TCN
THE CODING NETWORK, LLC

Documentation Guidelines for Coding What Auditors Look For

AMERICAN OSTEOPATHIC INFORMATION ASSOCIATION

1/9/2019

PRESENTED BY ~ SUSAN CARBONE, MBA, CPC, CPMA, CRC, BSMT, MCS-P

AHIMA APPROVED ICD-10-CM TRAINER

www.codingnetwork.com © 2019
The Coding Network, LLC

Course Agenda

THE CODING NETWORK, LLC

- Components of E&M Services
  - History
  - Examination
  - Medical Decision-Making
  - Coding using Time
- Categories of E/M services and Documentation Requirements
- Documentation requirements for procedures
  - OMT, Trigger Point Injections, Acupuncture
  - Documentation requirements for same day E/M service with a procedure, including examples
- ICD-10 Diagnosis Coding
- Cloned Notes
- 2019 Updates

www.codingnetwork.com © 2019
The Coding Network, LLC

References

- National Government Services
- https://www.ngsmedicare.com

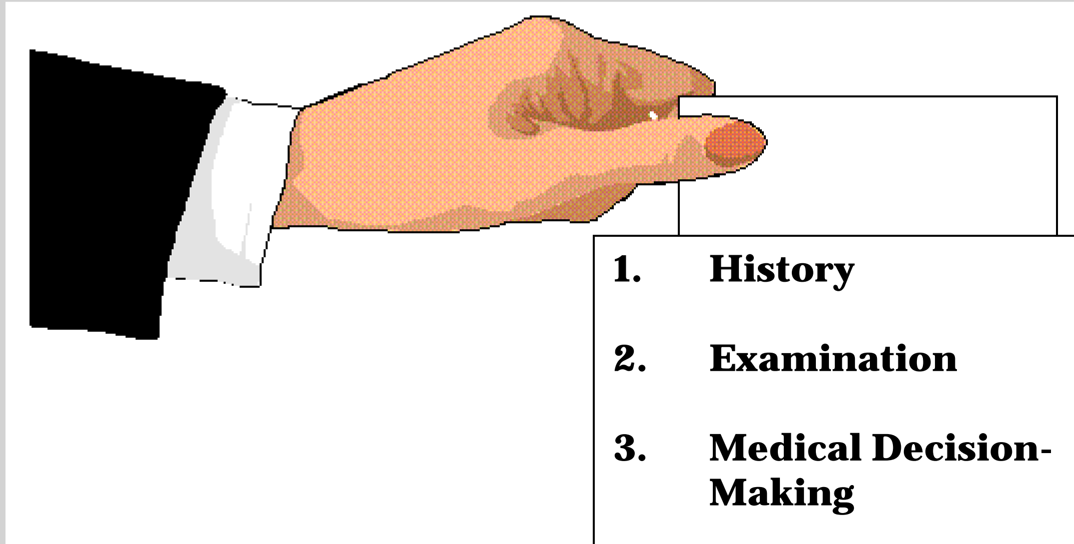
- LCD (Local Coverage Determination) for OMT L33616

- *ICD10 Official Guidelines for 2019*
- *https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf*

- American Osteopathic Association: GUIDE TO CODING & DOCUMENTATION: OSTEOPATHIC MANIPULATIVE TREATMENT, FIRST EDITION

Components of E&M Services

Seven Components are used to define the levels of E&M services.



1. **History**
2. **Examination**
3. **Medical Decision-Making**
4. **Counseling**
5. **Coordination of Care**
6. **Nature of Presenting Problem**
7. **Time**

www.codingnetwork.com © 2019
The Coding Network, LLC

Key Components for Selection of Level of Service

THE CODING NETWORK, LLC

Three (3) key components:

- History
- Examination
- Medical Decision-Making

Key components drive the decision for level of service unless a visit is predominantly counseling or coordination of care.

www.codingnetwork.com © 2019
The Coding Network, LLC

NATURE OF PRESENTING PROBLEM

TCN
THE CODING NETWORK, LLC

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter.

There are five (5) types of presenting problems defined as follows:

MINIMAL

- A problem that may not require the presence of the physician or other qualified health care professional, but service is provided under the physician's or other qualified health care professional's supervision.

SELF-LIMITED OR MINOR

- A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance.

www.codingnetwork.com © 2019
The Coding Network, LLC

THE CODING NETWORK, LLC

LOW SEVERITY

- A problem where the risk of morbidity without treatment is low; there is little or no risk of mortality without treatment; full recovery without functional impairment is expected.

MODERATE SEVERITY

- A problem where the risk of morbidity or mortality without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

HIGH SEVERITY

- A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

www.codingnetwork.com © 2019
The Coding Network, LLC

Outpatient Evaluation &. Management CPT Code Criteria

New Patient	99201	99202	99203	99204	99205
Avg. time (mins)	10	20	30	45	60
Required all three key components	CC: Required HPI: 1-3 ROS: None PFSH: None -------------------- Exam: *PF* -------------------- MDM: Straightforward	CC: Required HPI: 1-3 ROS: 1 Pertinent PFSH: None -------------------- Exam: *EPF* -------------------- MDM: Straightforward	CC: Required HPI: 4+ ROS: 2-9 PFSH: 1 ------------------ Exam: *Detailed* ------------------ MDM: Low	CC: Required HPI: 4+ ROS: 10+ PFSH: 3 ------------------ Exam: *Comprehensive* ------------------ MDM: Moderate	CC: Required HPI: 4+ ROS: 10+ PFSH: 3 ------------------ Exam: *Comprehensive* ------------------ MDM: High

www.codingnetwork.com © 2019
The Coding Network, LLC

Outpatient Evaluation &. Management CPT Code Criteria

Established Patient	99211	99212	99213	99214	99215
Avg. time (mins)	5	10	15	25	40
Requires two of the three key components	CC: Required HPI:1-3 ROS: None PFSH: None ----------------- Exam: None ----------------- MDM: na	CC: Required HPI: 1-3 ROS: None PFSH: None ------------------- Exam: *PF* ------------------- MDM: Straightforward	CC: Required HPI: 1-3 ROS: 1 PFSH: 1 ------------------ Exam: *EPF* ------------------ MDM: Low	CC: Required HPI: 4+ ROS: 2-9 PFSH: 1 ----------------- Exam: *Detailed* ----------------- MDM: Moderate	CC: Required HPI: 4+ ROS: 10+ PFSH: 2-3 ------------------ Exam: *Comprehensive* ------------------- MDM: High

www.codingnetwork.com © 2019
The Coding Network, LLC

NEW PATIENT AND ESTABLISHED PATIENT DEFINITIONS

NEW PATIENT

- A patient who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.

- Professional services are those face-to-face services rendered by physicians and other qualified health care professionals and reported by a specific CPT code(s).

- Per CMS, if no evaluation and management service has been performed, "the patient may continue to be treated as a new patient." Therefore, review of labs and other diagnostic studies prior to seeing a patient does not negate the new patient designation.

www.codingnetwork.com © 2019
The Coding Network, LLC

ESTABLISHED PATIENT

THE CODING NETWORK, LLC

- A patient who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the same exact specialty and subspecialty who belongs to the same group practice within the last three years.

- Note that subspecialties may be credentialed separately and considered a "separate specialty", which will affect new vs. established assignment.

www.codingnetwork.com © 2019
The Coding Network, LLC

Key Component #1: History

THE CODING NETWORK, LLC

The extent of history of present illness, review of systems and past family and/or social history obtained and documented is dependent upon clinical judgment and the nature of presenting problem(s).

- History is comprised of some or all of the following elements:
  - Chief Complaint **(CC)**
  - History of Present Illness (**HPI**)
  - Review of Systems (**ROS**)
  - Past, Family and/or Social History (**PFSH**)

www.codingnetwork.com © 2019
The Coding Network, LLC

Chief Complaint

- Ensure the chief complaint/reason for visit is documented in the history section. This establishes the medical necessity for the service.
- This may be stated as the chief complaint, or indicated within the history of present illness.

www.codingnetwork.com © 2019
The Coding Network, LLC

- There are four (4) types of history: Problem Focused, Expanded Problem Focused, Detailed and Comprehensive. To qualify for a given type of history, all three (3) criteria of HPI, ROS and PFSH must be met or exceeded.

TCN
THE CODING NETWORK, LLC

TYPES OF HISTORY	HPI	ROS	PFSH
PROBLEM FOCUSED	Brief 1-3	N/A	N/A
EXPANDED PROBLEM FOCUSED	Brief 1-3	Problem Pertinent 1	N/A
DETAILED	Extended 4+	Extended 2-9	Pertinent 1 Est. 1-2 New
COMPREHENSIVE	Extended 4+	Complete 10	Complete 2-3 Est. 3 New

www.codingnetwork.com © 2019
The Coding Network, LLC

The Elements of Present Illness are:

THE CODING NETWORK, LLC

location
quality
severity
duration
timing
context
modifying factors
associated signs and symptoms

Types of HPI

Brief

1-3 elements have been documented

Extended

At least 4 elements or the status of at least 3 chronic or inactive conditions have been documented.

www.codingnetwork.com © 2019
The Coding Network, LLC

HPI Elements Defined:

THE CODING NETWORK, LLC

- Site of the symptoms “where”, exact location of problem.

  Examples:

  Low back pain
  R leg pain

- *Features, characteristics or attributes of a symptom.*
- What does the problem look, feel or sound like?

  Examples: Pain – sharp, dull, radiating, throbbing, stabbing

www.codingnetwork.com © 2019
The Coding Network, LLC

HPI Elements Defined:

THE CODING NETWORK, LLC

- Hardness, sharpness, intensity of pain on a scale of 1-10. (Severity is also a quality.)

Examples: *Pain on scale of 1-10*
"Patient feeling better"

- "How Long," length of time of symptoms.

Examples: *For 1 week*
2 days ago

- Regularity of an occurrence, relationship to something else, why and when does the problem occur.

Examples: *During the night*
Frequent
Comes and goes
All the time

www.codingnetwork.com © 2019
The Coding Network, LLC

HPI Elements Defined:

TCN
THE CODING NETWORK, LLC

Context

- How the complaint occurred, circumstances surrounding a complaint; what precedes or follows a symptom.
- Under what circumstance did the patient first notice the problem?

Examples: *Hurt back in a motorcycle accident.*
Fell from tree.
While sleeping,
After lifting a heavy box

Modifying Factors

- Factors that alter, limit, change or reduce a symptom.
- What makes the symptom worse or better?

Examples:
OTC meds not helping pain
Pain is better since her surgery.

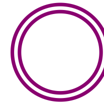
Associated Signs and Symptoms

- Factors that accompany the main symptom.
- What other symptoms are present?

Examples: *Stiffness, tingling*

www.codingnetwork.com © 2019
The Coding Network, LLC

Example HPI



Patient complains of sharp right leg pain for four days. Feels better when heat is applied.

HPI elements	Brief	Extended
HPI: Status of chronic conditions: ☐ 1 condition ☐ 2 conditions ☐ 3 conditions **OR**	☐ Status of 1-2 chronic conditions	☐ Status of 3 chronic conditions
HPI (history of present illness) elements: ☒ Location ☐ Severity ☐ Timing ☒ Modifying factors ☒ Quality ☒ Duration ☐ Context ☐ Associated signs and symptoms	☐ Brief (1-3)	☒ Extended (4 or more)

www.codingnetwork.com © 2019
The Coding Network, LLC

Status of 3 Chronic Conditions

Q. When documenting three chronic or inactive conditions, does the Provider have to do more than mention the conditions?

A. The documentation should show the status of the chronic or inactive conditions. The status would include whether the issue is better, worse, the same etc. and must be conditions you are actively following/managing.

<u>Example:</u>

- OA L knee pain is not improving. He continues to struggle with low back pain; bursitis L shoulder is currently controlled well with medication.

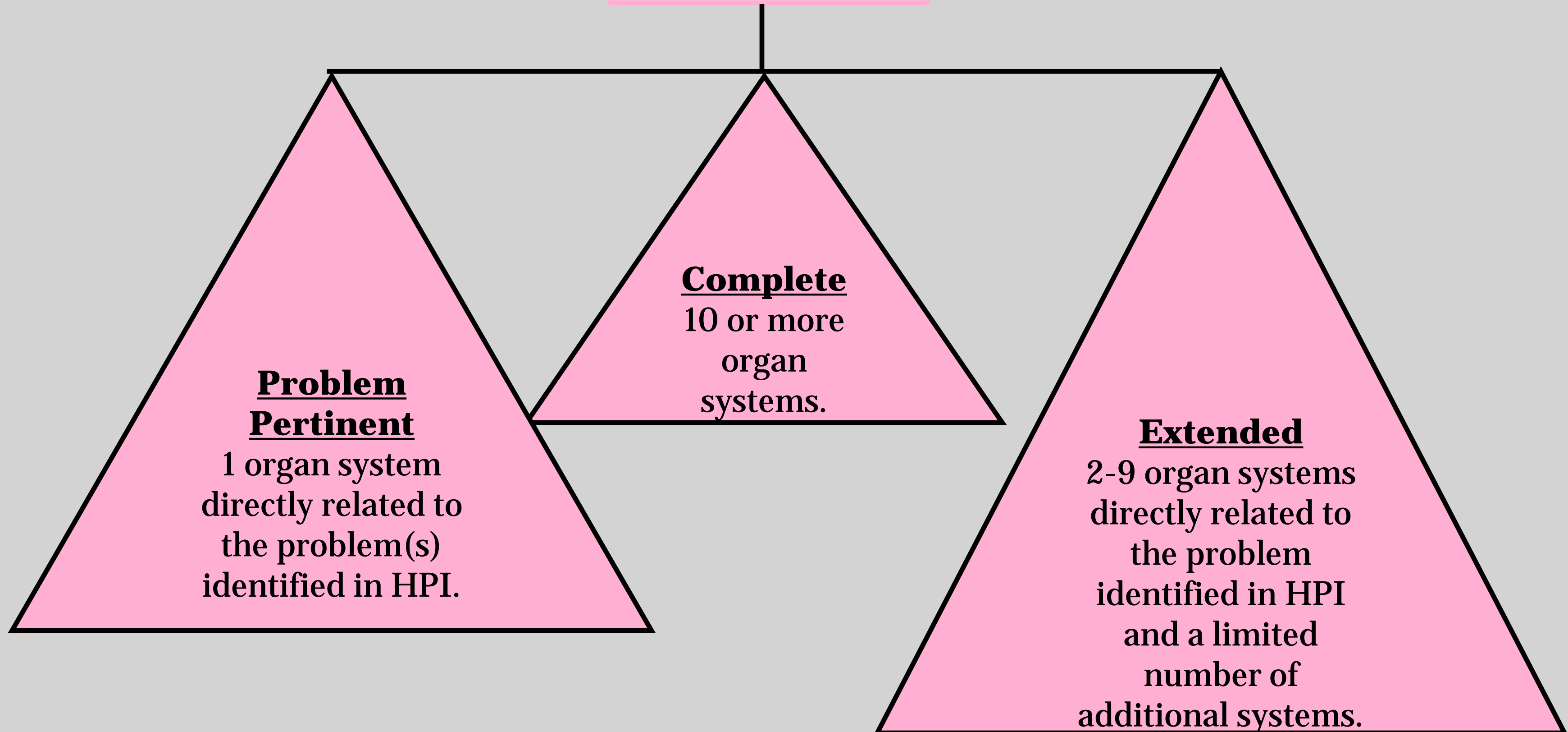
Review of Systems (ROS):

THE CODING NETWORK, LLC

An inventory of body systems obtained through a series of questions to identify signs and/or symptoms which the patient may be experiencing or has experienced. The following 14 systems are recognized:

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

www.codingnetwork.com © 2019
The Coding Network, LLC



TCN
THE CODING NETWORK, LLC

www.codingnetwork.com © 2019
The Coding Network, LLC

Complete ROS

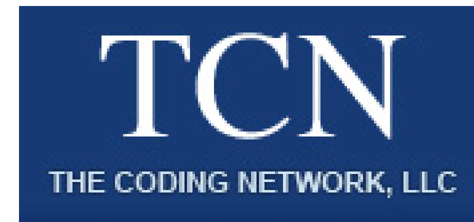
TCN
THE CODING NETWORK, LLC

- For new patient visits 99204 and 99205, or consults 99244 and 99245 a complete ROS is required. At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented.

- For the remaining systems, a notation indicating "all other systems have been reviewed and are negative" is permissible. In the absence of such a notation, at least ten systems must be individually documented.

www.codingnetwork.com © 2019
The Coding Network, LLC

Appropriate Reference for a Complete ROS



- All other systems have been reviewed and are negative
- The remainder of the systems were reviewed and are negative.
- ROS was obtained and except as listed in the HPI, all other systems are negative.
- A complete review of systems was otherwise negative.

www.codingnetwork.com © 2019
The Coding Network, LLC

Inappropriate Reference for a Complete ROS

TCN
THE CODING NETWORK, LLC

Do not just state:

- ROS negative
- ROS is unremarkable.
- ROS is noncontributory

www.codingnetwork.com © 2019
The Coding Network, LLC

Documentation Guidelines for History: General

- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition/circumstances which precludes obtaining history, i.e., patient unconscious, patient intubated.

www.codingnetwork.com © 2019
The Coding Network, LLC

Past, Family and/or Social History

TCN
THE CODING NETWORK, LLC

Past History

A review of the patient's past experience or lack thereof with illnesses, injuries and treatments that include significant information about:

- prior major illnesses and injuries
- prior operations
- prior hospitalizations
- current medications
- allergies (drug, food)
- age appropriate immunity status
- age appropriate feeding/dietary status
- pregnancy history
- growth history
- functional status history

www.codingnetwork.com © 2019
The Coding Network, LLC

Family History

THE CODING NETWORK, LLC

- A review of medical events in the patient's family, including diseases of family members which may be hereditary or place the patient at risk.

www.codingnetwork.com © 2019
The Coding Network, LLC

Unacceptable Family History Documentation

- Family history noncontributory
- No change.

www.codingnetwork.com © 2019
The Coding Network, LLC

Acceptable Family History Documentation

THE CODING NETWORK, LLC

- Family history reviewed and is non-contributory to this illness/condition.
- Family history unchanged since May 31, 2017.
- No family history of joint disorders.
- Patient adopted. Family history unknown.

www.codingnetwork.com © 2019
The Coding Network, LLC

Social History

THE CODING NETWORK, LLC

An age-appropriate review of past and current activities that includes significant information about:

- marital status and/or living arrangements
- current employment
- occupational history
- military history
- use of drugs, alcohol and tobacco
- level of education
- sexual history
- other relevant social factors

www.codingnetwork.com © 2019
The Coding Network, LLC

TYPES OF PFSH

TCN
THE CODING NETWORK, LLC

Complete
2-3 history areas reviewed and documented for established and emergency department patients.

Pertinent
One history area reviewed and documented.

Complete
3 history areas reviewed and documented for new patients, initial hospital care and consultations.

www.codingnetwork.com © 2019
The Coding Network, LLC

Key Component #2: Examination

THE CODING NETWORK, LLC

There are **four (4)** types of examination. These exams have been defined for general multi-system and ten (10) single organ systems.

PROBLEM FOCUSED

- Limited exam of the affected body area or organ system.

EXPANDED PROBLEM FOCUSED

- Limited exam of affected body area or organ system and other symptomatic or related body area(s) or organ system(s).

www.codingnetwork.com © 2019
The Coding Network, LLC

Key Component #2: Examination

THE CODING NETWORK, LLC

DETAILED

- An extended exam of the affected body area(s) or organ system(s) and other symptomatic or related body area(s) or organ system(s).

COMPREHENSIVE

- A general multi-system exam or a complete exam of a single organ system and other symptomatic or related body area(s) or organ system(s).

www.codingnetwork.com © 2019
The Coding Network, LLC

1995 Examination Documentation Guidelines

Body Areas:

- Head, including the face
- Neck
- Chest, including the breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

www.codingnetwork.com © 2019
The Coding Network, LLC

Organ Systems:

- Constitutional
- Eyes
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

www.codingnetwork.com © 2019
The Coding Network, LLC

1995 Guidelines

THE CODING NETWORK, LLC

Problem Focused Exam	* 1 body area or organ system
Expanded Problem Focused Exam	* 2-7 body areas or organ systems
Detailed Exam	* 2-7 body areas or organ systems (Discuss 2 body areas or organ systems in greater depth.)
Comprehensive	* 8 or more organ systems

www.codingnetwork.com © 2019
The Coding Network, LLC

DETAILED EXAM

Detailed Exam = 2-7 body areas or systems (expanded documentation of the areas and/or systems examined; requires more than checklists; needs to have normal/abnormal findings expanded upon)

Recommendation:

- 2 or more items for 2 or more body areas or organ systems, one of which must be related to the presenting problem = DETAILED exam.
- Musculoskeletal- 1) Focal exam of right shoulder demonstrates tenderness over the bicipital tendon on the right 2) No palpable deformity, no crepitus with range
- Neuro - 1) Strength 5 out of 5 2) Sensory exam demonstrates diminished sensation to his feet 3) Gait is stable, able to heel and toe walk

www.codingnetwork.com © 2019
The Coding Network, LLC

Example Comprehensive Exam of 8 Organ Systems 1995 Guidelines

Physical Examination:

General: The patient appears the stated age; body habitus is normal.

Eyes: Pupils are equal, round, reactive to light, and with no evidence of narcotism.

Cardiovascular: No significant swelling or edema is noted on inspection and palpation.

Abdomen: Soft, nontender, nondistended, no rebound.

Skin: Head, neck, trunk and all four limbs did not reveal scars or lesions.

Psychiatric: Alert and oriented x3; affect and mood are normal.

Neurologic/Sensory: There is normal light touch sensation in the bilateral upper and lower limbs. MMT revealed 5/5 strength both proximally and distally in the bilateral upper and lower limbs. Muscle stretch reflexes were 2+ and symmetric in bilateral upper and lower limbs. Upper motor neuron signs are negative bilaterally. Gait is antalgic with a normal base.

Musculoskeletal: Inspection, palpation, range of motion, and assessment for instability of the head, neck, trunk, and all four extremities reveals no gross abnormalities except for decreased range of motion of the right hip as well as the lumbar spine. He has tenderness in the medial and lateral joint lines of the right knee.

www.codingnetwork.com © 2019

1997 Exam CONTENT AND DOCUMENTATION REQUIREMENTS

Musculoskeletal Examination

Level of Exam	Perform and Document
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	At least 12 **elements identified by a bullet.**
Comprehensive	Perform **all** elements identified by a bullet; document every element in a shaded box and at least one element in each unshaded box.

www.codingnetwork.com © 2019
The Coding Network, LLC

1997 Exam Musculoskeletal

SPECIALTY EXAM: MUSCULOSKELETAL

HIC#	DATE OF SERVICE

Refer to data section (table below) in order to quantify. After reviewing the medical record documentation, identify the level of examination. Circle the level of examination within the appropriate grid in Section 5 (Page 3).

Performed and Documented	Level of Exam
One to five bullets	Problem Focused
Six to eleven bullets	Expanded Problem Focused
Twelve or more bullets	Detailed
All bullets	Comprehensive

(Circle the bullets that are documented.)

NOTE: For the descriptions of the elements of examination containing the words "and", "and/or", only one (1) of those elements must be documented.

System/Body Area	Elements of Examination
Cardiovascular	• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Extremities	(See Musculoskeletal and Skin)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, cafe-au-lait spots, ulcers) in four of the following six areas: 1) head and neck, 2) trunk, 3) right upper extremity, 4) left upper extremity, 5) right lower extremity, and 6) left lower extremity Note: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.
Neurological/ Psychiatric	• Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children) • Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski) • Examination of sensation (e.g., by touch, pin, vibration, proprioception) Brief assessment of mental status including: • Orientation to time, place and person • Mood and affect (e.g., depression, anxiety, agitation)

System/Body Area	Elements of Examination
Constitutional	• Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Musculoskeletal NOTE: Determine the number of body areas addressed within each bullet. Enter that number on the line beside each bullet. Total at the bottom of this box. Inspection, percussion and/or palpation: ______ Assessment of range of motion: ______ Assessment of stability: ______ Assessment of muscle strength and tone: ______ * Total Bullets: ______ (including gait and station)	• Examination of gait and station *(if circled, add to total at bottom of column to the left) Examination of joint(s), bone(s), and muscle(s)/tendon(s) of four of the following six areas: 1) head and neck; 2) spine, ribs, and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions • Assessment of range of motion with notation of any pain (e.g., straight leg raising), crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements Note: For the comprehensive level of examination, all four elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.

(Enter the number of circled bullets in the boxes below. Then circle the appropriate level of care.)

EXAM	One to Five Bullets	Six to Eleven Bullets	Twelve or more Bullets	All Bullets
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

Note: The Chest (Breasts); Gastrointestinal (Abdomen); Genitourinary; Head/Face; Eyes; Ears, Nose, Mouth and Throat; Neck and Respiratory systems/body areas are not considered to be part of this Musculoskeletal exam.

www.codingnetwork.com © 2019
The Coding Network, LLC

Exam-Key Components

- 1995 guidelines
  - Count the number of body areas/systems
  - Single system exams are not defined
  - Documentation requirements are less stringent

- 1997 guidelines
  - Count the number of elements/bullets performed in single organ system and other pertinent systems
  - Harder to meet without templates/macros

www.codingnetwork.com © 2019

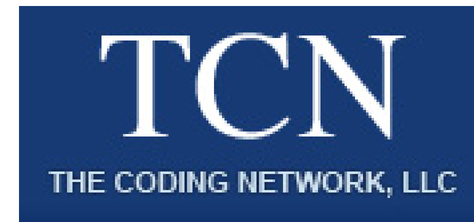
Documentation Guidelines for Examination

TCN
THE CODING NETWORK, LLC

- Specific abnormal and relevant negative findings of the examination should be documented. A notation of "abnormal" without elaboration is insufficient.
- The exam is real time. One cannot indicate "no change in the exam from previous encounter" for the entire exam.

www.codingnetwork.com © 2019
The Coding Network, LLC

Key Component #3: Complexity of Medical Decision-Making



Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option. The complexity of the assessment and plan of care for a patient is measured by:

- number of possible diagnoses and/or management options
- amount and complexity of medical records, diagnostic tests and
- other data to be obtained, reviewed and analyzed
- risk of significant complications, morbidity and mortality

www.codingnetwork.com © 2019
The Coding Network, LLC

Key Component #3: Complexity of Medical Decision-Making

- There are **four (4)** types of medical decision-making. To qualify for a given type of medical decision-making, criteria for two of the three tables must be either met or exceeded.

www.codingnetwork.com © 2019
The Coding Network, LLC

TCN
THE CODING NETWORK, LLC

MDM Tables

Number of diagnoses or management options (per points)	Amount and/or complexity of data obtained, reviewed, and analyzed (per points)	Risk of complications and/or morbidity or mortality	Type of Decision Making
Minimal (1)	Minimal or none (1)	Minimal	Straightforward
Limited (2)	Limited (2)	Low	Low Complexity
Multiple (3)	Moderate (3)	Moderate	Moderate Complexity
Extensive (≥4)	Extensive (≥4)	High	High Complexity

www.codingnetwork.com © 2019
The Coding Network, LLC

MDM Table #1: NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

TCN
THE CODING NETWORK, LLC

- The 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 by the physician.

Layman's Terms: What's wrong with the patient?

How many and what type of diagnoses are there on this visit?

www.codingnetwork.com © 2019
The Coding Network, LLC

MDM Table #1:

TCN
THE CODING NETWORK, LLC

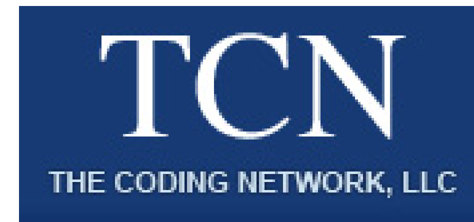
Number of Diagnoses or Treatment Options			
Problem(s) Status	Number	Points	Results
Self-Limited, Minor (Max=2)		1	
Est. Problem (to examiner): stable/improved		1	
Est. Problem (to examiner): that is inadequately controlled, worsening, or failing to progress as expected		2	
New problem (to examiner): no additional workup (Max=1)		3	
New problem (to examiner): additional workup planned		4	
	Total =		

DIAGNOSIS OR MANAGEMENT OPTIONS

- For each encounter, an assessment, diagnosis or clinical impression should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

- Indicate whether patients with established diagnoses are improving, well-controlled, resolving or resolved, inadequately controlled, worsening, or failing to change as expected.

www.codingnetwork.com © 2019
The Coding Network, LLC



DIAGNOSIS OR MANAGEMENT OPTIONS

- 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.
- The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options such as patient instructions, nursing instructions, therapies and medications.
- 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.

www.codingnetwork.com © 2019
The Coding Network, LLC

POINTS TO REMEMBER NUMBER OF DIAGNOSES

THE CODING NETWORK, LLC

A) New Patient:
- New problem with no additional workup (3)
- New problem with additional workup (4)
  - Additional tests or diagnostic studies
  - Request for consult
  - Need to review records of requesting/treating physician
  - Additional workup includes those efforts necessary to develop a diagnosis or to determine a course of treatment.

www.codingnetwork.com © 2019
The Coding Network, LLC

New vs Established Problem

- Problems are defined relative to the **examiner**, not the patient. Even if the problem was previously known to other physicians or to the patient, it is still considered new to **you** if you are seeing the problem for the first time.

www.codingnetwork.com © 2019
The Coding Network, LLC

POINTS TO REMEMBER NUMBER OF DIAGNOSES

TCN
THE CODING NETWORK, LLC

B) Established patient with multiple problems:

- 1) **OA left hip:** responding to therapy (1)
- 2) **Sciatica right side:** symptoms worsening (2), MRI ordered

List each problem addressed and/or treated individually. Document the status of each using keywords like "new problem", "stable", "improving", "worsening", "out of control" or "not responding to treatment".

Note: Diagnoses listed in the A/P but not otherwise supported with a status or treatment plan are not considered when assigning a level of service.

Do not choose ICD10 codes from the problem list if not addressed in the visit.

www.codingnetwork.com © 2019
The Coding Network, LLC

Example-? Which conditions are being treated

Assessment

Cervical thoracic radiculopathy

Musculoskeletal pain syndrome secondary to complex spinal alterations from idiopathic kyphoscoliosis, acquired stenosis, multiple somatic dysfunctions and spondylotic changes.

Myofascial Pain Syndrome/Myalgia/multiple trigger points

Osteoarthritis

Chronic lymphocytic leukemia

Personal history of cervical cancer

Hyperlipidemia

Diagnoses

THE CODING NETWORK, LLC

- New or established problems>Addressed during the visit
  - Qualify the diagnosis (e.g., acute, severe, chronic, mild, moderate, etc.).
- Co-morbid conditions include conditions that coexist at the time of the visit and influence, require, or affect patient care or treatment.
  - Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M service **unless** their presence increases the complexity of the medical decision-making.
  - Documentation needs to demonstrate that the comorbidity was a significant influence. Example:

low back pain and bilateral radicular symptoms may be responsive to a trial epidural steroid injection. She has agreed to proceed with this. We will see what her response is. It is conceivable that her lower extremity symptoms are also related to MS; however, based on the presence of significant spinal stenosis and spondylolisthesis, a trial of symptomatic treatment appears appropriate.

www.codingnetwork.com © 2019
The Coding Network, LLC

MDM Table #2: AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

TCN
THE CODING NETWORK, LLC

- Review/order clinical lab test(s)
- Review/order imaging studies
- Review/order medicine test(s) PFT, ECG, echoes, cardiac caths
- Discuss results with performing MD (contradictory or unexpected results)
- Decision to obtain and review old records and/or obtain history from someone other than patient.

www.codingnetwork.com © 2019
The Coding Network, LLC

MDM Table #2: AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

TCN
THE CODING NETWORK, LLC

- Review and summarize old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider

- Independent review of image, tracing or specimen (often supplements information from physician who prepared test report or interpretation

www.codingnetwork.com © 2019
The Coding Network, LLC

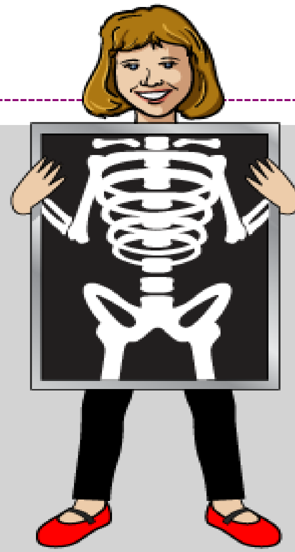
TCN
THE CODING NETWORK, LLC

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

- 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 "hand x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.

www.codingnetwork.com © 2019
The Coding Network, LLC



- A decision to obtain old records or a decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.

www.codingnetwork.com © 2019
The Coding Network, LLC

THE CODING NETWORK, LLC

- Relevant findings from the review of old records and/or the receipt of additional history from the family caretaker or other source supplementing that obtained from the patient should be documented. A notation of “old records reviewed” or “additional history obtained from the family” without elaboration is insufficient.

www.codingnetwork.com © 2019
The Coding Network, LLC

- The results of discussion of laboratory, radiology or other diagnostic tests with the physician 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 physician should be documented. A statement such as "I personally interpreted the x-rays. The findings are …" should be indicated.

www.codingnetwork.com © 2019
The Coding Network, LLC

POINTS TO REMEMBER AMOUNT OF DATA

TCN THE CODING NETWORK, LLC

		Points
Review/order clinical lab test(s)	max=1	1
Review/order imaging studies	max=1	1
Review/order diagnostic test(s) from medicine section	max=1	1
Discuss results with performing MD		1
Decision to obtain old records		1
Review and summarize old records		2
Obtain history from someone other than the patient		2
Independent review of image, tracing or specimen		2
Discussion of case with another health care provider		2

www.codingnetwork.com © 2019
The Coding Network, LLC

POINTS TO REMEMBER
AMOUNT OF DATA

TCN
THE CODING NETWORK, LLC

Recommended language:

- I have reviewed records from (document where records came from) and the summary is as follows: (i.e., brief summarization of outside consult notes, hospitalization treatment management).
- I have personally reviewed and interpreted (state the type of specimen, image or tracing) and my findings are ______________.
- I will request records from (document the name of the hospital or doctor's office).
- I will order and/or recommend the following (document all tests ordered and procedures that will be performed).

www.codingnetwork.com © 2019
The Coding Network, LLC

MDM Table #3:
RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the following categories:

- Presenting problem(s);
- Diagnostic procedure(s); and
- Possible management options.

www.codingnetwork.com © 2019
The Coding Network, LLC

MDM Table #3:
RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY AND/OR MORTALITY

- The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter.
- The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment.
- The highest level of risk in any one category determines the overall risk.

www.codingnetwork.com © 2019
The Coding Network, LLC

DOCUMENTATION GUIDELINES

TCN
THE CODING NETWORK, LLC

RISK OF COMPLICATIONS, MORBIDITY AND/OR MORTALITY

- 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. Examples include diabetes mellitus, hypertension, HIV and anti-coagulation therapy.

- If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E&M encounter, the type of procedure, e.g., laparoscopy, should be documented.

- If a surgical or invasive diagnostic procedure is performed at the time of the E&M encounter, the specific procedure should be documented.

www.codingnetwork.com © 2019
The Coding Network, LLC

- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or easily inferred.

www.codingnetwork.com © 2019
The Coding Network, LLC

Table of Risk

TCN THE CODING NETWORK, LLC

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	❖ One self-limited or minor problem (e.g., cold, insect bite, venipuncture, tinea corporis)	Laboratory tests requiring ❖ Chest x-rays ❖ EKG/EEG ❖ Urinalysis ❖ Ultrasound (e.g., echocardiography) ❖ KOH prep	❖ Rest ❖ Gargles ❖ Elastic Bandages ❖ Superficial Dressings
Low	❖ Two or more self-limited or minor problems ❖ One stable chronic illness (e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH) ❖ Acute uncomplicated illness or injury (e.g., cystitis, allergic rhinitis, simple sprain)	❖ Physiologic tests not under stress (e.g., pulmonary function tests) ❖ Non-cardiovascular imaging studies with contrast (e.g., barium enema) ❖ Superficial needle biopsies ❖ Clinical laboratory tests requiring arterial puncture ❖ Skin biopsies	❖ Over-the-counter drugs ❖ Minor surgery with no identified risk factors ❖ Physical therapy ❖ Occupational therapy ❖ IV fluids without additives

www.codingnetwork.com © 2019
The Coding Network, LLC

Table of Risk Cont'd

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Moderate	❖ 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 (e.g., pyelonephritis, pneumonitis, colitis)	❖ Physiologic tests under stress (e.g., cardiac tress test, fetal contraction stress test) ❖ Diagnostic endoscopies with no identified risk factors ❖ Deep needle or incisional biopsy ❖ Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization) ❖ Obtain fluid from body cavity (e.g., lumbar puncture, thoracentesis, culdocentesis)	❖ **Minor surgery with identified risk factors** ❖ Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ❖ Prescription drug management ❖ Therapeutic nuclear medicine ❖ IV fluids with additives ❖ Closed treatment of fracture or dislocation without manipulation

www.codingnetwork.com © 2019
The Coding Network, LLC

TCN THE CODING NETWORK, LLC

Table of Risk Cont'd

THE CODING NETWORK, LLC

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
High	❖ One or more chronic illnesses with **severe exacerbation**, progression, or side effects of treatment ❖ Acute or chronic illnesses or injuries that pose a threat to life or bodily function (e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure ❖ **An abrupt change in neurologic status** (e.g., seizure, TIA, weakness, sensory loss)	❖ Cardiovascular imaging studies with contrast with identified risk factors ❖ Cardiac electrophysiological tests ❖ Diagnostic endoscopies with identified risk factors ❖ Discography	❖ Elective major surgery (open, percutaneous or endoscopic)with identified risk factors ❖ Emergency major surgery (open, percutaneous or endoscopic) ❖ Parenteral controlled substances ❖ Drug therapy requiring intensive monitoring for toxicity ❖ Decision not to resuscitate or to de-escalate care because of poor prognosis

www.codingnetwork.com © 2019
The Coding Network, LLC

EXAMPLE MDM: L shoulder pain, stable, >new symptom low back pain

3. Medical Decision Making

Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.)

MAKING

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	1	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	1	4	4
		TOTAL	5

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)

www.codingnetwork.com © 2019
The Coding Network, LLC

EXAMPLE MDM: Order MRI, indep review

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	3

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

www.codingnetwork.com © 2019
The Coding Network, LLC

EXAMPLE MDM

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).

Risk of Complications and/or Morbidity or Mortality

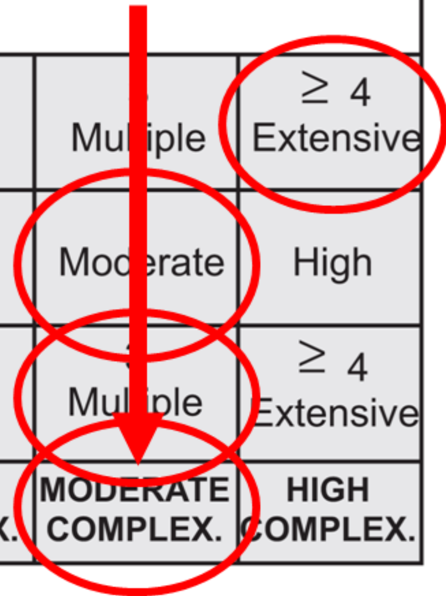
Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g.,pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clincal laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• 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, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with addititives • Closed treatment of fracture or dislocation without manipulation
High	• 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, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic with identified risk factors) • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

EXAMPLE MDM

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



www.codingnetwork.com © 2019

99213 Example

- **An established office patient with known osteoarthritis**

  CC : " L knee pain."

  History : Patient with known osteoarthritis which had been previously controlled on Tylenol. Now states his left knee has been aching for about two weeks despite two to three doses of Tylenol per day. *(4 HPI)*

  ROS : Musculoskeletal--Negative for arthralgias or worsening joint pain elsewhere *(1 ROS)*
  (history is EPF)

  Physical Exam

  Alert & Oriented x3. Normal mood and affect. Mild swelling of left knee compared to the right. Some pain with passive rotation. Palpable radial pulse, normal capillary refill. No overlying warmth or erythema.
  (exam is detailed)

- Assessment
- Worsening osteoarthritis left knee
- **Plan**
- Start Rx ibuprofen po TID, PRN
- Return visit in two weeks if no improvement, consider OMT

www.codingnetwork.com © 2019

99213 (continued)

- **Medical Decision-Making**
  The cognitive labor required for the clinical example satisfies the requirements for Low Complexity Medical Decision-Making.
  Low Complexity Medical Decision-Making requires **TWO** out of **THREE** of the following :

Requires:	Per note:
Two Problem Points →	2 points for one problem, not resolving = low
Two Data Points →	(0 points)
Table of Risk →	Moderate (1 problem with mild exacerbation)

- Although the table of risk falls into moderate, the other 2 MDM tables do not meet moderate complexity (need at least 1 more moderate)

www.codingnetwork.com © 2019
The Coding Network, LLC

Same patient but with co-morbidity>99214

THE CODING NETWORK, LLC

Established patient with multiple problems:

- 1) **OA L knee:** worsening (2), Rx
- 2) **RA:** contributing to pain(1), continue med and adding above Rx

- Number Dx/Management options → 3 points (moderate complexity)
- Data → none
- Table of Risk → Moderate (2 problems, Rx)

Exam is detailed, MDM moderate complexity

www.codingnetwork.com © 2019
The Coding Network, LLC

And one more example 99214

THE CODING NETWORK, LLC

Established patient with multiple problems:

- 1) **Muscle strain R thigh:** responding to therapy (1), continue
- 2) **Low back pain:** symptoms worsening (2), order MRI

- Number Dx/Management options → 3 points (1 stable, 1 worsening) (moderate)
- Data → 1 point (MRI)
- Table of Risk → Moderate (mild progression)

History Detailed <u>and</u>/ <u>or</u> **Exam Detailed**

4HPI
2-9 ROS
1 history

www.codingnetwork.com © 2019
The Coding Network, LLC

99212

Established patient with stable problem:

– 1) **Cervical strain :** improving (1)

- Number Dx/Management options → 1point (SF complexity)
- Data → none
- Table of Risk → Low (1 stable problem)

History or Exam is PF, MDM straightforward

www.codingnetwork.com © 2019
The Coding Network, LLC

THE CODING NETWORK, LLC

THREE (3) ADDITIONAL COMPONENTS

Counseling

Coordination of Care

Time

These components are considered contributory factors in the majority of encounters. However, counseling and coordination of care may not be provided at every patient encounter.

www.codingnetwork.com © 2019
The Coding Network, LLC

COUNSELING

THE CODING NETWORK, LLC

A discussion with a patient or family concerning one or more of the following areas:

- diagnostic results, impressions, and/or recommended diagnostic studies
- prognosis
- risks and benefits of management (treatment) options
- instructions for management (treatment) or follow up
- importance of compliance with chosen management (treatment) options
- risk factor reduction
- patient and family education

www.codingnetwork.com © 2019
The Coding Network, LLC

Using Time

- You may have noticed that there are "recommended" times for most, but not all E/M encounters. This allotted time is merely a guide. Some encounters may take longer than their allotted times, while others may take less than the time allowed. It is NOT necessary to use the allotted time for any particular encounter if you are coding based on the documentation of the three key components. In other words you are not penalized for being efficient.

Using Time

- However, the E/M guidelines do have a specific provision to allow physicians to use TIME as the controlling factor to determine the level of care when counseling and/or coordination of care equals more than 50% of the encounter, using the typical time assigned to a given E/M code.
- In these instances, the physician MUST spend the entire allotted time face-to-face with the patient AND more than HALF of that time must be used for "counseling and coordination of care."
- Record the duration of the face-to-face time in the record, AND also state that over half the time was spent on counseling and coordination of care. In addition, the nature of the counseling and coordination of care must be documented.

www.codingnetwork.com © 2019
The Coding Network, LLC

USING TIME

Document:

- Total face-to-face Physician/Provider time with the patient

  (not an estimate, be specific).
- That more than 50% of the visit was spent counseling
- Content of the counseling in sufficient detail

- Example:

❖ Total face-to-face time = 40 minutes; more than 50% spent counseling on treatment options xxx relating to diagnosis of …………

❖ CPT code =99215 (typical time of this code is 40 minutes)

❖ The time must meet or exceed the specific CPT code assigned and should not be "rounded" to the next higher level.

www.codingnetwork.com © 2019
The Coding Network, LLC

COUNSELING/COORDINATION OF CARE

4. Time

If the physician documents total time *and* suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

Question	Yes	No
Does documentation reveal total time? Time: Face-to-face in outpatient setting Unit/floor in inpatient setting	☐ Yes	☐ No
Does documentation describe the content of counseling or coordinating care?	☐ Yes	☐ No
Does documentation reveal that more than half of the time was counseling or coordinating care?	☐ Yes	☐ No

If all answers are "yes", select level based on time.

www.codingnetwork.com © 2019
The Coding Network, LLC

OFFICE OR OUTPATIENT CONSULTATIONS: 99241 - 99245

- Provided in the office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home or the emergency department.

- Use for initial consult request.

- Follow up visits in the consultant's office or other outpatient facility that are initiated by the consultant or patient are reported using the appropriate codes for established patient office visits (99211-99215).

www.codingnetwork.com © 2019
The Coding Network, LLC

CATEGORY: Consultation

TCN
THE CODING NETWORK, LLC

Documentation Requirements for consultations

- The written or verbal request and reason for a consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source.

- The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record (render service) and communicated back (response) to the requesting physician or other appropriate source.

www.codingnetwork.com © 2019
The Coding Network, LLC

Consultations (the 4 R's).

Documentation:

Your documentation must include:

- Document the name of the provider **requesting** the consultation
- Explain the **reason** for the consultation request

  Example: The patient is seen in consultation at the request of Dr. Wilson for evaluation of low back pain.

- Describe what services you **rendered** and
- Send a **response back** to the requestor sharing your findings, opinions and suggestions for further treatment. Confirmation of the the response back is required in the outpatient setting, but not in the inpatient setting.

www.codingnetwork.com © 2019
The Coding Network, LLC

Outpatient Evaluation &. Management CPT Code Criteria

Office Consultation					
New or Established	99241	99242	99243	99244	99245
Avg. time (mins)	15	30	40	60	80
Requires all <u>three</u> key components	CC: Required HPI: 1-3 ROS: None PFSH: None Exam: *PF* MDM: Straightforward	CC: Required HPI: 1-3 ROS: 1 Pertinent PFSH: None Exam: *EPF* MDM: Straightforward	CC: Required HPI: 4+ ROS: 2-9 PFSH: 1 Pertinent Exam: *Detailed* MDM: Low	CC: Required HPI: 4+ ROS: 10+ PFSH: 3 Exam: *Comprehensive* MDM: Moderate	CC: Required HPI: 4+ ROS: 10+ PFSH: 3 Exam: *Comprehensive* MDM: High

www.codingnetwork.com © 2019
The Coding Network, LLC

OMT procedures

CPT Codes for OMT Procedures

CPT Code	OMT Procedure
98925	Osteopathic manipulatve treatment (OMT); 1–2 body regions involved
98926	Osteopathic manipulatve treatment (OMT); 3–4 body regions involved
98927	Osteopathic manipulatve treatment (OMT); 5–6 body regions involved
98928	Osteopathic manipulatve treatment (OMT); 7–8 body regions involved
98929	Osteopathic manipulatve treatment (OMT); 9–10 body regions involved

* The 10 body regions referred to are head region, cervical region, thoracic region, lumbar region, sacral region, pelvic region, lower extremities, upper extremities, rib cage region, and abdomen and viscera region.

www.codingnetwork.com © 2019

OMT

Body regions referred to are:

- Head region
- Cervical region
- Thoracic region
- Lumbar region
- Sacral region
- Pelvic region
- Lower extremities
- Upper extremities
- Rib cage region
- Abdomen and viscera region

www.codingnetwork.com © 2019

OMT

- OMT treatments are not reported based on time.
- A given treatment may require manipulation or separate techniques that are performed in several body regions.

For example, OMT of the right shoulder, the right sacroiliac joint (SIJ), the left shoulder, and the left SIJ may all be performed in a single session.

Based on this example, the OMT services would be reported with code 98925, *Osteopathic manipulative treatment (OMT); 1-2 body regions involved,* because the upper extremities are collectively considered a single region and the bilateral SIJs is considered a second body region. While the right and left SIJ may represent two separate areas, they are both located within the sacral region.

www.codingnetwork.com © 2019

OMT

- OMT procedure codes should be reported based on the number of body regions involved that were treated. The medical record documentation should clearly note the body regions treated, which would justify the procedure code billed. Do not list the regions as ICD10 codes. A written diagnostic statement should be documented for each condition. It is not appropriate to select a code number from a list of codes in place of a written diagnostic statement.
- Only one OMT service should be billed per day, based on the description of the procedure code.
- Factors that may affect frequency and duration of treatment are: severity of illness, duration or chronicity of the patient's condition and the presence of co-morbidities. These factors should be reflected in the medical record if they contribute to the physician's treatment approach.

www.codingnetwork.com © 2019
The Coding Network, LLC

Example OMT

CPT CODE **98926**

DESCRIPTOR — **OMT; Three to Four Body Regions Involved**

VIGNETTE — A 39-year-old female presents with right lower back pain of two weeks duration after a lifting injury. Somatic dysfunction of lumbar, pelvis, and sacral regions are identified on exam.

DESCRIPTION OF **PRESERVICE WORK**

The physician determines which osteopathic techniques (e.g., HVLA, muscle energy, counterstrain, articulatory) would be most appropriate for this patient, in what order the affected body regions need to be treated, and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.

www.codingnetwork.com © 2019

98926 Example

DESCRIPTION OF **INTRASERVICE WORK**

The patient is initially in the prone position on the treatment table. Motion restrictions of sacrum and pelvis are isolated through palpation and treated using muscle energy and articulatory techniques. Dysfunctions of L1 and L5 are treated using passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

DESCRIPTION OF **POSTSERVICE WORK**

Postcare instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.

www.codingnetwork.com © 2019

Procedure Note

Because OMT is considered a procedure, this requires a procedure note. The procedure note should detail the regions manipulated, the techniques utilized, and a description of how the patient tolerated the treatment.

All regions of somatic dysfunction should be documented using "TART" terminology—Tissue texture changes, positional Asymmetry, Range of motion alterations, or changes in palpatory sensitivity (e.g., Tenderness). • Somatic dysfunction or other diagnosis should be clearly documented in the "objective findings" of the musculoskeletal examination section.

www.codingnetwork.com © 2019
The Coding Network, LLC

Per LCD 33616
National Government Services

- Osteopathic Manipulative Treatment specifically encompasses only the procedure itself. E&M services are covered as a separate and distinct service when medically necessary and appropriately documented.
- If a significant, separately identifiable evaluation and management service above and beyond the osteopathic manipulation service is provided, this must be indicated by reporting modifier 25 to the E&M service code.
- OMT utilized at a follow-up visit is not the same as *follow-up OMT*. A follow-up visit for OMT is a predetermined service and would not support another E/M (for the same problem).
- A follow-up visit where OMT is utilized is not necessarily predetermined unless the preceding progress note denoted it to be an OMT visit.

EVALUATION AND MANAGEMENT MODIFIERS

TCN
THE CODING NETWORK, LLC

- 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.

- Reflects that the day of a minor surgical procedure, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided.

www.codingnetwork.com © 2019
The Coding Network, LLC

E/M?

No E&M service is warranted for previously planned follow-up OMT treatments. Examples include:

1. If a patient is scheduled for a defined number of follow-up OMT treatments for an episode of care, no E/M should be reported on those dates of service unless a new condition occurs or the patient's condition has changed substantially, necessitating an overall reassessment of the treatment plan;
2. If a patient is seen and the E/M service determines that OMT is indicated, but the patient must be scheduled to receive the OMT the following day due to time constraints, no E/M should be reported on the following day unless the patient's condition has changed substantially. The medical record should clearly document this.

www.codingnetwork.com © 2019

Example-E/M billable

- An established patient comes to the office for evaluation of with new complaints of low back pain for one week. She complains of pain and swelling, radiates to right foot. No fever. Past, family, social history reviewed on patient intake form of 11/11/18.
- Exam of lumbar spine identifying somatic dysfunction is performed, includes detailed exam of musculoskeletal and other systems for detailed exam.
- An MRI of the lumbar spine is reviewed.
- A/P: Somatic dysfunction lumbar region.
- The physician determines that the patient would benefit from OMT. Verbal consent obtained.
- In this case, a separate and significant E/M service was prompted by the low back pain not previously evaluated.

CPT	**ICD10**
99213-25	M99.03 Segmental and somatic dysfunction of lumbar region
98925	M99.03

www.codingnetwork.com © 2019

?Code Procedure Only; E/M bundled into procedure

- Same established patient comes to the office with continued complaints of low back pain. No fever.
- Exam of lumbar spine is performed.
- Previous X-ray reviewed.
- The physician determines that the patient would benefit from another OMT procedure. *Was this part of multiple treatments planned vs. a new decision? Clarify intent of visit. For example, an evaluation to determine appropriate treatment vs. a planned OMT.*
- *If not clear, the E/M will not be supported.*

CPT

98925

ICD10

M99.03 Segmental and somatic dysfunction of lumbar region

www.codingnetwork.com © 2019
The Coding Network, LLC

E/M with OMT

- Same established patient comes to the office for re-evaluation of continued low back pain, which was previously relieved with OMT and has become painful again. Additional symptoms, including tingling noted. Re-evaluation is required to determine appropriate treatment.
- Detailed Exam is performed as well as other pertinent exam systems.
- Previous X-ray reviewed.
- A/P: Somatic dysfunction of lumbar region.
- Based on evaluation, patient would benefit from another OMT treatment. Verbal consent obtained.
- In this case, code E/M and the procedure.

CPT	ICD10
99213-25	M99.03 Segmental and somatic dysfunction of lumbar region
98925	M99.03 Segmental and somatic dysfunction of lumbar region

www.codingnetwork.com © 2019

E/M with OMT

- Describe how and when the patient's condition has substantially changed and that the reassessment of the treatment plan was performed.
- The patient's visit was not scheduled for the explicit purpose of performing OMT on that date.
- The purpose of the E/M service that was provided was to evaluate a specific complaint or problem.

www.codingnetwork.com © 2019

Trigger Point Injections

- 20552 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
- 20553 Injection(s); single or multiple trigger point(s), 3 or more muscles

Per Medicare Contractors: The involved muscle group(s) must be documented in the patient's medical record as well as the number of trigger points injected. A diagram with an "X" or other similar annotation is not adequate documentation.

CPT description: The physician identifies the trigger point injection site by palpation or radiographic imaging and marks the injection site. The needle is inserted and the medicine is injected into the trigger point (indicate number of muscles injected/anatomic site, drug and dosage).

The injection may be done under separately reportable image guidance. If imaging guidance is utilized, report the appropriate radiology code (76942, 77002, and 77021) in addition to the injection codes.

www.codingnetwork.com © 2019

CPT Example 20552 (1 or 2 muscles)

- After identification of the trigger point in the multifidus muscle left of the L5 spinous process by palpation, a 1.5- to 2-in, 25-gauge needle is inserted through the skin into the muscle. The needle is advanced a short distance, about 2 to 4 cm, observing any complaints of paresthesia while searching for the area of maximum tenderness. If any complaints or paresthesia are encountered the needle is withdrawn slightly until the complaints or paresthesia stop. Next the injectant solution is infiltrated in a fanwise method into the trigger point after aspiration is negative for blood. The solution is usually a mixture of 1 to 5 cc of anesthetic containing a corticosteroid (indicate medication in mg). Post procedure, the injection area is cleansed and a bandage applied to the site.

www.codingnetwork.com © 2019

Example of a procedure not supported

PLAN: I did inject the trigger point with 1 mL of Kenalog and 3 mL of Marcaine.

Need to include:

Documentation of the anatomic location and target

Number of muscles

Which muscles

- Preparation of the site
- Local anesthetic administration
- Approach/method used
- Name and dosage of drug administered (in mg)
- Kenalog (J3301) is per 10 mg

Coding for Medications

Indicate dosage in mg.

Celestone:

- J0702 Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg

Depo-Medrol has 3 codes:

- J1020 injection, methylprednisolone acetate, 20 mg
- J1030 injection, methylprednisolone acetate, 40 mg
- J1040 injection, methylprednisolone acetate, 80 mg

Acupuncture

- 97810 Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.
- 97811 Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
- 97813 Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
- 97814 Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

www.codingnetwork.com © 2019

Acupuncture

- Only one CPT code may be reported for each 15-minute increment. For the initial increment, either code *97810, Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient*,
- or code *97813, Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient*, should be reported.
- Additionally, only one initial acupuncture code is reported per date of service as these services include both the treatment, set-up, and evaluation necessary to identify the specific acupuncture service(s) necessary for the patient. Therefore, when reporting this service, only one initial code is reported per date-of-service to identify the complete initial service provided.
- For each additional increment of “personal one-on-one contact with the patient” performed, either 97811 or 97814 is reported, depending on the use or non-use of electrical stimulation during that increment.

www.codingnetwork.com © 2019

?E/M with Acupuncture

- Evaluation and management (E/M) services may be reported separately, by appending modifier 25, Significant*, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*, if the patient's condition requires a significant separately identifiable E/M service.

DIAGNOSIS CODING

THE CODING NETWORK, LLC

- Assign all codes to the highest level of specificity (3-7 digits).
- Only assign ICD10 codes that are supported by the documentation within the visit note. Do not assign ICD10 codes from the problem list or other list unless addressed within the note.
- Avoid unspecified codes when there is a more specific code to describe the patient's illness, condition or injury, and is supported in the documentation.
- Do not code probable, possible or suspected conditions as definitive diagnoses. Code signs and symptoms if a definitive diagnosis has not been determined.
- Do not need to code symptoms that are integral to a definitive diagnosis.

  Example: low back pain does not need to be coded with DDD (unless unrelated or unsure if related).
- Be specific in describing the condition, illness or disease of the patient.

  -acute vs. chronic

  -laterality (left side, right side, bilateral).

Do not select a code for unspecified laterality when documentation supports right, left, or bilateral

www.codingnetwork.com © 2019
The Coding Network, LLC

ICD-10: Expand documentation to include:

- Laterality (left vs.right, or bilateral)
  - *Over 1/3 of the expansion of ICD-10 codes is due to the addition of laterality*
- Anatomic details (for example, fractures)
- Complications>broken rod s/p fusion = T84.216A (breakdown (mechanical) of internal fixation device of vertebrae, initial encounter)
- Code all documented conditions that coexist at the time of the visit and require or affect patient care treatment or management (co-morbidities)
- ***Do not select codes from the problem list if not addressed in the visit. Only link ICD10 codes that are relevant to the visit.***

ICD10 codes that support medical necessity for OMT

- M99.00 Segmental and somatic dysfunction of head region
- M99.01 Segmental and somatic dysfunction of cervical region
- M99.02 Segmental and somatic dysfunction of thoracic region
- M99.03 Segmental and somatic dysfunction of lumbar region
- M99.04 Segmental and somatic dysfunction of sacral region
- M99.05 Segmental and somatic dysfunction of pelvic region
  M99.06 Segmental and somatic dysfunction of lower extremity
- M99.07 Segmental and somatic dysfunction of upper extremities
- M99.08 Segmental and somatic dysfunction of rib cage
  M99.09 Segmental and somatic dysfunction of abdomen and other regions

www.codingnetwork.com © 2019

Cloning

- NGS has specific policies on information in the medical record documentation that is cloned and or brought forward from previous encounters.
- For example, when all PFSH/ROS on the notes are worded exactly like previous entries. Specific information regarding ROS should be unique for each patient encounter. It is permissible to document the review of PFSH form an earlier date.
- Many records had lab and radiology historical data brought forward on each date of service. It is difficult for a reviewer to identify what was reviewed and not reviewed on a particular date of service in order to give credit.
- On many notes, with the exception of the vitals and OMT assessment, the exams appeared the same as the previous DOS. Again, each exam should be unique for that date of service.

www.codingnetwork.com © 2019

GUIDELINES FOR HISTORY: 2019

As of January 1, 2019 per CMS:

- For history for established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.

CMS GUIDELINES FOR HISTORY: 2019

- So for history for established patients, when relevant information is already contained in the medical record, practitioners can more simply focus their documentation on what is changed since the last visit, or pertinent items that is not changed and this will prevent the need to re-record a defined list of required elements that another practitioner or other staff may have already documented.

CMS GUIDELINES FOR HISTORY: 2019

What parts of the history can be documented by ancillary staff or the beneficiary starting in CY 2019?

- The CY 2019 PFS final rule expanded current policy for office/outpatient E/M visits starting January 1, 2019 to provide that any part of the chief complaint (CC) or history that is recorded in the medical record by ancillary staff or the beneficiary does not need to be re-documented by the billing practitioner.
- Instead, when the information is already documented, the billing practitioner can review the information, update or supplement it as necessary, and indicate in the medical record that she or she has done so. This is an optional approach for the billing practitioner, and applies to the chief complaint (CC) and any other part of the history (History of Present Illness (HPI), Past Family Social History (PFSH), or Review of Systems (ROS)) for new and established office/outpatient E/M visits.

Thank-you!

QUESTIONS?

www.codingnetwork.com © 2019