Part B Tips for Preventing Most Common Evaluation and Management (E/M) Service Coding Errors

History

1. **Indicate clearly the chief complaint and/or reason for the visit.**

   Do not limit the chief complaint to "follow-up" without identifying the problem(s) being followed.

2. **Describe the history of the present illness fully and in such a way that the nature of the presenting problem is clear.**

   - The documentation guidelines specify elements that must be recorded about the present illness. Higher-level services require four or more elements or a description of the **status** of three or more chronic problems.
   - Medical necessity of an Evaluation and Management (E/M) encounter is often visualized only when viewed through the prism of its characteristics captured in specific History of Present Illness (HPI) elements.

3. **Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services.**

   - Do not use the term "non-contributory."
   - Record information about all three realms to document "complete" PFSH for the following services: new patient or initial services in office and inpatient hospital, observation, domiciliary and home, as well as consultations and comprehensive Nursing Facility (NF) assessments.
   - Do not record unnecessary information **solely** to meet requirements of a high-level service when the nature of the visit dictates a lower-level service to have been medically appropriate.

4. **Record the Review of Systems (ROS) appropriate for the clinical circumstance of the encounter. Expansive ROS is unnecessary for lower-level services.**

   - Document an ROS for the system(s) related to the presenting problem. It is required for all levels of systemic review (meaning that it is required for all codes except the least codes in all code families).
   - Record positives and pertinent negatives.
     - Never note the system(s) related to the presenting problem as "negative."
     - Use notations such as "normal" or "negative" only for systems not related to the presenting problem.
     - When using "negative" notation, always identify which systems were queried and found to be "negative."
   - Do not count physical observations as ROS (count them as Physical Examination).

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- Do not record unnecessary information solely to meet requirements of a high-level service when the nature of the visit dictates a lower-level service to have been medically appropriate.

Physical Examination

1. **Understand the difference between "Expanded Problem-Focused (EPF)" and "Detailed" examination under 1995/1997 guideline requirements.**

   - The difference is not the number of systems examined. Two to seven systems are required for both examinations.
   - The difference is the detail in which the examined systems are described.

2. **Always examine the system(s) related to the presenting problem and do not describe it as "normal" or "negative."**

   Use "normal," "negative" and "WNL" notations only to describe unaffected or asymptomatic organ systems.

3. **Code the physical examination considering the clinical circumstances of the encounter. Do not code based on excessive and unnecessary information recorded solely to meet the requirements of a high-level service when the nature of the visit dictates a lower-level service to have been medically appropriate.**

Medical Decision-Making (MDM)

1. **Record relevant impressions, tentative diagnoses, confirmed diagnoses and all therapeutic options chosen related to every problem for which E/M is clearly demonstrated in the record of the other key components.**

   Do not count existent old diagnoses unless the record clearly demonstrates their presence increased physician work related to the encounter.

2. **Document all diagnostic tests ordered, reviewed and independently visualized as part of the work of the encounter.**

   Do not code MDM based solely on the severity of or number of presenting problems; decision-making also encompasses the numbers of and risk associated with diagnostic tests ordered/performed as well as the complexity of and risk associated with therapeutic options chosen.

3. **Summarize old records or other outside information reviewed and incorporated into decision-making.**

4. **Beware of templates that overestimate decision-making. Understand the logic of templates and/or computer programs used for E/M service coding.**