Evaluation and Management Documentation and Coding: Do You Know Where You Stand?

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A Roadmap for Impactful Change!

Operationalizing Health Reform was written by the entire MTM Services team to be an up to date view of what we have learned working to help hundreds of organizations across the country and abroad make the changes necessary to be successful in today’s ever changing environment of health reform. Each of the book’s 14 chapters deal with a specific change focus required to help vision based leaders improve their organization’s quality of care, efficiency, and the compliance of their service delivery system!

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Your MTM Consulting Team

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2013 and Behavioral Health Shift to Evaluation/Management

- Removal of “combination codes” for psychotherapy and evaluation/management (90805, 90807)
- Elimination of Medication Management codes in Psychotherapy section for providers who can use E/M codes for pharmacologic management
- Encouragement to use E/M codes rather than Psychiatric Diagnostic Evaluation Codes

**Additional changes:**
- New psychotherapy codes: time, place, number
- Addition of codes for crisis services
- Add-on codes for interactive complexity
Evaluation and Management

Compliance with proper code and documentation

Psych. Diagnostic Evaluations with Medical Services 90792

90791 +
– Examination (CMS psychiatric specialty examination)
– Prescription of medications, when appropriate
– Review and ordering of laboratory tests, as needed
Psych. Diagnostic Evaluations, General Guidance

- **90791** and **90792** are used for diagnostic assessment(s) or reassessment(s), if required
- Psychotherapy services (**90832 - 90838**), including for crisis (**90839, 90840**), may **not** be reported on the same day as **90791** or **90792**
- May report more than once when separate interviews are conducted with the patient and informant(s) according to payer rules. Many payers have limits.

New Patients – Disincentive and Incentives to Report E&M Codes

- Some clinicians use the Psychiatric Diagnostic Evaluation With Medical Services Code 90792 more often than the new patient E&M code 9920X.
- Rates for the 90792 vary between payers and can be higher or lower than new patient E&M.
- Some payers restrict the number of 90792's in a plan year-get to know your payer.
- If the 90792 is reported, no other service can be reported on the same day by another BH provider. This limits those centers that may provide a 90791 and an E/M new patient service on the same day for comprehensive same day access.
New Patient E&M Codes

- Know when to use the New patient vs. Established patient codes.

> CPT® 2012 states: “A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”

New Patient or Established Patient

- John, a new patient, sees Dr. Brown at XYZ Medical Group.
  - Afterwards, Dr. Brown refers John to Dr. Smith, who specializes in addiction psychiatry, and also practices with XYZ Medical Group.
  - Two weeks later, John sees Dr. Smith.
  - Is John a new patient?
Advantages in Using New Patient E&M Codes

- Consistent with other medical and specialist code usage.
- The three key components of E&M services (History, Exam, Medical Decision Making) generally lead to more comprehensive assessments and care.
- Allows for same day services with other non-physician providers (e.g. LCSW can provide 90791 and MD can provide a 9920X).
- Payers often limit the number and frequency of 90791/90792s.

E&M Overcoding and Undercoding

- Overcoding – when the E&M code reported is higher than what is supported in the documentation using the 1997 E&M Documentation Standards set by CMS.
- Undercoding – when the E&M code reported is lower than what is supported in the documentation.
- Target accurate coding
E&M Overcoding and Undercoding

- E&M Services are new to outpatient behavioral health (2013 forward).
- Little data is known to analyze trends and set benchmarks.
- Psychiatry is a specialty, and Child/Adolescent, ASAM (Addiction) and Geriatric are sub-specialties (ABPN).

Selecting E/M Codes

Path One
Based on Time

Path Two
Using the Three Key Components
E/M Codes and Time

Time shall be the key controlling factor used for the selection of the Level of the E/M Service when counseling or coordination of care dominates the encounter more than 50 percent EXCEPT when done in conjunction with a psychotherapy visit.

Counseling/Coordination of Care and E/M

When Discussing with the Patient or Family any of the following:

- Prognosis
- Test Results
- Compliance/Adherence
- Education
- Risk Reduction
- Instructions
Reporting For Actual Time of E&M Services

• Using time as the primary factor in determining the proper E&M code is permissible under the following additional factors:

• Counseling can be a discussion with the patient and/or family or other caregiver concerning one or more of the six areas previously mentioned.
• Examples of the six areas can include:
  – Recommended Diagnostic studies
  – Risks and benefits of treatment options
  – Follow-up importance
  – Patient and family education

Providing and Documenting Counseling and/or Coordination of Care for E&M Services

• MTM Services recommends that documentation for Counseling and/or Coordination of Care as a part of the E&M Service be clearly identified.
  – Total time captured
  – Time captured for Counseling and/or Coordination of Care
  – Describe and document the Counseling and/or activities to coordinate care.
  – Use the average time ranges provided for each E&M level.
  – Provide an indicator at the top or bottom of the template to check indicating Counseling and Coordination of Care were used to determine the level.
E/M Outpatient Services: Codes & Time

<table>
<thead>
<tr>
<th>NEW PATIENT VISIT TIME</th>
<th>ESTABLISHED PATIENT VISIT TIME</th>
<th>OFFICE CONSULTATION TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODE</td>
<td>MINUTES</td>
<td>CODE</td>
</tr>
<tr>
<td>99201</td>
<td>10</td>
<td>99211</td>
</tr>
<tr>
<td>99202</td>
<td>20</td>
<td>99212</td>
</tr>
<tr>
<td>99203</td>
<td>30</td>
<td>99213</td>
</tr>
<tr>
<td>99204</td>
<td>45</td>
<td>99214</td>
</tr>
<tr>
<td>99205</td>
<td>60</td>
<td>99215</td>
</tr>
</tbody>
</table>

E&M Issues and Findings From Audits

- History
- Exam
- Medical Decision Making
- Cloning
- Clinical Pearls
- Assisting prescriber staff
- Useful assistive documents from ACAP & MTM
History

• Chief Complaint
  – Easy pickins!
  – Frequently forgotten
  – Reason for visit.
  – “Doing fine” not a CC

History of Present Illness

• In a recent audit, 44.8% met 4-element standard required for 99214
• Elements can be tricky [location??] , but these are not:
  – Severity [mild, moderate, severe]
  – Timing [time of day, on the way to work…]
  – Quality [e.g., overwhelming, intrusive, terrifying….]
  – Duration
  – Context [at school, with spouse…]
  – Modifying factors [e.g., treatment, coping skills, stressful situations…]
  – Associated signs and symptoms [e.g., insomnia, nausea, social withdrawal…]
Review of systems
Also not that hard: 1 for 213, 2 for 214.
Psychiatric findings count: insomnia, for example.
Clinicians are not doing this with consistency,
though this is not so much difficult to perform as it
is to remember to do.
Formatting of the note template could help with
this.

Exam – See The Template

• 6 bullets for 213
• 9 bullets for 214
• Prompts can be helpful
• Plug-in formats
• Vital Signs only required strictly speaking
for 99215, but now are standard practice,
and should be supported.
Medical Decision Making

<table>
<thead>
<tr>
<th>Problem Points</th>
<th>Category of Problems/Major New symptoms</th>
<th>Points per problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limiting or minor (stable, improved, or worsening) (max=2)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established problem (to examining physician): stable or improved</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established problem (to examining physician): worsening</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problem (to examining physician); no additional workup or diagnostic procedures ordered (max=1)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New problem (to examining physician); additional workup planned*</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

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

Take-home messages for most cases [not “new” E&M]:

- If you hit history and exam marks, you are set.
- If you don’t, then need
  - For 99213: 2 problem points: One new, one worsening, or two stable.
  - For 99214: 3 problem points: One new plus one old, etc.
- **Medical problems are problems, but individual symptoms are not**
- Say if things are worse or better

Risk / Benefit of Cloning

- **Risk of idiocy:**
  - Saying “acutely suicidal” and “not suicidal” in same note.
- **Benefit:**
  - Invaluable in bringing needed clinical info forward.
  - Especially in complex cases
  - System should support the safe and ethical use of information by prescribers.
Clinical Pearls

- CC definition – “concise statement describing the symptom, problem, condition or reason patient is being seen.”
- Unacceptable documentation: “doing well on meds, follow up, patient looks good today…”
- CC, HPI, ROS & PFSH may be listed separately or may be included in the HPI.
- ROS & PFSH obtained during earlier encounter does not need to be recorded if there is EVIDENCE that the physician has reviewed and update previous information
- Statement ‘ all other systems reviewed negative' counts for comprehensive ROS
- Assessment and plan documentation must include whether problems stable, worsening, etc.
- Brief summary - tell your story

Administrative Pearls – Assisting Prescriber Staff

- Give your docs outlines and audit regularly.
- Template pros and cons
  - impact on collaborative documentation
  - limitations of documentation
    - worse yet, a check box that says “mood” or “3 of 7 vital signs” with no opportunity to elaborate, more like an audit sheet
    - Prompts can be helpful
      - risk of cloning, asserting examinations that were not performed
- Usefulness of brief clinical summary, e.g., “Bipolar depression, partly responsive to treatment, worsened by recent job loss, uncontrolled diabetes and ongoing alcohol abuse.”
- Support bringing info forth but audit for cloning.
E&M Electronic Templates
E&M Templates and “The 3 Bears”

• Some are too HARD (Overly Formatted)
• Some are too soft (Under Formatted)
• Some are “Just Right” (Appropriate Mix)

Check-Box Dominant Templates

• Leave little or no room for pertinent narrative information or clinical analysis
• Can institutionalize non-compliance by shortcutting elements (e.g. “2 of 3 systems reviewed” with no results/decisions or sometimes even which systems were reviewed
• Provide little clinical value for care coordination
Under Formatted Templates

- Require significant training and auditing
- Rely on ability of clinician to remember to include all required elements each session
- Require more documentation and documentation time than for a reasonably structured note
- Make it more difficult to find information for clinical or audit purposes

“Just Right” Templates

- Allow for bringing forward important information from previous note for continuity of care and efficiency purposes
- Have clear sections for E&M elements and where appropriate checkboxes that indicate if an element was assessed and what the outcome was (e.g. ROS, Vitals, Mental Status)
- Have room after each section for explanation/conclusions
- May be longer (in pages) than an blank note but take less time to document.
- Make it easy to find important information
- Have a concluding clinical formulation/plan section
“Just Right” Templates (Cont’d)

- Eliminate redundancy
- Support compliance and clinical value

In addition templates should include areas for:
- Session start & end times and session duration
- The E&M code being billed
- New vs. established patient designation
- Area to list problems addressed (psychiatric or physical diagnosable problems) and whether these are:
  - Self Limiting or Minor; Established; or New to the Physician
  - Improving, Stable, or Worsening

Bill Schmelter PhD
Senior Clinical Consultant

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MTM SERVICES

Sample E/M Template

Person’s Name (First M Last): Organization/Program Name: Record #: DOB:

New Patient ☐ Existing Patient ☐

1. HISTORY:
   - Chief Complaint:
   - 
   - Presenting symptoms, condition, severity, duration, O2 needed, response, change, current meds, lab tests

Post Medical/ Family Medical/ Social Hx:

Review of Systems (ROS): 1 for 99213, 2 for 99214

- Appetite/Sleep:
- Weight Change:
- Sexual function:
- Neurological: 5D to meds:
- Allergies:
- Exercise:
- Smoking/Drug use:
- Other:

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2. **EXAM:** [B-lutes: 99222, 99223, 99224, 99229, 99215, 99214, 99210]

Constitutional:

Vital Signs [5/7 required]

<table>
<thead>
<tr>
<th>BP</th>
<th>Pulse Rate</th>
<th>Respiration</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Temp</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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**MTM SERVICES**

Sample E/M Template

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<th>Organization/Program Name:</th>
<th>Record #:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
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<td></td>
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**General Appearance**

Musculoskeletal:

Muscle Strength & Tone:

Gait & Station:

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**Psychiatric:**

Speech:

Abnormal / Psychotic Thoughts:

Thought Processes:

Assessments:

Judgment and Insight:

Orientation:

Recent and Remote Memory:

Concentration/ Attention:

Language:

Fund of Knowledge:

Mood and Affect:

**Impression**

Brief summary of present status of case:

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#NatCon15

Bill Schmelter PhD
Senior Clinical Consultant
### Psych diagnoses & status

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>Stable</th>
<th>Worsening</th>
<th>New</th>
<th>New with additional workup planned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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### Medical diagnoses & status

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</tbody>
</table>

### 3. Plan

- [Medication changes, further workup/labs, other treatment modalities, care coordination, next visit]

<table>
<thead>
<tr>
<th>Start Time</th>
<th>AM</th>
<th>PM</th>
<th>End Time</th>
<th>AM</th>
<th>PM</th>
<th>Date</th>
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<tbody>
<tr>
<td>CPT Code:</td>
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<table>
<thead>
<tr>
<th>Name &amp; Credentials (Print)</th>
<th>Signature</th>
</tr>
</thead>
</table>
Questions and Feedback

• Questions?
• Feedback?
• Next Steps?