



Coding & Documentation for Physician/Professional Services



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- CPT Coding
 - E/M Levels of Service
- Miscellaneous
 - E/M and Other Services
 - Consultations
 - Preventive Medicine
 - ICD-9-CM
 - Modifiers
- Q&A/Discussion

After the session, we hope you will . . .

- Understand what needs to be documented for providers to get credit for all of their work.
 - Comprehend how the levels of E/M service relate to physician work.
- * *Though we will use an E/M audit tool, this is not intended to be audit training.*

- Must be timely (24-48 hours after the service)
- Must clearly identify the services provided without being too cumbersome
- Can take many forms:
 - SOAP format (transcription or handwritten)
 - Letter format (specialty providers)
 - Documentation forms and templates

- Request for consultation
- Time (total **and** counseling/coordination of care) when visit is “discussion based”
- Review of images (vs. reports)
- Patient’s treatment risk (for this visit)
- Examination of body areas/organ systems with normal findings
- Additional information obtained from other source (family, friend, other physician)
- Tests ordered and reason (unless easily inferred)

- Capture of new patient visits
- Consultations
- Coding based on time
- Status of three chronic or inactive conditions
- Preventive medicine and “sick” visit
- Minor procedures and E/M

E/M Coding Levels of Service

- Most E/M levels of service are selected using “Key Components”
 - History
 - Exam
 - Medical decision making
- When counseling or coordination of care dominates the encounter (>50%), time can be the controlling factor in selecting the level

- **Counseling** is a discussion with the patient and/or family members regarding:
 - Diagnosis, impressions, prognosis, or recommended diagnostic studies
 - Risk and benefit of treatment options
 - Instruction and/or importance of compliance, risk factor reduction
 - Emotional needs of the patient
 - Patient and/or family education

- The provider must document the time spent counseling or coordinating care AND total encounter time
 - In the clinic → Face-to-face time
 - In the hospital → Unit or floor time
 - (On unit/bedside rendering services for that patient:
 - Reviewing or adding to the record
 - Examining patient
 - Talking with patient/family or other providers)

Levels of Service – Using Time

The typical time spent for each level of service is included in the code definition:

New Pt. Visit		Consultations		Establ. Pt. Visit	
99201	10 min	99241	15 min	99211	5 min
99202	20 min	99242	30 min	99212	10 min
99203	30 min	99243	40 min	99213	15 min
99204	45 min	99244	60 min	99214	25 min
99205	60 min	99245	80 min	99215	40 min

8-10-09 Jane Doe DOB: 04/22/05

Jane is a 4-year-old girl in for re-check of her latest recurrent ear infections. Mother states the patient is currently sleeping well, happy and playful, and not tugging on her ears. She has completed her recent course of antibiotics.

VS: Temp: 97.6 degrees F.

Ears: Otoscopic exam revealed persistent bulging and redness of both ears, left greater than right.

N/T: Normal

Discussed with mom strategies to decrease the incidence of ear infections, treatment options, and allaying parent anxiety concerning the child's condition.

Total time of the appointment was 30 minutes, with 20 minutes spent in counseling.

- But the primary (and most confusing) method is to select the level of service based on:
 - History
 - Exam
 - Medical decision making
- The next three pages show an abbreviated version of an eight-page E/M audit form (*also see handout*)

E/M Review Form

Patient ID _____ DOS _____ Physician _____ CHIEF COMPLAINT _____

History		PF	EPF	DET	COMP
	HPI	Brief	Brief	Extended 4+ <i>or</i>	Extended 4+ <i>or</i>
	<ul style="list-style-type: none"> ▪ Location ▪ Severity ▪ Timing ▪ Modifying Factors ▪ Quality ▪ Duration ▪ Context ▪ Associated Signs & Symptoms 	1-3	1-3	3 Chronic Problems	3 Chronic Problems
	ROS	None	Pertinent (1 system)	2-9 systems	>10 systems or some systems w/statement "all others negative"
PFSH	None	None	Pertinent (1 for establ; 1-2 for new/consult)	Complete (2 for establ; 3 for new/consult)	
	<ul style="list-style-type: none"> ▪ PAST HISTORY (surgeries, illness, injuries/treatment, current medications) ▪ FAMILY HISTORY (review of PT's family, hereditary diseases) ▪ SOCIAL HISTORY (age appropriate review of past & current events) 				

Exam		PF	EPF	DET	COMP
	95	Limited exam of the affected body area or organ system	...and other symptomatic or related organ system(s) (2, 3 or 4)	Extended exam of the affected body area(s) and other symptomatic or related organ system(s) (5, 6 or 7)	General multi-system exam (8 or more systems) <i>OR</i> a complete single system exam
	97 General Multi	1-5 elements	At least 6 elements	At least 2 elements from 6 systems/body areas <i>OR</i> 12 elements in 2 or more systems/body areas	Perform all elements (bullets) in at least 9 organ systems/body areas and document at least two elements (bullets) from each of 9 areas/systems
	97 Single System	1-5 elements	At least 6 elements	12 elements identified by bullet (<i>except 9 elements for eye/psych</i>)	Perform all elements (bullet); document every element in each shaded box and at least one element in each unshaded box

E/M Review Form

A Number of Diagnoses					
		Number	X Points = Results		
Self-limited or minor; MAX 2 pts.			1	New prob. (to examiner); no additional work-up planned; MAX 3 pts	
Established problem (to examiner); stable, improved			1	New prob. (to examiner); additional work-up planned	
Established problem (to examiner); worsening			2		
				TOTAL	
B Amount and/or Complexity of Data to be Reviewed					
				Points	Points
Review and/or order clinical lab test			1	Review and/or order tests in the radiology section of CPT	
Review and/or order tests in the medicine section of CPT			1	Discussion of test results with performing physician	
Decision to obtain old records and/or obtain history from someone other than patient			1	Independent visualization of image, tracing, or specimen itself	
Review and summarization of old records and/or obtain history from someone other than the patient and/or discussion of case with another healthcare provider			2		
				TOTAL	
C Risk of Complications and/or Morbidity or Mortality (Highest Level of Risk in any Category determines overall Risk.)					
Risk Level	Presenting Problem(s)	Diagnostic Ordered		Management Options	
M I N	<ul style="list-style-type: none"> One self-limited or minor problem (cold, insect bite) 	<ul style="list-style-type: none"> Laboratory test requiring venipuncture Chest x-rays/EEG or EKG Ultrasound (e.g., echo) 		<ul style="list-style-type: none"> Rest, gargle Elastic bandages Superficial dressings 	
L O W	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness Acute uncomplicated illness or injury 	<ul style="list-style-type: none"> Physiologic test not under stress Non-cardio imaging studies w/contrast Superficial needle biopsy Skin biopsies 		<ul style="list-style-type: none"> Over the counter drugs Minor surgery w/no identified risk factors PT/OT IV fluids w/o additives 	
M O D	<ul style="list-style-type: none"> One or more chronic illnesses w/ mild progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem w/uncertain prognosis Acute illness w/systemic symptoms Acute complicated injury 	<ul style="list-style-type: none"> Physiologic test under stress Diagnostic endoscopies w/no risk factors Deep needle or incisional biopsy Cardiovascular imaging w/contrast and no risk factors Obtain fluid from body cavity 		<ul style="list-style-type: none"> Minor surgery w/identified risk factors Elective major surgery w/ no risk factors Prescription drug management IV fluids w/additives Closed treatment of fracture 	
H I G H	<ul style="list-style-type: none"> 1+ chronic illnesses w/ severe progression/tx side effects Acute or chronic illnesses or injuries that may pose a threat to life or bodily function An abrupt change in neurologic status 	<ul style="list-style-type: none"> Cardiovascular imaging w/contrast with risk factors Cardiac electrophysiologic tests Diag. endoscopies w/risk factors Discography 		<ul style="list-style-type: none"> Elective major with identified risk factors Emergency major surgery Drug therapy req. intensive monitoring for toxicity Decision not to resuscitate 	
FINAL RESULT FOR COMPLEXITY (2 of 3)					
Type of Decision Making		Straightforward	Low	Moderate	High
A	Number of diagnosis or management options	≤ 1 Minimal	2 Limited	3 Multiple	≥4 Extensive
B	Amount and complexity of data	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥4 Extensive
C	Highest Risk	Minimal	Low	Moderate	High

Medical Decision Making (MDM) Worksheet

E/M Review Form

Final Result

New Patient and Office Consults (3 of 3)

History	PF		EPF		Det		Comp		Comp	
Exam	PF		EPF		Det		Comp		Comp	
MDM	SF		SF		Low		Mod		High	
Code	99201 <i>(10 min)</i>	99241 <i>(15 min)</i>	99202 <i>(20 min)</i>	99242 <i>(30 min)</i>	99203 <i>(30 min)</i>	99243 <i>(40 min)</i>	99204 <i>(45 min)</i>	99244 <i>(60 min)</i>	99205 <i>(60 min)</i>	99245 <i>(80 min)</i>

Established Patient (2 of 3)

History	**	PF	EPF	Det	Comp
Exam	**	PF	EPF	Det	Comp
MDM	**	SF	Low	Mod	High
Code	99211 <i>(5 min)</i>	99212 <i>(10 min)</i>	99213 <i>(15 min)</i>	99214 <i>(25 min)</i>	99215 <i>(40 min)</i>

TIME: Does documentation reveal total time and that more than half of time was C/CC? Y N

Does documentation describe the content of counseling/coordination of care? Y N

CPT Code Billed _____ Reviewer's Code/Initials _____

Chief Complaint (CC)

- What problems are being addressed TODAY?
- The reason for the visit (medical necessity) must be *clearly* stated in documentation
 - “Recheck of UTI” (not “Re ✓”)
 - Often, CC is nonexistent
 - CC must be obtained and documented by the physician (not nurse)
 - CC set the stage for the rest of the note (i.e., how much history, exam, and medical decision making is medically necessary?)
- Make sure history is documented for these concerns (i.e., if its in the assessment, it should also be in the history)

- The extent of information obtained and documented determines the overall level of history
 - History of Present Illness (HPI)
 - Review of Systems (ROS)
 - Past, Family, and Social History (PFSH)
- If a patient is unable to provide history (e.g., comatose, poor historian), the provider must document his/her attempt

History of Present Illness (HPI)

- Chronological description of development of patient's illness from first sign and/or symptom to present
- E/M guidelines identify eight elements to describe the patient's condition
 - Or, status of three chronic or inactive conditions
- One sentence can contain multiple HPI

*“Sara continues to complain of **severe** pain and **numbness in both legs**, in spite of **Duloxetine** therapy for the past **six months**.”*

HPI Elements

Location	Site of problem
Duration	Length of time
Timing	Regularity of occurrences
Severity	Intensity or degree
Quality	Description or characteristic
Context	Events surrounding occurrence
Modify Factor	Effect on symptom
Associated Signs & Symptoms	Other symptoms related to presenting problem

The provider must personally document HPI.

Per CMS,

“...the provider/physician must document the chief complaint and the history of present illness. Ancillary personnel may not document the chief complaint or history of present illness.”

Review of Systems (ROS)

- Poor documentation of the ROS is one of the most common reasons reviewers down code the level of service
- The ROS is the provider questioning the patient about his/her chief complaint and related systems
- The number of systems reviewed and documented contributes to the overall level of history

- CMS requires a physician to question the patient about his/her CC and related systems
 - The physician must **make statements regarding positive and pertinent negative findings**
- Ten systems must be reviewed and documented to meet the comprehensive history level
- If ten systems are reviewed, it is ok to note “all other systems negative”
 - In the absence of this verbiage, documentation must reflect the systems reviewed

Past History	Family History	Social History
<ul style="list-style-type: none">• Past surgeries• Hospitalizations• Serious illnesses• Chronic medical problems	<ul style="list-style-type: none">• Health status/ cause of death of family members• Specific diseases in family	<ul style="list-style-type: none">• Occupation• Marital status• Hobbies• Children• Alcohol or substance abuse• Tobacco use• Seatbelts

Often documented: *“PFSH: No changes”*

Better: *“Refer to health history form (or office visit note), dated 9/12/09 in patient chart for additional details of past medical, social, family history, and review of systems.”*

“A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that a physician reviewed and updated the previous information.”

Source Data: 1997 Documentation Guidelines for Evaluation and Management Services

History – Levels of Service Breakdown

	Problem Focused 99212 99201	Expanded Problem Focused 99213 99202	Detailed 99214 99203	Comprehensive 99215 99204, 99205
HPI	Brief (1-3 elements)	Brief (1-3 elements)	Extended (4+ elements, 3 chronic or inactive problems)	Extended (4+ elements, 3 chronic or inactive problems)
ROS	None	1 (pertinent)	2-9	10+
PFSH	None	None	1 (pertinent)	2 or 3

History Case - Result

	PF	EPF	DET	COMP
History	HPI ▪ Location ▪ Severity ▪ Timing ▪ Modifying Factors ▪ Quality ▪ Duration ▪ Context ▪ Associated Signs & Symptoms			
	Brief 1-3	Brief 1-3	Extended 4+ or 3 Chronic Problems	Extended 4+ or 3 Chronic Problems
	ROS ▪ Const ▪ ENT/M ▪ GI ▪ Skin/Breast ▪ Endo ▪ Eyes ▪ CV ▪ GU ▪ Neuro ▪ Hem/Lymph ▪ Resp ▪ Musc ▪ Psych ▪ All/Immun			
PFSH ▪ PAST HISTORY (surgeries, illness, injuries/treatment, current medications) ▪ FAMILY HISTORY (review of PT's family, hereditary diseases) ▪ SOCIAL HISTORY (age appropriate review of past & current events)				
	None	Pertinent (1 system)	2-9 systems	>10 systems or some systems w/statement "all others negative"
	None	None	Pertinent (1 for establ; 1-2 for new/consult)	Complete (2 for establ; 3 for new/consult)

57 year old here for med refill.

1. Chronic headaches from several years ago when he had herpes encephalitis. Currently, the headaches are not a huge concern. He reports one every few weeks and much less severe. He takes...
2. Constipation. Improved considerably. The patient uses Miralax every 3rd day which helps.
3. Hypothyroidism. He has been taking his Synthroid and has not had any overt symptoms or problems.

ROS: No unusual fatigue or GI issues other than noted above, or problems with depression. All other systems are negative.

— PH: Unchanged from May 2009. Meds...

— SH: He has a new job that requires less physical effort and is less stressful. Otherwise SH is unchanged from May 2009.

- Medical necessity: areas related to the patient's CC/reason for visit should be examined and documented
- Physicians receive credit for the elements of the exam they actually perform and document
 - No credit for elements refused by patient
 - Credit is given if the provider attempts a portion of the exam
- For now, Medicare uses the 1995 and 1997 E/M documentation guidelines, whichever is most advantageous to the physician

Please refer to handouts

- 1995 Review Form
- 1997 Review Forms
 - General Multispecialty
 - Single Specialty (various)

“General appearance, gait and station, some cranial nerves, judgment, oriented x3; mood and affect . . .”

- All performed without “hands-on exam”
- Providers often miss these . . .

Exam – Levels of Service Breakdown

Level of service breakdown:

	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
1997	1-5 bullets	6-12 bullets	12 bullets	>= 2 bullets for each of 9 areas/systems OR “all” elements in a single system
1995	1 body area/ system	2-7 body areas/ systems <i>(2, 3, or 4 systems)</i>	2-7 body areas/ systems, more detail <i>(5, 6, or 7 systems)</i>	8 or more systems OR complete single system

NOTE: The 2,3,4 and 5,6,7 distinctions are commonly used interpretations of the 1995 guidelines – they cannot be found in the actual guidelines.

Exam Case

Exam	95	PF	EPF	DET	COMP
		Limited exam of the affected body area or organ system	...and other symptomatic or related organ system(s) (2, 3 or 4)	Extended exam of the affected body area(s) and other symptomatic or related organ system(s) (5, 6 or 7)	General multi-system exam (8 or more systems) OR a complete single system exam
97 General Multi	1-5 elements	At least 6 elements	At least 2 elements from 6 systems/body areas OR 12 elements in 2 or more systems/body areas	Perform all elements (bullets) in at least 9 organ systems/body areas and document at least two elements (bullets) from each of 9 areas/systems.	
97 Single System	1-5 elements	At least 6 elements	12 elements identified by bullet (except 9 elements for eye/psych)	Perform all elements (bullet); document every element in each shaded box and at least one element in each unshaded box.	

History: Headache P • ?

(if 3)

H —

O: Patient is alert and cooperative. VS are stable as mentioned above. HEENT: Normocephalic and atraumatic. PERRL. Mucous membranes are moist. Patient is tender when turning her head to the left.

E •

P • ?
N or M

M S •

1995

1997

- Providers (especially primary care) notoriously undervalue their decision-making efforts
- The extent of information obtained and documented determines the overall level of decision making
 - Number of diagnoses/treatment options
 - Amount and complexity of data reviewed
 - Risk of complications

Number of Diagnoses/Management Options

Self-limited or minor <i>MAX 2 pts</i>	1
Established problem (stable, improved)	1
Established problem (worsening)	2
New problem (no additional work-up planned) <i>MAX 3 pts</i>	3
New problem (additional work-up planned)	4

Amount and/or Complexity of Data to be Reviewed

Review and/or order clinical lab test	1
Review and/or order tests in the medicine section of CPT	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than the patient and/or discussion of case with another health care provider	2
Review and/or order tests in the radiology section of CPT	1
Discussion of test results with performing physician	1
Independent visualization of image, tracing, or specimen	2

Risk of Complications and/or Morbidity or Mortality

Presenting Problems	Diagnostic Ordered	Management Options
Number of problems	Labs	Minor treatment
Severity of Problems	X-rays	Surgical intervention
Prognosis	Procedures	Medication management

NOTE: Refers to the level of risk at the time of the visit (not “potential risk”)

- Decision making can be inferred, but documentation must “paint the picture.”
 - List all diagnoses dealt with at encounter
 - List all differential diagnoses or “rule outs”
 - List all medications prescribed at encounter
 - List all tests/procedures ordered
 - Document patient/family education provided
 - Clarify whether tests have been interpreted
 - Note encounter time, when applicable

MDM – Levels of Service Breakdown

	Strtfwd 99212 99201, 99202	Low 99213 99203	Moderate 99214 99204	High 99215 99205
Number of DX or Mgmt Options	Minimal	Limited	Multiple	Extensive
Amt and/or Complexity of Data Reviewed	Minimal/ None	Limited	Moderate	Extensive
Risk of Complic, Morbidity, or Mortality	Minimal	Low	Moderate	High

MDM Case

“21-month-old female with fever, runny nose, cough for 3 days. Emesis on Sunday . . .

O: All pertinent areas . . .

A: Bilateral OM

P: Rx . . .”

Case Studies – MDM

Medical Decision Making (MDM) Worksheet

A Number of Diagnoses

	Number	X	Points = Results		Number	X	Points = Results	
Self-limited or minor; MAX 2 pts.			1	New prob. (to examiner); no additional work-up planned; MAX 3 pts	1		3	
Established problem (to examiner); stable, improved			1	New prob. (to examiner); additional work-up planned			4	
Established problem (to examiner); worsening			2					
TOTAL								3

B Amount and/or Complexity of Data to be Reviewed

	Points		Points
Review and/or order clinical lab test	1	Review and/or order tests in the radiology section of CPT	1
Review and/or order tests in the medicine section of CPT	1	Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1	Independent visualization of image, tracing, or specimen itself	2
Review and summarization of old records and/or obtain history from someone other than the patient and/or discussion of case with another healthcare provider	2		
TOTAL			

C Risk of Complications and/or Morbidity or Mortality (Highest Level of Risk in any Category determines overall Risk.)

Risk Level	Presenting Problem(s)	Diagnostic Ordered	Management Options
M I N	<ul style="list-style-type: none"> One self-limited or minor problem (cold, insect bite) 	<ul style="list-style-type: none"> Laboratory test requiring venipuncture Chest x-rays/EEG or EKG Ultrasound (e.g., echo) 	<ul style="list-style-type: none"> Rest, gargle Elastic bandages Superficial dressings
L O W	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness Acute uncomplicated illness or injury 	<ul style="list-style-type: none"> Physiologic test not under stress Non-cardio imaging studies w/contrast Superficial needle biopsy Skin biopsies 	<ul style="list-style-type: none"> Over the counter drugs Minor surgery w/no identified risk factors PT/OT IV fluids w/o additives
M O D	<ul style="list-style-type: none"> One or more chronic illnesses w/ mild progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem w/uncertain prognosis Acute illness w/systemic symptoms Acute complicated injury 	<ul style="list-style-type: none"> Physiologic test under stress Diagnostic endoscopies w/no risk factors Deep needle or incisional biopsy Cardiovascular imaging w/contrast and no risk factors Obtain fluid from body cavity 	<ul style="list-style-type: none"> Minor surgery w/identified risk factors Elective major surgery w/ no risk factors Prescription drug management IV fluids w/additives Closed treatment of fracture
H I G H	<ul style="list-style-type: none"> 1+ chronic illnesses w/ severe progression/tx side effects Acute or chronic illnesses or injuries that may pose a threat to life or bodily function An abrupt change in neurologic status 	<ul style="list-style-type: none"> Cardiovascular imaging w/contrast with risk factors Cardiac electrophysiologic tests Diag. endoscopies w/risk factors Discography 	<ul style="list-style-type: none"> Elective major with identified risk factors Emergency major surgery Drug therapy req. intensive monitoring for toxicity Decision not to resuscitate

FINAL RESULT FOR COMPLEXITY (2 of 3)

Type of Decision Making	Straightforward	Low	Moderate	High
A Number of diagnosis or management options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B Amount and complexity of data	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥ 4 Extensive
C Highest Risk	Minimal	Low	Moderate	High

MDM Case

“HPI: 91 year old complaining of new ankle pain and swelling. No falls or injury . . .

Meds: (listed)

O: Relevant exam

Data: X-ray of the right ankle to my eye appears normal. Will be overread by radiologist.

A: Right ankle pain

P: Rest, Advil QID”

Case Studies – MDM

Medical Decision Making (MDM) Worksheet

A Number of Diagnoses

	Number	X Points = Results		Number	X Points = Results
Self -limited or minor; MAX 2 pts.		1			3
Established problem (to examiner); stable, improved		1		1	4
Established problem (to examiner); worsening		2			
TOTAL					

B Amount and/or Complexity of Data to be Reviewed

	Points		Points
Review and/or order clinical lab test	1	Review and/or order tests in the radiology section of CPT	1
Review and/or order tests in the medicine section of CPT	1	Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1	Independent visualization of image, tracing, or specimen itself	2
Review and summarization of old records and/or obtain history from someone other than the patient and/or discussion of case with another healthcare provider	2	TOTAL	2

C Risk of Complications and/or Morbidity or Mortality (Highest Level of Risk in any Category determines overall Risk.)

Risk Level	Presenting Problem(s)	Diagnostic Ordered	Management Options
M I N	<ul style="list-style-type: none"> One self-limited or minor problem (cold, insect bite) 	<ul style="list-style-type: none"> Laboratory test requiring venipuncture Chest x-rays/EEG or EKG Ultrasound (e.g., echo) 	<ul style="list-style-type: none"> Rest, gargle Elastic bandages Superficial dressings
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H I G H	<ul style="list-style-type: none"> 1+ chronic illnesses w/ severe progression/tx side effects Acute or chronic illnesses or injuries that may pose a threat to life or bodily function An abrupt change in neurologic status 	<ul style="list-style-type: none"> Cardiovascular imaging w/contrast with risk factors Cardiac electrophysiologic tests Diag. endoscopies w/risk factors Discography 	<ul style="list-style-type: none"> Elective major with identified risk factors Emergency major surgery Drug therapy req. intensive monitoring for toxicity Decision not to resuscitate

FINAL RESULT FOR COMPLEXITY (2 of 3)

	Type of Decision Making	Straightforward	Low	Moderate	High
A	Number of diagnosis or management options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Amount and complexity of data	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥ 4 Extensive
C	Highest Risk	Minimal	Low	Moderate	High

E/M – Selecting the Level

Example – New Patient Office Visit - 3 of 3
(or consultation)

	History	Exam	MDM	Time
99201	PF	PF	Strtfwd	
99202	EPF	EPF	Strtfwd	
99203	Det	Det	Low	
99204	Comp	Comp	Mod	
99205	Comp	Comp	High	

= 99202

E/M – Selecting the Level

Example – Established Patient Office Visit - 2 of 3

	History	Exam	MDM	Time
99211	NA	NA	NA	
99212	PF	PF	Strtfwd	
99213	EPF	EPF	Low	
99214	Det	Det	Mod	
99215	Comp	Comp	High	

= 99214

E/M – Selecting the Level

99213 (2 of 3)	One HPI & one ROS
	Exam of two body areas or six “bullets”
	One unstable problem
99214 (2 of 3)	Four HPI, two ROS, one PFSH
	Exam of five body areas or 12 “bullets”
	Two unstable problems (or one new) with medication management (or review/order extensive data)
99215 (2 of 3)	Four HPI, 10 ROS, two PFSH
	Exam of eight organ systems or all “bullets”
	Two unstable problems (or one new problem requiring additional workup); problem(s) must be significant enough to present a threat to life or bodily function

SOAP Component

Detail to be Included

Subjective

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, and Social History (PFSH)

Objective

- Exam (a template can be developed)
- Ancillary tests results reviewed

Assessment

- Diagnosis and/or differential diagnosis

Plan

- Prescriptions
- Follow-up visits/referrals/other orders

Counseling/Coordin. of Care

- Education and total/counseling time

Miscellaneous

- E/M and Other Services



- Consultations



- Preventive Medicine (PM)



- ICD-9-CM - Modifiers



Coding an E/M with Other Services

- Minor surgical procedures (defined by Medicare as a procedure with 0-10 day post-op period) can be billed with an E/M service on the same day if documentation supports both services.
- Append the E/M code with a 25 modifier.
- Link diagnoses to each CPT code, if they are different.

Coding an E/M with Other Services

	E/M-25 + Procedure	Procedure Only
1	Patient seen for nasal congestion and sore throat. During the visit asks provider to look at annoying skin tag. Provider examines skin tag and decides to remove it.	Patient presents asking for removal of an annoying skin tag. Provider asks patient how long it has been present (and other pertinent history questions), examines the area and removes it.
2	Patient is seen for annual physical. During the course of the visit complains of pain in the hand and wrist area. Provider completes the physical and obtains significant additional history, exam of problem area, orders/performs tests, and evaluates the hand and wrist pain.	Patient is seen for an annual physical and during the course of the visit physician reviews and adjusts medications the patient takes for existing conditions (e.g., hypertension); or patient complains of skin irritation and provider writes a prescription.
3	Patient presents with a laceration to the right arm sustained during an accident on the playground. Provider sutures the laceration and evaluates multiple other contusions and abrasions sustained during the accident.	Patient presents with laceration to arm sustained during hockey practice. Physician obtains a brief history, examines the arm, identifies the need for sutures, performs the repair, and instructs the patient in wound care.

Injections

- Injection administration code
 - (96372 - 96379) (**Code numbers changed in 2009**)
- Plus drug (J code)
 - B12 (J3420)
 - Depo (J1055)
- Plus E/M “visit” code, if supported by documentation

- Consultation rules (three Rs)
 - **Request** – Physician is asked by another provider for an opinion regarding a specific problem (must be documented by both parties)
 - **Render** – Physician evaluates the patient (history, exam, and decision making) and documents the service
 - **Report** – Physician communicates the evaluation and opinion to the requesting physician (cc note or separate report)

- Often confused with referrals
 - A **consultation** is a formal request for a *professional opinion or advice* about a patient's diagnosis and treatment.
 - A **referral** (visit code) is the *transfer* of the total or specific care of a problem from one physician to another.

- Two key sections from Medicare 30.6.10
 1. “The intent of a consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional’s knowledge.”

2. “Preoperative consultations are payable for new or established patients performed by any physician or qualified NPP at the request of a surgeon, as long as all of the requirements for performing and reporting the consultation codes are met and the service is medically necessary and not routine screening.”
- When consultations are requested to evaluate specific conditions prior to surgery (preoperative consultation), key components of the visit (history, exam, medical decision making) must describe those specific conditions, not just the surgical problem.

- Sample documentation:
 - “I was asked by Dr. Jones to evaluate this patient’s hypertensive disorder for surgical clearance prior to her hysterectomy scheduled for May 13th”
 - or*
 - “At your request, I am seeing John Doe in preoperative consultation to evaluate his hypertension and hyperlipidemia prior to scheduled hernia surgery...”
- Communication of findings, advice, or recommendations to the requesting physician must exist.

NOTE: It doesn’t say “...to the hospital.”

- New patient (99381 - 99387) and established patient services (99391 - 99397)
 - ***Comprehensive*** history and examination (age and gender appropriate)
 - Counseling/anticipatory guidance/risk factor reduction interventions
 - Ordering of appropriate laboratory or diagnostic procedures

Preventive Medicine (PM)

- Services involving *less than* a comprehensive history and examination should be reported by appending the 52 modifier to the PM code (payer-specific guidelines exist)
- Coverage varies by contract (non-covered by Medicare)

- If you find a medical problem or the patient brings up complaints during the PM encounter, an E/M “visit” may also be appropriately coded. CPT states:

“... the problem or abnormality is significant enough to require additional work to perform the key components of an E/M service, then the appropriate office/outpatient code for that service also should be reported.”

- When both codes are reported, the -25 modifier **must be** appended to the problem-oriented E/M code (e.g., 99213-25)
- This modifier identifies the service as a “**significant, separately identifiable E/M service** provided by the same provider on the same day”
- **NOTE:** It is preferable for documentation of the problem E/M to be separate from the PM (e.g., separate section of the note); certain payers require separate notes

- Documentation and ICD-9 coding must be very specific and linked to each service (CPT code).

CPT Description

ICD-9 Description

99396 Prev. Med.

→ V70.0 Gen'l Medical Exam

99212-25 Office Visit

→ 789.01 Abdom. Pain, RUQ

85048 CBC

→ 789.01 Abdom. Pain, RUQ

The level of specificity is very important

- Physicians rarely select ICD-9 codes themselves (contrast to CPT codes)
- Providers often provide insufficient detail for staff to locate a specific code
 - Abbreviations are not enough
 - DM (diabetes mellitus), Htn (hypertension), etc.

- More information is required to locate the most specific code. Is the problem . . .
 - Acute or chronic?
 - Unilateral or bilateral?
 - Controlled or uncontrolled?
 - Location (quadrant, upper/lower extremity, distal/proximal)?
 - Insulin or non-insulin dependent?

- This specific information allows the coder to locate the correct code in the Tabular Index
 - Correct code category; 4th and 5th digits

Provider's Note:	Correct Code
<i>"DM, no compl, I"</i>	250.00
<i>"Htn, benign"</i> (contrast this with <i>"HBP"</i>)	401.1 (796.2)

- For **diagnosis** coding purposes, terms such as “suspect,” “possible,” or “rule out” should not be used
 - If a definitive diagnosis can not be determined, use signs and symptoms
- Providers should link the appropriate diagnosis to each service

99213-25 → 789.04 (LLQ abdominal pain)

Flu shot → V04.81 (Prophylactic vaccine)

- Providers should list only diagnoses actively managed during the patient encounter
 - If documentation does not show attention to a problem, it should not be ICD-9 coded for the visit
- V-codes are not taboo!
 - They include personal/family “history of” diagnoses to support testing that may otherwise be viewed as screening
 - Primary or secondary

Common CPT modifiers for a physician's office:

- **24** – Unrelated E/M service by the same physician during a post-operative period
- **25** – Significant, separately identified E/M service by the same physician on the same day of a procedure/other service
- **26** – Professional component
- **55** – Postoperative management only
- **59** – Distinct procedural service

Questions

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Thank you!

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The information presented and responses to questions posed are not intended to serve as coding or legal advice. Many variables affect coding decisions and our response to the limited information provided in a presentation session is intended only to provide general information that might be considered in resolving coding issues. All coding must be considered on a case-by-case basis and must be supported by medical necessity and appropriate documentation. Therefore, Wipfli recommends considering a variety of sources to determine appropriate coding and claim submission.

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