Chapter 4
E&M Services

E&M Services

• Documentation Guidelines
  – 1995
  – 1997
  – CMS
    • LCD
• Documentation Components
• History
• Exam
• Medical Decision Making (MDM)
• Time based services
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• History
• History of the medical record documentation should include four areas:
  – Chief Complaint
  – History of Present Illness
  – Review of Systems
  – Past, Family and Social History
• Lowest documented area chooses Level of Service

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Chief Complaint
• Chief Complaint should be part of every medical record.
• Concise statement that describes the problem/condition for the patient encounter.
• Usually in the patient’s own words
• Chief Complaint helps to identify the medical necessity of the service.
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History of Present Illness

• Symptoms of patient due to the Chief Complaint
• Per date of service

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<table>
<thead>
<tr>
<th>HPI (History of Present Illness): Characterize HPI by considering EITHER the Status of 3 chronic or inactive conditions OR the number of elements recorded.</th>
<th>Status of 3 Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Quality</td>
</tr>
<tr>
<td>Location</td>
<td>Quality</td>
</tr>
</tbody>
</table>

1956 HPI Guidelines

- Constitutional
- Allergic
- Eyes
- Musculoskeletal
- Neurologic
- Genitourinary
- Respiratory
- Gastrointestinal
- Psychiatric
- Endocrine
- N/A

- Patient to problem (1 system)
- Extended (up to 6 others) (3-5 systems)
- Complete (up to all others) (10 systems)

- 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 that may be hereditary or place the patient at risk)
- Social history (an age-appropriate review of past and current activities)

- N/A
- Pertinent 1 history item
- Complete 2-3 history areas

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• Used for 95 or 97 guidelines
• Credit for minimum of 1 or maximum of 4
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• Additional HPI documentation style
  – 3 chronic or inactive problems
    • Status requirements
    • No less than 3
    • Comprehensive HPI credit

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• Review of Systems - ROS
  • Inventory of body systems obtained by questions from provider to identify how the patient is affected systematically by their problem.
  • Negative or positive
  • Mass Negative grouping
  • Unremarkable/Non-contributory
  • Laundry lists not applicable
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- Organ Systems that qualify:
  - Constitutional
  - ENT
  - Eyes
  - Cardiovascular
  - GI
  - GU
  - Respiratory
  - Musculoskeletal
  - Psychiatric
  - Integumentary
  - Endocrine
  - Hem/Lymph
  - Allergy/Immunology
  - Neurologic

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No Double Dipping

- If you use a symptom or system in the History of Present Illness, you cannot use it in Review of Systems
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Past Family & Social History (PFSH)

- **Past History**
  - Current medications, past surgeries, past illnesses, birth history

- **Family History**
  - Family; i.e., parents, siblings, children, aunts, uncles, grandparents, pregnancy of mother, birth mother/father

- **Social History**
  - Smoking, alcohol intake, marital status, sexual history, employment status, educational information, parents alcohol/smoking habits, childcare settings
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### Unobtainable History

- **Document why the history was unobtainable**
- **How to score**
  - 1st view – Omit the history as scoreable component
  - 2nd view – Allow a complete history
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Second Component/Examination

- An examination based on either the 95 or 97 documentation guidelines.
- 95 examinations are based on the **body systems and areas**.
- 97 examinations are based on **bullets outlined through specific system examinations**.

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- Examination is the hands on examination may not be referred to on another date of service
- Unremarkable and non-contributory do not meet the necessary requirements
- Negative or normal meet documentation guidelines
- If abnormal – reason it is abnormal must be documented
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95 examination
- Inventory of number of organ systems documented
- Body areas should only be used as chief complaint or as organ system if possible per exam documentation
- **Body areas:**
  - Head, neck, chest, abdomen, genitalia, back, each extremity
- **Body systems:**
  - Constitutional, eyes, ears, nose, throat, mouth, cardiovascular, respiratory, GI, GU, musculoskeletal, skin, neurologic, psychiatric, lymph

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95 Exam
- 1 system = PF
- 2 systems = EPF
- 2 systems with 1 in detail = Detailed
- 8 systems = Comprehensive
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97 Examination

- Based on bullets
- Specialty specific
- More extensive documentation requirements
- No use of normal or negative wording only
- Requirement’s maximum amount of detail
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Medical Decision Making (MDM)

- MDM explains the complexity of the patient’s problem based on the providers overall assessment
- Three areas of documentation:
  - Diagnosis
  - Complexity
  - Risk
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MDM-Diagnosis
- Must be applicable to the day’s visit
- Listing an increased number of diagnoses that are not addressed or that have no direct impact on that day’s encounter should not be counted
- Diagnosis is either:
  - New
    - With increased work up
    - Without increased work up
  - Established
    - Stable/Improving
    - Worsening

<table>
<thead>
<tr>
<th>Number of Diagnosis or Treatment Options</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem(s) Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stable/minor (stable, improved, or worsening)</td>
<td></td>
<td>Max=2</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Est. problem (to examiner); stable, improved</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Est. problem (to examiner); worsening</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>New problem (to examinee), no add workup planned</td>
<td></td>
<td>Max=1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>New problem (to examinee), add workup planned</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

Total:
E&M Services

MDM - Complexity of Data

- “Points” for the physician work during the encounter
  - Ordering/reviewing services
  - Requesting/reviewing records

<table>
<thead>
<tr>
<th>Amount and/or Complexity of Data Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of texts in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

E&M Services

<table>
<thead>
<tr>
<th>Site of Concerns and/or Morbidity or Morality</th>
<th>Physical Processes/Conditions</th>
<th>Management Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Risk: Minimal</td>
<td>0: One or more illness or injury problems, e.g., cold, minor cold, trivial injuries</td>
<td>0: Laboratory tests, requiring venipuncture, oral swabs, nasopharynx, EKG, x-rays, urinalysis, etc.</td>
</tr>
<tr>
<td>Low</td>
<td>1: Two or more ill-defined or minor problems, e.g., asymptomatic hypertension, or non-insulin dependent diabetes, spondylosis, joint problems, headache, abdominal pain, thrush</td>
<td>1: Physical therapy, minor surgery with no specialized skills, dressing of wounds, catheterization, minor nasopharynx tests, etc.</td>
</tr>
<tr>
<td>Moderate</td>
<td>2: Two or more greater illness or injury problems, e.g., pain in major organ system</td>
<td>2: Minor surgery with identified risk factors, e.g., abdominal irrigation, lumbar puncture, etc.</td>
</tr>
<tr>
<td>High</td>
<td>3: One or more serious illness or injury problems, e.g., potential for major organ system involvement, acute respiratory failure, progressive severe neuromuscular disease, psychiatric issues, potential threat to self or others, denial, acute renal failure</td>
<td>3: Major surgery open, emergent surgery, open, emergent endoscopy, or nasopharynx tests</td>
</tr>
</tbody>
</table>

[Table and diagram showing different levels of risk and corresponding physical processes/conditions and management considerations]
## E&M Services

### Level of Complexity: Medical or Surgical

<table>
<thead>
<tr>
<th>Level of Complexity</th>
<th>Presenting Problems</th>
<th>Diagnostic Tests</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>Presenting Problems</td>
<td>Diagnostic Tests</td>
<td>Management Options</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Presenting Problems</td>
<td>Diagnostic Tests</td>
<td>Management Options</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>Presenting Problems</td>
<td>Diagnostic Tests</td>
<td>Management Options</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>Presenting Problems</td>
<td>Diagnostic Tests</td>
<td>Management Options</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### E&M Services

**Final Result for Complexity**

<table>
<thead>
<tr>
<th>A: Number of diagnosis or treatment options</th>
<th>1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>4 Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>B: Highest risk options</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>C: Amount and complexity of data</td>
<td>1 Minimal or low</td>
<td>2 Limited</td>
<td>3 Multiple</td>
<td>4 Extensive</td>
</tr>
<tr>
<td>Type of decision making</td>
<td>Straight Forward</td>
<td>Low Complex</td>
<td>Moderate Complex</td>
<td>High Complex</td>
</tr>
</tbody>
</table>
### Final Result for Complexity

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of diagnosis or treatment options</td>
<td>Highest risk options</td>
<td>Amount and complexity of data</td>
<td>Straight Forward</td>
</tr>
<tr>
<td>1</td>
<td>Minimal</td>
<td>Minimal</td>
<td>1 Minimal or low</td>
<td>Low</td>
</tr>
<tr>
<td>2</td>
<td>Limited</td>
<td>Low</td>
<td>2 Limited</td>
<td>Moderate</td>
</tr>
<tr>
<td>3</td>
<td>Multiple</td>
<td>Moderate</td>
<td>3 Multiple</td>
<td>High</td>
</tr>
<tr>
<td>4</td>
<td>Extensive</td>
<td>High</td>
<td>4 Extensive</td>
<td>Complex</td>
</tr>
</tbody>
</table>

### Levels of Service

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>New Office Consults/ER requires 3 components within shaded area</td>
</tr>
<tr>
<td>II</td>
<td>Established Office Requires 2 components within shaded area</td>
</tr>
<tr>
<td>III</td>
<td><em>Level I established visit is for when a patient sees the nurse, not the doctor.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Confirmed consult &amp; ER have no average time)</td>
</tr>
<tr>
<td>9212</td>
</tr>
<tr>
<td>99213</td>
</tr>
<tr>
<td>99214</td>
</tr>
<tr>
<td>99215</td>
</tr>
<tr>
<td>10 min.</td>
</tr>
<tr>
<td>15 min.</td>
</tr>
<tr>
<td>25 min.</td>
</tr>
<tr>
<td>40 min.</td>
</tr>
</tbody>
</table>
E&M Services

Medical Necessity

- Overarching determining factor
- Trumps documentation guidelines that may support an increased Level of Service
- Maximize documentation and choose level of service on medical necessity

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Medical Necessity

Chronic Patient
- Level 3: (1) Stable Problem
- Level 4: (2) Stable Problems or (1) Chronic Not Stable
- Level 5: Seriously Unstable Chronic Problem

Acute Patient
- Level 4: Uncomplicated
- Level 4: Mild Complications
- Level 5: Complications Posing Threat to Life/Body Function
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New Patients

- 3 year rule
- Same group practice
- 3 of 3 components
  - Lesser determines level

<table>
<thead>
<tr>
<th>History</th>
<th>Detailed</th>
<th>Comprehensive</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Problem</td>
<td>Focus</td>
<td>Focus</td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward</td>
<td>Straightforward</td>
<td>Low</td>
</tr>
<tr>
<td>Level</td>
<td>99241</td>
<td>99242</td>
<td>99243</td>
</tr>
<tr>
<td>Time</td>
<td>10 min</td>
<td>20 min</td>
<td>30 min</td>
</tr>
</tbody>
</table>

E&M Services

Established Patients

- Current treatment by provider of same group practice
- Throw out lowest documented
- May not have all 3 areas documented

<table>
<thead>
<tr>
<th>History</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Problem</td>
<td>Focus</td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Level</td>
<td>99211</td>
<td>99212</td>
</tr>
<tr>
<td>Time</td>
<td>5 min</td>
<td>10 min</td>
</tr>
</tbody>
</table>
E&M Services

Initial Hospital Care

- **99221-99223**
- New or Established Patient
  - 3 of 3 components
- Time can be used

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>Detailed/Comp</th>
<th>Comprehensive</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAM</td>
<td>Detailed Comp</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward/Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>LEVEL</td>
<td>99221</td>
<td>99222</td>
<td>99223</td>
</tr>
<tr>
<td>TIME</td>
<td>30 minutes</td>
<td>60 minutes</td>
<td>90 minutes</td>
</tr>
</tbody>
</table>

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Subsequent Hospital Care

- **99231-99233**
  - 2 of 3 components
- After initial admit to the hospital
- Time can be used

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>Problem Focused</th>
<th>Deep Problem Focused</th>
<th>Detailed</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAM</td>
<td>Problem Focused</td>
<td>Deep Problem Focused</td>
<td>Detailed</td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward/Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>LEVEL</td>
<td>99231</td>
<td>99232</td>
<td>99233</td>
</tr>
<tr>
<td>TIME</td>
<td>15 minutes</td>
<td>25 minutes</td>
<td>35 minutes</td>
</tr>
</tbody>
</table>
E&M Services

Consultation Codes
• CMS changed payment rules in 2010
• Still document according to CMS guidelines
  – Initial statement of consult
  – Letter to regular provider
  – 3 of 3 key elements
    • New or Established patients

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Critical Care
• 99291 first 30 – 74 minutes
• +99292 each additional 30 minutes
• Documentation must support
  – Need for critical care
  – Time billed
• Vent management
• Bundled services
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Prolonged Physician Services
• Divided codes
• With/without face-to-face
• Outpatient/Inpatient

Prolonged Services Documentation
• Amount of total time
• Medical Necessity to support

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Preventive Services
• E&M services based on
  – New vs. Established
  – Age
• CMS services based on
  – Initial (IPPE)
  – Initial Wellness
  – Subsequent Wellness
E&M Services

Preventive Services

- CMS Specific to their guidelines
- E&M
  - Interval History
  - Complete Exam
  - Preventive Guidance plan of care

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Neonatal/Pediatric Critical Care

- Mirrors adult critical care services
- Documentation should reflect:
  - Total time
  - Justification of time
  - Medical necessity to support the need for critical care
  - Bundled services
E&M Services

E&M Modifiers

• 24 Modifier
• 25 Modifier
• 57 Modifier
• Documentation must support and justify use

Documentation Structure

• SOAP Note
• Cheddar Note
• Procedure with E&M encounter
E&M Services

Incident-To

- CMS Rules
  - The physician must be present in the office suite and immediately available
  - Available by phone does not constitute direct supervision.
  - All of the above is considered Direct Personal Supervision
  - NPP provides service bills under supervising provider CMS billing information
- Incident-to supervised by non-physicians are reimbursed 85% of physician’s fee schedule

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- To qualify as “incident-to,” certain criteria must be met.
  - There must be an employment relationship between the physician and the auxiliary personnel providing the service
  - New patients must be seen and examined by the supervising provider
  - Established patients with new problems must be seen and a new plan of care provided by supervising provider
  - Supervising provider must remain integral part of established patient’s care
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Incident-To Documentation
• Must include what services were provided by the supervising physician
• Should be signed by both

Chapter 5
Audit Results
Audit Results

• Compliance Audits
  • To evaluate the providers compliance with documentation rules and guidelines
  • Done internally or external auditor
  • Performed either as
    – Pre or post payment audits

• Risk Management Audits
  • Patient care from the beginning of the encounter through the entire process as well as practice liability
  • Focused audits
    – Audits on one particular service
    – Over utilization

Audit Results

• May vary by specialty
• Baseline audit 10-15 records per provider
• Use random approach
  – E&M Services
  – “Other” services
Audit Results

• Tools for an audit include
  – Documentation Guidelines
  – Audit Tool
  – Code Books
  – Payer Policy
  – Documentation to be audited

Audit Results

Communication of Audit Reports
• If results are not shared with providers, it would not serve its purpose
• Requests by healthcare attorneys
  – All information is sent/reviewed with them only
• Practice request
  – Communicate with Compliance Officer or liaison with the individual providers and practice manager
Audit Results

• Reports should be clear/concise comparing required documentation according to guidelines
• Be specific
  – Not just history is incorrect, be specific as to what is missing
• Don’t overwhelm them and give them grids, information to help guide them

Audit Results

• Billing Results
  – Modifier usage, ICD-9, CPT coding
• Regulatory Control Issues
  – Show why practice/provider did not meet necessary standards and show in writing
• Trending
  – Show where they are over or under utilizing services
  – Compare to national average statistic base on specialty
  – 6-12 months of plotted statistics should be used
  – Teach providers to bill services according to medical necessity and not trending, averages or reimbursement
Audit Results

Utilization Report and Analysis

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Medicare Distribution</th>
<th>Practice LOS Distribution</th>
<th>Practice $ Distribution</th>
<th>Medicare Distribution on Practice</th>
<th>Distribution Difference</th>
<th>Medicare $ Distribution on Practice</th>
<th>Distribution Difference in $'s</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>3%</td>
<td>0%</td>
<td>$0.00</td>
<td>3.82</td>
<td>2%</td>
<td>$126.22</td>
<td>($126.22)</td>
</tr>
<tr>
<td>99202</td>
<td>15%</td>
<td>0%</td>
<td>$0.00</td>
<td>31.60</td>
<td>15%</td>
<td>$1,864.45</td>
<td>($1,864.45)</td>
</tr>
<tr>
<td>99203</td>
<td>58%</td>
<td>74%</td>
<td>$14,938.00</td>
<td>$121.70</td>
<td>-15%</td>
<td>$10,709.66</td>
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<td>99204</td>
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<td>26%</td>
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<td>-.5%</td>
<td>$5,595.98</td>
<td>$1,939.63</td>
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<td>99205</td>
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<td>0%</td>
<td>$0.00</td>
<td>7.13</td>
<td>3%</td>
<td>$1,140.30</td>
<td>($1,140.30)</td>
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<tr>
<td>Totals</td>
<td>100%</td>
<td>100%</td>
<td>$122,473.00</td>
<td>209.62</td>
<td>0%</td>
<td>$19,436.60</td>
<td>$3,014.40</td>
</tr>
</tbody>
</table>

Audit Results

Finalization of the Report

• Formal report given to Compliance Office of type of audits performed and findings
  – Overall results
  – Individual provider

• Recommended one-on-one with each provider

• Group education does not always identify each individual deficiencies

• Overview letter that summarizes the specific identified problems
Audit Results

• Summarization for practice compliance plan to include:
  – Date of the audit
  – Who requested the audit
  – How many records were audited
  – Which providers were audited
  – Statement that a detailed report has been provided to each provider audited
  – Statement that a one-on-one or group session was provided for each provider audited and reviewed
  – Concise overview of the findings
  – Statement regarding intended or needed follow-up to be done for necessary compliance
  – Identification of the auditor performing the service

Audit Results

• Recommended each provider sign an acknowledgement statement for the following:
  – Audit report has been reviewed and understand the needed change
  – They are responsible for coding/billing of their services
  – They will make necessary adaptions that were discussed
• Disclaimer of Service
  – Intent of audit is to merely review a sample of their documentation and only specific to the records audited.
  – Results were reviewed with provider and failure to comply to recommendations will result in insufficient practice compliance