# Introduction to Evaluation and Management (E/M) Coding for the Child and Adolescent Psychiatrist

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## Overview

2

## E/M Learning Tips

- Recognize that there *is* a lot of information and it is likely not something you can learn without effort
- Go through this presentation and others first with an eye to learning the system rather than rather than remembering details
- Later, "cheat sheets" and templates may be helpful.
- Memorize portions related to the small number of codes you use every day

3

## What are E/M Codes?

- Code starts with "99"
- Used to report a medical service rendered during a patient visit
- Evaluation (collecting and assessing information) and Management (planning treatment or further assessment; prescribing medication)
- Used by all physicians and other medical providers
- May be reported in addition to a "procedure" unless specifically restricted

4

## Why use E/M?

- They pay more for the same service
- For most psychiatrists there will be no choice starting in 2013
- But,
  - Aren't these codes complicated, hard to document, easy to miscode, and vulnerable to audit?
    - Yes, yes, yes, yes
- We believe this series of webinars will give you the information you need to code in confidence

5

## PAYMENT

6

## Medicare Payments

| Code | Payment | Code | Payment |
|---|---|---|---|
| 90862 | $58.54 | 90801 | $152.49 |
| 99211 | $19.74 | 90802 | $166.10 |
| 99212 | $42.55 | 99204 | $160.66 |
| 99213 | $70.46 | 99205 | $199.46 |
| 99214 | $104.16 | 99222 | $133.09 |
| 99215 | $139.89 | 99223 | $195.38 |

7

## In Other Words…

| Code | Payment |
|---|---|
| **90862** | **$58.54** |
| 99211 | $19.74 |
| 99212 | $42.55 |
| **99213** | **$70.46** |
| **99214** | **$104.16** |
| 99215 | $139.89 |

- Medicare payment for 99213 is 20% more than it is for 90862 and, for 99214, is 78% more
- Payments from other payers may be similarly more

8

## DOCUMENTATION

9

## E/M Documentation Guidelines

- 1995
  - First expansion of CPT manual
- 1997
  - Spells out the elements of a general multi-system exam and 11 single organ system exams
    - Included in these is a single system psychiatric examination
  - Download: http://www.cms.gov/medicare/
- Voluntary auditing guidelines

10

11

## Reason for Documentation

- Facilitates:
  - The ability to evaluate and plan the patient's immediate treatment and to monitor his/her health care over time
  - Communication and continuity of care among health care professionals
  - Appropriate utilization review and quality of care evaluations
  - Collection of data that may be useful for research and education
  - Accurate and timely claims review and payment

12

## General Principles of Documentation

- Complete and legible
- Include:
  - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results
  - Assessment, clinical impression or diagnosis
  - Plan for care
  - Date and legible identity of the observer

13

## General Principles of Documentation

- Rationale for ordering ancillary services should be easily inferred
- Past and present diagnoses should be accessible
- Appropriate health risk factors should be identified
- Document the patient's response to, changes in treatment, and revision of diagnosis
- The CPT and ICD-9-CM codes reported should be supported

14

## General Audit Issues

- Upcoding
- Downcoding
- Meet E/M criteria
- Medical necessity
- Red flags
  - High use of highest level code
  - Exclusive use of one level code

15

## CODING STRUCTURE

16

## E/M Families

- Most E/M codes are part of "families"
  - Site of service, for example
    - Office
    - Hospital
    - Nursing facility
    - Emergency department
  - Patient status, for example
    - New
    - Established
    - Day of discharge
    - Consultation

17

## Levels

- Most families have multiple levels
  - Denoted by the 5th digit of the code
  - 3 or 5 levels are commonly used
  - We will now focus on choosing and documenting the appropriate level

18

## E/M Components

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Time
- Nature of presenting problem

19

## KEY COMPONENT OVERVIEW

20

## History

- Chief complaint
- History of present illness (HPI)
  - Elements
  - Chronic or inactive problems
- Past, family, social history (PFSH)
  - Past history
  - Family history
  - Social history
- Review of systems (ROS)
  - 14 organ systems

21

## Physical Examination

- Psychiatric single system examination
  - Constitutional
  - Psychiatric (mental status)
  - Musculoskeletal

22

## Medical Decision Making

- Number of diagnoses or management options
- Amount and/or complexity of data to be reviewed
- Risk of complications and/or morbidity or mortality, related to
  - presenting problem,
  - diagnostic procedure, or
  - management option

23

## HISTORY DETAIL

24

## History

- Chief Complaint
- History of Present Illness
- Past, Family, and Social History
- Review of Systems

25

## Chief Complaint

- Only 1 level, but all levels of history require
- CC states the reason for the encounter
  - May be from the provider perspective, e.g.,
    - Main symptom(s)
    - Follow up visit for …
  - May be from the patient perspective, e.g.,
    - "I cry too much."
    - "My mother told me to come."

26

## HPI

Description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present.

Elements:
- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

27

## HPI Example

The patient reports intermittent[1] emotional[2] problems of moderate[3] sadness[4] starting with a romantic breakup[5] six months ago[6], now more so when alone[7] and associated with poor sleep and appetite[8].

1. Timing
2. Location
3. Severity
4. Quality
5. Context
6. Duration
7. Modifying factors
8. Associated signs and symptoms

28

## HPI Levels

- Brief
  - 1-3 elements OR
  - Status of 1-2 chronic or inactive conditions
- Extended
  - 4 or more elements OR
  - Status of at least 3 chronic or inactive conditions

29

## Past, Family and/or Social History (PFSH)

- Past history
  - Illnesses
  - Operations
  - Injuries
  - Treatments
- Family history
  - Medical events in patient's family
- Social history
  - Past and current activities

30

## Past, Family and/or Social History (PFSH)

- Pertinent
  - Item from 1 area
- Complete
  - Item each from 2 areas (established patient)
  - Item each from all 3 areas (new patient)

31

## Review of Systems

- Constitutional
- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Genitourinary
- Musculoskeletal
- Gastrointestinal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic and Lymphatic
- Allergic/Immunologic

32

## Review of Systems

- *Problem pertinent*: System directly related to the problem(s) identified in the HPI
- *Extended*: 2-9 systems
- *Complete*: 10 or more systems
  - Document individually systems with positive or pertinent negative responses
  - "All other systems reviewed and are negative" is permissible
  - In the absence of such a notation, at least 10 systems must be individually documented

33

## History Type

| HPI | PFSH | ROS | Type |
|---|---|---|---|
| Brief | N/A | N/A | *Problem focused* |
| Brief | N/A | Problem pertinent | *Expanded problem focused* |
| Extended | Pertinent* | Extended | *Detailed* |
| Extended | Complete | Complete | *Comprehensive* |

*No PFSH required with subsequent hospital visits

34

## History Type

| HPI | PFSH | ROS | Type |
|---|---|---|---|
| 1-3 elements or 1-2 chronic | N/A | N/A | *Problem focused* |
| 1-3 elements or 1-2 chronic | N/A | 1 system | *Expanded problem focused* |
| 4 elements or 3 chronic | 1 element* | 2-9 systems | *Detailed* |
| 4 elements or 3 chronic | 3 elements** | 10-14 systems | *Comprehensive* |

*No PFSH required with subsequent hospital visits
**2 elements for established patients

35

## Physical Examination Detail

36

## Physical Examination

- Cardiovascular
- Ears, nose, mouth and throat
- Eyes
- Genitourinary (female)
- Genitourinary (male)
- Hematologic, Lymphatic, Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

37

## Psychiatric Exam Constitutional (shaded box)

- Three vital signs:
  - Sitting or standing blood pressure
  - Supine blood pressure
  - Pulse rate and regularity
  - Respiration
  - Temperature
  - Height
  - Weight
- General appearance of patient, e.g.:
  - Development
  - Nutrition
  - Body habitus, deformities
  - Attention to grooming

38

## Psychiatric Exam Musculoskeletal (unshaded box)

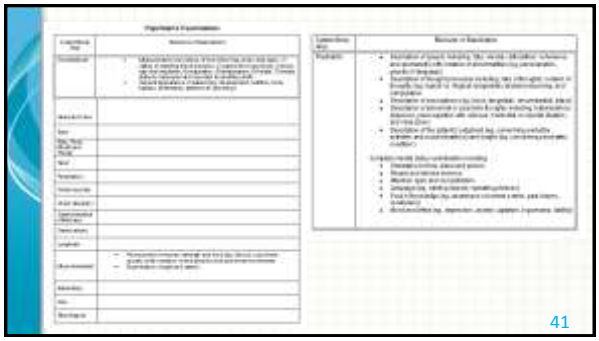
- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
- Examination of gait and station

39

## Psychiatric Exam
## Mental Status (shaded box)

- Speech
- Thought process
- Associations
- Abnormal or psychotic thoughts
- Judgment and insight
- Orientation
- Recent and remote memory
- Attention span and concentration
- Language
- Fund of knowledge
- Mood and affect

40



41

## Psychiatric Examination

| Level of Exam | Perform and Document |
|---|---|
| Problem Focused | **1-5** elements identified by a bullet |
| Expanded Problem Focused | **At least 6** elements identified by a bullet |
| Detailed | **At least 9** elements identified by a bullet |
| Comprehensive | Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border |

42

## MEDICAL DECISION MAKING DETAIL

43

## Medical Decision Making

- Number of diagnoses or management options
- Amount and/or complexity of data to be reviewed
- Risk of complications and/or morbidity or mortality

2/3 elements must be met or exceeded

44

## Number of Diagnoses or Management Options

- Based on
  - Number or types of problems addressed during the encounter
  - Complexity of establishing a diagnosis
  - The management decisions that were made
- Other indicators
  - Problem undiagnosed
  - Number or types of tests ordered
  - Need for consultation
  - Problem worsening

45

## Number of Diagnoses or Management Options

- Minimal
- Limited
- Multiple
- Extensive

46

## Problem Points

| Category of Problems/Major New symptoms | Points per problem |
|---|---|
| Self-limiting or minor (stable, improved, or worsening) (max=2) | 1 |
| Established problem (to examining physician); stable or improved | 1 |
| Established problem (to examining physician); worsening | 2 |
| New problem (to examining physician); no additional workup or diagnostic procedures ordered (max=1) | 3 |
| New problem (to examining physician); additional workup planned* | 4 |

*Additional workup does not include referring patient to another physician for future care

47

## Number of Diagnoses or Management Options

| Level | Total Problem Points |
|---|---|
| Minimal | 0-1 |
| Limited | 2 |
| Multiple | 3 |
| Extensive | 4 |

48

## Amount and/or Complexity of Data to be Reviewed

- Types of diagnostic tests ordered
- Review of old medical records
  - Document the relevant findings
- History from other sources
  - Document the relevant findings
- Discussion of test results with physician who interpreted the test

49

## Amount and/or Complexity of Data to be Reviewed

- Minimal or None
- Limited
- Moderate
- Extensive

50

## Data Points

| Categories of Data to be Reviewed (max=1 for each) | Points |
|---|---|
| Review and/or order of clinical lab tests | 1 |
| Review and/or order of tests in the radiology section of CPT | 1 |
| Review and/or order of tests in the medicine section of CPT | 1 |
| Discussion of test results with performing physician | 1 |
| Decision to obtain old records and/or obtain history from someone other than patient | 1 |
| Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider | 2 |
| Independent visualization of image, tracing, or specimen itself (not simply review report) | 2 |

51

## Amount and/or Complexity of Data to be Reviewed

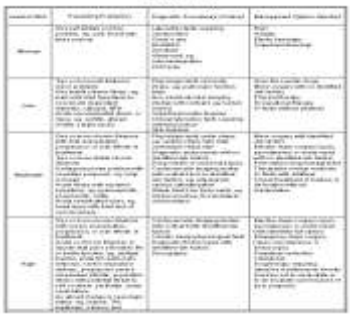
| Level | Total Data Points |
|---|---|
| Minimal or None | 0-1 |
| Limited | 2 |
| Moderate | 3 |
| Extensive | 4 |

52

## Risk of Significant Complications, Morbidity, and/or Mortality

- Based on risks associated with the presenting problem, diagnostic procedure, and the possible management options
- The highest level of risk in any one of these categories determines the overall risk

53



54

## Table of Risk

| Level of risk | Presenting problem(s) | Diagnostic procedure(s) ordered | Management options selected |
|---|---|---|---|
| Minimal | One self-limited or minor problem | Venipuncture; EKG; urinalysis | Rest |
| Low | Two or more self-limited or minor problems;<br>One stable chronic illness;<br>Acute uncomplicated illness | Arterial puncture | OTC drugs |
| Moderate | One or more chronic illnesses with mild exacerbation, progression, or side effects;<br>Two or more stable chronic illnesses;<br>Undiagnosed new problem with uncertain prognosis;<br>Acute illness with systemic symptoms | | Prescription drug management |
| High | One or more chronic illnesses with severe exacerbation, progression, or side effects;<br>Acute or chronic illnesses that pose a threat to life or bodily function | | Drug therapy requiring intensive monitoring for toxicity |

55

## Medical Decision Making

2/3 elements must be met or exceeded:

| Number of diagnoses or management options | Amount and/or complexity of data | Risk | Complexity of decision making |
|---|---|---|---|
| Minimal | Minimal or None | Minimal | ***Straightforward*** |
| Limited | Limited | Low | ***Low*** |
| Multiple | Moderate | Moderate | ***Moderate*** |
| Extensive | Extensive | High | ***High*** |

56

## Medical Decision Making

2/3 elements must be met or exceeded:

| Problem Points | Data Points | Risk | Complexity of Medical Decision Making |
|---|---|---|---|
| 0-1 | 0-1 | Minimal | ***Straightforward*** |
| 2 | 2 | Low | ***Low*** |
| 3 | 3 | Moderate | ***Moderate*** |
| 4 | 4 | High | ***High*** |

57

## TIME

58

## "Typical" Time

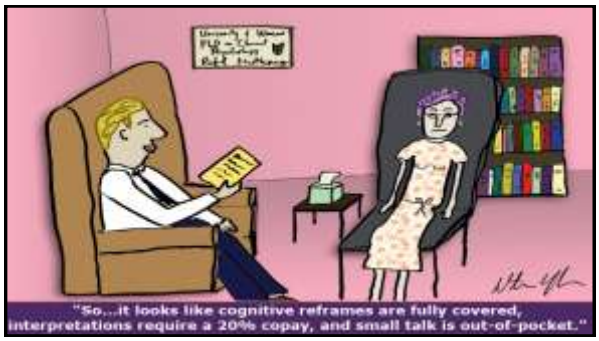
- Guide when code level is determined by key components
- Actual time may be more or less
- This system rewards efficiency
- No need to track or document

59

## Counseling and/or Coordination of Care Exception

- Counseling and/or coordination of care is more than 50% of the time of the encounter
- Time becomes the controlling factor
  - Face-to-face time for office visits
  - Unit time for facility visits
- Document
  - Length of time of the encounter and of the time spent in counseling and coordination of care
  - The counseling and/or coordination of care activities

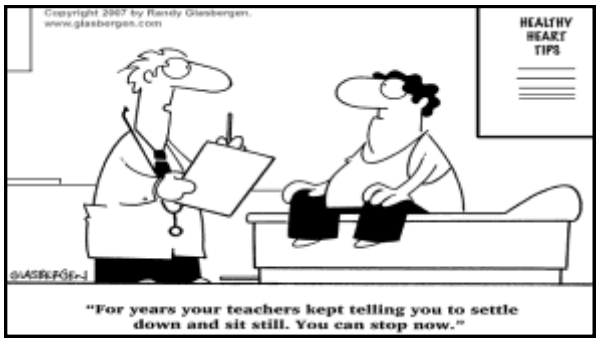
60




## Counseling

- Discussion of
  - Diagnostic results
  - Impressions
  - Recommended diagnostic studies
  - Prognosis
  - Risks and benefits of management options
  - Instructions for management and/or follow-up
  - Importance of compliance with chosen management options
  - Risk factor reduction
  - Patient and family education

62



## Code by Type of Visit

- Driven by complexity of medical decision making
  - Acute medical problems
  - Managing chronic conditions
- Exceptions
  - "Check up"
    - After gap in treatment
    - Stable patient requires careful monitoring
  - Counseling and/or coordination of care are greater than 50% of the time of the visit

64

## New and Established Patient

- New patient
  - Not seen within the past 3 years
- Established patient
  - Seen within the past 3 years
- "Seen"
  - **Exact** same specialty **and subspecialty**
  - Same group practice.
  - Covering same as covered

65

## That's It for Now!

- Please view other AACAP presentations for application of specific E/M codes to patient examples and other CPT coding topics
- Questions sent to Jennifer Medicus at jmedicus@aacap.org will be passed on to the AACAP CPT Coding Subcommittee.

66