Workbook STD Clinic Billing –Coding Evaluation & Management Visits

Developed by the University of Rochester
Center for Community Practice
Capacity Building Assistance (CBA)

**Adapted from 1997 CMS Guidance
Using Single Organ System Guidelines
Consistent with August 2017
Evaluation and Management Services
Guidance www.cms.gov**

Introduction

The purpose of this workbook is to provide information and tools to enhance the capacity of clinics in health departments and other settings in the documentation and coding of Evaluation and Management visits to increase their billing revenue.

Overview: Coding for Evaluation and Management (E&M) Visits

Coding for E&M visits depends on three main components of the clinic visit:

- What kind of history was taken
- What kind of examination was performed
- What was the level of complexity of the medical decision making

History	Examination	Medical Decision Making
❑ Chief Complaint (CC) ❑ History of Present Illness (HPI) • Brief • Extended ❑ Review of Systems (ROS) • Problem Pertinent • Extended • Complete ❑ Past Medical, Family, Social History (PFSH) • Pertinent • Complete	❑ Problem Focused ❑ Extended Problem Focused ❑ Detailed ❑ Comprehensive	❑ Straightforward ❑ Low Complexity ❑ Moderate Complexity ❑ High Complexity

Choose a Set of Guidelines to Follow that Best Matches Your Clinic

The Centers for Medicaid and Medicare Services (www.cms.gov) has issued a guidance document for coding Evaluation and Management (E&M) Visits, which can be found in its entirety in the *Evaluation and Management Services (August 2017).*

There are **three sets of documentation guidelines** currently in use for selecting E&M visit billing codes:

- 1995 Guidelines;
- 1997 Guidelines – Multi-System Exam; and
- 1997 Guidelines – Single Organ System Exam

The main difference between the 1995 and 1997 Guidelines is the exam component of the visit. In the 1995 Guidelines, there is one set of guidelines for the exam component. In the 1997 Guidelines, there are two sets; a Multi-System Exam or a Single Organ System Exam. Each requires documentation of different exam elements for each E&M type visit. Each clinic must

review the types of exams usually performed to determine which of the sets to implement. For example, in a specialized primary care clinic such as an STD or family planning clinic, the 1997 Single Organ System Guidelines for Genitourinary Examination may be more applicable.

Components and Elements Required for Documentation for E&M Visits

The components and elements that must be documented for each E&M visit are presented in detail in the following three sections:

1. History
2. Examination
3. Medical Decision Making

Section 1. History

There are four main types of history conducted; 1) chief complaint, 2) brief history of present illness (HPI), 3) review of systems (ROS), and 4) past, family, and/or social history (PFSH). The chief complaint is always required in the documentation of an E & M visit. The following table shows the history elements that may be documented for the other three types of history.

HPI **History of Present Illness**	**ROS** **Review of Systems**	**PFSH** **Past Medical, Family, & Social History**
• Location • Quality • Severity • Timing • Duration • Context • Modifying factors • Associated Signs/Symptoms	• Constitutional symptoms • Eyes • Ears, nose, mouth, throat • Cardiovascular • Respiratory • Gastrointestinal • Genitourinary • Musculoskeletal • Skin • Neurologic • Psychiatric • Endocrine • Hematologic/lymphatic/ immunologic • Allergic/immunologic	• Past history • Family history • Social history
Total HPI elements = 8; Elements needed for maximum reimbursement = 4	Total ROS elements = 14; Elements needed for maximum reimbursement = 10 or more	Total PFSH elements = 3; Elements needed for maximum reimbursement = 2 or all 3

Summary of History Elements Required for Each Level of E&M Visit

There are four levels of E & M visits; 1) Problem Focused, 2) Expanded Problem Focused, 3) Detailed, and 4) Comprehensive. The table below summarizes the types of history and, shown in parentheses, the number of history elements required for documentation for each level of E&M visit.

Levels of E & M Visits	Types of History and Number of Elements		
	HPI	ROS	PFSH
Problem Focused	Brief (1-3)	N/A	N/A
Expanded Problem Focused	Brief (1-3)	Problem pertinent (PP) [PP/1]	N/A
Detailed	Extended (4+)	Extended [PP + (2-9)]	Pertinent (1)
Comprehensive	Extended (4+)	Complete [PP + (10+)]	Complete (2-3)

A brief HPI includes documentation of one to three (1-3) HPI elements. An extended HPI requires 4 or more (4+) HPI elements.

A problem pertinent (PP) ROS includes one system review (PP/1). An extended ROS includes documentation of PP *and* a review of two to nine systems [PP + (2-9)]. A complete ROS includes documentation of PP *and* a review of 10 or more systems [PP + (10+)].

A pertinent PFSH is a review of at least one item of the PFSH. A complete PFSH is a review of two or three (2-3) items of the PFSH.

Section 2. Examination – Single Organ System (Genitourinary)

The number of bulleted elements performed varies for each type of E&M visit. Sections below shaded in blue represent the usual examination elements performed in an STD clinic setting.

Organ System or Body Area	Examination Elements
Constitutional	• Measurement of any three of the following seven vital signs: 1) sitting or standing BP, 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.)

Organ System or Body Area	Examination Elements
	• General appearance of patient (e.g. development, nutrition, body habitus, deformities, attention to grooming)
Neck	• Examination of neck (e.g. masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g. enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (e.g. intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g. breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g. swelling, varicosities) and palpation (e.g. pulses, temperature, edema, tenderness)
Chest (Breasts)	[See genitourinary – female]
Gastrointestinal	• Examination of abdomen with notation of presence of masses or tenderness • Examination for presence or absence of hernia • Examination of liver and spleen • Obtain stool sample for occult blood when indicated
Genitourinary – Male	• Inspection of anus and perineum *Examination (with or without specimen collection for smears and cultures) of genitalia including*: • Scrotum (e.g. lesions, cysts, rashes) • Epididymides (e.g. size, symmetry, masses) • Testes (e.g. size, symmetry, masses) • Urethral meatus (e.g. size, location, lesions, discharge) • Penis (e.g. lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities) *Digital rectal examination including:* • Prostate gland (e.g. size, symmetry, nodularity, tenderness) • Seminal vesicles (e.g. symmetry, tenderness, masses, enlargement • Sphincter tone, presence of hemorrhoids, rectal masses

Organ System or Body Area	Examination Elements
Genitourinary – Female	Includes **at least seven of the following eleven** elements identified by bullets: • Inspection and palpation of breasts (e.g. masses or lumps, tenderness, symmetry, nipple discharge) • Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses *Pelvic examination (with or w/out specimen collection for smears and cultures) including:* • External genitalia (e.g. general appearance, hair distribution, lesions) • Urethral meatus (e.g. size, location, lesions, prolapse) • Urethra (e.g. masses, tenderness, scarring) • Bladder (e.g. fullness, masses, tenderness) • Vagina (e.g. general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Cervix (e.g. general appearance, lesions, discharge) • Uterus (e.g. size, contour, position, mobility, tenderness, consistency, descent or support) • Adnexa/parametria (e.g. masses, tenderness, organomegaly, nodularity) • Anus and perineum
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (e.g. rashes, lesions and ulcers)
Neurological/ Psychiatric	*Brief assessment of mental status including:* • Orientation (e.g. time, place, and person) and • Mood and affect (e.g. depression, anxiety, agitation)

Examination: Single Organ System Content and Documentation Requirements

Level of Exam and E&M Visit	Perform and Document
Problem Focused	**1-5 bulleted elements**

Examination: Single Organ System Content and Documentation Requirements

Expanded Problem Focused	**At least 6 bulleted elements**
Detailed	**At least 12 bulleted elements**
Comprehensive	**All bulleted elements**

Section 3. Medical Decision Making

The Level of Medical Decision Making (MDM) indicates the overall complexity of the visit. Three main components are assessed: 1) the number of diagnosis (or diagnoses) or treatment options, 2) The amount and complexity of data reviewed, and 3) the risk of complications and/or morbidity/mortality. Factors considered are:

- How hard did the clinician have to work to determine the diagnosis (or diagnoses) and treatment(s), as well as other management needed?
- How much clinical data was obtained and reviewed?
- What is the risk to the patient for the diagnosis if the treatment doesn't work or what is the risk of the treatment itself?

The following table shows the required documentation for each component and the four levels of MDM. **Two of the three** components met or exceeded in each row of the table determines the Level of the MDM.

A. No. of Diagnoses / Treatment Options	B. Amount and/or Complexity of Data to be Reviewed	C. Risk of Complications and/or Morbidity/Mortality	Level of Medical Decision Making
Minimal (0-1)	Minimal/None (0-1)	Minimal	**Straightforward**
Limited (2)	Limited (2)	Low	**Low Complexity**
Multiple (3)	Moderate (3)	Moderate	**Moderate Complexity**
Extensive (4+)	Extensive (4+)	High	**High Complexity**

A. Number of Diagnoses/Treatment Options:

The number of possible diagnoses and/or the number of treatment options is often documented in the clinical impression listing problems and rule-outs and in the diagnosis part of the medical record.

An example in the clinical impression section may look like this: 1. Contact to gonorrhea (GC); 2. GC repeater; 3. Bisexual male; 4. Unprotected receptive anal intercourse (URAIC); 4. Urethritis with exposed oral, rectal sites.

Diagnosis: GC urethritis, await pharyngeal and rectal results

Treatment: Ceftriaxone 250 mg IM and Azithromycin 1000 mg. PO STAT

A. Criteria for Diagnosis/Treatment Options	
Self-Limiting or Minor Problem (max of 2)	**1 point each**
Established problem (to examiner) stable or improved (max of 1)	**1 point**
Established problem (to examiner) worsening (max of 1)	**2 points**
New problem (to examiner) no additional work-up planned (max of 1)	**3 points**
Condition new (to provider) and further work-up is planned (max of 1)	**4 points**

Score – Number of Diagnoses/Treatment Options	
Minimal	**< 1 or 1**
Limited	**2**
Multiple	**3**
Extensive	**4**

B. Amount and/or Complexity of Data Reviewed:

Data review refers to the amount and/or complexity of medical records, results of diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed. Obtaining and reviewing past medical records is considered part of the data review. Results of review must be documented as to relevancy to presenting problem for a given visit. For an STD Clinic visit, looking through past clinic or morbidity records is relevant to every visit.

B. Criteria for Data Review	
Laboratory testing ordered and/or reviewed	**1 point**
Radiology testing ordered and/or reviewed	**1 point**
Medical testing ordered and/or reviewed	**1 point**
Discussion of results with physician who performed or interpreted the test	**1 point**
Direct & independent review & interpretation of specimen, tracing, or image	**1 point each**
Decision to obtain old records and/or collateral information	**1 point**

B. Criteria for Data Review	
Review and written summary of old records and/or collateral information	**2 points**

Score – Data Review	
Minimal or none	**< 1 or 1**
Limited	**2**
Moderate	**3**
Extensive	**4 or more**

C. Level of Risk of Significant Complications, Morbidity and/or Mortality:

The assessment of level of risk is based on the chance of significant complications, morbidity and/or mortality associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options. The table below outlines in detail the level of risk. The item checked in the column that represents highest risk determines overall level of risk. For example, if prescription drug management is needed, the level of risk is moderate.

Table of Risk			
Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem, e.g. cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis KOH prep Ultrasound, e.g. echocardiography	Rest Gargles Elastic bandages Superficial dressings
	Two or more self-limited or minor problems One stable chronic illness, e.g. well controlled hypertension, non-insulin dependent diabetes, cataract, BPH **Acute uncomplicated illness or injury, e.g.**	Physiologic tests not under stress, e.g. pulmonary function tests Non-cardiovascular imaging studies with contrast, e.g. barium enema Superficial needle biopsies Clinical laboratory tests	Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives

Table of Risk			
	cystitis, allergic rhinitis, simple sprain	requiring arterial puncture Skin biopsies	
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment **Two or more stable chronic illnesses** Undiagnosed new problem with uncertain prognosis, e.g. lump in breast **Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis** Acute complicated injury, e.g. head injury with brief loss of consciousness	Physiologic tests under stress, e.g. cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram, cardiac catheterization Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors **Prescription drug management** Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
	One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g. multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others,	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography	Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

Table of Risk			
	peritonitis, acute renal failure **An abrupt change in neurologic status, e.g. seizure, TIA, weakness, sensory loss**		

New Patient Office Visit

Patient ***has not*** had face-to-face service by provider of same specialty within a group practice in the past 3 years.

Three of the three key components must meet or exceed the stated requirements to qualify for a particular level of services				
Code	**99201 Problem Focused**	**99202 Expanded Problem Focused**	**99203 Detailed**	**99204 Comprehensive**
Chief Complaint	Required	Required	Required	Required
1. History	1-3 HPI	1-3 HPI 1 problem pertinent (PP) ROS	4 HPI 1 PP ROS & 2-9 ROS 1 PP PFSH	4 HPI 1 PP ROS & 10+ ROS 2-3 PFSH
2. Exam – Single Organ System	1-5 bulleted elements	6 bulleted elements	12 bulleted elements	All bulleted elements
3. Medical Decision Making	Straightforward	Straightforward	Low	Moderate
Time	10	20	30	45

99205 not shown as this level of care is not normally seen in an STD clinic.

Established Patient Office Visit

Patient ***has*** received services from provider of same specialty within the same practice, in the past 3 years

Two of the three key components must meet or exceed the stated requirements to qualify for a particular level of services				
Code	**99211***	**99212 Problem Focused**	**99213 Expanded Problem Focused**	**99214 Detailed**
Chief Complaint	Required	Required	Required	Required
1. History	Minor problem provider, may not see a Qualified Provider (QP) (can bill 3rd party if seen by RN)	1-3 HPI	1-3 HPI 1 problem pertinent (PP) ROS	4 HPI 1 PP ROS & 2-9 ROS 1 PP PFSH
2. Exam – Single Organ System		1-5 bulleted elements	6 bulleted elements	12 bulleted elements
3. Medical Decision Making		Straightforward	Low	Moderate
Time	5	10	15	25

99215 not shown as this level of care is not normally seen in an STD clinic

* 99211 - May not require the presence of MD or NP/PA and may not include an exam. Patient must have been seen previously and this is a minimal (5 min) problem, or a follow up – not a new problem.

Exception to Billing by History, Exam, and Medical Decision Making When Time is the Controlling Factor

Billing by Time as the Controlling Factor: When **counseling** and **coordinating care** comprise more than 50% of the face to face time spent with the patient and/or family, **time** can be used as the key controlling factor in determining the level of E&M service billed. Both the extent of counseling and coordination of care and the total length of the visit must be documented in the medical record including the following statement:

"I spent 30 minutes with this patient; Greater than 50% of this _____ minute visit was spent in counseling and coordinating care of _____."

In this case, the provider uses the E&M CPT code that corresponds to the time spent, and does not meet the required history, exam, and medical decision making elements.

References

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