Evaluation and Management Coding 2019

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Evaluation and Management Codes

- Evaluation and Management codes (or E/M codes for a shorthand version) are used to designate some form of examination and/or consultation.
- For the use of E/M codes there are two types of patients.
  - New Patients
  - Established Patients
- At this time Medicare is not paying for E/M services when provided or ordered by a chiropractor.
- A new patient is a patient that has not been seen by the doctor before or one that has not been seen for three years or more.
- Therefore any patient that has not been seen by the doctor at all for three years is a new patient.
- An established patient is one that is currently under care or one that has not been absent from the practice for more than three years.
- There are five levels of E/M coding for new patients and five levels of E/M coding for established patients.
- The level of coding is determined by the specific complexity of the examination performed.
- The new patient codes are:
  - 99201 - The evaluation and management of a new patient. This visit requires these three components:
    - A problem focused history
    - A problem focused examination
    - Straightforward medical decision making
  - 99202 - The evaluation and management of a new patient. This visit requires these three components:
    - An expanded problem focused history
    - An expanded problem focused examination
    - Straightforward medical decision making
  - 99203 - The evaluation and management of a new patient. This visit requires these three components:
    - A detailed history
    - A detailed examination
    - Low complexity medical decision making
  - 99204 - The evaluation and management of a new patient. This visit requires these three components:
    - A comprehensive history
    - A comprehensive examination
    - Moderate complexity medical decision making

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  - 99205 - The evaluation and management of a new patient. This visit requires these three components:
    - A comprehensive history
    - A comprehensive examination
    - High complexity medical decision making
- The established patient codes are:
  - 99211 - The evaluation and management of an established patient that may not require the presence of a physician. An example of this would be when the nurse takes your height, weight, blood pressure, pulse, and respiration.
  - 99212 - The evaluation and management of an established patient. This visit requires two of these three components:
    - A problem focused history
    - A problem focused examination
    - Straightforward medical decision making
  - 99213 - The evaluation and management of an established patient. This visit requires two of these three components:
    - An expanded problem focused history
    - An expanded problem focused examination
    - Low complexity medical decision making
  - 99214 - The evaluation and management of an established patient. This visit requires two of these three components:
    - A detailed history
    - A detailed examination
    - Moderate complexity medical decision making
  - 99215 - The evaluation and management of an established patient. This visit requires two of these three components:
    - A comprehensive history
    - A comprehensive examination
    - High complexity medical decision making
- Three of these codes will rarely be used by chiropractors;
  - 99211
    - This code is referred to as the nurses code.
    - It is used when a nurse takes a patient's vital signs.
    - If the doctor is involved in the examination at all then this code is not appropriate.
  - 99205 and 99215
    - These are the highest level exam codes for both the new patient and established patient.
    - The examination required to justify these codes is extensive and covers virtually every element of the applicable guidelines.
    - While not impossible for a chiropractor to reach this standard in the course of their normal practice, it would be rare.

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- Starting on January 1, 2021, CMS is changing the E/M coding by combining the middle three codes into one.
- This will be:
    - 99201
    - 99202
    - 99203 } single new code
    - 99204
    - 99205
- Medical Decision Making will become the primary determinate of the code level at that time.

Evaluation and Management Code Components

- There are 7 components used to define the level of E/M service:
    - History
    - Examination
    - Medical Decision Making
    - Counseling
    - Coordination of care
    - Nature of presenting problem
    - Time
- The first 3 components;
    - History
    - Examination
    - Medical Decision Making
- Are the key components in selecting the level of E/M service.
- The exception to this rule is visits that consist primarily of counseling or coordination of care.
- For these services time overrides the key factors.
- There are also 2 sets of guidelines for E/M services.
- The first set was developed by CMS in 1995 and are creatively called the 1995 Guidelines.
- The 1995 Guidelines caused specialists to down-code there E/M services so CMS came up with a new set of guidelines two years later.
- These were creatively called the 1997 Guidelines.
- The primary difference between the two sets of guidelines is the examination.

History

- The History element has 4 parts:
- The Chief Complaint (CC)
- The History of Present Illness (HPI)
- The Review of Systems (ROS)
- The Past Medical, Family, and Social Histories (PFSH)

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- Starting on January 1, 2019, the Review of Systems (ROS) and the Past Medical, Family, and Social Histories (PFSH) do not need to be duplicated in established E/M visits unless there is new information.
- Be sure and document that you have asked the patient if there is anything new regarding the ROS and PFSH during established E/M visits for an episode of care and for the initial visit for a new episode of care.

Examination

- 1995 Guidelines
- The examination for the 1995 guidelines is a more general examination and basically designed for general practitioners.
- Practitioners that focus on specific body areas require specialized examinations tailored to the specific body area.
- The levels of E/M services are based on four types of examination that are defined as follows:
  - **Problem Focused** -- a limited examination of the affected body area or organ system.
  - **Expanded Problem Focused** -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
  - **Detailed** -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
  - **Comprehensive** -- a general multi-system examination or complete examination of a single organ system.
- The levels of examination are determined by the number of body areas or organ systems examined.
  - **Problem Focused** -- 1 body area or organ system.
  - **Expanded Problem Focused** – up to 7 systems.
  - **Detailed** – up to 7 systems*.
  - **Comprehensive** – 8 or more systems.
- Some third party payers use a criterion called 2 by 2 or 4 by 4 to distinguish between Expanded Problem Focused and Detailed.
- **Note:** You cannot combine body areas and organ systems together to increase the count.
- 1997 Guidelines:
- The examinations for the 1997 guidelines are divided into a general multi-system examination and 11 single organ system examinations.
- Specialists usually select the single organ system examination the best fits their specialty.
- The single organ system examinations are:
  - Cardiovascular
  - Ears, Nose, Mouth, and Throat
  - Eyes
  - Genitourinary (Female)
  - Genitourinary (Male)
  - Hematologic/Lymphatic/Immunologic
  - Musculoskeletal

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- Neurological
- Psychiatric
- Respiratory
- Skin

- Generally the musculoskeletal examination is considered the best fit for chiropractic.
- It covers six system/body areas; constitutional, cardiovascular, lymphatic, neurological/psychiatric, musculoskeletal, and skin.
- Each system/body area has specific items that must be covered to be counted.
- Each of these items must be mentioned in your examination documentation to be considered.
- One to five items examined is considered a Problem Focused examination.
- Six to eleven items examined is considered an Expanded Examination.
- Twelve or more items examined is considered a Detailed examination.
- All items examined is considered a Comprehensive examination.

Medical Decision Making

- The medical decision making section seeks to quantify the doctor's thought process and assign it specific values.
- As such, the medical decision making is a little more complicated than the history or examination.
- Determining the level of difficulty of the Medical Decision Making is a three step process.
- Step 1: Number of Diagnoses or Treatment Options
  - Identify each problem or treatment option identified in the patient's chart.
  - Enter the number in each of the categories in column B in the table, multiply by column C and total the results at the bottom of column D.

Step 1: Number of Diagnoses or Treatment Options

A	B x	C =	D
Problem(s) Status	**Number**	**Points**	**Result**
Self-limited or minor (stable, improved, 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 problem (to examiner); additional workup planned		4	
		Total	

- Step 2: Risk of Complications and/or Morbidity or Mortality
  - Use the risk table as a guide to assign risk factors.
  - Circle the presenting problem elements that apply.
  - The overall risk level corresponds with the highest level circled.

Step 2: 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/M Service	• Brief (<10 visits) treatment plan
Low	• Two or more self-limited or minor problems • One stable chronic illness • Acute uncomplicated illness or injury	• E/M Service • X-rays to one or two spinal regions	• Moderate (11 – 30 visits) treatment plan
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 • Acute illness with systemic symptoms • Acute complicated injury	• E/M service • X-rays to more than two spinal regions • X-ray(s) to extraspinal areas • Additional imaging e.g. CT, MRI	• Extended (>30 visits) treatment plan
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 • An abrupt change in neurologic status	• E/M service • X-rays to more than two spinal regions • X-ray(s) to extraspinal areas • Additional imaging e.g. CT, MRI	• Extended (>30 visits) treatment plan • Manipulation under anesthesia • Referral and/or coordination with other specialists

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- Step 3: Amount and/or Complexity of Data Reviewed
  - For each category of reviewed data identified, circle the number in the points column and total the points.

Step 3: 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 from someone other than patient and/or discussion of case with another heath care provider	2
Independent visualization of image, tracing, or specimen itself (not simply review of report)	2
Total	

- Final Result for Complexity
  - Draw a line down the column with 2 or 3 circled selections.
  - If no column has more than 1 selection, draw a line down the column with the selection second from the left.

Final Result for Complexity					
1	Number of Diagnoses or Treatment options	1 or less Minimal	2 Limited	3 Multiple	4 or more extensive
2	Highest Risk	Minimal	Low	Moderate	High
3	Amount and Complexity of Data	1 or less Minimal	2 Limited	3 Multiple	4 or more extensive
Type of Decision Making		Straight-forward	Low Complexity	Moderate Complexity	High Complexity

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Level of Service

- To determine the level of E/M service first determine if the patient is a New Patient or an Established Patient.
- A patient is new if they are new to the practice or if they have not been seen in the practice for more than three years.
- The correct E/M code for a new patient will be the code level with the row with all three selections circled or the column with the selection closest to the top.

New Patient E/M Coding			
Code	History	Examination	MDM Medical Decision Making
99201	Problem Focused	Problem Focused	Straight Forward
99202	Expanded Problem Focused	Expanded Problem Focused	Straight Forward
99203	Detailed	Detailed	Low
99204	Comprehensive	Comprehensive	Moderate
99205	Comprehensive	Comprehensive	High

- The correct E/M code for an established patient will be the code level with the row with two of the three selections circled or the column with the selection second closest to the top.

Established Patient E/M Coding			
Code	History	Examination	MDM Medical Decision Making
99211	None	None	N/A
99212	Problem Focused	Problem Focused	Straight Forward
99213	Expanded Problem Focused	Expanded Problem Focused	Low
99214	Detailed	Detailed	Moderate
99215	Comprehensive	Comprehensive	High

Evaluation and Management Codes

- One question that is often asked is if the report of findings (ROF) is part of the original E/M service or if a separate consultation service should be billed.
- The answer is that the ROF is part of the original E/M service usually, but there are exceptions.
- The E/M service includes consultation and coordination of care elements so if the ROF just covers what you found during the original history and examination then the ROF is included.
- If however, the ROF includes new information that you did not get from the history and exam (an example would be MRI results or information from other medical records) then billing a consultation code would be appropriate.
- It should be noted that Medicare does not consider a consultation to be a covered service for any doctor or provider.

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Consultation

- The consultation codes are:
  - 99241 - Consultation with a new patient or established patient. Usually the face-to-face time is 15 minutes. This consultation requires these three components:
    - A problem focused history
    - A problem focused examination
    - Straightforward medical decision making
  - 99242 - Consultation with a new patient or established patient. Usually the face-to-face time is 30 minutes. This consultation requires these three components:
    - An expanded problem focused history
    - An expanded problem focused examination
    - Straightforward medical decision making
  - 99243 - Consultation with a new patient or established patient. Usually the face-to-face time is 40 minutes. This consultation requires these three components:
    - A detailed history
    - A detailed examination
    - Low complexity medical decision making
  - 99244 - Consultation with a new patient or established patient. Usually the face-to-face time is 60 minutes. This consultation requires these three components:
    - A comprehensive history
    - A comprehensive examination
    - Moderate complexity medical decision making
  - 99245 - Consultation with a new patient or established patient. Usually the face-to-face time is 80 minutes. This consultation requires these three components:
    - A comprehensive history
    - A comprehensive examination
    - High complexity medical decision making
- When the consultation code is used to report a patient consultation (such as a ROF) then time overrides the other three elements.
- When another doctor requests a consult where you examine the patient and render an opinion to the doctor requesting the consult then the three elements would be the primary deciding factor for the level of code.
- Used properly, the consultation code can be beneficial to your practice.

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Evaluation and Management Codes

- According to the CPT® coding rules it is appropriate to perform both the E/M service and the adjustment on the same day at the same visit.
- If you perform both services you need to inform the third party payer that the E/M service was a separate and distinct service.
- You do this by billing the E/M service code with a -25 modifier appended.
- You would also use the -25 modifier on the E/M code when you bill a separate service such as 95851 or 95852.
- These are range of motion testing codes and can be billed on the same day as an E/M service when they fit the billing criteria.

Summary

- Evaluation and Management services are an important part of your practice.
- Knowing when and how to bill these services will make the difference between getting paid and not.

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