How 'Data Reviewed' Works When Coding E/M

Phyllis Dobberstein, CPC, CPMA, CPCO, CEMC, CCC

Three elements determine the level for evaluation and management coding (E/M). "Amount and/or Complexity of Data to be Reviewed and Analyzed" is 1 of them and also the most confusing. Data Reviewed remained a point system after guidelines changed in 2021. As an auditor, I see both undercoding and overcoding in E/M caused by not applying the rules correctly.

Let's start with what tests count toward Data Reviewed.

Lab tests—whether performed in-house or sent out to a laboratory—always count toward Data Reviewed. Labs do not require a separate interpretation. They are not a professional service.

Radiology tests rarely count toward Data Reviewed in the urgent care setting where x-rays are performed. If the practice is billing for the interpretation (ie, professional component) of an x-ray, it cannot also count it toward the level of E/M code. This is considered "double dipping," as in, being paid for the same service in 2 different ways.

If you send a patient out for an x-ray, this should be counted towards your E/M level as your practice is not billing for it. If your practice does not bill for the interpretation of an x-ray, you would add a technical component modifier to indicate only the technical component was performed. In this circumstance, you could count the x-rays.

So, how are they counted? Data is divided into 3 categories:

1. Tests, documents, orders, or independent historian(s) (each unique test, order, or document is counted to meet a threshold number)
2. Independent interpretation of tests (not separately reported)
3. Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source (not separately reported)

Phyllis Dobberstein, CPC, CPMA, CPCO, CEMC, CCC, is Revenue Integrity Manager at Experity.

Category 1: Tests and Documents

Review of prior external (notes) from each unique source: If records are obtained and reviewed from an external provider, 1 point can be counted from each source. An external provider is not a member of your group practice. Records could also be from a facility (eg, nursing facility). A review of the records will need to be documented. This item is rare in the urgent care setting.

Review of the result(s) of each unique test: This is also rarely counted in the urgent care setting where practices are ordering and performing the testing they need. In that case, reviewing the test results is part of the encounter and not counted separately.

Ordering of each unique test: As stated above, each lab should be counted as a unique test. A unique test is defined by the CPT code set. A panel is 1 CPT code and is only counted as 1 test. For example, CPT 87428 represents a test for COVID-19, influenza A, and influenza B. It's 1 CPT, so it is only 1 point.

Also counted toward ordering a test are tests "considered but not selected after shared medical decision making." Examples are tests a patient requests that are not necessary or testing the provider recommends but the patient declines. Shared decision making must be documented. It includes "eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options."

A common error is to count a lab as both ordered and reviewed. A lab test is counted only once, usually as an order in the urgent care setting. If the patient returns and labs are reviewed that were already counted as ordered, they should not be counted again.

Assessment requiring an independent historian(s): When a history is obtained from an individual (eg, parent, guard-

ian, surrogate, spouse, witness) in addition to the history from the patient, 1 point can be counted for each historian. The historian does not need to be present at the appointment. Common circumstances that require an independent historian are children, elderly parents, individuals with developmental delays, or individuals with psychosis.

Category 2: Independent Interpretation of Tests

Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported): This is rare in the urgent care setting. Urgent care is usually the patient's first stop, so they usually aren't coming in after x-rays were already performed. An example of when an independent interpretation would be counted is when your urgent care provider sends a patient to an orthopedist with a copy of an x-ray for their sprained ankle. Then the orthopedist could count their independent interpretation.

Common errors I see are counting an independent interpretation for tests performed and billed by the practice and counting an independent interpretation when labs are performed. Labs are results only. There is no interpretation to be performed.

Category 3: Discussion of Management or Test Interpretation

Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported): This is an exchange between the provider and another party that has impact on the management of the patient's condition, excluding family members. Examples from the American Medical Association (AMA) are a lawyer, parole officer, case manager, or teacher. A common example in the urgent care setting is when one provider calls another provider at the emergency department after sending a patient there. The communication must be direct and not through clinical staff.

Consider this example: The provider treats a patient with respiratory symptoms. A test is ordered for influenza A and B and strep as well as a chest x-ray. The patient declines the x-ray after discussion with the provider.

- **Billed:** 87804 x 2 (flu) and 87880 (strep test)
- **Counted:** 87804 (flu), 87880 (strep test), and 71046 (chest x-ray)

Two labs are counted though 3 are billed; the chest x-ray is counted as it is not being billed.

One of the goals of the AMA was for providers to get credit for all the work that goes into diagnosing a patient. Unfortunately, their guidance in the beginning of 2021 on Data Reviewed was inconsistent, resulting in incorrect information in the urgent care industry. Hopefully, the information above helps to clear up some of that confusion. ■