Evaluation and Management Coding and Documentation

Evaluation and management (E/M) encounters remain the most challenging coding areas for physicians and coders alike. If your coding patterns make you an outlier in your specialty and locality, it can be a red flag and may trigger an audit. Therefore, it is imperative that physicians master E/M coding and the documentation needed to support their code selections. Documentation that supports code selection must be present to prevail in an audit.

LEVEL OF CARE CODING KEY COMPONENTS

CPT Code	Presenting problem	Patient history	Examination	Medical decision-making
99201	is self-limited or minor; the physician typically spends 10 minutes face-to-face with the patient and/or family	problem focused	problem focused	straightforward
99202	low to moderate severity; the physician typically spends 20 minutes face-to-face with the patient and/or family	expanded problem focused	expanded problem focused	straightforward
99203	moderate severity; the physician typically spends 30 minutes face-to-face with the patient and/or family	detailed	detailed	low complexity
99204	moderate to high severity; the physician typically spends 45 minutes face-to-face with the patient and/or family	comprehensive	comprehensive	moderate complexity
99205	moderate to high severity; the physician typically spends 60 minutes face-to-face with the patient and/or family	comprehensive	comprehensive	high complexity

Source: Centers for Medicare and Medicaid Services

First, one must decide whether to follow the 1995 or 1997 E/M guidelines (you cannot use both in the same encounter). Many feel the 1997 guidelines are easier to follow and when adhered to, leave less room for an auditor to dispute in an audit as they are less subjective. Regardless of which guideline is chosen, there are standards and recommendations common to both.

There are three key components in E/M coding: History, Exam, and Medical Decision Making (MDM) (code selection can also be based on time alone as discussed below). While the History and Exam are more objective measures, MDM is subjective, but can be quantified using tools and charts developed by various sources. AAFP's Family Practice Management (FPM) journal has written a series of articles that go into detail and provide tools for these key components.

History: http://www.aafp.org/fpm/2010/0300/p22.html
Exam: http://www.aafp.org/fpm/2010/0500/p24.html
MDM: http://www.aafp.org/fpm/2010/0700/p10.html
Time: http://www.aafp.org/fpm/2008/1100/p17.html
FPM 1997 E/M Coding Tool:
https://www.hcms.org/TMAIMIS/HARRIS/assets/PRACTICE_RESOURCES/Tools-Resources/FPM_EvalMgmtCodingTool.pdf

For established patient encounters, only two of the three key components are required, however, it is best to include MDM as one of the two components in code selection. MDM is often viewed by auditors as the driving force in code selection. Merely checking off boxes to meet the numbers in the Exam and History sections aren't enough to demonstrate the code selected was justified. Also, the services performed must be medically necessary. Performing a complete history and comprehensive exam to get to a higher code for an encounter to remove a splinter is not medically necessary.

"If you didn't document it, you didn't do it". This is the prevailing principle held by coders, auditors, and payers whom often use a scoring process to determine if the evaluation and management (E/M) level of service billed (99201-99215) is supported by the documentation. Each element of the E/M service -- History, Exam, and Medical Decision-Making (MDM), has requirements that are needed to meet a given level of service. Complete, accurate, and detailed documentation is imperative. Always provide enough detail in the documentation to describe all elements of the visit necessary to justify your code selection, much like a SOAP note format. Documentation must support the code selected and it must be of sufficient detail to justify your coding to a third party. Conduct external audits annually, or more frequently if needed, to ensure that your documentation supports your coding. These audits can be an opportunity to improve your coding skills, operations, revenue, and help you avoid, or prevail in, a RAC audit.

Many physicians down-code when uncertain what code to use. However, down-coding has the same consequences as up-coding in an audit. Further, it has an adverse effect on practice revenue. A 2012 study conducted by the American Academy of Professional Coders (AAPC) found that out of 60,000 billing audits, more than a third of the records were down-coded, representing an average of $64,000 in lost annual revenue per physician.

History

Documenting the History

The History has 4 levels of complexity and is comprised of 4 elements. You may list the CC, ROS, and PFSH as separate elements of history or you may include them in the description of the HPI. To qualify for a given type of history, all four elements indicated in the row must be met. Failure to adequately document these elements to support the use of a given E/M code is considered up-coding and may result in reduced payment or denied claims. A pattern of up-coding could expose the practice to recoupments and lead to audits.

Elements Required for Each Type of History

TYPE OF HISTORY	CC	HPI	ROS	PFSH
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

- **Chief Complaint (CC):** Documentation of the specific presenting problem is crucial to establish medical necessity for the visit and must be specific. "Patient here for follow up" is an invalid chief complaint. For a follow-up, documentation must include the "status" of the condition (improving, worsening, new symptoms, stable, etc.). As of 1/1/2019 the CC may be completed by ancillary staff if the physician documents they reviewed and agree with the information.

- **History of Present Illness (HPI):** Documentation is required of the chronological account of the patient's present illness from the first sign/symptom, or from the previous encounter to the present. Elements include location, severity, duration, etc. There are two types of HPIs:
  - Brief – (99201-99202, 99212-99213) One to three HPI elements.
  - Extended – (99203-99205, 99214-99215) Four or more elements, or for the 1997 guidelines documentation of the status of at least three chronic or inactive conditions can be used. Example: "Patient is here for intermittent (timing) knee (location) pain lasting 2 weeks (duration). She states it is a dull ache (quality) type pain, that increases when she runs or stands for a long period of time (modifying factor).

- **Review of Systems (ROS):** This is an inventory to assist in identifying signs/symptoms *related to the condition* in the HPI and CC. Do not "double-dip" and count systems already discussed in the HPI for scoring. Also "all others negative" does not count towards the final score. The "others" should be specifically stated. Do not review additional systems in an effort to reach a higher level code as the systems reviewed must be medically necessary and related to the problem. There are three types of ROS:
  - Problem pertinent - (99201-99202, 99213) Inquires about the system directly related to the HPI.
  - Extended – (99203, 99214) Inquires about the system directly related to the HPI and a limited number (two to nine) of additional systems.
  - Complete – (99204-99205, 99215) Inquires about the system directly related to the HPI plus additional systems (minimum of ten). Individually document these systems with positive or *pertinent* negative responses.

- **Past Family/Social History (PFSH):**
    - Past history refers to prior major illnesses, injuries, operations, hospitalizations, *current* medications, allergies, and age-appropriate immunization and feeding/dietary status.

    - Family history is a list of conditions, diseases, causes of death, etc. of blood relatives that may be hereditary or put the patient at risk. If it is unknown, document such and state the reason why.

    - Social history is an age appropriate review of past and current activities that includes significant information about marital status/living arrangements, current employment, occupational and military history, drug, alcohol, and tobacco use, level of education, sexual history, and other *relevant* social factors.

  There are two types of PFSH:
    - Pertinent – (99203, 99214) Documentation of at least one item from any of the three history areas directly related to the problem identified in the HPI.
    - Complete – (99204-99205, 99215) Documentation of all three history areas for new patients, and two areas for established patients.

There is no need to re-record a ROS and/or a PFSH obtained during an earlier encounter if the physician documents the information was reviewed and updates the previous information by describing any new ROS and/or PFSH information or noting there is no change in the information, or noting the date and location of the earlier ROS and/or PFSH. Also ancillary staff may record the ROS and/or PFSH if the physician documents they have reviewed the information.

While documentation of the CC is required for all levels, the extent of information gathered for the remaining elements of History depends on clinical judgment and the presenting problem.

Exam

Documenting the Exam

The level of service is determined in part by the complexity of the exam performed. There are 2 versions of documentation guidelines-- the 1995 guidelines and the 1997 guidelines. The 1995 requirements are vague as to the exam portion, while the 1997 version is less subjective as there are specific measures. Thus, it is easier to defend a level of service denial using the 1997 guidelines. You may use either version of the documentation guidelines for a patient encounter, not a combination of the two with one exception-- if you prefer the 1995 guidelines, you may use the 1997 guidelines for an extended HPI along with other elements from the 1995 guidelines.

We'll focus on the 1997 guidelines and the required documentation for the four levels of service for the two types of exams-- general multi-system and single system exam.

	Gen'l Multi-System	Single System
Problem Focused (99201, 99212)	1 to 5 elements in one or more organ system(s) or body area(s)	1 to 5 elements
Expanded Problem Focused (99202, 99213)	at least 6 elements in one or more organ system(s) or body area(s)	at least six elements
Detailed (99203, 99214)	at least 12 elements from no less than 2 organ systems or body areas. For each system/area selected, documentation of at least two elements is expected.	at least twelve elements unless the examination is of the eyes or psychiatric, in which case at least nine elements are required.
Comprehensive (99204, 99205, 99215)	at least 18 elements from at least 9 organ systems or body areas. For each area/system, documentation of at least two elements is expected.	* all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected.

* Go to https://go.cms.gov/2y4I6na for each system's elements identified by a bullet.

Go to https://go.cms.gov/2JI8Sao for the elements for each organ system and body area.

It is important to note that you must examine organ systems OR body areas. You cannot examine both and add them together to meet the documentation requirements. Also, elaboration is required for any abnormal findings. For "normal" or "negative" findings, list the areas or systems examined; "all others negative" will not be counted towards the level of service. Do not expect a reviewer to make assumptions or look at the exam in context with the rest of the documentation to determine what transpired. It is imperative that you spell out exactly what was done in order to receive credit for it.

Medical Decision-Making

Documenting Medical Decision-Making

MDM is the key to establishing medical necessity for the encounter. While only two of the three key components (history, exam, and medical decision making) are required for established patient visits, MDM should always be one of the two. There are 4 levels of MDM – straightforward (99212, 99201-99202), low complexity (99213, 99203), moderate complexity (99214, 99204), and high complexity (99215, 99205).

MDM refers to the complexity of the encounter which is determined by considering these 3 factors:

1. Diagnoses and management options
   The number of possible diagnoses and/or management options that must be considered adds to complexity. MDM for a diagnosed problem is easier than for an undiagnosed problem. Problems that are improving or resolving are less complex than those problems that are worsening or failing

to change as expected. For established diagnoses, state if the condition is improved, well controlled, resolving or resolved, inadequately controlled, worsening, or failing to change as expected. For diagnoses not established, document a differential diagnosis or as a possible, probable, or rule out diagnosis.

The need to order tests or seek advice from other health care professionals can also contribute to complexity. Document this need including to whom or where the referral is being made. While noting that you've ordered a lab test can imply something about the diagnoses you're considering, you can't write “ECG and a Chem-21 profile” and expect a reviewer to know what you were thinking. You must be fairly specific. Also document any initiation or change to treatment including instructions given, medications, etc.

2. Data

   This relates to the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed from sources other than the HPI. Document labs, x-rays, etc., and their results, performed by others and reviewed or directly interpreted by you, any relevant findings from old medical records, and information from family/caregivers. Elaboration is key to showing complexity. A notation that labs were reviewed is not sufficient. Document what you found if relevant, and if not state the results were unremarkable. Also document any discussions with other physicians/providers.

3. Risk

   Risk is composed of the presenting problems, diagnostic procedures, and the possible management options and is impacted by the risk of significant complications, morbidity/ mortality comorbidities, diagnostic procedures, and possible management options. These play a major role in determining the level of risk - minimal, low, moderate, or high. The risk of the presenting problems are based on the risk related to the disease process anticipated between the present encounter and the next encounter. Document comorbidities, underlying diseases or other factors that increase the complexity of MDM by increasing the risk of complications, morbidity, or mortality. Also list procedures performed, ordered, planned, or scheduled at the time of the E/M encounter. In addition, any visit that involves a prescription is at least of moderate risk.

   This component of MDM evaluates the overall complexity of care and patient risk. Three categories are represented in the table below: presenting problem, diagnostic procedure(s) ordered and management options. Scoring each of the three categories is unnecessary. Instead, an element from the table that best describes the most complex level of risk can be used. It is most efficient to begin with the column on the right.

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	• One self-limited or minor problem (for example, cold, insect bite, tinea corporis)	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound (for example, echocardiography) • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness (for example, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH) • Acute uncomplicated illness or injury (for example, cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress (for example, pulmonary function tests) • Non-cardiovascular imaging studies with contrast (for example, barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (for example, lump in breast) • Acute illness with systemic symptoms (for example, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (for example, head injury with brief loss of consciousness)	• Physiologic tests under stress (for example, cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors (for example, arteriogram, cardiac catheterization) • Obtain fluid from body cavity (for example, lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function (for example, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) • An abrupt change in neurologic status (for example, seizure, TIA, weakness, sensory loss)	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Use the table below to choose a level from each of the last three columns and drop the lowest of the three. The lower of the remaining two is the MDM level.

TYPE OF DECISION MAKING	NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED	RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

MDM acts to validate the other two key E/M elements (History and Exam). While any two of the three can determine the overall E/M level for an established patient visit, MDM should always be one of the two required elements performed. Further, performing a high-level History or Exam with a minor problem will not establish medical necessity or justify the billing of a high-level E/M code. Also, never expect a reviewer to assume or infer anything. Your documentation should be such that you and a reviewer might reach the same conclusion about the level of decision making your note supports. In order to get credit for your work, you must elaborate, provide details, and be specific in your documentation.

Time

Coding based on time

To code based on time, the physician MUST spend the entire allotted time face-to-face with the patient AND more than HALF of that time must be counseling and coordination of care. Documentation must indicate the total face-to-face time, and the total time spent counseling/coordinating care (greater than 50% of the total face-to-face time). You must also detail the nature of the counseling and the topics discussed in some detail so that the reader/auditor would understand what was discussed with the patient. Example: A total of 15 minutes were spent face-to-face with the patient during this encounter and over half of that time was spent on counseling and coordination of care. We
discussed in depth the importance of primary prevention of coronary disease with aggressive treatment of high cholesterol. I also educated the patient about lifestyle modifications which may improve blood pressure.

Use theses scoring templates for new and established patients at:
https://www.hcms.org/TMAIMIS/HARRIS/assets/PRACTICE_RESOURCES/Tools-Resources/FPM_EvalMgmtCodingTool.pdf.

Other resources:
CMS Evaluation and Management Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

Medicare Program Integrity Manual Chapter 3, section 3.3.2: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03pdf.pdf

1995 Documentation Guidelines: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf

1997 Documentation Guidelines: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf

MGMA Medical Decision Making article: https://www.mgma.com/resources/revenue-cycle/medical-decision-making-what-is-it,-why-is-it-imp

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