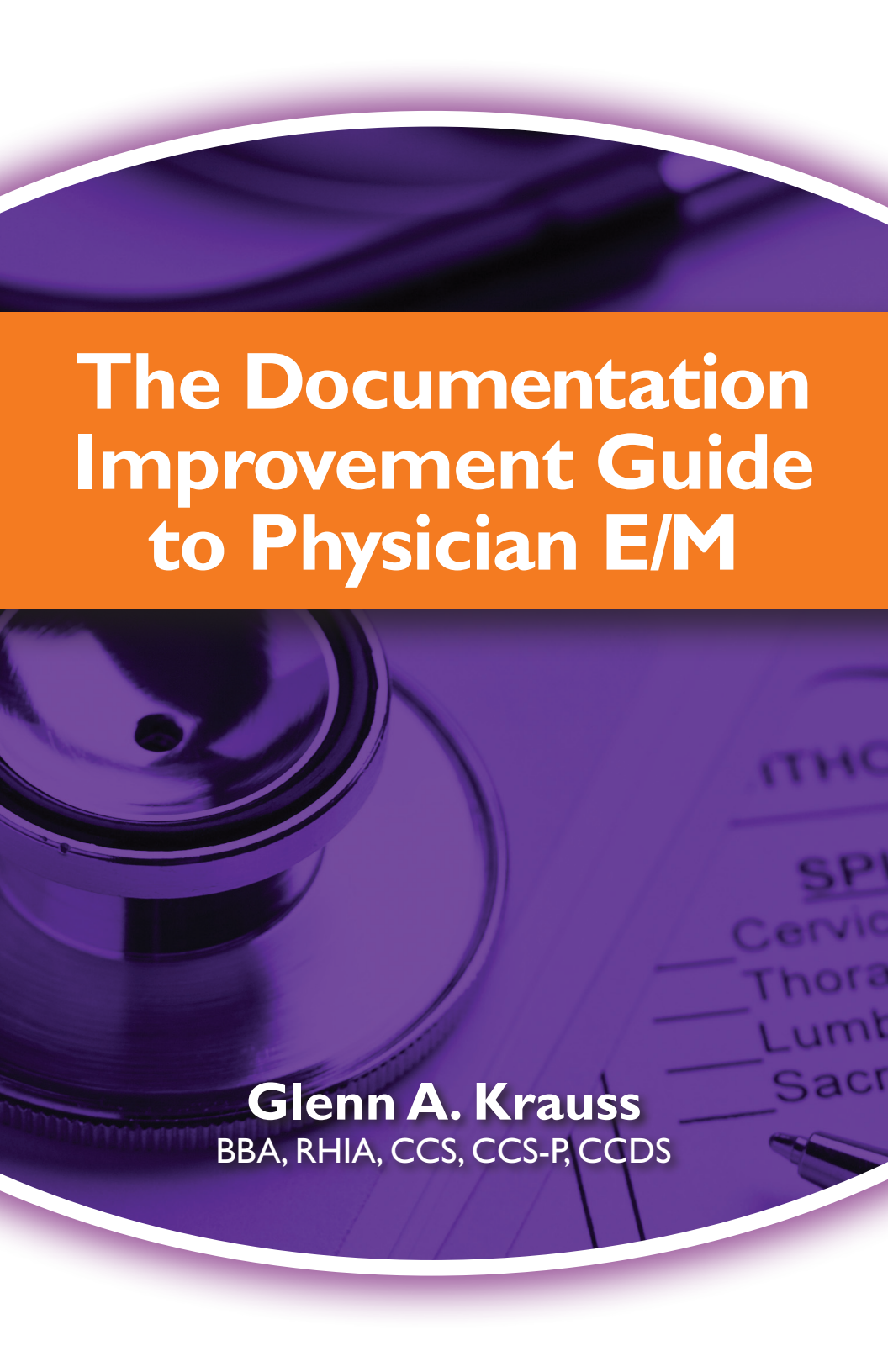
The Documentation Improvement Guide to Physician E/M
Glenn A. Krauss
BBA, RHIA, CCS, CCS-P, CCDS

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About the Author

Glenn Krauss, BBA, RHIA, CCS, CCS-P, CCDS

Glenn Krauss, a health information management (HIM) professional with extensive experience in Current Procedural Terminology (CPT®) and International Classification of Diseases, 9th Revision (ICD-9), focuses on the role of medical record clinical documentation in charge capture, reimbursement, quality and outcomes studies, and establishing medical necessity.

Krauss has served as a revenue cycle consultant, senior coding/reimbursement consultant and recovery audit contract project leader, manager of revenue systems and coding, revenue cycle coordinator and HIM director, vice president of coding and documentation compliance, coding instructor, coding technical advisor, data quality manager, HIM manager and health system analyst, clinical coding specialist, and medical records technician.

ABOUT THE AUTHOR

A member of the advisory board of the Association of Clinical Documentation Improvement Specialists, Krauss is a contributor to various print and electronic publications, including *Briefings on APCs*, published by HCPro, Inc., and *ADVANCE for Health Information Professionals*. His professional activities also include presentations during audio conferences, coding seminars, and symposiums that address various HIM and coding topics.

Krauss received a BBA in management from Hofstra University in Hempstead, NY; an RHIA Health Administration Certificate from the University of Washington in Seattle; and a Case Management and Health Outcomes Management Certificate from New England Healthcare Assembly in Boston.

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Introduction

The reasons for implementing a comprehensive clinical documentation improvement (CDI) program are many. Appropriate assessment of healthcare costs, government initiatives encouraging the use of electronic medical records, pay-for-performance and value-based purchasing efforts, and public reporting of healthcare quality data are just a few.[1]

CDI specialists may be nurses, coders, or physicians. Regardless of their professional background, they play an important role in helping physicians understand the significance of documenting the care they provide to patients.

All healthcare data and analysis begins with physician documentation. This documentation is transformed into a series of codes that government and private insurers use to calculate payment rates. The United States currently employs the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM).

1. Marion Kruse and Heather Taillon. (2011). *The Clinical Documentation Improvement Specialist's Handbook* (2nd ed.), p. 1. Danvers, MA: HCPro, Inc.

The World Health Organization developed this system to code and classify morbidity data from hospital inpatient and outpatient records, physician offices, and most National Center for Health Statistics surveys. The United States will transition to the 10th revision of the ICD October 1, 2013.

Current Procedural Terminology (CPT®), 4th edition, lists descriptive terms and identifying codes for reporting medical services and procedures that physicians perform. The American Medical Association reviews, revises, and republishes it annually.[2]

The CPT manual includes the rules that govern the reporting of physician evaluation and management (E/M) services. The term *E/M* encompasses the reimbursement system for physician services that consist primarily of face-to-face visits. This approximately 40-page section of the CPT manual includes helpful tables that physicians can use as a quick reference to facilitate their E/M documentation. The rules governing coding and documentation for E/M services are extensive and complex.

Physicians who provide E/M services must document necessary and clinically reasonable information required for the clinical management of their patients from a medical decision-making perspective. This is where CDI specialists play an import role.

2. *CPT® 2012, Professional Edition*, p. v.

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CDI programs typically begin by focusing on high-volume diagnoses and procedures for hospital inpatients, but mature programs have started to widen their scope to include documentation improvement efforts throughout the continuum of patient care. This type of comprehensive attention to physician documentation alignment with coding rules and regulations improves data capture, quality score measures, and reimbursement for facilities and physicians.

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1 E/M Documentation

A review of the basic components of documentation requirements for evaluation and management (E/M) coding, as described by *Current Procedural Terminology* (CPT®) *2012*, *Professional Edition*, is helpful.

E/M Reimbursement

Calculation of the reimbursement component of E/M requires dividing the relative value units by the following three components:

- Physician work, which includes the physician's physical time, clinical judgment, and medical decision-making associated with patient care.
- Practice expense, which includes the costs associated with operating a practice, such as office staff, rent or mortgage payments, office supplies, utilities, and other business expenses. (Physician services delivered in a hospital setting do not include an expense component because physicians don't personally incur any office expenses there.)

- The cost of malpractice insurance associated with practicing medicine.

Under this reimbursement methodology, the physician work component is the only element a physician can affect through the consistent practice of complete, accurate, concise, and effective clinical documentation of each and every patient encounter, regardless of provider setting (e.g., inpatient, observation, office).

Clinical documentation improvement (CDI) specialists need to understand that E/M codes apply to all patient settings, but the focus of this chapter is inpatient and observation services.

Office-based services or visits include the practice expense component (the cost of operating a physician practice [e.g., utilities, building lease]). Hospital-based services don't include this component because physicians don't incur any direct practice expenses associated with the provision of inpatient services regardless of whether they are attending or consulting.

The primary distinction between office and hospital E/M services, other than the site of service, is the number of E/M levels that providers may bill. Office-based E/M services distinguish between new and established patients. A new patient is one who has not been seen by a physician of the same practice group with the same physician specialty within the previous three years. A patient who has been seen by one primary care physician and is now being seen

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by another primary care physician within the same group practice within three years is considered an established patient for purposes of E/M assignment.

The new and established patient designations each have five E/M levels in the office and outpatient setting. Physician E/M in the hospital setting consists of three levels each for initial and subsequent inpatient care, and three levels each for initial and subsequent observation care. Inpatient discharge includes two E/M levels; one E/M level denotes discharge that takes less than 30 minutes and the other represents a discharge that takes more than 30 minutes.

Each level within each E/M category requires a specific level of clinical documentation consisting of history and physical and medical decision-making, as required by the *1995 Documentation Guidelines for Evaluation & Management Services* and the *1997 Documentation Guidelines for Evaluation & Management Services.*[1] Generally, more difficult and more complex diagnoses and management care plans justify E/M billing at higher levels if physicians meet the necessary clinical documentation requirements.

1. *1995 Documentation Guidelines for Evaluation & Management Services*, accessed December 12, 2011, *www.cms.gov/MLNProducts/Downloads/95Docguidelines.pdf. 1997 Documentation Guidelines for Evaluation & Management Services,* accessed December 12, 2011, *www.cms.gov/MLNProducts/Downloads/97Docguidelines.pdf.*

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Observation Care

CPT 2012, Professional Edition, pp. 13–14, lists the following three E/M levels for initial observation care:

- ***99218—Initial observation care**, per day, for the evaluation and management of a patient, which requires these 3 key components:*
  - *A detailed or comprehensive history;*
  - *A detailed or comprehensive examination;*
  - *Medical decision-making that is straightforward or of low complexity.*
- ***99219—Initial observation care**, per day, for the evaluation and management of a patient, which requires these 3 key components:*
  - *A comprehensive history;*
  - *A comprehensive examination;*
  - *Medical decision-making of moderate complexity.*
- ***99220—Initial observation care**, per day, for the evaluation and management of a patient, which requires these 3 key components:*
  - *A comprehensive history;*
  - *A comprehensive examination;*
  - *Medical decision-making of high complexity.*

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CPT 2012, Professional Edition, pp. 14–15, lists the following three E/M levels for subsequent observation care:

- ***99224—Subsequent observation care****, per day for the evaluation and management of a patient, which requires at least 2 of these 3 key components:*
  - *A problem-focused interval history;*
  - *A problem-focused examination;*
  - *Medical decision-making that is straightforward or of low complexity.*
- ***99225—Subsequent observation care****, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:*
  - *An expanded problem focused interval history;*
  - *An expanded problem focused examination;*
  - *Medical decision making of moderate complexity.*
- ***99226—Subsequent observation care****, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:*
  - *A detailed interval history;*
  - *A detailed examination;*
  - *Medical decision-making of high complexity.*

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CPT 2012, Professional Edition, p. 13, lists the following code for observation care discharge services:

- ***99217—Observation care discharge*** *day management. (This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status.")*

Inpatient Hospital Care

CPT 2012, Professional Edition, p. 16, lists the following three E/M levels for initial hospital care:

- ***99221—Initial hospital care****, per day, for the evaluation and management of a patient, which requires these 3 key components:*
  - *A detailed or comprehensive history;*
  - *A detailed or comprehensive examination;*
  - *Medical decision-making that is straightforward or of low complexity.*
- ***99222—Initial hospital care****, per day, for the evaluation and management of a patient, which requires these 3 key components:*
  - *A comprehensive history;*
  - *A comprehensive examination;*
  - *Medical decision-making of moderate complexity.*

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- ***99223—Initial hospital care****, per day, for the evaluation and management of a patient, which requires these 3 key components:*
  - *A comprehensive history;*
  - *A comprehensive examination;*
  - *Medical decision-making of high complexity.*

CPT 2012, Professional Edition, pp. 16–17, lists the following three E/M levels for subsequent hospital care:

- ***99231—Subsequent hospital care****, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:*
  - *A problem-focused interval history;*
  - *A problem-focused examination;*
  - *Medical decision-making that is straightforward or of low complexity.*
- ***99232—Subsequent hospital care****, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:*
  - *An expanded problem-focused interval history;*
  - *An expanded problem-focused examination;*
  - *Medical decision-making of moderate complexity.*

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- ***99233—Subsequent hospital care****, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:*

  – *A detailed interval history;*

  – *A detailed examination;*

  – *Medical decision-making of high complexity.*

CPT 2012, Professional Edition, pp. 16–17, lists the following two codes for hospital discharge services:

- ***99238—Hospital discharge day management****; 30 minutes or less*

- ***99239—Hospital discharge day management****; more than 30 minutes*

Assignment of discharge management codes 99238 and 99239 requires that physicians document the approximate amount of time involved in discharging patients. This includes dictation of a discharge summary, if applicable, to report and bill at the higher level (i.e., 99239). Simply stating "spent more than 30 minutes discharging the patient" is not permissible when assigning code 99239.

A physician's approximation of total time devoted to discharging a patient includes time spent performing a "final examination of

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the patient, discussion of the hospital stay, discussion of the hospital stay [with patient and family] (even if the time spent by the physician on that date is not continuous), instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms."[2]

> ***Editor's note:*** *Refer to* CPT 2012, Professional Edition, *for complete code descriptions of all E/M codes, including explanations of various code requirements. Refer to pp. 11–12 for the codes that denote the five E/M levels for new patient office and other outpatient visits, and pp. 12–13 for the codes that denote the five E/M levels for established patient office and other outpatient visits not provided here.*

Access the *Highmark Medicare Services Documentation Worksheet* that is one of the resources listed in the online Appendix for an illustration of the constituent parts of a history, a physical exam, and medical decision-making.

2. Highmark Medicare Services®, "Frequently Asked Questions: Discharge Day Management (Part B): "Why are our claims for Hospital Discharge Day Management being reduced from 99239 to 99238?" accessed December 16, 2011, *www.highmarkmedicareservices.com/faq/partb/pet/lpet-discharge_day_management.html#3.*

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Physicians who provide E/M services must document the necessary clinical information to support their medical decision-making. This is where CDI specialists play an important role, and **The Documentation Improvement Guide to Physician E/M** can help. This reference guide helps CDI specialists explain to physicians how complete and accurate documentation benefits their E/M payments, prevents medical necessity denials, and provides the information they need to document correctly.

This handbook offers the perfect portable reference guide for CDI specialists to educate physicians about E/M documentation. It is provided in packs of 10 so CDI specialists can distribute copies to physicians during documentation improvement education sessions or in response to physician questions and requests for additional information.

This reference guide will help CDI specialists:

- Better understand the complex guidelines that affect physician payment for E/M services
- Explain the importance of documentation to physicians beyond hospital reimbursement
- Clarify the purpose of queries and how responding to them benefits physicians' payments and public profiles
- Encourage physicians to provide adequate documentation that will reduce the number of denials for lack of documented medical necessity
- Access a comprehensive list of additional online resources to further aid them in their important role

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