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Frequently Asked Questions: Evaluation And Management Services (Part B)

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1. **Under the Examination Section of the 1995 Scoresheet, can we combine the body areas and organ systems?**

No. The examination section of the 1995 scoresheet is divided into body areas and organ systems. The Current Procedural Terminology (CPT) manual recognizes 7 body areas and 12 organ systems. Depending on the documentation in the patient's medical record you can use either the body areas or the organ systems. There is a dotted line between the body areas and organ systems indicating you must choose one or the other. If you combined the body areas and organ systems you would be giving credit twice which would be incorrect when determining the final score for the examination section of the scoresheet. An example could be: the documentation in the patient's medical record stated, abdomen soft, credit can only be given in the body areas under abdomen or in the organ systems under GI which ever area benefited the physician the most.

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2. **If we are using the 1997 evaluation and management guidelines for the examination component, do we have to use the 1995 guidelines for the history and medical decision-making components?**

The 1997 guidelines provided the specialty examination guidelines only. Therefore, the history and medical-decision making components from the 1995 guidelines are used for all evaluation and management services. This said, under the history

component, the Status of chronic conditions was added after the 1995 guidelines were instituted. This element of the history component is also available for all services.

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3. **What is meant by "Status of chronic conditions"?**

In 1997 the Evaluation and Management (E/M) Guidelines were enhanced under the History of Present Illness (HPI) section of the 1995 score sheet to include patient's chronic conditions in which an exacerbation may have occurred resulting in the chief complaint and the reason for the patient encounter. The documentation in the patient's medical record must state a status of the chronic condition in order to meet the requirement under the History: HPI Status of 1, 2, or 3 Chronic Conditions on the 1995 scoresheet. An example could be: hypertension - stable on Atenolol.

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4. **When scoring medical records, how is medical necessity considered?**

All services under Medicare must be reasonable and necessary as defined in Title XVIII of the Social Security Act, Section 1862(a)(1)(A). This section states, no payment may be made for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of injury or to improve the functioning of a malformed body member. Therefore, medical necessity is the first consideration in reviewing all services.

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5. **How do you take credit for family history, if there are no family members to refer to?**

If the family history is addressed, and the response is that there is no known family history, credit may be given. However, the provider must document non-contributory or unknown, for credit to be given.

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6. **If the physician states same/unchanged from last visit, will he receive credit for reviewing the last visit information?**

Credit may be taken only if the physician includes the documentation from the previous visit. Otherwise, the reviewer would not know what was the same or unchanged from the previous visit.

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7. **If a patient is sent home, is Medical Decision Making automatically going to be a moderate complexity?**

No, the complexity depends on the three parts of the Medical Decision Making component (Number of Diagnosis and Treatment Options, Amount and/or Complexity of Data Reviewed, and the Risk of Complications and/or Morbidity or Mortality).

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8. **Does a physician billing an evaluation and management (E/M) service have to specifically indicate the amount of time they spend with a patient?**

No, time is only used to determine the level of care when the E/M service was mainly used for counseling and/or coordination of care. Specifically, where counseling and/or coordination of care dominates more than 50% of the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services. In these instances, the time of the visit and the time spent providing the counseling and/or the coordination of care must be documented.

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9. **For the Review of Systems, can the physician reference a sheet that he has in the patients chart where the physician checked off items?**

Yes. However, if medical records are requested, the sheet must be submitted with all of the other documentation for that date of service. Otherwise, no credit can be given for the information on the check-off sheet.

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10. If a physician sees a patient in the morning and again in the afternoon for a new or worsened condition, do we report modifier 25 for the second visit?

No, modifier 25 is used to identify a significantly, separately identifiable E/M service performed by a physician on the same date as a procedure or other service. Highmark Medicare Services would not expect to see two E/M services reported on the same date on a routine basis. A second E/M service would be billed for rare circumstances only. If a second E/M service is required on the same date of service, the documentation should clearly provide evidence that the second E/M service occurred, the reason for the additional E/M service, and documentation of the medical necessity of the second E/M service. If a second E/M service is reported on the same date, the service could initially be denied. The denial can be appealed using the appeal guidelines available in [Chapter 18 of the Part B Reference Manual](#).

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11. What is the 4 x 4 method for determining if an examination is scored as an expanded problem focused or detailed?

Under the 1995 guidelines both the expanded problem focused examination and the detailed examination provide for the examination of up to 7 systems or 7 body areas. This has led to variability in reviews utilizing the 95 guidelines, and requiring an interpretation for proper and consistent implementation of the E/M guidelines. By providing a tool we call 4X4 (4 elements examined in 4 body areas or 4 organ systems satisfies a detailed examination; however, less than such can be a detailed exam based on the reviewers clinical judgment) our reviewers and the physicians in PA have a clinically derived tool to assist in implementing the E/M guidelines and decreasing one area of ambiguity. This tool is consistent with the way medicine is practiced, as confirmed in **Documentation Coding & Billing** by Laxmaiah Manchikanti, M.D, and **A Guide to Physical Examination** by Barbara Bates, M.D. And, it is a tool to reduce reviewer variability.

Highmark Medicare Services nurse reviewers follow the guidelines for auditing E/M services that are provided by CMS and the American Medical Association (AMA). This includes consideration of both the 1995 and 1997 guidelines, with the utilization of the guidelines that are most beneficial to the physician. We also instruct our nurse reviewers to use their clinical knowledge while reviewing the medical record documentation to determine the correct and appropriate level of care. Clinical inference overrides the 4 x 4 tool. It provides for an individual consideration, and makes the review of all services (including E/M examinations) fairer to the physician. Clinical inference is in keeping with CMS current instructions for reviewing all medical records. Again, our reviewers utilize either the 95 or the 97 guidelines when reviewing E/M services, and utilize the guidelines that benefit the provider.

With all of this said, our reviewers utilize one of the following when making a determination on whether an examination is expanded problem focused or detailed. The method chosen must be the one that is most beneficial to the physician.

- o 1997 E&M examination guidelines,
- o 1995 E&M examination guidelines utilizing the 4 x 4 tool, or
- o 1995 E&M examination guidelines utilizing clinical inference.

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12. Our office requests that our patients complete a form by checking yes or no regarding their medications, medical history, family history, and social history information. Can we include this information as documentation of the PFSH and ROS?

Yes, this information may be used if the physician notes that he has reviewed the form. It is also appropriate for the physician to note in the medical records any additional information obtained during the face-to-face encounter. Information is available regarding E/M documentation in [Chapter 23 of the Medicare Part B Reference Manual](#).

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13. Can I use a patients past history in the review of systems (ROS) or history of present illness (HPI) elements of the E/M score sheet?

No. The ROS and HPI elements pertain to the chief complaint and the reason for the patients visit that day, not past history information.

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14. Where can I find the E/M specialty score sheets on the Internet?

They are found at <http://www.highmarkmedicare.com/partb/reference/scoresheets.html>.

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15. When scoring the review of systems (ROS), can you use the systems addressed in the history of present illness (HPI) elements or is that "double dipping"?

According to The [Medicare Part B Reference Manual, Chapter 23](#), "Evaluation and Management", section e.3, ROS inquiries are questions concerning the system(s) directly related to the problem(s) identified in the HPI. Therefore, it is not considered "double dipping" to use the system(s) addressed in the HPI for ROS credit.

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16. Can you bill for an E/M visit on the same day as a cardiac catheterization?

You may bill an evaluation and management (E/M) service with modifier 25 if there is a significant, separately identifiable E/M service by the same physician on the same day of a procedure or other service. For example, if on the same day as the cardiac catheterization the physician performed an E/M service that addressed the patient's diabetes, the E/M service is a significant, separately identifiable service that may be billed and reimbursed using modifier 25 with the E/M code. For more information, please refer to the [Medicare Part B Reference Manual, Appendix B](#).

However, the reimbursement for the catheterization includes a pre-operative E/M visit; therefore, it is inappropriate to bill the E/M for a pre-operative visit with modifier-25. The global surgery guidelines are available in the [Medicare Part B Reference Manual, Chapter 22](#).

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17. Does the body areas of the examination section of the 1995 score sheet work exactly as the organ systems?

You may count up to 7 body areas or 7 organ systems for an expanded problem focused or detailed examination, and you may count 8 body areas or 8 organ systems for a comprehensive examination. However, you may not add body areas and organ systems together to determine the level of the examination.

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18. How do we get credit for a test under the Amount and/or Complexity of Data Reviewed section of the E/M score sheet?

Credit is given in this section when the test (clinical lab test, test in the radiology section of the CPT, or test in the medicine section of the CPT) is documented as reviewed and/or ordered, and the service is medically indicated.

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19. What constitutes additional workup in the Amount and Complexity of Data grid for Medical Decision Making?

The number of possible diagnosis and/or the number of management options that must be considered is based on the number of types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician. For each encounter an assessment clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation. Additional workup is defined as anything that is being done beyond that encounter at that time. For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision making. For more information, please refer to The [Medicare Part B Reference Manual, Chapter 23, "Evaluation and Management"](#).

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20. My patient visits are dominated primarily by counseling and coordination of care. How do I bill for this type of patient visit?

When counseling and/or coordination of care dominate more than 50% of the time that a physician spends with a patient during an evaluation and management (E/M) service, then time may be considered as the controlling factor to qualify the E/M service for a particular level of care. If the physician elects to report the level of care based on counseling and/or coordination of care, then a number of factors must be documented in the patient's medical record. The following must be documented in the patient's medical record in order to report an E/M service based on time: The total length of time of the E/M visit; evidence that more than half of the total length of time of the E/M visit was spent in counseling and coordinating of care; and the content of the counseling and coordination of care provided during the E/M visit.

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21. If I personally review a film, e.g. x-ray, EKG in my office, will I receive additional credit on the E/M score sheet?

Yes, two points may be given for independent visualization of an image, tracing or specimen on the E/M score sheet in the Amount and/or Complexity of Data Reviewed section under the Medical Decision Making key component. The medical record documentation must clearly indicate that the physician/qualified NPP personally (independently) visualized and performed the interpretation of the image, tracing or specimen and that he/she did not simply read/review a report from another physician/qualified NPP. For additional information on E/M services, please refer to [Medicare Part B Reference Manual, Chapter 23](#) and/or the [E/M score sheets](#).

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22. Can the Review of Systems (ROS) and/or Past, Family, Social History (PFSH) sections of the History component of an Evaluation and Management (E/M) be recorded by ancillary staff?

Yes, according to the 1995 E/M Documentation Guidelines, The ROS and/or PFSH section of the history component of an E/M may be recorded by ancillary staff. There must be a notation supplementing or or confirming the information that was recorded by the ancillary staff member by the physician.

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23. When is it appropriate to append modifier 51 to a service?

When multiple procedures, other than evaluation and management services, are performed on the same day or at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier 51 to the additional procedure or service code(s). This modifier should not be appended to designated "add-on" codes or codes identified in the CPT manual as modifier 51 exempt.

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