HEALTH RECORD AUDIT TRAINING

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MCCG240: Evaluation and Management Services

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E/M overview

In-service Health Record Audit Training is crucial in the healthcare setting to ensure accurate coding and billing practices. One important aspect of this training is understanding E/M coding or also known as Evaluation and Management coding. E/M coding is crucial in maintaining the efficiency and productivity of a medical practice today. E/M coding is used to describe the level of care provided during an encounter between a healthcare provider and a patient. E/M coding is based on various factors, including the complexity of the patient's condition, the amount of time spent with the patient, and the level of documentation required. E/M coding involves the use of CPT codes ranging from 99202 and 99499. Although, E/M coding is not diagnostic tests, radiology, surgeries, and other particular therapies.

All the E/M codes are divided into different categories with their own set of punctuation and abbreviations as well. Some common symbols that are used in E/M coding are HX for History, EX for examination, MDM for Medical decision making, T for time, and POS for Point of Service. It is essential to familiarize yourself with these symbols and abbreviations to accurately code and bill for services rendered. We also have CPT symbols for new codes, add on codes, etc. For example, a Triangle identifies revised code descriptions, while a bullet identifies new procedures and services added to the CPT. Then we have horizontal triangles which are used to surround revised guidelines and notes. While a plus sign identifies add on codes. Then a bull's-eye identifies a procedure that includes a moderate sedation, and a flash identifies codes that classify products pending FDA approval. We also have a circle and number sign. A circle indicates a reinstated or recycled code in Category III of cpt, while a number sign indicates an

out-of-numerical sequence code. Lastly, we have the red reference symbol and green reference symbol. The red reference symbol is located below a code description in some CPT coding manuals and indicates that the coder should refer to the clinical examples in radiology quarterly newsletters. While the Green reference symbol indicates that the coder should refer to the CPT assistant monthly newsletter and/or the CPT changes.

Another important aspect of E/M coding is understanding the difference between new and established patients. New patients are those who have not received any professional services from the healthcare provider or another provider of the same specialty within the past three years who belong to the same group practice. While established patients are those who have received professional services from a healthcare provider in the same specialty who belongs to the same group practice within the past three years. The level of care provided may vary depending on whether the patient is new or established.

Everyone should also understand the difference between places of service for example inpatient, outpatient, and office visit. For example inpatient services is when the patient receives medical treatment and is hospitalized meaning they received food and lodging in the hospital for more than 24 hours. While outpatient care also called ambulatory or one day patient care, does not require hospitalization. Outpatient care can be to a hospital, clinic or similar facility for diagnosis, treatment, or a procedure and then they are free to go home. Outpatient, though can include an overnight stay for observation without a doctor's order. If there is a doctors order to admit you as inpatient, then you would be moved to inpatient. Some examples of inpatient treatments are rehabilitation services, surgeries, childbirth, and serious illnesses that require a

patient to be monitored in the hospital all of these may require a few days hospitalization or a few weeks, it all depends. While some examples of outpatient is minor surgeries, physical therapy, mental health services, emergency care that doesn't require hospitalization, blood work and other labs, mammograms, etc. Lastly, we have office visit which is any direct exchange between a provider or their staff and a patient for the purpose of seeking care and rendering health services. There is a difference between outpatient and office visit as well. The main difference between the two is cost, you'll receive the same care regardless of the facility being used, but outpatient facilities tend to charge patients additional hospital affiliation fees. While an example of an office visit would be a physical at your doctor office, a follow-up, etc.

Lastly, everyone should understand types of services. And how to code them. They are many different types of services and you have to take the location, whether a patient is new or establish and the decision making into consideration. For types of service we have office or other outpatient services new, Office or other outpatient services established, initial hospital inpatient or observation care new or established, subsequent hospital inpatient or observation care new or established, hospital inpatient or observation care including admission and discharge services new or established, inpatient or observation consultation new or established, office or other outpatient consultations new or established, emergency department services new or established, initial nursing facility care new or established, subsequent nursing facility care new or established, home or residence services new, home or residence services established, neonatal and pediatric critical intensive care , and reporting critical time. So, as you can tell there are many types of services and some are based on time , some on medical decision making, etc. You must pay very close attention to your reports when coding these services.

In conclusion, in service health record audit training should include a comprehensive understanding of E/M coding, including symbols, abbreviations, new vs. established patients, place of service, and lastly type of services. This knowledge is essential for ensuring accurate coding and billing practices in the healthcare setting.

Medical Decision Making

We have now reviewed what E/M coding is and why it is crucial in maintaining the efficiency and productivity of medical practices today. Now we will go a little more in depth and explain how Medical Decision Making or MDM is a part of this as well. Medical decision making is the process by which healthcare providers determine the appropriate diagnosis, treatment, and ongoing management of a patient's medical condition. It involves considering factors such as the patient's history, physical examination findings, results of diagnostic test, and potential treatment options. MDM is a key component of Evaluation and Management coding along with history taking, and physical examination. The complexity of MDM is used to determine the level of service provided during the patient encounter, which in turn determines the code to be assigned for billing purposes.

There are four types of Medical Decision Making. There is straightforward, low, moderate, and high medical decision making and they are all different. Straightforward Medical Decision Making is straightforward cases where the diagnosis and treatment plan are clear and can be easily determined based on the patient's symptoms and medical history. While Low Medical Decision Making involves cases that require some level of complexity, such as the need for additional diagnostic tests or consideration of multiple treatment options. Then we have Moderate Medical Decision Making which involves cases that require more detailed analysis of the patient's condition, involving a comprehensive review of the patient's medical history, physical examination, and diagnostic test. Lastly, we have High Medical Decision Making which involves cases that are very complex and may require consultations with other specialists,

additional diagnostic tests, or consideration of multiple treatment options. High Medical Decision Making usually involves high levels of uncertainty and risk.

There are also three elements of medical decision making. The first one number and complexity of problems addressed during the encounter refers to the range and difficulty of medical issues that needs to be considered and managed by the healthcare provider. This typically involves assessing the severity and intricacy of the patient's health concerns in order to develop and appropriate treatment plan. The second one amount and/or complexity of data to be reviewed and analyzed involves the examination and interpretation of various medical tests, imaging results, and patient history. Health care providers have to analyze the information to make informed decisions about the patient's condition and treatment options. Lastly, risk of complications and/or morbidity or mortality of patient management refers to the potential risks and negative outcomes associated with the chosen treatment plan. Healthcare providers have to carefully weigh the risks and benefits of different interventions to minimize harm and ensure the best possible outcome for the patient. Overall, the three elements of Medical Decision Making provide a structured approach for healthcare providers to assess, analyze, and manage patient care effectively, leading to better outcomes and improved patient wellbeing.

Next, there are three modifiers that are important to Evaluation and Management service coding. Those three modifiers are 24,25, and 27. Modifiers are two digit codes used in medical billing to provide additional information about service or procedure performed by a healthcare providers. Modifier 24 is a modifier that is used to indicate that an E/M service provided during a post operative period is unrelated to the initial procedure. In other words it signifies that a separate

and distinct E/M service was provided by the healthcare provider for a different reason than the initial surgery. This modifier would be used to help ensure proper reimbursement for services that are rendered outside the global surgical period. Which a global surgical period is a period of time starting with a surgical procedure ending some period of time after the procedure. Then there is Modifier 25 which is used to indicate that an E/M service performed on the same day as a procedure is significant and separately identifiable from the procedure. This modifier demonstrates that the E/M service was necessary to address a different medical issue or condition than the procedure itself. This modifier helps healthcare providers receive appropriate reimbursement for both the procedure and the E/M service performed on the same day. Lastly, we have Modifier 57 which is used to indicate that a decision for a surgery was made during a E/M service that may lead to major surgery. It signifies that the E/M visit resulted in a decision to perform surgery in the near future. This modifier also helps to ensure that healthcare providers are properly reimbursed for the preoperative evaluation and decision-making process that occurs before a surgical procedure.

E/M Guidelines Review

We have now reviewed E/M coding and why it is crucial for maintaining the efficiency of medical practices today and we have reviewed what Medical Decision Making is and the four types of Medical Decision Making. Now, we will be going over the seven categories the E/M guidelines are written for and explain the difference between initial services and subsequent services.

As stated above, there are seven categories that E/M guidelines are written for. The first category being office or other outpatient services. The guidelines cover services provided in an office or other outpatient setting where the patient is not an inpatient of a hospital. This means it would include routine check-ups, follow-ups, and consultations with a healthcare provider.

Next, we have Hospital Inpatient and Observation Care services, which focuses on services provided to patients who are admitted to a hospital or are under observation in a healthcare setting. This would include initial or subsequent visits, as well as discharged visits.

Then the next category is consultations which the guidelines outlined the requirements for providing consultations to another healthcare provider. This includes evaluating a patient at the request of another provider and providing recommendations for their care.

Then, we also have Emergency Department Services, which the guidelines are very specific to services provided in the emergency department. The emergency department is where patients are provided urgent or emergency care. This includes initial evaluations, reevaluations, and critical care services.

Next, we have Nursing Facility Services, which is where services are provided to patients in a nursing facility or skilled nursing facility. The guidelines are specific and include initial visits, subsequent visits, and follow-up care for residents.

Then we have Home or Residence Services, which the guidelines address services provided to patients in their home or other residential settings. This includes home health visits, telehealth services, and other care provided in a non-office setting.

Lastly, we have Prolonged Services with or without direct patient contact on the date of an E/M service. The guidelines cover situations where additional time is spent on the patient's care beyond the typical E/M service. This includes prolonged face-to-face time with the patient, as well as time spent on care coordination, chart review, and other activities related to patient care.

You may have noted that initial services and subsequent services were mentioned quiet frequently. These are two types of services a patient may receive. These differentiate services for the categories mentioned above. Initial service is when the patient has not been treated by any professional health care physicians of the same specialty during the inpatient, observation, or nursing facility admission and stay. While subsequent service is when the patient received professional services from a physician or healthcare professional of the exact same specialty during admission and stays. Initial services are typically more comprehensive, detailed, and time consuming as they often involve setting up a system, conducting assessments, or addressing urgent needs. While subsequent services may be ongoing or periodic and are often more focused on maintenance, follow-up, or addressing new issues that arise over time. In summary, the main

difference between initial services and subsequent services is timing and scope of the services provided with initial services being more comprehensive and foundational, while subsequent services are often more focused and follow-up in nature.

Case Scenario-Medical Decision Making and Time Criteria

Now, we will be going over a practice case. We have patient case number OPC120-Giles, Roderick which is an outpatient case. Based on the patient file, the patient presented with bilateral hand pain due to Rheumatoid Arthritis and Degenerative Disk Disease. The total time spent with the patient was more than 60 minutes. So, now that we know the key concepts lets code the case.

For this outpatient consultation, we can determine the E/M service level using both Medical Decision Making and Time Criteria. Let's break it down. If we are coding by Medical Decision Making, we must look at the case. The patient has a chronic condition (Rheumatoid Arthritis) requiring chronic medications and he has a history of lung problems related to medication use, requiring ongoing management and monitoring. The physician also discussed switching medications and prescribed a new medication for the patient. Lastly, the patient's condition is considered high complexity due to the need for multiple management options and monitoring. If we are coding off medical decision making on its own, I would code for 99245 office or other outpatient consultation high complexity.

Now, if we were coding off time management, the total face-to-face time spent with the patient was more than 60 minutes, which exceeds the time requirements for a level 4 outpatient consultation. So, because of this we would code based on the MDM and Time criteria, this outpatient consultation would be coded as a level 4 E/M service. In conclusion, the E/M service for this outpatient consultation for MR. Roderick Giles would be coded as 99245 based on the documentation we have.

Next, we will go in and code the diagnoses. Based on the patient documentation, we are coding for Rheumatoid Arthritis (RA) and Degenerative Disc Disease (DDD). We will also code for the long-term use of non-steroidal anti-inflammatories and immunosuppressive biologic. So, let's start with Rheumatoid Arthritis. I went to the index and found Arthritis and then found the sub term Rheumatoid and I was given the code M06.9. I then when to the code and found that M06.9 is Rheumatoid arthritis, unspecified. Based on the documentation we have this is the most accurate code.

Next, we will code for Degenerative Disc Disease (DDD. I went to the index and found Disease then found the subterm disc, and another subterm degenerative which said see Degeneration, degeneration by site. So, I found intervertebral disc and lumbar region and was given M51.36. I then went to the main section of the book to find M51.36. M51.36 is other intervertebral disc degeneration lumbar region. Based on the documentation we have this is the most accurate code.

Next, we are going to code for our long-term use of non-steroidal anti-inflammatories. I went to the index and found long term and looked for the subterm anti-inflammatory, non-steroidal and was given the code Z79.1. I then went to the code and found Z79.1. Z79.1 is long term (current) use of non-steroidal anti-inflammatory. Based on our documentation this is the most accurate code for our case.

Lastly, we are going to code for our long-term use of immunosuppressive biologic. I went to the index again and found long term. I then went and found the subterm immunosuppressive biologic and was given the code Z79,620. I then went to the code in the book to confirm the code. Z79,620 is long term (current) use of immunosuppressive biologic. Based on our documentation this would be the most accurate code.

In conclusion, we have successfully coded the outpatient consultation for Mr. Roderick Giles based on Medical Decision Making and Time Criteria. The E/M service level for this consultation is determined to be 99245, reflecting the high complexity of the patient's condition and the extended time spent with the physician. Additionally, we have accurately coded the diagnosis for Rheumatoid Arthritis, Degenerative Disc Disease, Long term use of non-steroidal anti-inflammatory, and the long term use of immunosuppressive biologic. Overall, this practice case has allowed us to put our coding skills to the test and ensure that we are capturing the complexity of the patient's conditions in an accurate and efficient manner. By following the guidelines and utilizing our knowledge of coding principles, we can effectively support the patient's care and contribute to the healthcare delivery process.

Level of E/M services: Medical Decision Making

Lastly, we have another practice case OPC-120- Capeltoon, Estel which is another outpatient case. This chief complaint is for a new patient here for a hospital follow up for a large ovarian mass that looks malignant. Based on all the information provided, this seems to be a category 2 because it is an independent interpretation of tests and there was discussion of management and test interpretation. This is also a undiagnosed new problem with uncertain prognosis. The case also appears to be a moderate complexity level of Medical Decision Making as the patient's chief complaint involves a new problem with a potentially serious condition that requires further Evaluation and Management being laparotomy and possible staging. The physician will need to also consider additional test and treatment options, which would involve more complex decision making compared to a straightforward case. So, that being said we now have our key concepts to code.

For this outpatient consultation, we can determine the E/M service level using Medical Decision Making. We have already broken it down, so now let's code the case. We know this is a new patient for an office or other outpatient services. So, the code range is 99202-99205. We also know that based on Medical Decision Making, this case is moderate complexity. So, that being said, the code that would fit the best is 99204, which is office or other outpatient visist for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

Next, we will go in and code the diagnosis. Based on the patient's documentation, we are coding for an Ovarian cyst, the chronic pain, and the long term use of non-steroidal anti-inflammatories. So, we are going to code for the Ovarian Cyst first. We are going to go to the

index of our ICD-10-CM book and find cyst and the sub term Ovarian. I was given the base code N83.20. I then went to the main section of our book and found the base code and realized there is an additional character required. I then found N83.209 which is an unspecified ovarian cyst, unspecified side. Based on the documentation we have this would be the most accurate code. It was not confirmed whether the cyst was cancer or not.

Next, we are going to code for the chronic pain. We are going to go to the index and find the main term pain, then we are going to find the subterm chronic. We I did this I found code G89.29. I then went to the main section of our book and found G89.29. G89.29 is other chronic pain. Based on our patient's documentation this code would be the most accurate.

Next, we are going to code for the long term use of non-steroidal anti-inflammatories. We are going to go to the index and find long term. Then we are going to find the sub term anti-inflammatory, non-steroidal. When we find that subterm we are going to see cod Z79.1. I then went to the main section of the book and found code Z79.1. Z79.1 is long term(current) use of non-steroidal anti-inflammatories. This code is accurate based on the documentation provided.

Lastly, we are going to use a modifier. In this case we would use the modifier -57. Modifier -57 is an evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service. So, Modifier 57 in our case would be used to show show the decision for surgery. So our code would be 99204-57.

In conclusion, the outpatient consultation case for Estel Capleton involves a new patient with a large ovarian mass suspected of being malignant. This case is classified as a category 1 encounter due to independent interpretation of tests, discussion of management and test

interpretation, and an undiagnosed new problem with uncertain prognosis. The Medical-Decision-Making complexity is moderate as it involves further evaluation and management, potential surgical intervention, and consideration of additional tests and treatment options. The appropriate E/M service level code is determined to be 99204, reflecting moderate complexity in evaluation and management. The diagnoses codes are N83.209, G89.29, and Z79.1 and are coded based on the patient's documentation. Additionally, the modifier -57 is added to signify the decision for surgery. So, the comprehensive approach ensures accurate coding and billing for the outpatient consultation. By following our guidelines and utilizing our knowledge of coding principles, we can effectively support the patient's care and contribute to the healthcare delivery process.

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Tip Sheet: Evaluation & Management Services E/M Service Level Time in minutes JUMP TO PAGE: MDM Leveling Steps Data Usage Table Using Time Using MDM Prolonged Time Top Attestations Definitions. (2023). https://compliance.bsd.uchicago.edu/Documents/E&M%20Services%20Tip%20Sheet.pdf

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