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Infectious Disease: E/M Update

UCLA Health

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Contents

Medical Necessity

What is Medical Necessity?

Definition: A US legal doctrine related to activities which may be justified as

- Reasonable
- Necessary
- Medically appropriate based on clinical standards
- Other relevant factors

Medical necessity is determined by the following guidance:

- Credible scientific evidence published in peer-reviewed medical literature recognized by the medical community
- Based on physician specialty society recommendations

CMS Says: "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted."

Medically Necessary" or "Medical Necessity" shall mean healthcare services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

- In accordance with the **generally accepted standards** of medical practice.
- **Clinically appropriate**, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and
- **Not primarily for the convenience** of the patient or physician and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

All services must be sufficiently documented so the medical necessity is clearly evident. Medicare cannot pay for services for which the documentation does not establish the medical necessity. Section 1862(a)(1)(A) of Title XVIII of the Social Security Act provides "no payment may be made under Part A or B (of Medicare) for any expense incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member".

Services rendered should be billed to Medicare based on the medical necessity of the visit. If the visit does not necessitate the detail of documentation required to meet CPT code 99XXX a lower level of service should be billed. **Do not** include additional components in the record for the sole purpose of meeting a specific CPT code.

E/M FOR Infectious Disease

Medical necessity cannot be quantified using a points system. Determining the medically necessary level of service (LOS) involves many factors and is not the same from patient to patient and day to day. Medical necessity is determined through a culmination of vital factors, including, but not limited to:

- Clinical judgment
- Standards of practice
- Why the patient needs to be seen (chief complaint),
- Any acute exacerbations/onsets of medical conditions or injuries,
- The stability/acuity of the patient,
- Multiple medical co-morbidities,
- And the management of the patient for that specific DOS.

When supporting medical necessity for an Evaluation and Management Service, the presenting problem(s), the history, examination, and medical decision-making all play a key role in validating medical necessity for the level of service billed. Even if a comprehensive level of service is documented, it does not always mean that billing the higher level is warranted. Specific and accurate diagnosis coding is critical in supporting medical necessity.

The Cloning Dilemma

The widespread adoption of electronic health records (EHRs) has resulted in a shift from the clinical narrative writing style to reliance on the computer function known as copy and paste which encourages cloned documentation. Copy/paste allows physicians to incorporate documentation from a previous progress note, labs, diagnostic testing, vitals, etc.

When a clinician relies on copy/paste in the EHR, clinical data can be compromised. The data you pull into your record may be outdated or inaccurate. Many times, clinicians pull in the entire note from the previous encounter and change very little or many times the note looks exactly the same from one date of service to another which is considered "cloning". Cloning also occurs when medical record documentation is exactly the same from patient to patient. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

Cloned notes may cause:

- Inability to distinguish notes from one date of service to another.
- Difficulty in establishing medical necessity
- Failure to provide appropriate documentation to support a service billed which can result in payment recoupment.
- Falsification of the medical record since cloned notes may not pertain to the current patient encounter.

While EHR cloning appears to save time, the Office of the Inspector General (OIG) stated that the use of duplicate entries "may be associated with improper payments": Medicare defines cloning as multiple entries in a patient chart that are identical or similar to other entries in the same chart. The Centers for Medicare and Medicaid Services (CMS) has directed Medicare Administrative Contractors (MACs) to identify "suspected fraud, including inappropriate copying of heath information" under the Benefit Integrity/Medical Review Determinations mandate. MACs have begun to deny payment on the assumption that cloning is a "misrepresentation of the medical necessity required for the service rendered".

Source: CMS, Medicare Program Integrity Manual, Pub. No. 100-08, ch.1, § 1.3.1 5

Medicare's General Principles of Medical Record Documentation

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results.
   - assessment, clinical impression, or diagnosis.
   - plan for care; and
   - date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

E/M FOR Infectious Disease

Overview of E/M Coding

Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
1.Chief complaint	1.Chief complaint	1.Chief complaint	1.Chief complaint
2.Brief history of present illness (HPI) (1-3 elements)	2.Brief HPI	2.Extended HPI (4 or more elements)	2.Extended HPI
	3.Problem pertinent system review	3.Extended review of systems (ROS) (2-9 systems)	3.Complete ROS (10 systems)
		4.One of three: pertinent past, family, or social history (PFSH)	4.For NP and OC: all three PFSH For EPV: two of three PFSH

Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
1995: Limited exam of affected body area or organ system	1995: Limited exam of affected body area or organ system and other symptomatic or related organ system(s)	1995: Extended exam of affected body area(s) and other symptomatic or related organ system(s)	1995: A general multi-system exam or a complete exam of a single organ system
1997: 1-5 elements	1997: 6-11 elements	1997: At least 12 elements	1997: All elements

	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Data Review	None or Minimal	Limited	Moderate	Extensive
Risk	Minimal	Low	Moderate	High
Diagnosis/Treatment Options	Minimal	Limited	Multiple	Extensive

New Patient/Outpatient Consultation

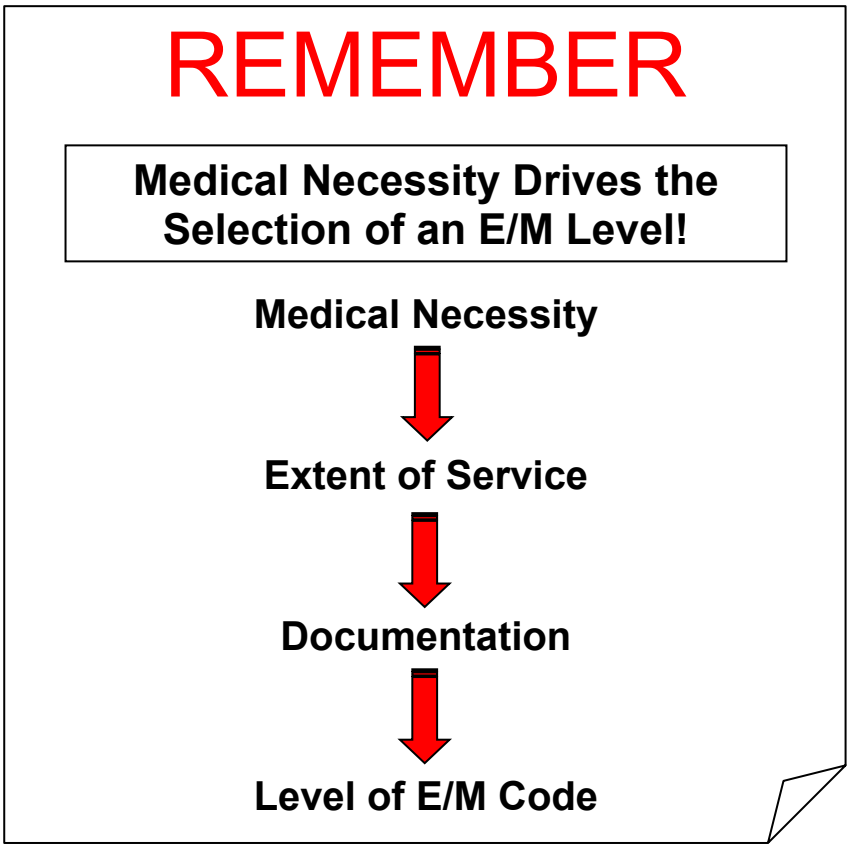
Meet or Exceed 3 of 3	99201 99241	99202 99242	99203 99243	99204 99244	99205 99245
History	PF	EPF	DET	COMP	COMP
Exam	PF	EPF	DET	COMP	COMP
MDM	SF	SF	LOWcom	MODcom	HIcom

Established Patient Visit

Meet or Exceed 2 of 3	99211	99212	99213	99214	99215
History	Does not require presence of a physician	PF	EPF	DET	COMP
Exam		PF	EPF	DET	COMP
MDM		SF	LOWcom	MODcom	HIcom

E/M FOR Infectious Disease

- Choose the level based on the three key components; History, Examination, Medical decision making, you performed and documented.
- Document using History, Exam, Medical Decision Making format, not SOAP (subjective, objective, assessment and plan).
- Make sure your EHR templates are consistent with E/M key components (History, Exam, Medical Decision Making) and E/M guidelines.
- Make sure your documentation supports the category and level of service reported.
- Perform and document what is relevant/pertinent to the patient's presenting problem. Beware of over documenting – the documentation should be clinically relevant.
- Consider choosing a code based on time. When counseling or coordination of care dominates the visit (more than 50%).



1995/1997 E/M Documentation Guidelines

History

Documentation Do's and Don'ts

Don't:

- Document "follow-up," "new patient visit," or other vague reason as the chief complaint
- Document "Get acquainted visit". Payors do not consider these visits medically necessary
- Count the same element in both the History of Present Illness (HPI) and the Review of Systems (ROS) (e.g., double-dipping)
- Document: "A 10-12, or 14 point review of systems was performed"
- Use the statement "as per HPI" or "see HPI" and count it as a complete ROS when there is no ROS in the HPI.

Do:

- Document "follow-up for chest wound", "new patient visit for HIV care," or other specific reason as the chief complaint
- Document a complete past medical, family, and social history (PFSH) on all hospital admissions
- Document in the review of systems all pertinent positives and pertinent negatives. You may use the statement "All other systems reviewed negative" for the remainder of systems for a comprehensive ROS.
- Document 4 HPI elements for a detailed or comprehensive HPI
- Document that history elements recorded by staff or the patient have been reviewed and verified or make any necessary changes.

History of Present Illness (HPI)

	Problem Focused (99201, 99241, 99212, 99251, 99231*, 99281)	Expanded Problem Focused (99202, 99242, 99213, 99252, 99232*, 99282, 99283)	Detailed (99203, 99243, 99214, 99253, 99221, 99233*, 99284)	Comprehensive (99204, 99244, 99205, 99245, 99215, 99222, 99223, 99254, 99255, 99285)
Chief Complaint	Required	Required	Required	Required
History of Present Illness	**Brief** ***(1-3 elements)***	**Brief** ***(1-3 elements)***	**Extended** ***(4 or more elements)***	**Extended** ***(4 or more elements)***
Review of Systems		Problem pertinent *(1 system)*	Extended *(2-9 systems)*	Complete *(10 systems)*
Past History			Pertinent *1 of 3 required*	Complete *New/consult/initial: 3 of 3 Established/ subsequent: 2 of 3*
Family History				
Social History				

History of Present Illness (HPI): A chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI elements are:

1. Location (e.g., where the chief complaint is)
2. Quality (e.g., aching, burning, radiating pain)
3. Severity (e.g., 8 on a scale of 1 to 10)
4. Timing (e.g., constant, comes and goes, intermittent)
5. Context (e.g., how it started)
6. Modifying factors (e.g., what helps, what doesn't help, what's been tried)
7. Associated signs and symptoms (e.g., signs and/or symptoms other than the Chief Complaint).

Medicare adds an 8th element: Duration (e.g., how long the Chief Complaint has occurred).

CMS Says:

- 1995 Documentation Guidelines – Should describe four or more elements of the present HPI or associated comorbidities.
- 1997 Documentation Guidelines – Should describe at least four elements of the present HPI or the status of at least three chronic or inactive conditions.