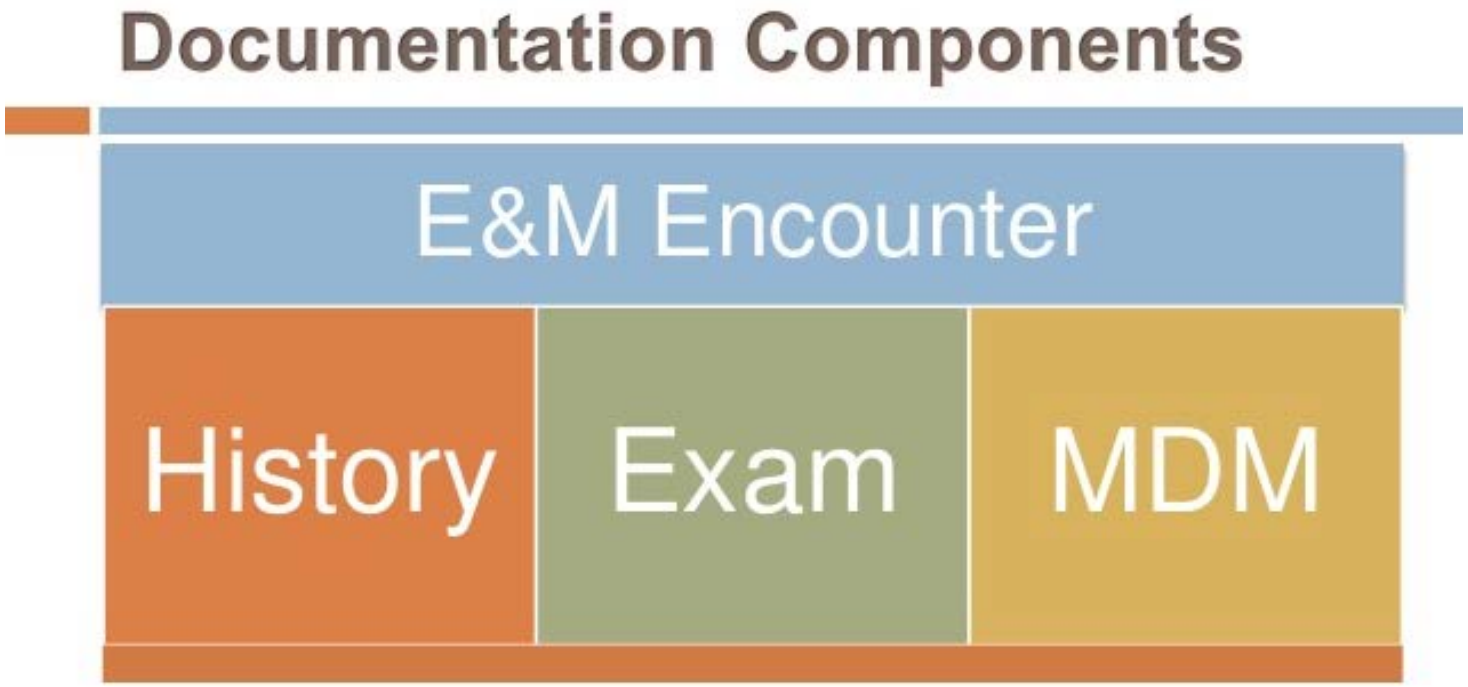
Documentation Components
E&M Encounter
History
Exam
MDM

Session Guidelines

This is a 15 minute webinar session for CNC physicians and staff

CNC holds webinars monthly to address topics related to risk adjustment documentation and coding

Next scheduled webinar:

- April
- Topic: Neoplasms/Lymphoma/Leukemia

CNC does not accept responsibility or liability for any adverse outcome from this training for any reason including undetected inaccuracy, opinion, and analysis that might prove erroneous or amended, or the coder/physician's misunderstanding or misapplication of topics. Application of the information in this training does not imply or guarantee claims payment.

Agenda

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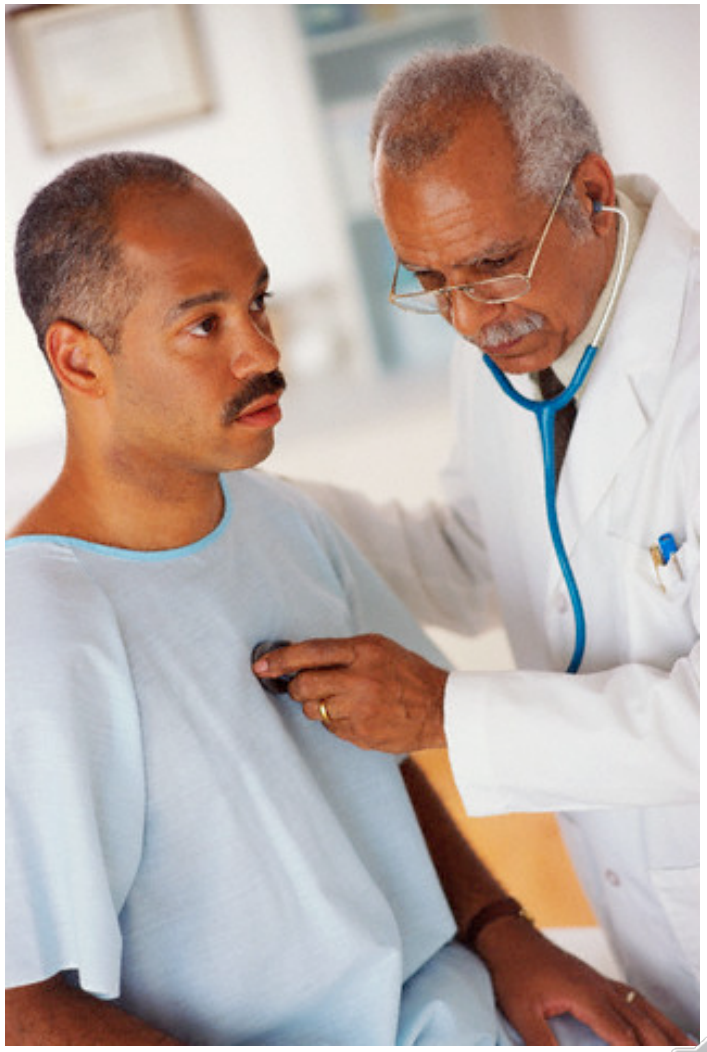
- Components of E&M
  - Office or Other Outpatient Services



COMPONENET

History

Exam

Medical Decision Making (MDM)

3 Key Components

Counseling

Coordination of Care

Time

Nature of Presenting Problem

HISTORY

The history section of the Key Components includes:

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

A chief complaint is a medically necessary reason for the patient to meet with the physician or other qualified health care provider

History of Present Illness

- According to CMS, the HPI must be documented by the physician or other qualified health care professional; it cannot be documented by ancillary staff
- The number of components documented for the history of present illness will determine the HPI level
- The history of present illness can be considered brief or extended

History of Present Illness

- ✓ Location
- ✓ Quality
- ✓ Severity
- ✓ Duration
- ✓ Timing
- ✓ Context
- ✓ Modifying Factors
- ✓ Associated Signs & Symptoms

OR

The status of at least three chronic conditions

HISTORY: hpi

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HPI Level	Elements Required	Example
Brief	1 to 3 HPI	Patient is here for knee (**location**) pain lasting 2 weeks (**duration**).
Extended	4 or more HPI	Patient is here for intermittent (**timing**) knee (**location**) pain lasting 2 weeks (**duration**). She states it is a dull (**quality**) pain that increases when she runs (**modifying factor**).

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Review of Systems

- According to CMS' documentation guidelines, the ROS can be obtained by ancillary staff (e.g., nurse) or on a form completed by the patient
- A complete list of systems used in the Review of Systems can be found in your CPT® codebook, in the Evaluation and Management Guidelines
- Medical necessity determines the extent of the ROS

ROS Level	Elements Required	Example
Problem Pertinent	1 (addresses only the body system directly related to the problem)	Patient denies itching or blisters with the hives.
Extended	2-9 (The system directly affected and related systems are reviewed)	She denies any N/V, diarrhea, or changes in her bowel or bladder function. She denies any SOB or palpitations. She denies headache or visual disturbance
Complete	10+	

HISTORY: PFSH (Past, Family, and Social History)

The past history focuses on the patient's prior medical treatments and can include:

- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies
- Age appropriate immunization status
- Age appropriate feeding/dietary status

The family history describes occurrences in the patient's family and typically includes a list of diseases or hereditary conditions that may place the patient at risk

The social history identifies current and past patient activities, such as:

- Social status or living arrangements
- Employment status
- Occupational history
- Drug, tobacco, alcohol use
- Education level
- Sexual history
- Any social event/occurrence impacting patient's condition

HISTORY: PFSH (Past, Family, and Social History)

Office or other outpatient services, established patient – requires 2 of the 3 history areas to be documented

Office or other outpatient services, new patient – requires that at least 1 item from each history must be documented

PFSH Level	Elements Required	Example
Pertinent	1	PMH: Prozac for depression x 3 years; 3 pregnancies, 1 spontaneous Ab, 2 SVDs, 1 at term, 1 at 35 weeks, living male age 8 years, female age 5 years. Postpartum BTL for contraception 5 years ago. No chronic illnesses.
Complete	2 of 3	PMH: CAD s/p CABG Family History: Father MI, Mother Stroke and Diabetes Social: Non-smoker, exercise daily, married

HISTORY: HPI, ROS, PFSH

When the level of each element of history has been determined, the levels are combined to determine the overall level of history.

There are four levels of history defined in the Evaluation and Management Guidelines:

- Problem Focused
- Expanded Problem Focused
- Detailed
- Comprehensive

HISTORY					
	*Status of 3 Chronic Conditions is **not available** within the context of 1995 Guidelines*				
	HPI (history of present illness) elements: ☐Location ☐ Severity ☐ Timing ☐Modifying factors ☐ Quality ☐ Duration ☐ Context ☐Associated signs and symptoms	☐ Brief (1-3)	☐ Brief (1-3)	☐ Extended (4 or more)	☐ Extended (4 or more)
	ROS (review of systems): ☐ Eyes ☐ Ears, nose, mouth, throat ☐ Constitutional (wt loss, etc) ☐ All others negative ☐ Cardiovascular ☐ Endocrine ☐ Musculoskeletal ☐ Gastrointestinal ☐ Genitourinary ☐ Neurological ☐ Integumentary ☐ Hematological/Lymph ☐ Psychological ☐ Respiratory ☐ Allergy/Immuno	☐ None	☐ Pertinent to Problem (1 system)	☐ Extended (2-9 Systems)	☐ **Complete
	PFSH (past medical, family, social history) areas: ☐ Past history (the patient's past experiences with illnesses, operation, injuries and treatments) ☐ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) ☐ Social history (an age appropriate review of past and current activities)	☐ None	☐ None	☐ Pertinent (1or 2 history areas)	☐ Complete* (2 or 3 history areas)
	HISTORY SCORE.....	PROBLEM FOCUSED	EXP.PROB. FOCUSED	Detailed	COMPREHENSIVE

*Complete PFSH: **2 history areas**: a) Established patients – office (outpatient) care, domiciliary care, home care b) Emergency department; c) Subsequent nursing facility care; d) Subsequent hospital care

3 history areas: a) New patients – office (outpatient) care, domiciliary care, home care; b) Initial consultations; c) Initial hospital care; d) Hospital observation; and, e) Comprehensive nursing facility assessments.

EXAM

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The 1995 & 1997 guidelines define differently the specific elements determining the exam

The guidelines most beneficial to the specific encounter should be used for that encounter

Both guidelines recognize the same <u>body areas</u>:

- Head, including the face
- Neck
- Chest, including the breast and axillae
- Abdomen
- Genitalia, groin, and buttocks
- Back, including spine
- Each extremity

Most payers require you to work with either the body areas or organ systems, *<u>not both</u>*

Both guidelines recognize the same <u>organ systems</u>:

- Constitutional
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic, lymphatic, and immunologic

EXAM

The 1995 and 1997 guidelines define the four levels of exam differently:

- Problem Focused
- Expanded Problem Focused
- Detailed
- Comprehensive

Limited to affected body area or organ system (one body area or system related to problem)	PROBLEM FOCUSED EXAM
Affected body area or organ system and other symptomatic or related organ system(s) (additional systems)	EXPANDED PROBLEM FOCUSED EXAM
Extended exam of **affected** area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 (**more depth and elaboration than above**)	DETAILED EXAM
General multi-system exam (8 or more systems) or complete exam of a single organ system (Body areas do not count)	COMPREHENSIVE EXAM

EXAM	☐ 1 body area or organ system	☐ 2 – 4 body areas **or** organ systems	☐ 5 – 7 body areas **or** organ systems ***WITH MORE DEPTH***	☐ 8 or more organ systems or comprehens. single organ system exam
Body area: ☐Head, including face ☐ Chest, including breasts and axillae ☐ Abdomen ☐Neck ☐ Back, including spine ☐ Genitalia, groin, buttocks ☐Each extremity **OR** **Organ systems:** ☐Constitutional (e.g., vitals, gen app) ☐ Ears, nose, mouth, throat ☐ Respiratory ☐ Gastrointestinal ☐ Musculoskeletal ☐ Skin ☐ GU ☐Psych ☐Hem/lymph/imm ☐ Neuro ☐Eyes ☐Cardiovascular				
Exam Score – (_____)	PROBLEM FOCUSED	EXP.PROB FOCUSED	DETAILED	COMPRE HENSIVE

MEDICAL DECISION MAKING (MDM)

Whether you use the 1995 or 1997 E/M Documentation Guidelines, the nature of the presenting problem and medical necessity of the encounter are the best MDM indicators.

The nature of presenting problem, as defined by the CPT® codebook is, “a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for the encounter, with or without a diagnosis being established at the time of the encounter.”

You will choose an overall MDM level based on three factors:

1. The number of diagnoses or management options
2. The amount and/or complexity of data to be reviewed
3. The risk of complications and morbidity or mortality

MEDICAL DECISION MAKING (MDM)

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3. Medical Decision Making

Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (Maximum number = two categories.) Do not categorize the problem(s) if the encounter is dominated by counseling/coordinating of care, and duration of time is not specified. In that case, enter 3 in the total box.

Number of Diagnoses or Treatment Options

A	B X C = D		
Problem(s) Status	**Number**	**Points**	**Result**
Self-limited or Minor (stable, improved or worsening)	Max=2	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	Max=1	3	
New prob (to examiner); add workup planned		4	
		TOTAL	

Multiply the number in columns B & C and put the product in column D.
Enter a total for column D.
Bring total to **line A** in Final Result for Complexity (table below)

Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the point's column. Total the points.

Amount and/or Complexity of Data Reviewed

Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history form someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

Bring total to **line C** in Final Result for Complexity (table below)

MEDICAL DECISION MAKING (MDM)

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Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care, the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below)

Risk of Complications and/or Morbidity or Mortality			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Options Selected**
Minimal	• One self-limited or minor problem e.g. cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g. well controlled hypertension or non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • 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, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath • Obtain fluid from body cavity, e.g., 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 may pose a threat to life or bodily function, e.g., 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, e.g., seizure, TIA, weakness or 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

MEDICAL DECISION MAKING (MDM)

To select an overall MDM level, at least *two of three elements* (number of diagnoses or management options; amount and/or complexity of data to be reviewed; risk of complications and/ or morbidity or mortality) for that level must be met.

Driving Factor

Final Result for Complexity

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

Final Result for Complexity					
A	Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and complexity of data	< 1 Minimal or Low	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making		STRAIGHT-FORWARD	LOW COMPLEX.	MODERATE COMPLEX.	HIGH COMPLEX.

CONTRIBUTORY FACTORS

- Counseling & Coordination of Care
- Time
  - ✓ When counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family (face-to-face in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time shall be considered the key or controlling factor to qualify for a particular level of E/M services.

Office or Other Outpatient Services – New Patient

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CPT	History	Exam	MDM	Time
99201	Problem Focused	Problem Focused	Straight Forward	10 Min
99202	Expanded Problem Focused	Expanded Problem Focused	Straight Forward	20 Min
99203	Detailed	Detailed	Low	30 Min
99204	Comprehensive	Comprehensive	Moderate	45 Min
99205	Comprehensive	Comprehensive	High	60 Min

Requires All 3 Key Components

Office or Other Outpatient Services – Established Patient

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CPT	History	Exam	MDM	Time
99211	Presenting Problem Minimal			5 Min
99212	Problem Focused	Problem Focused	Straight Forward	10 Min
99213	Expanded Problem Focused	Expanded Problem Focused	Low	15 Min
99214	Detailed	Detailed	Moderate	25 Min
99215	Comprehensive	Comprehensive	High	40 Min

Requires 2 of 3 Key Components

Questions

Please submit coding and documentation questions to RAFeducation@cnchealthplan.com