



**Nuts & Bolts  
Evaluation & Management**

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**DISCLAIMER**

- This information is for educational purposes only. The use of this material is voluntary and should not be construed as an attempt to establish standards of care or practice mandates. Providers must completely and accurately document all medical services provided consistent with applicable state and federal guidelines based upon the patient's clinical presentation and the provider's assessment of need. Failure to accurately document may result in legal consequences, including prohibition from participation in federal programs.

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**Evaluation & Management**

- What is an Evaluation & Management Service (E/M, E&M)?
  - E/M services are cognitive services in which a physician or other qualified healthcare professional diagnoses and treats illness or injury.
  - Inpatient / Outpatient
  - New or established patients
  - 1995 Guidelines
  - 1997 Guidelines
  - 2021 ?

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### Outpatient Services

- Office Visits
  - Initial/New Patient Visit (99201-99205)
  - Established Patient Visit (99211-99215)
  - Consultations (99241-99245)
  - Place of Service 11
- Office Visits at a Hospital
  - Same E/M's
  - POS 22 (On Campus, Outpatient Hospital)
  - POS 19 (Off Campus, Hospital Owned)

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### Emergency Department = Outpatient Services

- Emergency Department
  - (99281-99285)
  - Consultations in ED (99241-99245)
  - POS 23
- Observation/ Inpatient or Outpatient?
  - Observation 99218-99220/ 99234-99236
  - POS 22 (On Campus, Outpatient Hospital)

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### Inpatient Services

- Inpatient Evaluation & Management Visits
  - Initial /Consultation (99221-99223)
  - Established Patient Visit (99231-99233)
  - Consultations (99251-99255)
  - Critical Care (99291-99292)
  - Place of Service 21

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### New Patient & Established

- New & Established patients are defined by whether if or when a patient has been seen by a practice.
  - A new patient is one who has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three (3) years.
  - An established patient is one who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three (3) years.

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### Elements of E&M Visits

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### New Patient E/M Requirements

**REQUIRE ALL 3 Key Factors:**

- History
- Exam
- Medical Decision-Making (MDM or Risk determination)



The lowest element determines your overall level of service

**SCHEDULED TO CHANGE 2021\*\***

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## History

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### History Elements

- History is composed of:
  - Chief Complaint
  - History of present illness
  - Past, family, social history
  - Review of Systems

The **LOWEST** score out of these three areas determines the ultimate history score

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### Chief Complaint

- Providers should always document a concise chief complaint as it:
  - Describes the reason for the visit
  - *Should be in patient's own words*
  - Forms the foundation for medical necessity

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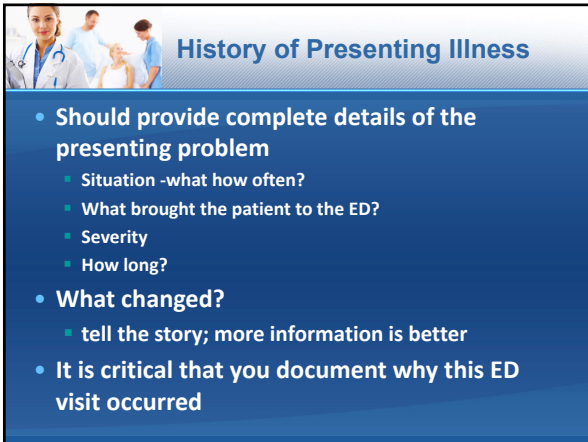
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### History of Presenting Illness

- Should provide complete details of the presenting problem
  - Situation -what how often?
  - What brought the patient to the ED?
  - Severity
  - How long?
- What changed?
  - tell the story; more information is better
- It is critical that you document why this ED visit occurred

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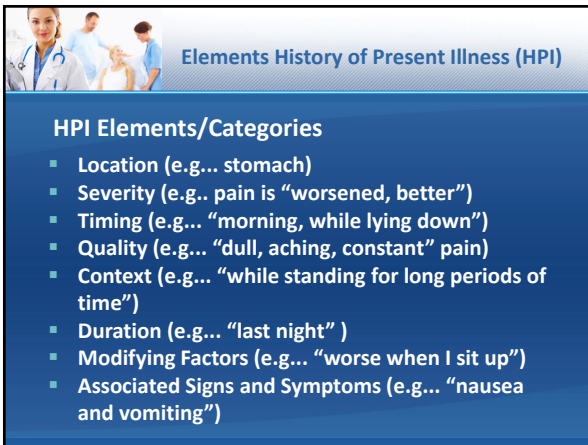
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### Elements History of Present Illness (HPI)

#### HPI Elements/Categories

- Location (e.g... stomach)
- Severity (e.g.. pain is “worsened, better”)
- Timing (e.g... “morning, while lying down”)
- Quality (e.g... “dull, aching, constant” pain)
- Context (e.g... “while standing for long periods of time”)
- Duration (e.g... “last night” )
- Modifying Factors (e.g... “worse when I sit up”)
- Associated Signs and Symptoms (e.g... “nausea and vomiting”)

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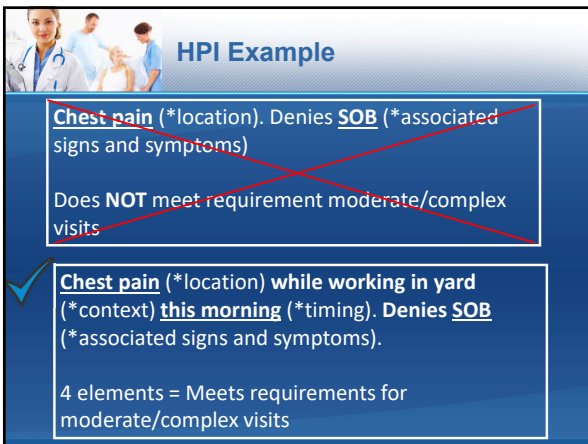
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### HPI Example

~~Chest pain (\*location). Denies SOB (\*associated signs and symptoms)~~

~~Does NOT meet requirement moderate/complex visits~~

✓ Chest pain (\*location) while working in yard (\*context) **this morning** (\*timing). Denies SOB (\*associated signs and symptoms).

4 elements = Meets requirements for moderate/complex visits

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### Review of Systems

- May be credited from the HPI or Past Medical History
- May list pertinent positives and negative responses then state, "All other systems reviewed and are negative (or normal)."
- If the history is unobtainable, you must document the reason; e.g., the patient:
  - has dementia
  - is unconscious
  - is aphasic

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### Unacceptable History Statements

Unacceptable statements:

- "History limited as patient is poor historian"*
- "History difficult to obtain as patient is not answering direct questions"*
- "History unobtainable because patient does not speak English."*

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### Past, Family and Social History

#### Past History

A review of the patient's prior experience with illness, injuries, and treatments

#### Family History

A review of medical events in the patient's family

#### Social History

An age appropriate review of past and current activities

#### Other Social Factors

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## Past, Family and Social History

### Past History

A review of the patient's prior experience with illness, injuries, and treatments

PMH:

- No major hospitalizations or surgeries
- No known allergies
- Tetanus shot produced local swelling
- Medications include: Plavix and Lanoxin

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## Past, Family and Social History

### Family History

A review of medical events in the patient's family

PFH:

- Mother – diabetes and hypertension
- Father – three heart attacks; died at age 52; strong family history of coronary artery disease and heart disease as well as myocardial infarction

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## Past, Family and Social History

### Social History

An age appropriate review of past and current activities

PSH:

- Smokes pack a day, decreased from three packs a day. Some days only smokes a pack every 4 days
- Fairly heavy drinker in the past.
- Wife of 22 years with him today

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### Unacceptable History Documentation

Unacceptable for ROS and PFSH:

- “Noncontributory”*
- “Negative”*
- “None”*
- “Not significant”*

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### Template Documentation of History

- It is important from a risk management perspective to utilize areas on documentation templates such as *“nursing notes reviewed”* and *“initial vital signs reviewed”*.
- Documentation should indicate that the provider read the nursing notes to ascertain if there was any additional problem that was stated to the nurses, but not to the provider.

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### Use of “Non-contributory”

- Medicare has deemed the use of *“non-contributory”* unacceptable documentation of history and/or exam elements.
- By using *“non-contributory”* in your documentation, it can lower your level of service as it will not be accepted.

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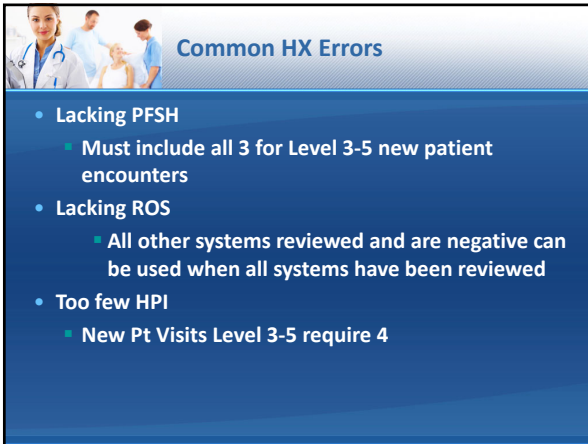
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**Common HX Errors**

- Lacking PFSH
  - Must include all 3 for Level 3-5 new patient encounters
- Lacking ROS
  - All other systems reviewed and are negative can be used when all systems have been reviewed
- Too few HPI
  - New Pt Visits Level 3-5 require 4

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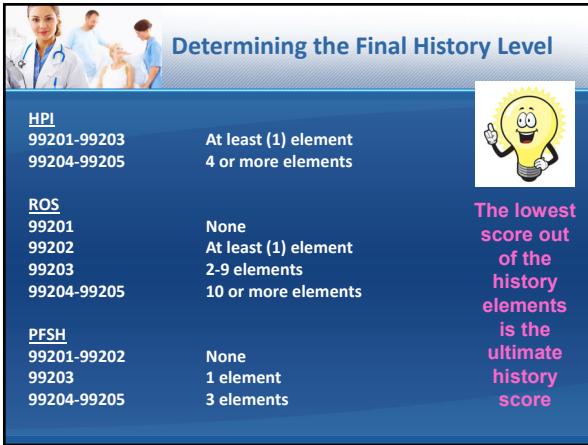
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**Determining the Final History Level**

HPI	At least (1) element
99201-99203	4 or more elements

ROS	None
99201	At least (1) element
99202	2-9 elements
99203	10 or more elements

PFSH	None
99201-99202	1 element
99203	3 elements

**The lowest score out of the history elements is the ultimate history score**

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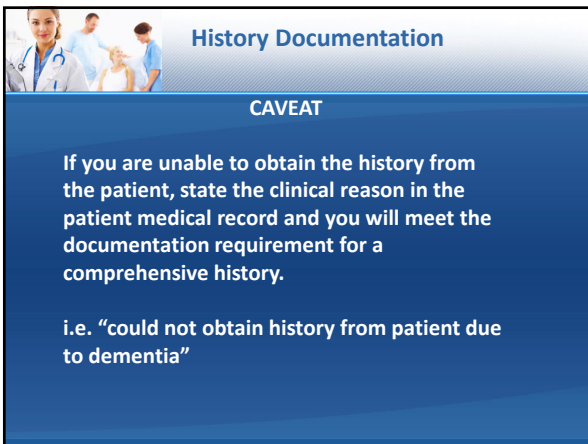
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**History Documentation**

**CAVEAT**

If you are unable to obtain the history from the patient, state the clinical reason in the patient medical record and you will meet the documentation requirement for a comprehensive history.

i.e. "could not obtain history from patient due to dementia"

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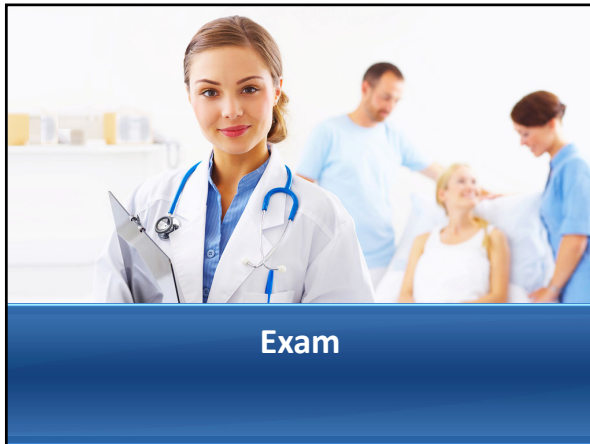
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## Exam

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### Exam Elements 95 Guidelines

- **New Patients**
  - Level 1      1 organ system
  - Level 2      2-7 organ systems
  - Level 3      2-7 organ systems
  - Level 4-5    8 organ systems
- **Established Patients**
  - Level 2      1 organ system
  - Level 3      Up to 7 organ systems
  - Level 4      Up to 7 organ systems
  - Level 5      8 organ systems

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### Examination Components

Body Areas	Organ Systems
<ul style="list-style-type: none"> <li>• Head, including face</li> <li>• Neck</li> <li>• Chest</li> <li>• Abdomen</li> <li>• Genitalia, groin, buttocks</li> <li>• Back, including spine</li> <li>• Each extremity (each counts as one body area)</li> </ul>	<ul style="list-style-type: none"> <li>• Constitutional</li> <li>• Eyes</li> <li>• ENT and Mouth</li> <li>• Cardiovascular</li> <li>• Gastrointestinal</li> <li>• Musculoskeletal</li> <li>• Neurological</li> <li>• Integumentary</li> <li>• Psychiatric</li> <li>• Genitourinary</li> <li>• Respiratory</li> <li>• Hematologic / Lymphatic</li> </ul>

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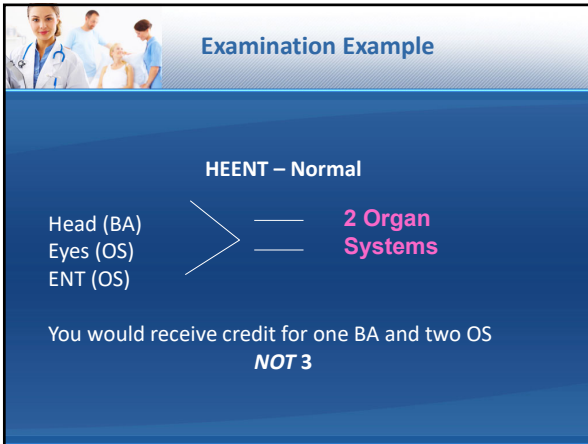
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**Examination Example**

HEENT – Normal

Head (BA) ———— **2 Organ Systems**  
 Eyes (OS) ————  
 ENT (OS)

You would receive credit for one BA and two OS  
**NOT 3**

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**Where is Neck?**

Organ Systems

- Constitutional
- Eyes
- ENT and Mouth
- Cardiovascular
- Gastrointestinal
- Musculoskeletal
- Endocrine
- Neurologic
- Integumentary
- Psychiatric
- Genitourinary
- Allergic / Immunologic
- Respiratory
- Hematologic / Lymphatic

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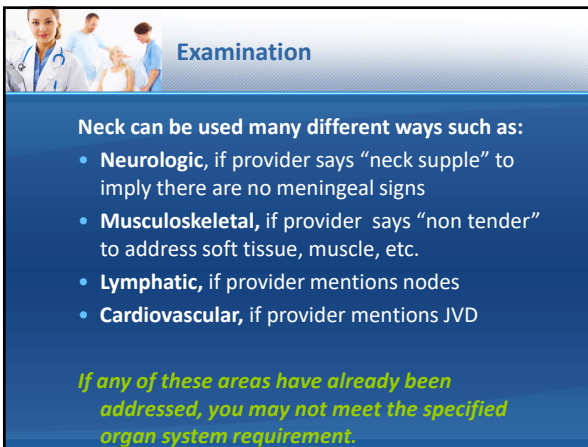
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**Examination**

Neck can be used many different ways such as:

- **Neurologic**, if provider says “neck supple” to imply there are no meningeal signs
- **Musculoskeletal**, if provider says “non tender” to address soft tissue, muscle, etc.
- **Lymphatic**, if provider mentions nodes
- **Cardiovascular**, if provider mentions JVD

*If any of these areas have already been addressed, you may not meet the specified organ system requirement.*

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### Risk Determination

Comprised of the following components:

- Number of Diagnoses and/or Management Options
- Amount of Complexity of Data to be Reviewed
- Risk of Complications and/or Morbidity or Mortality

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### Number of Diagnoses and/or Management Options

List the primary diagnosis as the reason for the medical care or service

Chief Complaint: *Fever and infiltrate on x-ray*

1. Bilateral lower lobe pneumonia
2. Gastroesophageal reflux disease
3. Elevated cholesterol
4. Osteoarthritis

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**Number of Diagnoses and/or Management Options**

Assign the highest level of specificity

<u>Diagnosis</u>	<u>ICD-10-CM</u>
Diabetes Mellitus	Can't code
Type 1 Diabetes Mellitus without mention of complications	E10
Type 2 Diabetes Mellitus without mention of complications	E11

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**Number of Diagnoses and/or Management Options**

List symptoms when no definitive diagnosis is made at visit

- Weakness
- Abdominal Pain
- Dizziness
- Headache
- N/V

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**Risk Determination**

Number of Diagnoses and/or Management Options

Be specific in describing patient's condition!

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### Risk Determination

#### Number of Diagnoses and/or Management Options

Distinguish between acute and chronic conditions. List the acute condition first and the chronic as secondary

e.g.  
 Primary Diagnosis: Pneumonia  
 Secondary Diagnosis: COPD

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### Number of Diagnoses and/or Management Options

Exercise caution when coding pre-existing conditions on and code ONLY those conditions treated during the encounter

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### Number of Diagnoses and/or Management Options

Description of Problem Categories	Diagnosis	Number of DX or Mgmt Options
Self limited or minor (stable, improved or worsened) (Max = 2)	1	Minimal
Established problem, stable, improved	1	Minimal
Established problem, worsening	2	Limited
New Problem (to examiner), no additional work-up planned (Max = 1)	3	Multiple
New problem (to examiner), additional work-up planned	4	Extensive
<b>TOTAL SCORE</b>		

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### Amount of Complexity of Data to be Reviewed

Amount and type of diagnostic test(s) ordered and/or reviewed

- Indication of interpretation of diagnostic test results
- Order to obtain old records
- Review of old records or obtaining history from someone other than the patient (You must state pertinent new or confirmed information. If no new pertinent data has been added beyond what was previously obtained, state such).

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Description	Category	Value
Pathology and Laboratory	One or more tests, (CBC Count, urinalysis, etc.)	1
Radiology	One or more tests (Chest x-ray, CT Scan, etc.)	1
Other diagnostic studies	One or more studies, or services in CPT Medicine section (EKG, EMG, allergy tests, audiometry, pulse oximeter, etc. 90701-99199)	1
Discussion of test results	Discussion of test results with performing provider	1
Independent visualization	Independent visualization of image, tracing or report	2
Old records / additional history	Decision to obtain old records/obtain history from other than patient/discuss case with another provider.	2
TOTAL SCORE		

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### Risk of Complications and/or Morbidity or Mortality

- The risk is based on risk to the patient associated with the presenting problem, diagnostic/therapeutic procedures and management options.
- Underlying diseases or other factors that increase the complexity of patient management by increasing the risk of complications, must be documented.

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**Medical Decision Making (MDM)**

DATA	DX	RISK	MDM
1 (Minimal)	1 (Minimal)	Minimum	Straightforward
2 (Limited)	<b>2 (Limited)</b>	Low	<b>Low</b>
3 (Moderate)	3 (Multiple)	<b>Moderate</b>	Moderate
4 (Extensive)	4 (Extensive)	High	High

\*\*\*The SECOND highest column determines the final MDM level

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**Medical Decision Making (MDM)**

DATA	DX	RISK	MDM
1 (Minimal)	1 (Minimal)	Minimum	Straightforward
2 (Limited)	<b>2 (Limited)</b>	<b>Low</b>	Low
3 (Moderate)	3 (Multiple)	Moderate	Moderate
4 (Extensive)	4 (Extensive)	High	<b>High</b>

\*\*\*The SECOND highest column determines the final MDM level

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**Example #1**

Chest pain  
 EKG ordered and read by hospitalist  
 CXR  
 Labs ordered

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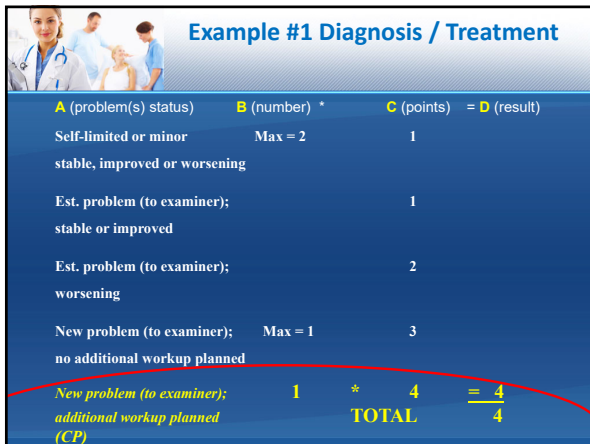
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**Example #1 Diagnosis / Treatment**

A (problem(s) status)	B (number) *	C (points)	= D (result)
Self-limited or minor stable, improved or worsening	Max = 2	1	
Est. problem (to examiner); stable or improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	Max = 1	3	
<i>New problem (to examiner); additional workup planned (CP)</i>	<b>1</b>	<b>*</b>	<b>4 = 4</b>
		<b>TOTAL</b>	<b>4</b>

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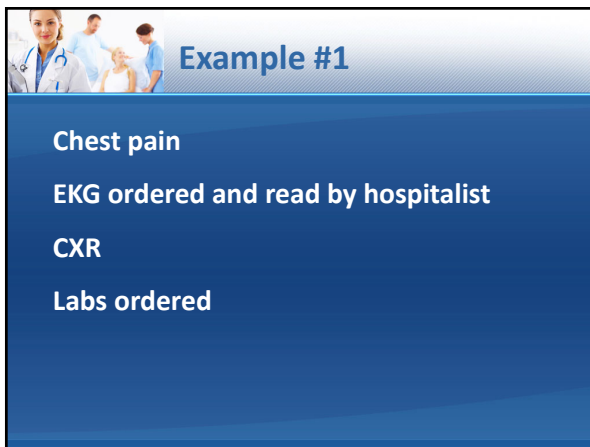
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**Example #1**

Chest pain

EKG ordered and read by hospitalist

CXR

Labs ordered

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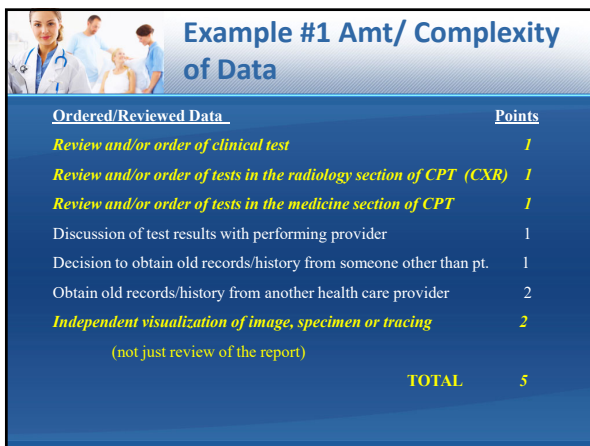
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**Example #1 Amt/ Complexity of Data**

Ordered/Reviewed Data	Points
<i>Review and/or order of clinical test</i>	1
<i>Review and/or order of tests in the radiology section of CPT (CXR)</i>	1
<i>Review and/or order of tests in the medicine section of CPT</i>	1
Discussion of test results with performing provider	1
Decision to obtain old records/history from someone other than pt.	1
Obtain old records/history from another health care provider	2
<i>Independent visualization of image, specimen or tracing</i> (not just review of the report)	2
	<b>TOTAL 5</b>

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## Example #1

**Chest pain**  
**EKG ordered and read by hospitalist**  
**CXR**  
**Labs ordered**

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## Table of Risk

Table 10

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Option Selected
Minimal	<ul style="list-style-type: none"> <li>One self limited or minor problem, e.g. cold acute low back sprain</li> </ul>	<ul style="list-style-type: none"> <li>Laboratory tests requiring interpretation</li> <li>Class X-rays</li> <li>EKG/EKG</li> <li>Ultrasound</li> <li>Urinalysis, e.g. urine</li> <li>ECG/emp</li> </ul>	<ul style="list-style-type: none"> <li>Rest</li> <li>Analgesic</li> <li>Urologic referral</li> <li>Supervised discharge</li> </ul>
Low	<ul style="list-style-type: none"> <li>Two or more self limited or minor problems</li> <li>One stable chronic illness, e.g. well controlled hypertension or noninsulin dependent diabetes, contact with BPH</li> <li>Acute noncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain</li> </ul>	<ul style="list-style-type: none"> <li>Physiologic tests not under stress, e.g. pulmonary function tests</li> <li>Noncardiovascular imaging studies with contrast, e.g. barium enema</li> <li>Supervised ambulatory surgery</li> <li>Classical laboratory tests requiring special practice</li> <li>Skin biopsy</li> </ul>	<ul style="list-style-type: none"> <li>Over the Counter drugs</li> <li>Minor surgery with no identified risk factors</li> <li>Physical therapy</li> <li>Outpatient surgery</li> <li>IV fluids without additives</li> </ul>
Moderate	<ul style="list-style-type: none"> <li>One or more chronic illness with mild exacerbation, progression, or side effects of treatment</li> <li>Two or more stable chronic illnesses</li> <li>Undisputed acute problem with no current progression, e.g. lung or bone</li> <li>Acute illness with systemic progression, e.g. pyelonephritis, pneumonia, colitis</li> <li>Acute complicated injury, e.g. head injury with brief loss of consciousness</li> </ul>	<ul style="list-style-type: none"> <li>Physiologic tests under stress, e.g. cardiac stress test, final capnography stress test</li> <li>Diagnostic endoscopies with no identified risk factors</li> <li>Drug profile or associated biopsy</li> <li>Cardiovascular imaging studies with contrast and no identified risk factors, e.g. aortic aneurysm, cardiac catheterization</li> <li>Other final third level surgery, e.g. lumbar procedure, thoracotomy, oophorectomy</li> </ul>	<ul style="list-style-type: none"> <li>Minor surgery with identified risk factors</li> <li>Elective major surgery (open, percutaneous or endoscopic with an identified risk factor)</li> <li>Prescription drug management (maintenance &amp; new prescriptions)</li> <li>Therapeutic nuclear medicine</li> <li>IV fluids with additives</li> <li>Classical treatment of fracture or dislocation without amputation</li> </ul>
High	<ul style="list-style-type: none"> <li>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</li> <li>Acute or chronic illnesses or injuries that may pose a threat to life or limb (e.g. multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive acute bacterial meningitis, peritonitis, illness with potential threat to self or others, pneumonia, acute renal failure)</li> <li>An acute change in an already acute illness, e.g. severe stroke, aneurysm or urinary tract</li> </ul>	<ul style="list-style-type: none"> <li>Cardiovascular imaging studies with contrast with identified risk factors</li> <li>Cardiac electrophysiological tests</li> <li>Diagnostic endoscopies with identified risk factors</li> <li>Diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>Elective major surgery (open, percutaneous or endoscopic with identified risk factors)</li> <li>Emergency major surgery (open, percutaneous or endoscopic)</li> <li>Parenteral nutritional substances</li> <li>Drug therapy requiring attention monitoring for toxicity</li> <li>Discussion with or consultation with the specialist upon because of poor prognosis</li> </ul>

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## Example #1 MDM

Complexity	Data	Dx	Risk <small>(see table)</small>
Straightforward	Minimal (≤1)	Minimal (≤1)	Minimal
Low	Limited (2)	Limited (2)	Low
Moderate	Multiple (3)	Multiple (3)	Moderate
<b>High</b>	<b>Extensive (4)</b>	<b>Extensive (4)</b>	<b>High</b>

\*\*\*The SECOND highest column determines the final MDM level

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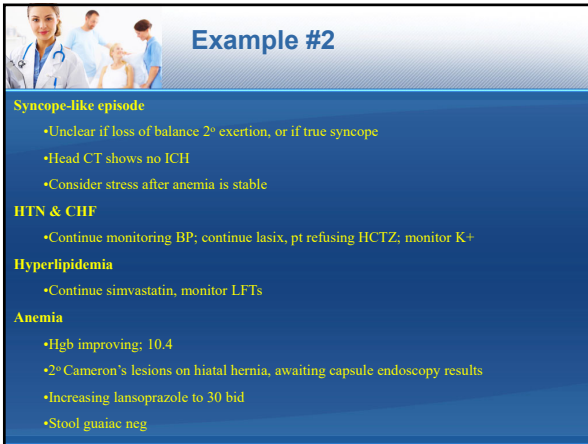
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**Example #2**

**Syncope-like episode**

- Unclear if loss of balance 2<sup>o</sup> exertion, or if true syncope
- Head CT shows no ICH
- Consider stress after anemia is stable

**HTN & CHF**

- Continue monitoring BP; continue lasix, pt refusing HCTZ; monitor K+

**Hyperlipidemia**

- Continue simvastatin, monitor LFTs

**Anemia**

- Hgb improving; 10.4
- 2<sup>o</sup> Cameron's lesions on hiatal hernia, awaiting capsule endoscopy results
- Increasing lansoprazole to 30 bid
- Stool guaiac neg

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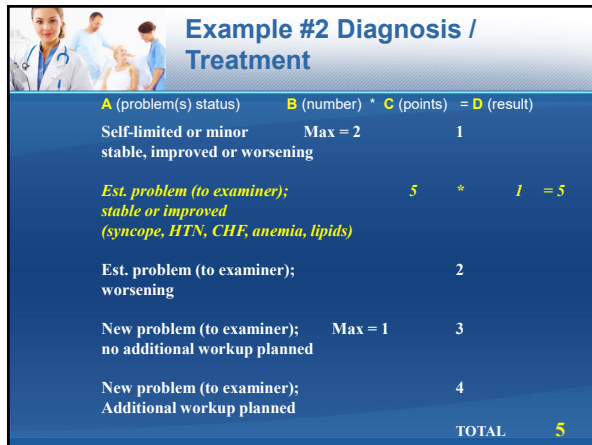
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**Example #2 Diagnosis / Treatment**

A (problem(s) status)	B (number)	C (points)	= D (result)
Self-limited or minor stable, improved or worsening	Max = 2	1	
<i>Est. problem (to examiner); stable or improved (syncope, HTN, CHF, anemia, lipids)</i>	5	*	1 = 5
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	Max = 1	3	
New problem (to examiner); Additional workup planned		4	
<b>TOTAL</b>			<b>5</b>

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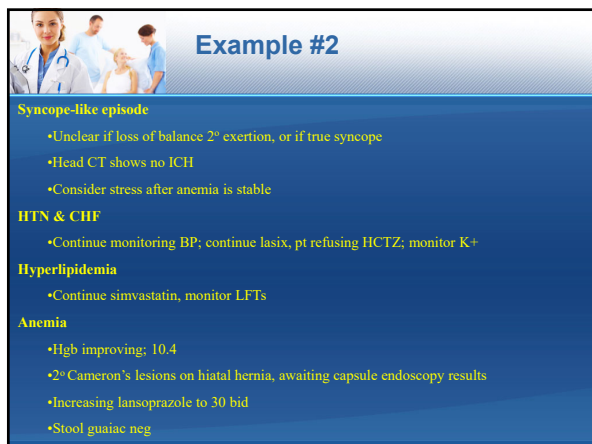
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**Example #2**

**Syncope-like episode**

- Unclear if loss of balance 2<sup>o</sup> exertion, or if true syncope
- Head CT shows no ICH
- Consider stress after anemia is stable

**HTN & CHF**

- Continue monitoring BP; continue lasix, pt refusing HCTZ; monitor K+

**Hyperlipidemia**

- Continue simvastatin, monitor LFTs

**Anemia**

- Hgb improving; 10.4
- 2<sup>o</sup> Cameron's lesions on hiatal hernia, awaiting capsule endoscopy results
- Increasing lansoprazole to 30 bid
- Stool guaiac neg

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## Example #2 Complexity of Data

Ordered/Reviewed Data	Points
Review and/or order of clinical test (Hgb, LFTs, guaiac)	1
Review and/or order of tests in the radiology section of CPT (CT)	1
Review and/or order of tests in the medicine section of CPT (stress)	1
Discussion of test results with performing provider	1
Decision to obtain old records/history from someone other than pt	1
Obtain old records/history from another health care provider	2
Independent visualization of image, specimen or tracing (not just review of the report)	2
<b>TOTAL</b>	<b>3</b>

Unclear if CT viewed or report reviewed

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## Example #2

### Syncopalike episode

- Unclear if loss of balance 2° exertion, or if true syncope
- Head CT shows no ICH
- Consider stress after anemia is stable

### HTN & CHF

- Continue monitoring BP; continue lasix, pt refusing HCTZ; monitor K+

### Hyperlipidemia

- Continue simvastatin, monitor LFTs

### Anemia

- Hgb improving; 10.4
- 2° Cameron's lesions on hiatal hernia, awaiting capsule endoscopy results
- Increasing lansoprazole to 30 bid
- Stool guaiac neg

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Level of Risk	Preexisting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	<ul style="list-style-type: none"> <li>• One self limited or minor problem, e.g., cold, upset, bite, insect exposure</li> </ul>	<ul style="list-style-type: none"> <li>• Laboratory tests requiring venipuncture</li> <li>• Chest X-ray</li> <li>• ECG/EDR</li> <li>• Urinalysis</li> <li>• Urinalysis, e.g., uric acid</li> <li>• KOH prep</li> </ul>	<ul style="list-style-type: none"> <li>• Rest</li> <li>• Gargles</li> <li>• Elastic bandages</li> <li>• Superficial dressings</li> </ul>
Low	<ul style="list-style-type: none"> <li>• Two or more self limited or minor problems</li> <li>• One stable chronic illness, e.g., well-controlled hypertension or</li> <li>• noninsulin dependent diabetes, contact, SBE</li> <li>• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, single sprain</li> </ul>	<ul style="list-style-type: none"> <li>• Physiologic tests not under stress, e.g., pulmonary function tests</li> <li>• Noncardiovascular imaging studies with contrast, e.g., barium swallow</li> <li>• Superficial needle biopsies</li> <li>• Clinical laboratory tests requiring arterial puncture</li> <li>• Skin biopsies</li> </ul>	<ul style="list-style-type: none"> <li>• Over-the-counter drugs</li> <li>• Minor surgery with an identified risk factor</li> <li>• Physical therapy</li> <li>• Occupational therapy</li> <li>• IV fluids without additives</li> </ul>
Moderate	<ul style="list-style-type: none"> <li>• One or more chronic illness with mild exacerbation, progression, or side effects of treatment</li> <li>• Two or more stable chronic illnesses</li> <li>• Uncomplicated acute problem with moderate progression, e.g., lung or bone</li> <li>• Acute illness with moderate complications, e.g., pyelonephritis, pneumonia, colitis</li> <li>• Acute uncomplicated injury, e.g., hand injury with brief loss of consciousness</li> </ul>	<ul style="list-style-type: none"> <li>• Physiologic tests under stress, e.g., cardiac stress test, final catheterized stress test</li> <li>• Diagnostic endoscopies with no identified risk factors</li> <li>• Drug therapy or increased length</li> <li>• Cardiovascular imaging studies with contrast and identified risk factors, e.g., intravenous cardiac catheter</li> <li>• Other fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</li> </ul>	<ul style="list-style-type: none"> <li>• Minor surgery with identified risk factors</li> <li>• Elective major surgery (open, percutaneous or endoscopic with an identified risk factor)</li> <li>• Physical therapy (intensive) (resistance, &amp; etc.)</li> <li>• Therapeutic endoscopic procedures</li> <li>• IV fluids with additives</li> <li>• Closed treatment of fracture or dislocation without manipulation</li> </ul>
High	<ul style="list-style-type: none"> <li>• One or more chronic illness with moderate to severe exacerbation, progression, or side effects of treatment</li> <li>• Acute or chronic illness or injury that may pose a threat to life or body function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, preterm, acute renal failure</li> <li>• An acute change in neurologic status, e.g., stroke, TIA, weakness or sensory loss</li> </ul>	<ul style="list-style-type: none"> <li>• Cardiovascular imaging studies with contrast with identified risk factors</li> <li>• Cardiac electrophysiology tests</li> <li>• Diagnostic endoscopies with identified risk factors</li> <li>• Diagnostic endoscopies with identified risk factors</li> </ul>	<ul style="list-style-type: none"> <li>• Elective major surgery (open, percutaneous or endoscopic with identified risk factors)</li> <li>• Emergency major surgery (open, percutaneous or endoscopic)</li> <li>• Parenteral nutritional solutions</li> <li>• Drug therapy requiring attention according to toxicity</li> <li>• Therapy not so restrictive as to be excessive and limit all past programs</li> </ul>

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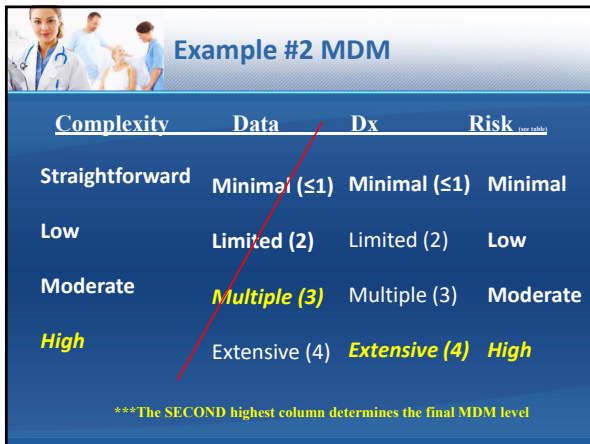
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**Example #2 MDM**

Complexity	Data	Dx	Risk <small>(see table)</small>
Straightforward	Minimal (≤1)	Minimal (≤1)	Minimal
Low	Limited (2)	Limited (2)	Low
Moderate	<b>Multiple (3)</b>	Multiple (3)	Moderate
<b>High</b>	Extensive (4)	<b>Extensive (4)</b>	<b>High</b>

\*\*\*The SECOND highest column determines the final MDM level

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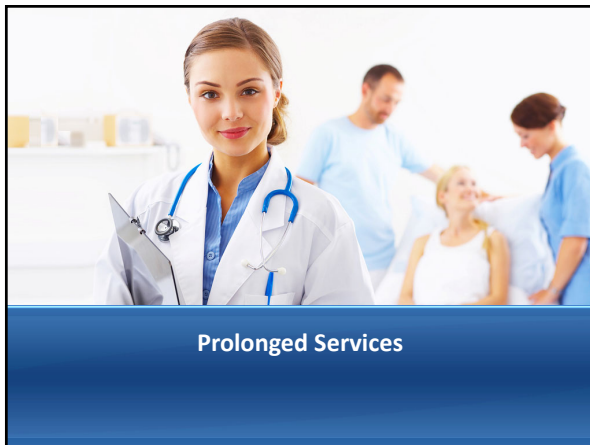
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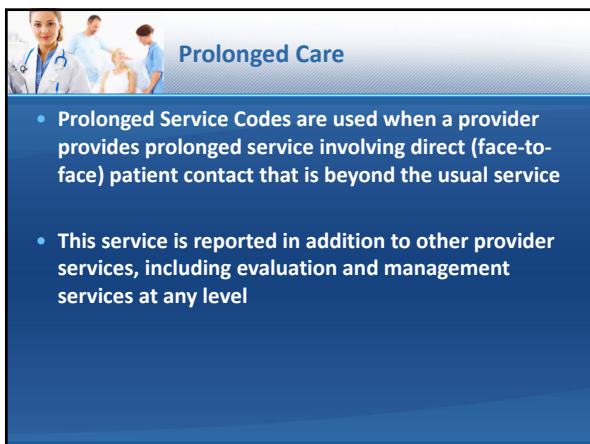
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**Prolonged Care**

- Prolonged Service Codes are used when a provider provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service
- This service is reported in addition to other provider services, including evaluation and management services at any level

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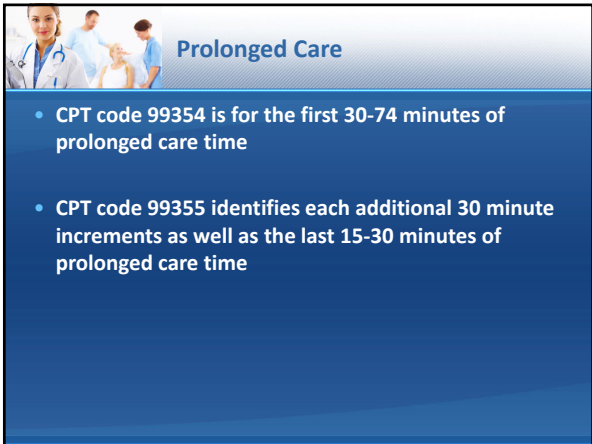
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**Prolonged Care**

- CPT code 99354 is for the first 30-74 minutes of prolonged care time
- CPT code 99355 identifies each additional 30 minute increments as well as the last 15-30 minutes of prolonged care time

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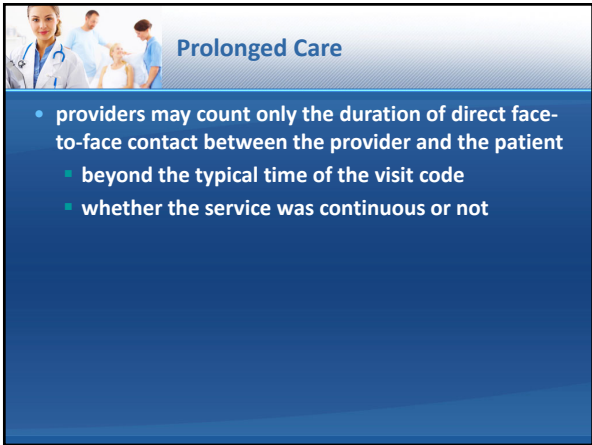
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**Prolonged Care**

- providers may count only the duration of direct face-to-face contact between the provider and the patient
  - beyond the typical time of the visit code
  - whether the service was continuous or not

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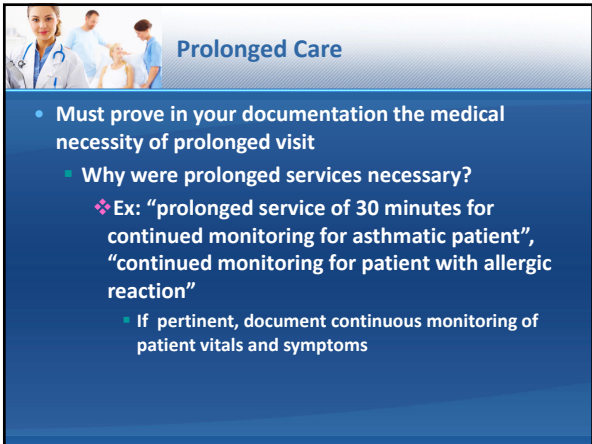
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**Prolonged Care**

- Must prove in your documentation the medical necessity of prolonged visit
  - Why were prolonged services necessary?
    - ❖ Ex: "prolonged service of 30 minutes for continued monitoring for asthmatic patient", "continued monitoring for patient with allergic reaction"
    - If pertinent, document continuous monitoring of patient vitals and symptoms

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### Documentation for Prolonged Care

- Document medical necessity for prolonged care
- Include a time statement for the prolonged services.
  - i.e., “prolonged service of 30 minutes for continued monitoring for asthmatic patient”,
- Include start and stop times of the prolonged care

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### Prolonged Care

- Time must be in excess of 30 minutes *beyond* the typical bedside/floor time
- Prolonged Care codes are add-on codes
  - Must be billed alongside the initial E/M code
  - Can not be billed alone

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### Payer Policies & Common Problems

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### Common Documentation Problems

- Missing signature and/or attestations
  - *BCBS- 7 days or unbillable*
- Illegible handwriting
- Too few elements in HPI
- Too few elements in Review of Systems
- Too few systems in the examination
- Lacking detail of severity of illness
- Incomplete procedure documentation
- Incorrect use of templates

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### Illegible Handwriting

- Handwriting
  - Should be legible
  - Medicare Rule- if can't be read, it didn't happen
  - Unrecognized abbreviations

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### BCBS & Medicare- Signatures

- The teaching provider must complete their documentation in the medical record within *seven* days of the date of service and before submitting claims to insure notations by trainees are accurate and complete to support correct coding of services.

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 Questions?



If you have additional questions contact my office at  
617.444.9847  
or by email: [scamero1@bidmc.harvard.edu](mailto:scamero1@bidmc.harvard.edu)

Shannon C. Cameron, MBA, MHIIM, CPC

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