Second Edition

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Auditing Evaluation AND Management Services

A STEP-BY-STEP GUIDE TO ACCURATE CODING, REIMBURSEMENT, AND COMPLIANCE

Joe Rivet
CCS-P, CPC, CEMC, CPMA, CICA, CHRC, CHC

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HCPro

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CONTENTS

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Joe Rivet is the corporate compliance officer at Wayne State University Physician Group, a large physician group affiliated with Wayne State University School of Medicine in Detroit. He has direct responsibility for all compliance activities, including coordinating, communicating, planning, implementing, and monitoring the compliance program.

Rivet previously was a coding compliance specialist at Hall Render Killian Heath & Lyman in Troy, MI, the nation's second largest health law firm, where he served as a subject matter expert for attorneys and clients. He conducted audits for clients as part of routine compliance programs and as a result of external investigations. He also educated providers and their coding and billing staff about various coding compliance subjects.

Before joining Hall Render, Rivet was a regulatory specialist at HCPro, Inc., in Danvers, MA. He taught the Certified Coding Boot Camp® and helped develop the E/M Boot Camp®. He also served as the lead consultant for the company's Revenue Cycle Institute and as an instructor for the Department of Justice Medicaid Integrity Institute.

Previously, Rivet was a revenue manager in the Department of Internal Medicine at Henry Ford Health System in Detroit, where he managed the revenue cycle process and conducted coding audits, including special investigation unit audits and routine monitoring audits in several practice areas. Rivet joined Henry Ford, a $3 billion health system consisting of five hospitals and more than 1,800 providers representing more than 40 different specialties, as a medical billing auditor II

in 2004. In this position, he developed audit standards for departmental medical billing, work programs for billing audits, and audit protocols. He helped identify risk exposure and control weaknesses. He also served as a compliance specialist at Henry Ford. In this role, he drafted policies, created a compliance risk assessment, and educated staff on general compliance topics.

Rivet began his coding career in 1997 at PeaceHealth in Longview, WA, a 180-bed hospital with a multispecialty medical group of 175 providers. There he worked as a patient financial services representative and a data entry operator. Rivet became an emergency department coder at PeaceHealth in 1999; he was responsible for coding emergency department services, outpatient records, trauma services, laboratory services, and labor and industry claims. He also performed evaluation and management (E/M) and Current Procedural Terminology (CPT®) coding for emergency department facility and professional services. Rivet became PeaceHealth's E/M coding auditor in 2002. His responsibilities included conducting routine prospective documentation and E/M coding audits, communicating audit results, providing expert coding advice to clinicians on a daily basis, and supporting patient financial services to enhance coding accuracy.

He has written articles for *E-Perspectives*, published by the Association of Healthcare Internal Auditors; *BC Advantage*, published by Billing-Coding.com; *Justcoding.com*, published by HCPro, Inc.; and *Briefings on APCs*, also published by HCPro, Inc. His numerous presentations address topics such as emergency department coding, coding and billing audits, and coding compliance.

Rivet is a former member of the American Health Information Management Association's Professional Ethics Committee and Certified Construction Committee. He is active in several professional associations, including the American Academy of Professional Coders, the Association of Healthcare Internal Auditors, and the Health Care Compliance Association. He frequently presents education sessions for various professional organizations.

SPECIAL ACKNOWLEDGMENT

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Sharon Bolarakis is co-author of the first edition of *Auditing Evaluation and Management Coding: A Step-By-Step Guide to Enhancing Your Practice's Revenue and Compliance.*

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Previously, Bolarakis was a coding and compliance auditor at OrthoCarolina, where her responsibilities included coding spine surgeries, physiatrist procedures, and general orthopedic procedures. She also audited physicians' E/M documentation and provided physician and staff education. Earlier in her career, she was a senior compliance specialist and spine coder at Carolinas HealthCare System. In this role, she audited approximately 100 physicians once or twice annually with documentation criteria, diagnosis coding, correct linking to procedures, modifiers, and missed revenue as her primary focus.

Her health information management career began more than 20 years ago. Beginning as a unit secretary at a spine center, she became a medical transcriptionist and then a billing manager before venturing into health insurance, reimbursement, coding, and compliance.

Bolarakis is a regular contributor to HCPro's *JustCoding.com* and she has shared her expertise during its audio conferences.

HCPro, Inc., and Joe Rivet, her first edition co-author and author of this second edition, *Auditing Evaluation and Management Services: A Step-By-Step Guide to Accurate Coding, Reimbursement, and Compliance,* gratefully acknowledge her contribution.

INTRODUCTION

Evaluation and management (E/M) codes describe the complexity of the professional services that a provider renders during a visit. The American Medical Association (AMA) publishes its Current Procedural Terminology (CPT®) codes in a manual it updates annually. These codes represent office, hospital, and nursing home visits, as well as consultations and other nonprocedural services.

Importance of Auditing E/M Codes

Whether a practice is small or large, E/M coding is an integral part of the revenue cycle. In 2002, the Centers for Medicare & Medicaid Services (CMS) allowed approximately $18 billion per year for payment of E/M services. In 2009, that allotment increased to $25 billion, representing 19% of the total Medicare Part B payments.

Conducting routine audits of E/M coding is best practice for the following reasons:

- E/M coding represents a significant portion of a practice's billing and is potentially subject to overpayment or underpayment
- Providers often unintentionally code incorrectly due to the complexity of code assignment
- Providers often inappropriately assign E/M levels because they don't understand which elements of the documentation actually support an E/M level
- E/M audits help identify areas of opportunities for increased revenue and ways to reduce compliance risks
- CMS has said that providers are responsible for knowing the rules and regulations that apply to all services billed to Medicare

Common Auditing Errors

The Department of Health and Human Services Office of Inspector General (OIG) has increased its auditing efforts regarding E/M coding and has found a significant error rate, which has resulted in overpayment to physician practices.

Some specific E/M errors—many of which are among the most common auditors encounter—include overcoding the services denoted by the following CPT® codes without providing the required documentation:

- 99214, 99215 (office/outpatient visit, established patient)
- 99203, 99204, 99205 (office/outpatient visit, new patient)
- 99244, 99245 (office consultation)

Auditors also may discover that a practice loses money because it undercodes the services denoted by the following CPT® codes, which documentation reveals could be coded at a higher level:

- 99211, 99212, 99213 (office/outpatient visit, established patient)
- 99241, 99242 (office consultation)

Undercoding often occurs because providers, fearful of becoming outliers or being targeted for an audit by regulatory agencies or third-party payers, are not comfortable billing higher levels of service. Medicare no longer recognizes consultations codes, but many private payers continue to do so; an audit risk exists for providers because these codes typically have the highest reimbursement among E/M codes.

E/M-Related Resources

Providers and auditors should refer to the following resources that publish information related to E/M coding errors:

- ***Compliance Program for Individual and Small Group Physician Practices*:** The OIG published this compliance guidance to help practices adhere to compliant billing and coding guidelines. This document provides an example of a compliance program for group practices. It also lists common risk areas for physician practices, such as coding and billing, reasonable and necessary services, documentation, and improper inducements, kickbacks, and self-referrals. Access it in the Tools folder and in the *Federal Register*, Vol. 65, No. 194, October 5, 2000, at *http://www.gpoaccess.gov/fr/*.

- **Comprehensive Error Rate Testing (CERT):** CMS initiated this program in 2002 to track E/M errors. CMS publishes CERT data, including national E/M error rates and carrier-specific error rates, available in the Tools folder and at *www.cms.gov/cert/*. During a CERT review, an independent contractor selects random samples of claims processed by each CMS contractor and reviews them to verify that paid claims are accurate. Results included in CERT publications vary by state; information pertaining to specific geographic locations is available. CERT also publishes data based on national findings and general themes it discovers. Use this data to help guide an audit plan and determine where to focus auditing efforts.

- **OIG *Work Plan:*** This annual OIG publication includes information about services that the OIG investigates. Access the *Work Plan* in the Tools folder and at *http://oig.hhs.gov/publications/workplan.asp*.

- **Recovery audit contractors (RAC):** RACs identify overpayments and underpayments made by CMS. Four jurisdictions are responsible for specific audit regions. Visit your state's RAC contractor website frequently to review current audit activities. Access information about RACs in the Tools folder and at *www.cms.gov/RAC/*.

- **Carrier communications:** Many carriers regularly publish information about common coding errors they encounter. These resources can help practices ensure they have current information with respect to carrier billing protocols and use of coding modifiers with specific E/M services and procedures. Not all government and commercial carriers treat nurse practitioners, midwives, and other midlevel providers similarly. Consult your carrier for specific billing requirements when auditing services performed by a registered nurse, nurse practitioner, physician assistant, nurse midwife, or other midlevel provider or physician extender.

E/M Guidelines: 1995 and 1997

Two sets of E/M coding guidelines published jointly by CMS and the AMA, the *1995 Documentation Guidelines for Evaluation and Management Services* and the *1997 Documentation Guidelines for Evaluation and Management Services*, are currently in use.

When thinking about the guidelines, remember the following:

- The two major differences between the 1995 and 1997 guidelines are coding the history of present illness and the exam elements.
- CMS allows providers to use either set of guidelines depending on which is more advantageous. However, providers may not mix and match the guidelines to support a particular level of service.
- Some local state carriers impose further requirements for E/M services. Consult your state's Medicare carrier for more information.

Auditors must thoroughly understand how the two sets of guidelines differ. Without this knowledge, a practice could be at risk of noncompliance. Auditors must not misconstrue the guidelines and inappropriately suggest to providers that they can either increase or decrease E/M levels in the absence of documentation that supports doing so.

Access the 1995 and 1997 guidelines in the Tools folder.

Documentation Essentials

A thorough understanding of E/M coding begins with documentation. If it's not documented, it didn't happen. Documentation is crucial to any area of coding and is especially important when determining an E/M level. Documentation for E/M services must include:

- Place of service (i.e., office, outpatient hospital, nursing home, inpatient hospital)
- Patient status (i.e., new patient, established patient)
- Type of service (i.e., consultation, office visit)

When determining E/M accuracy, begin by asking which level of service the provider selected, which level the provider should have selected, and whether the provider or coder selected the appropriate diagnosis codes.

The steps that auditors need to take when conducting an E/M documentation audit, which are discussed in this book, include the following:

- Conduct a risk assessment to identify high-risk areas and other elements that can affect risk
- Design a sample size and payer mix for tracked data
- Trend information to compare results internally, by region, and by specialty
- Develop a compliance plan to relay information to providers and establish ongoing monitoring

Administrative Buy-In

Eliciting input from administrative staff and physician leaders is important for practices that have never conducted an audit. Physician leadership participation is essential because auditors rely on these individuals to set an example and to relay information to providers throughout the audit process.

Begin by presenting the plan to the practice's administrative leadership or executive team. A positive reception at this level will filter down to staff providers. When presenting the idea to senior leadership, emphasize the following information:

- The OIG frequently monitors E/M coding
- The practice could lose much revenue if it does not properly document and code these services
- The OIG recommends that every practice establish an ongoing auditing/monitoring system
- An audit can significantly reduce the practice's risk, thereby avoiding numerous overpaid claims that must be refunded

How This Book Will Help You

This book will guide you through the E/M audit process from beginning to end. You will learn how to select an E/M code, how to conduct an entire audit of your E/M services, and how to report your E/M audit findings. E/M audits enhance compliance and can also identify under-coding, underreporting, revenue opportunities, and avenues for documentation improvement. This book can help enhance existing auditing programs by exploring different ways to determine E/M error rates that represent an accurate error rate, which can help assess a practice's risk.

How This Book Is Organized

Chapter 1: E/M Code Categories reviews the major E/M categories and provides a working knowledge of their appropriate use based on the AMA CPT® definition. Many E/M categories are straightforward, but some code categories contain nuances.

Chapter 2: Selecting an E/M Code provides a step-by-step approach to E/M code selection, including determining the history, exam, medical decision-making, counseling, coordination of care, nature of presenting illness, and time portions of the service.

Chapter 3: Conducting a Risk Assessment explains how to conduct a risk assessment to inventory risk areas, identify current and potential risks, and control weaknesses. It also explores common high-risk areas, useful references auditors can refer to for guidance, and documents to include in an assessment.

Chapter 4: E/M Audit Structure explains how to structure an audit, including determining sample size, establishing a baseline, tracking audit results, and determining an audit cycle.

Chapter 5: Using an Audit Tool explains the audit process with an audit tool and case study scenario that highlights the differences between the 1995 and 1997 guidelines.

Chapter 6: Packaging an Audit explains how to draft a provider audit summary, a practice audit summary, revenue reports, and an action plan.

Chapter 7: Facility E/M Services discusses guidelines for clinic and emergency department E/M services published in the *Federal Register*. It discusses suggested E/M level selection for both clinic and emergency department services.

Chapter 8: Teaching Physician Services examines the plethora of Medicare rules that must be met to report E/M services involving residents or fellows. This chapter also discusses documentation components considered acceptable and unacceptable.

Chapter 9: Developing a Compliance Plan describes how to implement a new provider orientation, target outlier providers, conduct provider education sessions, and draft an audit policy and procedure.

Chapter 10: Education Techniques discusses education methods for providers and coding staff. Education is a necessary element in an effective compliance program and is essential to improve future audit outcomes.

Additional Resources

Audit tools/forms, supplemental chapters, case study exercises, and other resources are available with the purchase of this product.

Look for these icons, which denote information available with the purchase of this product, throughout the book:


Custom forms


Supplemental chapters


Tools

CONTINUING EDUCATION INFORMATION

Target Audience

- Managing physicians
- Physician owners
- Managing partners
- Business managers
- Practice administrators
- Office managers
- Medical office coders
- Auditors
- Compliance officers
- Health information management directors
- Coding managers

Statement of Need

This comprehensive book will teach readers how to assign an evaluation and management (E/M) code as well as how to conduct an audit to ensure accurate data capture and maximum reimbursement. The book takes a step-by-step approach to the audit process and enables readers to do the following:

- Understand the importance of conducting regular audits
- Describe each element of an E/M code
- Determine the level of E/M codes using the 1995 and 1997 guidelines
- Establish an audit structure, including identifying an objective, scope, and level of risk
- Discuss the advantages and disadvantages of prebill and postbill audits
- Use an audit tool to audit a medical record
- Package audit results into an audit summary
- Devise a compliance plan to reduce future errors
- Test auditing knowledge using various case study scenarios

Educational Objectives

After reading *Auditing Evaluation and Management Services: A Step-by-Step Guide to Accurate Coding, Reimbursement, and Compliance*, Second Edition, readers will be able to do the following:

- Audit physicians' use of E/M codes
- Select E/M codes based on 1995 and 1997 guidelines
- Create an E/M auditing cycle

- Monitor use of E/M codes
- Produce meaningful data to present to senior leadership

Faculty

Joe Rivet, CCS-P, CPC, CEMC, CPMA, CICA, CHRC, CHC is the corporate compliance officer at Wayne State University Physician Group, a large physician group affiliated with Wayne State University School of Medicine in Detroit. He has direct responsibility for all compliance activities, including coordinating, communicating, planning, implementing, and monitoring the compliance program.

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American Academy of Professional Coders

This program has prior approval of the American Academy of Professional Coders (AAPC) for 3 Continuing Education Units. Granting of this approval in no way constitutes endorsement by the AAPC of the program, content, or the program sponsor.

American Health Information Management Association

This program has been approved for 4 continuing education units for use in fulfilling the continuing education requirements of the American Health Information Management Association.

Continuing Education Instructions

To be eligible to receive your continuing education credits for this activity, you are required to do the following:

1. Read the book, *Auditing Evaluation and Management Services: A Step-by-Step Guide to Accurate Coding, Reimbursement, and Compliance*, Second Edition.

2. Complete the continuing education exam by visiting the link provided below. You must receive a score of at least 80% to pass.

3. Provide your contact information at the end of the exam.

4. Upon successful completion of the exam, you will receive an e-mail with a link to your continuing education certificate. Save this e-mail in case you need to reprint your certificate in the future.

To start the continuing education exam, visit:

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NOTES:

If you cannot access the online continuing education exam, contact customer service at 877/727-1728. A copy of the exam can be e-mailed that you can return by mail or fax upon completion.

This book and associated exam are intended for individual use only. If you want to provide this continuing education exam to other members of your staff, contact HCPro's customer service department at 877/727-1728 to place your order. The exam fee schedule is as follows:

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- Provider Scoring Matrix Based on Point System
- Risk Assessment Spreadsheet
- Sample Policy on Standardizing E/M Audits
- Training Process for a New Auditor

Supplemental Chapters

- Case Studies
- Case Study Answers
- Leveling Established Patient Office Visits
- Leveling Consultation Office Visits
- Leveling New Patient Office Visits

Tools

- 1995 Documentation Guidelines for Evaluation & Management Services
- 1997 Documentation Guidelines for Evaluation & Management Services
- ACEP ED Facility Level Coding Guidelines
- AHA/AHIMA Recommendation for Standardized Hospital Evaluation and Management Coding of Emergency Department and Clinic Services
- Department of Health and Human Services and Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010
- E/M Audit Tool
- *Federal Register*, November 27, 2007
- HPI/ROS Reference Tool
- Department of Health and Human Services OIG Compliance Program for Individual and Small Group Physician Practices
- Outpatient Visit Template
- Single Organ System Exam Template
- Useful Websites

Website available upon the purchase of this book.

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Chapter 1

E/M Code Categories

CHAPTER 1

E/M Code Categories

In 1996, the Health Care Financing Administration, now the Centers for Medicare & Medicaid Services (CMS) introduced payments for evaluation and management (E/M) services. Since the American Medical Association first published the E/M codes in 1992, this section of the code book has seen many changes, including a number of regulatory changes.

The intent of this book is to provide the guidelines and mechanical principles for selecting an E/M level.

Selection of the appropriate E/M code is based on:

- Patient type—Is the patient new or established?
- Service type—Office visit, nursing home, observation, or something else?

Understanding the difference between a new patient and an established patient is extremely important. Incorrect application of these concepts will result in the incorrect category selection of a code.

New Patient

CMS' *Medicare Claims Processing Manual*, Chapter 12 - Physicians/Nonphysician Practitioners, §30.6.7.A states:

> *Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the*

physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit.

For example, if a patient has not seen Dr. Smith who is an internal medicine physician at Valley Medical Group in the past three years, then today's visit would be considered new for Dr. Smith. If the patient had seen an internal medicine provider at Valley Medical Group within the past three years, then Dr. Smith would bill an established patient for today's visit.

CMS' *Medicare Claims Processing Manual*, Chapter 12 - Physicians/Nonphysician Practitioners, §30.6.7.A further states:

An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

Established Patient

The definition of an established patient is the exact opposite of the definition of a new patient. A patient who has been seen within the past three years by a provider or a provider of the same specialty within the same group practice is considered established.

For example, a patient was seen 28 months ago by Dr. Cooper, an internal medicine physician at Valley Medical Group. Today, the patient is seen for the first time by Dr. Smith, also an internal medicine physician at Valley Medical Group. Dr. Smith would report today's E/M service as an established patient. The reason is that this patient has been seen within the past three years by a provider of the same specialty within the same group practice.

FAQs: New and Established Patients

Q: During a hospital stay, a patient is seen by a provider who is an internist. This was the provider's first encounter with this patient. The provider later sees the patient during a follow-up visit at the clinic after the inpatient stay. How should the provider report that service?

A: Because the patient received face-to-face service from the provider and today's visit occurred within three years of the face-to-face visit, today's visit is considered that of an established patient.

Q: A patient is seen by Dr. Corbin, a pediatrician. Today's visit is the first visit by Dr. Corbin and no other pediatrician in the group has seen this patient. The patient was formally seen last week by a family physician within the same group. How should the provider report this service?

A: Because this is the first visit by the pediatrician and no other pediatrician in the group has seen this patient, today's visit should be reported as a new E/M service.

Q: Dr. Evan, a family physician, is new to his practice and some of his patients have followed him. He thinks that he can bill all of his patients who followed him as new patients because he has not seen them previously at the new group. How should he report these services?

A: Dr. Evan should report them as visits with new or established patients, depending on when he last saw the patients. If he saw a patient for a physical a month ago and sees the patient today for congestion, he should report today's visit as occurring with an established patient because he has provided professional face-to-face service to the patient within the past three years.

Many scenarios involving new and established patients can be confusing if providers do not follow the rules correctly. Providers who are uncertain whether a patient is new or established should contact those patients' insurance providers for clarification.

Category Selection

Understanding from which category to select the appropriate code is the next step in determining which E/M service to report. This requires a thorough understanding of what constitutes new and established patients.

Office visits

An office visit, also known as an outpatient visit, has two Current Procedural Terminology (CPT®) categories: new (99201–99205) and established (99211–99215).

Selection of codes 99201–99215 depend on key components or time. New patient codes (99201–99205) require documentation of three key components. Established patient codes (92211–99215) require documentation of two of three key components. Key components are history, examination, and medical decision-making. Time documentation also is important.

The American Medical Association (AMA) states that "[a] patient is considered an outpatient until inpatient admissions to a health care facility occurs" (*CPT® 2011 Professional Edition,* p. 10).

CMS' *Medicare Claims Processing Manual*, Chapter 12 - Physicians/Nonphysician Practitioners, §30.6.7.B states:

> *[C]arriers may not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office or outpatient setting which could not be provided during the same encounter.*

For example, a patient is seen in the morning for evaluation of hypertension and arthritis; later that day, the patient is seen for foot pain after a bowl fell onto the patient's foot. This example illustrates how two unrelated E/M services might occur during the same day.

Hospital observation services

Hospital observation care services consist of three categories:

- Initial observation care
- Subsequent observation care
- Observation care discharge services

CMS' *Medicare Claims Processing Manual*, Chapter 12 - Physicians/Nonphysician Practitioners, §30.6.8.A states:

> *Observation services are often ordered when a patient presents through the emergency department and who then requires a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.*
>
> *In majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually less than 24 hours.*

Report observation care discharge services only when a patient is discharged on a different calendar day. This is the only time when use of CPT® code 99217 is appropriate. Don't confuse this code with admission and discharge services on the same day, which have their own code category (99234–99236).

Patient status (I.e., observation rather than new or established) determines proper reporting of code range 99218–99220. Selection of these codes relies on the three key components—history, examination, and medical decision-making.

Report codes 99224–99226 for subsequent observation care. Base proper selection on two of the three key components; time is associated with them.

Note that physical location does not determine whether you should report observation codes. Patient status is determinative. These codes apply to patients whose status is observation. Reporting these codes doesn't require patients' physical presence in a designated observation unit.

With respect to observation codes, the term "per day" means per calendar day.

Hospital inpatient services

Hospital inpatient services consist of two categories:

- Initial hospital care
- Subsequent hospital care

All physicians and qualified nonphysician practitioners who perform initial evaluations should use hospital care services codes (99221–99223). Principle physicians of record (i.e., admitting providers) should append modifier -AI, which denotes principal physician of record, to inpatient hospital care E/M service codes. All other physicians performing their first evaluation of a patient, such as specialists, also should use these codes for initial visits without modifier -AI.

Report follow-up visits with all providers with the appropriate subsequent hospital care codes (99231–99233). Time is associated with both initial and subsequent codes.

Attending physicians should append modifier -AI to codes 99221–99223.

Admit and discharge same day

Report same calendar day admission and discharge of patients with codes 99234–99236. Use these codes to report observation or inpatient hospital services when patients are admitted and discharged the same day. Three key components (i.e., history, exam, and medical decision-making) determine the proper selection of these codes.

Do not confuse these codes with observation discharges that occur on a different calendar day from the initial day of observation care.

Hospital discharge services

Report hospital discharge services (codes 99238 and 99239) based solely on time. If a discharge service is 30 minutes or less, report 99238. If a discharge service exceeds 30 minutes, report 99239.

CMS' *Medicare Claims Processing Manual*, Chapter 12 - Physicians/Nonphysician Practitioners, §30.6.9.2.B states:

> *Hospital Discharge Day Management Services, CPT code 99238 and 99239 is a face-to-face E/M service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified nonphysician practitioner even if the patient is discharged from the facility on a different calendar date.*

Time must be documented because these are time-based codes. Absent documentation of time, providers must default to code 99238 regardless of the length of the physician's note. Time may be interrupted; time spent by physicians is the only time that may be counted.

Only attending physicians of record report discharge day management service.

Other providers who participate in patient management during hospitalization concurrent with the attending physician should report their final visits with a subsequent hospital care E/M code (99231–99233).

Consultations

Medicare does not cover consultations, but other insurance carriers do. Consultations are divided into two categories: office or other outpatient and inpatient consultations. Code selection depends on key components (history, exam, and medical decision-making) or time. Understanding the detailed requirements is essential. Proper reporting of codes 99241–99255 requires that providers document:

- The requesting physician
- The reason for the consultation
- The opinion rendered
- The report to the requesting physician (if not a shared medical record)

Patients and family members may not initiate consultations. When a patient or family member requests consultation by a physician, the physician should report the appropriate E/M category outside the consultation section. A consultation initiated by a patient or family member is not an appropriate source.

Appropriate sources other than a physician include a "physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company" (*CPT® 2011 Professional Edition*, p. 17). A court of law also would be an appropriate source with respect to requesting a consultation.

When a third party, typically an insurance company, mandates a consultation, append CPT® modifier -32, which denotes mandated services, to the appropriate consultation code. (Refer to *CPT® 2011 Professional Edition*, p. 549, for a complete description of this modifier.) Don't report a consultation if the medical record doesn't include documentation of any required

elements, including requesting physician, reason for consultation, opinion rendered, and report to requesting source.

Emergency department services

Some E/M services don't have physical location restrictions (e.g., services provided to patients in observation care status or critical care services during which patients may be physically located anywhere in a facility). However, reporting an emergency department (ED) service (99281–99285) requires that a patient be registered in the ED. Report these codes based on meeting the three key components described for the selected code.

Do not report ED E/M services outside the ED.

Providers do not need to be emergency physicians to report codes 99281–99285.

Critical care services

Report critical care service codes (99291–99292) based solely on time. Report critical care when a provider documents critical care time and the type of critical care service performed.

Reporting critical care requires documentation that clearly describes the type of critical care service provided, including the amount of critical care time spent with a patient. Critical care may be reported when it is necessary to prevent a threat to the patient's life, limb, or organ failure. *CPT® 2011 Professional Edition* explains in great detail what critical care involves. Review all CPT® codes reported in addition to codes 99291 and 99292 to determine whether any National Correct Coding Initiative (NCCI) edits apply. A number of procedures are bundled into critical care codes and may not be reported separately, such as x-rays, pulse oximetry, and blood gases. Other procedures such as cardiopulmonary resuscitation and central lines may be reported in addition to critical care services and are not considered bundled. When services not included in critical

care are performed, do not count the time spent performing those separately reportable service(s) in the total critical care time.

Providers who don't document how much time they spent performing critical care may not report critical care. When critical care lasts fewer than 30 minutes, report the appropriate E/M code rather than critical care.

Nursing facility services

Report E/M services provided to patients in nursing facilities (skilled nursing facilities, intermediate care facilities, and long-term care facilities) with nursing facility service codes. This code section consists of four categories:

- Initial nursing facility care (99304–99306)
- Subsequent nursing facility care (99307–99310)
- Nursing facility discharge services (99315–99316)
- Other nursing facility series (99318)

The principal physician of record (admitting physician) must append modifier -AI to the appropriate code when reporting initial nursing facility care codes 99304–99306.

CMS' *Medicare Claims Processing Manual*, Chapter 12 - Physicians/Nonphysician Practitioners, §30.6.13.A states:

> *This modifier will identify the physician who oversees the patient's care from other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation in the nursing facility will also report the initial nursing facility care code [99304–99306 without modifier -AI.]*

Report discharge services 99315 and 99316 based on time documentation. CMS requires a face-to-face encounter occur with a patient to report these codes along with other E/M codes.

Providers may report codes 99315 or 99316 when a patient expires only if the physician or qualified nonphysician practitioner personally performed the death pronouncement.

Reporting the annual nursing facility assessment with code 99318 requires that the three key components defined in that code are met.

Domiciliary, rest home, or custodial care services

This section consists of new and established patient subsections. Reporting new patient codes 99324–99328 requires that three key components be met as described in the code, or reporting may be time based. Established patient codes (99334–99337) require two of three key components be met as described in the code, or reporting may be time based.

Domiciliary, assisted living facility, or home care plan oversight services

Physicians who provide E/M services to patients at rest homes or assisted living facilities who require multidisciplinary care modalities may report codes 99339 or 99340 based on time. Report the lowest code when time is not documented.

Home services

CMS' *Medicare Claims Processing Manual*, Chapter 12 - Physicians/Nonphysician Practitioners, §30.6.14 states:

> *The CPT codes 99341 through 99350, Home Services codes, are used to report E/M services furnished to a patient residing in his or her own private residence (e.g., private home, apartment, town home) and not residing in any type of congregate/shared facility living arrangement including assisted living facilities and group homes.*

Report codes 99341–99345 for new patients and codes 99347–99350 for established patients. New patient services must meet the three key components from the appropriate code, or report the code based on time. Two of three key components must be met for established patients, or report the code based on time.

Home services codes may not be used for billing E/M services provided in settings other than a private residence.

Prolonged services

Prolonged services consist of two categories: direct face-to-face service and service without direct face-to-face patient contact. In the unusual situation when a practitioner provides services beyond the typical E/M service, reporting prolonged time is permissible. Time spent by office staff with the patient or someone other than the billing provider may not be counted in the total time. The encounter note must clearly document the duration and content of the medically necessary E/M service and prolonged services billed. The encounter note must appropriately indicate that the practitioner personally provided direct face-to-face time with the patient. Document the visit start and end times in the encounter note along with the date of service.

Preventive medicine services

Preventive medicine services consist of two categories: new and established patients. Code selection is based on age when providers report a preventive medicine service. Selection of the correct code by age but under the wrong category is a common mistake.

Medicare does not pay for services that do not occur face-to-face with a patient.

Providers who address a problem above and beyond a preventive medicine service may report both the preventive medicine E/M code along with the problem-oriented E/M service by appending CPT® modifier -25, which denotes a "significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service," to the problem-oriented E/M code (99201–99215). Refer to *CPT® 2011 Professional Edition*, p. 549, for a complete description of this modifier.

Simply renewing a prescription to treat a chronic condition is not by itself sufficient to support reporting a problem-oriented code in addition to a preventive service code. Providers who report a problem-oriented service along with a preventive medicine service are performing two services during the same encounter. Each service must be supported individually. For example, when a provider reports code 99214 in addition to a preventive medicine code, the note must support above and beyond an age-appropriate preventive service with at least two key components (e.g., detailed history, detailed exam, moderate medical decision-making). Providers often document the medical decision-making of the problem-oriented service, but they fail to clearly document the additional components.

Summary

Selecting the appropriate E/M services requires the ability to identify a patient as new or established when necessary to do so and knowing which E/M category is applicable for the service provided. A provider might document in the encounter note that a patient is new, but the patient might not satisfy CMS or AMA criteria in this regard. Other times, the provider might document a consultation but necessary documentation elements may be missing. This prevents assignment of a consultation category code.

