Disclaimers

- **Disclaimer for Today's Presentation**

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Currently, physicians may use 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.
Medical Necessity

Social Security Act 1862(a)(1)(A)
All billed services must be based only on activities that are reasonable and necessary for the diagnosis or treatment of illness or injury.

E & M Components

- There are 3 key components for E&M services.
  - History
  - Physical Exam
  - Medical Decision Making

- There are 3 contributing components for E&M services.
  - Counseling
  - Coordination of care
  - Nature of presenting problem; and
  - Time (50% or greater), if devoted to counseling and coordination of care.
E & M Components

The documentation of the history, Physical exam and Medical Decision Making should support the code billed, however, the extent of the History documented, the extent of the Physical Examination documented and the level of Medical Decision Making should not be greater than the levels required by the patient’s condition.

Nature of Presenting Problem

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. There are five types of presenting problems for E&M codes:

- Minimal
- Self-limited or minor
- Low severity
- Moderate severity
- High severity
History

- Four Levels of History
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive

Elements of History

- Chief Complaint (CC);
- History of Present Illness (HPI);
- Review of Systems (ROS); and
- Past, Family and/or Social History (PFSH).

A chief complaint is indicated at ALL levels.

HPI, ROS and PFSH (all three elements) of the history must be met to qualify for a given type of history.
History of Present Illness (HPI) Elements

A chronological development of the present illness from first sign and/or symptom or from the previous encounter to the present. The following elements are included:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

History of Present Illness (HPI)

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
- An extended HPI consists of **four or more elements** of the HPI

It is expected that the HPI will be performed by the provider billing the service, and not by ancillary personnel.
Review of Systems (ROS)

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

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

- A **pertinent** PFSH is a 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.

- A **complete** PFSH is a review of **two or all three** of the PFSH history areas, depending on the level of E&M.

- **All three** are required for comprehensive assessment or reassessment.
### History

To qualify for a given type of history, all three elements in the table must be met.

<table>
<thead>
<tr>
<th>Type of History</th>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems</th>
<th>Past, Family and/or Social History (PFSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused Brief</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Problem Focused Brief (1-3 Elements)</td>
<td>Problem Pertinent (At least one systems)</td>
<td>N/A</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>Extended (4 or more elements)</td>
<td>Extended (2-9 systems)</td>
<td>Pertinent (At least 1 specific area from 3 history areas)</td>
<td>Detailed</td>
</tr>
<tr>
<td>Extended (4 or more elements)</td>
<td>Complete (At least 10 systems)</td>
<td>Complete (2 or all 3 of PFSH areas)</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

* No. of elements, systems and areas are noted in red

### Physical Exam

- Four Levels of Physical Exam
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive

The extent of physical examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem.
### Physical Exam

#### Body Areas

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

#### Organ Systems

- Constitutional
- Genitourinary
- Eyes
- Musculoskeletal
- Ears, nose, mouth, throat
- Skin
- Cardiovascular
- Neurologic
- Respiratory
- Psychiatric
- Gastrointestinal
- Hematologic/lymphatic
- Immunologic
Four types of medical decision making:

- Straight-forward
- Low complexity
- Moderate complexity
- High complexity

Medical Decision Making

Two of three elements in the table must be either met or exceeded; refer to table of Risk in 1997 E&M Guidelines

<table>
<thead>
<tr>
<th>No. of diagnoses or mgmt. Options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of complications morbidity or mortality</th>
<th>Type of Decision Making**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
<td>Moderate</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
Recap

In review of records:

- 3 Key components – History, Physical Exam and Medical Decision Making
  - New visit requires all 3 components
  - Subsequent - 2 of 3 components
    - History and Physical
    - Physical and DM
    - History and DM
  - Time (50% or greater), if devoted to counseling and coordination of care.

- Levels of E&M Services
  - 4 levels of History
  - 4 levels of Physical Exam
  - 4 levels of Decision Making

Medical record documentation determines how we arrive at the level of coding.

What Do We Look for In Your Medical Records?
Documentation Requirements

“If It Is Not Documented, It’s Not Done”

• Complete and legible record

• 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; a stamp signature is not accepted (Program Integrity Manual, chapter 3.4.1.1B)

• Rationale for ordering diagnostic & other ancillary services should be documented or easily inferred;

Documentation Requirements

• Past & present diagnoses should be accessible to the treating and/or consulting physician;

• Identify health risk factors;

• Patient’s progress, response to treatment, changes in treatment or revisions in diagnoses should be documented; and

• Document any revisions to the plan of treatment
Documentation Requirements

• CPT/ICD-9 codes billed on the insurance claim form should be supported by documentation in the medical record; code correctly;

➢ If an E&M code is billed based upon counseling or coordination of care, the time must be documented along with the nature of the counseling or coordination of care (Time 50% or greater);

• Who, what, when, where, why and how long?

Two Documentation Articles posted to What’s News on March 9, 2009

• www.cahabagba.com/part_b/whats_new/20090309_incident_to.htm

• www.cahabagba.com/part_b/whats_new/20090309_e_and_m.htm

Example: Levels of E & M - Subsequent Hospital Care

Reasonable to expect higher levels of history and physical exams is needed in the days immediately following:

1) hospital admission
2) following transfer from intensive care
3) following an acute exacerbation, complication or de-compensation of the patient’s condition (s)
Provider Signatures

Acceptable Signatures

- Documentation that states *electronically signed and has a typed signature*
- Documentation that states *signature on file*
- Documentation that is *digitally signed*
- Documentation that states *dictated by/transcribed by (must be signed or initialed by the physician)*
- Documentation that states *authenticated by*
- Documentation that states *generated by*
- Documentation that states *electronically authenticated by*

*Per CMD, a signature is required for services provided/ordered. There must be a legible, authenticated identifier.*
Documentation Examples

Case no. 1: Two of three components are required for CPT 99214: Service was down coded to CPT 99213; documentation did not support the code billed.

The record documents, the patient has recurrent carpal tunnel syndrome right wrist, numbness and tingling into fingers. Hypertension, questioned secondary to pain, menopausal symptoms. Patient return for follow up visit. The following was determined:

Nature of Presenting Problem: Self-limited or minor Severity

Expanded Problem Focused History
- HPI: 3 elements = Brief
- ROS: None
- PFSH: Pertinent

Detailed Physical Exam
- Physical exam = 8 body / organ systems

Low Complexity Decision Making (Decision Making requires 2 of 3 elements)
- Options = Limited
- Data = None
- Risk = Moderate; refill prescriptions

Case no. 2: Two of three components are required for CPT 99214: Documentation supported the code billed. Service Approved

The record documents, the patient has a urinary tract infection, dysuria and frequency, history of Osteoarthritis with joint pain. Patient return for follow up visit. History of Anxiety disorder. The following was determined:

Nature of Presenting Problem: Self-limited or minor Severity

Expanded Problem Focused History
- HPI: 2 = Brief
- ROS: None
- PFSH: Pertinent

Comprehensive
- Physical Exam = 13 body / organ systems

Moderate Complexity Decision Making (Decision Making requires 2 of 3 elements)
- Options = Limited
- Diagnostic Data = Moderate; UA done in the office
- Risk = Moderate; refill prescription management
Recent Data Analysis

![Graph showing data analysis results for Prov A and Peers across different years]

- Prov A
  - 99231: 0.15%
  - 99232: 8.56%
  - 99233: 28.63%

- Peers
  - 99231: 9.25%
  - 99232: 62.12%
  - 99233: 91.29%
Recent Data Analysis

Appropriate Use of Modifiers

- Modifier 24
- Modifier 25
- CERT
- Resources
Modifier 24

Evaluation/Management

• 24 – Unrelated E&M service during a post-op period of a major or minor surgical procedure
  • Minor surgery is 0 or 10 days global period*
  • Major surgery is 90 days global period*
• Append to E&M codes only

* Global periods found on the Medicare Physician Fee Schedule Database

Example of correct usage:

Patient has an office visit (CPT 99213) with her physician because of a sprained wrist. Three weeks prior, the patient had surgery to repair a fractured leg. The physician should submit the office visit with modifier 24, indicating service is unrelated to previous diagnosis of the surgical procedure.
Modifier 24

Extra Examples:

• **Use modifier 24** - A patient had right hand surgery; patient is still within 90 day global period. The patient is evaluated by the same provider for a left hand complaint within that global period. Provider *should* file a modifier 24 with the second E&M visit code.

• **Do not use modifier 24** – A patient had right hand surgery; patient is still within 90 day global period. The patient is evaluated by the same provider for a right hand complication within the global period. Provider *should not* file a modifier 24 with the second E&M visit code.

Modifier 25

Evaluation/Management

• 25 – Significant, separately identifiable evaluation and management service by same physician on day of procedure

• For codes with “0 day or 10 day” global period*

• Established patient only
  • New illness
  • Follow up visit with multiple complaints

*Global periods found on the Medicare Physician Fee Schedule Database
Modifier 25

Example of correct usage:

Patient complains of decreased hearing and pain in left ear. Physician removes ear wax. He re-examines and finds a red bulging tympanic membrane with yellow fluid behind as well as tenderness. Physician would submit the bill for the removal of ear wax with modifier 25 as well as the appropriate E/M for the ear infection.

Modifier 25

Extra Examples:

• **Use modifier 25** - A provider sees a patient for abdominal pain in the AM and on that same day, the patient sees the same provider for chest pains. Modifier 25 **should be** filed with the second visit E&M code.

• **Do Not Add modifier 25** – If the patient is there for a joint injection (endoscopy, skin biopsy, etc.) only, an E&M service should not be billed. If an E&M service is billed, modifier 25 **should not** be used unless a significant, separate E&M service is also provided.
Comprehensive Error Rate Testing

• CERT Goals
  – Protect the Medicare trust fund
  – Measure Medicare’s ability to pay claims correctly
  – Assess provider behavior
  – Evaluate contractor behavior

• Documentation can be submitted electronic on CD, by mail or fax

For more information, visit these websites:
  ➢ www.cms.hhs.gov/CERT/
  ➢ www.certcdc.com/certproviderportal/

Evaluation and Management Resources

Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 30.6: Evaluation and Management Service Codes - General (Codes 99201 - 99499):

The 1995 and 1997 Evaluation and Management Services Documentation Guidelines:

Evaluation and Management Services Guide

CMS - MLN Evaluation and Management Services Web Based Course
www.cms.hhs.gov/apps/apn2/default.asp

Modifiers for Billing Medicare - Scroll to E&M modifiers:
www.cahabagba.com/part_b/education_and_outreach/general_billing_info/modifiers.htm
Additional Resources

- National Physician Fee Schedule  
  www.cms.hhs.gov/PhysicianFeeSched/PFSNPAF/list.asp#TopOfPage

- CMS Web Site: www.cms.hhs.gov

- Cahaba GBA Web Site: www.cahabagba.com/part_b/index.htm

- Cahaba GBA Global Surgery Manual:  

- Cahaba GBA Listserv:  
  www.cahabagba.com/part_b/whats_new/email_service.htm

- Provider Contact Centers:  
  AL 1-866-539-5598  GA 1-877-567-7271  MS 1-866-419-9454

  For coding information and ordering:  
  American Medical Association (AMA) products  
  www.ama-assn.org and www.amapress.com

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Calendar of Events

- May 14, 2009 – Evaluation & Management

- May 28, 2009 - Medicare 102 Series: ABN

- June 4, 2009 – Medicare 102 Series: LCD & Incident-to

- June 11, 2009 – Medicare 102 Series: Evaluation & Management
Questions

Please complete your evaluations and post-test assessment and FAX to (205) 220-1526

Thank You

We appreciate your attendance and hope this educational event has been helpful.

Enjoy the remainder of your day!