

Creation & Auditing of MH Evaluation and Management (E/M) Documentation*

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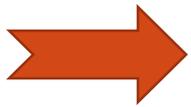
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Audience

- Quality Assurance Staff



- Medical Providers:
 - Psychiatrists (MD, DO)
 - Advanced Practice Nurses:
 - Clinical Nurse Specialists (CNS)
 - Nurse Practitioners (NP)
 - Physician Assistants (PA)



Note: RN, LVN, CNA, & PT's do NOT bill E/M codes (they bill code **369** only).

Overview of this session

- **Length of time:**

- 180 minutes Presentation:

- Break down E/M coding into components
- Go over criteria for documentation of these components

- 60 minutes Interactive Exercises:

- Practice reviewing records (hand outs) to determine what elements need to be obtained and documented
- Q & A

- **Key**

 = “of note”

讲 = Outline



= “good news”



= Caution



= Audit Tool



= “Red Flag”



= Progress Note ex.

E/M Codes – Introduction

- MH Medical Providers (Psychiatrists, CNS, NP, & PA) may bill E/M codes
- Codes start with “99” and are 5 digits
- Codes are divided by:
 - "New Patient"(CBO's only--**Caution**) vs. "Established Patient"
 - Site of Service
 - If you do not have a needed E/M code (i.e. different settings: home, Board & Care, or SNF) contact Jackie Paris at 510.383.1545
 - Level of complexity or amount of work required
 - The amount of work required is driven by the nature of the presenting problem
- **Complexity of services and resultant documentation determines the level of service claimed (that is the correct code)—not time—EXCEPT:**



Counseling & Coordination of Care

- If “Counseling & Coordination of Care”—as defined by the *AMA 2013 CPT Manual*—is greater than 50% of the Face-to-Face time:
 - The code must be selected on the basis of time
 - Except when done in conjunction with a psychotherapy visit (which is not recommended as > vulnerable to disallowances)
 - *ACBHCS providers—County and Contractors—do NOT normally provide E/M + Psychotherapy.*
 - *They usually provide Counseling & Coordination of Care E/M services*
 - Documentation must meet Counseling & Coordination of Care Guidelines—see slides beginning on pg. #7: slide #13: “Path 1”



"New Patient"—Office E/M Codes

- 545 – 549 / 99201 – 99205
- Only allowed by CBO providers—that is those who are not employed directly by ACBHCS
 - **However, These codes are NOT RECOMMENDED and often disallowed**
 - **If you decide to use "New Patient" codes—research disallowances thoroughly!**
- **BEST TO USE 565—90792: Psychiatric Diagnostic Evaluation (MH assessment or reassessment) with Medical Components**
- **Or Established Patient Codes: 641 -646 / 99211 - 92115**



"New Patient" Office E/M Codes

- A "New Patient" is one who has not received any professional services within the past 3 years from:
 - The medical provider, or another medical provider of the same specialty or sub-specialty
 - Who belongs to the same group practice (same Tax ID Number (TIN))
 - Each ACBHCS Contracted CBO (all their sites) is it's own group practice.
 - Check the InSyst Facesheet—if client has been open to your umbrella agency in the past three years (same Tax ID Number) YOU MAY NOT USE "New Patient" Codes
 - **BEST TO USE 565—90792: Psychiatric Diagnostic Evaluation (MH assessment or reassessment) with Medical Components—Office or other Outpatient**
 - **Or Established Patient Codes: 641 -646 / 99211 - 92115**

MH Assessment Codes

- **323-90791 – Psychiatric Diagnostic Evaluation (Initial & Reassessment)**
 - Non-Medical MH Providers must use this code
 - Evaluate current mental, emotional, or behavioral health.
 - Includes but is not limited to:
 - Mental Status
 - Clinical History
 - Relevant cultural issues
 - Diagnosis
 - Use of Testing Procedures for assessment purposes
- **565-90792 – Psychiatric Diagnostic Evaluation w/ Medical Component—only performed by Medical Providers (MD, DO, APN—CNS or NP, & PA)**
- **324-96151– Behavioral Evaluation (CFE or approved equivalent)**

Psychiatric Diagnostic Evaluation Procedure Codes: 323—90791, 565—90792

- Reporting Psychiatric Diagnostic Procedures:
 - Each Psychiatric Diagnostic Codes may be reported only once per day (unless seeing the client and significant other separately).
 - 323-90791 Psych Diag Eval may be provided by a non-medical provider on the same day as 565-90792 Psych Diag Eval with Medical Component is provided by a medical provider (Psychiatrist/ANP/PA).
 - Cannot be reported with an E/M code on same day by same individual provider or same agency.
 - Cannot be reported with psychotherapy service code on same day by any provider.
Medical Provider may use 641/99211—646/99215 Est. Pt. Office Visit.
 - May be reported more than once for a client when *separate diagnostic evaluations* are conducted with the *client* and *other collaterals* (such as family members, guardians, and significant others).
 - Diagnostic evaluation for child with child.
 - Diagnostic evaluation for child with caretaker.
 - Use the same codes, for later reassessment, as indicated.

E/M "Established Patient" — Office or Other Outpatient

- **641-99211** E/M "Established Patient" Office or other Outpatient **Simple**
- **643-99212** E/M "Established Patient" Office or other Outpatient **Problem Focused**
- **644-99213** E/M "Established Patient" Office or other Outpatient **Expanded**
- **645-99214** E/M "Established Patient" Office or other Outpatient **Moderate**
- **646-99215** E/M "Established Patient" Office or other Outpatient **High Complexity**

ACBHCS does not utilize E/M Consultation Codes

See InSyst Procedure Code Table (hand-out) for Established E/M Home, SNF and B&C Codes

E/M "Established Patient" — Office or Other Outpatient

- **Two Paths to E/M Selection:**
 - **Path One:** select the code based on face-to-face time when Counseling and Coordination of Care is $> 50\%$ of face-to-face time (or unit time for inpatient)
 - **Path Two:** select the code based on the documented components:
 - History
 - Exam
 - Medical Decision Making

讲 E/M Documentation Outline

(This is the outline that specifies which specific component(s) / element(S) we are focusing on during this presentation.)

Path 1: Counseling & Coordination of Care

Path 2: Level of Care (Score highest of two components for Established Patient E/M)

1. History
2. Psychiatric Exam
3. Medical Decision Making

Path One: Counseling & Coordination of Care

- The majority of E/M services provided in Community Mental Health involve >50% of face-to-face time is Counseling and Coordination of Care
 - Especially extended visits such as [645—99214](#) & [646-99215](#)
 - However, always bill to actual service provided.
 - Utilizing the same code, or always utilizing Counseling & Coordination of Care documentation, over and over again is a **Red Flag to Medicare Auditors!**
 - *Even if your agency routinely schedules the same amount of time for all client visits.*
 - **Client needs must dictate service provided—not the agency’s scheduling framework**



Counseling and Coordination of Care Documentation Requirements:

- Face-to-Face time
- Counseling and Coordination of Care time
 - Or at least statement: “Counseling and Coordination time was greater than 50% of face-to-face time.”
 - Start and end times also recommended.
 - Example:
 - 646-99215; F-F time = 50”: start 13:00 and end 13:50;
 - Counseling and Coordination of Care time = 40”
 - Doc time = 8”; Total time = 48”
- List the content topics of Counseling and Coordination of Care discussed &
- Provide a detailed description of discussion of each content topic documented

Content Topics of Counseling and Coordination of Care

- >50% of face-to-face time was spent discussing with the client, *or family*, any of the following Counseling topics:
 - Prognosis
 - Test Results
 - Compliance/ Adherence
 - Education
 - Risk Reduction
 - Instructions

Is Listing the Content Topics of Counseling and Coordination of Care Sufficient?

- ***NO!!!!***



- Provider must detail and thoroughly document what was discussed for each content topic covered!

- E.g. for Compliance/Adherence discussion:



- *“20 minutes of 25 minutes face-to-face time spent counseling/coordination care re: importance of medication compliance with mood stabilizer for bipolar disorder. Explored impact of when client went off her medications—including recent 5150 and involuntary hospitalizations...”*

Counseling and Coordination of Care: Code Selection Based on Time

"Established Patient"—Office Codes	Face-to-Face Minutes
641 – 99211 Simple Visit	5 (3 – 7 minutes)
643 – 99212 Problem Focused Visit	10 (8 – 12 minutes)
644 – 99213 Expanded Prob Focused Visit	15 (13 – 20 minutes)
645 – 99214 Mod Complexity Visit	25 (21 – 32 minutes)
646 – 99215 High Complexity Visit	40 (33 + minutes)

➔ *What if face-to-face time greatly exceeds 33 minutes? Choose code 646—99215 and balance of f-f time, along with documentation time, will be billed to Medi-Cal.*

What is Counseling & Coordination of Care per the CPT Manual?

- **Counseling:** Discussion with a client, or the client's family, concerning one or more of the following issues:
 - Diagnostic results, Prior studies, Need for further testing
 - Impressions
 - Clinical course, Prognosis
 - Treatment options, Medication Issues, Risks and benefits of management options
 - Instructions for management and/or follow-up
 - Importance of compliance with chosen management options
 - Risk factor reduction
 - Client education

Counseling vs. “Supportive Psychotherapy”

- Although CPT considers “counseling” as separate and distinct from psychotherapy, psychiatrists typically include counseling (as defined by CPT) as part of their regular treatment.
- Many of the components of “Supportive Psychotherapy” may be considered as overlapping with “Counseling” (as defined by CPT).
 - *“From the clinician’s objectives—to maintain or improve the client’s self-esteem, to minimize or prevent recurrence of symptoms, and to maximize the client’s adaptive capacities.”**
 - *“From the client’s goals—to maintain or reestablish the best-possible level of functioning given the limitations of his or her personality, ability, and life circumstances...”**

**An Introduction to Supportive Psychotherapy published by the American Psychiatry Press, Inc.*



Comparing Counseling and “Supportive Psychotherapy”

CPT Elements of Counseling	Corresponding Elements of Supportive Psychotherapy*
Diagnostic results, impressions, and/or recommended diagnostic studies	Advice and Teaching
Prognosis	Reassurance & Encouragement
Risks and benefits of management (treatment) options	Advice and Teaching, Rationalizing and Reframing
Instructions for management (treatment) and/or follow-up	Anticipatory Guidance, Reducing and Preventing Anxiety Naming the Problem Advice and Teaching
Importance of compliance with chosen management (treatment) options	Expanding the client’s Awareness
Risk factor reduction	Naming the Problem Expanding the Client’s Awareness Advice and Teaching

Coordination of Care

- Services provided by the medical provider responsible for the direct care of a client when he or she **coordinates or controls access to care or initiates or supervises other healthcare services** needed by the client.
 - outpatient **coordination of care must be provided while face-to-face with the client (or family)**.
-  • *Coordination of care with other providers or agencies without the client being present on that day is reported with the non face-face code **367**—*Med Training & Support (non face-to-face)*.*

Part 1: E/M Review Questions

Q: Which E/M codes may ACBHCS employee providers use?

- "Established Patient"
- "New Patient"
- Consultation

A: "Established Patient" only

Q: In community MH which of the following components is it most common that the majority (> 50%) of f-f time is spent on?

- Gathering History
- Psychiatric Exam
- Medical Decision Making
- Counseling & Coordination of Care

A: Counseling and Coordination of Care

Part 1: E/M Review Questions cont.

Q: Coordination of care with another provider, which is critical to the success of the client's treatment plan, may be billed as an E/M code when the client is not present in the room? Yes or No?

A: No—use 367—Med Training & Support

Q: Medical Providers may bill an E/M code when seeing a family member without the client present? Yes or No?

A: Yes

Q: For medical providers, which CPT code is recommended to use instead of "New Patient"?

A: 565—90792 Psychiatric Diag Eval with Medical Component

B: 641/99211—646/99215 Est. Pt. Office Visit

Counseling & Coordination of Care: Template Form Examples

Counseling & Coordination of Care progress note templates from the New York State Psychiatric Association:

- [Instructions for E/M Progress Note Template: Counseling & Coordination of Care](#)
- [Outpatient E&M Template](#)
- [Inpatient E&M Template](#)
- [Nursing Home E&M Template](#)



Auditing E/M Counseling and Coordination of Care Notes



Auditor's Worksheet	Yes	No
Does documentation reveal total time (Face-to-face in outpatient setting; unit/floor in inpatient setting) and indicate > 50% of the time was counseling and coordination of care services?		
Does documentation list and <u>describe</u> the content of counseling or coordinating care?		
Does documentation support that more than half of the total time was counseling or coordination of care?		

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E/M Documentation Outline

(This is the outline that specifies which specific component(s)/element(S) we are focusing on during this presentation.)

Path 1: Counseling & Coordination of Care

Path 2: Level of Care – Charting by the Elements (Score highest of two—for “Established Patient”)

1. History
2. Psychiatric Exam
3. Medical Decision Making

Path Two: Choosing E/M Codes Based on the Level of Care

- E/M codes, which are used by all prescribers, have very specific documentation guidelines that were created by the Centers for Medicare and Medicaid Services (CMS). CMS published two sets of guidelines, one in 1995 and another in 1997. See link below for 1997 standards (CMS pamphlet).
- When documenting an E/M note—you must use 1995 OR 1997 guidelines.
- 1997 Guidelines are the most relevant to psychiatry since they contain the documentation requirements for a single-system psychiatry exam vs. a less relevant general multi-systems exam.
- A CMS pamphlet explains how to use the E/M documentation guidelines at www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf. This includes both 1995 & 1997 guidelines. See hand out.
- [Codes & Documentation for Evaluation & Management with Vignettes](#) [Chapter 4 from CPT Handbook for Psychiatrists. The basics on how to do E/M coding] See hand out.

Path 2: Determine Level of Care

Components (3):

Elements (4, 3 & 3) within Components:

1.) **History**

- Chief Complaint (**CC**)

- History of Present Illness (**HPI**)

- Past Medical, Family and/or Social History (**PFSH**)

- Review of Systems (**ROS**)

2.) **Exam**

- **Number** of “Bullets” or elements completed within psychiatric exam

3.) **Medical Decision Making**

- **Number** of Diagnoses or Management Options

- Amount and/or **Complexity** of Data to be Reviewed

- **Risk** of Significant Complications, Morbidity, and/or Mortality

Path 2: Documentation Strategy to Determine Level of Care



- Assess appropriate level of care required in the first 5 minutes of that day's encounter
 - Helps to organize the gathering of information
- Organize documentation to identify the elements that support the expected complexity of E/M code level
- Highest two of three scores will be used to determine appropriate E/M code for "Established Patient" (3/3 for "New Patient"):
 - 1—History
 - 2—Exam
 - 3—Medical Decision Making
- Ask yourself:
 - Which two areas will document the level of E/M code claimed?
 - What are the minimum elements needed in each of those two areas for the complexity of the anticipated visit to meet documentation guidelines?

Path 2 – Charting to the Elements

- **Audit Form**
 - [Audit Sheet for Charting by the Elements—Level of Care](#)
- **Sample Progress Note Forms for Charting to the Elements:**
 - [E-M-Elements FINAL.doc](#)
 - Two additional examples.

讲 E/M Documentation Outline

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements. (Score highest two of #1 – 3 for Est Pt)

1. History

Chief Complaint (CC)

a.) History of Present Illness (HPI)

i.) 1 – 3 chronic conditions OR

ii.) 0 – 6 elements

b.) Review of Systems (ROS)

i.) 0 – 15 bullets

c.) PFSH

i.) Client's Past Medical History

ii.) Family History

iii.) Social History

2. Psychiatric Exam

3. Medical Decision Making

Path 2: 1—History Components—CC

- Chief Complaint
 - Required for all levels of E/M services
 - A concise statement that describes the symptom, problem, condition, diagnosis, or reason for the encounter
 - Frequently stated in the client’s own words
 - A Chief Complaint is not:
 - A one word symptom; FU; Follow-up; OV; Office Visit; EST; Established Care; Med Recheck or Refill; Lab Results; A Dx or Chronic Condition; Fill out client Note/Paperwork; Sick, etc.
 - A Chief Complaint is:
 - “Today client complains of depression, anxiety and insomnia.”
 - “Client presents today for review of abnormal lab results.”
 - “Client presents today for MD ordered return to follow-up for Rx titration to d/c Rx.”

讲 E/M Documentation Outline

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements. (Score highest two of #1 – 3 for Est Pt)

1. History

Chief Complaint

a.) History of Present Illness (HPI)

i.) 1 – 3 chronic conditions OR

ii.) 0 – 6 elements

b.) Review of Systems (ROS)

i.) 0 – 15 bullets

c.) PFSH

i.) Client's Past Medical History

ii.) Family History

iii.) Social History

2. Psychiatric Exam

3. Medical Decision Making

Path 2: 1a.—History Components: HPI

- HPI is a chronological description of the development of the client's present illness from the first sign and/or symptom OR from the previous encounter to the present ("Established Patient" visits).
 - State 1 – 3 chronic conditions being treated
- OR**
- History of Present Illness elements:
 - Location (e.g. low mood)
 - Quality (e.g. hopeless, emptiness)
 - Severity (e.g. 7 on a scale of 1 to 10)
 - Timing (e.g. constant, especially at night)
 - Context (e.g. when alone)
 - Modifying factors (e.g. felt better after bowling)
 - Associated signs and symptoms (e.g. crying, insomnia)
 - Duration (e.g. length of presence)



Path 2: 1a.—Hx Components: HPI PN

Chief Complaint/Reason for Encounter (Required):

A. HPI. History of Present Illness:

Elements: Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, & Associated Signs and Symptoms. If unable to gather from client or others, indicate and describe condition preventing collection.

One – three elements = Brief; Four or more elements = Extended.

OR Status of Chronic Conditions:

One – two conditions = Brief; Three or more conditions = Extended.

Describe HPI and/or Status of Chronic Conditions:

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E/M Documentation Outline

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements. (Score highest two of #1 – 3 for Est Pt)

1. History

Chief Complaint

a.) History of Present Illness (HPI)

i.) 1 – 3 chronic conditions OR

ii.) 0 – 6 elements

b.) Review of Systems (ROS)

i.) 0 – 15 bullets

c.) PFSH

i.) Client's Past Medical History

ii.) Family History

iii.) Social History

2. Psychiatric Exam

3. Medical Decision Making

Path 2: 1b.—History Components--ROS

- Review of Systems is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the client may be experiencing or has experienced.
- The client's positive responses and pertinent negatives for the system related to the problem should be documented (when documenting 1- 9 systems).
-  When documenting 10 or > systems: those with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least 10 systems must be individually documented.

Path 2: 1b.—History Components--ROS



- If provider is unable to obtain a history from client or other source, record should describe the client's condition which precluded obtaining a history and then a “Complete History” may be scored.



- Review of Systems may be collected by Ancillary Staff, or by client self-report form, if provider's documentation notes review and confirmation (or supplementation) of information recorded by others



- Review of Systems obtained during an earlier encounter does not need to be re-recorded if provider references:
 - Date collected
 - That it was reviewed and updates (or indicates no change) previous information

Path 2: 1b.—History Components--ROS

- Review of Systems Elements (Systems in red frequently reviewed with Psychiatric problems.):
 - Constitutional (e.g. fatigue)
 - Eyes (e.g. blurry vision)
 - Ears, Nose, Mouth, Throat (e.g. dry mouth)
 - Cardiovascular (e.g. palpitations—due to anxiety)
 - Respiratory (e.g. cough)
 - Gastrointestinal (e.g. constipation—due to anti-psychotic Rx)
 - Genitourinary (e.g. decreased libido)
 - Musculoskeletal (e.g. tremor)
 - Integumentary (skin +/- breast) (e.g. itching)
 - Neurological (e.g. weakness, tardive dyskinesia)
 - Psychiatric
 - Endocrine (e.g. polydipsia)
 - Hematologic/Lymphatic (e.g. bruising)
 - Allergic/Immunologic (e.g. hives, NKDA)

Path 2: 1b.—Hx Components—ROS PN



B. Review of Systems & Active Medical Problems

of systems completed: One = Problem Pertinent; Two – nine = Extended; Ten or > = Complete.

Systems:	<u>Document Notes if Positive:</u>	
1. Constitutional	pos ___	neg ___
2. Eyes	pos ___	neg ___
3. Ears/Nose/Mouth/Throat	pos ___	neg ___
4. Cardiovascular	pos ___	neg ___
5. Respiratory	pos ___	neg ___
6. Gastrointestinal	pos ___	neg ___
7. Genitourinary	pos ___	neg ___
8. Muscular	pos ___	neg ___
9. Integumentary	pos ___	neg ___
10. Neurological	pos ___	neg ___
11. Endocrine	pos ___	neg ___
12. Hemotologic/Lymphatic	pos ___	neg ___
13. Allergies/Immune	Pos ___	neg ___
TOTAL # OF SYSTEMS:	_____	

Path 2: 1b.—Hx Components: ROS PN Scoring

- Chief Complaint (CC) present

A small, light blue grid or table icon, possibly representing a data table or a form used in the context of the presentation.

- **Problem Pertinent ROS:**

- 1 system reviewed

- **Extended ROS:**

- 2 – 9 systems reviewed

- **Complete ROS:**

- 10 + systems reviewed

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E/M Documentation Outline

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements. (Score highest two of #1 – 3 for Est Pt)

1. History

Chief Complaint

a.) History of Present Illness (HPI)

i.) 1 – 3 chronic conditions OR

ii.) 0 – 6 elements

b.) Review of Systems (ROS)

i.) 0 – 15

c.) PFSH (two of three areas for "Established Patient" visits, and three of three areas for "New Patient" visits)

i.) Client's Past Medical History

ii.) Family History

iii.) Social History

2. Psychiatric Exam

3. Medical Decision Making

Path 2: 1c.—History Components: PFSH

- Two of three areas required for "Established Patient" E/M visits.
- Three of three areas required for "New Patient" E/M visits.
- Past Medical, Past Family, Social History
 - Past mental health & past medical health: illnesses, operations, injuries, treatments, medications, allergies
 - Family History: medical events, including diseases which may be hereditary conditions or place the client at risk
 - Social History: age appropriate review of past and current activities
- For those categories of E/M that include only an interval history a PFSH is not required (subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care).

Path 2: 1c.—History Components--PFSH



- If provider is unable to obtain a history from client or other source, record should describe the client's condition which precluded obtaining a history and then a “Complete History” may be scored.



- PFSH may be collected by Ancillary Staff, or by client self-report form, if provider's documentation notes review and confirmation (or supplementation) of information recorded by others



- PFSH obtained during an earlier encounter does not need to be re-recorded if provider references:
 - Date collected
 - That it was reviewed and updates (or indicates no change) previous information



Path 2: 1c.—Hx Components: PFSH PN

C. PFSH. Past Medical History, Family History & Social History:

Elements Completed: One element = Pertinent; Two elements for Established (Three for New Client) Client = Complete .

Past Medical History: Check if no change and see note dated ___/___/___ for detail.

Diagnoses:

Medications:

Surgeries:

Allergies:

Family History: Check if no change and see note dated ___/___/___ for detail.

Social History: Check if not change and see note dated ___/___/___ for detail.

Path 2: 1c.—Hx Components: PFSH PN Scoring

- Chief Complaint (CC) present



- **Pertinent PFSH:**

- 1 area reviewed

- **Complete PFSH (“Established Patient”):**

- 2 areas reviewed

- **Complete PFSH (“New Patient”):**

- 3 areas reviewed

讲 E/M Documentation Outline

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements. (Score highest two of 1 - 3)

1. History

Chief Complaint

a.) History of Present Illness (HPI)

i.) 1 – 3 chronic conditions OR

ii.) 0 – 6 elements

b.) Review of Systems (ROS)

i.) 0 – 15 bullets

c.) PFSH (two of three for est patient—office/outpatient)

i.) Client's Past Medical History

ii.) Family History

iii.) Social History

2. Psychiatric Exam

3. Medical Decision Making

Path 2: 1—History: Code Scoring Requirements

If Chief Complaint is present:

- **641—99211: (No Hx)**
 - Minimal problem that may not require physician
- **643—99212: (Prob Focused Hx)**
 - 1a—Brief HPI: 1 chronic condition or 1 element
 - 1b—ROS: none required
 - 1c—PFSH: none required
- **644—99213: (Exp Prob Focused Hx)**
 - 1a—Brief HPI: 1-2 chronic conditions or 1-3 elements
 - 1b—Problem Pertinent ROS: 1 system reviewed
 - 1c—PFSH: none required

If Chief Complaint is present:

- **645—99214: (Detailed Hx)**
 - 1a—Brief HPI: 1-2 chronic conditions or 1 - 3 or more elements
 - 1b—Extended ROS: 2 - 9 systems reviewed
 - 1c—Pertinent PFSH: 1 history area
- **646—99215: (Complete Hx)**
 - 1a—Extended HPI: 3 chronic conditions or 4 elements
 - 1b—Complete ROS: 10 systems reviewed, or some described and statement “all others negative”
 - 1c—Complete PFSH: 2 history areas ("Established Patient") or 3 history areas ("New Patient")

Path 2: 1–History Audit Tool



E/M Documentation Auditor's Instructions

Client:

E/M Code:

Time:

Date of Service:

1. History – MUST INDICATE CHIEF COMPLAINT

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the *RIGHT* in the table, which best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the *LEFT*, identifies the type of history.

After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 5.

HISTORY	HPI: Status of chronic conditions: <input type="checkbox"/> 1 condition <input type="checkbox"/> 2 conditions <input type="checkbox"/> 3 conditions OR HPI (history of present illness) elements: <input type="checkbox"/> Location <small>(WHERE)</small> <input type="checkbox"/> Severity <small>(1-10)</small> <input type="checkbox"/> Timing <small>(WHEN/OFTEN)</small> <input type="checkbox"/> Modifying factors <small>(WHAT WORSE/LESSENS)</small> <input type="checkbox"/> Quality <small>(DESCRIBE)</small> <input type="checkbox"/> Duration <small>(ONSET TO)</small> <input type="checkbox"/> Context <small>(WHAT/WHEN)</small> <input type="checkbox"/> Associated signs and symptoms <small>(ELSE)</small>		Status of 1-2 chronic conditions	Status of 3 chronic conditions
	ROS (review of systems--May be collected by staff or Ct. self-report form if reviewed): <input type="checkbox"/> Constitutional (wt loss, etc) <input type="checkbox"/> Ears, nose, mouth, throat <input type="checkbox"/> GI <input type="checkbox"/> Integumentary (skin, breast) <input type="checkbox"/> Endo Hem/lymph <input type="checkbox"/> Eyes <input type="checkbox"/> Card/vasc <input type="checkbox"/> Musculo <input type="checkbox"/> Neuro <input type="checkbox"/> A lrgy /immuno <input type="checkbox"/> Resp <input type="checkbox"/> Psych <input type="checkbox"/> All others negative	None	Pertinent to problem (1 system)	Extended (2-9 systems) **Complete
	PFSH (past medical, family, social history) areas (collection same as ROS): <input type="checkbox"/> Past history (the patient's past experiences with illnesses, operation, injuries and treatments) <input type="checkbox"/> Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) <input type="checkbox"/> Social history (an age appropriate review of past and current activities)	None	Pertinent 1 history area	***Complete (2 or 3 history areas)
		PROBLEM FOCUSED	EXP. PROB. FOCUSED	DETAILED

***Complete Hx** Allow if unable to obtain & describe condition preventing.

****Complete ROS** 10 or more, or some systems with statement "all others neg."

*****Complete PFSH** 2 history areas: a) Established patients - office (outpatient) care; b) Emergency department.

3 history areas: a) New patients - office (outpatient) care, domiciliary care, home care; b) Consultations; c) Initial hospital care; d) Hospital observation; e) Initial Nursing Facility Care.

NOTE: Subsequent Hospital & Subsequent Nursing Facility Care E/M services require only an interval history, it is not necessary to record information about the PFSH. Refer to procedure code descriptions.

Path 2: 1—History:

Example PN Scored, 645–99214



Office visit for a 70-year-old male, established patient, with stable depression and recent mild forgetfulness.

70-year-old male seen for follow up visit for depression. Visit attended by patient and daughter; history obtained from both.

Patient and daughter report increasing distress related to finding that he has repeatedly lost small objects (e.g., keys, bills, items of clothing) over the past 2-3 months (duration). Patient notices intermittent (timing), mild (severity) forgetfulness (quality) of people's names and what he is about to say in a conversation. There are no particular stressors (modifying factors) and little sadness (associated signs and symptoms).

HPI scoring: 6 elements = *Extended*

Less attention to hobbies

PFSH scoring: 1 element; social = *Perinent*

Psychiatric: no problems with sleep or anger;
Neurological: no headaches, dizziness, or weakness

ROS scoring: 2 systems = *Extended*

HISTORY:
Detailed

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E/M Documentation Outline

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements. (Score highest two of 1 - 3)

1. History

Chief Complaint

a.) History of Present Illness (HPI)

i.) 1 – 3 chronic conditions OR

ii.) 0 – 6 elements

b.) Review of Systems (ROS)

i.) 0 – 15 bullets

c.) PFSH (2 of 3 areas for est patient—office/outpatient)

i.) Client's Past Medical History

ii.) Family History

iii.) Social History

2. Psychiatric Exam

a.) Constitutional

b.) Musculoskeletal

c.) Psychiatric

3. Medical Decision Making

Path 2: 2—Single Organ Exam: Psychiatric

- The 1997 Guidelines—a single organ system can be used for examination of client with a mental health presenting problem, in place of a general multi-system examination
- The type and extent of the examination is based upon clinical judgment, client's history, and nature of presenting problem(s)

Path 2: 2—Psychiatric Exam

- Single Organ Psychiatric Exam: 3 General System/Body Areas
 - A. Constitutional
 - B. Musculoskeletal
 - C. Psychiatric

- Specific abnormal and relevant negative findings should be documented—a notation of “abnormal” without elaboration is NOT sufficient—it must be described.



- A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

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E/M Documentation Outline

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements. (Score highest two of 1 - 3)

1. History

2. Psychiatric Exam

a.) Constitutional

i. 3/7 vital signs

ii. General Appearance

b.) Musculoskeletal

c.) Psychiatric

3. Medical Decision Making

Path 2: 2a—Psychiatric Exam: Constitutional

- 3 of 7 vital signs (ancillary staff may collect vitals if reviewed by prescriber & indicated as such in the medical record), **red** common:
 - **Sitting**/standing **BP**
 - Supine BP
 - Pulse rate, regularity
 - Respiration
 - **Height**
 - **Weight**
- General Appearance
 - Development
 - Nutrition
 - **Body Habitus** (Weight loss/gain, etc.)
 - Deformities
 - **Attention to grooming**

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E/M Documentation Outline

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements. (Score highest two of 1 - 3)

1. History

2. Psychiatric Exam

a.) Constitutional

i. 3/7 vital signs

ii. General Appearance

b.) Musculoskeletal (esp with anti-psychotic rx)

i. Muscle strength and tone

ii. Gait and Station

c.) Psychiatric

3. Medical Decision Making

Path 2: 2b—Psychiatric Exam: Musculoskeletal

- Muscle strength & tone:
 - Flaccid, cog wheel, spastic
 - Atrophy
 - Abnormal movements
 - AIM Scale
- Examination of Gait and Station

讲 E/M Documentation Outline

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements. (Score highest two of 1 - 3)

1. History

2. Psychiatric Exam

a.) Constitutional

i. 3/7 vital signs

ii. General Appearance

b.) Musculoskeletal

i. Muscle strength and tone

ii. Gait and Station

c.) Psychiatric

speech, thought process, associations, abnormal/psychotic thoughts, judgment and insight, orientation, recent and remote memory, attention and concentration, language, fund of knowledge, mood and affect

3. Medical Decision Making

Path 2: 2c Psychiatric Exam: Psychiatric Elements

- i. speech,
- ii. thought process,
- iii. associations,
- iv. abnormal/psychotic thoughts,
- v. judgment and insight,
- vi. orientation,
- vii. recent and remote memory,
- viii. attention and concentration,
- ix. language,
- x. fund of knowledge,
- xi. mood and affect

Path 2: 2c Psychiatric Exam: Psychiatric Elements

- i. Speech: rate, volume, articulation, coherence, spontaneity, with notation of abnormalities (perseveration, paucity of language)
- ii. Thought processes: rate of thoughts, content of thoughts (eg. logical vs. illogical, tangential), abstract reasoning, and computation
- iii. Associations: loose, tangential, circumstantial, intact
- iv. Abnormal or psychotic thoughts: hallucination, delusions, homicidal or suicidal ideation, obsessions, preoccupation with violence

Path 2: 2c Psychiatric Exam: Psychiatric Elements

- v. Judgment-- ability to identify a problem and understand it's nature: social judgment (e.g.. concerning everyday activities and social situations) and insight (e.g.. concerning psychiatric condition)
- vi. Orientation: person, place, time, event
- vii. Memory (recent and remote)
- viii. Attention span and concentration
- ix. Language: naming objects, repeating phrases
- x. Fund of knowledge (e.g.. awareness of current events, past history, vocabulary): intact, inadequate
- xi. Mood and Affect: depression, anxiety, hypomania, agitation, lability, etc.



Path 2: 2 Psychiatric Exam

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements. (Score highest two of 1 - 3)

1. History

2. Psychiatric Exam

a.) Constitutional

i. 3/7 vital signs

ii. General Appearance

b.) Musculoskeletal

i. Muscle strength and tone

ii. Gait and Station

c.) Psychiatric

**speech, thought process, associations,
abnormal/psychotic thoughts, judgment and insight,
orientation, recent and remote memory, attention and
concentration, language, fund of knowledge, mood
affect**

and

3. Medical Decision Making



Path 2: 2 Psychiatric Exam: PN pg 1

--Vital Signs (any 3 or more of the 7 listed):

Blood Pressure: (Sitting/Standing) _____ (Supine) _____ Height _____ Weight _____

Temp _____ Pulse (Rate/Regularity) _____ Respiration _____

--General Appearance and Manner (E.g., Development, Nutrition, Body Habitus, Deformities, Attention to Grooming, etc.):

--Musculoskeletal: __ Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) (note any atrophy or abnormal movements):

(and/or) __ Examination of gait and station:

-- Speech: Check if normal: __ rate __ volume __ articulation __ coherence __ spontaneity

Abnormalities; e.g., perseveration, paucity of language:

--Thought processes: Check if normal: __ associations __ processes __ abstraction __ computation

Indicate abnormalities:

--Associations (e.g., loose, tangential, circumstantial, intact):

Path 2: 2 Psychiatric Exam: PN pg 2



--Abnormal or psychotic thoughts (e.g., hallucinations, delusions, preoccupation with violence (V/I), homicidal (H/I), or suicidal ideation (S/I), obsessions):

S/I: Present Absent H/I: Present Absent V/I: Present Absent

--Judgment and insight:

--Orientation:

--Memory (Recent/Remote):

--Attention/Concentration:

--Language:

-- Fund of knowledge: intact inadequate

--Mood and affect:

TOTAL BULLETS: _____

Other Findings—*not a countable bullet* (e.g. cognitive screens, personality, etc.):

Path 2: 2 Psychiatric Exam Scoring Considerations

- Specific abnormal and relevant negative findings of the examination should be *documented*



- Abnormal or unexpected findings of the examination of any asymptomatic area/system should be *described*



- A brief statement indicating “*negative*” or “*normal*” is sufficient to document normal findings related unaffected area/system



Path 2: 2 – Psychiatric Exam

E/M Code Scoring

- **641—99211:** minimal problem that may not require physician
- **643—99212:** 1 – 5 bullets (**Problem Focused Exam**)
- **644—99213:** at least 6 bullets (**Exp Prob Focused Exam**)
- **645—99214:** at least 9 bullets (**Detailed Exam**)
- **646—99215:** all bullets in constitutional and psychiatric sections and at least 1 bullet in musculoskeletal (**Comp Exam**)



(Rarely achieved—an extended visit in Community MH more likely contains >50% f-f time—Counseling & Coordination of Care.)



Path 2: 2—Psych Exam Audit Tool



2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

EXAM	SYSTEM/BODY AREA
<ul style="list-style-type: none"> • 3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight • General appearance 	Constitutional
<ul style="list-style-type: none"> • Muscle strength and tone • Gait and Station 	Musculoskeletal
<ul style="list-style-type: none"> • Speech • Thought process • Associations • Abnormal/psychotic thoughts • Judgment and insight • Orientation • Recent and remote memory • Attention and concentration • Language • Fund of knowledge • Mood and affect 	Psychiatric
1 – 5 bullets	<i>PROBLEM FOCUSED EXAM</i>
At least 6 bullets	<i>EXPAND PROB FOC'S'D EXAM</i>
At least 9 bullets	<i>DETAILED EXAM</i>
All bullets in Constitutional and Psychiatric boxes and 1 bullet in Musculoskeletal box.	<i>COMPREHENSIVE EXAM</i>

Path 2: 2 – Psychiatric Exam: Example PN Scored, **645–99214**



Office Visit for a 70 yo man, established pt., w/ stable depression and recent mild forgetfulness.

Appearance: appropriate dress, appears stated age

Muscle strength and tone: normal

Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: x 3; Attention and concentration: unable to focus on serial 7s; Mood and affect: euthymic and full and appropriate; Recent and remote memory: mild struggle with telling history and remembered 1/3 objects

Examination scoring: 10 elements = *Detailed*

EXAM:
Detailed

Part 2: E/M Review Questions

Q: In the History Component of an E/M note one must list both the number and status of chronic conditions AND describe the relevant elements (Quality, Severity, Context, etc.) of those conditions to meet 1997 documentation requirements?

A: False—Number & Status of Chronic Conditions

OR

Description of the Relevant Elements

Q: How many of the 7 vital signs are required in an E/M visit to meet the inclusion criteria for this element?

A: 3 of 7

Q: A specific Psychiatric Exam may replace a General Multi-Systems Exam when documenting an E/M code for a psychiatric service?

A: Yes—per 1997 Guidelines

Part 2: E/M Review Questions cont.

Q: When documenting an E/M service you may select criteria from both the 1995 and 1997 guidelines?

A: No, you must select one guideline to follow. Do not mix and match 1995 and 1997 criteria in one note.

1997 Guidelines are recommended as it allows for a Psychiatric specific exam rather than a General Exam

Q: When documenting an “Established Patient” E/M how many of the following categories must be documented to meet criteria: History, Psychiatric Exam, & Medical Decision Making

A: 2 of 3

3 of 3 for “New Patient”

Q: A separate and distinct Chief Complaint must be present in every E/M note?

A: Yes

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E/M Documentation Outline

Path 1: Counseling & Coordination of Care

**Path 2: Level of Care: Charting by the Elements
(Score highest two of 1 - 3)**

1. History

2. Psychiatric Exam

3. Medical Decision Making (MDM)

a.) Number of Diagnoses or Treatment Options

b.) Amount and/or Complexity of Data Reviewed

c.) Risk of Complications and/or Morbidity or Mortality

Path 2: 3 Medical Decision Making (MDM)

Score the two of three highest:

- a.) Number of Diagnoses or Treatment Options
- b.) Amount of Complexity of Data Reviewed
- c.) Risk of Complications and/or Morbidity or Mortality

Path 2: 3 – MDM Considerations

- Clinically, there is a close relationship between the nature of the presenting problem and the complexity of medical decision making
 - Client comes in for a prescription refill: Straightforward decision making
 - v.s.
 - Client comes in with suicidal ideation: decision making of High Complexity

讲 E/M Documentation Outline

Path 1: Counseling & Coordination of Care

**Path 2: Level of Care: Charting by the Elements.
(Score highest two of 1 - 3)**

1. History

2. Psychiatric Exam

3. Medical Decision Making (MDM)

(Score highest two of a – c.)

**a.) Number of Diagnoses or Treatment
Options**

b.) Amount and/or Complexity of Data
Reviewed

c.) Risk of Complications and/or
Morbidity or Mortality

Path 2: 3a – MDM: Number of Dx or Tx Options--Scoring

a.) Number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made. **(MDM: Score highest two of a – c.)**

- Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

Path 2: 3a – MDM: Number of Dx or Tx Options--Scoring

- For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plan and/or further evaluation.
- For a presenting problem with an established diagnosis the record should reflect whether the problem is: (a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.
- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a “possible”, “probable”, or “rule out” (R/O) diagnosis.

Path 2: 3a – MDM: Number of Dx or Tx Options--Scoring

- The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including client instructions, nursing instructions, therapies, and medication.
- If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.

Path 2: 3a – MDM: Number of Dx or Tx Options—Scoring PN



A. Diagnosis/Problem	
Indicate <u>Status</u> and points for each: -Self-limiting or <u>minor</u> (<u>stable</u> , <u>improved</u> , or <u>worsening</u>) (1 point: max=2 Dx/Problem) - <u>Established</u> problem (to examining provider); <u>stable</u> or <u>improved</u> (1 point) - <u>Established</u> problem (to examining provider); <u>worsening</u> (2 point) - <u>New</u> problem (to examining provider); <u>no additional</u> workup or diagnostic procedures ordered (3 point: max=1 Dx/Problem) - <u>New</u> problem (to examining provider); <u>additional workup planned</u> *(4 point) *Additional workup does not include referring client to another provider for future care	
Axis I-V: Status: _____ Points____ Plan (RX, Lab, etc.):	Axis I-V: Status: _____ Points____ Plan (RX, Lab, etc.):
Axis I-V: Status: _____ Points____ Plan (RX, Lab, etc.):	Axis I-V: Status: _____ Points____ Plan (RX, Lab, etc.):
Axis I-V: Status: _____ Points____ Plan (RX, Lab, etc.):	Axis I-V: Status: _____ Points____ Plan (RX, Lab, etc.):
DIAG/PROBLEMS TOTAL POINTS: _____	

Path 2: 3a – MDM: Number of Dx or Tx Options--Scoring

- i. None **(641—99211)** Minimal problem that may not require a physician
- ii. Minimal Dx or Tx Options **(643—99212)**
 - 1 stable Dx,
 - 1 Dx/problem improved, or
 - 1 management option

Path 2: 3a – MDM: Number of Dx or Tx Options--Scoring

iii. Limited Dx/Tx Options (644—99213)

- 1 established stable Dx and 1 rule-out or differential Dx, or
- 2 stable Dx/problems being treated, or
- 1 established Dx/problem worsening, or
- 2-3 management problems

iv. Multiple Dx/Tx Options (645—99214)

- 2 rule-out or differential Dx, or
- 2 unstable or failing to change problem(s), or
- 3 changes in Tx Plan

v. Extensive Dx/Tx Options (646--99215)

- more than 2 rule-out or differential Dx, or
- 2 worsening or marked change in problems, or
- 4 or more changes in Tx Plan



Path 2: 3b Amount &/or Complexity of Data Reviewed

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements.

(Score highest two of 1 - 3)

1. History

2. Psychiatric Exam

3. Medical Decision Making (MDM)

(Score highest two of a – c.)

a.) Number of Diagnoses or Treatment Options

b.) Amount and/or Complexity of Data Reviewed

c.) Risk of Complications and/or Morbidity or Mortality

Path 2: 3b – MDM: Amount &/or Complexity of Data Reviewed-Scoring

b.) The amount &/or Complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed.

(MDM: Score highest two of a – c.)

- Discussion of contradictory or unexpected test results with the provider who performed or interpreted the test is an indication of the complexity of data being reviewed.
- On occasion the provider who ordered a test may personally review the image, tracing or specimen to supplement information from the provider who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

Path 2: 3b – MDM: Amount &/or Complexity of Data Reviewed-Scoring

- If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, e.g. lab or x-ray, should be documented.
-  The review of lab, radiology and/or other diagnostic tests should be documented. A simple notation such as “WBC elevated” or “chest x-ray unremarkable” is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.
-  A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the client should be documented.

Path 2: 3b – MDM: Amount &/or Complexity of Data Reviewed-Scoring



- Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source to supplement that obtained from the client should be documented. If there is no relevant information beyond that already obtained, the fact should be documented. A notation of “Old records reviewed” or “additional history obtained from family” without elaboration is insufficient.
- The results of discussion of laboratory, radiology, or other diagnostic tests with the provider who performed or interpreted the study should be documented.
- The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another provider should be documented.

Path 2: 3b – MDM: Amt &/or Complexity of Data Reviewed-Scoring PN



B. Data Reviewed:	Points:	Description:
___ Review and/or order of clinical lab tests	1 POINT	DESCRIBE:
___ Review and/or order of tests in the radiology section of CPT	1 POINT	DESCRIBE:
___ Review and/or order of tests in the medicine section of CPT	1 POINT	DESCRIBE:
___ Discussion of test results with performing provider	1 POINT	DESCRIBE:
___ Decision to obtain old records and/or obtain history from someone other than client	1 POINT	DESCRIBE:
___ Review and summarization of old records and/or obtaining history from someone other than client and/or discussion of case with another health care provider	2 POINT	DESCRIBE:
___ Independent visualization of image, tracing, or specimen itself (not simply review report)	2 POINT	DESCRIBE:
DATA TOTAL POINTS: _____		

Path 2: 3b – MDM: Amount &/or Complexity of Data Reviewed-Scoring

- i. None (641—99211)
- ii. Minimal or low Amount/Complexity of Data (643—99212)
 - 1 Reviewed Data point:
 - 1 source of medical data, or
 - 2 Dx tests, or
 - Confirmatory review of results
- iii. Limited Amount/Complexity of Data (644—99213)
- iv. - 2 Reviewed Data points:
 - i. 2 sources of medical data, or
 - ii. 3 Dx tests, or
 - iii. Confirmation of results with another health care provider

Path 2: 3b – MDM: Amount &/or Complexity of Data Reviewed-Scoring

iv. Multiple/Complexity of Data (645—99214)

- 3 Reviewed Data points

3 sources of medical data, or

4 diagnostic tests, or

Results discussed with provider who performed tests

v. Extensive/Complexity of Data (646—99215)

- 4 Reviewed Data Points

4+ sources of medical data, or

>4 diagnostic tests, or

unexpected results, contradictory review, requires additional review



Path 2: 3c MDM: Risk of Complications &/or Morbidity/Mortality

Path 1: Counseling & Coordination of Care

**Path 2: Level of Care: Charting by the Elements.
(Score highest two of 1 - 3)**

1. History

2. Psychiatric Exam

3. Medical Decision Making (MDM) (Score highest two of a – c.)

a.) Number of Diagnoses or Treatment Options

b.) Amount and/or Complexity of Data Reviewed

c.) Risk of Significant Complications and/or Morbidity or Mortality

Path 2: 3c MDM: Risk of Complications and/or Morbidity or Mortality

- The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the client's presenting problem(s), the diagnostic procedures(s) and/or the possible management options.
- Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.
- If a surgical or invasive diagnostic procedure is performed, ordered, planned or scheduled at the time of the E/M encounter should be documented.
- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.
- The highest level of risk in any one category (presenting problems(s), diagnostic procedure(s), or management options) determines the overall risk. See Table:

Path 2: 3c MDM: Risk of Complications

Level Risk	Presenting Problem	Dx Procedures Ordered	Med Mgt Options
Minimal	-One self-limited or minor problem	-lab tests requiring venipuncture -EKG/EEG -urinalysis	Rest
Low	-2 or more self-limited or minor problems -1 stable chronic illness -Acute uncomplicated illness	-psychological testing -skull film -psychotherapy & environmental interaction (eg. agency/school or vocational placement -referral for consultation	OTC drugs
Moderate	-1 or > chronic illnesses with mild exacerbation, progression or s/e of tx -2 or > stable illnesses -Undiagnosed new problem with uncertain prognosis -Acute illness with systemic symptoms	-neuropsychological testing -open door seclusion -ECT (no co-morbid medical conditons)	Rx Drug mgt. 

Path 2: 3c MDM: Risk of Complications and/or Morbidity or Mortality cont.

Level Risk	Presenting Problem	Dx Procedures Ordered	Med Mgt Options
High	<ul style="list-style-type: none"> -1 or more illnesses with severe exacerbation, progression, or s/e of tx -Acute or chronic illnesses or injuries that may pose a threat to life or bodily function (self/other) -abrupt change in neurological status 	<ul style="list-style-type: none"> -suicide risk assessment -homicide risk assessment 	<ul style="list-style-type: none"> Drug therapy requiring intensive monitoring for toxicity (Lithium, clozapine—clozaril, carbamazepine—tegretol, valproate—depakote, sometimes TCA's) -rapid IM neuroleptic administration -pharmacological restraint

Path 2: 3c MDM: Risk of Complications and/or Morbidity or Mortality E/M Code Scoring

Minimal Risk: **641—99211** or **643—99212**

Low Risk: **644—99213**

Moderate Risk: **645—99214**

High Risk: **646—99215**

Ways to Document Complexity--MDM

- Barriers obtaining history, additional sources
- Old records reviewed
- Labs/EKG reviewed or ordered
- Treatment or medications ordered
- Differential diagnoses
- Co-morbidities or underlying diseases
- Client instructions given
- (This is not interactive complexity code **491—90785**)

Multiple MDM Examples

- **643—99212**
 - Weekly weight check-in on client with anorexia.
 - Prescription refill with no examination (seen f-f).
 - Routine (e.g. weekly) CBC with diff for client taking clozapine (seen f-f).
 - Advice to client
- **644—99213**
 - Major depression, mild (PHQ-10), with recommendation for psychotherapy
 - Dry mouth as a side effect to treatment with nortriptyline, client agrees to monitor symptoms (no med adjustment) and will try to drink more water and chew sugarless gum
 - Stable anxiety without complications or comorbidities, continue CBT
 - OTC sleep aid (e.g. melatonin) for insomnia

MDM Examples

- **645—99214**
 - Client with worsening depression
 - Client with bipolar disorder, developed mild rash with lamotrigine, which has been stopped. The risk is resolved. Client needs an alternative mood stabilizer
 - Client with alcohol dependence in partial remission who would like to try naltrexone
- **646—99215**
 - Client with suicidal ideation, new or worsening
 - Client with first psychotic break
 - A client with anorexia nervosa who is now below 85% ideal body weight

Path 2: 3—MDM Audit Tool



3. Medical Decision Making

Number of Diagnoses or Treatment Options

Identify each problem or treatment option addressed. Enter the number in each of the categories in Column B in the table below. (There are maximum numbers in two categories.) Do not categorize the problem(s) if the encounter is dominated by counseling/coordinates of care—go to box 4.

Number of Diagnoses or Treatment Options			
A	B	X	C = D
Problem(s) Status	Number	Points	Result
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	Max = 1	3	
New prob. (to examiner); add. workup planned		4	
TOTAL			

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.

Bring total to line A in Final Result for Complexity (table below)

Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the points column. Total the points.

Amount and/or Complexity of Data Reviewed	
Reviewed Data	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 of report)	2
TOTAL	

Bring total to line C in Final Result for Complexity (table below)

Risk of Complications and/or Morbidity or Mortality Highest level from presenting problem, Dx procedure, or Med Mgt Options selected.

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below).

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Med. Management Options
Minimal	<ul style="list-style-type: none"> One self-limited or minor problem 	<ul style="list-style-type: none"> Laboratory tests requiring venipuncture EKG/EEG Urinalysis 	<ul style="list-style-type: none"> Rest
Low	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness Acute uncomplicated illness 		<ul style="list-style-type: none"> Over-the-counter drugs
Moderate	<ul style="list-style-type: none"> One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, Acute illness with systemic symptoms 		<ul style="list-style-type: none"> Prescription drug management
High	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that may pose a threat to life or bodily function (self/other) 		<ul style="list-style-type: none"> Drug therapy requiring intensive monitoring for toxicity (Lithium, clozapine--clozaril, carbamazepine--tegetrol, valproate--depakote, sometimes TCA's)

Path 2: 3–MDM Audit Tool cont.

Final Result for Complexity

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

Final Result for Complexity					
		≤ 1	2	3	≥ 4
A	Number diagnoses or treatment options	Minimal	Limited	Multiple	Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making		STRAIGHT-FORWARD	LOW-COMPLEX.	MODERATE-COMPLEX.	HIGH-COMPLEX.

Path 2: 3—MDM: 645—99214

PN Example Scored,

Office Visit for a 70 yo man, established pt., w/ stable depression and recent mild forgetfulness.



Problem 1: Depression
Comment: Stable; few symptoms
Plan: Continue same dose of SSRI; write script
Return visit in 1 month

Problem 2: Forgetfulness
Comment: New; mildly impaired attention and memory
Plan: Brain MRI; consider referral to a neurologist if persists

MEDICAL DECISION MAKING:
Moderate Complexity

Problem scoring: 1 established problem, stable (1),
1 new problem with additional workup (4); total of 5 = *Extensive*

Data scoring: Order of test in the radiology section of CPT (1),
Obtain history from other (2); total of 3 = *Multiple*

Risk scoring: Undiagnosed new problem with uncertain prognosis, and
Prescription drug management = *Moderate*

Path 2: Putting It All Together

Path 1: Counseling & Coordination of Care

Path 2: Level of Care: Charting by the Elements. (Score highest two of #1 - 3)

1. History

2. Psychiatric Exam

3. Medical Decision Making (MDM) (Score highest two of a – c.)

a.) Number of Diagnoses or Treatment Options

b.) Amount and/or Complexity of Data Reviewed

c.) Risk of Complications and/or Morbidity or Mortality

Path 2: 3: Audit Tool

Level of Service Determination



5. LEVEL OF SERVICE

	New Office					Established Office				
	Requires 3 components within shaded area					Requires 2 components within shaded area				
History	P	EPF	D	C	C	Minimal problem	PF	EPF	D	C
Examination	P	EPF	D	C	C	that may not require	PF	EPF	D	C
Complexity	S	SF	L	M	H	physician	SF	L	M	H
Time Code	10" 99201	20" 99202	30" 99203	45" 99204	60" 99205	5" 99211	10" 99212	15" 99213	25" 99214	40" 99215

Part 3: E/M Review Questions

Q: When reviewing lab, radiology, and/or other diagnostic tests is a simple notation such as “WBC elevated” acceptable? Y/N

A: Yes

Q: When reviewing relevant findings from the review of old records (or receipt of additional history from family members) a notation of “old records reviewed” and/or “additional history obtained from the family” without elaboration is insufficient? T/F

A: True—one must state what the relevant findings/history was.

Part 3: E/M Review Questions

Q: When documenting or scoring Medical Decision Making, for an established patient, how many of the following 3 areas must meet inclusion criteria: # of Dx or Tx Options, Amt/Complexity of Data Reviewed, and Risk? 1, 2, or 3?

A: 2

Q: When documenting or scoring—by the elements—how many of the 3 content areas (History, Psych Exam, and MDM) must meet inclusion criteria for an established office E/M visit? 1, 2, or 3?

A: 2

Path 2: What are the E/M Codes?

Established Client: Office or other Outpatient visits:

- **641-99211** E/M "Established Patient" Office or other Outpatient **Simple**
- **643-99212** E/M "Established Patient" Office or other Outpatient **Problem Focused**
- **644-99213** E/M "Established Patient" Office or other Outpatient **Expanded**
- **645-99214** E/M "Established Patient" Office or other Outpatient **Moderate**
- **646-99215** E/M "Established Patient" Office or other Outpatient **High Complexity**

Path 2: 641–99211

- This code is used for a service that may not require the presence of a prescriber. Presenting problems are minimal, and 5 minutes is the typical time that would be spent performing or supervising these services.

Path 2: **641–99211**: Examples

- BP check
- Weight check for metabolic syndrome
- Lab draw
- Client picking up prescription refill (f-f)
- Client picking up return to work or school certificate (f-f).
(If mail or call in, no CPT code allowed)
- May not require physician presence

Path 2: 643-99212

- **Two of three required:**
 - 1 – 2 HPI elements (**Problem Focused History**)
 - 1 – 5 elements of Psychiatric Exam (**Problem Focused Exam**)
 - **Straightforward MDM (2 of 3):**
 - 1 or less Dx/Tx options (**Minimal Dx/Tx Options**)
 - **Minimal Risk**
 - 1 or less points Data (**Minimal Data Complexity**)
- CC: self-limited or minor
- Typical time: 10 minutes face-to-face with client and/or family

Path 2: 643–99212: Example

- One self limited problem
- 1 – 3 HPI elements
 - (no ROS)
- Focused Psychiatric Exam (1 – 5 elements)
- Example: 1 month follow up after stopping a medication to confirm client is still doing well

Path 2: 644-99213

- **Two of three required:**
 - 1 – 3 HPI, 1 ROS elements (**Extended Problem Focused History**)
 - 6 – 8 elements of Psychiatric Exam (**Expanded Problem Focused Exam**)
 - **Low Complexity MDM** (2 of 3):
 - 2 points Dx/Tx options (**Limited Dx/Tx Options**)
 - **Low Risk**
 - 2 points Data (**Limited Data Complexity**)
- CC: low to moderate severity
- Typical time: 15 minutes face-to-face with client and/or family

Path 2: 644–99213: Example

- **Two of three required:**
 - **History**
 - 1 – 3 HPI elements
 - Pertinent ROS
 - **Physical Exam**
 - 6+ elements
 - **MDM** -- Medical Decision Making (low)
 - 2 or more self limited problems, or
 - One stable chronic illness, or
 - Acute uncomplicated illness (social anxiety)

Path 2: 645-99214

- **Two of three required:**
 - 4+ HPI, 1 PFSH, 2 – 9 ROS elements (Detailed **History**)
 - 9 – 13 elements of Psychiatric exam (Detailed **Exam**)
 - **Moderate** Complexity MDM (2 of 3)
 - 3 Dx/Tx Options points (**Multiple Dx/Tx Options**)
 - **Moderate Risk**
 - 3 points Data (**Multiple Data Complexity**)
- CC: moderate to high severity
- Typical time: 25 minutes face-to-face with client and/or family

Path 2: 645–99214: Example

- **Two of three required:**
 - **History**
 - 4+ HPI elements
 - 2 – 9 ROS
 - 1 of 3 PFSH
 - **Physical Exam**
 - Affected are and related organ system (Detailed)
 - **MDM -- Medical Decision Making (low)**
 - 1+ chronic illness with mild exacerbation, or
 - 2+ or more stable chronic illnesses, or
 - Undiagnosed new problem with uncertain Dx, or
 - Acute illness with systemic symptoms, or
 - Acute complicated injury

Path 2: 646 – 99215

- **Two of three required:**
 - 4+ HPI, 2 PFSH, 10+ ROS elements (Comprehensive **History**)
 - 14 – 15 elements of Psychiatric exam (Comprehensive **Exam**)
 - High Complexity **MDM (2 of 3)**
 - 4 or more Dx/Tx Options points (**Extensive Dx/Tx Options**)
 - High Risk
 - 4 or more points Data (**Extensive Data Complexity**)
- CC: moderate to high severity
- Typical time: 40 minutes face-to-face with client and/or family
- Consider charting to Counseling & Coordination of Care—was C&CC more than 50% of f-f time?



Path 2: Typical Times

- The specific times expressed in the visit code descriptors are averages, and therefore represent a range of time which may be higher or lower depending on actual clinical circumstances.
- Face-to-Face for office and outpatient
- Unit/Floor for hospital and inpatient
- Time is NOT a criteria for level (E/M code) of service

Add-On Code for Additional Service Provided: Interactive Complexity

Refers to specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure:

- Typical clients:
 - Have others legally responsible for their care, such as minors or adults with guardians
 - Request others to be involved in their care during the visit
 - Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools

Procedure Codes continued

Interactive Complexity +491-90785

- 4 Specific communication factors during a visit that complicate delivery of the primary psychiatric procedure.
 - The need to manage maladaptive communication.
 - Caregiver emotions or behaviors that interfere with implementation of the treatment plan.
 - Evidence or disclosure of a Sentinel Event and mandated reporting to a 3rd party with initiation of discussion of the event.
 - Use of play equipment to overcome barriers to diagnostic or therapeutic interaction.

Add-On Code for Additional Service Provided: Interactive Complexity (491-90785) cont.

4 specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure:

1. The need to manage maladaptive communication (related to e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
- Vignette (reported with 442-90834, Psychotherapy 45 min)
 - *Psychotherapy for an older elementary school-aged child accompanied by divorced parents, reporting declining grades, temper outbursts, and bedtime difficulties. Parents are extremely anxious and repeatedly ask questions about the treatment process. Each parent continually challenges the other's observations of the client.*

Add-On Code for Additional Service Provided: Interactive Complexity (491-90785) cont.

4 specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure:

2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan
- Vignette (reported with 441-90832, psychotherapy 30 min)
 - *Psychotherapy for young elementary school-aged child. During the parent portion of the visit, mother has difficulty refocusing from verbalizing her own job stress to grasp the recommended behavioral interventions for her child.*

Add-On Code for Additional Service Provided: Interactive Complexity (491-90785) cont.

4 specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure:

3. Evidence or disclosure of a Sentinel Event and mandated reporting to a 3rd party (e.g., abuse or neglect with report to state agency) *with* initiation of discussion of the sentinel event and/or report with client and other visit participants
- Vignette (reported with 565-90792, psychiatric diagnostic evaluation with medical services)
 - *In the process of an evaluation, adolescent reports several episodes of sexual molestation by her older brother. The allegations are discussed with parents and report is made to state agency.*
 - *Time completing a report outside of the session is not billable.*

Add-On Code for Additional Service Provided: Interactive Complexity (491-90785) cont.

4 specific communication factors *during* a visit that complicate delivery of the primary psychiatric procedure:

4. Use of play equipment, physical devices, ~~interpreter or translator~~** to overcome barriers to diagnostic or therapeutic interaction with a client ~~who is not fluent in the same language~~ or who has not developed or lost expressive or receptive language skills to use or understand typical language.
 - Vignette (reported with 456-90853, group psychotherapy)
 - *Group psychotherapy for a young child who requires play equipment to participate in the group therapeutic interaction*

****Per CMS, 491 should not be used to bill *solely* for translation or interpretation services as that may be a violation of federal statute.**

Add-On (+) Procedure Code for Interactive Complexity (+491-90785)

Can only be used with these codes:

- **323-90791 & 565-90792 Psychiatric Diagnostic Evaluation.**
- **441-90832, 442-90834, 443-90837 Psychotherapy**
- **E/M with + Psychotherapy add-on**
 - E/M+465-90833, E/M+467-90836, E/M+468-90838
- **456-90853 Group Psychotherapy**

*Cannot be used with Crisis Therapy, Family Therapy, or with other
E/M codes when no psychotherapy was provided.*

Interactive Complexity (+) 491-90785 Add-on in InSyst & CG

- Select primary procedure code and indicate minutes (into InSyst or Clinician's Gateway) as previously described.
- Select Interactive Complexity Add-on Code (no associated minutes).
 - InSyst, Select code 491-90785 and enter one (1) minute
 - Clinician's Gateway, Select "Interactive Complexity: Present"

Interactive Complexity 491-90785 Add-on (+) in Clinician's Gateway (CG) EHR

Service Entry, Individual

Provider: R. ANTHONY SANDERS-PFEIFER

Home

Me

Interventions

Service #: New Title: Clinician's Progress Note



Service date: 03/05/2015

Client: Number: 75087772 Last Name: TEST First Name: CINDYTWO

Client opened: 3/8/2007

Util. review date:

Procedures: 441 90832 Psychotherapy30 min

Client Plan due date: 10/31/2014 C/P has expired!

KTA ELIGIBLE (Jul 1 2013)

Last assessment: 10/26/2012

Service Location: Select Location

Med. Compliant: N/A Side Effects: N/A

Emergency? Pregnant?

Staff Time

Primary Clinician: 14219 - SANDERS-PFEIFER, R. ANTHONY Provider: 9999CG - CLINICIAN GATEWAY TEST MHS AD Primary Total Time: 01:08

[Add Additional Clinicians](#)

EM Plus Psychotherapy or Additional Crisis: None 2nd FF Time: 2nd Tot Time:

Interactive Complexity: 90785 Present

Instructions

Respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

Primary FF Time: 00:36 Hours:Minutes

Services were provided in English

by Interpreter clinician

Episode Diagnosis Information

Axis I	Axis II	Axis III	Axis IV	Axis V
296.44	799.9	99	J	000

E/M Charting by the Elements

- **American Psychiatric Association**
 - **E and M Documentation Templates**
 - <http://www.psych.org/practice/managing-a-practice/cpt-changes-2013/e-and-m-documentation-templates>
- **American Academy of Child & Adolescent Psychiatry**
 - **E/M (Services) Summary Guide**
 - **E/M Patient Examples**
 - http://www.aacap.org/AACAP/AACAP/Clinical_Practice_Center/Business_of_Practice/CPT_and_Reimbursement.aspx

E/M: Charting by the Elements Resources

The National Council Resource Page:

- http://www.thenationalcouncil.org/cs/cpt_codes
- resources such as:
 - 2012-2013 Crosswalk
 - Frequently Asked Questions
 - Free training resources

The AMA

- <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page?>
- The AMA app: EM Quickref (android or apple)
- AMA Code Book www.amabookstore.com or 1-800-621-8335

E/M: Charting by the Elements Resources

- American Psychiatric Association: <http://www.psych.org>
(search for CPT codes)
 - *CPT Handbook for Psychiatrists*, American Psychiatric Press Inc., Third Edition, 2004
- 1997 Documentation Guidelines for Evaluation and Management Services <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf>

E/M: Charting by the Elements Resources

- Family Practice Management Web Site: www.aafp.org/fpm
 - Documenting History in Compliance With Medicare's Guidelines
 - <http://www.aafp.org/fpm/2010/0300/p22.html>
 - Exam Documentation: Charting Within the Guidelines
 - <http://www.aafp.org/fpm/2010/0500/p24.html>
 - Thinking on Paper: Documenting Decision Making
 - <http://www.aafp.org/fpm/2010/0700/p10.html>
 - E/M Coding and the Documentation Guidelines: Putting It All Together
 - <http://www.aafp.org/fpm/2011/0900/p33.html>