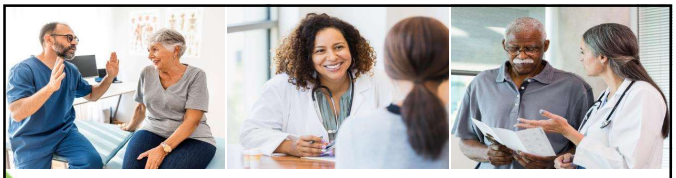

Evaluation and Management: Leveling Your Service KC Chapter AAPC

March 2024

1

Disclaimer

- We prepared this education as a tool to assist the provider community. Medicare rules change often. They are in the relevant laws, regulations and rulings on the Centers for Medicare & Medicaid Services (CMS) website.
- We will provide responses to questions based on the facts given, but the Medicare rules will determine final coverage.
- CMS prohibits recording of the presentation for profit-making purposes.

2

Acronyms

- AMA – American Medical Association
- CERT – Comprehensive Error Rate Testing
- E/M – Evaluation and Management
- IOM – Internet-Only Manual
- MDM – Medical Decision-Making
- NP – Nurse Practitioner
- SDOH – Social Determinants of Health

3

Medical Necessity

E/M must be reasonable and necessary.

Sec. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

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American Medical Association (AMA) Changes

The AMA owns the description of the procedure codes.

- Effective date of changes:
  - January 1, 2021, office and other outpatient services
  - January 1, 2023, other categories of services
- Level of service chosen based on time or medical decision-making (MDM)
- Exception:
  - Emergency department
  - Critical care

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Levels of Service

Most categories of service have four levels.

- Straightforward
- Low
- Moderate
- High

- Some categories combine straightforward and low
- Must meet or exceed two of the three levels for the components

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Using Time to Choose your Level

- Time identified in the code descriptor
- On the same calendar date
- Includes
  - Face-to-face
  - Non-face-to-face
- Time is by the practitioner
- Document specific time

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Non-Face-to-Face time

Practitioner professional time includes the following when performed:

- Preparing to see the patient (review of tests)
- Obtaining or reviewing separately obtained history
- Performing medically appropriate exam
- Counseling or educating patient/family/caregiver
- Ordering medications, tests, or procedures

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Non-Face-to-Face Time Continued

- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the medical record
- Independently interpreting results and communicating to patient/family/caregiver (when not separately reported)
- Care coordination (when not separately reported)

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Do Not Count

Do not count the following time when calculating the practitioner's time.

- Performance of other services separately reported
- Travel time
- Teaching that is general and not specific for management of individual patient

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Examples

▲★ 99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

★ 99232 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

★ 99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

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Separately Reported Services

- Time spent on separately reported services are not part of the E/M
- Documentation shows 47 minutes for a procedure and the E/M
- How will you determine the time spent on the separately reported procedure and the E/M?

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What does Medicare Expect?

Documentation should be an accurate reflection of the time practitioner spent on that patient on the date of service.

- CMS instructs to verify time is accurate
- How will we do that?
  - Evaluating the patient's medical needs versus the time spent
  - Looking at the activities documented and asking whether it makes sense

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Prolonged Services – Office or Other Outpatient Procedure Codes

- Procedure code G2212
- Level of service chosen by time

Codes	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

Must meet a full 15 minutes

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Prolonged Care Services – Inpatient

Use of prolonged codes only valid when using time to choose your level of service.

- Must exceed time for highest level of initial or subsequent care code by 15 minutes or more
- Procedure Code G0316

Primary Code	Threshold Time	Date
Initial 99223	90 minutes	Same date
Subsequent 99233	65 minutes	Same date
Same day Admit/Discharge 99236	110 minutes	Date of visit to three days following

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Prolonged Care Services Nursing Facility

Use of prolonged codes only valid when using time to choose your level of service.

- Must exceed time for highest level of initial or subsequent care code by 15 minutes or more
- Procedure code G0317

Primary Code	Threshold Time	Date
Initial 99306	95 minutes	One day before + date of service + three days after
Subsequent 99310	85 minutes	One day before + date of service + three days after

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Prolonged Care – Home Services

- Use time to choose the level of service
- Must exceed time for highest level of initial or subsequent by 15 minutes or more
- Procedure code G0318
- Do not count travel time

Primary Code	Threshold Time	Date
Initial 99345	140 minutes	Three (3) days before, date of service and seven (7) days after
Subsequent 99350	110 minutes	Three (3) days before, date of service and seven (7) days after

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Time Additional Information

- Critical care
  - 99291 – First 30 to 74 minutes
  - 99292 – Each additional full 30 minutes
- Discharge management
  - First 30 minutes
    - 99238
    - 99315
  - Each addition 30 minutes
    - 99239
    - 99316

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Categories of MDM

The AMA uses three elements to choose your level of service.

- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

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Problem

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Problem Defined

- Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter

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Problem Addressed

A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.

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Problem – Straightforward

Straightforward	**Minimal** • 1 self-limited or minor problem

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Self-Limited or Minor Problem

A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

- Definition specific to the patient

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Problem Level – Low

Low	**Low** • 2 or more self-limited or minor problems; **or** • 1 stable chronic illness; **or** • 1 acute, uncomplicated illness or injury **or** • 1 stable, acute illness; **or** • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care

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Stable Chronic Illness

- Expected duration of at least one year or until the death of the patient
- Stable – patient is at treatment goal

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Acute, Uncomplicated Illness or Injury

- Recent or short-term problem with low risk of morbidity for which treatment is considered
- Little to no risk of mortality with treatment
- Full recovery without functional impairment expected
- Problem normally self-limited or minor but not resolving

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Stable, Acute Illness

- A new or recent problem for which treatment initiated
- Patient is improved
- Resolution is not complete
- Patient is where practitioner expects

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Acute, Uncomplicated Illness or Injury Requiring Higher Level of Care

- Recent or new problem with low risk of mortality
- Requires treatment
- Full recovery without functional impairment expected
- Hospital or observation care required

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Problem Level – Moderate

Moderate	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • 2 or more stable, chronic illnesses; **or** • 1 undiagnosed new problem with uncertain prognosis; **or** • 1 acute illness with systemic symptoms; **or** • 1 acute complicated injury

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Chronic Illness with Exacerbation

- Chronic illness – expected to or has lasted at least 12 months
- Not at goal
- Acutely worsening
- Requiring additional supportive care
- Requiring attention for side effects

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Undiagnosed New Problem with Uncertain Prognosis

- Problem in differential diagnosis
- Represents condition likely to result in high risk of mortality or morbidity without treatment

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Acute Illness with Systemic Symptoms

- Systemic symptoms
- Examples
  - Respiratory
  - Cardiovascular
  - Musculoskeletal
- Not general
  - Fatigue
  - Fever
  - Body aches

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Acute, Complicated Injury

- Required treatment includes evaluation of body systems not directly part of injury
- Injury could be extensive
- Multiple treatment options

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Problem Level – High

High

- 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;

or

- 1 acute or chronic illness or injury that poses a threat to life or bodily function

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Chronic Illness with Severe Exacerbation

- Severe
- Documentation must support
- May require an escalation of care

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Illness or Injury Poses a Threat to Life or Bodily Function

- Acute
- Chronic
- Systemic conditions
- Exacerbation or progression
- Side effects of treatment
- Evaluation and treatment consistent

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Data

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Categories

The categories show increasing level of review and analysis based on the level of care.

- Straightforward level
  - Minimal or none
- Low
  - Must meet requirements of at least 1 or 2 categories
  - Tests and documents
    - Must have two
  - Assessment requiring independent historian

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Categories continued

- Moderate
  - Must meet the requirements of 1 out of 3 categories
    - Tests – requires three
    - Independent interpretation of tests
    - Discussion of management or test interpretation
- High
  - Must meet the requirements of 2 out of 3 categories
    - Tests – requires three
    - Independent interpretation of tests
    - Discussion of management or test interpretation

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Data Analyzed

The process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed.

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Tests Defined

Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purpose of data reviewed and analyzed, pulse oximetry is not a test.

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Unique Defined

A test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique.… A unique source is defined as a physician or other qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

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External Defined

- External records, or communications and/or test results are from an external physician or other qualified health care professional, facility or health care organization
- External physician or other qualified health care professional: Not in same group practice or if of different specialty or subspecialty. Includes licensed practitioners practicing independently. May also be a facility or organizational provider such as hospital, nursing facility or home health agency

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Discussion Defined

Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time-period (eg, within a day or two).

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Straightforward

- Minimal or none

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Low

Limited
(Must meet the requirements of at least 1 of the 2 categories)
Category 1: Tests and documents
Any combination of 2 from the following:
- Review of prior external note(s) from each unique source*
- Review of the result(s) of each unitue test*
- Ordering of each unique test

or
Category 2: Assessment requireing an independent historian(s)
(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)

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Low – Category 1

Tests and Documents – Any combination of two of the following:

- Review of external note(s) from each unique source
- Review result(s) of each unique test
- Ordering of each unique test

CPT Evaluation and Management (E/M) revisions FAQs

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Independent Historian

- An individual who provides history in addition to that provided by the patient who is unable to provide a complete or reliable history or because a confirmatory history is necessary
- Does not include translation services

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Moderate

Moderate
(Must meet the requirements of at least 1 out of 3 categories)

Category 1: Tests, documents, or independent historian(s)
- **Any combination of 3 from the following:**
  --Review of prior external note(s) from each unique source
  --Review of the result(s) of each unique test
  --Ordering of each unique test
  --Assessment requiring an independent historian(s)

or

Category 2: Independent interpretation of tests
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)

or

Category 3: Discussion of management or test interpretation
- Discussion of management or test interpretation with external physician/ other qualified health care professional / appropriate source (not separately reported)

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Independent Interpretation of Tests

- Procedure code would require interpretation
- Would not submit a separate charge
- Document the interpretation

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Discussion of Management

- Direct interactive exchange
- Real-time communication
- Between appropriate source

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High

Extensive
(Must meet the requirements of at least 2 out of 3 categories)

Category 1: Tests, documents, or independent historian(s)
- Any combination of 3 from the following:
  - --Review of prior external note(s) from each unique source*
  - --Review of the result(s) of each unique test*
  - --Ordering of each unique test*
  - --Assessment requiring an independent historian(s)

or

Category 2: Independent interpretation of tests
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);

or

Category 3: Discussion of management or test interpretation
- Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

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Risk

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Risk Defined

The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. …For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter

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Risk Table Title

Risk of complications and/or morbidity or mortality of patient management.

58

Morbidity Defined

A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

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Straightforward and Low Risk

Straightforward	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low risk of morbidity from additional diagnostic testing or treatment

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Moderate Risk

Moderate risk of morbidity from additional diagnostic testing or treatment

Examples only:

- Prescription drug management
- Decision regarding minor surgery with identified patient or procedure risk factors
- Decision regarding elective major surgery without identified patient or procedure risk factors
- Diagnosis or treatment significantly limited by social determinants of health

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Prescription Drug Management

Prescription Drug Management is one of the examples of risk.

- Determine level of risk to the patient from the medical decision
- Can include over-the-counter drugs when managed by the physician and provide risk to the patient

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Social Determinants of Health (SDOH)

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

- Provide the SDOH
- How this affects the proposed MDM

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High Risk

High risk of morbidity from additional diagnostic testing or treatment

Examples only:

- Drug therapy requiring intensive monitoring for toxicity
- Decision regarding elective major surgery with identified patient or procedure risk factors
- Decision regarding emergency major surgery
- Decision regarding hospitalization or escalation of hospital-level care
- Decision not to resuscitate or to de-escalate care because of poor prognosis
- Decision regarding parenteral controlled substances

CMS WPS GOVERNMENT HEALTH ADMINISTRATORS

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Monitoring for Toxicity

Drug therapy requiring intensive monitoring for toxicity: … therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. … may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. …

CMS WPS GOVERNMENT HEALTH ADMINISTRATORS

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Example 1 – CERT Error

Encounter Notes

Progress Notes by [redacted] APRN-NP at 7/20/2022 2:30 PM

Author: [redacted] APRN-NP Service: — Author Type: Nurse Practitioner
Filed: 7/20/2022 5:19 PM Encounter Date: 7/20/2022 Status: Signed
Editor: [redacted] APRN-NP (Nurse Practitioner)

[redacted] is a 73yo female who presents to the clinic today with husband for evaluation of neck pain.

She presents today with concern for intermittent neck pain which has gradually worsened over a few years. She states turning her head laterally reproduces pain. She has been evaluated by Dr. [redacted] who recommended cervical surgery due to impingement of cervical nerve. She states that she was informed this would alleviate her right shoulder, right hip, and right ankle pain related to the cervical nerve. Her right hip pain is located in her right superior gluteus and sometimes she experiences a catching sensation. She states she does have generalized pain due to arthritis and fibromyalgia. She has a history of ACDF C4-7 with Dr. [redacted] in 2007. She has not received injections, physical therapy, and she does not exercise regularly.
She denies numbness, tingling, weakness, positive bowel or bladder, saddle anesthesia, radiation pain.

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Example 1 – Continued

Past medical history: Fibromyalgia, hypertension, irritable bowel, urinary incontinence, mild cognitive impairment, frequent falls

Medications: Tylenol, amitriptyline, Lipitor, Tums, Hygroton, metoprolol, Remeron, omeprazole, Micardis

Social history: Former smoker, denies recreational drug and alcohol use. She does not exercise regularly.

Family history: Non-contributory

Physical exam: BMI 31.37. On exam, she ambulates well independently. She is mildly kyphotic. She has normal strength and sensation of bilateral upper and lower extremities. Brisk 3+ patellar reflexes, normal upper extremity reflexes. Negative Hoffmann sign. Negative straight leg raise. No clonus or atrophy. Generalized tenderness upon palpation of all extremities. No tenderness upon palpation of spine. Hips do not reproduce pain upon rotation. Right trochanter is mildly tender. Bilateral hand DIPs are arthritic. Skin is intact. She is alert and oriented appropriately.

Imaging: Cervical x-ray obtained reviewed today showing multilevel facet arthritis, C1-2 DDD, C3-4 spinal listhesis. MRI from March 2021 shows C3-4 moderate stenosis.

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Example 1 – CERT Error More

Plan: Discussed at length her imaging is stable, she does have multilevel facet arthritis, C1-2 DDD, C3-4 spinal listhesis. Her MRI from 2021 shows C3-4 moderate stenosis. Her low-back issues are likely related to fibromyalgia and musculoskeletal pain. We discussed conservative management at this time such as physical therapy, daily exercise, increase mobility, daily walking and stretching. She does not want formal physical therapy, but states she will exercise on her own. Discussed surgical intervention is not necessary at this time. She will follow-up as needed.

All questions and concerns discussed, she is content with plan of care.

[redacted] APRN-NP
4:24 PM, 7/20/2022

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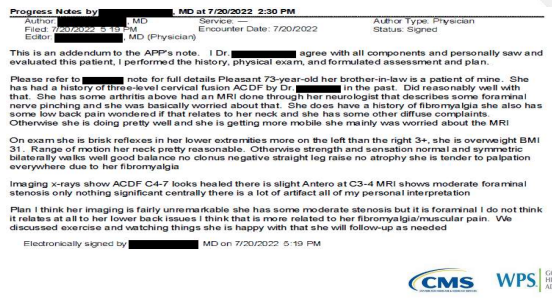
Example 1 – CERT Error MD Note



Progress Notes by [redacted], MD at 7/20/2022 2:30 PM

Author: [redacted], MD | Service: — | Author Type: Physician
Filed: 7/20/2022 5:19 PM | Encounter Date: 7/20/2022 | Status: Signed
Editor: [redacted], MD (Physician)

This is an addendum to the APP's note. I Dr. [redacted] agree with all components and personally saw and evaluated this patient, I performed the history, physical exam, and formulated assessment and plan.

Please refer to [redacted] note for full details Pleasant 73-year-old her brother-in-law is a patient of mine. She has had a history of three-level cervical fusion ACDF by Dr [redacted] in the past. Did reasonably well with that. She has some arthritis above had an MRI done through her neurologist that describes some foraminal nerve pinching and she was basically worried about that. She does have a history of fibromyalgia she also has some low back pain wondered if that relates to her neck and she has some other diffuse complaints. Otherwise she is doing pretty well and she is getting more mobile she mainly was worried about the MRI

On exam she is brisk reflexes in her lower extremities more on the left than the right 3+, she is overweight BMI 31. Range of motion her neck pretty reasonable. Otherwise strength and sensation normal and symmetric bilaterally walks well good balance no clonus negative straight leg raise no atrophy she is tender to palpation everywhere due to her fibromyalgia

Imaging x-rays show ACDF C4-7 looks healed there is slight Antero at C3-4 MRI shows moderate foraminal stenosis only nothing significant centrally there is a lot of artifact all of my personal interpretation

Plan I think her imaging is fairly unremarkable she has some moderate stenosis but it is foraminal I do not think it relates at all to her lower back issues I think that is more related to her fibromyalgia/muscular pain. We discussed exercise and watching things she is happy with that she will follow-up as needed

Electronically signed by [redacted] MD on 7/20/2022 5:19 PM

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Explanation of Example 1

- NP billing is 99212
  - Problem – straightforward
  - Data – straightforward
  - Risk – straightforward
- MD billing is 99214
  - Problem – moderate
  - Data – moderate
  - Risk – straightforward

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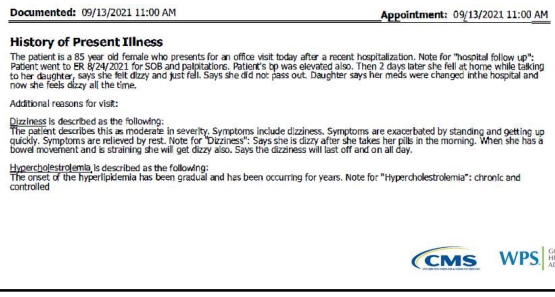
Example 2 – CERT Approved



Documented: 09/13/2021 11:00 AM **Appointment:** 09/13/2021 11:00 AM

History of Present Illness

The patient is a 85 year old female who presents for an office visit today after a recent hospitalization. Note for "hospital follow up": Patient went to ER 8/24/2021 for SOB and palpitations. Patient's bp was elevated also. Then 2 days later she fell at home while talking to her daughter, says she felt dizzy and just fell. Says she did not pass out. Daughter says her meds were changed inthe hospital and now she feels dizzy all the time.

Additional reasons for visit:

Dizziness is described as the following:
The patient describes this as moderate in severity. Symptoms include dizziness. Symptoms are exacerbated by standing and getting up quickly. Symptoms are relieved by rest. Note for "Dizziness": Says she is dizzy after she takes her pills in the morning. When she has a bowel movement and is straining she will get dizzy also. Says the dizziness will last off and on all day.

Hypercholestrolemia is described as the following:
The onset of the hyperlipidemia has been gradual and has been occurring for years. Note for "Hypercholestrolemia": chronic and controlled

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Example 2 – CERT Approved Continued

Assessments & Plans

DIZZINESS (R42)
Problem Story: chronic controlled

HOSPITAL DISCHARGE FOLLOW-UP (Z09)
Impression: Recent referral controlled blood pressure. She was started on nifedipine 60 mg and add carvedilol. And she is off the amlodipine and metoprolol. And she is on amlodarone also. And her blood pressure appears to be on the lower side. Systolic around 100 she is on Xanax 2 times a day. Will stop nifedipine for the time being. And will change the Xanax to once a day at bedtime. And she is unable to get Eliquis. Started on Xarelto 20 mg a day. Will put her on patient assistance program. And I will see her again after 48 hours and see how her blood pressure behaves. Basing on her systolic blood pressure we will adjust her medications further.

Additional Instructions
Patient advised to follow up in 1 week./thursday 9/16/21

HYPERCHOLESTEREMIA (E78.00)
Problem Story: Continue present management

HYPERTENSION (I10)
Problem Story: Continue present management
Chronic controlled

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Explanation of Example 2

- Office service
- Level of service is 99214
  - Problem – moderate
  - Data – straightforward
  - Risk – moderate

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Resources

- Social Security Act Section 1862(a)(1)(A)
- AMA CPT® Evaluation and Management (E/M) Code and Guideline Changes
- Schedules of Controlled Substances in Section 102 of the Controlled Substances Act (21U.S.C. 802)
- CMS Internet-Only Manual, Publication 100-04, Chapter 12, Section 30.6
- CMS MLN 006764 Evaluation and Management Services Guide

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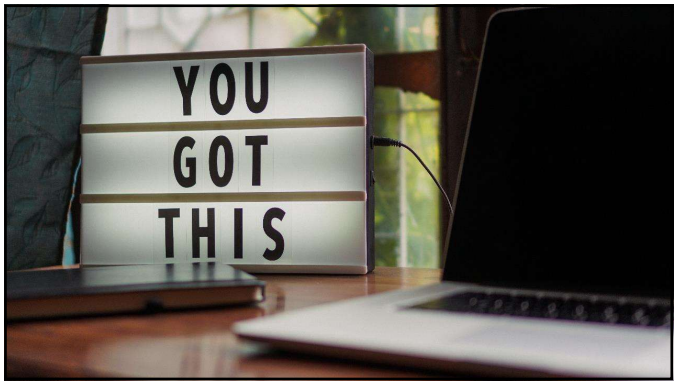

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