Basics of Evaluation and Management (E/M) Services

- Audio is available via teleconference:
  - Teleconference number: 1-800-592-2259
  - Participant code: 408029
- All lines are muted and there will be silence until the session begins.
- Questions will be addressed at the end of the session.
- A certificate of attendance and instructions for obtaining CEU credits from the AAPC will be provided at the end of the session.

Basics of Evaluation and Management (E/M) Services

Webinar | Kendra Pickle, RN | May 21, 2013

CGS℠

A CELERIAN GROUP COMPANY

Disclaimer

- This presentation was current at the time it was published or uploaded onto the CGS website. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.
- This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.
- This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Objectives

- Define medical necessity and how it relates to E/M services.
- 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.
- Outline general principles of E/M documentation.
- Discuss the components of selecting the proper E/M code.

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)

E/M Guidelines

There are two sets of guidelines that providers may use:

- 1995 E/M guidelines
- 1997 E/M guidelines

Components of an E/M service

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- History;
- Examination;
- Medical Decision Making (MDM);
- Counseling;
- Coordination of care;
- Nature of presenting problem; and
- Time.

Three *Key* Components

There are three key components when selecting the code that should be billed. These components are:

- History;
- Examination; and
- Medical Decision Making.

The History

Provides insight into:

- The reason for the patient encounter or Chief Complaint (CC);
- The History of Present Illness (HPI);
- Provides a review of systems based on the patient's perspective; and
- Past, Family and Social History (PFSH)

The History

Type of History	Chief Complaint	History of Present Illness	Review Of Systems	Past, Family and/or Social History
Problem Focused	Required	Brief		
Expanded Problem Focused	Required	Brief	Problem Pertinent	
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

The Chief Complaint

- A chief complaint is a concise statement summarizing the symptom, problem, condition, diagnosis or reason for the patient encounter.
- Usually stated in the patient's own words.
- For example, "Patient complains of back pain."

History of Present Illness (HPI)

A chronological description of the development of the patient's chief complaint. HPI elements, with examples, are:

- Location (example: low back);
- Quality (example: burning, radiating into left leg);
- Severity (example: 7 on a scale of 1 – 10);
- Duration (example: started one week ago, progressively worsening);
- Timing (example: constant);
- Context (example: noticed after lifting furniture while moving);
- Modifying factors (example: lying down makes pain better, OTC medications relieves some pain); and
- Associated signs and symptoms (example: numbness in the extremity).

History of Present Illness

Brief HPI – Complains of low back pain, starting one week ago has tried OTC ibuprofen has had minimal relief.

- Location – low back
- Duration – one week
- Modifying factors – OTC ibuprofen

History of Present Illness

Extended HPI – Patient complains of low back pain described as a burning pain that radiates into left leg, rates pain a 7 on a scale of 1-10, starting one week ago and progressively worsening, has tried OTC ibuprofen with minimal relief.

- Location – low back
- Quality – burning pain
- Severity – 7 on a scale of 1-10
- Duration – starting one week ago
- Modifying factors – OTC ibuprofen with minimal relief

Review of Systems (ROS)

The review of systems is an account of body systems obtained through a series of questions based on the patients perspective.

Constitutional (e.g., fever, weight loss)	Integumentary (skin and/or breast)
Eyes	Musculoskeletal
Ear, Nose, Mouth, & Throat	Neurological
Cardiovascular	Psychiatric
Respiratory	Endocrine
Gastrointestinal	Hematologic/Lymphatic
Genitourinary	Allergic/Immunologic

Review of Systems

There are three types of ROS:

- Problem Pertinent – inquires about the system directly related to the problems identified in the HPI.
- Extended ROS – adds a limited number of additional systems.
- Complete ROS – inquires about the system(s) directly related to the problems identified in the HPI plus **all** additional organ systems.

Past, Family and Social History (PFSH)

The PFSH consists of a review of three history areas:

- Past history: includes recording of prior major illnesses and injuries; operations; hospitalizations; current medications; and allergies.
- Family history: involves the recording of the health status or cause of death of parents, siblings and children.
- Social history: contains marital status and/or living arrangements; current employment; and any relevant social history such as the use of drugs, alcohol or tobacco.

Past, Family and Social History

There are two types of PFSH:

- Pertinent – review of the history areas directly related to the problem(s) identified in the HPI.
- Complete – review of two or all three of the areas, depending on the category of E/M service.

The History

Some tips to remember when documenting the history:

Do:

- Clearly indicate the chief complaint.
- Describe the HPI in a way that the nature of the presenting problem is clear.
- Record positive and pertinent negatives.

The History

Some tips to remember when documenting the history:

Do **not**:

- Use the term “non-contributory” for PFSH.
- Use “negative” for the system related to the presenting problem.
- Count physical observations as the ROS.

The Exam

The exam is an assessment of body areas or organ systems performed by the clinician. The exam along with the medical history aids in determining the correct diagnosis and devising a treatment plan.

The Exam

The levels of E/M services are based on four types of examination:

- **Problem Focused** – A limited examination of the affected body area or organ system;
- **Expanded Problem Focused (EPF)** – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s);
- **Detailed** – An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s); and
- **Comprehensive** – A general multi-system examination or complete examination of a single organ system (and other symptomatic or related body area(s) or organ system(s) – 1997 guidelines).

The Exam

For purposes of examination, the following body areas are recognized:

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

The Exam

For the purpose of the examination, the following organ systems are recognized:

Constitutional	Genitourinary
Eyes	Musculoskeletal
Ear, Nose, Mouth, & Throat	Skin
Cardiovascular	Neurologic
Respiratory	Psychiatric
Gastrointestinal	Hematologic/immunologic/ lymphatic

The Exam

In addition to including a more specific general multi-system exam, the 1997 guidelines describe the following single system/organ systems:

- Cardiovascular
- Ear, nose and throat
- Eyes
- Genitourinary
- Hematologic/lymphatic/immunologic
- Musculoskeletal
- Psychiatric
- Respiratory
- Skin

The Exam

Some important points that should be kept in mind when documenting the exam:

- A notation of “abnormal” of the symptomatic or affected area or organ systems without elaboration is not sufficient.
- Abnormal or unexpected findings of the examination of any asymptomatic body area or organ system should be described.
- A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to **unaffected** or **asymptomatic** area(s) or organ systems.

Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option. This is determined by three factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and,
- The risk of significant complications, morbidity and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Medical Decision Making

The levels of E/M services recognize four types of medical decision making:

- Straightforward
- Low complexity
- Moderate complexity
- High Complexity

Medical Decision Making

Type of Decision Making	Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of Complications and/or morbidity
Straightforward	Minimal	Minimal or None	Minimal
Low complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Tips for Documenting the MDM

- **Record** relevant impressions, tentative diagnoses, confirmed diagnoses and all therapeutic options chosen related to every problem which E/M is clearly demonstrated in the record of the other key components.
- **Document** all diagnostic tests ordered, reviewed and individually visualized as part of the work of the encounter.
- **Summarize** old records or other outside information reviewed and incorporated into decision-making.

General rules for Documenting E/M services

- If it isn't documented, it hasn't been done.
- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
  - Reason for the encounter;
  - Assessment, clinical impression or diagnosis;
  - Plan of care;
  - Legible identity of the observer along with the date of the signature;

General rules for Documenting E/M services

- The rationale for ordering diagnostic and other ancillary services, if not documented, should be easily understood;
- Health risk factors should be identified;
- The patient's progress, response to and changes in treatment and revision of diagnosis should be documented; and
- The information in the medical documentation should support the diagnosis codes billed.

Selecting the Appropriate Code

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

- Identify the category or subcategory of the service provided.
- Review the reporting instructions for the selected category or subcategory according to the CPT book.
- Review the level of E/M service descriptors.
- Determine the extent of the history obtained.
- Determine the extent of the examination performed.
- Determine the complexity of MDM.
- Select the appropriate level of E/M service.

FAQs

Q: Can I document a single item in more than one section of the history? For example, can I document a single historical item in both the HPI and ROS?

A: It is not acceptable to document a single historical item in two sections of the history unless the problem is expanded upon. For example, the HPI states Abdominal pain x 2 days, described as a burning pain, rates pain 4 on a scale of 1-10. It would be acceptable to document abdominal pain again in the ROS if it showed that the provider expanded upon the problem by asking other leading questions. For example, Gastrointestinal - abdominal pain, c/o nausea, no vomiting.

FAQs

Q: What if my patient is unable to provide a history due to factors that would impair their ability to answer questions?

A: If the patient is unable to provide a history and there are no medical records or family present to assist in obtaining the patient's history, the provider should document in the record a description of the patients condition that prevents the provider from obtaining a history. For example, patient unconscious, no medical records available.

FAQs

Q: When time is the controlling factor for the visit, how do we document the time? Is it total time or start/stop time?

A: When 50 percent or greater of the time is spent on counseling and/or coordination of care. The documentation should have the total time spent with the patient along with documentation supporting that over half of the time spent was spent on counseling and/or coordination of care.

FAQs

Q: What should be documented to support counseling and/or coordination of care?

A: You would want to document in detail what was discussed. For example, test results, medication options, side effects of the medications, etc. in order to support that the majority of the time was spent providing counseling and/or coordination of care.

FAQs

Q: When is it appropriate to use the -25 modifier and what should be included in the documentation to show that the E/M was distinct and separately identifiable?

A: The -25 modifier should be used for significant, separately identifiable E/M services by the same physician on the same day that a procedure or other service was performed. The provider would need to clearly document what was above and beyond the procedure performed.

Resources

- Evaluation and Management Services Guide - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764.pdf
- 1995 Documentation Guidelines for Evaluation and Management Services - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
- 1997 Documentation Guidelines for Evaluation and Management Services - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf
- Medicare Claims Processing Manual, Pub. 100-04, Ch. 12, Sec. 30.6 - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- Current Procedural Terminology (CPT) Standard Edition

Additional Resources

- CGS website

Questions

Basics of Evaluation and Management (E/M) Services

Thank you for attending!

CEUs – AAPC Instructions

If you are a member of the American Academy of Professional Coders (AAPC), log into the AAPC site with your user name and password.

1.Click on “CEU Tracker”.

2.When prompted for the “index number,” answer “no”.

3.A new screen will appear prompting you to type the date of the event.

4.When a drop-down box appears choose “CMS/MAC-Sponsored”.

5.In the required field titled “Title of Course/Presentation,” type the course name (as advertised).

6.Enter the number of CEUs – enter “1”. (Only one CEU is allowed for CMS-sponsored events.)

7.Click on “Save.”

AAPC contact information: 1.800.626.2633 http://www.aapc.com/

CEUs: Other Organizations

- Other organizations may (or may not) honor the certificate of attendance and award CEUs.
- If you are a member of an organization other than AAPC and wish to apply to them for CEUs for this course, please contact the organization directly.

CEUs: Other Notes

- CGS does not maintain attendance records for CEU purposes.
- Please keep your certificate. We are unable to print duplicate copies after the event.