



A GUIDE TO

EVALUATION & MANAGEMENT

CODING AND DOCUMENTATION

Produced by
ConnectiCare, Inc.
in conjunction with its affiliate
Group Health Incorporated

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SUMMARY AND OVERVIEW

ConnectiCare, Inc. has observed an increasing trend in office visits coded at high levels of service (level 4 and 5). We have noted this increase despite the fact that the level/severity of illness of our members has not changed significantly from year to year. Although there may be several explanations for this trend, one possibility may be the difficulty busy provider offices often encounter when making decisions about correct coding. In order to select the appropriate level of service based upon the work that has been performed, it is critical to understand all of the necessary elements that are required in the evaluation, decision making, treatment, and documentation of each patient encounter.

In addition to ConnectiCare's observations regarding provider coding, our members--your patients--have become increasingly aware not only of the scope of medical services available, but also how these services are reimbursed. This consumer awareness is the result of increased media attention and decisions by employer groups and members to choose insurance products that increase member financial liability. In the past, claims payment was primarily a dialog between the provider billing for the health service and the individual insurance carrier responsible for the reimbursement. While this payment mechanism still predominates in the commercial market, the introduction of high deductible health plans, health savings accounts (HSAs), and health reimbursement accounts (HRAs) has changed the payment dynamic to include the individual members in the mix.

In an attempt to help providers and their offices facilitate correct coding and reimbursement, ConnectiCare is providing this Guide to Evaluation & Management Coding and Documentation. This guide provides basic information regarding Evaluation & Management coding and documentation. A pocket guide and quick reference are also included to assist providers and office staff. The scope of this guide is limited and is not meant to be either an exhaustive source of information or legal advice. The guide should be used as a supplement to both the Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) manuals. The recommendations outlined in this guide are based upon discussions with our affiliate, Group Health Incorporated, New York, and guidance from the American Medical Association, the Centers for Medicare and Medicaid Services, and Health and Human Services, Office of Inspector General.

Note: Refer to ConnectiCare's Physician & Provider Manual for ConnectiCare-specific billing policies. The Manual is available online at www.connecticare.com. Or, call Provider Services at 1-800-828-3407.

EVALUATION & MANAGEMENT CODING AND DOCUMENTATION

Part I Six Steps to Improved Evaluation & Management Coding and Documentation

The AMA defines six (6) steps to selecting the appropriate Evaluation & Management (E&M) code for the services you provided.

Step 1: Identify the Category and Subcategory of Service

There are several categories and subcategories of service. Each category represents a specific type of Evaluation & Management service, such as “Office or Other Outpatient Services.”

Within each category there are subcategories that define the type of service provided with more specificity. For example, the subcategories of “Office or Other Outpatient Services” would include “New Patient” and “Established Patient.” Understanding these categories and subcategories are the first step to accurate coding.

For your reference, **Table 1** below includes the current categories and subcategories as provided by the AMA. It should be noted that, while all of the codes listed are reportable, reimbursement policies may vary from carrier to carrier. Please refer to ConnectiCare's Physician and Provider Manual for ConnectiCare-specific reimbursement policies (available online at www.connecticare.com).

Table 1

| Category/Subcategory | CPT Code(s) |
|---|-------------|
| Office or Other Outpatient Services | |
| • New Patient | 99201-99205 |
| • Established Patient | 99211-99215 |
| Hospital Observation Services | |
| • Hospital Observation Care Discharge Services | 99217 |
| • Initial Observation Care | 99218-99220 |
| Hospital Inpatient Services | |
| • Initial Hospital Care | 99221-99223 |
| • Subsequent Hospital Care | 99231-99233 |
| • Observation or Inpatient Care Services (Including | 99234-99236 |
| • Admission and Discharge Services) | 99238-99239 |
| • Hospital Discharge Services | |
| Consultations | |
| • Office Consultations | 99241-99245 |
| • Inpatient Consultations | 99251-99255 |
| Emergency Department Services | 99281-99288 |
| Pediatric Critical Care Patient Transport | 99289-99290 |
| Critical Care Services | |
| • Adult (over 24 months of age) | 99291-99292 |
| • Pediatric | 99293-99294 |
| • Neonatal | 99295-99296 |
| • Continuing Care, Very Low Birth Weight Infant, Low Birth Weight Infant, Normal Weight Newborn | 99298-99300 |

Table 1 (continued)

| Category/Subcategory | CPT Code(s) |
|---|---|
| Nursing Facility Services | |
| <ul style="list-style-type: none"> • Initial Nursing Facility Care • Subsequent Nursing Facility Care • Nursing Facility Discharge Services • Other Nursing Facility Services | 99304-99306 99307-99310 99315-99316 99318 |
| Domiciliary, Rest Home or Custodial Care Services | |
| <ul style="list-style-type: none"> • New Patient • Established Patient | 99324-99328 99334-99337 |
| Domiciliary, Rest Home or Home Care Plan Oversight Services | 99339-99340 |
| Home Services | |
| <ul style="list-style-type: none"> • New Patient • Established Patient | 99341-99345 99347-99350 |
| Prolonged Services | |
| <ul style="list-style-type: none"> • With Direct Patient Contact • Without Direct Patient Contact | 99354-99357 99358-99359 |
| Physician Standby Services | 99360 |
| Case Management Services | |
| <ul style="list-style-type: none"> • Team Conferences • Anticoagulant Management • Telephone Calls | 99361-99362 99363-99364 99371-99373 |
| Care Plan Oversight Services | 99374-99380 |
| Preventive Medicine Services | |
| <ul style="list-style-type: none"> • New Patient • Established Patient • Individual Counseling • Group Counseling • Other Preventive Medicine Services | 99381-99387 99391-99397 99401-99404 99411-99412 99420-99429 |
| Newborn Care | 99431-99440 |
| Special E&M Services | |
| <ul style="list-style-type: none"> • Basic Life and/or Disability Evaluation • Work Related or Medical Disability Evaluation | 99450 99455-99456 |
| Other E&M Services | 99499 |

Step 2: Review the Reporting Instructions for the Selected Category and Subcategory

Once you have selected the appropriate category and subcategory of service, based upon the services and/or care you provided, you should consult the “reporting instructions” for that section in the CPT Coding Manual.

The sections of the CPT Coding Manual will include critical guidance in understanding the appropriate use of the codes, what is included under that code, and proper reporting. In addition, the instructions will advise you if an alternate code should be used.

Reading, understanding, and following the reporting instructions will ensure that you are reporting the appropriate code based upon the services you provided.

Step 3: Review the Level of E&M Service Descriptor Examples

Evaluation & Management (E & M) Services are comprised of seven components and include:

1. History (**Key Component**)
2. Examination (**Key Component**)
3. Medical Decision Making (**Key Component**)
4. Counseling
5. Coordination of Care
6. Nature of Presenting Problem
7. Time

The first three components (history, examination, and medical decision making) are **key components**. Key components are a controlling factor and are critical to determining the level of service for E & M services.

Exception: The use of “time” as a component for determining the level of service is also relevant, as it pertains to visits where the majority of time is spent on counseling or coordination of care. This is covered more specifically in **Step 6**.

Step 4: Determine the Extent of History Obtained

The AMA recognizes four (4) types of history that are defined as follows:

Problem Focused

- Chief complaint
- Brief history of present illness or problem

Expanded Problem Focused

- Chief complaint
- Brief history of present illness or problem
- Problem pertinent system review

Detailed

- Chief complaint
- Extended history of present illness
- Problem pertinent system review extended to include a review of a limited number of additional systems
- Pertinent past family and/or social history directly related to the patient’s problem

Comprehensive

- Chief complaint
- Extended history of present illness
- Review of systems which directly relate to the problem(s) identified in the history of present illness
- A review of all additional body systems
- Complete past, family and social history

Step 5: Determine the Extent of Examination Performed

The AMA recognizes four (4) types of examinations that are defined as follows:

Problem Focused

- A limited examination of the affected body area or organ system (**Table 2**).

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) or organ system and other symptomatic or related organ system(s)

Comprehensive

- A general, multi-system examination or a complete examination of a single organ system

Table 2

| Body Areas | Organ Systems |
|------------------------------------|-------------------------------------|
| Head | Eyes |
| Neck | Ears, Nose, Mouth, Throat |
| Chest, including breast and axilla | Cardiovascular |
| Abdomen | Respiratory |
| Genitalia, groin, buttocks | Gastrointestinal |
| Each Extremity | Genitourinary |
| Back | Musculoskeletal |
| | Skin |
| | Neurologic |
| | Psychiatric |
| | Hematologic, Lymphatic, Immunologic |

Step 6: Determine the Complexity of Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option. This is measured by:

- The number of possible diagnoses and/or the number of management options that must be considered; or
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; or
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The four specific types of medical decision making are:

1. Straightforward
2. Low Complexity
3. Moderate Complexity
4. High Complexity

To qualify for a given decision-making type, two of the three elements in **Table 3** must be met or exceeded.

Table 3

| Type of Decision Making | # of Diagnoses or Management Options | Amount and/or Complexity of Data to be Reviewed | Risk of Complications and/or Morbidity or Mortality |
|-------------------------|--------------------------------------|---|---|
| Straightforward | Minimal | Minimal or none | Minimal |
| Low Complexity | Limited | Limited | Low |
| Moderate Complexity | Multiple | Moderate | Moderate |
| High Complexity | Extensive | Extensive | High |

Note: Use of Time as a Controlling Factor

The AMA also provides for an option to bill based upon counseling and coordination of care. If counseling and/or coordination of care accounted for **more than 50%** of the time spent face-to-face with the patient and/or family, then time may be used as the key or controlling factor. However, how the time was spent and the amount of time must be documented in the medical record.

Part II Consultations

Sometimes a consultation is billed, yet the actual service provided was not a consultative service. According to the AMA, a “consultation” is defined as a type of service that:

- Is provided by a physician,
- Requires an opinion or advice regarding the evaluation and management of a specific problem, and
- Is requested by another physician or other appropriate source.

The AMA cites several other **key** important factors when considering the use of a consultation code.

1. The consultant’s opinion and any services that are ordered or performed **must be documented** in the patient’s medical record and communicated by written report to the requesting physician or other appropriate source.
2. A consultation initiated by a patient and/or family member, and not requested by a physician or other appropriate source, is not reported using consultation codes but may be reported using the office visit, home services, or domiciliary/rest home care codes.

Part III Basic E & M Documentation Guidelines

Why Documentation is Important

Medical documentation serves multiple purposes. However, the most important purpose is to establish a chronological record of the patient's care to ensure high-quality care. The medical record helps facilitate the following:

- The ability of the treating physician, as well as other health care professionals, to evaluate and plan the patient's immediate care and treatment, in addition to monitor health status over time,
- Communication and continuity of care among providers involved in the patient's care,
- Accurate and timely claims review and payment,
- Appropriate quality of care evaluations, and
- Protect the provider from legal issues related to allegations of fraud, waste, abuse and medical malpractice.

Basic Principles of Medical Record Documentation

1. There is no specific format required for documenting the components of an E&M service.
2. The medical record should be complete and legible.
3. The documentation of each patient encounter should include:
 - a. The patient's name and appropriate demographic information
 - b. The chief complaint and/or reason for the encounter and relevant history, physical examination findings and prior diagnostic results,
 - c. Assessment, clinical impression or diagnosis,
 - d. Plan for care, and
 - e. Date and a verifiable legible identity of the health care professional who provided the service.
4. If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.
5. To the greatest extent possible, past and present diagnoses and conditions should be accessible to the treating and/or consulting physician. This should include those diagnoses and conditions from the prenatal and intrapartum period that affect the newborn.
6. Appropriate health risk factors, including allergies, should be identified
7. The patient's progress, response to and changes in treatment, planned follow-up care, and instructions and diagnosis should be documented.
8. The Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes reported on the health insurance claim form (CMS 1500) or billing statement should be supported by the documentation in the medical record.
9. Any addendum to the medical record should be **dated the day the information is added** to the medical record and not dated for the date the service was provided.
10. Documentation should be timely. A service should be documented during the visit, or soon after it is provided, in order to maintain an accurate medical record.
11. The confidentiality of the medical record should be fully maintained, consistent with the requirements of medical ethics and of law.

Appendix A: Pocket Guide to Compliance and Evaluation & Management

✂: Cut along the dotted line to remove the pocket guide as a reference. Lamination of the guide will increase its longevity.

6 STEPS TO IMPROVED E&M CODING

1. Identify the Category and Subcategory of Service
2. Review Reporting Instructions
3. Review Descriptors and Examples in Category
4. Determine the Extent of History Obtained
5. Determine the Extent of Examination
6. Determine Complexity of Medical Decisions

Appendix B: Evaluation & Management Documentation Quick Reference

| Components | New Patient | | | | | Established Patient | | | | |
|---------------------------------------|--|-----------|------------|-----------|----------|--|-----------|------------|-----------|----------|
| | Requires 3 components within shaded area | | | | | Requires 2 components within shaded area | | | | |
| History | PF | EPF | D | C | C | May not require presence of a physician | PF | EPF | D | C |
| Examination | PF | EPF | D | C | C | | PF | EPF | D | C |
| Complexity of Medical Decision Making | SF | SF | L | M | H | | SF | L | M | H |
| Average Time (minutes) | 10 | 20 | 30 | 45 | 60 | 5 | 10 | 15 | 25 | 40 |
| Level of Service | I | II | III | IV | V | I | II | III | IV | V |

KEY

| Abbreviation | Description |
|--------------|--------------------------|
| PF | Problem Focused |
| EPF | Expanded Problem Focused |
| D | Detailed |
| C | Comprehensive |
| SF | Straight Forward |
| L | Low |
| M | Moderate |
| H | High |