Part B Insider (Multispecialty) Coding Alert

E/M Coding: Translate the Alphabet Soup of E/M Coding With These 5 FAQs

From HPI to PMFSH, we've got the scoop on E/M coding.

Last week, we told you that Part B MACs will be scrutinizing your evaluation and management claims to see if you are billing the proper levels of service. But how can you make sure you are selecting the proper codes?

Review this compilation of frequently asked E/M questions and answers to set your practice on the right track for E/M billing success.

1. How Do We Calculate HPI?

For coding purposes, HPI is the chronological description of development of the present illness from first sign or symptom, or prior encounter, to present. With HPI recording, the provider should document the unique situation of each patient at each encounter to clearly substantiate the medical necessity of the service(s) rendered that day.

Depending on the payer, there are seven or eight HPI elements. For Medicaid payers, the HPI elements are location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms.

HPI is one of the three parts comprising an outpatient E/M services history component. There are two levels of HPI: brief and extended. A brief HPI consists of one to three elements. When the provider's documentation satisfies four or more elements, she has performed an extended HPI.

For a new patient encounter, a brief HPI can support reporting up to 99202 and for established patients, 99213. The physician must achieve an extended HPI to document at least a detailed history -- meaning that an extended HPI is a requirement for all new patient E/Ms above 99202, and all established outpatient E/Ms beyond 99213 if the physician relies on history as one of the key components.

2. What Are the Different ROS Levels?

Review of systems (ROS) is part of the history component of an E/M service. CPT® defines it as "[a]n inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced."

During ROS, the physician might review systems directly related to the problem or problems identified in the HPI portion of the E/M and a number of additional systems.

According to both the 1995 and 1997 CMS documentation rules, there are three different levels of ROS, and you must identify ROS level before choosing a level of history and, subsequently, an E/M code.

When the physician reviews a single system, it is a problem-pertinent ROS. This ROS level can support up to a level-two new patient E/M (99202) or a level-three established patient service (99213).

When the physician reviews two to nine systems, the encounter is an extended ROS. Extended ROS can support up to a level-three new patient service (99203) or level-four established patient service (99214).

Caveat: An extended ROS does not necessarily qualify an encounter for 99203 or 99214; though it does make reporting these codes possible.

For a complete ROS, most insurers accept a review of 10 or more systems. The provider must individually document those systems with positive or pertinent negative responses. For the remaining systems, a notation indicating all other systems are negative is permissible. Absent such a notation, the provider must individually document at least 10 systems.

With a complete ROS, reporting a 99204, 99205, or 99215 is possible -- depending on other encounter specifics.

3. Does Provider Have to Capture New PMFSH Every Time?

Based on E/M guidelines, if a patient's past medical, family, and social history (PMFSH) has not changed since a prior visit your provider doesn't have to document the information again. He does, however, need to document that he reviewed the previous information to be sure it's up to date and also note in the present encounter's documentation the date and location of the initial earlier acquisition of the PMFSH. Some payers will give no PMFSH credit if you overlook one of these criterion.

There are three levels of PMFSH: none, pertinent, and complete:

None: If your provider does not document any PMFSH elements, you can only reach an extended problem-focused level of history. That means the highest codes you'll be able to report are a level-two new patient code (99202) or a level-three established patient code (99213).

Pertinent: To reach a detailed level of history for the encounter, you need a pertinent PMFSH. According to Medicare's Documentation Guidelines for E/M Services, you need at least one specific item from any of the three PMFSH areas to achieve the pertinent level. When the provider asks only about one history area related to the main problem, this is a pertinent PMFSH. Pertinent PMFSH supports a detailed history level. With detailed history you can report a level-three new patient code (99203) and a level-four established patient code (99214).

Complete: A complete PMFSH includes, per Medicare's Documentation Guidelines, at least one specific item from two of the three areas for the following categories of E/M services: established patient office/outpatient services, emergency department services, established patient domiciliary care, and established patient home care. For all other E/M services, a complete PMFSH includes at least one specific item from each of the three areas. To get to level-four and five new patient visits and level-five established patient visits, you need to have a comprehensive level of history. To do that, you must find complete PMFSH in your provider's documentation.

4. What are the 1995 vs. 1997 Guideline Exam Differences?

Any time you select the best E/M code for a patient's office visit, you need to decide whether to follow the 1995 or 1997 E/M coding guidelines. The exam element is the most significant difference between the two sets of guidelines.

1997: The 1997 guidelines include specific physical exam elements that the provider must address in the documentation. If a physician addresses elements other than those specified in the guidelines, he won't necessarily receive credit for that element in the level of service. Also, if the language pertaining to an exam element included in the documentation differs from the language included in the guidelines, an auditor who has not had much clinical experience may exclude the element from being credited in the level of service.

1995: The 1995 guidelines are much less restrictive. They allow the physician to comment on any of the designated body areas and/or organ systems he examines. What the physician examines within the areas and systems and the wording he or she chooses to document are ultimately decided by the physician.

So which set of guidelines should you use? The answer depends on your physician and his documentation.

Typically the 1995 documentation guidelines are going to be more advantageous for most practices because they are more flexible and also because they reflect the way most physicians were taught to document. However, some physicians may have been taught or may have developed good documentation practices around the 1997 guidelines, and this may be advantageous to them.

Remember: Medical necessity must guide the exam -- and your physician may not need to examine every system trying to reach a higher E/M level.

5. Does Overall Risk Determine MDM Level?

Most billers and coders find the medical decision making (MDM) piece of the puzzle the hardest to fit into place. Determining the difference between straightforward, low, moderate, and high MDM can be an arduous task. You determine the level of MDM by looking at three aspects of the visit:

1. Number of possible diagnoses and/or management options

2. Amount and/or complexity of medical records, diagnostic tests and/or other information that is obtained, reviewed and analyzed

3. Risk of significant complications, morbidity and/or mortality including comorbidities associated with the patient's presenting problem(s), diagnostic procedure(s) and/or the possible management options

Determining the level of risk can be the hardest of the three components, since it requires more than just counting diagnosis options or lab tests ordered. This category includes risks associated with the presenting problems, the diagnostic procedures, and the management options. The highest level of risk in any of these areas determines whether the overall risk is minimal, low, moderate, or high.

Although determining the level of risk may be the most difficult for you, the number of diagnoses and treatment options should not be overlooked. You also need to weigh the complexity of data ordered and/or reviewed during the encounter.