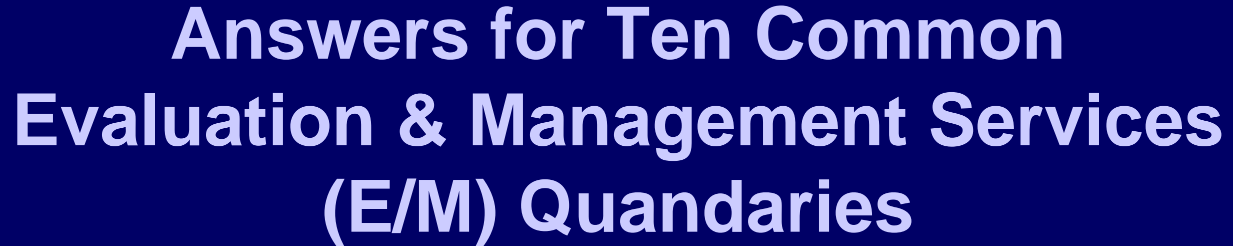

Answers for Ten Common Evaluation & Management Services (E/M) Quandaries

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Today's Discussion

- Review background related to "10" E/M Quandaries
- Discuss and highlight common problems typically associated with each type of scenario
  - E/M Level of Service
  - Consultation versus Referral
  - Preventive Medicine
  - E/M with Preventive Medicine
  - E/M Counseling & Coordination of Care
  - Teaching Physician/Resident
  - Primary Care Exception
  - Incident-to
  - Hospital Admission
  - Critical Care
- Questions/Answers

E/M Level of Service

- Background
  - Evaluation and Management Services
    - Divided into broad categories – Office and Hospital Visits, Consultations, etc.
    - Code "levels" based on two or three key components (history, exam and medical decision making)
    - Each component level is used to obtain the "total" service level
    - Provider documentation must support each component level which in turn equals the total E/M level of service coded
- Common E/M Level of Service Coding Issues
  - Up-coding or down-coding by more than one level
  - Incorrectly coding based on reason for visit (i.e., "only a f/u", "only talked about meds")
  - Incorrectly coding based only on patient risk (i.e. patient has "many" issues, patient is in "ICU")
  - Incorrectly coding due to type of service (i.e., "new" patient versus "consult")

E/M Level of Service (cont.)

- Common Problem Scenario
  - Patient presents for a routine follow-up of Crohn's Disease
  - Provider based the level of service on this being a "follow-up", not on actual documentation
  - Provider selected CPT code 99212
  - Documentation supports detailed history, detailed exam and moderate complexity of medical decision making.
  - Based on two of three key components, this service meets CPT code 99214

New versus Established Patient

- Background
  - New Patient Visits
    - Five code levels (CPT Codes 99201-99205)
    - Requires 3 key components
      - History
      - Exam
      - Medical Decision Making
  - CPT Definition
  - Medicare Carrier Manual Definition
- Common Problem Scenario
  - Patient seen in the hospital and presents to the clinic 3 weeks later
  - Service billed as “new” patient

Consultation versus Referral

- Background
  - New Patient Visits
    - Five levels of service (99201-99205)
    - Require 3 key components, (history, exam and medical decision making)
    - Defined by CPT to be used for patients that have not been seen in the last three years
  - Consultations
    - By setting (office and hospital)
    - Five levels (99241-99245 or 99251-99255 or 99271-99275)
    - Three levels hospital follow-up (99261-99263)
    - No distinction between new or established patients
    - Require 3 key components (history, exam and medical decision making)
    - Require a request for an opinion/advice from another physician or other appropriate source
    - Require documentation of request and written report back to requesting physician (with the exception of shared common records or those rendered in the hospital setting)

Consultation versus Referral

- Common Problem Scenario # 1
  - Physician documents that patient is being referred by Dr. X for possible condition Y.
  - Physician documents extent of history, exam and medical decision making rendered
  - No clear request or reason documented
  - No evidence of written report back to the requesting physician
- Common Problem Scenario # 2
  - Medical record documentation indicates that the patient was sent over by Dr. Y to manage condition X. No evidence that requesting physician is requesting an opinion and/or advice on the condition
- Common Problem Scenario # 3
  - Physician documents a history and lengthy assessment and plan
  - No evidence or documentation to support that a physical examination was conducted
  - Service meets only 2 of 3 required key components

Preventive Medicine

- <u>Background</u>
  - E&M and Preventive Medicine Services
    - To properly bill for such services you must:
      - Determine your usual fee for the non-covered, routine physical exam
      - Determine your fee for the covered portion of the exam
      - Bill the covered portion using the appropriate E/M visit code (new or established)
      - Bill the balance (the difference between the non-covered and covered fees) using the codes for preventive medicine (99381-99397)

E/M with Preventive Medicine

- **Common Problem Scenario # 1**

  A normal healthy patient makes an appointment for treatment of a sore throat, but also wants a complete physical and a screening cervical pap smear with a pelvic and breast examination. The physician provides a separately, identifiable service on the same day and documents as such.

  -Treatment and evaluation of the sore throat is coded as a Level II follow-up office visit (99212 -25), 99387 Preventive Medicine Exam, and G0101 Cervical or vaginal screening; pelvic and clinical breast exam.

- **Common Problem Scenario # 2**

  A twelve year old girl came with her mother for a comprehensive annual check-up. No physical complaints were present. The young woman did have some questions for her physician. Following the routine evaluation, the physician provided 15 minutes of counseling about hygiene, and other physical and emotional changes the young woman would encounter as she entered puberty.

  - Comprehensive annual check-up adolescent established patient (age 12 through 17 years) code 99394

Est. Patient versus Preventive Medicine

- Background
  - Preventive Medicine Services
    - Age-based codes
    - New and Established patient categories
    - Patient presents asymptomatic
    - Includes comprehensive review of systems, past/family/ and surgical history, examination and counseling on risk factor reduction, etc.
- Common Problem Scenario
    - Patient presents with for annual physical with multiple stable chronic problems
    - Service billed with only an established patient service code
    - Service is billed with both an established patient service code and a preventive medicine service when patient is asymptomatic
    - Preventive medicine service is reported alone with either a –52 modifier and/or a –GA

E/M Counseling & Coordination of Care

- Background
  - Per CPT – When counseling and/or coordination of care dominates more than 50% of the encounter then TIME may be considered the key or controlling factor to determine the level of E/M service.
  - Physician MUST document the amount of time spent in counseling and/or coordination of care.
- Common Problem Scenario #1
  - New Patient presents with a worsening condition.
  - Provider documents an appropriate expanded problem history, expanded problem focused exam and low complexity medical decision making.
  - Provider spends an hour counseling the patient on the importance of having a colonoscopy.
  - Documents: "60 minutes – significant time spent counseling patient on adherence with colonoscopy".
  - Provider selects Code 99205 on the encounter form.

E/M Counseling & Coordination of Care (Cont.)

Common Problem Scenario # 2

- Patient presents for a follow-up of uncontrolled hypertension
- Provider documents an appropriate expanded problem history, expanded problem focused exam and moderate complexity medical decision making.
- Provider spends an hour counseling the patient on the importance of taking medication properly, diet, exercise and risks.
- Provider does NOT document time spent in counseling patient.
- Provider selects Codes 99205 and 99354.
- To support billing the prolonged service code, the provider MUST document time!

Teaching Physician/Resident

- Background
  - Evaluation and Management Services provided by a resident in conjunction with a teaching physician
  - Specific guidelines (Medicare Carriers Manual) revised Transmittal 1780, November 22, 2002
  - Teaching physician MUST PERSONALLY document their presence for the key or critical portion of the E/M service or personally perform the service, refer or “tie” to the resident involved in the care of the patient, and document his/her involvement in the care management of the patient.
  - “ATTEST-TIE-MANAGE”

Teaching Physician/Resident (cont.)

- Example “ties” with resident documentation
  - “I saw and evaluated the patient, discussed w/resident and agree with resident’s findings and plans”
  - “I saw the patient with Dr. X, agree with A/P, Schedule MRI x 1 week”.
  - “I saw and examined the patient, discussed with resident and I agree with findings and plans to transfer the patient”
  - “Patient seen and examined by me with resident. Temp. 100, exam verified, UOP 1400cc, labs noted. ID following”

Teaching Physician/Resident (cont.)

Common Problem Scenario #1

- Resident visits hospitalized patient at 8:45 a.m. He/she examines the patient, checks labs and documents these in the patient chart along with his/her plan of care.
- Later that morning during grand rounds, the teaching physician examines the patient, reviews the resident's note, and documents and signs as follows:
  - "Agree, w/ resident's note"

- This is a non-billable service, teaching physician must indicate his presence, and his involvement with the care management of the patient.

Primary Care Exception

- Background
  - Per Medicare Carriers Manual
    - Teaching physicians may bill for lower E/M services provided by residents in the absence of the teaching physician
    - E/M codes 99201-99203 and 99211-99213
    - Specific guidelines on what type of facility may provide exception services, teaching physician responsibility, and resident residency status
    - Teaching physician only has to "review" the care provided by the resident during or immediately after the patient visit
    - To bill above 99203 or 99213 the teaching physician must "see" the patient
    - An acceptable teaching physician attestation for an exception service would be: "Patient discussed with Dr. Resident, reviewed exam, and agree with A/P"

Primary Care Exception (cont.)

- Common Problem Scenario # 1
  - Patient presents for follow-up visit to the Internal Medicine Clinic
    - Resident sees the patient and documents appropriate History, Exam and Medical Decision Making.
    - Resident leaves patient exam room and presents case to the teaching physician
    - Teaching physician discusses the patient and review's the residents documentation
    - Teaching physician then signs the chart with the following attestations:

      -"Reviewed and agree"
  - This would be a non-billable service since the teaching physician did not indicate WHAT resident's documentation he reviewed.

Primary Care Exception (cont.)

- Common Problem Scenario # 2
  - Patient presents to Family Medicine clinic for follow-up
    - Resident sees the patient and documents appropriate History, Exam and Medical Decision Making.
    - Resident leaves patient exam room and presents case to the teaching physician
    - Teaching physician discusses the patient and review's the residents documentation
    - Teaching physician then signs the chart with the following attestations:
      - "Patient discussed with Dr. Resident, reviewed exam, and agree with A/P" and the service is billed as a 99214
  - This is a non-billable service because the teaching provider did not "see" the patient which is required for code above a 99213 or 99203.

“Incident-to”

- **Background**
- Section 1861(s)(2)(A) defines an “incident-to” service as:
  - An integral, although incidental, part of the physician’s professional services
  - Commonly furnished in physician’s offices
  - Either rendered without charge or included in the physician’s bill
  - Representative of an expense incurred by the physician/non-physician in professional practice
  - Performed under the direct supervision of the physician/non-physician provider
  - Performed by an employee of the physician/non-physician or physician-directed center
  - Initiated and managed by the employing physician/non-physician

“Incident-to” (cont.)

- **Common Problem Scenario # 1**
  - Nurse Practitioner examines and documents the care provided to a new patient who recently moved from out of state and wishes to establish a primary care provider
  - Supervising physician is not on the premises
  - Bill is sent out under supervising physicians name
  - No documentation by supervision physician
- **Common Problem Scenario # 2**
  - Nurse Practitioner examines the patient and documents the care
  - No evidence of supervising physician involvement
  - Service billed on claim form as code 99213 under place of service “22”

Hospital Admission

- Background
  - Initial Hospital Admission
    - Three code levels (CPT Codes 99221, 99222 and 99223)
    - Level One (CPT Code 99221) requires 3 key components
      - Detailed History
      - Detailed Exam
      - Straightforward/Low Complexity of Medical Decision Making
- Common Problem Scenario
  - Documentation contains:
    - Expanded Problem Focused History
    - Expanded Problem Focused Exam
    - Straightforward Medical Decision Making
  - Do not support the lowest level required

Critical Care

- Background
  - Providing medical care to a critically ill patient in a critical care unit does not in itself qualify as a critical care service
  - Critical care is a time based code. As such, the progress note must contain documentation of the actual time spent providing critical care
  - Only one physician may bill for a given hour of critical care even if more than one physician is providing care to a critically ill patient
  - The teaching physician must be present during the entire period of time billed as critical care
  - Time spent teaching may not be counted towards critical care time

Critical Care (cont.)

- Common Problem Scenario #1
  - **Patient is in ICU and physician documents care, notes he is stable and indicates time in/out for the day as 20 minutes.**
- Common Problem Scenario #2
  - Patient on Surgical Ward and is critically ill. Resident sees the patient in the morning and spends 30 minutes examining him.
  - Teaching physician examines the patient later that evening for approximately 35 minutes.
  - Teaching physician records the patient condition, changes in treatment, etc. and indicates the total visit time for the day was one hour.
  - Teaching physician records codes 99291 for 35 minutes of critical care.
  - Time resident spent examining patient does not count toward critical care time. Teaching physician must be present for entire time billed as critical care.

References

- American Medical Association Current Procedural Terminology (CPT), 2005
- Medicare Carriers Manual, Part 3, Transmittal 1780. revised November 22, 2002
- Medicare Claims Processing Manual
  - Chapter 12
    - 30.6: Evaluation and Management (E/M) Service Codes General (Codes 99201- 99499)
    - 30.6.1: Selection of Level of E/M Service
    - 30.6.1. B: Selection of Level of E/M Service (counseling)
    - 30.6.2: Billing for Medically Necessary Visit on Same Occasion as Preventive Medicine Service
    - 30.6.4: E/M Services Furnished Incident-to Physicians Service by Non-physician practitioner
    - 30.6.7: Payment for Office/Outpatient Visits (Codes 99201-99215)
    - 30.6.10: Consultations (Codes 99241-99275)
    - 30.6.12: Critical Care Visits and Neonatal Intensive Care (Codes 99291- 99292)
    - 100.1: Payment for Physician Services in Teaching Setting under the Medicare Physician Fee Schedule
    - 100.1.1: E/M Services

Questions/Answers