UCLA Health System

Compliance Department

Neurosurgery

Evaluation and Management (E/M) Services, Codes, and Documentation

11/2010

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E/M Services Classifications

- Office or other outpatient
- Hospital Observation
- Hospital Inpatient
- Consultations
- Emergency Department
- Critical Care
- Neonatal Intensive Care
- Nursing Facility
- Domiciliary / Rest Home Care
- Home Services
- Prolonged Services
- Case Management
- Care Plan Oversight
- Preventive Medicine
- Newborn Care
- Special E/M Services
- Other E/M Services

E/M Services Subject to the Guidelines

- Office or other outpatient
- Hospital Inpatient (including Initial)
- Consultations

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New or Established Patient

- New Patient
  - Has not received any professional E/M services from the physician or another physician of the same specialty who belongs to the same group practice within three years
- Established Patient
  - Has received E/M services from the group within three years

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Consultation Subcategories

- Office-Outpatient
- Hospital-Inpatient
  - There are no follow-up consult codes.

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Consultations

- E/M service provided by a physician whose opinion and advice is requested by another physician or appropriate requestor
- May initiate diagnostic and/or therapeutic services at the same visit
- A patient who is self-referred or “referred for management of a condition” is a NEW or ESTABLISHED patient, not a consult.
- If ongoing care of a particular condition is assumed, service is not a consult but a newest. patient visit.

Consult Documentation Requirements

3 R’s

- REQUEST for a consultation must be documented by the attending physician (written or verbal). A resident may ask on behalf of the attending. However, the resident may not initiate the consult.

- The consultant must RENDER an opinion regarding the patient’s management.

- A written REPORT of the consult is furnished to the requesting physician.

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Levels of Service

- History
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past, Family and Social History (PFSH)
- Physical Examination
- Medical Decision Making
  - Time
  - Counseling
  - Coordination of Care
  - Nature of Presenting Problem

Chief Complaint Should Normally be the First Thing in the Note

- Sign, Symptom or Condition - “pain, shortness of breath, fever.”
- Management or Follow-up visit – “management of diabetes & HTN,” “follow-up visit for dizziness.”
- Request for Service – “annual physical exam.”

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History

- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past Medical History, Family History, and Social History (PMFSH)
- If unable to obtain, document why, and receive full credit for the history

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History of Present Illness

- Location - Where is the pain/problem?
- Quality - Describe the pain/problem?
- Severity - How severe is the pain /problem?
- Duration - How long have you had this pain/problem?
  When did it start? How long does it last?
- Timing - Does this pain/problem occur at a specific time?
- Context - Where were you at the onset of this pain/problem?
  What were you doing?
- Modifying Factor - What makes the pain/problem worse or better?
  Have you had any previous episodes?
- Associated Signs/ Symptoms - What other associated problems are present?

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Two Levels of History of Present Illness

- Brief = 1-3 elements described
- Extended = 4+ elements described, or Status of at least 3 chronic or inactive conditions

✓Duration ✓Quality

“Mr. Doe has for two weeks felt a sharp pain in his left shoulder when he raises his arm.”

✓Location ✓Context

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Review of Systems (ROS)

An inventory of body systems obtained through questions seeking to identify signs and/or symptoms which the patient has or has had.

- Constitutional symptoms (e.g. fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (including breasts)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

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Three Levels of ROS

- Problem Pertinent (1 system)
  - Directly related to the problem(s) identified in the HPI
- Extended (2-9 systems)
  - Directly related to the problem(s) identified in the HPI and a limited number of additional systems
- Complete (at least 10 systems)
  - Medi-Cal requires all 14 systems
- May be completed by patient, nurse or other staff
- Pertinent positives and negatives must be referred to in the note

Past Medical, Family, and Social History (PMFSH)

- **Past Medical**
  - Current medications
  - Prior illnesses/injuries
  - Dietary status
  - Operations/hospitalizations
  - Allergies
- **Family**
  - Health status or cause of death of siblings/parents
  - Hereditary/high risk diseases
  - Diseases related to the chief complaint, HPI, ROS
- **Social**
  - Living arrangements
  - Marital status
  - Drug or tobacco use
  - Occupational/educational history

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Two Levels of PFSH

- **Pertinent:** one of the three areas
- **Complete:** document specific item from all three areas
- **Complete - for established patients:** two of three areas is sufficient

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Patient Questionnaires

Patient questionnaires may be used for the ROS and the past medical, family, and social histories. However, the patient questionnaire must be referenced in the attending physician's or NPP's note and signed by the patient and provider.

Four Levels of History Minimum Requirements

- Problem focused (PF)
  - Brief HPI
    - 1 HPI
- Expanded problem focused
  - Brief HPI, Pertinent ROS, no PMFSH
    - 1 HPI & 1 ROS
- Detailed
  - Extended HPI and ROS, 1 PMFSH element
    - 4 HPI's, 2 ROS, & 1 Hx element
- Comprehensive
  - Extended HPI, Complete ROS and PMFSH
    - 4 HPI's, 10 ROS (14 MCal), & PMFSH

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Documenting the Physical Exam

- A general multi-system exam or any single organ system exam may be performed by any provider.
- The type and content are selected by the provider **depending upon medical necessity**.
- Note specific abnormal & relevant negative findings of the affected or symptomatic area(s)--“abnormal” is insufficient.
- Describe abnormal or unexpected findings of asymptomatic areas or systems.
- Noting “negative” or “normal” is sufficient to document normal findings in unaffected areas.

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General Multi-System Exam (1997)

- **Problem Focused**
  - Documentation of 1-5 elements
- **Expanded Problem Focused**
  - At least 6 elements
  - One or more organ/body system
- **Detailed**
  - at least 6 organ/body system covered
  - for each system/area, at least 2 elements noted

    OR
  - At least 12 elements total
  - 2 or more organ/body systems
- **Comprehensive**
  - At least nine organ systems/areas covered
  - For each, all elements should be performed
  - Document at least 2 elements in each system/area

See separate General Multi-System Exam slides for specific exam elements

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Single Organ System Examination

- Requirements for elements documented similar to 1997 multi-system
- Single organ system exams for the following:
  - Eyes
  - Ears, Nose, Mouth, and Throat
  - Cardiovascular
  - Respiratory
  - Genitourinary
  - Musculoskeletal
  - Skin
  - Neurological
  - Psychiatric
  - Hematologic/Lymphatic/Immunologic

See separate Single Organ System Exams for specific exam elements

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Elements of Neurological Examination

System/ Body Area	Elements of Examination Neurological
Constitutional	• Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

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Elements of Neurological Examination
(Continuation)

System/ Body Area	Elements of Examination Neurological
Cardiovascular	• Examination of carotid arteries (e.g., pulse amplitude, bruits) • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Musculoskeletal	• **Examination of gait and station** **Assessment of motor function including:** • **Muscle strength in upper and lower extremities** • **Muscle tone in upper and lower extremities (e.g., flaccid, cod wheel, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation, tardive dyskinesia)**

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Elements of Neurological Examination
(Continuation)

System/ Body Area	Elements of Examination Neurological
Extremities	[See musculoskeletal]
Neurological	**Evaluation of higher integrative functions including:** • **Orientation to time, place and person** • **Recent and remote memory** • **Attention span and concentration** • **Language (e.g., naming objects, repeating phrases, spontaneous speech)** • **Fund of knowledge (e.g., awareness of current events, past history, vocabulary)**

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Elements of Neurological Examination
(Continuation)

System/ Body Area	Elements of Examination Neurological
Neurological (Cont'd)	**Test the following cranial nerves:** • **2nd cranial nerve (e.g., visual fields, fundi)** • **3rd, 4th and 6th cranial nerves (e.g., pupils, eye movements)** • **5th cranial nerve (e.g., facial sensation, corneal reflexes)** • **7th cranial nerve (e.g., facial symmetry, strength)** • **8th cranial nerve (e.g., hearing with tuning fork, whispered voice and/or finger rub)** • **9th cranial nerve (e.g., spontaneous or reflex palate movement)** • **11th cranial nerve (e.g., shoulder shrug strength)** • **12th cranial nerve (e.g., tongue protrusion)**

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Elements of Neurological Examination
(Continuation)

System/ Body Area	Elements of Examination Neurological
Neurological (Cont'd)	• Examination of sensation (e.g., by touch, pin, vibration, proprioception) • Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (e.g., Babinski) • Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

Elements of Neurological Examination
(Continuation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detail	**At least twelve** elements identified by a bullet.
Comprehensive document	Perform **all** elements identified by a bullet; every element in an **Underlined/bold** box and at least one element in a non-underlined/bold box.

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Medical Decision Making (MDM)

Complexity is Measured by:

- ✓ Number of Diagnostic and/or Management Options
- ✓ Amount and Complexity of Data
- ✓ Overall Risk
  - ✓ See Table of Risk
    - ✓ Presenting problem
    - ✓ Diagnostic procedures and orders
    - ✓ Management options selected

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Medical Decision Making Elements

- **Diagnostic and/or management options**
- Billing credit is based on a point system
  (Comprehensive = 4 “points”)
  - Self-limited, minor **(1 pt.)**
  - Established problem stable, improved **(1 pt.)**
  - Established problem worsening **(2 pts.)**
  - New problem, without workup planned **(3pts.)**
  - New problem, with workup planned **(4pt.)**

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Medical Decision Making Elements
(Continuation)

- Amount and/or Complexity of data
- Billing Credit is based on a point system
  (Comprehensive = 4 points)
  - Review/order of clinical lab, radiologic study, other non-invasive diagnostic study **(1 pt. per category of test)**
  - Discussion of diagnostic study w/interpreting phys. **(1 pt.)**
  - Independent review of diagnostic study **(2pts.)**
  - Decision to obtain old records or get data from source other than patient. **(1pt.)**
  - Review/summary old med records or gathering data from source other than patient **(2pts.)**

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Medical Decision Making Elements
(Continuation)

- Risk
  - Presenting problem
  - Diagnostic procedures
  - Management options

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Medical Decision Making Elements (Continuation)

Table of Risk (Billing credit is based on the highest level of one subcategory)

Level of Risk	Presenting Problem(s)	Diagnostic Procedures Ordered	Management Options Selected
Minimal	One self-limited or minor problem	Lab tests (blood, X-rays, EKG) Chest X-rays Urinalysis Ultrasound	Rest Superficial dressings Gargles
Low	Two of more self-limited problems One stable chronic illness (e.g., well-controlled hypertension or insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury	Non-CV imaging studies with contrast e.g., barium enema Superficial needle biopsy Lab test requiring arterial puncture Skin biopsies Physiologic tests not under stress, e.g., PFTs	OTC drugs Minor surgery with no identified risk factors PT/OT IV fluids without additives
Moderate	1 chronic illness with mild exacerbation 2 or more stable chronic illness Undiagnosed new problem with uncertain prognosis Acute illness with systemic symptoms Acute complicated injury	Physiologic tests under stress Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk fxs Obtain fluid from body cavity	Prescription drug management Minor surgery with risk factors Decision to perform elective major surgery with no identified risk fxs Therapeutic nuclear med. IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	1or more chronic illnesses with severe exacerbation Acute or chronic illness or injures that pose a threat to life or bodily function (e.g., multiple An abrupt change in neurological status	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography	Elective major surgery with identified risk factors Decision to perform major emergency surgery Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

Level of Medical Decision-Making

Four levels:

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

Two of the three areas:

dx options, amount of data, risk establish the MDM level

Dx/mgt options	**0-1pt**	**2pts**	**3pts**	**4pts**
Amount of data	**0-1pt**	**2pts**	**3pts**	**4pts**
Overall risk	**Minimal**	**Low**	**Moderate**	**High**
Level of MDM	***Strghtfwd***	***Low***	***Moderate***	***High***

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Note on Establishing MDM

Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services *unless* their presence significantly increases the complexity of the medical decision-making.

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New Outpatient Visits/Consults
All 3 Components Are Required

Level	History	Exam 1997 MS	MDM
99201, 99241	Problem Focused (PF) 1 HPI	PF 1-5 Elements	Straightforward
99202, 99242	Exp Prob Focused (EPF) 1 HPI & 1 ROS	EPF 6-11 Elements	SF
99203, 99243	Detailed 4 HPIs, 2 ROS, & 1 Hx.	Detailed 12 Elements	Low
99204, 99244	Compr. 4 HPIs, 10 ROS, & PMFSH	Compr. 2 from 9 systems or areas	Moderate
99205, 99245	Compr. 4 HPIs, 10 ROS, & PMFSH	Compr. 2 from 9 systems or areas	High

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Established Outpatient Visits
2 Out Of The 3 Components Are Required

Level	History	Exam	MDM
99211	N/A	N/A	N/A
99212	PF	PF	SF
99213	EPF	EPF	Low
99214	Detailed	Detailed	Moderate
99215	Compr.	Compr.	High

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Initial Hospital/Observation
All 3 Components Are Required

Level	History	Exam	MDM
99221, 99218	Detailed	Detailed	SF/Low
99222, 99219	Compr.	Compr.	Moderate
99223, 99220	Compr.	Compr.	High

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Subsequent Hospital
2 Out of the 3 Components Are Required

Level	History	Exam	MDM
99231	PF	PF	SF/LOW
99232	EPF	EPF	Moderate
99233	Detailed	Detailed	High

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ICD-9CM Coding Diagnosis

- The CPT code or service is the driving force behind reimbursement. However, the ICD-9 diagnosis code must support the CPT code in order to be reimbursed.

- The system of diagnosis codes used is the International Classification of Diseases, 9the revision, Clinical Modification (ICD-9CM).

- The primary diagnosis must support or justify the physician's services. For instance, the inpatient consultant’s primary diagnosis would be the reason for the consult and not necessarily the admitting diagnosis.

ICD-9CM Coding Diagnosis
(Continuation)

- The highest level of specificity should be given when establishing a diagnosis. For instance, GI bleed has subclassifications, upper GI bleed and lower GI bleed. Sites of injuries, infections, and burns should also be provided. The claim should be as clean as possible. Therefore, try to avoid unspecified diagnoses and codes.

ICD-9CM Coding Diagnosis
(Continuation)

- The highest level of certainty should be given when establishing a diagnosis. “Suspected” or “Rule Out” diagnoses cannot be coded. If the physician is working only with phenomena and has not yet formed a diagnosis, then the sign, symptom, or laboratory abnormality should be selected.

- Document all conditions that co-exist at the time of the visit that require or affect patient care, treatment or management. Conditions that were previously treated and no longer exist should not be coded.

Resources

- UCLA Compliance Office
  - Marti Arvin, Chief Compliance Officer (310) 794-6763

- Confidential Hotline **1-800 296-7188**

- UCLA Compliance Website http://www.mednet.ucla.edu/compliance/.

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