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

INTRODUCTION TO EVALUATION AND MANAGEMENT (E/M) CODING FOR THE CHILD AND ADOLESCENT PSYCHIATRIST

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OVERVIEW

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
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

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
Medicare Payments

<table>
<thead>
<tr>
<th>Code</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90862</td>
<td>$58.54</td>
</tr>
<tr>
<td>99211</td>
<td>$19.74</td>
</tr>
<tr>
<td>99212</td>
<td>$42.55</td>
</tr>
<tr>
<td>99213</td>
<td>$70.46</td>
</tr>
<tr>
<td>99214</td>
<td>$104.16</td>
</tr>
<tr>
<td>99215</td>
<td>$139.89</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801</td>
<td>$152.49</td>
</tr>
<tr>
<td>90802</td>
<td>$166.10</td>
</tr>
<tr>
<td>99204</td>
<td>$160.66</td>
</tr>
<tr>
<td>99205</td>
<td>$199.46</td>
</tr>
<tr>
<td>99222</td>
<td>$133.09</td>
</tr>
<tr>
<td>99223</td>
<td>$195.38</td>
</tr>
</tbody>
</table>

In Other Words...

- 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.

DOCUMENTATION
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

• Voluntary auditing guidelines

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

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

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

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
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

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
**E/M Components**

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

**KEY COMPONENT OVERVIEW**

**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
Physical Examination

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

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
History

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

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.”

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
HPI Example
The patient reports intermittent emotional problems of moderate sadness starting with a romantic breakup six months ago, now more so when alone and associated with poor sleep and appetite.

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

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

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
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)

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

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
### History Type

<table>
<thead>
<tr>
<th>HPI</th>
<th>PFSH</th>
<th>ROS</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem focused</td>
</tr>
<tr>
<td>Brief</td>
<td>N/A</td>
<td>Problem pertinent</td>
<td>Expanded problem focused</td>
</tr>
<tr>
<td>Extended</td>
<td>Pertinent*</td>
<td>Extended</td>
<td>Detailed</td>
</tr>
<tr>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

*No PFSH required with subsequent hospital visits

---

### History Type

<table>
<thead>
<tr>
<th>HPI</th>
<th>PFSH</th>
<th>ROS</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 elements or 1-2 chronic</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem focused</td>
</tr>
<tr>
<td>1-3 elements or 1-2 chronic</td>
<td>N/A</td>
<td>1 system</td>
<td>Expanded problem focused</td>
</tr>
<tr>
<td>4 elements or 3 chronic</td>
<td>1 element*</td>
<td>2-9 systems</td>
<td>Detailed</td>
</tr>
<tr>
<td>4 elements or 3 chronic</td>
<td>3 elements**</td>
<td>10-14 systems</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

*No PFSH required with subsequent hospital visits

**2 elements for established patients

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### Physical Examination Detail
Physical Examination

- Cardiovascular
- Ears, nose, mouth and throat
- Eyes
- Genitourinary (female)
- Genitourinary (male)

- Hematologic, Lymphatic, Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

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

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
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

Psychiatric Examination

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>1-5 elements identified by a bullet</td>
</tr>
<tr>
<td>Expanded Problem</td>
<td>At least 6 elements identified by a bullet</td>
</tr>
<tr>
<td>Detailed</td>
<td>At least 9 elements identified by a bullet</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>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</td>
</tr>
</tbody>
</table>
Medical Decision Making

- Number of diagnoses or management options
- Amount and/or complexity of data to be reviewed

2/3 elements must be met or exceeded

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
Number of Diagnoses or Management Options
• Minimal
• Limited
• Multiple
• Extensive

Problem Points

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

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

Number of Diagnoses or Management Options

<table>
<thead>
<tr>
<th>Level</th>
<th>Total Problem Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>0-1</td>
</tr>
<tr>
<td>Limited</td>
<td>2</td>
</tr>
<tr>
<td>Multiple</td>
<td>3</td>
</tr>
<tr>
<td>Extensive</td>
<td>4</td>
</tr>
</tbody>
</table>
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

Amount and/or Complexity of Data to be Reviewed

- Minimal or None
- Limited
- Moderate
- Extensive

Data Points

<table>
<thead>
<tr>
<th>Categories of Data to be Reviewed (max=1 for each)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>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</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing, or specimen itself (not simply review report)</td>
<td>2</td>
</tr>
</tbody>
</table>
Amount and/or Complexity of Data to be Reviewed

<table>
<thead>
<tr>
<th>Level</th>
<th>Total Data Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal or None</td>
<td>0-1</td>
</tr>
<tr>
<td>Limited</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
</tr>
<tr>
<td>Extensive</td>
<td>4</td>
</tr>
</tbody>
</table>

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
### Table of Risk

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

### Medical Decision Making

2/3 elements must be met or exceeded:

<table>
<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data</th>
<th>Risk</th>
<th>Complexity of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

### Medical Decision Making

2/3 elements must be met or exceeded:

<table>
<thead>
<tr>
<th>Problem Points</th>
<th>Data Points</th>
<th>Risk</th>
<th>Complexity of Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>0-1</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>
“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

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
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
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

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

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.