# Indian Health Service

# E/M Documentation & Compliance

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# Objectives

Documentation challenges in MDM

- History and Physical Exam
- Problems Addressed
- Data Analyzed
- Risk to Patient Management

Documentation challenges in Time

Avoid risk with effective documentation compliance

Selecting E/M code

Summary

# Medical Decision Making (MDM) – History & Exam

## HISTORY

Clinically relevant history for the patient encounter

Documentation must contain history in order to report 99202-99215

## EXAM

Medically appropriate physical examination for the patient encounter

Eliminate outdated EMR templates and formatting from 1995 and 1997 guidelines for general multi-system and single organ system physical exams

Documentation must contain an exam in order to report 99202-99215

# MDM – History & Exam

## HISTORY

Disconnect early in 2021 for simply not including it based on misunderstanding

Patients Over Paperwork Initiative in 2020 was meant to alleviate administrative burden, and the why behind the 2021 overhaul

Internal audits reflect this

Simply a removal of history and exam as 2 of 3 key components used to select E/M in CPT code definition, not the removal of history completely!

Post-payment audits have stated for 2021

## EXAM

Disconnect early in 2021 for simply not including it based on misunderstanding

Patients Over Paperwork Initiative in 2020 was meant to alleviate administrative burden, and the why behind the 2021 overhaul

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# MDM – Problems Addressed

## STRAIGHTFORWARD

1 self-limited or minor problem
- Example: Cough
- Example: Dermatitis

## LOW

2 or more self-limited or minor problems
- Example: Cough and low fever
- Example: Seborrheic dermatitis (scalp) and atopic dermatitis (eczema)

1 stable chronic illness
- Example: Well-controlled hypertension or diabetes

1 acute, uncomplicated illness or injury
- Example: Simple wrist sprain
- Example: Allergic rhinitis

1 stable, acute illness
- Example: Improving wrist sprain or allergic rhinitis

1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
- Example: Acute dehydration requiring IV fluids to rehydrate

# MDM – Problems Addressed

## MODERATE

1 or more chronic illnesses with exacerbation, progression, or side effects of treatment
- Example: Osteoarthritis with pain
- Example: Hypertension with continued elevated blood pressure

2 or more stable chronic illnesses
- Example: Well-controlled osteoarthritis and hypertension

1 undiagnosed new problem with uncertain prognosis
- Example: Suspicious skin lesion or Breast lump

1 acute illness with systemic symptoms
- Example: Colitis or Pyelonephritis

1 acute, complicated injury
- Head injury with brief loss of consciousness

## HIGH

1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
- Example: Asthma in status asthmaticus
- Example: Hypertensive crisis

1 acute or chronic illness or injury that poses a threat to life or bodily function
- Example: Acute myocardial infarction
- Example: Psychiatric illness with potential threat to others or self

# MDM – Data Analyzed

TESTS, IMAGES, AND DOCUMENTS

CATEGORY 1 – MUST MEET 2 OUT OF 3 FOR LOW MDM

Review of prior external note(s) from each unique source:

- All hospital notes from 1 stay are counted 1x (each note cannot be counted separately)
- Documentation should clearly state the notes are from an external source (i.e., ABC ACS, ABC Hospital, Dr. ABC)

Review of the result(s) of each unique test:

- If practice ordered the labs, cannot count again for reviewing
- Documentation should clearly state number of tests and types (i.e. eliminate vague “labs reviewed”

Ordering each unique test

- Documentation should clearly state number of tests and types (i.e., eliminate vague “labs ordered”)
- Includes tests considered but not executed
- Pulse oximetry is not considered a test for purpose of data ordered, nor is considered a test for purpose of data reviewed/analyzed

# MDM – Data Analyzed

Assessment Requiring Independent Historian

Independent historian can be parent, guardian, surrogate, spouse, witness

- Patient has to be unable to provide a complete or reliable history (e.g., pediatric patient and elderly patient with Parkinson's)
- The independent history does not need to be taken in person but DOES need to be obtained directly from the historian providing the independent information
- Documentation should clearly state: "History provided by mother…";
- Or "Father provided confirmation of…";
- Or "Due to patient's dementia, the daughter provided a complete history…"
- Translators providing translation services are not counted as independent historians

Can meet Low MDM as Category 2 alone

Can meet Moderate MDM with any combination of 3 elements in Category 1

Can meet High MDM, but only if 2 out of 3 Categories are met

# MDM – Data Analyzed

Independent Interpretation of Tests

Used when there is a CPT code for a test where an interpretation or report is customary.

A form of interpretation should be documented but does not have to conform to the usual standards of a complete report.

This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient

“A test is ordered and independently interpreted may count as both a test ordered and interpreted” – March 2023 AMA CPT Errata and Technical Corrections

Can meet Moderate MDM as Category 2 alone

Can meet High MDM as Category 2 alone, in addition to if 2 out of 3 Categories are met

# MDM – Data Analyzed

Discussion of management or test interpretation

Discussion with another physician or QHP or appropriate source

Discussion requires an interactive exchange

- Exchange must be direct (no through clinical staff, trainees, etc.)
- Just sending chart notes or written exchanges in the progress note does not meet criteria for discussion
- Does not have to be on the date of the encounter
- Can only be counted once and only when it is used in the decision-making process for the encounter
- Does not need to be in person
- Must be initiated an completed in a short period of time (within a day or two)

Can meet Moderate MDM as Category 3 alone

Can meet High MDM as Category 3 alone, in addition to if 2 out of 3 Categories are met

# MDM – Risk to Patient Management

One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk – The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration.

- For example, a low probability of death may be high risk, whereas a high change of a minor, self-limited adverse effect of treatment may be low risk.

Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification of these definitions (though quantification may be provided when evidence-based medicine has established probabilities).

For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

# MDM – Risk to Patient Management

Effective documentation includes decisions made at the encounter associated with diagnostic procedure(s) and treatment(s).

Effective documentation includes possible management options selected and those considered but not selected after shared decision making with the patient/family.

Effective documentation includes shared decision-making involving patient/family preferences, patient/family education, and explaining risks and benefits of management options.

# MDM – Risk to Patient Management

## MINIMAL

No examples in MDM Table

- Rest
- Saltwater gargle
- Gauze, bandages
- Superficial dressing (Band-Aids with Neosporin)
- Diet and exercise

## LOW

No examples in MDM Table

- Over the counter medications (eg, Tylenol, Advil)
- X-Rays
- CT/MRI without contrast
- Physical/Occupational therapy
- DME
- Minor surgery with no identified patient or procedure risk factors

# MDM – Risk to Patient Management

## MODERATE

### Examples in MDM Table

- Prescription drug management
- Decision regarding minor surgery with identified patient or procedure risk factors
- Decision regarding elective major surgery without identified patient or procedure risk factors
- Diagnosis or treatment significantly limited by social determinants of health (SDOH)

## HIGH

### Examples in MDM Table

- Drug therapy requiring intensive monitoring for toxicity
- Decision regarding elective major surgery with identified patient or procedure risk factors
- Decision regarding emergency major surgery
- Decision regarding hospitalization or escalation of hospital-level care
- Decision not to resuscitate or to deescalate care because of poor prognosis

# MDM – Risk to Patient Management

Effective documentation includes prescription drugs that are managed at the encounter – increased dose, decreased dose, starting meds, stopping meds

Effective documentation includes eliminating the outdated consolidated drug list

Effective documentation for surgery incudes adding simple improvements like “the procedure poses no significant risk to the patient” and “the procedure is serious and can cause”

- The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.

# MDM – Selection

To score the MDM, 2 of the 3 columns for that level must be met or exceeded

| Level of Medical Decision Making (MDM)<br>MUST consider 2 of the 3 MDM elements for the overall MDM Level<br>- Use any two components that meet or exceed<br>- Drop the lowest one | Number/Complexity of Problems | Minimal | Low | Moderate | High |
|---|---|---|---|---|---|
| | Amount/Complexity of Data | Minimal or none | Limited | Moderate | Extensive |
| | Risk | Minimal | Low | Moderate | High |
| | MDM Level | Straightforward | Low | Moderate | High |
| | NEW Patient | 99202 | 99203 | 99204 | 99205 |
| | Established Patient | 99212 | 99213 | 99214 | 99215 |

# Time

## TIME YOU CAN COUNT

Preparing to see the patient (eg, review of tests)

Obtaining and/or reviewing separately obtained history

Performing a medically appropriate examination and/or evaluation

Counseling and educating the patient/family/caregiver

Ordering medications, tests, or procedures

Referring and communicating with other health care professionals (when not separately reported)

Documenting clinical information in the electronic or other health record

Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver

Care coordination (not separately reported

## TIME YOU CANNOT COUNT

Activities performed by clinical staff

Performance of other services that are reported separately

Travel

Teaching that is general and not limited to discussion that is required for the management of a specific patient

# Time

Effective documentation includes documenting exact times versus old verbiage “approximately spent” since CPT definitions have more succinct verbiage of “30 minutes must be met or exceeded to report 99213”

- Effective January 1, 2024 all time thresholds are eliminated from CPT coding definitions for office and other outpatient settings to better align with all other E/M code sets since 2023

Effective documentation for supporting medical necessity is always the driving factor so ensure a 99215 for 50 minutes is supported for a stomachache/indigestion (ie, how much time for clinically relevant history and exam, how much time it took to order an EGD, independently interpret an external barium swallow film and discuss with patent need to order EGD, how much time it took to take information from parent as additional historian, how much time it took to communicate with other physicians, etc)

# Avoid Risk

Front and center – CMS defines medically necessary services as, “Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren’t mainly for the convenience of you and your doctor.”

Front and center – The post-payment audits have started on 2021 E/M claims

Front and center – 5 Fraud and Abuse Laws that could be triggered

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Stark Law
- Exclusion Statute
- Civil Monetary Penalties

# Wrap Up

Avoid rolling out the red carpet to risk

Work with EMR/EHR vendors to update outdated 1995 and 1997 templates

For MDM, take each column separately to make documentation improvements

For Time, include exact time with all allowable activities

Perform small sample self-audits per month

# E/M Code Selection

# Evaluation and Management

Inspection and observation

Palpation- examination by touch

Auscultation-listening to body sounds

Percussion-Creating sounds from tapping on body areas

# CPT Coding

Levels of E/M Services using one set of guidelines that apply to many of the E/M categories

# New vs. Established Patients

New – has not received any face-to-face professional services from the physician/qualified health care professional, or a physician/qualified health care professional of the exact same specialty/subspecialty within the group practice, within the last three years

Established – has received face-to-face services in the last three years

# Categories and Subcategories

Category:  Office or Other Outpatient Services

New or Established

Code:  99202-99215

Level is determined by:

1. The level of the medical decision making as defined for each service;

or

2. The total time for E/M services performed on the date of the encounter.

# AMA Guidelines for E/M Services

Medically appropriate history and examination

- Not counted in the level

Medical Decision Making used to determine the E/M level

- Medical Decision Making defined for each service
- Total time for E/M service

# MDM Levels

| New Patient Code | Established Patient Code | Level of MDM |
|---|---|---|
| | 99211 | N/A<br>99211 is reported for services that typically do not require the presence of a provider. As such, the concept of MDM does not apply to code 99211 |
| 99202 | 99212 | Straightforward |
| 99203 | 99213 | Low |
| 99204 | 99214 | Moderate |
| 99205 | 99215 | High |

# Medical Decision Making

Number and Complexity of Problems Addressed

Amount and Complexity of data to be Reviewed and Analyzed

Risk of Complication and Morbidity or Mortality of patient management

# Example 1

HPI: Patient is a 6-year-old established patient who presents with a sore throat. Mom indicates he has had a fever and cough for 2 days. His fever was 100 yesterday evening. she has given him Tylenol which has kept the fever down but has not helped with the sore throat. He has not had any diarrhea, nausea, or vomiting. No headache, no rash. He has had some muscle aching and fatigue. He is not allergic to any medication. He is current on immunizations. He attends school at Woodbridge Elementary.

Exam:

Wt. 50# BP 100/60 Temp 99.8 O2 99 Normal appearing 6-year-old.

Skin is dry. Pupils are equal and reactive to light. Tympanic membranes are red bilaterally. Tonsils are red, swollen with enlarged lymph nodes in the neck. Lungs clear to auscultation and percussion. Heart: Regular rate and rhythm. Abdomen is soft, no mass, hernia, or bruits. Bowel sounds normal.

Assessment/Plan: Tonsillitis with acute otitis media

Amoxicillin 5 days, gargle, Tylenol as needed for discomfort. Call or return if symptoms worsen.

# Example 1

Patient is a 6-year-old established patient who presents with a **sore throat**. He has had a **fever and cough for 2 days**. His fever was 100 yesterday evening. Mom has given him Tylenol which has kept the fever down but has not helped with the sore throat.

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# MDM Calculation Guide

Table D: Medical Decision Making (MDM)

| Final Results of Tables A, B, C = Level of Medical Decision Making (MDM)<br>• Must consider 2 of the 3 MDM elements for the overall MDM level<br>– Use any two components that meet or exceed<br>– Drop the lowest one | | | | | |
|---|---|---|---|---|---|
| Table A | Number/Complexity of Problems Addressed | Minimal | Low | Moderate | High |
| Table B | Amount and/or Complexity of Data to be Reviewed and Analyzed | Minimal or none | Limited | Moderate | Extensive |
| Table C | Risk of Complications and/or Morbidity or Mortality of Patient Management | Minimal | Low | Moderate | High |
| MDM Level | | Straightforward | Low | Moderate | High |
| New Patient Code | | 99202 | 99203 | 99204 | 99205 |
| Established Patient Code | | 99212 | 99213 | 99214 | 99215 |

# Total Time Defined

Preparing to see the patient (eg, review of tests)

Obtaining and/or reviewing separately obtained history

Performing a medically appropriate examination and/or evaluation

Counseling and educating the patient/family/caregiver

Documenting clinical information in the electronic or other health record

Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver

Care coordination (not separately reported)

# E/M Based on Total Time

| Est Pt Code | Time | New Pt Code | Time |
|---|---|---|---|
| 99211 | | | |
| 99212 | 10 minutes must be met or exceeded | 99202 | 15 minutes must be met or exceeded |
| 99213 | 20 minutes must be meet or exceeded | 99203 | 30 minutes must be met or exceeded |
| 99214 | 30 minutes must be met or exceeded | 99204 | 45 minutes must be met our exceeded |
| 99215 | 40 minutes must me bet or exceeded | 99205 | 60 minutes must be met or exceeded |

# Prolonged Service – Office and Other Outpatient +99417

| Total Duration of New Patient Office and Other Outpatient Services (use with 99205) | Code |
|---|---|
| Less than 75 minutes | Not reported separately |
| 75-89 minutes | 99205 X 1 and 99417 X 1 |
| 90-104 minutes | 99205 X 1 and 99417 X 2 |
| 105 minutes or more | 99205 X 1 and 99417 X 3 or more for each additional 15 minutes |

| Total Duration of Established Patient Office and Other Outpatient Services (use with 99215) | Code |
|---|---|
| Less than 55 minutes | Not reported separately |
| 55-69 minutes | 99215 X 1 and 99417 X 1 |
| 70-84 minutes | 99215 X 1 and 99417 X 2 |
| 85 minutes or more | 99215 X 1 and 99417 X 3 or more for each additional 15 minutes |

Use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483

# Example

A patient is seen in the office because she is experiencing fatigue, can't stop crying, and is feeling like she is making bad decisions. We discussed her situation and homelife. I have seen the patient for several years. We discussed options of individual and family counseling and medications. We ordered a CBC and electrolytes and will follow-up after results. Total time spent was 65 minutes with the patient and she is agreeable to start Paxil. I made contact with a psychologist and she will see the patient for counseling.

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# E/M Leveling

Many factors to consider when determining a level of Evaluation and Management Service

Be sure to review the Guidelines and code descriptions.

# Modifier 25

Modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

Examples:

Outpatient Visit where Vaccines are given

Preventive Care Visit that has enough documentation to also have an office/other outpatient visit

# Resources

2024 CPT Coding Manual

https://www.ama-assn.org/system/files/2023-cpt-corrections-errata.pdf

https://oig.hhs.gov/documents/physiciansresources/947/roadmap_web_version.pdf

https://www.cms.gov/glossary?page=57


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