EVALUATION AND MANAGEMENT DOCUMENTATION

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INTRODUCTION:

Most patients' visits with their doctor are called Evaluation and Management (E/M) services.

In the 1980's, Congress mandated a system to categorized these visits. Working with medical societies, the Health Care Financing Administration, HCFA, developed families of E/M codes with rules about how to assign visits to a particular family and level of service. HCFA since changed its name to the Center for Medicare and Medicaid Services (CMS). Their rules established standards that could be audited to assure that codes were correctly assigned. The standards were based on Documentation, i.e. the visit's notes.

These rules are awkward and undesirable. But they are the rules by which we are paid and audited by most carriers and hospitals. It is important for all neurologists to know the rules well. This syllabus attempts to show how to work through the maze of options, and still meet documentation standards without investing excessive time.

These rules use the 1997 standards. These rules benefit Neurology with the implementation of a neurological single system examination. The standards are available on line at:

http://www.cms.hhs.gov/medlearn/emdoc.asp

DEFINITIONS:

New or Established:

Patients are **new** when they have not been seen in the past 3 years by any neurologist in the same group practice. Subspecialties of neurology (i.e. epilepsy, vascular) are not recognized for this purpose.

If they have been seen in the past 3 years, they are **established** patients.

Consults:

A **consult** is a request for an opinion. A consult is a one-time visit. A referral to assume the ongoing care of a patient is not a consultation (e.g. a patient sent to your office from an emergency room).

Since consults are one-time visits, there is no differentiation of new and established. Consults can be requested on patients you had seen previously.

Who can order a consult? A physician or another health care provider can request a consult. The patient or family cannot request a consult.

Document who requested it and why. Show that you sent your opinion to the referring physician.

Sometimes after a consultation, the consultant may undertake the ongoing care of that patient. In that case, consultation codes are used for that first visit. The **established patient visit codes** are used for additional outpatient visits, and **subsequent hospital visit codes** for inpatients.

Site of Service:

Separate code families exist for

- inpatient
- outpatient
- inpatient observation
- emergency department
- nursing home
- rest home
- home visits

If you do a consult **in the ER**, code it as an outpatient consult. But if the patient is hospitalized later that day, code your ER consult as an inpatient consult.

Hospitalized patients:

Admission note as the attending is an **initial hospital visit**. Subsequent days as the attending are **subsequent hospital visits**.

A consultation code, such as 99254, can be appropriately used for an **inpatient consultation**, even if you had seen the same patient prior to this hospitalization.

Sometimes after a consultation, the consultant may undertake all or part of the ongoing care of that patient. The **established patient codes** are used for additional outpatient visits. That is the same code as used by the primary attending.

E/M on the Same Day as a Procedure:

Sometimes a physician performs another **procedure on the same day** as an E/M service. A procedure might be a trigger point injection or an LP. (EMGs and EEGs are exempted from this rule.) In general, in these cases, modifier 25 must be used with the E/M service. This verifies that the E/M was a separate service from the procedure.

OTHER TYPES OF EVALUATION AND MANAGEMENT SERVICES:

Prolonged Care:

99354: First hour of prolonged outpatient service (31 to 74 minutes)
99355: Each additional half hour

99356-**99357**: Similar codes for inpatient setting

Prolonged care codes are used when service involving direct patient contact exceeds the usual, and is reported in addition to the appropriate E/M code for the workup.

The reason and time taken for the prolonged service must be included in the note.

Emergency Room:

Emergency Room codes **99281** - **99285** are for the primary ER physician.

Most neurologists' ER services are as a consultant. Use Outpatient Consult codes **99241- 99245.** If the patient is admitted to the hospital, use Inpatient codes instead.

Critical Care services provided in an emergency room should be reported using the Critical Care codes **99291**-**99292,** e.g. for initiating tPA.

Critical Care:

99291: First hour of critical care (31-74 minutes)
99292: each additional 30 minutes

They are for care for an unstable, critically ill patient. They are not simply for routine consults or daily follow-up visits of ICU patients. They are coded by time, representing bedside and other physician work directly related to the patient's care during a 24 hour period. The time need not be continuous. More than one physician can used these codes for each patient, if each is managing part of the patient's care. In that case, using different diagnosis codes can facilitate payment from some carriers.

If the total time is less than 30 minutes, another appropriate hospital care E/M code should be used.

Hospital Discharge Day Codes:

99238: 30 minutes or less
99239: more than 30 minutes

The discharge day is coded as **hospital discharge day** management. This code allows the attending physician to summarize all services on the day of discharge i.e., final examination, discussion, instructions, and record preparation. Time need not be continuous. Total time must be documented.

Common Errors

1. Failure to mention the referring physician's name for consults.
2. Incorrect code category for consults, new and established patients.
3. Insufficient documentation to support complexity of decision-making
4. Failure to note face-to-face time
5. Incomplete ROS

OVERVIEW OF THE DOCUMENTATION STANDARDS:

There are two different ways to choose the level of service:

- the bulleted system
- the counseling or coordination of care optional system

You should be familiar with each.

THE BULLETED SYSTEM

Three parts to Bulletted Notes:

There are three principal parts to E/M documentation standards:

- History
- Physical Exam
- Medical Decision Making

Each has several components or options:

1. History

- Chief complaint (CC)
- History of the present illness (HPI)
- Past medical, family and social history (PFSH)
- Review of systems (ROS)

2. Physical Exam

25 elements of the Neurological Single System Exam (Neuro-SSE)

3. Medical Decision Making

- Number of diagnoses or management options
- Data complexity
- Risk of morbidity & mortality

This simplified outline will help guide you to the correct **level of service** (LOS).

All visits require a stated chief complaint.
All new patient visits and consultations require a history and physical examination.
LOS is driven mainly by MDM.

A complete complicated schematic of LOS is presented in the Appendix.

New Patients and Consults:

Here are three steps to decide the level of service:

Step One: Does the Patient's Problem qualify for High LOS?

High LOS is used for patients with any of:

- Chronic illness with severe exacerbation/progression/side effects
- Risk of mortality or serious morbidity
- Abrupt neurological change (e.g. TIA, CVA, seizure)
- Use high risk medications (e.g. Coumadin)
- Are given parenteral controlled substances

Most other neurological visits will be moderate.

Step Two: Does the Visit's Work Done qualify for High?

For High LOS, your note should describe at least one of these:

- Extensive differential diagnosis
- Extensive management options
- Extensive data/records/test results reviewed
- Highly complex decision making

Extensive differential or management can be:

- one new significant presenting problem needing additional assessment, or
- two continuing chronic problems inadequately controlled

The additional assessment or management should result in orders for each problem, such as a lab request, a new or changed prescription, or ordering a test.

Step Three: History or Exam or Both

Follow up visits require either a History or an Exam.
New patient visits and consults require both a History and an Exam.

New patients, consults, and admission notes all need:

1	CC
4	facts HPI
3	facts PSFH (one fact each about past, family and social history)
10	system ROS
23	Neurological SSE

Follow up visits:

Hospital follow-up visit, level 1:
Medical Decision Making: No new or continuing problems needing new actions
Note has Chief complaint, and anything about the HPI

Hospital follow-up visit, level 2:
Medical Decision Making: One continuing problem needing evaluation/management
Note has Chief complaint, pertinent positives and negatives about the problem, plans re labs/meds/etc to address the problem

Hospital follow-up visit, level 3:
Medical Decision Making: New significant problem, or significant risk of morbidity or prolonged functional impairment, or many ongoing significant problems; and these problems need evaluation/management
Note has Chief complaint, 4 facts re HPI, mention some current medications (Past Hx), 2-system ROS, and plans re labs/meds/etc to address the problems.

Office established patient, level 3:
Medical Decision Making: One self-limited or stable chronic problem of low risk, needing evaluation/management
Note has Chief complaint, pertinent positives and negatives about the problem, plans re labs/meds/etc to address the problem.

Office established patient, level 4:
Medical Decision Making: One new or two chronic problems, or an uncertainty about risk or prognosis; these problems need evaluation/management
Note has Chief complaint, 4 facts re HPI, mention some current medications (Past Hx), 2-system ROS, and plans re labs/meds/etc to address the problems.

Office established patient, level 5:
Medical Decision Making: High as discussed above for New and Consult patients
Note has Chief complaint, 4 facts re HPI, med list, a social fact, 10 system ROS, and plans re labs/meds/etc to address the problems.

Examples of established outpatients whose presentation and visit work qualifies for High:

- An MS patient with 1 new symptom needing evaluation/treatment
- An MS patient with 2 inadequately controlled problems
- A Parkinsons patient who fell
- A patient who still has seizures and AED side effects
- A patient recently started on Tegretal
- A patient on Coumadin

Review of Systems:

These 14 systems are recognized. Ten of the 14 are required for a comprehensive ROS.

Constitutional (fever, weight)	Musculoskeletal
Eyes	Skin, breast
Ears, nose, throat	Neurological
Cardiovascular	Endocrine
Respiratory	Hematological/lymphatic
Gastrointestinal	Allergic/immunologic
Genitourinary	Psychiatric

ROS can be done in any of several ways:

- completed in the E/M note
- on a separate sheet
- by reference to another note

Facts mentioned elsewhere in the note do count, e.g. facts mentioned in the HPI.

ROS on a separate sheet: ROS can be on a separate sheet, e.g. one filled out by the patient or a nurse just before the visit. In that case, the physician must sign and date it, and refer to it in the E/M note. For example, "See attached ROS sheet."

ROS by reference: ROS can be documented by referring to another specific note. The new note would state, "ROS unchanged since note of _____ (date and person who wrote it)." For example, "ROS unchanged since my note of 6/23."

COUNSELING AND COORDINATION OF CARE OPTIONAL METHOD:

Counseling is a discussion with the patient or family about diagnoses, test results, recommended tests, prognosis, treatment alternatives, compliance, risk factor reduction, and patient and family education.

Coordination of care is arranging for care with other health care providers. This includes any type of such activity.

This can be used in place of the bulleted HX-PX-MDM system. It uses time to set LOS.
The documentation must state:

- the number of minutes spent face-to-face, and
- that more than 50% of the time was spent on counseling/coordination of care, and
- a general idea of what was the counseling/coordination of care.

Time is:

- face-to-face with patient or family (outpatient)
- bedside and on unit/floor (inpatient)

For example a new outpatient note can say, ">1/2 this 60 min visit spent counseling pt/wife re med options, causes of seizures, prognosis, risk, compliance, etc." That sentence alone meets the level 5 new outpatient documentation standards. When using this documentation method, no history or exam elements are required. The rest of your note can be whatever is appropriate for good patient care.

The following tables show minimum time (in minutes) needed for each common service:

New Outpatient

Time	Code
10	**99201**
20	**99202**
30	**99203**
45	**99204**
60	**99205**

Established Outpatient

Time	Code
5	**99211**
10	**99212**
15	**99213**
25	**99214**
40	**99215**

Inpatient Admitting Note

Time	Code
30	**99221**
50	**99222**
70	**99223**

Hospital Subsequent Care

Time	Code
15	**99231**
25	**99232**
35	**99233**

Outpatient Consult

Time	Code
15	**99241**
30	**99242**
40	**99243**
60	**99244**
80	**99245**

Inpatient Consult

Time	Code
20	**99251**
40	**99252**
55	**99253**
80	**99254**
110	**99255**

NEUROLOGICAL SINGLE SYSTEM EXAM (1997 Guidelines):

There are 25 elements. All must be documented, except in the cardiovascular group where you have a choice of one out of three elements.

The required elements are:

- General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
- 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)
- Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
- Cardiovascular: Document any **one** of these three elements:
    - Examination of carotid arteries (e.g., pulse amplitude, bruits)
    - 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)

Evaluation of higher integrative functions including:

- Orientation to time, place and person
- Recent and remote memory
- Attention span and concentration

- Language (e.g., naming objects, repeating phrases, spontaneous speech)

- Fund of knowledge (e.g., awareness of current events, past history, vocabulary)

Test the following cranial nerves:

- 2nd cranial nerve (e.g., visual acuity, visual fields)
- 3rd, 4th and 6th cranial nerves (e.g., pupils, eye movements)
- 5th cranial nerve (e.g., facial sensation, corneal reflexes)
- 7th cranial nerve (e.g., facial symmetry, strength)
- 8th cranial nerve (e.g., hearing with tuning fork, whispered voice and/or finger rub)
- 9th cranial nerve (e.g., spontaneous or reflex palate movement)
- 11th cranial nerve (e.g., shoulder shrug strength)
- 12th cranial nerve (e.g., tongue protrusion)

Sensation:

- Examination of sensation (e.g., by touch, pin, vibration, proprioception)

Motor:

- Muscle strength in upper and lower extremities

- Muscle tone in upper and lower extremities (e.g., flaccid, cogwheel, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation, dyskinesia)

- Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (e.g., Babinski)

- Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

- Examination of gait and station

All twenty-three are needed for a comprehensive neurological single system exam.

For example, the following two notes satisfies the 23 elements:

> Lethargic, 145/92, 72, 37.9Tmax, fundi ok, no bruit
> A&0x3, dig 5F, 2/3 at 5´, fluent, knows recent events
> Fields&EOMs full, face sens/power Nl, hear decr AS,
> palate/tongue mvmt midline, SCM Nl
> Decr PP distal LEs
> Nl power/tone x 4 extr, absent ankle DTRs, toes mute,
> FNF Nl, gait can't test
>
> WDWN, 120/80, HR 72, RR 16, fundi benign, cor RR
> A&O, Nl memory/atten'n, good naming/vocab
> Acutiy OK, EOMs full, face sens/power Nl, hears well, palate/tongue move midline, shoulder shrug Nl
> Nl PP 4 extr, Nl power/tone/DTRs 4 extr, Nl FNF/gait

Some hints:

- You get credit for what you cannot do, but mention it
  e.g. coma exam – can't evaluate many elements
- If normal, can say so
  e.g. Nl alert/memory/atten'n/speech/knowledge

- If abnormal, must say what was found
  e.g. Cannot say "DTRs abnormal"
- Cannot bunch together CNs
  e.g. Cannot say "CN OK 2-12"

SUPERVISION OF HOUSE STAFF IN A TEACHING SETTING

When supervising residents in a teaching setting, the attending physician must document his/her presence and involvement in patient care, and refer to the house officer's notes. The level of service (LOS) is based upon the same principles. The house officer's and attending's notes are combined together for documentation purposes. Therefore, the house officer's notes must meet the traditional documentation standards, or else any missing pieces must be in the attending's note.

The teaching physician must be physically present and verify his/her involvement in the case by a written or dictated note. The attending's note should include statements that he or she:

- *examined* the patient
- participated with the house officer in formulation of the *impressions*
- participated with the house officer in formulation of the *plans*
- *reviewed* and *agreed* with the house officer's note or state the discrepancies
- link the attending's note with the house officer's note with words like *we*.

An example of a brief, qualifying teaching physician linking statement is:

> "Dr Jones and I examined the patient. We developed the impressions and plans together. I agree with Dr Jones's note above."

An INSUFFICENT NOTE is: "Seen and examined".

When timed-based codes are billed, the teaching physician must be present for that period of time determined by the code. One cannot add the house officer's time to the attending physician's time to arrive at a billing level for the time-based codes.

APPENDIX 1:

Medical Decision Making

Quantifying the complexity of medical decision making (MDM) has proven to be the most complex and difficult task for neurologists. This key element was originally left vague, and the perceived need by third party payers for audit criteria in this area has resulted in more specificity and thus less flexibility than many physicians are comfortable with. Nevertheless, the overall outlines are reasonable although complicated, and documentation of this critical area for neurological patients is crucial to seeking adequate reimbursement for services rendered.

Four levels of MDM complexity are recognized:

1. Straightforward
2. Low
3. Moderate
4. High

To set the MDM level, there are two formal steps. In the first, three aspects are assessed. Thereafter, the MDM level is set as the middle of those three aspects. This is explained more below.

Three aspects of complexity:

Three aspects of complexity have been chosen as the key components to determine the complexity level:

1. **Number of diagnosis or management options** (minimal, limited, multiple, or extensive).

2. **Complexity of data reviewed** (minimal, limited, moderate, or extensive)

3. **Risk of morbidity and mortality** (minimal, low, moderate, high) - recognizes that risk may arise from the presenting problem, from diagnostic testing, or from the treatment. Note the "high risk" assigned to abrupt changes of neurological status.

The Marshfield Systematic Approach to Measuring Complexity:

This system is one way to assess Medical Decision Making. It is not required to use this system. But it is commonly used by auditors.

Three aspects of complexity have been chosen as the key components to determine the complexity level:

1. **Number of diagnosis or management options** (minimal, limited, multiple, or extensive). This scoring scheme recognizes that established diagnoses are less complex than undiagnosed problems, improving problems less complex than non-resolving or progressing, and that the need for additional assessment implies increased complexity.

Each established diagnosis (to the examiner): improved, well controlled, resolved or resolving :	1 pt
Each established diagnosis (to the examiner): inadequately controlled, worsening, failing to improve as expected:	2 pt
For 1 or more new problems, not previously diagnosed or identified for which additional assessment is not required (maximum of 1): *(may include new symptom which may or may not be due to established disease)*	3 pt
For each new problem not previously diagnosed or identified for which additional assessment is planned or performed: *(may include new symptom which may or may not be due to established disease)*	4 pt

Sum: 1 = minimal, 2 = limited, 3 = multiple, 4 or more = extensive

2. **Complexity of data reviewed** (minimal, limited, moderate, or extensive) This scoring scheme recognizes that the extent of investigation already done or planned is a measure of complexity of the case. In addition the need to obtain and review additional history or records (from health care providers or family) indicates increased complexity of the problem.

Order and/or review reports of pathology and lab tests:	1 pt
Order and/or review reports of radiology tests:	1 pt
Order and/or review reports of other tests: (EEG, EMG, NCSs, SSEPs)	1 pt
Discussion of test results with performing physician	1 pt
Direct visualization and independent interpretation of a specimen, an image or tracing previously interpreted by another or discussion of the results with MD who performed/interpreted study:	2 pt
Deciding to obtain old records/additional history:	1pt
Summarizing old records or additional history from someone other than patient and/or discussion of case with another health care provider	2pt

Sum: 0-1 = minimal or none, 2 = limited, 3 = moderate, 4 or more = extensive

3. **Risk of morbidity and mortality** (minimal, low, moderate, high) - recognizes that risk may arise from the presenting problem, from diagnostic testing, or from treatment. Note the "high risk" of abrupt changes of neurological status.

Chose the Highest of following 3:

Risk of presenting problem

Low = 1 stable chronic illness, well controlled (not CNS progressive or degenerative diseases)
Moderate = 1 chronic illness with mild exacerbation, progression, or side effects of treatment (worsening headache or back pain), 2 or more stable chronic illnesses, undiagnosed new problem of uncertain prognosis (dizziness, new back/leg pain, new headache), acute illness with systemic symptoms
High = 1 or more chronic illnesses with severe exacerbation, progression, or side effects from treatment (markedly worsening headache or back/leg pain preventing work), acute or chronic illnesses that pose a threat to life or bodily function including an abrupt change in neurological status. (TIA, seizure, stroke, weakness or sensory loss, PNS or CNS degenerative disease)

Risk of investigation ordered

Minimal = blood, ECG, ultrasound, X-ray, urine (probably all neurophysiology except EMG)
Low = non-stress physiology, barium swallow, superficial needle biopsy, arterial puncture (probably EMG)
Moderate = physiology with stress testing, angiograms without risk factors, CSF analysis
High = angiograms with risk factors

Risk of treatment ordered

Low = over-the-counter drugs, PT/OT, IV fluids with additives
Moderate = referral for (perform or decision) major elective surgery w/out risk factors, prescription drug management, nuclear medicine referral, IV fluids with additives.
High = referral for (perform or decision) major elective surgery with risk factors (symptomatic TIA patient, laminectomy with previous surgery), or emergency surgery regardless of risk factors (laminectomy with new deficit), parenteral controlled substances, drug therapy requiring intensive monitoring for toxicity (antiepileptics, steroids, azathioprine, warfarin, ticlopidine), and treatment with 4 or more prescription drugs, and decision to DNR or to de-escalate care because of poor prognosis.

Moving from the Three Aspects to the Medical Decision Making Level:

Final determination: The overall decision-making complexity is the level supported by 2 of the 3 subcategories.

# diagnoses or management options	Data Complexity	Risk of morbidity & mortality (dz, dx, or rx)	DECISION MAKING
minimal	minimal or none	Minimal	**Straightforward**
limited	limited	Low	**Low**
multiple	moderate	Moderate	**Moderate**
extensive	extensive	High	**High**

Example 1:

# diagnoses or management options	Data Complexity	Risk of morbidity & mortality (dz, dx, or rx)	DECISION MAKING
Minimal	minimal or none	Minimal	Straightforward
Limited	limited	Low	Low
Multiple	**moderate**	Moderate	**Moderate**
Extensive	extensive	**High**	High

Example 2:

# diagnoses or management options	Data Complexity	Risk of morbidity & mortality (dz, dx, or rx)	DECISION MAKING
minimal	minimal or none	Minimal	Straightforward
limited	**limited**	**Low**	**Low**
multiple	moderate	Moderate	Moderate
extensive	extensive	High	High

APPENDIX 2:
CODES AND THEIR ELEMENTS

Outpatient-New

History	Exam	Decision Making	Time* (minutes)	Code
Detailed	detailed	low	30	**99203**
Comprehensive	comprehensive	moderate	45	**99204**
Comprehensive	comprehensive	high	60	**99205**

Outpatient -Established

History	Exam	Decision Making	Time* (minutes)	Code
-	-	minimal or none	5	**99211**
Problem focused	problem focused	straight-forward	10	**99212**
Expanded problem focused	expanded problem focused	low	15	**99213**
Detailed	detailed	moderate	25	**99214**
Comprehensive	comprehensive	high	40	**99215**

Inpatient - Initial Care

History	Exam	Decision Making	Time* (minutes)	Code
Detailed	detailed	straight-forward or low	30	**99221**
Comprehensive	comprehensive	moderate	50	**99222**
Comprehensive	comprehensive	high	70	**99223**

Inpatient - Subsequent Care

History	Exam	Decision Making	Time* (minutes)	Code
problem focused	problem focused	Low or straight-forward	15	**99231**
Expanded problem focused	expanded problem focused	moderate	25	**99232**
detailed	detailed	high	35	**99233**

Consultation-Outpatient

History	Exam	Decision Making	Time* (minutes)	Code
detailed	detailed	low	40	**99243**
comprehensive	comprehensive	moderate	60	**99244**
comprehensive	comprehensive	high	80	**99245**

Consultation-Initial Inpatient

History	Exam	Decision Making	Time* (minutes)	Code
expanded problem focused	expanded problem focused	straight-forward	40	**99252**
detailed	Detailed	low	55	**99253**
comprehensive	comprehensive	moderate	80	**99254**
comprehensive	comprehensive	high	110	**99255**

*Time is used only if the Counseling/Coordination of Care method is used.

APPENDIX 3:
OTHER CODES TO USE DURING CERTAIN PATIENT EVALUATIONS

These codes might be used during certain patient evaluations. However, they are often considered a part of larger E/M procedures. Rules vary among carriers.

AAN recommends that physicians bundled their services by including all related services in the main E/M code that day.

90782 Injection, SQ or IM, diagnostic or therapeutic
Also use a J-code for the drug injected

90862 Pharmacologic management for psychiatric patients,
no more than minimal counseling

96116 Neurobehavioral status exam, with interpretation and report, per hour.
Use this for extensive mental status testing. First hour is 31 to 90 minutes. Mini-mental status exam does not qualify by itself, but may be a part of a larger battery of testing.

97750 Physical performance test or measurement (e.g. musculoskeletal or functional capacity) with written report, each 15 minutes.

99211 Established outpatient visit, straight forward (may be done by staff alone)
For example, patient returns to pick up triplicate prescription and receives screening by nurse e.g. BP check and questions.

Disclaimer

This course and syllabus are provided as a service to participants in this course. Views expressed are those of the authors and should not be construed as reflecting policy of the AAN, CMS, third party insurance companies, or insurance carriers. Auditors and carriers sometimes use their own initiative to create other rules, or to view rules differently.

(Name label goes here)

NEUROLOGY OUTPATIENT FOLLOW-UP

DATE:

MEDS:

CHIEF COMPLAINT:

INTERVAL HISTORY (4 facts):

SOCIAL/DISABILITY:
_____See separate ROS sheet

EXAM, LABS (optional):

ASSESSMENT:
One from each step:
STEP 1: 2 problems inadequately controlled or
1 new problem needing assessment/treatment
STEP 2: High risk of morbidity or prolonged functional impairment
Acute neuro change (TIA, seizure, etc.)
Manage 4 prescription drugs

PLANS:

____Greater than half this _____ min visit spent counseling pt regarding:

Signature:

(Name label goes here)

NEUROLOGY

DATE:

MEDS:

CHIEF COMPLAINT:

HISTORY (4 facts):

FAMILY HISTORY:

SOCIAL/DISABILITY:
_____See separate ROS sheet

EXAM (list finding if abnormal, check off if normal) BP_____ HR_____ Wgt_____
NORMAL
__ general appearance
__ fundi
__ heart
__ orientation
__ memory
__ attention
__ speech
__ knowledge
__ visual fields
__ EOM
__ face sensation
__ face power
__ hearing
__ uvula
__ shoulder shrug
__ tongue
__ power
__ tone
__ reflexes
__ coordination
__ gait
__ sensation

ASSESSMENT:

PLANS:

____Greater than half this _____ min visit spent counseling pt regarding:

Signature:

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INTRODUCTION

E/M

Evaluation and Management, i.e. typical patient care visits

Neurological Single System Examination

23-25 list of required neurologic exam elements

1997 Standards

www.cms.hhs.gov/medlearn/emdoc.asp

NEW, ESTABLISHED, and CONSULT

A **Consult** is a request for an opinion.
New patients are self-referred or sent for ongoing care.

Consult:

- requested by any health care provider
- must document the reason, source
- one-time visits, but you may have seen patient before

New patient:

- not seen in the past 3 years
  by any member of the physician's group practice
  of the same specialty (i.e. neurologist).

Established patient:

- ongoing care, including follow-up after a consultation

HOSPITALIZED PATIENTS

Initial hospital visit is the attending's admission note.

Inpatient consult is used even if you had seen the same patient prior to this hospitalization.

Subsequent hospital visit codes are used both by the attending and by the consultants.

Hospital discharge day for**:**

99238: 30 minutes or less

99239: more than 30 minutes

- total time must be documented for 99239.
- time need not be continuous.

If you see the patient in the ER and they are admitted that day, use inpatient codes for your ER service

CRITICAL CARE

99291: first hour of critical care (31-74 minutes)
99292: each additional 30 minutes

coded by time
for bedside and unit physician work
for unstable, critically ill patient
by a management physician
not for consultants
time need not be continuous
in any location
if 2 MDs use these codes, use different ICD codes
aggregate time for practice partners

PROLONGED CARE

Used for prolonged direct patient contact.
Report in addition to the E/M code.

99354: first hour of prolonged outpatient service (hour = 31 to 74 minutes)
99355: each additional half hour
99356 - 99357: similar codes for inpatients

Document reason for the prolonged service.
Likely need to submit note to carrier.

DELETED CODES

Follow-up consultation
- Use **hospital subsequent visit** codes

Confirmatory consultation
- Use regular consultation codes

E/M ON THE SAME DAY AS A PROCEDURE

For a **procedure on the same day** as an E/M service (e.g. LP):

Use modifier -25 with the E/M service.
This verifies that the E/M was a separately identified service.
EMG, EEG and some other neurodiagnostic tests usually exempt.

OVERVIEW OF THE DOCUMENTATION STANDARDS

1. History
   - Chief Complaint (CC)
   - History of the present illness (HPI)
   - Past medical, family and social history (PFSH)
   - Review of systems (ROS)
2. Physical Exam
   - Neurological Single System Exam
3. Medical Decision Making
   - Number of diagnoses or management options
   - Data complexity
   - Risk of morbidity and mortality

CHOOSING THE LEVEL OF SERVICE

Three steps:

1. Presenting problem severity
2. Describe work, orders
3. History or exam or both

CHOOSING THE LEVEL OF SERVICE

Step 1: Presenting Problem Severity

High includes:

1. Chronic illness with
   severe exacerbation/progression/side effects
2. Risk of mortality or serious morbidity
3. Abrupt Neuro change (e.g. TIA, CVA, seizure, AMS)
4. Prescribe high risk medications (e.g. coumadin)
5. Administer parenteral controlled substances

Most other Neuro visits will be Moderate.

CHOOSING THE LEVEL OF SERVICE

Step 2: Describe Additional Work

For High Level, describe at least one:

1. One new presenting problem needing additional assessment
2. Two continuing problems inadequately controlled

3. A differential diagnosis with >3 possibilities
4. >3 management options considered
5. Extensive data/records/test results were reviewed

CHOOSING THE LEVEL OF SERVICE

Step 3: History, Exam, or Both

Follow-ups: either a History or an Exam

New, consults, admission notes need:

1	CC
4	facts HPI
3	facts PSF (1 each)
10	system ROS
23	Neuro SSE

OFFICE ESTABLISHED LEVEL OF SERVICE

99215, level 5:

- one new or two ongoing problems of severe degree, e.g.
    1. Chronic illness with severe exacerbation/progression/side effects
    2. Risk of mortality or serious morbidity
    3. Abrupt Neuro change (e.g. TIA, CVA, seizure, AMS)
    4. Prescribe high risk medications (e.g. coumadin)
    5. Administer parenteral controlled substances
- chief complaint,
- 4 facts re HPI,
- med list,
- a social fact,
- 10 system ROS,
- plans re labs/meds/etc to address the problem(s).

OFFICE ESTABLISHED LEVEL OF SERVICE

99214, level 4:

- 1 new or 2 chronic problems of moderate degree,
  or an uncertainty about risk or prognosis;
  these need evaluation/management
- chief complaint,
- 4 facts re HPI,
- mention some current medications (Past Hx),
- 2-system ROS,
- plans re labs/meds/etc to address the problems.

OFFICE ESTABLISHED LEVEL OF SERVICE

99213, level 3:

- a self-limited or stable chronic problem
  of low risk, needing evaluation/management
- chief complaint,
- pertinent positives and negatives about the problem,
- plans re labs/meds/etc to address the problem.

OFFICE ESTABLISHED LEVEL OF SERVICE

Examples of level 5 established outpatients:

- MS patient with 1 new symptom needing evaluation/treatment
- MS patient with 2 inadequately controlled problems

- Parkinsons patient who fell
- Patient who still has seizures and AED side effects
- Patient recently started on Tegretal
- Patient on Coumadin

HOSPITAL SUBSEQUENT DAY LEVEL OF SERVICE

99231, level 1:

- no new or continuing problems needing new actions
- chief complaint, and anything about the HPI

99232, level 2:

- 1 continuing problem needing evaluation/management
- chief complaint, pertinent positives/negatives,
- orders re labs/meds/etc to address the problem

HOSPITAL SUBSEQUENT DAY LEVEL OF SERVICE

99233, level 3:

- new significant problem,
  or significant risk of morbidity or prolonged functional impairment,
  or multiple ongoing significant problems;
  and these problems need evaluation/management
- chief complaint,
- 4 facts re HPI,
- mention medications,
- 2-system ROS,
- order/plans re labs/meds/etc to address the problems.

REVIEW OF SYSTEMS

Constitutional	Musculoskeletal
Eyes	Skin and/or Breast
Ears, Nose, Throat	Neurologic
Cardiovascular	Endocrine
Respiratory	Hematologic/Lymphatic
Gastrointestinal	Allergic/Immunologic
Genitourinary	Psychiatric

REVIEW OF SYSTEMS

ROS can be on a separate sheet
e.g. filled out by the patient just before the visit,
if the physician signs, dates it
and refers to it in the E/M note

ROS can be documented by referring to another note;
must say "ROS unchanged since note (date and author)"

A comprehensive ROS requires 10 systems to be mentioned
Facts mentioned elsewhere in the note do count

COUNSELING AND COORDINATION OF CARE

Counseling is a discussion with patient or family about diagnoses, test results, recommended tests, prognosis, treatment alternatives, compliance, risk factor reduction, and patient and family education.

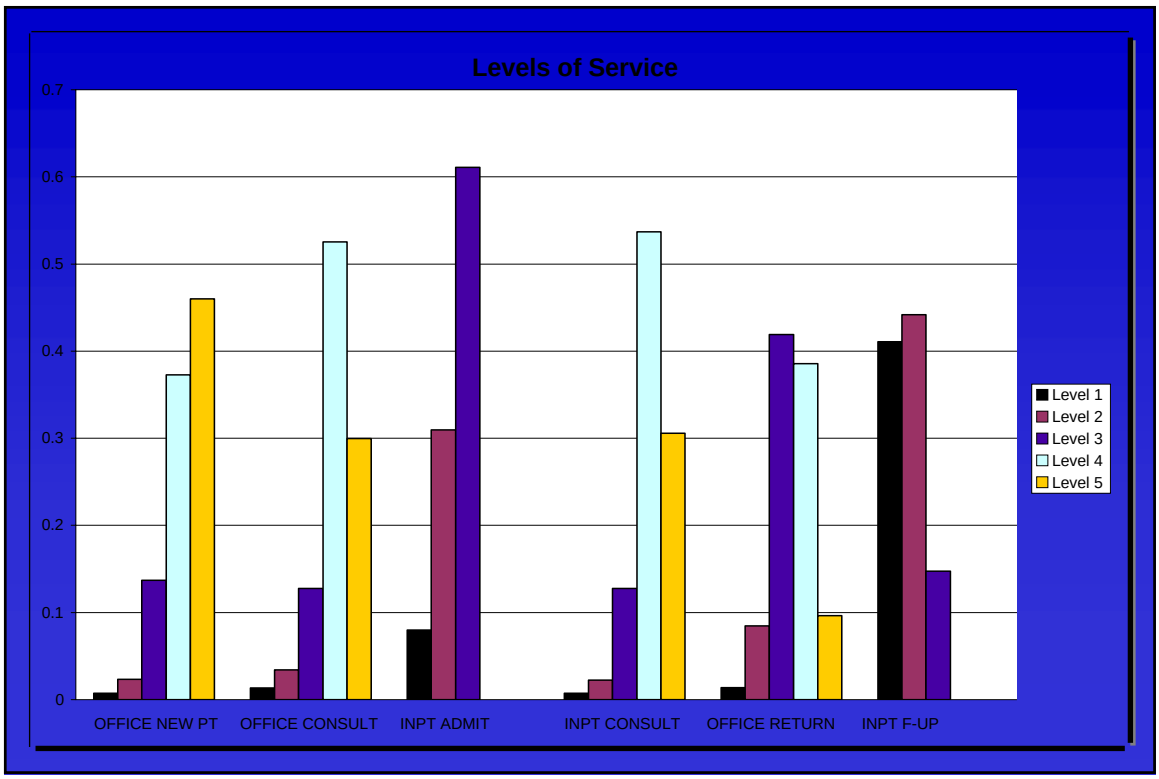
Coordination of care is arranging for care with other health care providers. This includes any type of such activity.

COUNSELING AND COORDINATION OF CARE METHOD

This can be used in place of the above HX-PX-MDM.
It uses time to set LOS.
The documentation should state:
- minutes spent face-to-face,
- that more than 50% of time was counsel/coord. care,
- give some general idea of what counsel/coord. care.

Time is face-to-face with patient or family (outpatient);
- or, at bedside and on unit/floor (inpatient).

No history or exam elements are needed
- (except, of course, for real patient care purposes!).



COMMON ERRORS

1. Failure to document referring physician name for consults
2. Incorrect family for consult v. new v. established
3. Failure to document decision making complexity
4. Failure to document face to face contact time
5. Under-coding level of service

NEUROLOGICAL SINGLE SYSTEM EXAM

- 25 bulleted elements
- 23 bullets required
- Choose 1 of 3 cardiovascular elements
- Considered minimum standards
  - usually more is needed for patient care
- Follow up visits require history or exam, not both
- A dozen other SSEs or the General Exam
  - could be used instead
  - different exams can't be mixed together

GENERAL SIGNS

Measure any three vital signs:

BP, HR, RR, temp, height, weight, orthostatic BP

General appearance

Fundoscopic exam

Cardiovascular -- choose one of:

Examine carotids,

Heart auscultation,

Examine peripheral vascular system

MENTAL STATUS

Orientation

Memory recent and remote

Attention and concentration

Language

Fund of knowledge

(e.g., current events, past history, vocabulary)

CRANIAL NERVES

CN 2	(e.g., acuity, fields)
CN 3,4,6	(e.g., pupils, eye movements)
CN 5	(e.g., facial sensation, corneal reflex)
CN 7	(e.g., facial symmetry, strength)
CN 8	(e.g., hearing whispers, finger rub)
CN 9	(e.g., palate movement)
CN 11	(e.g, shoulder shrug)
CN 12	(e.g., tongue protrusion)

MOTOR

Strength	4 extremities
Tone	4 extremities, note any atrophy or abnormal movement
DTR	4 extremities, note any pathologic reflexes
Coordination	
Gait and station	

SENSATION

Examine sensation by any means

OTHER RULES

- Cannot say “cranial nerves 2-12 normal”
- Constitutional signs can be documented by staff
- Your institution or practice can approve its own list of abbreviations
- Illegible entries will be disallowed

SIMPLIFYING COMPLIANCE

- Use a preprinted template
- Notes must refer to separate templates
- Templates must be signed and dated to be a part of the official record
- Use word processor macros for bulleted elements
- Use pocket cards to remind you of elements for inpatient handwritten notes

EXAMPLE OF A COMPREHENSIVE NEUROLOGICAL SINGLE SYSTEM EXAM

PX:	Well Devel.
VS:	120/80, HR 72, RR 16
HEENT:	fundi ok, no bruit
MS:	A+Ox3, dig 6F, 3/3 obj at 5', nl naming and vocab
CN:	fields + EOMs full, face sense/power Nl, hears well, palate/tongue move midline, SCM nl
Sense:	nl PP
Motor:	nl power/tone/DTRs 4 extr, FNF and gait nl

EXAMPLE OF A RETURN OUTPATIENT VISIT

Seizures - none in past year.
Dilantin 300 mg HS. *(CC and 4 facts about HPI)*
Two auras past month w mild epigastric rising, 30" each,
after decreased sleep and increased stress at job, s LOS
Began driving again last August *(1 fact about PFSHx)*
No drowsiness, diplopia *(2 systems mentioned)*
PX - alert, minimal nystagmus, fundi benign, power full UEs
(No exam detail needed)
Impression: complex partial seizures,
??subther/breakthru sz risk *(Abrupt Neuro change)*
Plan: DPH level, call in 2 days, ? to increase DPH
LFTs, CBC w diff now *(Many management plans)*
Avoid sleep deprivation, OK to drive for now
Call and RTC if increased auras, or if seizures

EXAMPLE OF A RETURN OUTPATIENT VISIT

GTC sz 2d ago. Occas partial sz >6yr ago.
Wife noted blank stare before sz. Now c/o memory problems.
(CC and at least 4 facts about HPI)
DPH 300 mg/day - recent noncompliant. Drives.
(2 facts about PFSHx)
ROS form in chart. *(Full 10 item ROS signed, dated)*
PX: recall 3/3 @ 5', digits 6F, no nystagmus, nl power/tone, toes down.
(No exam detail needed).
Impr: Breakthrough seizures, r/o tumor, etc.
(Risk of mortality, serious morbidity)
Plan: MRI, EEG, DPH level, LFTs, CBC, ANA
Cont DPH, discuss noncompliance, extra 300 mg today.
Admit if more GTC seizures, home w close observation by family,
(Many management decisions, plans)

ALTERNATE REPORT FOR THE SAME RETURN OUTPATIENT VISIT

GTC sz 2d ago. No szs >6yr. DPH 300 mg/day but noncompliant.
No recent illness, stress. *(No history required)*

PX: recall 3/3 @ 5', digits 6F, no nystagmus, nl power/tone, toes down.
(No exam required)

Impr: Breakthrough szs, r/o tumor, etc. *(Risk mortality, morbidity)*

Plan: DPH level, LFTs, CBC, ANA
Extra DPH and incr to 200 b.i.d.; Admit if more GTC seizures
Home, close obs. by family. *(Many management plans)*

>50% this 45 min visit counsel/educate pt/family re Rx and Dx options, risks, need for f-up, compliance, first aid for seizures.
(Uses Counseling,Coord of Care option for documenting)

EXAMPLE OF INPATIENT CONSULT

Asked to see pt by Dr. Jones. *(To qualify as a consult)*

Seizure this AM. *(CC)*

2 d S/P CABG, was recovering well. On Demerol, Abx, Glucatrol, Prograft. Unwitnessed onset sz in ICU. Loaded w phosphen 1500 mg IV. Slow to awaken. No prev Hx seizures. *(4 facts HPI)*

Renal transplant '97, diabetic, HBP, cor art dis c angina.

FHx neg seiz/neuro. Retired. *(3 facts in PFSH)*

No ROS change since Dr. Jones's admit note. *(ROS by reference)*

Lethargic, 145/92, 72, 37.9 Tmax, fundi ok, no bruit

A&0x3, dig 5F, 2/3 obj at 5', fluent, aware recent events

Fields&EOMs full, face sens/power nl, hear decr AS, palate/tongue mvmt midline, SCM nl, nl power/tone 4 extr, DTRs absent ankle/traceUEs, toes mute, FNF Nl, gait can't test, decr PP distal LEs
(23 Neuro-SSE PX)

(continued)

EXAMPLE OF INPATIENT NEW CONSULT

(continued from previous slide)

Impr: Seizure, r/o CVA, metabolic, med effect, intracr mass/infect, with lethargy, likely p-ictal/drug effects, r/o other CNS process *(Abrupt Neuro change)*

Plan: MRI/CT, EEG
Cont DPH 300 mg/d PO
Check DPH, Prograft levels, 'lytes, CBC, BUN/Cr
Substitute MS for Demerol
Will Follow *(Extensive DDX and eval.)*
After imaging, will consider LP