The Nuts and Bolts of E/M Coding:
A detailed look at the codes used by ID specialists

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The Nuts and Bolts of E/M Coding

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- **Disclosure: Nothing to disclose**

Overview

- E/M Basics, the CPT perspective
- CMS/AMA Documentation guidelines
  - History, Examination, **Medical Decision Making**
- Consultations
- Office E/M coding
- Hospital E/M coding
- Critical care and prolonged services
- Modifiers
- E/M coding compliance

E/M Documentation

- **Medical Necessity**, above all else…
- Record must be complete and legible
  - Even the signature or identification
  - Signature log
- Record stands on its own…but can incorporate by reference

Templates and other tools

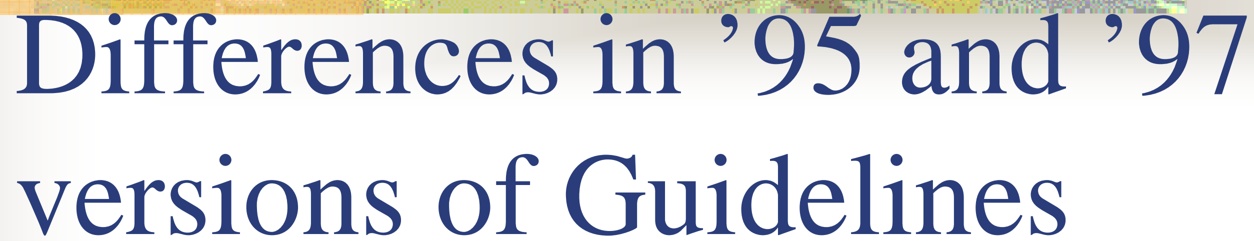
- History forms completed by patient or staff with past history, family history, social history, and system review
  - This information needs to be incorporated by reference appropriately
- Progress notes that prompt the provider of documentation requirements (and may reduce transcription costs)
- Build a helpful encounter form
  - New vs. established E/M codes don't crosswalk
  - Include all levels
  - Common procedures
- The electronic medical record

E/M Codes

- Evaluation and Management
- Determined by site of service
  - Office, outpatient
  - Observation
  - ED
  - Inpatient
- Categorized as new vs. established for office services
  - New if not seen within past three years by provider of same specialty in same group practice
- Categorized as initial vs. subsequent for hospital services

CMS/AMA Documentation Guidelines

- A history lesson
- Are these just for Medicare purposes?
  - How do third party payors utilize the guidelines?
- How do I know which version to use?
  - Probably the 1995 guidelines (because of the more general exam) will work best for ID providers
- http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp



Differences in ’95 and ’97 versions of Guidelines

- Major changes in examination section
  - ’95 is more general
  - ‘97 is very specific (bullets)
  - ’97 contains specialty specific exams
- History section has one major change for ’97
  - History: HPI can be status of 3 chronic or inactive conditions
    - Instead of the “usual” HPI elements of: location, quality, severity, duration, timing, context, modifying factors, associated signs/symptoms

Levels within a category

- Some have 5 levels such as office visits, consults, ER visits
- Some have 3 levels such as admissions, daily hospital care
- Nursing home subsequent visits have 4 levels
- A “Level 3” visit doesn’t have consistent requirements across all categories

Level 3

- 99213 (need 2/3)
  - EPF history
  - EPF exam
  - Low MDM
- 99203 (need 3/3)
  - Det history
  - Det exam
  - Low MDM
- 99223 (need 3/3)
  - Comp history
  - Comp exam
  - High MDM

3/3 or 2/3 ??

- Key components = history, examination, and medical decision making
- New patient visits, consultations, hospital admits are examples that require 3/3
- Established patient visits, daily hospital care are examples that require 2/3

History…HPI and ROS

- Based on Chief Complaint (CC), History of Present Illness (HPI), Review of Systems (ROS) and Past, family, social history (PFSH)
- Page 6 of DG:
  - Can incorporate by reference information recorded by ancillary staff or patient or information elsewhere in chart … ROS and PFSH only
    - Update the information
    - Document date and location of that information
  - If unable to get history, say why
  - "all others negative" and "noncontributory"

History …Past, Family, Social

- Only one item from an area is “required”
- For higher levels of care, some codes require something from all three history areas: past, family, and social

Examination

- 1995 guidelines are more generic by body system
- 1997 guidelines are very specific..the “bullets”
  - numeric requirements must be met
  - parenthetical examples are for clarification and guidance only
  - “and” really means “or”

1997 Specialty Specific Exams

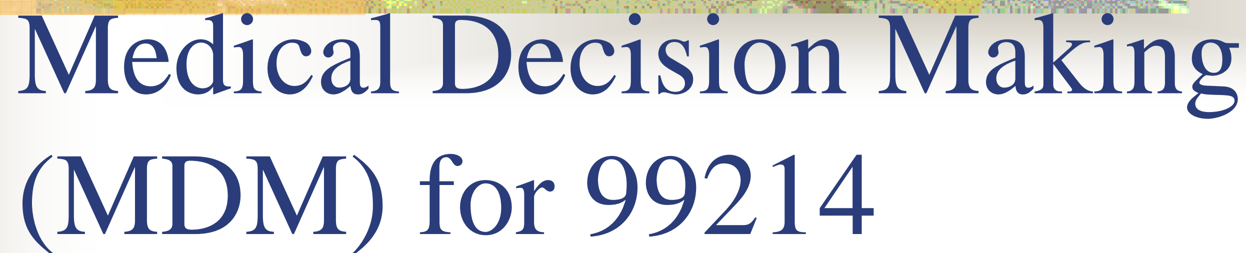
- Not all specialties are represented
- Find one that works well for you
- One size doesn't fit all

Medical Decision Making

- Point system for number of dx/management options
  - More credit for new problems vs established problems
  - More credit for worsening established problem vs stable established problem
- Point system for data
  - Order or review: lab, X-ray, EKG, etc.
  - Extra credit if personally review image or test
  - Additional credit for discussing test results with another dr or obtaining hx from other than patient
- Table of Risk
  - Nature of presenting problem, diagnostic procedure(s) ordered, management option(s) selected
  - expand list of examples, especially high risk…specialty specific

Using the "status of three" instead of typical HPI elements often leads to 99214

- Many return visits are for follow-up of conditions. Use the 1997 Documentation Guidelines where they substitute the status of 3 chronic or inactive conditions for 4 HPI elements
  - Helpful hints: Add 2 more ROS and something from PFSH to get detailed history.
  - Combine with Moderate MDM for a 99214
    - Using the point system you'll get at least 3 points for number of problems addressed and at least moderate risk which equates to a moderate level of MDM
  - Detailed history + Moderate MDM = 99214



Medical Decision Making (MDM) for 99214

- Using the point system, 3 stable established problems = 3 points
- Using the table of risk, “two or more stable chronic illnesses” = moderate risk *–or-*
- Using the table of risk, “prescription drug management” = moderate risk
- Final complexity of MDM = moderate

Coding by time

- Time becomes the controlling factor (as opposed to history, exam, MDM) when:
  - Greater than 50% of the face-to-face time was spent counseling and/or coordinating care
  - Face-to-face time versus unit/floor time in hospital and nursing facility
  - Patient must be present !!
  - For example:
    - 99214 = 25 minutes
    - 99215 = 40 minutes

Consultations

- Consultations
  - Consider the ***Intent***
  - ***Requesting*** physician
  - ***R***ender an opinion
  - Send a ***R***eport
  - No distinction new vs. established or initial vs. subsequent
  - Can have repeat consultations and no three-year rule
  - CanNOT be shared with NPP
  - Medicare Transmittal 782 and Medlearn Matters MM4215

Consultations

- Medicare's Transmittal 12/16/05
  - No split/shared consultations between physician and NPP
  - "A consultation request may be verbal; however, the verbal interaction identifying the request and reason for a consult must be documented in the patient's medical record by the requesting physician or qualified NPP and also by the consultant physician or qualified NPP in the patient's medical record"
  - And more clarifications and examples

Consultations

- Office/Outpatient 99241 - 99245
- Initial Inpatient 99251 – 99255
- **Gone for 2006**: Follow-up Inpatient 99261 – 99263 so now it's a subsequent hospital visit
- **Gone for 2006**: Confirmatory 99271 - 99275…(second opinion requested by patient, family, insurance company) so now it's a subsequent hospital visit, unless the service meets the definition of a consultation and requested by a provider

Pre-op “consultations”

- Patient may need “H & P” prior to surgery. This fact alone does not meet criteria for using the consult codes 99241 - 99245
- H & P is actually part of the global surgery package
- Need to meet the 3 R’s (need more than merely dictating “H & P” to the hospital
- Use V code primary to indicate nature of the visit…V72.8_
- CPT 99241 – 99245 depending on history, exam and MDM
  - The form requested by the surgeon or hospital may be limiting your code selection

Sample consultation confirmation

- Fax to requesting provider (so you both have a written copy in your files) by receptionist or scheduler
- "Thank you for asking us to schedule an appointment for your patient, John Doe. Dr. Smith will be happy to see your patient on _______ at _______. It is our understanding that you have requested us to see this patient in consultation for _______, whereby we will render an opinion regarding this patient's diagnosis and care. We will contact your office after the patient has been seen and advise you of any anticipated therapeutic or diagnostic services. Again, thank you for allowing us to see this patient in consultation. If we have misunderstood the nature of this request or if you have any questions, please feel free to give our office a call"

99211

- "Nurse" visit
- Follow incident-to guidelines
  - Provider on premises, and bill under that provider
  - Incident to a provider's already established care plan
    - So, no new patient and no established patients with new problems
  - Appropriate employer/employee relationship
- Establish a policy and procedure
  - Find out what goes on in the back office
  - Decide which services warrant a separately identifiable 99211
- Good, bad, and ugly examples

A closer look at:

- Admission codes
- OBS Admission codes
- In/out same day codes
- Discharge codes:
- Subsequent hospital care codes
- Consultations
- ER visits
- Shared visits
- Critical Care
- Modifiers
- Diagnosis coding

Inpatient Admissions

- Intent of 99221 – 99223:
  - Report the first hospital inpatient encounter
  - Not necessarily the date of admission
  - Used for admission services unless work is done elsewhere
    - Admission from office
  - Not used if patient seen subsequently that date and discharged

Inpatient Admissions

- 99221 requires
  - Detailed history **and**
  - Detailed exam **and**
  - Straightforward medical decision making
- 99222 requires
  - Comprehensive history **and**
  - Comprehensive exam **and**
  - Moderate medical decision making
- 99223 requires
  - Comprehensive history **and**
  - Comprehensive exam **and**
  - High medical decision making

Subsequent Hospital Care

- Intent of 99231 – 99233
  - Daily inpatient care
  - If more than one in a day, combine the services (doesn't necessarily mean you'll get a higher level of code)
    - Could be 2 providers in same group
  - Usually not used for date of discharge, unless another physician is considered the admitting physician

Subsequent Hospital Care

- CPT descriptions for 99231 – 99233
- 99231
  - Problem focused internal history
  - Problem focused examination
  - Straight forward or low complexity MDM
  - Requires 2 of 3 above
  - “Usually the patient is stable, recovering or improving”
  - Unit/floor time = 15 minutes
    - >50% counseling or coordinating care

Subsequent Hospital Care

- 99232
  - Expanded problem focused interval history
  - Expanded problem focused examination
  - Moderate MDM
  - Requires 2 of 3 above
  - “Usually the patient is responding inadequately to therapy or has developed a minor complication”
  - Unit/floor time = 25 minutes
    - >50% counseling or coordinating care

Subsequent Hospital Care

- 99233
  - Detailed interval history
  - Detailed examination
  - High MDM
  - Requires 2 of 3 above
  - “Usually the patient is unstable or has developed a significant complication or a significant new problem”
  - Unit/floor time = 35 minutes
    - >50% counseling or coordinating care

Inpatient Discharge

- 99238
  - Discharge day management, 30 minutes or less
- 99239
  - Discharge day management, more than 30 minutes
  - Documentation must indicate that >30 minutes spent and why
- Includes:
  - Final evaluation of the patient
  - Discussion of hospital stay
  - Instructions (may include caregivers)
  - Preparing discharge records, prescriptions and referral forms

Observation Admissions

- 99218, 99219, 99220
- Exact same criteria of history, exam, and MDM as the Inpatient Admissions
- Intent: Used for patients in "observation status"
- Used for OBS admission services unless work is done elsewhere
  - OBS Admission from office
- If patient goes from OBS to full admit same calendar day, "roll" everything into an Inpatient Admission code
- Can't code by time

Observation Admissions

- 99218 requires
  - Detailed history **and**
  - Detailed exam **and**
  - Straightforward medical decision making
- 99219 requires
  - Comprehensive history **and**
  - Comprehensive exam **and**
  - Moderate medical decision making
- 99220 requires
  - Comprehensive history **and**
  - Comprehensive exam **and**
  - High medical decision making

Observation Subsequent and Discharge Care

- If the patient is held in OBS for 3 calendar days (possible), then the middle day gets coded as an office/outpatient visit
  - 99212, 99213, 99214, or 99215
  - NOT 99231 – 99233
- Use 99217 for OBS discharge
- When the patient is discharged from OBS and admitted as inpatient, code only one or the other
  - Think about it … we usually "roll" into the higher service … but … was enough documented to meet at least a 99221 that day? (detailed history and detailed exam)

OBS or Inpatient Care - Admit and Discharge Same Date

- Same **calendar date**
- Can be used for OBS or inpatients
- Medicare guidelines require that the patient be there at least 8 hours if using these codes and provider must document that fact
- Patient could be inpatient status or OBS status … codes are the same, place of service would be different
- 99234, 99235, or 99236 (same criteria for history, examination, and MDM as other admission codes)
- Require two face-to-face visits
  - Why? The RVU for these codes = admit + discharge
  - Face-to-face for one and phone call for other won’t work
    - If only seen once, then bill for the service rendered, which might be the admit (inpatient or OBS) or it might be the discharge

ER Visits

- 99281 – 99285
- Codes usually used by the provider assigned to the ER
- Could be possible for more than one provider to use this code on same patient
  - But … probably a consultation or office/out-patient service instead

Critical Care

- 99291 for first hour; 99292 for each additional 30 minutes
  - See grid in CPT book for exact times
- Need to combine critical care time within a calendar day
- Can bill "regular" E/M additionally **IF** visit was earlier in day and later the patient required critical care. E/M code will need –25 modifier.

Critical Care

- Patient must meet critical care criteria
  - "Critical care is the direct delivery by a physician of medical care for a critically ill or critically injured patient. A critical illness or 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. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition" ….
- Read the CPT book for further information on what are considered "critical care services"

Prolonged Services

- Add-on codes to your "regular" E/M service to indicate additional time spent with patient
  - For office, it's face-to-face time
  - For hospital or nursing facility, it's unit/floor time (that's a change for 2009)
  - Time does not need to be continuous
  - Multiple providers need to add their time together

Prolonged Services

- Office 99354 and 99355
  - 30-74 minutes = 99354
  - 75-104 minutes = 99354, 99355
  - 105+ minutes = 99354, 99355 x 2 (plus additional units of 99355 as appropriate)
- Inpatient 99356 and 99357
  - 30-74 minutes = 99356
  - 75-104 minutes = 99356, 99357
  - 105+ minutes = 99356, 99357 x 2 (plus additional units of 99357 as appropriate)
- The typical time specified for the base CPT code needs to be subtracted from the total time

Working with Resident or Medical Student

- Medical Students are not residents and the "usual" teaching physician rules don't apply
  - Medical students can document ROS and/or PFSH (needs to be incorporated by billing provider)
- Follow the Teaching Physician rules
  - Date of service = date seen by teaching physician
  - Combination of notes = E/M code if documented appropriately
    - "agree" isn't enough
    - Attestation by TP should be in first person
    - Make it specific to that patient

Medical Necessity and ICD-9 Coding

- More than one provider can see a patient each day … stick with your own diagnosis(es)
  - Make sure documentation supports not only the CPT billed, but also the diagnosis code(s) billed
  - If patient's status changes, use diagnosis(es) that will support the level of service billed

Minor Procedure and E/M on Same Day

- Minor procedures require a separately identifiable and separately documented procedure note
- Bill both the visit and procedure **IF** significant and separately identifiable history, exam and/or MDM is done and documented
- Is a different diagnosis required?
  - No, but may need to appeal
- -25 modifier on E/M code
  - Modifier –25 indicates a significant and separately identifiable E/M service on the same day as another service

Policies and Procedures/Education

- 99211
- Procedures with E/M
- Use of modifiers
- New vs. established patients
- Incident-to rules
- Teaching rules
- Importance of ICD-9 coding and linking

Keep going ….

- Consultation codes
- Proper documentation of time
- Look at some EOB's