diagnosis or Management Options**

*to examiner

- Review &/or order of clinical lab tests
- Review &/or order of tests in the radiology section
- Discussion of test results with performing physician
- Decision to obtain old records &/or obtaining history from someone other than patient
- Review & summarization of old records
- Independent visualization of images, tracing or specimen itself

**TOTAL**

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**E/M Documentation Guidelines**

Use the risk table below as a guide to assign risk factors. We understand that the table below does not cover all specific instances of medical care. The table is intended to be used as a guide. Guide the appropriate column to each category. The overall score of an E/M is limited to the highest level scored.

**Risk of Complications and/or Mortality or Morbidity**

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s)</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One well-limited or minor problem, e.g., cold, insect bite, lacerations</td>
<td>Electrocardiogram (ECG)</td>
<td>Assess, consult, refer, written orders, telephone notes, antibiotic orders, lab orders, or other orders</td>
</tr>
<tr>
<td>Low</td>
<td>Minor or well-limited or minor problem, e.g., well-controlled hypertension or non-insulin dependent diabetes, stable renal status</td>
<td>Peripheral venous access, e.g., femoral, or other veins</td>
<td>Consult, refer, letter, written orders, or other orders</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic problems with mild exacerbation, e.g., heart failure, hypertension, arthritis, diabetes, chronic obstructive pulmonary disease</td>
<td>Chest x-ray, echocardiogram, holter monitor, stress test, or other tests</td>
<td>Consult, refer, letter, written orders, or other orders</td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic problems with severe exacerbation, e.g., heart failure, hypertension, arthritis, diabetes, chronic obstructive pulmonary disease</td>
<td>Elective hospitalization or major surgery, e.g., open heart surgery or major orthopedic surgery</td>
<td>Consult, refer, letter, written orders, or other orders</td>
</tr>
</tbody>
</table>

---

**It only takes one**

- Baseline pre-op exam (serial, non-invasive or invasive, to evaluate risk factors)
- Emergency/trauma surgery (open, converted, or endoscopic)
- Unplanned postoperative management: surgery, ICU, or hospitalization
- Prolonged critical care admission
- Decision to rescue or to de-escalate care because of poor prognosis
E/M Documentation Guidelines

- **High Risk Medication**

  - Drugs that have a narrow therapeutic window and a low therapeutic index may exhibit toxicity at concentrations close to the upper limit of the therapeutic range and may require intensive clinical monitoring.

  - Administration of cytotoxic chemotherapy is always considered *high risk* under management options when monitoring of blood cell counts is used as a surrogate for toxicity.

  - The table on the next slide lists examples of drugs that may need to have drug levels monitored for toxicity. This is not an all exclusive list.

  - On medical review, to consider therapy with one of these drugs as a high risk management option, it would be expected to see documentation in the medical record of drug levels obtained at appropriate intervals.

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Drugs in that Category</th>
<th>Treatment Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
<td>Digoxin, Digitoxin, Quinidine, Procainamide, Amiodarone</td>
<td>Congestive heart failure, angina, arrhythmias</td>
</tr>
<tr>
<td>Anticoagulants</td>
<td>Coumadin and intravenous Heparin drip (Heparin must be provided in the hospital setting)</td>
<td>Prevention of thrombosis and thromboembolisms</td>
</tr>
<tr>
<td>Antiepileptic</td>
<td>Phenytoin, Phenobarbital, Valproic Acid, Carbamazepine, Ethosuximide, sometimes Gabapentin, Lamotrigine</td>
<td>Epilepsy, prevention of seizures, sometimes to stabilize mood</td>
</tr>
<tr>
<td>Bronchodilators</td>
<td>Theophylline, Caffeine</td>
<td>Asthma, chronic obstructive pulmonary disorder (COPD), neonatal apnea</td>
</tr>
<tr>
<td>Immunosuppressant</td>
<td>Cyclosporine, Tacrolimus, Sirolimus, Mycophenolate Mofetil, Azathioprine</td>
<td>Prevent rejection of transplanted organs, autoimmune disorders</td>
</tr>
<tr>
<td>Anti-Cancer</td>
<td>All Cytotoxic agents</td>
<td>Multiple malignancies</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Lithium, Valproic Acid, some antidepressants (Imipramine, Amitriptyline, Nortriptyline, Doxepin, Desipramine)</td>
<td>Bipolar disorder (manic depression), depression</td>
</tr>
<tr>
<td>Protease Inhibitors</td>
<td>Indinavir, Ritonavir, Lopinavir, Saquinavir, Atazanavir, Nelfinavir</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Aminoglycosides (Gentamycin, Tobramycin, Amikacin), Vancomycin, Chloramphenicol, Cefixim, Disulfiram</td>
<td>Infections with bacteria that are resistant to less toxic antibiotics</td>
</tr>
<tr>
<td>Insulin/Anti-Diabetic</td>
<td>Intravenous Insulin drip</td>
<td>Hyperglycemia</td>
</tr>
<tr>
<td>Erythropoiesis-Stimulating Agents (ESA)</td>
<td>Procrit and Epogen (Epoetin Alfa) and Aranesp (Darbepoetin Alfa)</td>
<td>Anemia</td>
</tr>
</tbody>
</table>
Points to Remember – Medical Decision Making

- Additional work-up
  - Work done after the day of the encounter
    - Labs and other diagnostics ordered during the visit which are resulted before the visit ends are not considered additional work-up

- Established diagnoses should indicate: stable, well-controlled, worsening, failing to improve.

- Independent review of diagnostic test: document visualization of image, tracing or specimen.

- Referral for urgent invasive procedures and surgeries should be documented or implied.

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 advice is requested.

- Review of old records: document relative findings or lack of findings.

- Review of laboratory, radiology, and/or other diagnostic tests: Simple notation such as ‘WBC elevated’ or ‘Chest X-ray unremarkable’ is acceptable or initial & date the report that contains the test results.

- Document co-morbidities, underlying diseases that increase risk of presenting illness

- Document assessment of problems without clear diagnosis: differential diagnosis, possible, probable, rule out

- Document the initiation or change in treatment.
E/M Documentation Guidelines

Documentation Example of MDM

A/P: Type 1 DM, SOB, confusion, N/V, increased thirst, frequent urination, fruity-scented breath... Suspect diabetic ketoacidosis. Order Stat Comprehensive metabolic panel, ABGs, EKG, CXR...

MDM Elements

- Number of dx/tx options = new problem with additional workup (4 – High compl)
- Amt/complexity of data = ordered radiology/lab & medicine test (2 – Low compl)
- Risk = acute injury that poses a threat to life or bodily function (High – High compl)

Level of MDM = High Complexity
Number diagnoses/management options – Extensive/High
Level of risk - High
2 of 3 MDM levels met

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E/M Documentation Guidelines

4. Time

If the physician documents total time and suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

<table>
<thead>
<tr>
<th>Does documentation reveal total time?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does documentation describe the content of counseling or coordinating care?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does documentation reveal that more than half of the time was counseling or coordinating care?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If all answers are "yes", select level based on time.

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E/M Documentation Guidelines

• Time
  – Time threshold tables describe how much total minimum time is required to use for time based billing and coding.
  – In the office or outpatient setting is defined by face-to-face time.
    • Time spent reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contacts is considered non face-to-face and cannot be included in the time when billing based on time.
  – In the hospital setting or inpatient setting is defined by unit/floor time.
    • Time spent on the patient either at bedside or on the unit reviewing the patient’s chart and communicating with other providers.
    • Time spent on the patient that is not performed on the unit is not included when calculating time.
  – Time spent counseling the patient or coordinating care after the patient has left the office or the physician has left the patient’s floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

• Counseling and Coordination of Care
  – Discussion with patient and/or family with regards to:
    • Diagnostic results, impressions, and/or recommended studies
    • Prognosis
    • Risks and benefits of management or treatment options
    • Instructions for management (treatment) and/or follow-up
    • Importance of compliance with chosen treatment or management options
    • Risk factor reduction
    • Patient and family education
E/M Documentation Guidelines

• Points to Remember – Time
  – The encounter must be dominated by counseling and/or coordination of care (at least 50%)
  – Total time determines the level of service
  – Time must be noted in the medical record to bill for time based codes
    • Time is provided only as an estimate
    • May document minutes or percentage of time
  – Document the following in the record:
    • A description of the counseling and/or activities to coordinate care
    • Total time of visit
    • Time spent providing counseling/coordination of care

Consultations

• A type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.
  – 3 R’s are required in order to bill for Consultation Services
    • Request is documented for advice/opinion
      – For inpatient, must be in writing
    • Render an Opinion
    • Written Response to requesting physician
  – No longer reimbursed by Medicare.
  – New and established patient rules apply.
  – Only one consultation is reported by a consultant per admission.
Consultations

- Use codes which represent where the visit occurs and identify the complexity of the visit performed.

- **OUTPATIENT CONSULTATIONS**: Instead of using guidelines for CPT’s Consultation subsection codes 99241-99245, providers will use guidelines for Office or Other Outpatient Visit new patient codes 99201-99205 and established patient codes 99211-99215.

- **INPATIENT HOSPITAL VISITS**: Instead of using guidelines for CPT’s Consultation subsection codes 99241-99255, when providers perform an initial consultation on a hospital inpatient, they will use guidelines for Inpatient Hospital Visits initial hospital care codes 99221-99223.

- **NURSING FACILITY SERVICES**: Instead of using guidelines for CPT’s Consultation subsection codes 99241-99255, when providers perform an initial consultation on a nursing facility patient, they will use guidelines for Nursing Facility Visits initial nursing facility care codes 99304-99306.

Teaching Physician Guidelines

- Teaching physician (TP) means a physician (other than a resident/fellow) who involves residents in the care of his or her patients.

- **General Rule**
  - The teaching physician must be physically present during the key portion of the service.
  - The documentation must reflect the teaching physician’s presence and participation.
  - The service is billed using the “GC” modifier.
Teaching Physician Guidelines

• TP MUST personally document:
  – Personally performed the service or was physically present during critical or key portion
  – Participation in the management
  – Reference to resident’s note, by name & date
    • Resident’s documentation of TP’s presence is not sufficient to establish the presence and participation of the TP.
    • If the TP’s note is not tied-in with the resident’s note, the TP’s note will stand alone.
    • The level of service will reflect only what the TP has performed and documented.
    • When billing based on time, the resident’s time alone cannot be considered.

Unacceptable Documentation

  – “Agree with above”
  – “Rounded, Reviewed, Agree”
  – “Discussed with resident. Agree”
  – “Seen and Agree”
  – “Patient seen and evaluated”
  – Countersignature or identity alone
Teaching Physician Guidelines

• Minimal E/M Documentation Examples
  – Admit Note
    • I performed a history and physical examination of the patient and discussed with Dr. Resident. I reviewed his/her note dated 11/17/17 & agree with the documented findings & plan of care.
  – Follow-up Visit
    • Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented by Dr. Resident above.
  – Follow-up Visit
    • Hospital Day #5. I saw and examined the patient. I agree with Dr. Resident’s note dated 05/07/18 except the heart murmur is louder, so I will obtain an echo to evaluate.

Data Analysis

• Comparative Billing Reports (CBRs)
  – Educational tools used to provide insight into billing trends.
  – Designed to assist you when performing self-audits of both procedures and billing practices.
  – You can use CBR reports to see how your provider practice or individual practitioner compares to your peers.
  – The peer group is comprised of providers with the same specialty and within the same geographic area.
  – You can access CBRs through your local MAC.

Note: CMS may use CBRs to compare utilization across providers within relevant peer groupings and may focus on providers who have accumulated excessive services and dollars by conducting a medical review audit (probe review).
### Data Analysis

#### JM Part B South Carolina E/M Procedure Code Range Summary for BESS Data Sorted by Procedure Code Within Specialty Code Dates of Service: 01/01/2017 - 06/30/2017

<table>
<thead>
<tr>
<th>Within Specialty Code</th>
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<th>SC Specialty % of Use</th>
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#### Source of Report: Medicare Statistical Analysis Department (E/M Code Comparison) Run Date: 12/21/2017

### Summary

#### E/M Coding Profile: Endocrinology – Dr. Endo

#### New Pt. E/M Utilization: Actual vs. National Medicare Averages

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<thead>
<tr>
<th>Code</th>
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<th>Actual Medicare Difference</th>
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</table>


<table>
<thead>
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<th>Actual Medicare Difference</th>
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Summary

- Documentation should be clear, concise and timely.
- Be knowledgeable about the E/M Coding guidelines.
- Understand the components that substantiate the E/M codes.
- E/M code selection should be based on medical necessity.
- Documentation should spell out the specific service provided.
- Claim submission should be based on only what was needed and documented.

Summary

- Develop an effective compliance program
  - Implement compliance and practice standards
  - Designate a compliance officer or contact
  - Conduct internal monitoring and auditing
  - Conduct appropriate training and education
  - Respond appropriately to detected offenses and develop corrective action
  - Develop open lines of communication
  - Enforce disciplinary standards through well-publicized guidelines
- Conduct audits and reviews.
- Trend your billing.
- Benchmark your performance.
- Look for opportunities for improvement.
Questions

Thank you for attending!!

You can contact me at:

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References

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<th>For Information About</th>
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