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## OptumInsight Learning:

# Understanding E/M Coding

2013

*10th edition*

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Ingenix
2525 Lake Park Blvd
West Valley City, UT 84120

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Made in the USA
ISBN 978-1-60151-428-8

## ACKNOWLEDGMENTS

**Julie Orton Van**, CPC, CPC-P, *Product Manager*
**Karen Schmidt**, *BSN, Technical Director*
**Stacy Perry**, *Manager, Desktop Publishing*
**Lisa Singley**, *Project Manager*
**Nannette Orme**, CPC, CCS-P, CPMA, CEMC, *Clinical/Technical Editor*
**Temeka Lewis,** MBA, CCS, *Clinical/Technical Editor*
**Tracy Betzler**, *Desktop Publishing Specialist*
**Kate Holden,** *Editor*

### *About the Technical Editors*

**Nannette Orme**, CCS-P, CPC, CPMA, CEMC, *Clinical/Technical Editor*
Ms. Orme has more than 15 years of experience in the health care profession. She has extensive background in CPT/HCPCS and ICD-9-CM coding. Her prior experience includes physician clinics and healthcare consulting. Her areas of expertise include physician audits and education, compliance and HIPAA legislation, litigation support for Medicare self-disclosure cases, hospital chargemaster maintenance, workers' compensation and emergency department coding. Ms. Orme has presented at national professional conferences and contributed articles for several professional publications. She is a member of the American Academy of Professional Coders.

**Temeka Lewis,** MBA, CCS, *Clinical/Technical Editor*
Ms. Lewis is a clinical/technical editor for Ingenix with expertise in hospital and physician coding. Her areas of expertise include ICD-9-CM, CPT, and HCPCS coding. Ms Lewis' past experience includes conducting coding audits and physician education, teaching ICD-9-CM and CPT coding, functioning as a member of a revenue cycle team, chargemaster maintenance, and writing compliance newsletters. Most recently she was responsible for coding and compliance in a specialty hospital. She is an active member of the American Health Information Management Association (AHIMA).

# Contents

## Teaching Physician Documentation

Teaching physicians and residents may both chart on the same patient. However, a teaching physician who is billing Medicare must personally document "his or her participation in the management of the patient." This includes managing the patient or being present during the critical or key portions of the patient care. (*Guidelines for Teaching Physicians, Interns, and Residents*, July 2007, ICN: 006347, pages 2–3) The statement that "the resident's certification that the attending physician was present is not sufficient" helps to clarify the level of documentation required by the teaching physician.

Students may document in the medical record. However, the teaching physician can refer only to the portion "related to a review of systems and/or past, family, and/or social history."

## Incident-to Services

### Incident-to Protocols

If the practice employs limited-licensed practitioners, it is advisable to periodically determine that the "incident-to" guidelines are being adhered to. Incident-to services are defined by the Centers for Medicare and Medicaid Services as "those services that are furnished incident to a physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home."

To qualify as incident-to, the services must be part of the patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of the patient's treatment. The physician does not have to be physically present in the treatment room while these services are provided but must be present in the office suite to render assistance, if necessary (direct supervision). The patient record should document the essential requirements for incident-to services.

In other words, the medical records should document the following:

- The service was an integral part of the patient's treatment course.
- The service is commonly included in the physician's services.
- The service is furnished in a physician's office or clinic (not in an institutional setting).
- The service was an expense to the practice.

Examples of qualifying incident-to services include cardiac rehabilitation, providing non-self-administrable drugs and other biologicals, and supplies usually furnished by the physician in the course of performing his or her services (e.g., gauze, ointments, bandages, and oxygen).

It is important to note that the Office of the Inspector General (OIG) work plans have included reviews of incident-to-services in recent years. These reviews are ongoing and may take several years to complete.

**Key Point**

The Physician Quality Reporting System (PQRS) was formerly referred to as the Physician Quality Reporting Initiative (PQRI).

## Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) measures were developed by the Centers for Medicare and Medicaid Services in cooperation with consensus

- When a common chart is used, a separate report to the requesting provider does not need to be sent. Examples of a common chart include large multispecialty clinics with electronic medical records.
- Use the appropriate office consultation code if the consultant was asked again for an opinion or advice regarding the same problem or a new problem.
- Assign the appropriate critical care code instead of these codes if the physician provided constant attention to a critically ill patient.
- Assign the appropriate office visit code if the patient or family member and not another physician (or appropriate source) requested the consultation.
- Do not consider the time spent by other staff (e.g., nurse) as part of the face-to-face time.
- Report 99354–99359 for E/M services that run 30 minutes beyond the typical time specified in the code narrative. The time must be clearly documented in the medical record.
- Add modifier 25 to report that a separately identifiable E/M service was performed by the same physician on the same day as a procedure or service. Only the work involved in the separate E/M service should be considered when determining the correct level of service.
- Use modifier 32 when the services were mandated, such as by a third-party payer, or as a result of a governmental, legislative or regulatory requirement.
- Add modifier 57 to indicate that the decision to perform major surgery has been made.
- Report separately the codes for the diagnostic tests or studies performed.
- Codes for high-level E/M services have been targeted in the CERT program as being overutilized. Medical necessity and the level of medical decision making should be verified for all high-level E/M services.
- Follow-up visits initiated by the physician consultant or patient are reported with the appropriate site-of-service codes (e.g., office visits) for established patients. However, if an additional request is documented in the record for an additional opinion or advice for the same or separate problem, the consultation codes may be reported again.
- Transfer-of-care services (for either specific condition or the patient's entire care) are reported with the appropriate new or established patient codes for the site of service.
- Medicare does not accept consultation codes. Report outpatient consultations with the appropriate E/M service code for the site of service and new or established patient.

**✓ QUICK TIP**

Modifiers 25, 32, and 57 are to be appended to the E/M code and not to the codes for the other procedures or services that may be performed.

# 99241

## DOCUMENTATION REQUIREMENTS

**Medical Decision Making: straightforward**

- Minimal number of diagnoses or management options considered
- No or minimal amount and complexity of data reviewed
- Minimal risk of complications or morbidity or mortality

**Problem Severity: minor or self-limited**

- Little, if any, risk of morbidity without treatment

- Little, if any, risk of mortality without treatment
- Transient problem, low probability of permanently altered status
- Good prognosis

**History: problem focused**
- Chief complaint
- Brief history of present illness or problem (one to three HPI elements)

**Examination: problem focused**
- 1995: one organ system or body area
- 1997: one to five bullet (•) elements in one or more organ systems/body areas

### Code Indicators (from tables of risk—including some AMA indicators in italic)

**Presenting Problem(s)**
- One self-limited or minor problem

**Management Options**
- Rest, gargles, elastic bandages, superficial dressings

**Counseling and/or Coordination of Care**
- As appropriate for the problem

**Time Spent Face to Face (average)**
- 15 minutes

### Sample Documentation—99241

**Level I Office/Outpatient Consultation**

TO: Dr. Attending Physician

FROM: Dr. Consultant

This 26-year-old female is seen at the request of Dr. Attending Physician to evaluate a lump the patient found in her right breast. She states that she found the mass three days ago during a regular, monthly self examination. She states that the mass is "a little sore." She has had no such masses before; no history of injury to the area. No other significant past history. No family history of breast cancer.
Menses are regular, and the patient is "within a couple of days" of beginning her menses.
The patient is not on oral contraceptives or other medications.

Px: BP 120/80, respirations I8, temperature 98.7, pulse 65. Neck shows no masses or palpable nodes. Breasts are small, symmetrical and generally nontender. There is a small, 1.5-cm nodule palpable in the right inner quadrant; it is easily movable, well circumscribed and feels cystic. There are no other masses. No nipple discharge or other abnormalities. No axillae lymphadenopathy.

**Assessment:** Cyst of breast, right

**Recommendation**: Patient was reassured that this mass is probably a cyst and not likely to be malignant, and this seemed to relieve her anxiety. We discussed the possibility of fine-needle aspiration of the cyst. The patient, however, indicates that she is "very afraid" of needles and prefers not to have this procedure done today. Because of the patient's concern over aspiration, I recommend ultrasound to distinguish simple vs. complex cyst. She agrees to the ultrasound, which our office will schedule.

Thank you for asking me to see your patient. I recommend that we proceed with the needle aspiration in the near future if the ultrasound shows the cyst to be suspicious.

**(Single organ system—GYN)**

**✓ QUICK TIP**

The consulting provider initiated a diagnostic procedure and made follow-up recommendations based upon the outcome of the testing.

| *Respiratory Examination* | |
|---|---|
| **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).<br>• General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) |
| Head and Face | |
| Eyes | |
| Ears, Nose, Mouth and Throat | • Inspection of nasal mucosa, septum and turbinates<br>• Inspection of teeth and gums<br>• Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx) |
| Neck | • Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)<br>• Examination of thyroid (e.g., enlargement, tenderness, mass)<br>• Examination of jugular veins (e.g., dissension; a, v or cannon a waves) |
| Respiratory | • Inspection of chest with notation of symmetry and expansion<br>• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) |
| Respiratory (continued) | • Percussion of chest (e.g., dullness, flatness, hyperresonance)<br>• Palpation of chest (e.g., tactile fremitus)<br>• Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs) |
| Cardiovascular | • Auscultation of heart with notation of abnormal sounds and murmurs<br>• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness) |
| Chest (Breasts) | |
| Gastrointestinal (Abdomen) | • Examination of abdomen with notation of presence of masses or tenderness<br>• Examination of liver and spleen |
| Genitourinary | |
| Lymphatic | • Palpation of lymph nodes in neck, axillae, groin and/or other location. |
| Musculoskeletal | • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements<br>• Examination of gait and station |
| Extremities | • Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes) |
| Skin | • Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers) |
| Neurological/ Psychiatric | • Brief assessment of mental status including:<br>  • orientation to time, place and person<br>  • mood and affect (e.g., depression, anxiety, agitation) |

*Content and Documentation Requirements*

| **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 twelve** elements identified by a bullet. |
| Comprehensive | Perform **all** elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box. |