E/M:
Black, White or Gray

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AAPC OF KC
Fall Conference, August 10, 2018
Presented By:
Patti Frank, CPC

Disclaimer

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- This presentation is for educational purposes only.
- Reasonable efforts have been made to provide the most accurate and current information. However codes, guidelines, and policies are subject to change and interpretation.
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Why Does CMS Focus on E/M Coding

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- In 2010 E/M services were 30% of Part B payments
- Medicare paid $32.3 billion for E/M services in 2010
- E/M services are 50% more likely to be paid in error than other Part B services
- Medicare inappropriately paid $6.7 billion for claims for E/M services in 2010

Source: OIG Report OEI-04-10-00181, 5/28/2014, Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010

What's New in E/M

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- Re-entering student E/M documentation
  - Allows the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work.
  - Effective January 1, 2018
  - Must be performed in the physical presence of the teaching physician or resident
  - Teaching physician must personally perform or re-perform the exam and MDM
  - Teaching physician must verify all student documentation or findings including history, exam and MDM

What's New in E/M

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- Re-entering student E/M documentation
  - Teaching physician must verify all student documentation or findings including history, exam and MDM
  - EMR considerations
    - Time and date stamp
    - Storage of student and teaching physician documentation
  - Sources:
    - R4068CP
    - MM10412
    - 100-04, Chapter 12, Section 100.1.1

What's New in E/M

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- Proposed changes to E/M coding for 2019
- Comment period ends September 10, 2018
- New choices for providers to fulfill the documentation requirements include:
  - Use the 1995 or 1997 Documentation Guidelines
  - Use medical decision making only (requires documentation supporting straight-forward MDM)
  - Use time only
- Allow ancillary staff to record all of the history including HPI

What's New in E/M

Single PFS Rate for New Office Visits (99202-99205) and Established Visits (99212-99215)

CPT	Proposed	WPS 2018		CPT	Proposed	WPS 2018
99201	$44	$44.52		99211	$24	$21.43
99202	$135	$75.05		99212	$93	$43.79
99203		$108.22		99213		$72.98
99204		$165.31		99214		$107.78
99205		$208.18		99215		$145.54

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What's New in E/M

8

- Requires documentation to support medical necessity and documentation associated with current level 2 codes
- Typical time for proposed new visit is 38 minutes and for established visit is 31 minutes
- Soliciting comments on deleting prohibition against same day visits, same specialty, same practice (team approach?)
- Reduced payment for E/M service on day of zero global day procedure

What's New in E/M

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- Virtual Check-in
  - 5-10 minutes of medical discussion between patient and provider
  - Established patient only
  - $15.40 (non-facility) and $13.37 (facility)
  - Not related to E/M service in last 7 days or next 24 hours appt.
- Interprofessional consults
  - CPT 99446-99449
  - Status indicator change from bundled to active

What's New in E/M

10

- Remote pre-recorded service via recorded video and/or image
  - "Send your doctor a picture of that rash!!"
  - Submitted by patient
  - Includes interpretation and verbal follow-up with patient within 24 business hours
- New prolonged service code
  - 30 minutes
  - Meet the threshold of the base code and half the prolonged time
  - $67.40 (non-facility) and $63.80 (facility)

What's New in E/M

11

- Inherent Complexity Codes
  - Add-on codes to E/M service
  - Primary care
    - $5.40 (non-facility) an $3.96 (facility)
  - Specialties
    - $13.70 (non-facility or facility)
    - Specialties that perform few procedures targeted
    - Specialties: endocrinology, rheumatology, hematology/oncology, urology, neurology, OB/GYN, allergy/immunology, otolaryngology, interventional pain management
    - Practices will need to carefully consider taxonomy codes

Questions to Ponder

12

- Will patient expectations still be met?
- How will non-Medicare insurers respond?
- How much documentation is enough for liability?
- How much is enough for communication?
- Will Medicare no longer audit office visits?
- How will secondaries be affected?
- How will Medicare Advantage plans be affected?
- How will quality programs be impacted?

Medical Necessity

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- CMS definition:
  - Reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E&M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed.

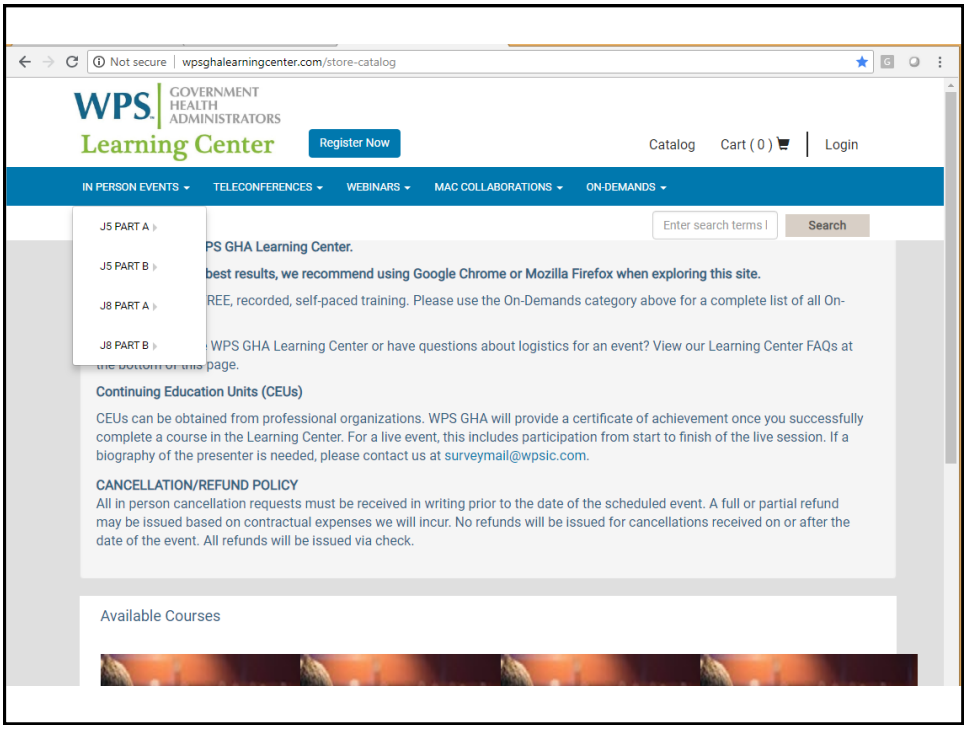
Volume of Documentation

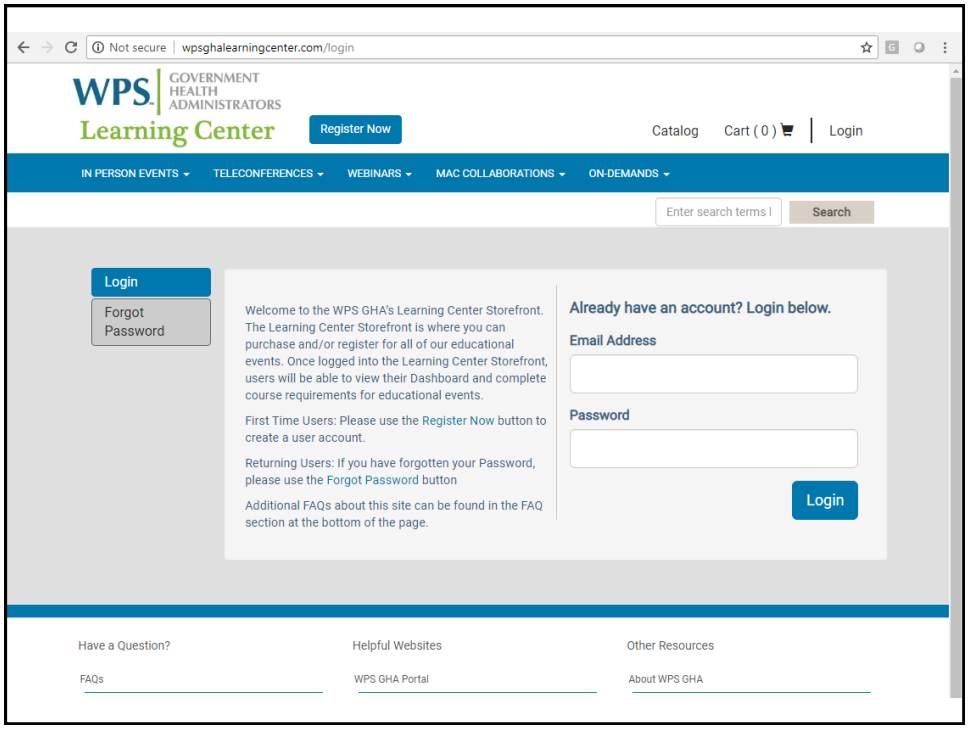
14

- CERT (Comprehensive Error Rate Testing) Report:
  - Billed CPT 99205. Documentation supports code change from 99205 to 99204 with comprehensive history, comprehensive exam and medical decision making (MDM) of moderate complexity.
  - Documentation supports a down code from 99285 to 99284 with a comprehensive history, comprehensive examination and medical decision making of moderate complexity based on the documentation submitted. CERT received an authenticated visit note that does not meet the required 3 of 3 key components (Comprehensive History, Comprehensive Examination, Medical Decision Making of High Complexity) for the level of E/M billed.

You have questions?

Medicare has answers!

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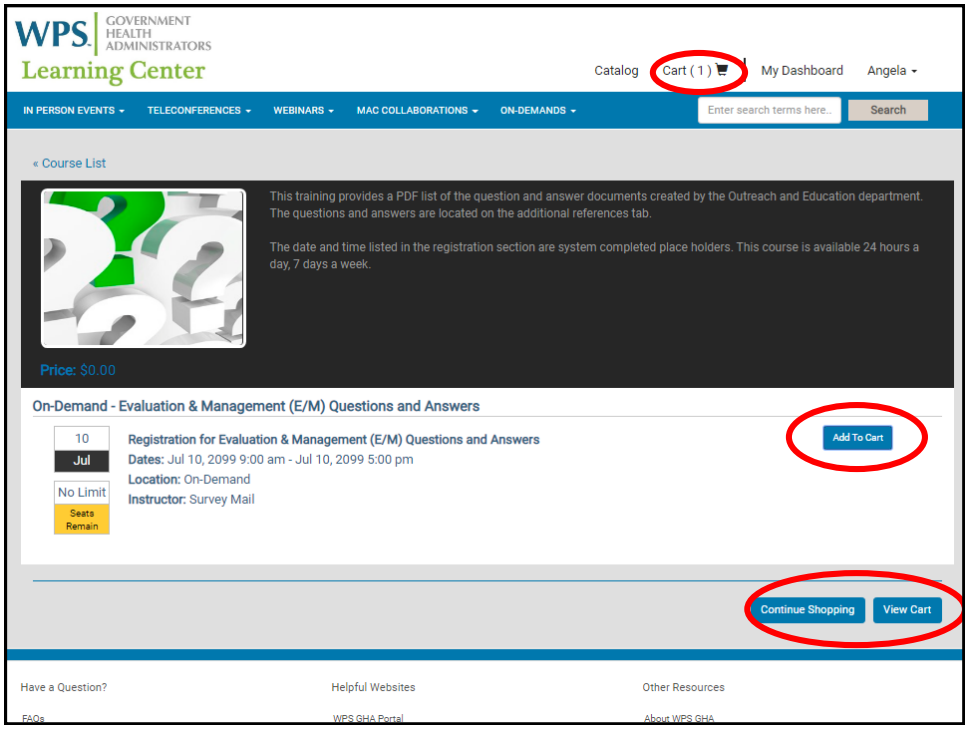
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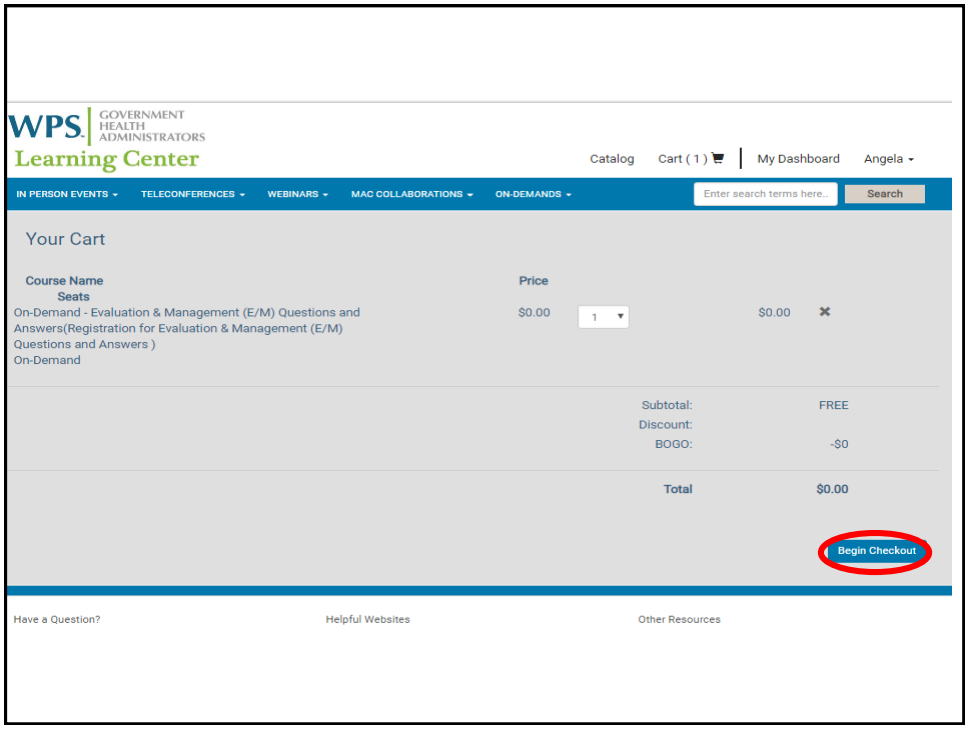
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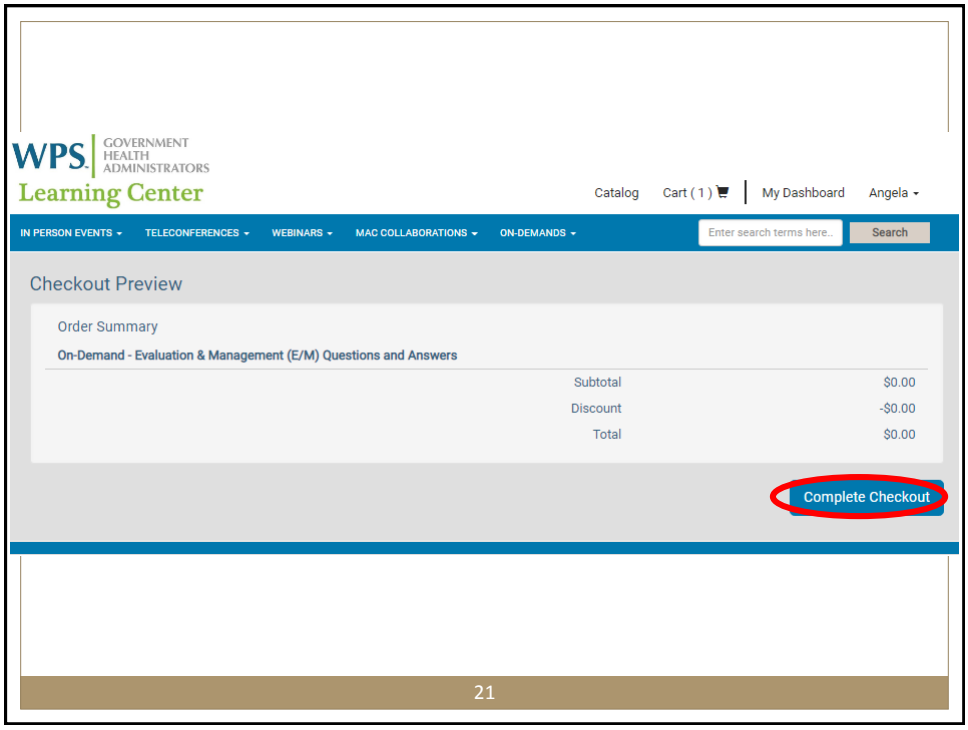
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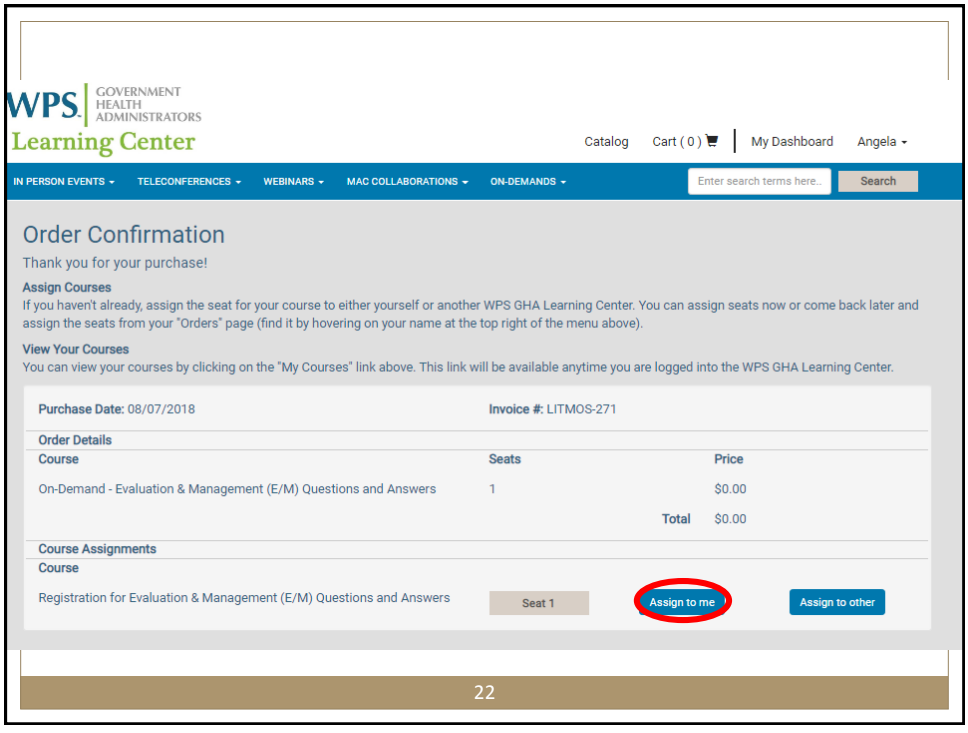
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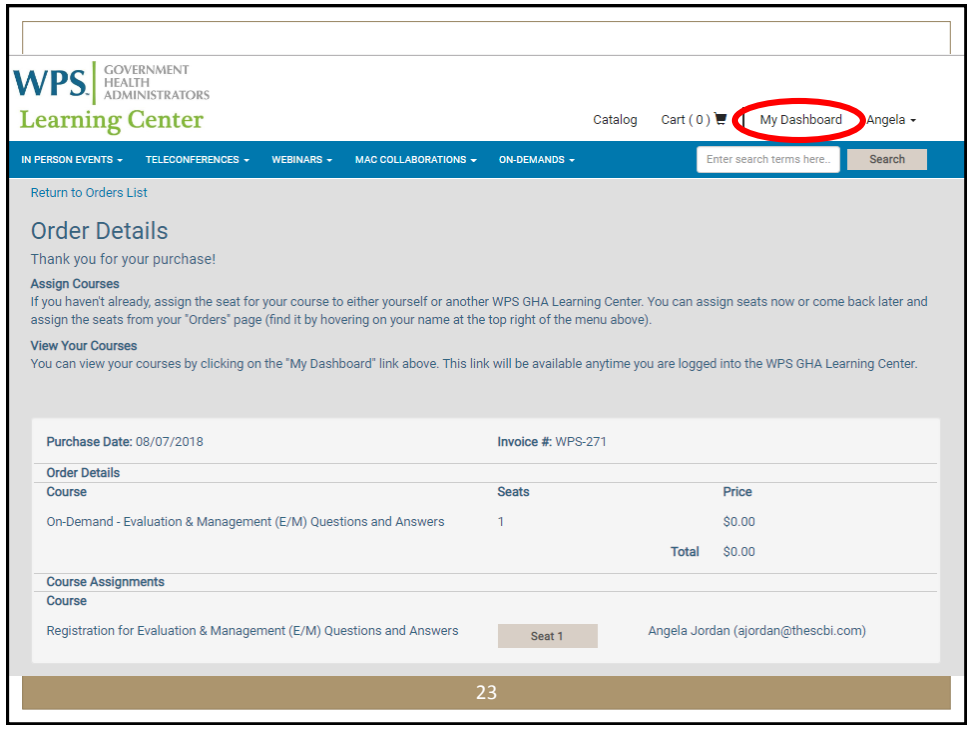
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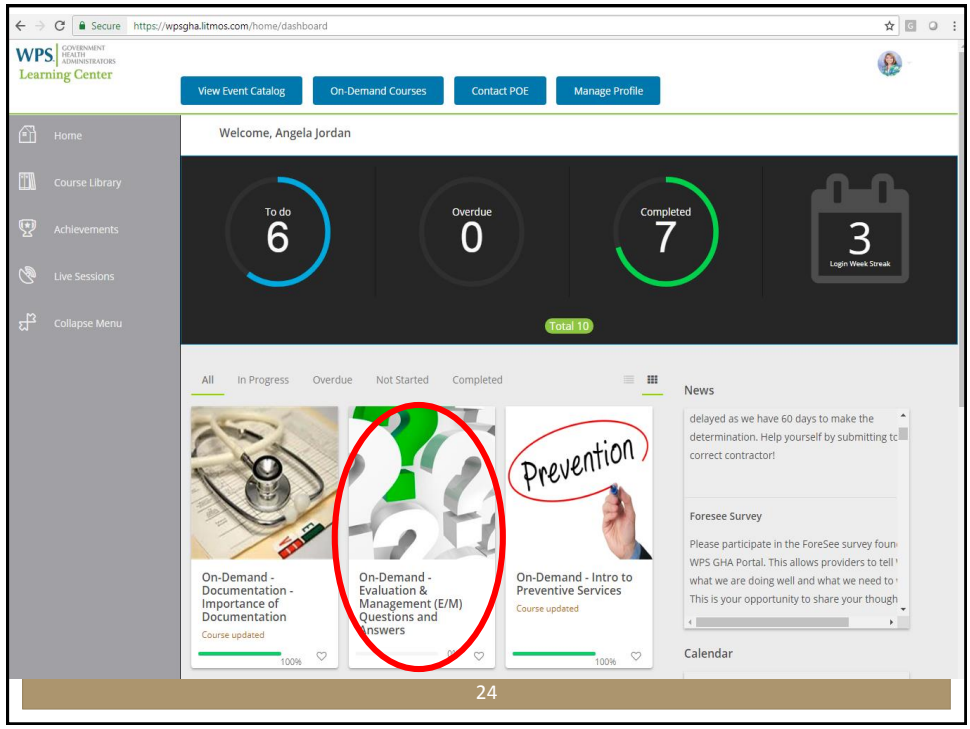
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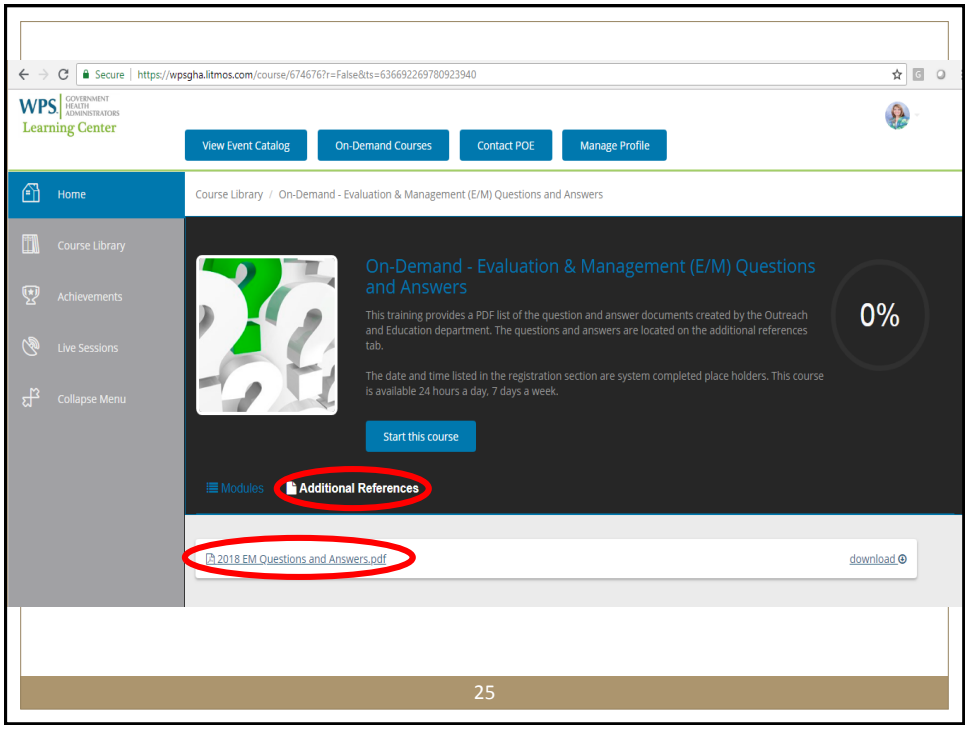
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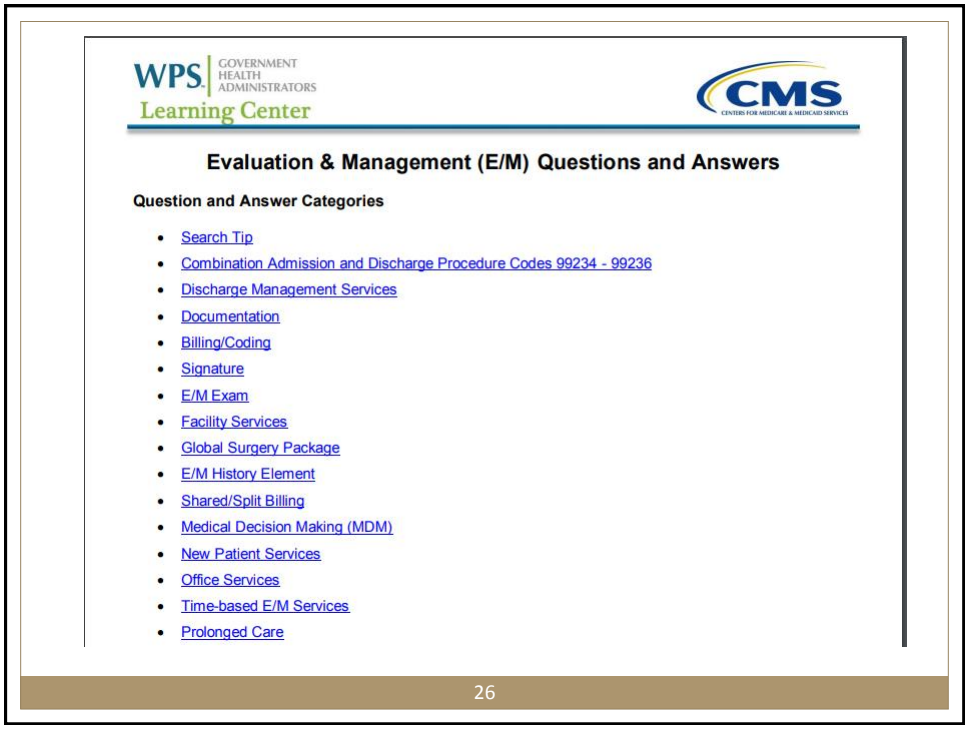
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Medical Decision Making (MDM)
New Patient Services
Office Services
Time-based E/M Services
Prolonged Care
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Evaluation & Management Coding

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- Levels of E & M services are based on 7 components:
  - History*
  - Exam*
  - Medical decision making*
  - Counseling
  - Coordination of care
  - Nature of the presenting problem
  - Time

Black, White and Gray Defined

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- **Black**-clear evidence in writing from an accepted source (CMS, WPS, manuals)
- White-credible evidence from an authoritative source
  - Specialty societies
  - Journals (Healthcare Business Monthly)
  - Coding Clinic, CPT Assistant
  - AMA
- Gray-subject to interpretation/opinion

General Issues

29

- Mixing 1995 and 1997 guidelines
  - **Black**: WPS Q&A "– Providers can only use one of the Documentation Guidelines (DG) for a single patient encounter"
- History documented as "unobtainable
  - White: WPS Q&A – "…document the work performed and code based on the work performed."
    - Document the reason the patient is unable to provide history
    - Document efforts to obtain history from other sources.
  - **Black**: Q&A Novitas – If attempts were made to obtain the history from other sources, a comprehensive history level may be credited

General Issues

30

- MDM required to be one of the in 2/3 codes
  - **Black**: Q&A WPS – "We cannot find any information that would require the MDM to be one of the two components…"
- New vs established when a preventive visit and problem focused E/M are billed the same day
  - **Black**: Q&A WPS – The preventive visit does not preclude billing a new patient visit for the covered portion of the service if all requirements are met.

General Issues

31

- Use of an element of history or exam in different places
  - **Gray**: WPS Q&A
  - Q: Can an allergy to Penicillin be ROS rather than PHx?
  - A: "No, questions and responses concerning any past allergies and the resulting reactions are part of the PFSH. They are not part of the ROS. If the reason for the visit is an allergy or reaction, this could be part of the ROS."
- Does a scribe have to sign the documentation?
  - **Black**: 100-08, Chap 3, 3.3.2.4 - "CMS does not require the scribe to sign/date the documentation."

One of the Key Components for Selecting the Level of E&M Code

32

Evaluation & Management Coding

33

- History
  - Chief complaint
  - History of the present illness
  - Review of systems
  - Past, family, social history

Chief Complaint

34

- Required for all E&M codes
  - **Black**: WPS Q&A"…all E/M services must include the CC."
- Who can document the CC?
  - **Black**: WPS Q&A –
    - "1995 DG and 1997 DG do not address who can record the CC.
    - WPS GHA will allow the CC when recorded by ancillary staff."
- "Follow-up" and "Establish care" are not a CC
  - **Opinion**: Patti Frank

Chief Complaint

35

- Can CC elements be counted for both the CC and HPI?
  - **Black**: WPS Q&A – "According to the 1995 DG and 1997 DG, "The CC, ROS, and PFSH may be listed as separate elements of history or they may be included in the description of the history of present illness."

Elements of HPI

36

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

(Mnemonics: OLD CARTS; Socrates; LIQOR AAA)

History of Present Illness

37

- Who can perform the HPI
  - **Black**: WPS Q&A – "Only the physician or non-physician practitioner can perform the HPI."
- Can location be inferred for diseases such as diabetes, hypertension, depression
  - **Black**: WPS Q&A – "A provider may not infer a location. The location element of the HPI would be a definitive location on the patient's body.
  - **Opinion**: Patti Frank – Can you point to the location?

History of Present Illness

38

- Use of HPI documented by the nurse
  - **Black**: WPS Q&A – "The physician billing the service must document the HPI."
- Documentation needed when using status of 3 chronic conditions?
  - **Black**: WPS Q&A – "The documentation should not only identify the chronic or inactive conditions but should also show the status. The status would include whether the issue is better, worse, the same etc."

Alternative HPI

39

- Status of 3 chronic conditions in lieu of 4 elements of HPI in 1995 guidelines
  - **Black**: WPS Q&A – "CMS changed the description of history component for the 1995 DG in September 2013. Both the 1995 and the 1997 DG will now allow the use of 4 or more elements of the history of present illness (HPI) or the status of 3 chronic or inactive conditions as part of a comprehensive HPI."
- Pertains only to an extended HPI
- Listed only in the 1997 E&M Documentation Guidelines

Alternative HPI

40

- Must the elements or the chronic conditions have a bearing on the CC for that encounter?
  - **Black**: WPS Q&A – "The elements of the HPI, location, modifying factors, severity etc., would have a direct bearing on the CC. The status of three chronic or inactive conditions would show the condition along with the status such as better, stable, worsening etc. The chronic or inactive conditions may or may not be related to the CC." (This is a WOW!)

History of the Present Illness (HPI)

41

- Gray areas not currently addressed in the guidelines
  - No HPI documented
    - **Opinion**: Patti Frank – If a code with 2/3, use the two remaining key components to select the level of service.
    - **White**: WPS Q&A - "We would expect to see all 3 components documented, although only 2 would be used for coding a subsequent or established patient service."
    - **White**: WPS CERT Report – "Documentation supports an upcode from 99334 to 99335 with No History, an expanded problem-focused examination, and medical decision making of low complexity based on the documentation submitted."

History of the Present Illness (HPI)

42

- Gray areas not currently addressed in the guidelines
  - Counting an element of HPI more than once
    - **Opinion**: Patti Frank – Count the same element for each sign, symptom, condition addressed by the provider
  - Use of 1-2 chronic conditions to fulfill a brief (PF or EPF) HPI (Novitas has 1-2 on their audit tool for Brief HPI)
- Counting the status of a condition being treated by another doctor as HPI
  - **White**: ICD-10 Official Guidelines – "Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management."

EMR Issues With HPI

43

- Vague documentation
  - "There are no aggravating factors. There are no alleviating factors."
  - **Opinion**: Patti Frank – Do not count as HPI. Educate physician
- Authorship: can you tell for sure if provider documented the HPI
  - Nurse's note should be identifiable by signature stamp or labeling as something other than HPI
  - Provider should be required to add significantly to the text copied and pasted

Intake Comments: Bad headache last pm – pounding, back of eyes, stiff neck – lasted about 3 hr. Severe pounding of head and nausea with movement. Took advil sinus which caused more nausea, and took Tylenol. Finally went to bed and sleep. Today only slight headache – pounding with movement of head. Was sick a week ago with fever and headache – only family members ill. Denies cough or other congestion.

Vital Signs
Height: 75 **Weight:** 153
Temperature: 98.3 degrees F (oral)
Pulse rate: 72 **Pulse rhythm:** regular **Respirations:** 20
Blood Pressure: Standard

BP #1: 130/78mm Hg **Cuff Size:** Std
Body Mass Index: 19.19 **New Medication:**
MULTIVITAMINS TABS (MULTIPLE VITAMIN) 1 tablet po daily

Note:
1. Physician copied and pasted nurse intake comments into HPI and added a small amount.
2. Is this enough to use the intake comments in calculation of level of Hx and E&M code?
3. What suggestions would you offer the physician during an audit review of this note?

Signed by: Jane J. Smith, RN August 3, 2010 9:41 AM

****

History of Present Illness
History from: patient
Reason for visit: see chief complaint
Chief Complaint: headache
History of Present Illness: Bad headache last pm – pounding, back of eyes, stiff neck – lasted about 3 hr. Severe pounding of head and nausea with movement. Took advil sinus which caused more nausea, and took Tylenol. Finally went to bed and sleep. Today only slight headache – pounding with movement of head. Was sick a week ago with fever and headache – only family members ill. Denies cough or other congestion.
No hx of migraines. Ate last yesterday. Drank little since then. Outdoors and uses bug spray, no mosquito bites known.

Review of Systems

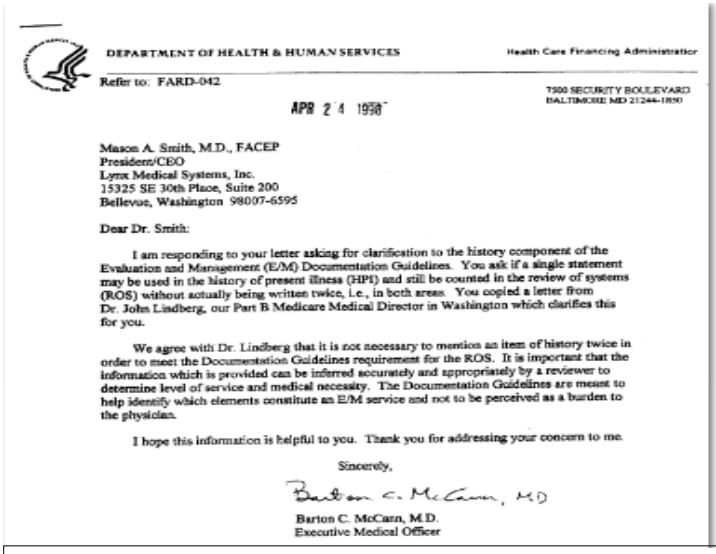
45

- Constitutional
- Eyes
- ENT, Mouth
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/ Lymphatic
- Allergy/Immunologic

Review of Systems (ROS)

46

- Use of a single statement to fulfill the requirement for both ROS and HPI (double-dipping)
  - White: WPS Q&A – "…WPS GHA, in rare circumstances, could accept counting one statement in both areas if appropriate."
  - White: HHS Executive Medical Officer, HHS. See next slide.
  - **Black**: Q&A Novitas – "…it is not considered "double dipping" to use the system(s) addressed in the HPI for ROS credit."



DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

Refer to: FARD-042

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

APR 2 4 1998

Mason A. Smith, M.D., FACEP
President/CEO
Lynx Medical Systems, Inc.
15325 SE 30th Place, Suite 200
Bellevue, Washington 98007-6595

Dear Dr. Smith:

I am responding to your letter asking for clarification to the history component of the Evaluation and Management (E/M) Documentation Guidelines. You ask if a single statement may be used in the history of present illness (HPI) and still be counted in the review of systems (ROS) without actually being written twice, i.e., in both areas. You copied a letter from Dr. John Lindberg, our Part B Medicare Medical Director in Washington which clarifies this for you.

We agree with Dr. Lindberg that it is not necessary to mention an item of history twice in order to meet the Documentation Guidelines requirement for the ROS. It is important that the information which is provided can be inferred accurately and appropriately by a reviewer to determine level of service and medical necessity. The Documentation Guidelines are meant to help identify which elements constitute an E/M service and not to be perceived as a burden to the physician.

I hope this information is helpful to you. Thank you for addressing your concern to me.

Sincerely,

Barton C. McCann, M.D.
Executive Medical Officer

"You ask if a single statement may be used in the history of present illness (HPI) and still be counted in the review of systems (ROS) without actually being written twice, i.e., in both areas.

…it is not necessary to mention an item of history twice in order to meet the Documentation Guidelines requirement for the ROS." Barton C. McCann, MD
Executive Medical Officer

Review of Systems (ROS)

48

- Documentation of "all other systems negative"
  - **Black**: "DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible."
  - **Black: "**10-Pt ROS negative" alone is unacceptable
- Use of "see HPI"
  - No credible evidence found
  - **Gray: Opinion**: Patti Frank – Yes. Best practice would be to name the systems to be found in the HPI. I suggest creating an E/M policy for your entity to address these gray areas.

EMR Issues With ROS

49

- ROS not relevant to the CC
  - 1995 and 1997 DG: A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.
  - WPS Q&A: A PHx would not contain a patient's pertinent positive and/or negative response as related to the problems identified in the patient's HPI. (h/o DM, h/o HTN, h/o COPD)

EMR Issues With ROS

50

- ROS not relevant to the CC
  - Example - CC: The patient is a 39 year old female referred for evaluation of sinus congestion and facial pain. ROS: Pt denies breast lumps or tenderness, urgency, frequency, dysuria, rash, itching, pigmentation changes, muscular weakness, seizures, cold intolerance, heat intolerance, anxiety, depression, easy bleeding, easy bruising.

EMR Issues With ROS

51

- Overdocumentation
- Charting by exception
  - Example - CC: Pt c/o headache. ROS Neurological: No numbness, tingling, headache, dizziness
- Contradictory documentation
  - Example - Female pt. "…patient denies impotence trouble, discharge from the penis…"

Past, Family, Social History (PFSH)

52

- Documentation of "FH unremarkable"
  - **Black**: Palmetto GBA – "No, because the statement 'noncontributory, unremarkable or negative' does not indicate what was addressed."
  - **Black**: Q&A Novitas – "The term 'noncontributory' may also be appropriate documentation when referring to a patient's family history during an E/M visit, if the family history is not pertinent to the presenting problem."
  - WPS is silent on this

EMR Issues With PFSH

53

- Location of the ROS and PFSH mentioned in a note
  - **White**: Q&A, WPS – "When responding to a request for documentation from WPS GHA or other entity, you would need to supply documentation to support the service billed, including any previously recorded information. You will need to know where the previous information is stored."
  - Is the EMR a "living history"

EMR Issues With PFSH

54

- Location of previously documented ROS and PFSH
  - **Black**: 1995/7 DGs state:
    - DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:
      - Describing any new ROS and/or PFSH information or noting there has been no change in the information; and
      - Noting the date and location of the earlier ROS and/or PFSH

EMR Issues With PFSH

55

- Verification of information recorded by others
  - **Black**: 1995/7 Documentation Guidelines state:
    - DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
      - Document on the DOS encounter note?
      - Document on the document where the information is recorded?
      - If not referenced, count or do not count?

EMR Issues With PFSH

56

- Material in the EMR not referenced in the note
  - Can they be counted toward the level of E/M service
  - Examples: growth charts, medical history questionnaire, PFSH, medication listings, allergies, xrays, diagnostic studies, lab
  - **Black**: Q&A WPS – "If the physician were not referencing previous material in the EMR, then the information would not be used in choosing the level of E/M service. The physician would document any previous information he/she reviewed for today's encounter."
- Material in the EMR but not documented as reviewed
  - Information (lab, imaging) pulled in by the template

EMR Issues With PFSH

57

- From where in the encounter documentation can a physician or coder pull information?
  - Medicare Advantage plans
  - White: Q&A WPS:
    - **Q**: If the past medical section states a chronic or current illness (that the physician is not treating), can it be used in the ROS? If the past medical section lists several conditions and there is no mention of controlled or uncontrolled, could this be used in the ROS?
      - Can PMH be used in the assessment and plan (A/P)?
      - Added by a coder?
      - Examples: pacemaker, DM2 insulin use, ostomy, joint replacement, warfarin, CKD stage

EMR Issues With PFSH

58

- White: Q&A WPS:
  - **A**: No, per both the 1995 DG and 1997 DG, "A Review of Systems is an inventory of body systems obtained through a series of questions seeking to identify signs or symptoms that the patient may be experiencing or has experienced." A past medical history would not contain a patient's pertinent positive and/or negative response as related to the problems identified in the patient's history of the present illness.
- "History of" is sometimes used by specialists as ROS

Example of Irrelevant PFSH

59

FAMILY HISTORY:
Father Alive & well
Mother Alive & well
Siblings 5 siblings, alive & well

SOCIAL HISTORY:
Occupation: Teacher
Smoke Detector: Yes
Seat Belts: Yes

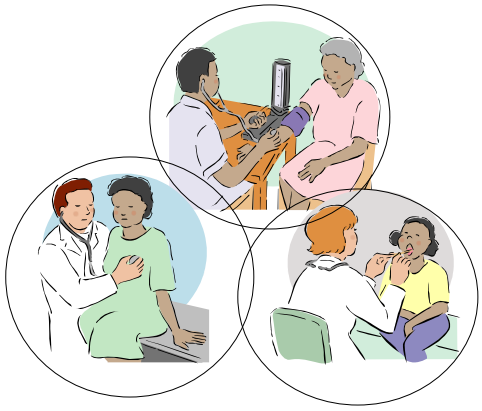
Living Situation: lives alone

Assessment
Status of Existing Problems:
Assessed TOBACCO ABUSE as improved – John Doe, MD
Assessed BRONCHITIS, ACUTE as deteriorated – John Doe, MD

New Problems:
BACK PAIN, THORACIC REGION (ICD – 724.1)

Physical Exam

60



1995 Exam

61

Organ Systems	Organ Systems
• Constitutional • Eyes • Ears, nose, mouth and throat • Cardiovascular • Respiratory • Gastrointestinal • Genitourinary	• Musculoskeletal • Skin • Neurologic • Psychiatric • Hematologic/lymphatic/immunologic

1995 Exam

62

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

1995 Exam

63

LEVEL OF EXAM	PERFORM AND DOCUMENT
Problem Focused	Limited exam of affected body area or organ system
Expanded Problem Focused	Limited exam of affected body area or organ system and other symptomatic or related organ system(s)
Detailed	Extended exam of the affected body area(s) and other symptomatic or related organ system(s)
Comprehensive	A general multi-system exam (≥8 organ systems) **OR** complete exam of a single organ system

1995 Exam Scoring

64

LEVEL OF EXAM	BODY AREAS/ORGAN SYSTEMS
Problem Focused	1
Expanded Problem Focused	2-7
Detailed	2-7
Comprehensive	≥8 Organ Systems

1997 Exam

65

General Multisystem Exam	General Multisystem Exam
• Constitutional • Eyes • Ears, Nose, Mouth Throat • Neck • Respiratory • Cardiovascular • Chest (Breasts) • Neurologic	• Gastrointestinal (Abdomen) • Genitourinary – Male • Genitourinary – female • Lymphatic • Skin • Musculoskeletal • Psychiatric

1997 Exam Scoring

66

LEVEL OF EXAM	NUMBER OF BULLETS
Problem Focused	1 – 5
Expanded Problem Focused	6 – 11
Detailed	12 – 17 At least 2 bullets from each of 6 body areas/organ systems OR 12 bullets in 2 or more areas or systems
Comprehensive	≥18 At least 2 bullets in at least 9 body areas/organ systems

1997 Specialty Exams

67

- Can be used by any specialty
- Number of bullets needed for a given level of exam differs slightly depending on the exam
- Comprehensive exam:
  - "Perform all elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border."
  - Some physicians refuse to use 1997 guidelines because they think they are accountable for performing every bulleted element.

1997 Specialty Exams

68

- Single organ system exams
  - Cardiovascular
  - Ears, Nose, Mouth and Throat
  - Eyes
  - Genitourinary (Female)
  - Genitourinary (Male)
  - Hematologic/Lymphatic/Immunologic
  - Musculoskeletal
  - Neurological
  - Psychiatric
  - Respiratory
  - Skin

Documenting Physical Exam

69

- 1995: Count only organ systems or body areas too?
  - *DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented.*
  - *DG: The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.*

Documenting Physical Exam

70

- 1995: Count only organ systems or body areas too?
  - **Black**: Q&A Novitas – "You may count up to 7 body areas or 7 organ systems for an expanded problem focused or detailed examination and you may count 8 body areas or 8 organ systems for a comprehensive examination. However, you may not add body areas and organ systems together to determine the level of the examination."
- 1995: Count each extremity as one body area examined?
  - Some audit software count each. Know your software!

Documenting Physical Exam

71

- For credit in "Constitutional" does the physician need to reference the vital signs in the note?
  - **Black**: Q&A WPS - Yes, the vital signs need to be referenced. If the MA wrote them in the flow chart, it would not be apparent the physician reviewed the information unless the physician referenced them or re-dictated them in his/her note.
- 1995: Do vitals count as exam if only one other body area or organ system is documented? (E.g., skin, VS)
  - No evidence found that addresses this topic.
  - **Gray**: Patti Frank-When I audit, no!

Documenting Physical Exam

72

- 1997: Is it acceptable to add bullets to those listed?
  - 1997 DG – "It is possible for a given examination to be expanded beyond what is defined here. When that occurs, findings related to the additional systems and/or areas should be documented."

EMR Issues With Exam

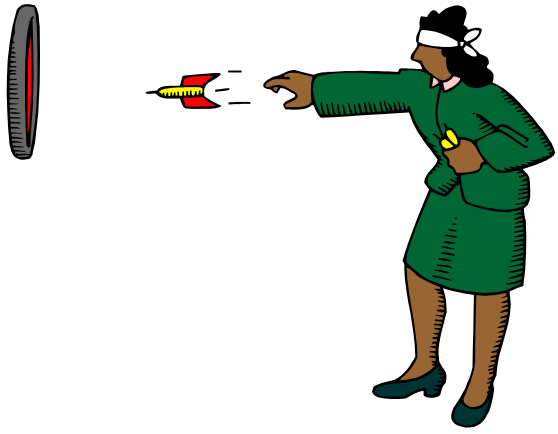
73

- HEENT is hard to count but is often a check box on an EMR
- Overdocumentation
- Exam is not relevant to CC
- Cloning: physicians document the exact same exam on all patients regardless of CC
- Contradictory information

Examples of EMR Issues With Exam

74

- Exam: No m/c/g. Pt has a 2/6 holosystolic murmur at the tricuspid and mitral area
- Vitals: HR 130. Exam CV: RRR, no m/c/g, normal S1 and S2
- Exam Neck: no JVD, no carotid bruits, no LAD
  - JVD: CV or neck?
  - Carotid bruits: CV or neck?
  - LAD: neck or lymphatic?
- Exam: No CCE
  - CV or CV (edema) and musculoskeletal (cyanosis and clubbing)



Medical Decision Making

75

Medical Decision Making

76

- Medical decision making depends on three things:
  - Number of diagnoses and/or management options considered
  - Data reviewed
  - Risk of complications, morbidity and/or mortality

Scoring Diagnoses/Management Options

77

#DIAGNOSES OR TREATMENT OPTIONS		# x Pts=Result		
Self-Limited or Minor	max 2		1	
Established problem; stable, improved			1	
Established problem; worsening			2	
New problem; no add'l workup	max 1		3	
New problem; add'l workup planned			4	

Data Reviewed

78

Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records	1
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	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2

	RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY		
	Presenting Problem	**Diagnostic Procedures**	**Management Options**
Minimal	•One self-limited or minor Problem, e.g., cold, insect bite, tinea corporis	•Laboratory tests requiring venipuncture •Chest X-ray •EKG/EEG •Urinalysis •Ultrasound, e.g. echo •KOH prep	•Rest •Gargle •Elastic bandage •Superficial dressings
Low	•Two or more self-limited or minor problems •One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH •Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	•Physiologic tests not under stress, e.g., pulmonary function tests •Non-cardiovascular imaging studies with contrast, e.g., barium enema •Superficial needle biopsies •Lab tests requiring arterial puncture •Skin biopsies	•Over-the-counter drugs •Minor surgery with no identified risk factors •Physical therapy •Occupational therapy •IV fluids w/o additives
Moderate	•One or more chronic illnesses w. mild exacerbation, progression or side effects of treatment Two or more stable chronic illnesses •Undiagnosed new problem with uncertain prognosis, lump in breast •Acute illness w. systemic Symptoms, e.g., pyelonephritis, pneumonitis, colitis •Acute complicated injury, e.g., head injury with brief LOC	•Physiologic test under stress, e.g., cardiac stress test, fetal contraction stress test •Diagnostic endoscopies with no identified risk factors •Deep needle or incisional biopsy •Cardiovascular imaging studies w. contrast & no identified risk factors, e.g., arteriogram •Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis	•Minor surgery with identified risk factors •Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors •Prescription drug mgmt •Therapeutic nuclear medicine •IV fluids w. additives •Closed treatment of fracture or dislocation w/o manipulation
High	•One or more chronic illnesses w. severe exacerbation, progression or side effects of treatment •Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus •An abrupt change in neuro-logical status, e.g., seizure, TIA	•Cardiovascular imaging studies w. contrast w. identified risk factors •Cardiac electrophysiological tests •Diagnostic endoscopy with identified risk factors •Discography	•Elective major surgery (open, percutaneous, endoscopic) w. identified risk factors •Emergency major surgery (open, percutanous, endoscopic) •Parenteral controlled substances •Drug therapy requiring intensive monitoring for toxicity •Decision not to resuscitate or de-escalate care because of poor prognosis
The highest level of risk in any one category determines the overall risk.			

Medical Decision Making Selection Table

80

	Straight Forward	Low Complexity	Moderate Complexity	High Complexity
Dx/Mx Options	1	2	3	4
Data	1	2	3	4
Risk	1	2	3	4
2 out of 3 required				

Medical Decision Making

81

- MDM is based on the assessment and plan in the note. What should be in a plan?
  - **Gray**: Q&A WPS – "A plan of care identifies the clinical decisions made by the practitioner to treat the patient's condition. The documentation could include the patient's diagnosis, the long-term treatment goals, the type, amount, duration, and frequency of services, and any medications and/or test ordered. The physician establishes the plan prior to treatment and adjusts as needed for changes in the patient's condition."

Medical Decision Making

82

- What is additional work-up?
  - **White**: Q&A Novitas – "Additional workup is anything done beyond that encounter at that time. For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision-making."
  - Possibilities: consultations, admits, emergency room

Medical Decision Making

83

- Defining a problem as self-limiting/minor problem versus a new problem with no additional workup
  - "The 1995 DG and 1997 DG have a table the provider can use in determining the level of MDM. There is no specific "new problem" category." (WPS MDM Q6)
  - "The 1995 DG and 1997 DG…..do not address a new problem with no additional work up planned. Therefore, you can use the examples provided in the DGs to determine the level of the presenting problem." (WPS MDM Q2)
  - In other words: Use the risk table

Medical Decision Making

84

- Counting a disease and symptoms of the disease when both are documented in the Assessment/Plan?
  - **Q**: The patient has Parkinson's and the doctor addresses the impaired gait, reduced appetite and language problems. In MDM, are these considered separate "number of diagnosis or management options" or are they simply considered part of the Parkinson's diagnosis?
  - **A**: These items would be part of the Parkinson's diagnosis and you would not use these separately in choosing your level of MDM.

Medical Decision Making

85

- New problem to the examiner
  - Q: The patient sees Doctor A in 2015 for left knee pain. The patient comes back and sees Doctor B (a member of the same group with the same specialty) for left knee pain in 2017. Is this a new problem to Doctor B?
  - **Black**: Q&A WPS - For purposes of the MDM for the E/M service, the left knee pain is a new problem to both physicians. While the problem is new to the second physician, the patient is not.

Medical Decision Making

86

- Counting a resolved condition
  - Some audit software counts the condition as low in the risk table.
  - No credible evidence was found on this question.
- Can the physician carry forward a chronic problem in his/her documentation for an inpatient visit?
  - **Black**: Q&A WPS – "The documentation for the subsequent inpatient visit must include the documentation to support the service just like any other E/M service. The physician would document the CC, HPI and ROS."

Medical Decision Making

87

- Prescription drug management
  - White: Q&A WPS – "A new prescription is not required for this level. The medical record documentation must show you are managing the patient's prescription medications. This could include writing a new prescription, discontinuing a prescription, changing a dosage, or keep everything the same. Documentation would show you are evaluating any current prescriptions, including determining whether the drug, dosage, and frequency are still appropriate for the patient's condition."

Medical Decision Making

88

- High risk medication and intensive monitoring
  - Gray: Q&A WPS – "Intensive monitoring for toxicity is evaluating the possible harmful effects of a toxin or poison prescribed for or used on the patient. The most common example is chemotherapy drugs, although it is not exclusive. The documentation would show the intensive monitoring and why."
  - See table provided by WPSGHA

Drugs Requiring Intensive Monitoring		
Drug Category	**Drugs in that Category**	**Treatment Use**
Cardiac	Digoxin, Digitoxin, Quinidine, Procainamide, Amiodarone	Congestive heart failure, angina, arrhythmias
Anticoagulants	Coumadin, and intravenous Heparin drip (Heparin must be provided in the hospital setting)	Prevention of thrombosis and thromboembolisms
Antiepileptic	Phenobarbital, Phenytoin, Valproic Acid, Carbamazepine, Ethosuximide, sometimes Gabapentin, Lamotrigine	Epilepsy, prevention of seizures, sometimes to stabilize moods
Bronchodilators	Theophylline, Caffeine	Asthma, chronic obstructive pulmonary disorder (COPD), neonatal apnea
Immunosuppressant	Cyclosporine, Tacrolimus, Sirolimus, Mycophenolate Mofetil, Azathioprine	Prevent rejection of transplanted organs, autoimmune disorders
Anti-Cancer	All Cytotoxic agents	Multiple malignancies
Psychiatric	Lithium, Valproic Acid, some antidepressants (Imipramine, Amitriptyline, Nortriptyline, Doxepin, Desipramine)	Bipolar disorder (manic depression), depression
Protease Inhibitors	Indinavir, Ritonavir, Lopinavir, Saquinavir, Atazanavir, Nelfinavir	HIV/AIDS
Antibiotics	Aminoglycosides (Gentamicin, Tobramycin, Amikacin), Vancomycin, Chloramphenicol, Cubicin, Zyvox	Infections with bacteria that are resistant to less toxic antibiotics
Insulin/Anti-Diabetic	Intravenous Insulin Drip	Hyperglycemia
Erythropoiesis-Stimulating Agents (ESA)	Procrit and Epogen (Epoetin Alfa) and Aranesp (Darbepoetin Alfa)	Anemia

Medical Decision Making

90

- What is the difference between review of a report and independent visualization?
  - **Black**: Q&A Novitas - Two points may be given in the Amount and/or Complexity of Data Reviewed when a practitioner independently visualizes an image, tracing or specimen previously or subsequently interpreted by another physician. The medical record documentation must clearly indicate that the physician/qualified NPP personally (independently) visualized and performed the interpretation of the image; tracing or specimen. Credit will not be given if the documentation reveals the practitioner only read/reviewed a report from another physician/qualified NPP.

    If the same practitioner performing the E/M service is also billing separately for the professional component of a test in the radiology and/or medicine section of the CPT, two points should not be credited for independent visualization the same image, tracing or specimen.
  - **Black**: Q&A WPS – "[The review] is part of the amount and complexity of data reviewed. Your physician cannot submit a claim for the professional component of the radiology procedure since he/she is not providing the interpretation and report. However, your physician can document his/her review of the data. He/she would also document how the data affects the patient's possible treatment.
  - **Black**: Q&A Novitas - If the provider performs and bills 93000 (professional and technical component), he cannot take credit for it again in the E/M.

Medical Decision Making

91

- In data, what is meant by "obtaining history from someone other than the patient?"
  - Do you get 2 points for using an interpreter?
  - Parent of infant or child
  - Family member in attendance at encounter
  - Nursing home staff, PCP or ED doctor
- Counting in data if the patient refuses or fails to get the recommended service
  - **Gray**: 1995 and 1997 DG – "If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray, should be documented."

Medical Decision Making

92

- Labs or imaging reviewed but none ordered
  - Black: Q&A Novitas - You can get credit in this section when the test (clinical lab test, test in the radiology section of the CPT, or test in the medicine section of the CPT) is documented as reviewed and/or ordered, and the service is medically indicated.

Patti Frank, CPC
Consultants in Practice Management
Lenexa, Kansas
913-541-0496
pfrank@kc.rr.com