Evaluation & Management Services: A Practical Approach

Part B Provider Outreach and Education

Creating Success Through Service

April 2017
Disclaimer

This resource is not a legal document. This presentation was prepared as a tool to assist our providers. This presentation was current at the time it was created.

Although every reasonable effort has been made to assure accurate information, responsibility for correct claims submission lies with the provider of services.
Topics

• Evaluation & Management (E/M) Guidelines
• Overview of Code Selection
• Components of the E/M Service
• Evaluation & Management Spotlight
• Medical Necessity
• Documentation
• Errors Identified Through Review of E/M
Evaluation and Management Guidelines

Physicians may utilize the Evaluation and Management Services 1995 guidelines or 1997 guidelines. Medical records are reviewed utilizing the guidelines that afford the provider the best opportunity to support the highest appropriate code with the greatest reimbursement.
Where to Start?

Select a code that best represents:
- Patient Type
- Setting of Service
- Level of Service Performed
Patient Type

- New Patient
- Established Patient
Setting of Service

• Office or Other Outpatient Setting
• Hospital Inpatient
• Emergency Department
• Nursing Facility
Code Structure

- Categories
- Levels
Defining the Level of Service

Seven Recognized Components (3 are **key** components)

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time
## History

<table>
<thead>
<tr>
<th>Elements</th>
<th>Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint (CC)</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>History of Present Illness (HPI)</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>Review of Systems (ROS)</td>
<td>Detailed</td>
</tr>
<tr>
<td>Past, Family and/or Social History (PFSH)</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>
HPI Elements

A chronological development of the present illness from the first sign and/or symptom or from the previous encounter to the present

The following elements are included:

<table>
<thead>
<tr>
<th>Location</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Context</td>
</tr>
<tr>
<td>Severity</td>
<td>Modifying Factors</td>
</tr>
<tr>
<td>Duration</td>
<td>Associated Signs and Symptoms</td>
</tr>
</tbody>
</table>
Review of Systems

- **Problem pertinent** - inquires about the system directly related to the problem(s) identified in the HPI

- **Extended** - inquires about the system directly related to the problem(s) identified in the HPI & a limited number of additional systems (2-9 systems documented)

- **Complete** - inquires about the system(s) directly related to the problem(s) identified in the HPI; and at least ten organ system must be reviewed.
  - Those with positive or pertinent negative responses must be individually documented.
  - A notation indicating all other systems are negative is permissible.
  - In the absence of such a notation, at least ten systems must be individually documented.
Past Family and/or Social History

- **Pertinent** - review of the history area(s) directly related to the problem identified in the HPI (at least one specific item from any of the three history areas must be documented)

- **Complete** - review of two or three of the PFSH history areas (depending on the level of E&M)

- **Comprehensive** – review of all three history areas
## Level of History Requirements

<table>
<thead>
<tr>
<th>Type of History</th>
<th>CC</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Required</td>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Required</td>
<td>Brief</td>
<td>Problem Pertinent</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed</td>
<td>Required</td>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Required</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
</tr>
</tbody>
</table>
Physical Examination

Four Levels of Physical Exam

- Problem Focused
- Expanded Problem Focused
- Detailed
- Comprehensive
Medical Decision Making

Four Types of Medical Decision Making

- Straight-forward
- Low complexity
- Moderate complexity
- High complexity
# Medical Decision Making

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Number of Diagnoses or 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>
Evaluation & Management Spotlight

- Hospital Observation Services
- Critical Care Services
- Prolonged Services
- Modifiers
Observation Services

- CPT Codes 99217, 99218-99220, 99224-99226, 99234-99236
- Per Day Codes (Not per Encounter!)
- Keys to Appropriately Utilizing Observation Codes
  - Status of Patient
  - Physician Overseeing Care
  - Adherence to Rules on Billing Other E/M Codes on Day of Initial Observation
Observation Services

- **Initial Observation**
  - May be billed **only** by the physician who ordered hospital observation services and was responsible for the patient during the observation care

- **Subsequent Observation**
  - Payment is for all the care rendered by the treating physician on the day(s) other than the initial or discharge date

- **Observation Care Discharge**
  - Encompasses all services on day of discharge from observation status
  - Cannot be used if discharge date is same as “initial observation” date
Observation Services

• Medical Observation Record Components
  • Dated and timed physician’s order for observation services
  • Nursing notes
  • Progress notes
  • Any record prepared as a result of an emergency department or outpatient clinic encounter
Observation Services

• Admission to Inpatient Status Following Observation Care
  • Bill for an initial hospital visit
  • Do not bill an initial or subsequent observation code for services on this date
Critical Care Services

• What is Critical Care?
  • Critical Care is the direct delivery of medical care, by a physician(s), to a critically ill/critically injured patient

• Who qualifies as critically ill?
  • Critical illness/critical injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition
  • Patient’s physical location in an intensive care/critical unit is not the defining factor
Critical Care Services

• 99291 – Critical Care, evaluation and management of the critically ill/critically injured patient, first 30-74 minutes
  • Use only once per date

• 99292 – Each additional 30 minutes

• These codes used to report the total amount of time the physician spends providing critical care services

• Total time <30 minutes, use other appropriate E/M code
Critical Care Services

• Time based codes
• Require full attention of physician
• At bedside and on unit reviewing test results, imaging, etc.
• Physician must be immediately available to count time toward these codes
• Some otherwise separately reportable services are included in the Critical Care codes
## Critical Care Services

<table>
<thead>
<tr>
<th>Total Duration of Critical Care</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 minutes</td>
<td>Other appropriate E/M code</td>
</tr>
<tr>
<td>30-74 minutes</td>
<td>99291 X 1</td>
</tr>
<tr>
<td>75-104 minutes</td>
<td>99291 X 1 and 99292 X 1</td>
</tr>
<tr>
<td>105-134 minutes</td>
<td>99291 X 1 and 99292 X 2</td>
</tr>
<tr>
<td>135-164 minutes</td>
<td>99291 X 1 and 99292 X 3</td>
</tr>
<tr>
<td>165-194 minutes</td>
<td>99291 X 1 and 99292 X 4</td>
</tr>
<tr>
<td>195 minutes or longer</td>
<td>99291 X 1 and 99292 as appropriate (as illustrated above)</td>
</tr>
</tbody>
</table>
Prolonged Services

*With Direct Patient Contact*

- Codes 99354-99355 – Office/Other Outpatient Setting
- Codes 99356-99357 – Inpatient Setting

- Codes 99354 & 99355 – Prolong physician services with direct face-to-face patient contact that requires one hour beyond the usual service
- Codes 99355 & 99357 - each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services
Prolonged Services

With Direct Patient Contact

• Must be submitted with required companion code
• Use 99354 or 99356 only once per day
• Time spent performing separately reported services other than E/M or psychotherapy service cannot be counted toward prolonged service
• Must meet threshold times in order to bill prolonged services
• Documentation must detail the duration and the content of services provided
• Must document start and end times along with date of service
Prolonged Services

*Without Direct Patient Contact*

- Codes 99358 and 99359
  - New for CY 2017! Separately Payable Under Physician Fee Schedule
  - Must relate to both of the following:
    - A service or patient where face-to-face patient care has occurred/will occur
    - Ongoing patient management
  - Code 99358 should be used only once per date
  - Cannot report these codes when a more specific code (with no upper time limit) is available (ex. care plan oversight, anticoagulant management)
Modifiers

- Append the appropriate modifier, as indicated
  - 24 – Unrelated E/M during post operative period (by same physician)
  - 25 – Significant/separately identifiable E/M on same day
  - 27 – Multiple outpatient hospital E/M services on same date
  - 57 – Decision for surgery
Medical Necessity

Social Security Act 1862(a)(1)(A)
Medicare may only pay for services that are reasonable and necessary for the diagnosis and treatment of an illness or injury*

*Note exceptions listed in succeeding paragraph of SSA 1862(a)(1)(A)
Medical Necessity

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.

• Factors to assist in determining medical necessity
  • Clinical judgment
  • Standards of practice
  • Chief Complaint
  • Exacerbations/onsets of injuries/medical conditions
  • Co-morbidities
Documentation

• Complete and legible
• **Documentation for each encounter should include**
  • Reason for the encounter, relevant history, exam and prior diagnostic test results, reports if applicable
  • Assessment, clinical impression
  • Plan for care and
  • Date and legible identity of the provider, signature required – stamp signature is not acceptable
• Rationale for ordering diagnostic & other ancillary services should be documented or easily inferred
Documentation Tips

- The medical record should clearly reflect the chief complaint
- ROS and/or a 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.
- The ROS and/or PFSH may be recorded by ancillary staff or on a form
- Examination - A notation of "abnormal" without elaboration is insufficient
- The initiation of, or changes in, treatment should be documented
- Referrals and consultations should be documented
Documentation Tips

Adhere to Signature Guidelines

- Change Request (CR) 6698: For Medical Review purposes, Medicare requires that services provided/ordered be authenticated by the author
  - Hand written (legible)
    - May include a signature log
    - May include a signature attestation
  - Electronic

*Stamp signatures are not acceptable – one exception*
  - Change Request 8219 – Use of Rubber Stamp
  - Effective June 18, 2013
Common Evaluation & Management Errors

- Insufficient documentation to support level billed
- Medical necessity
- Up-coding
- No documentation
- Time requirements not met
- Time not documented in medical record
References

• Evaluation and Management Guide

• 1995 Guidelines

• 1997 Guidelines

• IOM 100-04 Medicare Claims Processing Manual, Chapter 12
MAC Satisfaction Indicator

• What?
  10 minute survey administered by CMS.

• Why?
  Tell us how we’re doing, what you like, and what we can do to improve.

• When?
  Available now!

• Where?
  Visit our website, Cahabagba.com and click the link to the MSI Survey under featured news.
FORESEE Survey

We'd welcome your feedback!

Thank you for visiting our website. You have been selected to participate in a brief customer satisfaction survey to let us know how we can improve your experience.

The survey is designed to measure your entire experience, please look for it at the conclusion of your visit.

This survey is conducted by an independent company ForeSee, on behalf of the site you are visiting.

No, thanks  Yes, I'll give feedback
Questions
Thank You

Creating Success Through Service