Introduction to Evaluation and Management Services and the Scoring Process

Virtual Symposium

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11:00 a.m. CT

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Acronym List

Acronym	Definition
ADR	Additional Development Response
CC	Chief Compliant
CERT	Comprehensive Error Rate Testing Program
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
E/M	Evaluation and Management
HPI	History of Present Illness
NPP	Non-Physician Practitioners
MDM	Medical Decision Making
PFSH	Past Medical, Family, and Social History
ROS	Review of Systems

Today's Presentation

- Agenda:
  - Evaluation and Management Services Coding Rules
  - Fundamentals of Coding Evaluation and Management Services
  - Novitas Score Sheet Introduction
  - 2021 Office/Outpatient Introduction
- Objectives:
  - Navigate the website to locate the resources available to ensure understanding of rules for evaluation and management codes
  - Introduce interactive tools utilized for billing and coding evaluation and management services
  - Review important requirements to eliminate documentation and coding errors
  - Introduce the 2021 Office/Outpatient revisions

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Evaluation and Management Services Coding Rules

Evaluation and Management Guidelines

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- The 2020 Current Procedural Terminology (CPT) manual is a medical coding set used to report medical, surgical, and diagnostic procedures to physicians and health insurance companies
- Guidance on billing and coding Evaluation and Management Services can be referenced in Internet Only Manual Medicare Claims Processing Manual, Pub. 100-4, Chapter 12 - Physicians/Nonphysician Practitioners, Section 30.6, “E/M Service Codes”
- The CMS Evaluation and Management Guide is a reference tool that provides direction based on the 1995 and 1997 Documentation guidelines for E/M services
- 1995 Documentation Guidelines for evaluation and management services provides guidance on billing the history, exam and medical decision making
- 1997 Documentation Guidelines for evaluation and management services provides an expanded definitions of status of chronic conditions and specialty examination scoring

Novitas Solution's Website

- Evaluation and Management Center (JH) (JL):
  - Interactive Tools & Printable E/M, Specialty Score Sheets
  - Fact Sheets
  - Coding Instructions
  - E/M Frequently Asked Questions
  - Education and Training
  - CERT program findings
  - Targeted Probe and Educate
  - Additional Coding Assistance

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Fundamentals of Coding Evaluation and Management Services

Principles of Medical Record Documentation

- Medical record should be complete and legible
- Documentation of each patient encounter should include:
  - Reason for encounter and relevant history
  - Physical examination findings
  - Prior diagnostic test results
  - Assessment, clinical impression or diagnosis
  - Plan for care
  - Date and legible identity of observer:
    - ✓ Medical Review Signature Requirements (JH) (JL)

Medical Necessity

- All E/M services must be adequately documented so medical necessity is evident
- Medical necessity is the overarching criteria for payment in addition to the individual requirements of CPT
- Medicare does not pay for services not medically necessary
- References:
  - Claims Processing Manual, Pub. 100-04, Chapter 12 – Physicians/Nonphysician Practitioner, Section 30.6.1.A, “Use of CPT Codes”
  - The Social Security Act 1862 (a)(1)(A)

Components of an Evaluation and Management Service

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- History
- Physical Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time

Types of Evaluation and Management Services Based on Key Components

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- Office/Outpatient
- Emergency Department
- Observation
- Hospital Care
- Nursing Facility
- Domiciliary
- Home Care

Evaluation and Management Services Based on Other Criteria

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- Discharge Care
- Critical Care Services
- Prolonged Services
- Care Plan Oversight Services
- Preventive Medicine
- Non-Face-to-Face Services
- Chronic Care Management
- Transitional Care Management
- Advanced Care Planning

E/M Scoring Process

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- Definition:
  - A EM scoring process is defined as a means to determine range of codes based on EM category of service, place of service and status of the patient
- Purpose:
  - Measure the extent of history obtained by practitioner using the chief complaint, history of present illness, review of systems, and past medical, family and social history
  - Measure the extent of the examination using the 1995 or 1997
  - Measure the complexity of establishing a diagnosis and/or selecting a management option based on the number of possible diagnoses and/or the number of management options, the amount and/or complexity of data and the risk of significant complications, morbidity, and/or mortality

Minimize Coding Errors

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- Thoroughly review E/M guidelines
- Consider self-auditing claims
- Use available resources to aide in the audit process
- If requested, respond to ADRs timely and with proper documentation

Prevent One Level Down Codes

- Be specific and exacting in your documentation
- Do not give credit for what is not in the record
- History – often missing one component of the PFSH
- Exam – scored as detailed when documentation reveals expanded problem focused
- MDM – prescription drug management versus drug therapy requiring extensive monitoring for toxicity

Review Documentation

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- Services must be reasonable and necessary
- Verify codes billed represent:
  - Patient type (for example, new or established patient)
  - Setting/place of service
- Base the level of service on the number and type of key components performed and documented
- Ensure records meet authentication requirements:
  - Utilize signature attestation statement or signature log, if necessary
  - Confirm records include authenticated order or authenticated documentation showing intent to order
- If requested, respond to ADRs timely and with proper documentation
- Audit documentation prior to submission

Authenticate Medical Records

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- Ensure proper signatures are included in medical records
- Late signatures not accepted
- Use attestation statements in lieu of adding late signatures
- Signature logs accepted for illegible handwritten signatures

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Novitas Score Sheet Introduction

Score Sheets for Evaluation and Management Services

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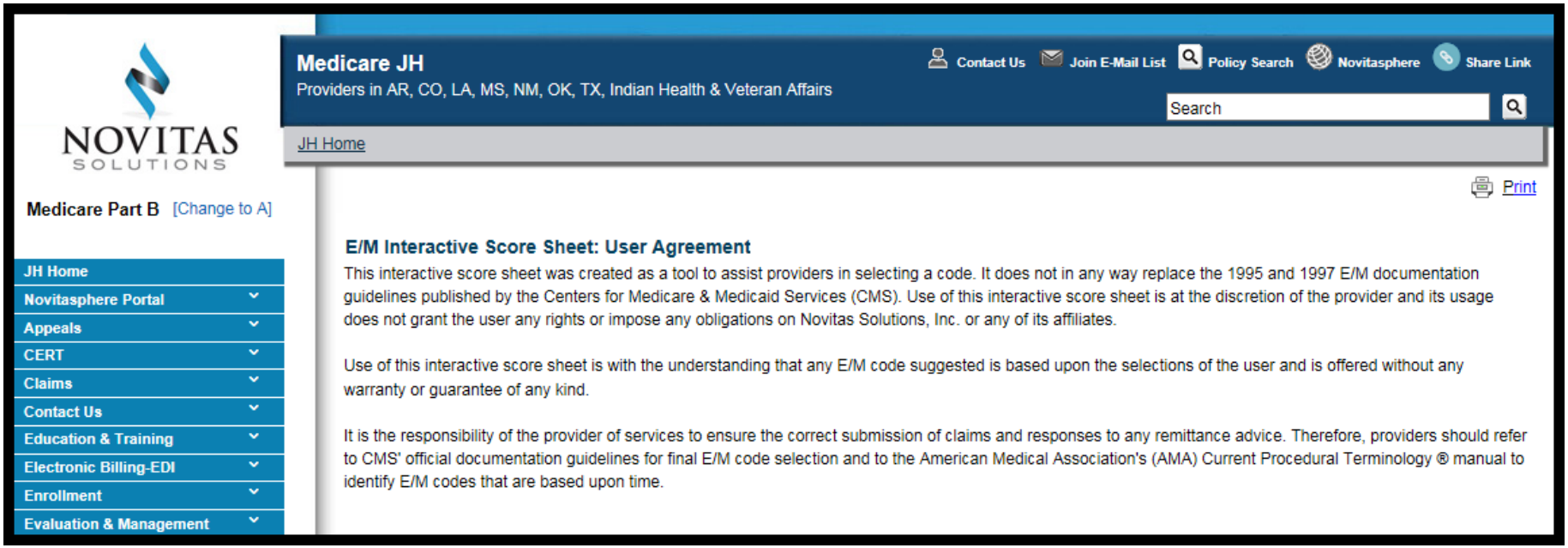
- Purpose:
  - Designed to assist only with identifying the appropriate level of service defined by the work documented as rendered using the CMS Documentation Guidelines for Evaluation and Management Services
  - Must be used in conjunction with the CMS Evaluation and Management Guidelines for 1995 and 1997
  - Other factors must be considered before arriving at the final code reported to Medicare (e.g., medical necessity and removing from the scoring any documented services reflective of separately reported preventive services and non-relevant documentation)
- Interactive Score Sheet (JH) (JL):
  - Online, click and print score sheet based on the 1995 documentation guidelines
- Print and Fill Score Sheets (JH) (JL):
  - Blank printable score sheets available for the 1995 and 1997 guidelines

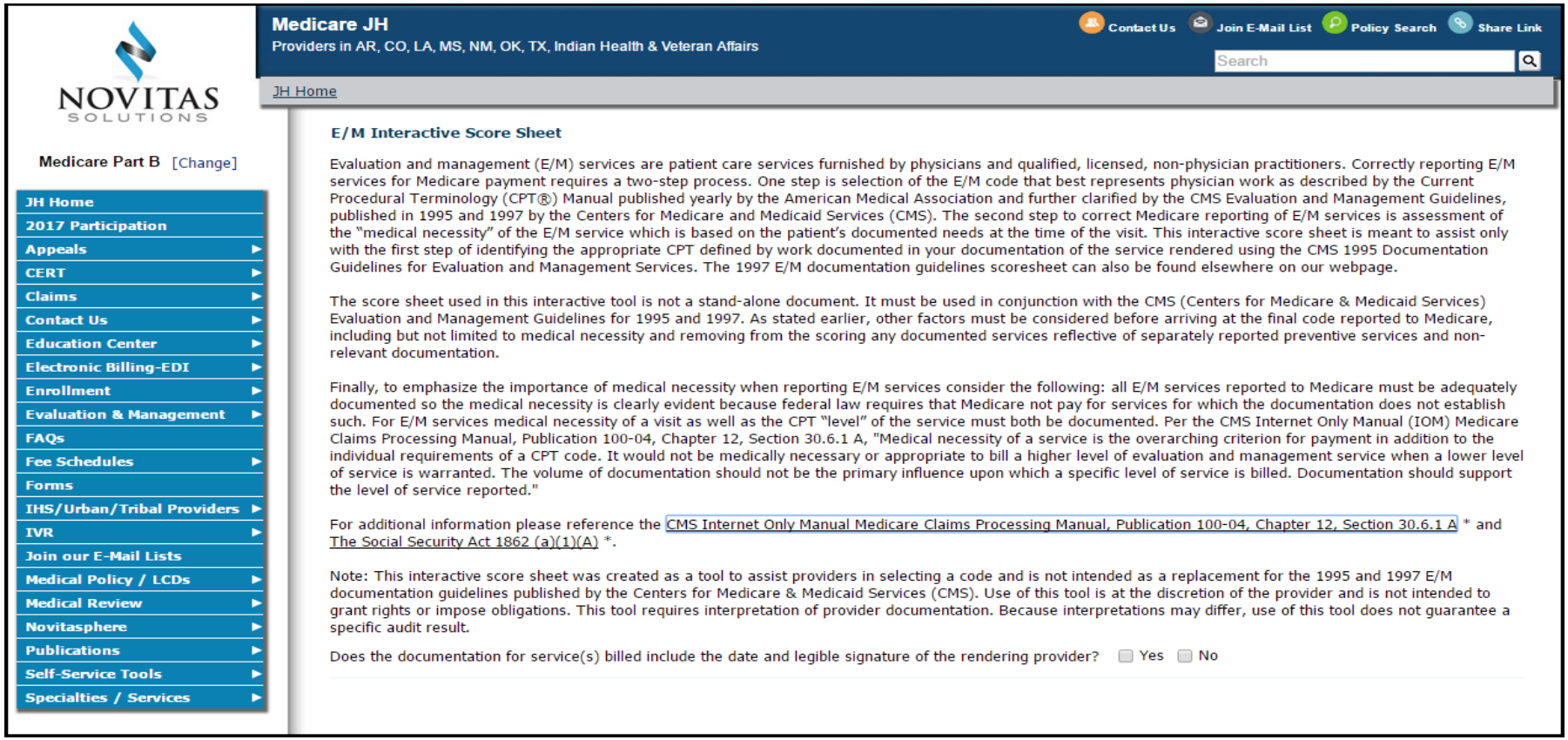
User Agreement

- Must accept User Agreement



Interactive E/M Score Sheet

- Interactive Score Sheet (JH) (JL) page containing the definition of E/M services, purpose of the score sheet, and medical necessity



Signature Requirements

- Must verify medical record is dated and contains legible signature of the rendering provider before using interactive score sheet

E/M Interactive Score Sheet

Evaluation and management (E/M) services are patient care services furnished by physicians and qualified, licensed, non-physician practitioners. Correctly reporting E/M services for Medicare payment requires a two-step process. One step is selection of the E/M code that best represents physician work as described by the Current Procedural Terminology (CPT®) Manual published yearly by the American Medical Association and further clarified by the CMS Evaluation and Management Guidelines, published in 1995 and 1997 by the Centers for Medicare and Medicaid Services (CMS). The second step to correct Medicare reporting of E/M services is assessment of the "medical necessity" of the E/M service which is based on the patient's documented needs at the time of the visit. This interactive score sheet is meant to assist only with the first step of identifying [illegible] CPT [illegible] ordered using the CMS 1995 Documentation Guidelines for Evaluation and M[illegible] Services. [illegible] elsewhere on our webpage.

NO SIGNATURE =

The score sheet used in this interactive tool is not a stand-alone document as it must be used in conjunction with the [illegible] Centers for Medicare & Medicaid Services) Evaluation and Management Guidelines for 1995 and 1997. As stated earlier, other factors must be considered before arriving at the final code reported to Medicare, including but not limited to medical necessity and removing from the scoring any documented services reflective of separately reported preventive services and non-relevant documentation.

NO PAYMENT

Finally, to emphasize the importance of medical necessity when reporting E/M services, [illegible] services reported to Medicare must be adequately documented so the medical necessity is clear. [illegible] federal laws [illegible] for which the documentation does not establish such. For E/M services medical necessity of a visit as well as the CPT level of the service must both be documented. Per the CMS Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1 A, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."

For additional information please reference the CMS Internet Only Manual Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1 A " and The Social Security Act 1862 (a)(1)(A) ".

Note: This interactive score sheet was created as a tool to assist providers in selecting a code and is not intended as a replacement for the 1995 and 1997 E/M documentation guidelines published by the Centers for Medicare & Medicaid Services (CMS). Use of this tool is at the discretion of the provider and is not intended to grant rights or impose obligations. This tool requires interpretation of provider documentation. Because interpretations may differ, use of this tool does not guarantee a specific audit result.

Does the documentation for service(s) billed include the date and legible signature of the rendering provider? ☐ Yes ☐ No

Select E/M Service Category

- Select the proper category to determine the level of service

Determining Level of E/M Services

(Performance and documentation requirements for key components: History, Examination, and Medical Decision Making)

To determine the appropriate level of service for a patient's visit, it is necessary to first determine whether the patient is new or already established. The physician then uses the presenting illness as a guiding factor and his or her clinical judgement about the patient's condition to determine the extent of service to be performed. The key components of this determination are history, examination, and medical decision making.

Instructions: Please make your selection based upon your place of service, whether patient is new or established, the description that best characterizes the nature of visit, and the number of key components documented.

Office or Other Outpatient Services

- ◯ New Patient -- Office or Other Outpatient Services (3 of 3 components required)
- ◯ Established Patient -- Office or Other Outpatient Services (2 of 3 components required)

Hospital Inpatient, Observation, or Emergency Department Services

- ◯ Initial Hospital Care (3 of 3 components required)
- ◯ Subsequent Hospital Care (2 of 3 components required)
- ◯ Initial Observation Care (3 of 3 components required)
- ◯ Subsequent Observation Care (2 of 3 components required)
- ◯ Emergency Department Services (3 of 3 components required)

Nursing Facility Services

- ◯ Initial Nursing Facility Care (3 of 3 components required)
- ◯ Subsequent Nursing Facility Care (2 of 3 components required)
- ◯ Annual Nursing Facility Assessment (3 of 3 components required)

Domiciliary, Rest Home or Custodial Care Services

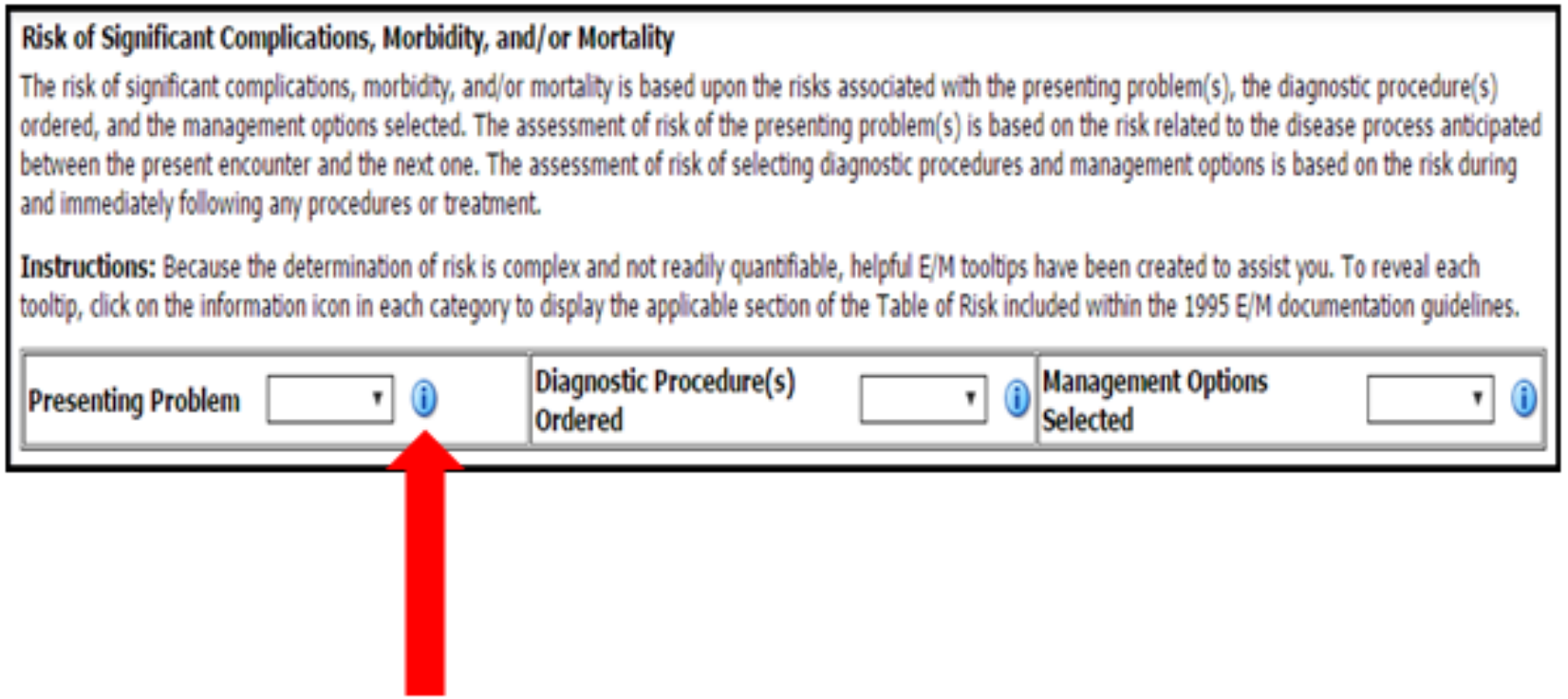
- ◯ New Patient -- Domiciliary, Rest Home or Custodial Care Services (3 of 3 components required)
- ◯ Established Patient -- Domiciliary, Rest Home or Custodial Care Services (2 of 3 components required)

Home Care Services

- ◯ New Patient -- Home Care Services (3 of 3 components required)
- ◯ Established Patient -- Home Care Services (2 of 3 components required)

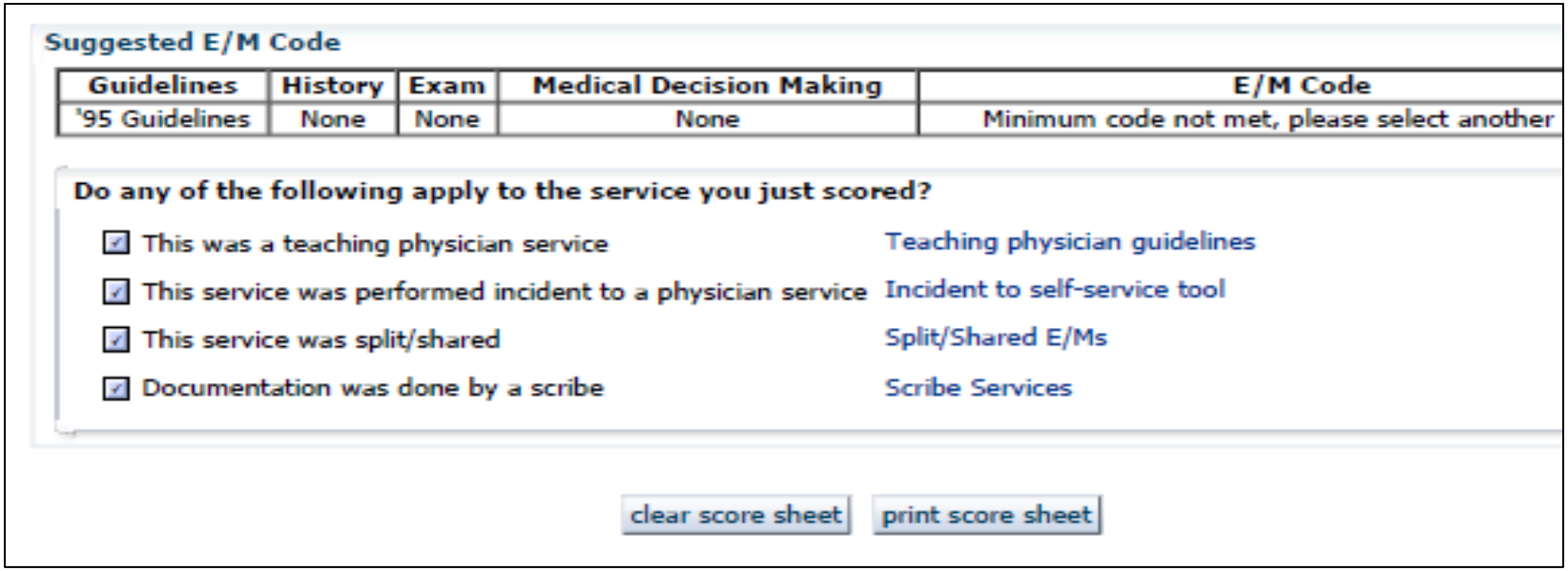
Information Icons

- Information icons indicate more information is available



Hyperlinks to Articles

- Links to articles to assist with understanding concepts



History

- Purpose:
  - To provide information about the clinical problems or symptoms addressed during the encounter
- Extent of history documented is dependent upon the physician's clinical judgment and the nature of the presenting illness or problem
- May be obtained from someone other than the patient

History Elements Defined

- Chief Complaint (CC) – the reason for the patient encounter
- History of Present Illness (HPI) – a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present
- Review of Systems (ROS) – inventory of questions related to the illness or condition
- Past Medical, Family, and Social History (PFSH):
  - 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

History Documentation and Scoring Tips

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- Indicate clearly the CC and/or reason for the visit
- Fully describe the history of the present illness and in a way that the nature of the presenting problem is clear
- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history
- Record the ROS appropriate for the clinical circumstance of the encounter
- Record PFSH appropriately considering the clinical circumstance of the encounter
- Ancillary staff may document the ROS and PFSH of the history:
  - HPI can be documented by ancillary staff for office/outpatient EM services only
- Non-Contributory may be appropriate documentation when referring to a patient's family history during an evaluation and management visit, if the family history is not pertinent to the presenting problem

Elements of HPI Defined

- Location – Place, site, position of the problem
- Quality – Describes the sign or symptom
- Severity – Describes the intensity of the symptom or pain
- Duration – Length of time the symptom has occurred
- Timing – Describes when patient experiences the symptom
- Context – Circumstances, cause, outside factors that started the problem
- Modifying Factors – What is done to make symptom worse or better
- Associated Signs and Symptoms – Describes what happens or does not happen at same time as symptom

Examination

- Definition:
  - Assessment of body areas or organ systems performed by clinician-physician's "hands on" exam
- Purpose:
  - Aids in determining the correct diagnosis and devising a treatment plan
- Types of exam:
  - Exam may involve several organ systems or a single organ system
  - Type and content of exam based on clinical judgment and nature of presenting problem
- Two sets of exam guidelines:
  - 1995 - includes General Multisystem Exam
  - 1997 - includes General Multisystem and 11 single organ system exams

Exam Documentation and Scoring Tips

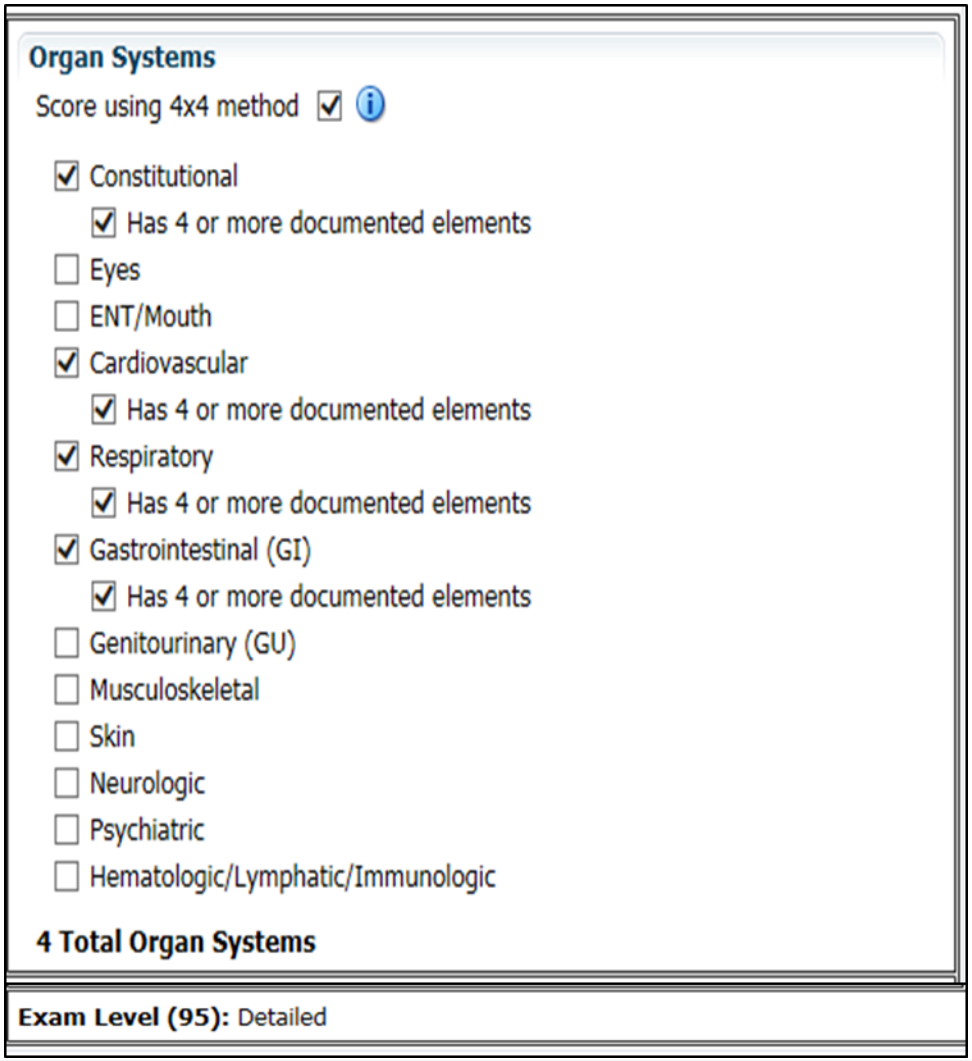
- Document specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s)
- Notation of “abnormal” without elaboration is not sufficient
- Describe abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s)
- Sufficient to provide a brief statement or notation indicating “negative” or “normal” to document normal findings related to unaffected area(s) or asymptomatic organ system(s)

Expanded Problem Focused or Detailed

- 1995 Exam:
  - Expanded Problem Focused – “Affected” body areas or organ system
  - Detailed – “Extended exam of affected” body areas or organ system
- Score a detailed exam using Evaluation and Management 4 x 4 Method (JH) (JL):
  - Four or more items documented for four or more body areas or organ systems
- Clinical inference overrides “4 x 4” tool providing individual consideration
- 1997 single organ system exams may be more beneficial in scoring
- 4 x 4 does not apply when using the 1997 guidelines

Example Using “4 x 4”

- Constitutional – B/P 125/80, Temp 98.7, Pulse 80, Respiration 20
- Respiratory – Clear to auscultation bilaterally with no rubs, no rhonchi, no wheezes, no rales
- Cardiovascular – Regular rate and rhythm, normal S1 and S2, no murmur, rub or gallop
- Gastrointestinal – Abdomen soft, non-tender, non-distended, normoactive bowel sounds



Medical Decision Making (MDM)

- Definition:
  - Complexity of establishing a diagnosis and/or selecting a management option
- Measured by three elements:
  - Number of Diagnosis and Treatment Options
  - Amount and Complexity of Data Reviewed
  - Risk of Complications, and/or Morbidity or Mortality

Medical Decision Making Documentation and Scoring Tips

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- Number of Diagnosis or Treatment Options:
  - New problem means new to the examiner
  - Established problems - documentation must reveal the status of the problem
  - Additional workup – anything that is being done beyond the encounter
- Amount and/or Complexity of Data Reviewed:
  - Point values are not cumulative
  - Independent visualization must be clearly documented
- Risk of Complications and/or Morbidity or Mortality:
  - The level of risk is based on the content of the entire note for the encounter

Encounter Dominated by Time

- Time may be considered the key or controlling factor to qualify for a particular level of E/M services
- Counseling and/or coordination of care must dominate (more than 50 percent) of the physician/patient and/or family encounter
- Total time sets level of service
- Measured differently for outpatient versus inpatient:
  - Outpatient = face-to-face time
  - Inpatient = unit/floor time

2021 Office/Outpatient Introduction

Introduction

- Definition:
  - Proposed changes to the CY 2021 Physician Fee Schedule illustrated revisions to the 2021 office and outpatient services:
    - ✓ CMS is aligning E/M coding with changes adopted by the American Medical Association (AMA) CPT Editorial Panel scoring including following the AMA
- Purpose:
  - Aimed to reduce provider burden and put patients over paperwork
  - Recognizing clinicians for the time they spend taking care of patients
  - Making it easier for clinicians to be on the path towards value-based care
- Why did the AMA tackle CPT E/M office /outpatient visits:
  - CPT E/M office/outpatient visits were last updated nearly 30 years ago
  - Emphasis on charting based on billing requirements more than clinical needs
  - CMS felt that current E/M office visits were outdated and needed changing

Overview of the 2021 Office/Outpatient Revisions

- Retains 5 levels of coding for established patients
- Reduces the number of levels to 4 for office/outpatient E/M visits for new patients
- Revises the code definitions
- Revises the times and medical decision making process for all of the codes
- Requires performance of history and exam only as medically appropriate
- Allows clinicians to choose the E/M visit level based on either medical decision making or time
- Deletion of CPT code 99201

Office/Outpatient Revisions

- Eliminate history and physical as elements for code selection:
  - Providers should perform a “medically appropriate history and/or examination”
- Allow providers to choose whether their documentation is based on Medical Decision Making (MDM) or Total Time:
  - MDM – extensive edits to the elements for code selection and revised/created numerous clarifying definitions in the E/M guidelines
  - Time – definition of time is minimum time, not typical time, and represents total physician/qualified health care professional time on the date of service
- Modifications to the criteria for MDM:
  - Removed ambiguous terms (e.g. “mild”) and defined previously ambiguous concepts (e.g. “acute or chronic illness with systemic symptoms”)
  - Defined important terms, such as “Independent historian”
  - Re-defined the data element to focus on tasks that affect management of the patient

Additional Office/Outpatient Revisions

- Deletion of CPT code 99201:
  - Eliminate code 99201 as 99201 and 99202 are both straightforward MDM and only differentiated by history and exam elements
- Creation of a shorter prolonged services code:
  - Created a shorter prolonged services code that would capture provider time in 15-minute increments
  - This code would only be reported with codes 99205 and 99215
  - Used when time was the primary basis for code selection

E/M Resources

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- Learn about key changes to E/M services taking place in 2021, including recent and upcoming revisions impacting E/M coding and documentation guidelines:
  - Fact Sheet: Finalized Policy, Payment and Quality Provision Changes to Medicare Physician Fee Schedule for CY 2020
  - Fact Sheet: Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021
  - American Medical Association (AMA) Current Procedural Terminology® (CPT) Revisions – 2021
  - CPT E/M Office Revisions - Medical Decision Making (MDM)

Key Points to Remember

- Medical records should be complete and legible
- Send a transcription of illegible documentation or a hard to read copy and include the original record with the transcription
- Documentation must contain a legible handwritten signature or appropriately formatted electronic signature
- Document first and then choose the appropriate level of service

Summary

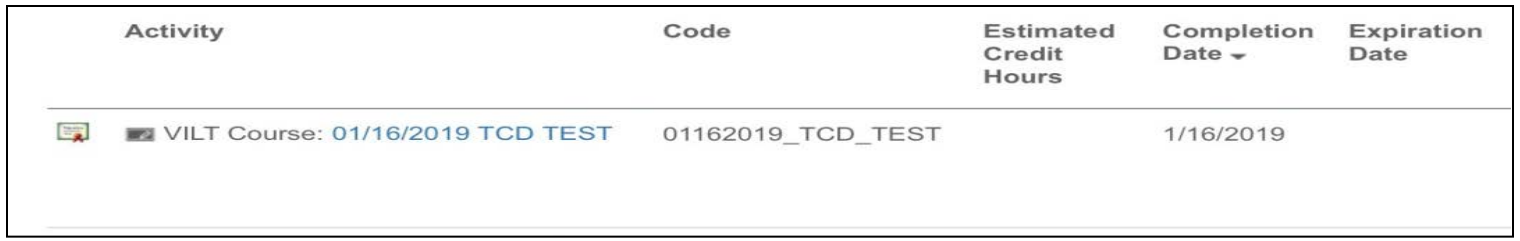
- Examined the evaluation and management services coding rules
- Reviewed the fundamentals of coding evaluation and management services
- Demonstrated the Novitas Solutions score sheet
- Introduced the 2021 office and outpatient revisions

Customer Contact Information

- Providers are required to use the IVR unit to obtain:
  - Claim Status
  - Patient Eligibility
  - Check/Earning
  - Remittance inquiries
- Jurisdiction H:
  - Customer Contact Center- 1-855-252-8782
  - Provider Teletypewriter- 1-855-498-2447
- Jurisdiction L:
  - Customer Contact Center- 1-877-235-8073
  - Provider Teletypewriter- 1-877-235-8051
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)
  - http://www.medicare.gov

Thank You for Attending

- Complete the event satisfaction survey:
  - Pops up immediately after the event ends
- Continuing Education Unit (CEU):
  - Once your attendance for an event is confirmed, you will receive an email notification that you have completed the course:
    - ✓ This process could take up to seven days
  - After you receive your event completed notification email, you can print your CEU Certificate via the Novitas Learning Center:
    - ✓ Click Completed Training icon from Home Page
    - ✓ Certificate icon will be on the left of the Class activity name
    - ✓ Click icon to print your certificate



Activity	Code	Estimated Credit Hours	Completion Date	Expiration Date
VILT Course: 01/16/2019 TCD TEST	01162019_TCD_TEST		1/16/2019	