



# Rational Physician Coding for E/M Services

CO-NM-OK-TX-VA

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# **Rational Physician Coding for E/M Services**



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## **Goals**

- 1) Improve physician E/M compliance
- 2) Avoid undercoding
- 3) Decrease E/M coding anxiety
- 4) Save time
- 5) Keep the focus on patient care

## A “Routine” Office Patient

- You see an established office patient with stable HTN, DM2 and dyslipidemia.
- There is also a history of CAD, which is well controlled.

139	101	12	
4.6	23	124	12
		0.8	36

MA/Cr = 28, LDL 77, HgbA1c 6.8

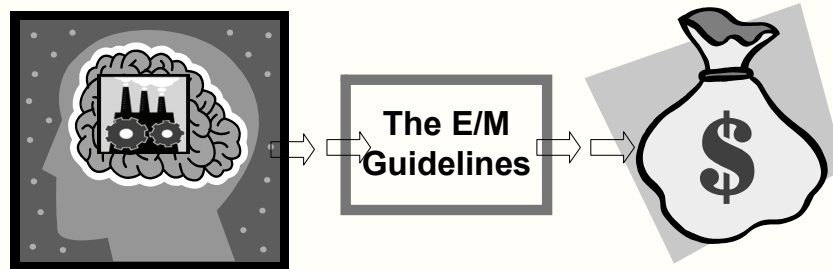
- You make no changes in medications and schedule return visit in four months.
- Time spent is 15 minutes
- What is this encounter worth?

## E/M Coding

- E/M = Evaluation and Management
- How patient encounters are translated into 5 digit numbers to facilitate billing
- Within each type of encounter there are various levels of care

99211	\$20.60	<b>50%</b>
99212	\$36.82	
99213	\$51.63	
99214	\$80.53	
99215	\$117.21	

## E/M = Cognitive Labor

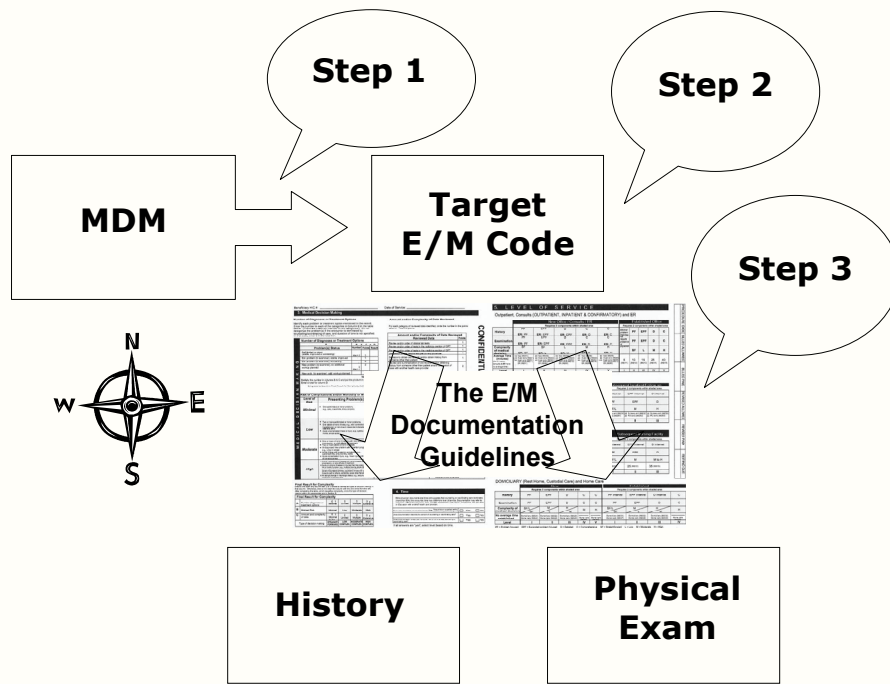


## The E/M Guidelines

- Developed by the AMA and CMS
- First set released in 1995
- Second set released in 1997
- Based on three “Key Components”
  - History
  - Physical Exam
  - Medical Decision-Making



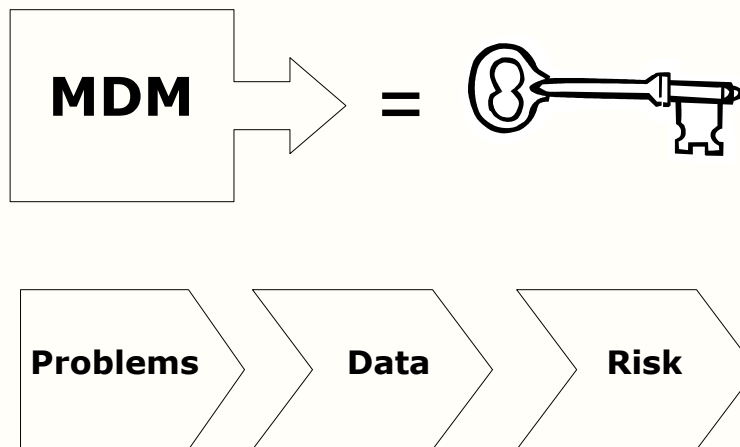




**Rational Physician Coding is a simple three step process:**

1. Calculate the medical decision-making
2. Identify the target code
3. Perform and document the required elements of history/exam

**Primacy of Medical Decision-Making**



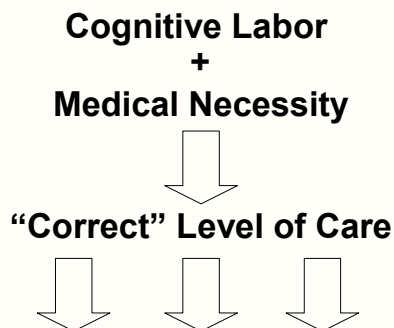


# The Importance of Medical Necessity

“Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed.”



The quote above is taken directly from the Medicare carrier manual and it points out the fact that there must be sufficient medical necessity to support the intensity of the history and exam performed and documented. The key component of medical decision-making can act as an objective index of medical necessity and help us identify the highest ethical level of care based on the clinical circumstances of the patient.



## The Secret of True E/M Compliance

If you can find the level of care which matches both the cognitive labor provided and the intrinsic medical necessity of the encounter, you can find the “correct” level of care. If you let the key component of MDM lead the way, you can find this level of care each and every time. This is the secret of true E/M compliance because it allows you to avoid under-coding while ensuring that the level of care selected is congruent with the medical necessity of the encounter.

## Determining the MDM

<b>Number of Diagnoses</b>	<b>Data Reviewed</b>	<b>Risk</b>	<b>Level of MDM</b>
Minimal	Minimal	Minimal	Straight-Forward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

**Need 2 out of 3 to qualify for given level of MDM**

Given the importance of the MDM, it is essential that we be able to quantify this key component in an objective and repeatable manner. Unfortunately, the official table of MDM from both the 1995 and 1997 E/M guidelines (shown above) makes this a very difficult thing to do. The problem is that the terms used to stratify the dimensions of MDM are too vague.

## MDM Points

<b>MDM Complexity</b>	<b>Problems</b>	<b>Data</b>	<b>Risk</b>
<b>Straight Forward</b>	1	1	Minimal
<b>Low</b>	2	2	Low
<b>Moderate</b>	3	3	Moderate
<b>High</b>	4	4	High

**Need 2 out of 3 to qualify for given level of MDM**

The framers of the E/M guidelines realized that the MDM rules were too vague to be used by auditors, so they came up with a weighted point system which was eventually released to all Medicare carriers to be used on a "voluntary" basis.

## Problem Points

Problems/DDx	Points
Self limited or minor (Max 2)	1
Established problem, stable	1
Established problem, worsening	2
New problem, no additional work-up planned	3
New problem, additional work-up planned	4

The problem points are tabulated by referring to this table. You add up all the problems you are addressing during the encounter and come up with the final number of total problem points. “New” problems are defined relative to the physician, not the patient.

## Points for Data Reviewed

Data Reviewed	Points
Review/order clinical lab tests	1
Review/order X-rays	1
Review/order tests in the medicine section (echo, EKG, LHC, PFTs)	1
Discussion of test results with performing MD	1
Independent review of image, tracing, or specimen	2
Decision to obtain old records	1
Review and summation of old records	2

The data points are calculated using this table. You only get one data point for reviewing and/or ordering labs and ordering or reviewing X-ray reports. If you personally review any primary data (such as an EKG, an X-ray or a blood smear, etc.), you get two data points, but you *must record your findings in the chart*.

## Table of Risk

Risk	Presenting Problem(s)	Diagnostic Procedures	Management Options Selected
<b>Minimal</b>	<ul style="list-style-type: none"> <li>• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis</li> </ul>	<ul style="list-style-type: none"> <li>• Laboratory tests</li> <li>• Chest X-rays</li> <li>• EKG/EEG</li> <li>• Urinalysis</li> <li>• Ultrasound/ Echocardiogram</li> <li>• KOH prep</li> </ul>	<ul style="list-style-type: none"> <li>• Rest</li> <li>• Gargles</li> <li>• Elastic bandages</li> <li>• Superficial dressings</li> </ul>
<b>Low</b>	<ul style="list-style-type: none"> <li>• Two or more self-limited or minor problems</li> <li>• One stable chronic illness, e.g., well controlled HTN, DM2, cataract</li> <li>• Acute uncomplicated injury or illness, e.g., cystitis, allergic rhinitis, sprain</li> </ul>	<ul style="list-style-type: none"> <li>• Physiologic tests not under stress, e.g., PFTs</li> <li>• Non-cardiovascular imaging studies with contrast, e.g., barium enema</li> <li>• Superficial needle biopsy</li> <li>• ABG</li> <li>• Skin biopsies</li> </ul>	<ul style="list-style-type: none"> <li>• Over the counter drugs</li> <li>• Minor surgery, with no identified risk factors</li> <li>• Physical therapy</li> <li>• Occupational therapy</li> <li>• IV fluids, without additives</li> </ul>
<b>Moderate</b>	<ul style="list-style-type: none"> <li>• One or more chronic illness, with mild exacerbation, progression, or side effects of treatment</li> <li>• Two or more stable chronic illnesses</li> <li>• Undiagnosed new problem, with uncertain prognosis, e.g., lump in breast</li> <li>• Acute illness, with systemic symptoms, e.g., pyelonephritis, pleuritis, colitis</li> <li>• Acute complicated injury, e.g., head injury, with brief loss of consciousness</li> </ul>	<ul style="list-style-type: none"> <li>• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test</li> <li>• Diagnostic endoscopies, with no identified risk factors</li> <li>• Deep needle, or incisional biopsies</li> <li>• Cardiovascular imaging studies, with contrast, with no identified risk factors, e.g., arteriogram, cardiac catheterization</li> <li>• Obtain fluid from body cavity, (e.g., LP or thoracentesis)</li> </ul>	<ul style="list-style-type: none"> <li>• Minor surgery, with identified risk factors</li> <li>• Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors</li> <li>• Prescription drug management</li> <li>• Therapeutic nuclear medicine</li> <li>• IV fluids, with additives</li> <li>• Closed treatment of fracture or dislocation, without manipulation</li> </ul>
<b>High</b>	<ul style="list-style-type: none"> <li>• One or more chronic illness, with severe exacerbation, progression, or side effects of treatment</li> <li>• Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others, peritonitis, ARF</li> <li>• An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss</li> </ul>	<ul style="list-style-type: none"> <li>• Cardiovascular imaging, with contrast, with identified risk factors</li> <li>• Cardiac EP studies</li> <li>• Diagnostic endoscopies, with identified risk factors</li> <li>• Discography</li> </ul>	<ul style="list-style-type: none"> <li>• Elective major surgery (open, percutaneous, endoscopic), with identified risk factors</li> <li>• Emergency major surgery (open, percutaneous, endoscopic)</li> <li>• Parenteral controlled substances</li> <li>• Drug therapy requiring intensive monitoring for toxicity</li> <li>• Decision not to resuscitate, or to de-escalate care because of poor prognosis</li> </ul>

This is the official table of risk for both the 1995 and 1997 E/M guidelines. The rules explicitly state that it only takes *one element* in any of the categories above to qualify for any given level of risk. Use highest level of risk present to stratify the overall level of risk for any encounter.

## Calculating the Overall MDM

MDM Complexity	Problems	Data	Risk
Straight Forward	1	1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4	4	High

**Need 2 out of 3 to qualify for given level of MDM**

The overall level of MDM is determined by referring to the table above. Only two out of three elements are needed to qualify for any given level of MDM. The example above would qualify for moderate complexity MDM based on the presence of three problem points and three data points, even though the level of risk is only low.

## TrailBlazer Changes the Rules

Unfortunately, if you practice in CO, NM, OK, TX or VA, your Medicare carrier (TrailBlazer) recently came up with a completely new medical decision-making point system.

The rules are much more complex than the standard MDM rules used by everyone else.

## TrailBlazer Changes the Rules

- TrailBlazer is the Medicare carrier for CO, NM, OK, TX and VA.
- They have unilaterally changed the way that they audit the key component of Medical Decision-Making:
  - Problem points are added up differently
  - Different values for data points
  - Risk is identical to the old rules

## TrailBlazer MDM Points

MDM Complexity	Problems	Data	Risk
SF	≤1	≤1	Min
Low	2	2	Low
Moderate	3	3	Mod
High	≥4	≥4	High

**Need 2 out of 3 to qualify for given level of MDM**

<b>Table A.1 Number of Diagnoses</b>		
A "problem" is defined as a definitive diagnosis or, for undiagnosed problems, a related group of presenting symptoms and/or clinical findings.		PTS
Each new or established problem for which the diagnosis and/or treatment plan is evident		1
Each new or established problem for which the diagnosis and treatment plan is not evident	2 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	2
	3 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	3
	4 or more plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	4
	Total Points	

<b>Table A.2 Management Options</b>		<b>PTS</b>
Do not count as treatment option's notations such as: Continue "same" therapy or "no change" in therapy if therapy is not described .		0
Drug management, per problem. Includes "same" therapy or "no change" in therapy if specified therapy is described (i.e., record documents what the current therapy is and that the physician reviewed it). Dose changes for current medications are not required, but the record must reflect conscious decision-making.	≤3 new or current meds per problem	1
	>3 new or current meds per problem	2
Open or percutaneous therapeutic cardiac, surgical or radiological procedure; minor or major		1
PT/OT, speech therapy or other manipulation		1
Closed treatment for fracture or dislocation		1
IV fluid or fluid component replacement, or establish IV access when record is clear that such involved physician decision-making (not standard "protocol")		1
Complex insulin prescription (SC or combo of SC/IV), TPN, insulin drip or other admixture		2
Conservative therapy: rest, ice, bandages, diet		1
Radiation therapy		1
Joint, body cavity, soft tissue, etc injection/aspiration		1
Patient education regarding self or home care		1
Decision to admit to hospital		1
Discuss case with other physician		1
Other – specify		1
Total Points		



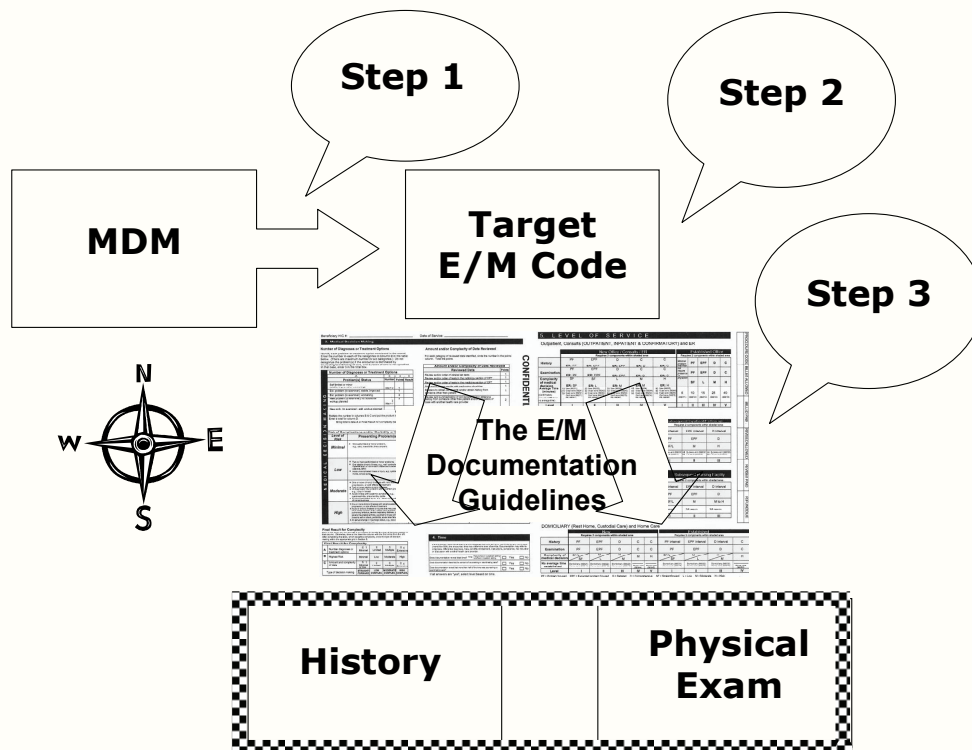
Table B Data Reviewed or Ordered		PTS
Order and/or review labs (Count lab panels as one procedure).	1 – 3 Procedures	1
	≥ 4 Procedures	2
Order X-rays or review X-ray reports	1 – 3 Procedures	1
	≥ 4 Procedures	2
Order and/or review tests in medical section of CPT.	1 – 3 Procedures	1
	≥ 4 Procedures	2
Discuss test results with performing physician.		1
Discuss case with other physician or consult another physician		1
Order and/or review old records.	Without summation	1
	With summation	2
Independent visualization and interpretation of an image, EKG or lab specimen (Each visualization and is allowed one point.)		1
Review of significant physiologic monitoring or testing data.		1
Total Points		

<b>Risk</b>	<b>Presenting Problems</b>	<b>Diagnostic Procedures</b>	<b>Management Options</b>
<b>Minimal</b>	<ul style="list-style-type: none"> <li>•One self-limited or minor problem, e.g., cold, insect bite, tinea corporis.</li> </ul>	<ul style="list-style-type: none"> <li>•Laboratory tests</li> <li>•Chest X-rays</li> <li>•EKG/EEG, Echocardiogram</li> </ul>	<ul style="list-style-type: none"> <li>•Rest</li> <li>•Gargles</li> <li>•Superficial dressings</li> </ul>
<b>Low</b>	<ul style="list-style-type: none"> <li>•Two or more self-limited or minor problems</li> <li>•One stable chronic illness</li> <li>•Acute uncomplicated injury or illness, e.g., cystitis, allergic rhinitis, sprain</li> </ul>	<ul style="list-style-type: none"> <li>•Physiologic tests not under stress, e.g., PFTs</li> <li>•Non-cardiovascular imaging studies with contrast</li> <li>•ABG</li> <li>•Skin biopsies</li> </ul>	<ul style="list-style-type: none"> <li>•Over the counter drugs</li> <li>•Minor surgery, with no risk factors</li> <li>•PT/OT</li> <li>•IV fluids, without additives</li> </ul>
<b>Moderate</b>	<ul style="list-style-type: none"> <li>•One chronic illness, with mild exacerbation,</li> <li>•Two stable chronic illnesses</li> <li>•Undiagnosed new problem, with uncertain prognosis</li> </ul>	<ul style="list-style-type: none"> <li>•Cardiac stress test</li> <li>•Cardiovascular imaging studies, with contrast, with no identified risk factors</li> </ul>	<ul style="list-style-type: none"> <li>•Prescription drug management</li> <li>•IV fluids, with additives</li> </ul>
<b>High</b>	<ul style="list-style-type: none"> <li>•One or more chronic illness, with severe exacerbation,</li> <li>•Acute or chronic illness or injury, which poses a threat to life or bodily function</li> <li>•An abrupt change in neurological status</li> </ul>	<ul style="list-style-type: none"> <li>•Cardiovascular imaging, with contrast, with identified risk factors</li> <li>•Cardiac EP studies</li> <li>•Diagnostic endoscopies, with identified risk factors</li> </ul>	<ul style="list-style-type: none"> <li>•Parenteral controlled substances</li> <li>•Drug therapy requiring intensive monitoring for toxicity</li> <li>•Obtain DNR or de-escalate care</li> </ul>

## TrailBlazer MDM Points

MDM Complexity	Problems	Data	Risk
SF	$\leq 1$	$\leq 1$	Min
Low	2	2	Low
Moderate	3	3	Mod
High	$\geq 4$	$\geq 4$	High

**Need 2 out of 3 to qualify for given level of MDM**



## History

<b>CC</b>	▪ <b>Problem Focused</b>
<b>HPI</b>	▪ <b>Expanded Problem Focused</b>
<b>ROS</b>	
<b>PFSH</b>	▪ <b>Detailed</b>
	▪ <b>Comprehensive</b>

## Levels of History

<b>History</b>	<b>HPI</b>	<b>ROS</b>	<b>PFSH</b>
PF	Brief	None	None
EPF	Brief	1	None
Detailed	Extended	2 – 9	1 out of 3
Comp	Extended	10	3 out of 3

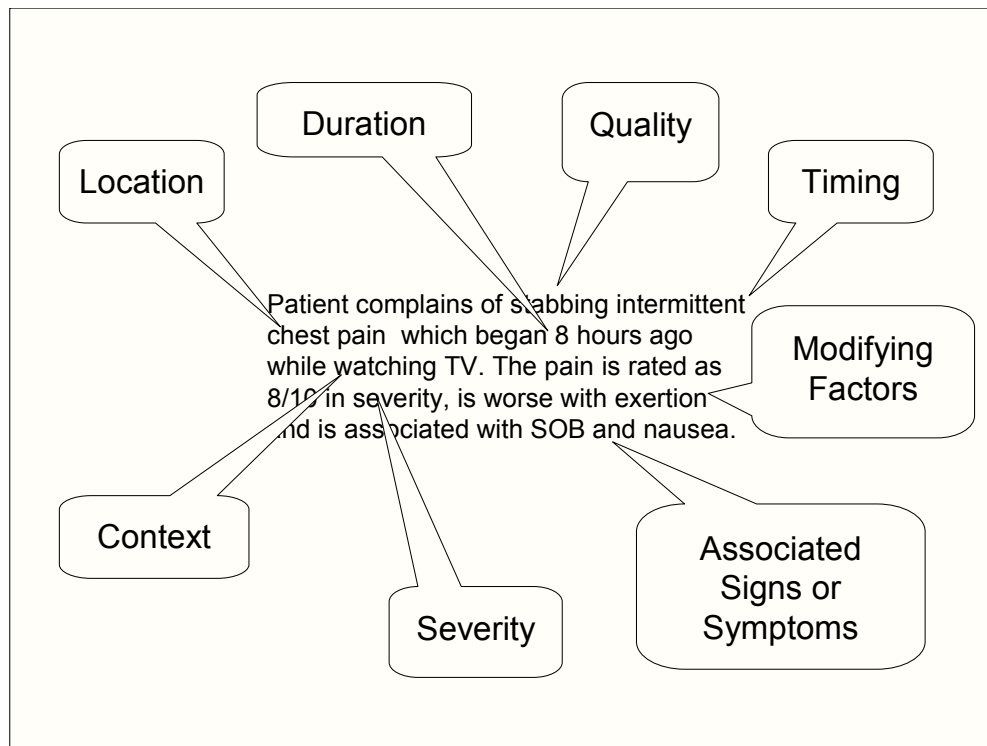
There are four levels of history based on the documentation of the HPI, ROS and elements of past medical, family and social history.

## HPI

- A narrative of the patient's symptoms or illnesses since onset or since the previous encounter
- Every level of history requires and HPI, which may be referred to as an "interval history" for follow-up encounters
- *The HPI is the only component of history which MUST be personally obtained and documented by the provider*

### Elements of HPI

- Location
- Duration
- Timing
- Quality
- Severity
- Context
- Modifying factors
- Associated signs or symptoms



Example of an extended HPI using all eight of the HPI elements.

## Levels of HPI

### Brief HPI

- Requires only one to three HPI elements

### Extended HPI

- Requires four HPI elements or the status of three chronic or inactive problems

## What if the patient has no complaints?

Without a specific somatic complaint, it may be difficult or outright impossible to qualify for any level of HPI using the HPI elements. This problem was addressed in the 1997 E/M guidelines. If there are no somatic complaints, the 1997 E/M guidelines allow you to qualify for extended HPI by commenting on the status of three or more chronic or inactive problems.

### ROS

- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- GI
- GU
- Musculoskeletal
- Skin
- Neurological
- Psychiatric
- Endocrine
- Hem/Lymphatic
- Allergic/Immunologic

*The ROS may be completed by the physician, ancillary staff or by having the patient fill out a questionnaire.*

## PFSH

- Past Medical History
  - Previously existing illnesses, prior operations, current medications, allergies, immunizations
- Family History
  - Health status of parents/siblings/children including relevant or hereditary diseases
- Social History
  - Marital status, employment, DOA, education, sexual history

*The PFSH may be completed by the physician, ancillary staff or by having the patient fill out a questionnaire.*

## Levels of History

<b>History</b>	<b>HPI</b>	<b>ROS</b>	<b>PFSH</b>
PF	Brief	None	None
EPF	Brief	1	None
Detailed	Extended	2 – 9	1 out of 3
Comp	Extended	10	3 out of 3

The documentation requirements for each level of history are very specific. Therefore, the history should be recorded in a purpose-driven manner to ensure compliance while avoiding time-wasting over-documentation.



## History Tips and Shortcuts

1. You need a chief complaint for each and every encounter. It may be a symptom or it may be a statement such as “follow-up HTN.”
2. The physician must always complete the HPI. However, it is acceptable to have the patient or a member of your staff fill out a questionnaire for the past medical, family, and social history (PFSH). However, in order for this information to be counted in your history, you must initial the document and include any pertinent positive and negative information in the body of your note. You should also mention that you reviewed the form in its entirety. Finally, you must keep the questionnaire as a permanent part of the medical record.
3. You don't have to list out the ROS; it is acceptable to have the patient fill out a form and then initial it, but that form must remain in the chart and you must refer to it in the body of your note. For example, “Complete 10 system ROS performed and documented, with pertinent findings included in the interval history.”
4. A Complete ROS requires that at least 10 systems be documented. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating “all other systems are negative” is permissible. In the absence of such a notation, at least 10 systems must be individually documented. (This shortcut is NOT accepted by ALL Medicare carriers, so check before you use it.)
5. When doing a comprehensive history on a follow-up patient in the office, you do not need to re-dictate a previous PMFSH if it is already in the chart. It is acceptable to refer to the earlier PMFSH and make any additions as needed. For example: “The comprehensive past medical, family, and social history obtained during our initial encounter was re-examined and reviewed with the patient. For details, please refer to my dictated note in this chart, dated September 23, 2003. Nothing more to add at this time.”
6. If the patient is too ill or confused to give a reliable history or ROS, you do not need to include this information in the documentation, but you must explain why the data is missing, e.g., “Unable to obtain ROS or past medical, family and social history due to patient's mental status”
7. At least **one** element from **EACH** of family, medical, and social history (PFSH) are required for a complete PFSH for the following categories: Office New Patient, Hospital Observation Care, Initial inpatient services, Consults, Comprehensive Nursing Facility Assessments (new patient), domiciliary care (new patient), and home care (new patient).
8. Only **2** out of **3** elements of PFSH are required to qualify for Comprehensive History for established office patients, ER visits, and established domiciliary or home patients.
9. PFSH Exemption: hospital progress notes require only an interval history. These encounters are officially exempt from the requirement for any elements of PFSH. Therefore a level 3 hospital progress note (99233)--which requires a Detailed History--*does not* require documentation of any elements of PFSH.
10. When using time as a determining factor, you must see the patient face to face for the entire time allotted for that particular level of care (for instance 25 minutes for a level 4 office follow-up visit.) You **MUST** document in the time spent **AND** the fact that **OVER** half of that time was devoted to counseling and/or coordination of care.
11. Prolonged services may be billed separately when a physician provides extended service involving direct (face-to-face) patient contact that is beyond the usual time allotted to a given encounter in either the inpatient or outpatient setting. This service is reported in addition to other physician services, including E/M services at any level. Report the total duration of face-to-face time spent by a physician on a given date, even if the time spent is not continuous. Prolonged services of less than 30 minutes are not reported separately. Code 99354 for the first 30 minutes to one hour of additional face-to-face service in the outpatient setting. This code is used in addition to the outpatient E/M visit codes. Code 99355 for each additional 30 minutes beyond the first hour. Code 99356 for the first 30 minutes to one hour of prolonged services in the inpatient setting. Code 99357 for each additional 30 minutes beyond the first hour of prolonged services in the inpatient setting. These codes are used in addition to the inpatient E/M codes.

## Physical Exam

- 1997 Physical Exam
- 15 Organ Systems and 59 bullets

<b>Exam</b>	<b>Bullets</b>
<b>PF</b>	<b>1 - 5</b>
<b>EPF</b>	<b>6 - 11</b>
<b>Detailed</b>	<b>12</b>
<b>Comp</b>	<b>18</b>

### 1997 Physical Exam Organ Systems

- Constitutional
- Eyes
- Ears, nose, mouth and throat
- Neck
- Respiratory
- Cardiovascular
- Chest (breasts)
- Gastrointestinal
- GU (male, female)
- Musculoskeletal
- Lymphatic
- Skin
- Neurologic
- Psychiatric

See individual bullets  
on next page.

# The 1997 Multi-System Exam Bullets

## Constitutional

- Three vital signs
- General appearance

## Eyes

- Inspection of conjunctiva and lids
- Examination of pupils and irises (PERRLA)
- Ophthalmoscopic discs and posterior segments

## Ears, Nose, Mouth, and Throat

- External appearance of the ears and nose
- Otoscopic examination of the external auditory canals and tympanic membranes
- Assessment of hearing
- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx

## Neck

- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of thyroid

## Respiratory

- Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic excursions)
- Percussion of chest
- Palpation of chest (e.g., tactile fremitus)
- Auscultation of the lungs

## Cardiovascular

- Palpation of the heart (PMI)
- Auscultation of the heart
- Assessment of lower extremity edema
- Examination of the carotid arteries
- Examination of abdominal aorta
- Examination of the femoral pulses
- Examination of the pedal pulses

## Chest (Breasts)

- Inspection of the breasts
- Palpation of the breasts and axillae

## Gastrointestinal (Abdomen)

- Examination of the abdomen with notation of presence of masses or tenderness
- Examination of the liver and spleen
- Examination for the presence or absence of hernias
- Examination of anus, perineum, and rectum, including sphincter tone, presence of hemorrhoids, rectal masses
- Obtain stool for occult blood testing

## Genitourinary (Male)

- Examination of the scrotal contents (e.g., tenderness of cord)
- Examination of the penis
- DRE of the prostate

## Genitourinary (Female)

- Examination of the external genitalia
- Examination of the urethra
- Examination of the bladder (e.g., fullness, masses, tenderness)
- Examination of the cervix
- Examination of the uterus (e.g., size, contour, position, mobility)
- Examination of the adnexa (e.g., masses, tenderness, nodularity)

## Musculoskeletal

- Examination of gait and station
- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, ischemia)

Examination of the joints, bones, and muscles of one or more of the following six areas:

1. Head and neck
2. Spine, ribs, and pelvis
3. Right upper extremity
4. Left upper extremity
5. Right lower extremity
6. Left lower extremity

The examination of a given area includes:

- Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
- Assessment of range of motion with notation of any pain, crepitation or contracture
- Assessment of stability with notation of any dislocation, subluxation, or laxity
- Assessment of muscle strength and tone with notation of any atrophy or abnormal movements

## Lymphatic

Palpation of lymph nodes **two** or more areas

- Neck
- Axillae
- Groin
- Other

## Skin

- Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
- Palpation of the skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)

## Neurologic

- Test cranial nerves with notation of any deficits
- Examination of DTRs with notation of any pathologic reflexes (e.g., Babinski)
- Examination of sensation (e.g., by touch, pin, vibration, proprioception)

## Psychiatric

- Description of patient's judgment and insight

Brief assessment of mental status, which may include:

- Orientation to time, place, and person
- Recent and remote memory
- Mood and affect

## 1995 Exam Rules

### Body Areas

- ◆Head/face
- ◆Neck
- ◆Chest/breast/axillae
- ◆Abdomen
- ◆Genitalia/groin/buttocks
- ◆Back/spine
- ◆Each extremity

### Organ Systems

- ◆Constitutional
- ◆Eyes
- ◆ENMT
- ◆Cardiovascular
- ◆Respiratory
- ◆GI
- ◆GU
- ◆Musculoskeletal
- ◆Skin
- ◆Neuro
- ◆Psychiatric
- ◆Hematologic-lymphatic

**Problem Focused:** a limited exam of affected body area or organ system

**Expanded Problem Focused:** a limited exam of the affected body area or organ system and other symptomatic or related organ systems

**Detailed:** an extended exam of the affected body area or organ system and other symptomatic or related organ systems

**Comprehensive:** a general multi-system exam or complete exam of a single organ system

*The 1995 exam rules are included here for the sake of completeness. We recommend using the 1997 physical exam rules because they are less open to individual interpretation and therefore more likely to stand up against an audit.*

## **Rational Physician Coding**

1. What level of care is supported by the MDM?
2. What documentation is required?
3. Is it reasonable to do what the documentation asks?

## **Established Office Patients**

- Accounted for \$11,155,924,872 in 2004
- 39% of E/M spending
- Five levels of care
  - 99211 \$21.00
  - 99212 \$37.00
  - 99213 \$52.00
  - 99214 \$81.00
  - 99215 \$117.00
- Two out of three key components



## Established Office Patients

E/M Code	History	Exam	MDM	Time
99211	None	None	None	5
99212	PF	PF	SF	10
99213	EPF	EPF	Low	15
99214	Detailed	Detailed	Mod	25
99215	Comp	Comp	High	40

**2 out of 3 key components must qualify**

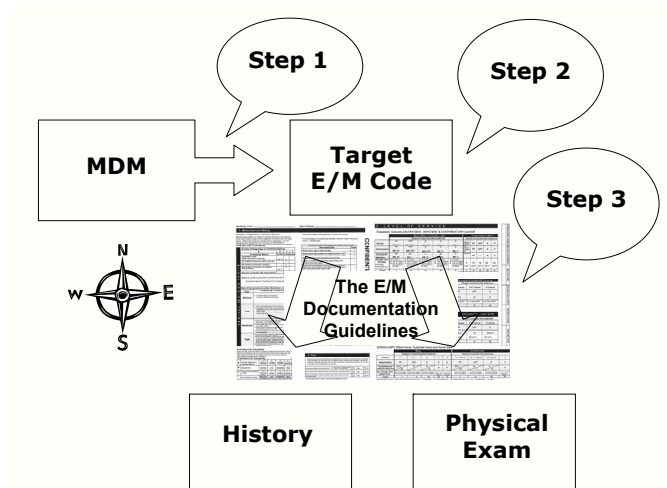
### A “Routine” Office Patient

- You see an established office patient with stable HTN, DM2 and dyslipidemia.
- There is also a history of CAD, which is well controlled.

$$\begin{array}{r|l} 139 & 101 \\ \hline 4.6 & 23 \end{array} \begin{array}{l} 12 \\ 124 \\ 0.8 \end{array} \quad \begin{array}{l} 12 \\ 36 \end{array}$$

MA/Cr = 28, LDL 77, HgbA1c 6.8

- You make no changes in medications and schedule return visit in four months.
- Time spent is 15 minutes
- What is this encounter worth?



<b>Table A.1 Number of Diagnoses</b>		PTS	
A "problem" is defined as a definitive diagnosis or, for undiagnosed problems, a related group of presenting symptoms and/or clinical findings.			
Each new or established problem for which the diagnosis and/or treatment plan is evident		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Each new or established problem for which the diagnosis and treatment plan is not evident  <div style="border: 1px solid black; border-radius: 15px; padding: 10px; display: inline-block;">             Diabetes HTN Dyslipidemia           </div>	2 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	1	<input checked="" type="checkbox"/>
	3 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	3	
	4 or more plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	4	
	<b>Total Points</b>	<b>3</b>	

<b>Table A.2 Management Options</b>		<b>PTS</b>
Do not count as treatment option's notations such as: Continue "same" therapy or "no change" in therapy if therapy is not described .		0
Drug management, per problem. Includes "same" therapy or "no change" in therapy if specified therapy is described (i.e., record documents what the current therapy is and that the physician reviewed it). Dose changes for current medications are not required, but the record must reflect conscious decision-making.	≤3 new or current meds per problem	1 <input checked="" type="checkbox"/>
	>3 new or current meds per problem	2
Open or percutaneous therapeutic cardiac, surgical or radiological procedure; minor or major		1
PT/OT, speech therapy or other manipulation		1
Closed treatment for fracture or dislocation		1
IV fluid or fluid component replacement, or establish IV access when record is clear that such involved physician decision-making (not standard "protocol")		1
Complex insulin prescription (SC or combo of SC/IV), TPN, insulin drip or other admixture		2
Conservative therapy: rest, ice, bandages, diet		1
Radiation therapy		1
Joint, body cavity, soft tissue, etc injection/aspiration		1
Patient education regarding self or home care		1
Decision to admit to hospital		1
Discuss case with other physician		1
Other – specify		1
<b>Total Points</b>		<b>1</b>



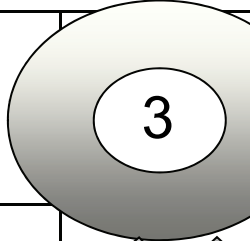

<b>Total TrailBlazer Problem Points</b>	
<b>Diagnosis Points</b>	
<b>Management Points</b>	
<b>Final Problem Points</b>	<b>3</b>

Table B Data Reviewed or Ordered		PTS
Order and/or review labs (Count lab panels as one procedure).	1 – 3 Procedures	1 <input checked="" type="checkbox"/>
	≥ 4 Procedures	2
Order X-rays or review X-ray reports	1 – 3 Procedures	1
	≥ 4 Procedures	2
Order and/or review tests in medical section of CPT.	1 – 3 Procedures	1
	≥ 4 Procedures	2
Discuss test results with performing physician.		1
Discuss case with other physician or consult another physician		1
Order and/or review old records.	Without summation	1
	With summation	2
Independent visualization and interpretation of an image, EKG or lab specimen (Each visualization and is allowed one point.)		1
Review of significant physiologic monitoring or testing data.		1
<b>Total Points</b>		<b>1</b>

<b>Risk</b>	<b>Presenting Problems</b>	<b>Diagnostic Procedures</b>	<b>Management Options</b>
<b>Minimal</b>	<ul style="list-style-type: none"> <li>•One self-limited or minor problem, e.g., cold, insect bite, tinea corporis.</li> </ul>	<ul style="list-style-type: none"> <li>•Laboratory tests</li> <li>•Chest X-rays</li> <li>•EKG/EEG, Echocardiogram</li> </ul>	<ul style="list-style-type: none"> <li>•Rest</li> <li>•Gargles</li> <li>•Superficial dressings</li> </ul>
<b>Low</b>	<ul style="list-style-type: none"> <li>•Two or more self-limited or minor problems</li> <li>•One stable chronic illness</li> <li>•Acute uncomplicated injury or illness, e.g., cystitis, allergic rhinitis, sprain</li> </ul>	<ul style="list-style-type: none"> <li>•Physiologic tests not under stress, e.g., PFTs</li> <li>•Non-cardiovascular imaging studies with contrast</li> <li>•ABG</li> <li>•Skin biopsies</li> </ul>	<ul style="list-style-type: none"> <li>•Over the counter drugs</li> <li>•Minor surgery, with no risk factors</li> <li>•PT/OT</li> <li>•IV fluids, without additives</li> </ul>
<b>Moderate</b>	<ul style="list-style-type: none"> <li>•One chronic illness, with mild exacerbation,</li> <li>•Two stable chronic illnesses <input checked="" type="checkbox"/></li> <li>•Undiagnosed new problem, with uncertain prognosis</li> </ul>	<ul style="list-style-type: none"> <li>•Cardiac stress test</li> <li>•Cardiovascular imaging studies, with contrast, with no identified risk factors</li> </ul>	<ul style="list-style-type: none"> <li>•Prescription drug management</li> <li>•IV fluids, with additives</li> </ul>
<b>High</b>	<ul style="list-style-type: none"> <li>•One or more chronic illness, with severe exacerbation,</li> <li>•Acute or chronic illness or injury, which poses a threat to life or bodily function</li> <li>•An abrupt change in neurological status</li> </ul>	<ul style="list-style-type: none"> <li>•Cardiovascular imaging, with contrast, with identified risk factors</li> <li>•Cardiac EP studies</li> <li>•Diagnostic endoscopies, with identified risk factors</li> </ul>	<ul style="list-style-type: none"> <li>•Parenteral controlled substances</li> <li>•Drug therapy requiring intensive monitoring for toxicity</li> <li>•Obtain DNR or de-escalate care</li> </ul>

## Calculating the Overall MDM

MDM Complexity	Problems	Data	Risk
Straight Forward	1	0 - 1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4	4	High

**Need 2 out of 3 to qualify for given level of MDM**

## Coding Based on Time

E/M Code		Time
99211	Must spend the entire allotted time with the patient AND at least half of that time must have been devoted to counseling and coordination of care	Required
99212		10
99213	Must document the time spent and the nature of the counseling and/or coordination of care	15
99214		25
99215	When coding based on time, there are no specific documentation requirements for History, Physical and MDM	40

In this case, we only spent 15 minutes with the patient, so if we coded based solely on time, the highest possible level of care would be a 99213.



## Selecting the Target Code

### Established Office Patients

E/M Code	History	Exam	MDM	Time
99211	No	MD	Presence	Required
99212	PF	PF	SF	10
99213	EPF	EPF	Mod	15
99214	Detailed	Detailed	Mod	25
99215	Comp	Complex	High	40

**2 out of 3 key components must qualify**

In this case, moderate complexity MDM points us toward a target code of a 99214 or a level four office visit.



## 99214

E/M Code	History	Exam	MDM	Time
99214	Det	Det	Mod	25

**2 out of 3 key components must qualify**

Time required would be 25 minutes

- Second most frequently used code for these encounters
- Reimbursement is about \$88.00

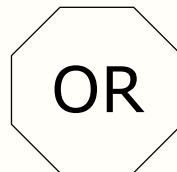
99211	5.2%
99212	6.7%
99213	57.7%
99214	27.3%
99215	4.0%

# 99214

E/M Code	History	Exam	MDM	Time
99214	Det	Det	Mod <input checked="" type="checkbox"/>	25

**2 out of 3 key components must qualify**

Hx	HPI	ROS	PFSH
PF	Brief	None	None
EPF	Brief	1	None
Det	Ext	2 – 9	1/3
Comp	Ext	10	3/3



Exam	Bullets
PF	1 – 5 from any systems
EPF	6 – 11 from any systems
Det	12 from any systems
Comp	2 from EACH of NINE systems



How do you choose which one to do?



Target Code	History	Exam	MDM
99214	Detailed <b>OR</b> Detailed	Moderate <input checked="" type="checkbox"/>	

**2 out of 3 key components must qualify**

Detailed History

Which is more reasonable and medically necessary?


Detailed Exam

Detailed History: Four HPI elements (or status of three chronic problems), plus 2 – 9 ROS and ONE area of PFSH

A Detailed Exam requires at LEAST 12 bullets from ANY organ systems

## Ethical Documentation

## Purpose-Driven Documentation



### 99214

Detailed History

~~Detailed Exam~~

Moderate MDM

### 2 out of 3 key components must qualify

Target Code	History	Exam	MDM
99214	Detailed	Detailed	Moderate

In this example, we know we only need to document two out of three qualifying key components. We have decided in advance to go for the qualifying history and MDM and we're not going to worry about qualifying for the exam. This allows us to streamline the documentation by performing and recording the minimal exam needed to take good medical care of the patient without worrying about including specific bullets.

History	HPI	ROS	PFSH
Detailed	Extended <input checked="" type="checkbox"/>	2 - 9 <input checked="" type="checkbox"/>	1/3 <input checked="" type="checkbox"/>

CC: F/U HTN and DM2

Status of Three Problems  
 HTN, DM2, Dyslipidemia

Interval History: The patient's HTN remains well controlled on current medications. Diabetes is stable as well, with no symptomatic hypoglycemia or severe hyperglycemia. Dyslipidemia remains stable on statin therapy.

PFSH is remarkable for CAD, s/p CABG in 2001.

One component  
 of PFSH

ROS: Constitutional: Negative for fatigue/anorexia  
 CV: Negative for chest pain/orthopnea/PND  
 Neuro: Negative for paresthesias

Review of two  
 clinically relevant  
 systems

### 2 out of 3 key components must qualify

Target Code	History	Exam	MDM
99214	Detailed <input checked="" type="checkbox"/>	Detailed	Moderate

1	2	3	4	5	6
Historical	Eyes	ENMT	Neck	Lungs	GU
<p>Vitals: 120/80, 18, 82, 98.6          Gen: NAD, conversant, well nourished WM looks stated age          HEENT: No JVD or carotid bruits          Lungs: Clear to auscultation          CV: RRR, no MRG's          Ext: No peripheral edema</p>					<p><b>Chest/Breasts</b></p> <p><b>Skin</b></p> <p><b>Musculoskeletal</b></p> <p><b>Neurologic</b></p> <p><b>Psychiatric</b></p>
<div style="border: 2px dashed gray; padding: 5px; display: inline-block;">             Requires AT LEAST 12 bullets from ANY organ systems           </div>					
<b>Target Code</b>	<b>History</b>	<b>Exam</b>	<b>MDM</b>		
99214	Detailed <input checked="" type="checkbox"/>	Detailed	Moderate		

Here, only six bullets are documented, which does not even come close to a detailed exam. But that's okay because we know we are going to qualify with the history and the medical decision-making.

## Medical Decision-Making

$\frac{139}{4.6} \frac{101}{23} \frac{124}{0.8} \frac{12}{36}$

HGBA1c = 6.8  
 LDL = 77  
 MA/Cr = 28

### Assessment

- Well controlled DM2
- Well controlled HTN
- Stable dyslipidemia

MDM	Prob Pts	Data Pts	Risk
SF	1	0 - 1	Min
Low	2	2	Low
Mod	3	3	Mod
High	≥4	≥4	High

Requires two out of three

### Plan

- Continue lisinopril unchanged for HTN
- Renal profile, Urine microalbumin, CBC on return
- Also check LFTs due to ongoing statin therapy
- Return visit in four months

<b>Target Code</b>	<b>History</b>	<b>Exam</b>	<b>MDM</b>
99214	Detailed <input checked="" type="checkbox"/>	Detailed	Moderate

# 99214

CC: F/U HTN and DM2

**Status of Three Chronic Problems**  
HTN, DM2, Dyslipidemia

Interval History: The patient's HTN remains well controlled on current medications. Diabetes is stable as well, with no symptomatic hypoglycemia or severe hyperglycemia. Dyslipidemia remains stable on statin therapy.

**One Component of PFSH**  
PMH of CAD

PFSH is remarkable for CAD, s/p CABG in 2001.

**Two Clinically Relevant ROS**  
Cardiovascular, Neurological

ROS CV: Negative for Chest pain/orthopnea/PND  
Neuro: Negative for paresthesias

MA/Cr = 28

Vitals: 120/80, 18, 82, 98.6

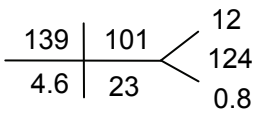
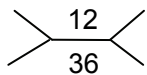
General: NAD, conversant,

Lungs: Clear to auscultation

CV: RRR, no MRG

Abd: Soft, non-tender

Ext: No peripheral edema



LDL = 77

**Only Six Bullets Used**

- Three vital signs
- General appearance
- Auscultation of lungs
- Auscultation of heart
- Brief abdominal exam
- Assessment of extremity edema

(Does NOT qualify as a detailed exam)

**Assessment**

1. Well controlled DM2
2. Well Controlled HTN
3. Stable dyslipidemia

HGBA1c = 6.8

MDM	Prob Pts	Data Pts	Risk
SF	≤ 1	≤ 1	Min
Low	2	2	Low
Mod	3	3	Mod
High	≥ 4	≥ 4	High

**Plan**

1. Continue lisinopril unchanged for HTN
2. Renal profile, Urine microalbumin, CBC on return
3. Also check LFTs due to ongoing statin therapy
4. Return visit in four months

This example qualifies as moderate complexity MDM due to three problem points and the presence of moderate risk. Since only two out of three dimension are needed, it does not matter that you only have one data point.

Requires two out of three qualifying key components

Target Code	History	Exam	MDM
99214	Detailed <input checked="" type="checkbox"/>	Detailed <input type="checkbox"/>	Moderate <input checked="" type="checkbox"/>



# Alternative Ending

CC: F/U HTN and DM2

Interval History: The patient's HTN remains well controlled on current medications. Diabetes is stable as well, with no symptomatic hypoglycemia or severe hyperglycemia. Dyslipidemia remains stable on statin therapy.

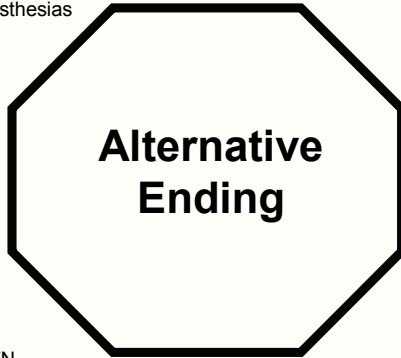
PFSH is remarkable for CAD, s/p CABG in 2001.

ROS: CV: Negative for Chest pain/orthopnea/PND  
Neuro: Negative for parasthesias

Vitals: 120/80, 18, 82, 98.6  
General: NAD, conversant,  
Lungs: Clear to auscultation  
CV: RRR, no MRG  
Abd: Soft, non-tender  
Ext: No peripheral edema

Assessment  
1. Well controlled DM2  
2. Well controlled HTN  
3. Stable dyslipidemia

Plan  
1. Continue lisinopril unchanged for HTN  
2. Renal profile, Urine microalbumin, CBC on return  
3. Also check LFTs due to ongoing statin therapy  
4. Return visit in four months



**Detailed History**  
Requires an extended HPI  
2 – 9 ROS and ONE element  
of PFSH

**Detailed Exam**  
Requires AT LEAST 12 bullets  
from ANY organ systems

MDM	Prob Pts	Data Pts	Risk
SF	1	0 - 1	Min
Low	2	2	Low
Mod	3	3	Mod
High	≥4	≥4	High

Moderate MDM

**2 out of 3 key components must qualify**

Target Code	History	Exam	MDM
<b>99214</b>	Detailed <input checked="" type="checkbox"/>	Detailed <input type="checkbox"/>	Moderate <input checked="" type="checkbox"/>

For established office patients, only two out of three qualifying key components are needed. In the above example, we qualified with the history and the MDM and we didn't worry about the exam.

On the other hand, you could just as well have qualified with a detailed exam along with the MDM and not worried about the history. The next page shows how the documentation for this "alternative ending" might look.

CC: F/U HTN and DM2

Interval History: The patient has no spontaneous somatic complaints.

Vitals: 120/80, 18, 82, 98.6

General: NAD, conversant

HEENT: Anicteric sclerae

Neck: No JVD or carotid bruits

Lungs: Clear to auscultation and percussion

CV: RRR, no MRG; normal PMI

Abd: Soft, non-tender; no HSM

Ext: No peripheral edema; good pedal pulses

Skin: Warm and dry; well-perfused

MA/Cr = 28      LDL = 77      HgbA1c 6.8

12	139	101	12
36	4.6	23	124
			0.8

Contains NO elements of HPI, ROS or PFSH and therefore does NOT qualify for ANY level of history

- 12 Bullets Used**
- Three vital signs
  - General appearance
  - Exam of conjunctiva/lids
  - Exam of neck
  - Auscultation of the lungs
  - Percussion of the lungs
  - Auscultation of heart
  - Brief abdominal exam
  - Exam of liver and spleen
  - Assessment of extremity edema
  - Assessment of pedal pulses
  - Palpation of the skin
- (DOES qualify as a detailed exam)**

**Assessment**

1. Well controlled DM2
2. Well Controlled HTN
3. Stable dyslipidemia

MDM	Prob Pts	Data Pts	Risk
SF	≤ 1	≤ 1	Min
Low	2	2	Low
Mod	3	3	Mod
High	≥ 4	≥ 4	High

**Plan**

1. Continue lisinopril unchanged for HTN
2. Renal profile, Urine microalbumin, CBC on return
3. Also check LFTs due to ongoing statin therapy
4. Return visit in four months

This example qualifies as moderate complexity MDM due to three problem points and the presence of moderate risk. Since only two out of three dimension are needed, it does not matter that you only have one data point.

Requires two out of three qualifying key components

Target Code	History	Exam	MDM
99214	Detailed ✗	Detailed ✓	Moderate ✓

## Hospital Progress Notes

- Accounted for a total of \$4.9 billion in allowed charges in 2005
- This adds up to 16.5% of E/M spending
- Three levels of care
  - 99231 \$36.00
  - 99232 \$64.00
  - 99233 \$91.00
- Requires documentation of 2 out of 3 key components



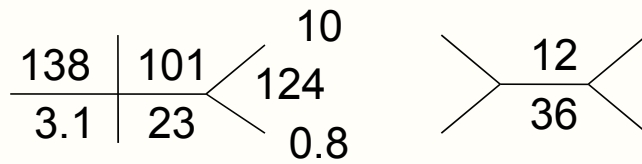
## Hospital Progress Notes

<b>E/M Code</b>	<b>History</b>	<b>Exam</b>	<b>MDM</b>	<b>Time</b>
<b>99231</b>	<b>PF</b>	<b>PF</b>	<b>SF/Low</b>	<b>15</b>
<b>99232</b>	<b>EPF</b>	<b>EPF</b>	<b>Moderate</b>	<b>25</b>
<b>99233</b>	<b>Detailed</b>	<b>Detailed</b>	<b>High</b>	<b>35</b>

**Only 2 out of 3 key components must qualify**

# Hospital Progress Note

- You see a patient with CHF exacerbation which had been improving on oral diuretics. CAD has been stable on oral nitrates with no active chest pain.



BNP is 1450

- You notice an empty bag of potato chips on the tray table.
- BP is 160/90, edema has worsened and patient c/o orthopnea requiring 2 liters NC O2 at rest.
- Echo report from yesterday shows an EF of 25%.
- You replete K+, change the patient to a strict 2 gram sodium diet, look at the CXR, order labs and repeat CXR for the a.m. You also change pt to IV Bumex.
- Total time spent is 25 minutes

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<b>Table A.1 Number of Diagnoses</b>		PTS
A "problem" is defined as a definitive diagnosis or, for undiagnosed problems, a related group of presenting symptoms and/or clinical findings.		
Each new or established problem for which the diagnosis and/or treatment plan is evident		<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> 1
<div style="border: 1px solid black; border-radius: 15px; padding: 10px; width: fit-content; margin: 0 auto;">           CHF HTN Hypokalemia CAD         </div>	2 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	2
	3 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	3
	4 or more plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	4
	<b>Total Points</b>	

Table A.2 Management Options		PTS
Do not count as treatment option's notations such as: Continue "same" therapy or "no change" in therapy if therapy is not described .		0
Drug management, per problem. Includes "same" therapy or "no change" in therapy if specified therapy is described (i.e., record documents what the current therapy is and that the physician reviewed it). Dose changes for current medications are not required, but the record must reflect conscious decision-making.	≤3 new or current meds per problem	<input checked="" type="checkbox"/> 1 <input checked="" type="checkbox"/>
	>3 new or current meds per problem	2
Open or percutaneous therapeutic cardiac, surgical or radiological procedure; minor or major		1
PT/OT, speech therapy or other manipulation		1
Closed treatment for fracture or dislocation		1
IV fluid or fluid component replacement, or establish IV access when record is clear that such involved physician decision-making (not standard "protocol")		1
Complex insulin prescription (SC or combo of SC/IV), TPN, insulin drip or other admixture		2
Conservative therapy: rest, ice, bandages, diet		1 <input checked="" type="checkbox"/>
Radiation therapy		1
Joint, body cavity, soft tissue, etc injection/aspiration		1
Patient education regarding self or home care		1
Decision to admit to hospital		1
Discuss case with other physician		1
Other – specify		1
<b>Total Points</b>		<b>3</b>

Total TrailBlazer Problem Points	
Diagnosis Points	4
Management Points	<input checked="" type="checkbox"/>
<b>Final Problem Points</b>	<b>4</b>

Table B Data Reviewed or Ordered		PTS
Order and/or review labs (Count lab panels as one procedure).	1 – 3 Procedures	1 <input checked="" type="checkbox"/>
	≥ 4 Procedures	2
Order X-rays or review X-ray reports	1 – 3 Procedures	1 <input checked="" type="checkbox"/>
	≥ 4 Procedures	2
Order and/or review tests in medical section of CPT.	1 – 3 Procedures	1 <input checked="" type="checkbox"/>
	≥ 4 Procedures	2
Discuss test results with performing physician.		1
Discuss case with other physician or consult another physician		1
Order and/or review old records.	Without summation	1
	With summation	2
Independent visualization and interpretation of an image, EKG or lab specimen (Each visualization and is allowed one point.)		1 <input checked="" type="checkbox"/>
Review of significant physiologic monitoring or testing data.		1
<b>Total Points</b>		<b>4</b>

Risk	Presenting Problems	Diagnostic Procedures	Management Options
<b>Minimal</b>	<ul style="list-style-type: none"> <li>•One self-limited or minor problem, e.g., cold, insect bite, tinea corporis.</li> </ul>	<ul style="list-style-type: none"> <li>•Laboratory tests</li> <li>•Chest X-rays</li> <li>•EKG/EEG, Echocardiogram</li> </ul>	<ul style="list-style-type: none"> <li>•Rest</li> <li>•Gargles</li> <li>•Superficial dressings</li> </ul>
<b>Low</b>	<ul style="list-style-type: none"> <li>•Two or more self-limited or minor problems</li> <li>•One stable chronic illness</li> <li>•Acute uncomplicated injury or illness, e.g., cystitis, allergic rhinitis, sprain</li> </ul>	<ul style="list-style-type: none"> <li>•Physiologic tests not under stress, e.g., PFTs</li> <li>•Non-cardiovascular imaging studies with contrast</li> <li>•ABG</li> <li>•Skin biopsies</li> </ul>	<ul style="list-style-type: none"> <li>•Over the counter drugs</li> <li>•Minor surgery, with no risk factors</li> <li>•PT/OT</li> <li>•IV fluids, without additives</li> </ul>
<b>Moderate</b>	<ul style="list-style-type: none"> <li>•One chronic illness, with mild exacerbation <input checked="" type="checkbox"/></li> <li>•Two stable chronic illnesses</li> <li>•Undiagnosed new problem, with uncertain prognosis</li> </ul>	<ul style="list-style-type: none"> <li>•Cardiac stress test</li> <li>•Cardiovascular imaging studies, with contrast, with no identified risk factors</li> </ul>	<ul style="list-style-type: none"> <li>•Prescription drug management <input checked="" type="checkbox"/></li> <li>•IV fluids, with additives</li> </ul>
<b>High</b>	<ul style="list-style-type: none"> <li>•One or more chronic illness, with severe exacerbation, <input type="checkbox"/></li> <li>•Acute or chronic illness or injury, which poses a threat to life or bodily function</li> <li>•An abrupt change in neurological status</li> </ul>	<ul style="list-style-type: none"> <li>•Cardiovascular imaging, with contrast, with identified risk factors</li> <li>•Cardiac EP studies</li> <li>•Diagnostic endoscopies, with identified risk factors</li> </ul>	<ul style="list-style-type: none"> <li>•Parenteral controlled substances</li> <li>•Drug therapy requiring intensive monitoring for toxicity</li> <li>•Obtain DNR or de-escalate care</li> </ul>

## Calculating the Overall MDM

MDM Complexity	Problems	Data	Risk
Straight Forward	1	0 - 1	Minimal
Low	2	2	Low
Moderate	3	3	Mod
High	4	4	High

Need 2 out of 3 to qualify for given level of MDM



## Selecting the Target Code

### Hospital Progress Notes

EPF Code	History	Exam	MDM	Time
00221	PF	PF	SF/Low	15
00222	PF	EPF	Mod	25
99233	Det	Det	High	35

2 out of 3 key components must qualify



**99233**

E/M Code	History	Exam	MDM	Time
99233	Det	Det	High	35

**2 out of 3 key components must qualify**

Time required would be 35 minutes

- Least frequently used code for these encounters
- Reimbursement is about \$78.00

99231	23.4%
99232	58.5%
<b>99233</b>	<b>18.1%</b>

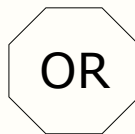


**99233**

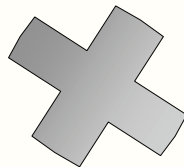
E/M Code	History	Exam	MDM	Time
99233	Det	Det	High <input checked="" type="checkbox"/>	35

**2 out of 3 key components must qualify**

Hx	HPI	ROS	PFSH
PF	Brief	None	None
EPF	Brief	1	None
Det	Ext	2 – 9	1/3
Comp	Ext	10	3/3




Exam	Bullets
PF	1 – 5 from any systems
EPF	6 – 11 from any systems
Det	12 from any systems
Comp	2 from EACH of NINE systems



In this case, we know that only two out of three key components are needed AND that we already have the qualifying MDM. This means we have to perform and document EITHER a detailed history OR a detailed exam in addition to our qualifying MDM order to ensure compliance. First, let's see how the documentation would look if we decided to go for the exam instead of the history.



# Rational Documentation



**99233**






~~Detailed History~~

Detailed Exam

High Complexity MDM

**2 out of 3 key components must qualify**

## History


<b>History</b>			
<b>Detailed</b>	<b>Exempted</b>		

CC: F/U CHF

HPI: The patient says he feels generally "lousy."

Contains no elements of HPI, PFSH or ROS and therefore does not qualify for ANY level of history

**2 out of 3 key components must qualify**

<b>Target Code</b>		<b>Exam</b>	<b>MDM</b>
<b>99233</b>	<b>Detailed</b>	<b>Detailed</b>	<b>High</b>

C	1	2	nal	Eyes	ENMT	3	4	5	6	7	8	9	10	GU
<p>Vitals: 160/90, 18, 82, 98.6</p> <p>General: NAD, well nourished WM looks stated age</p> <p>Neck: FROM, supple; no JVD</p> <p>Lungs: Bibasilar crackles; clear to percussion</p> <p>CV: RRR, no MRGs; normal PMI in the MCL</p> <p>Abd: Soft, non-tender; NABS, no HSM</p> <p>Ext: 2+ peripheral edema; no digital cyanosis</p> <p>Skin: Warm and dry; well perfused</p>													<b>Chest/Breasts</b>	
<p>Requires AT LEAST 12 bullets from ANY organ systems <input checked="" type="checkbox"/></p>													11	
<p><b>12 bullets:</b></p> <ul style="list-style-type: none"> <li>• Three vital signs</li> <li>• General appearance</li> <li>• Exam of neck</li> <li>• Auscultation of lungs</li> <li>• Percussion of lungs</li> <li>• Auscultation of heart</li> <li>• Palpation of PMI</li> <li>• Exam of the abdomen</li> <li>• Exam of liver and spleen</li> <li>• Assessment of lower extremity edema</li> <li>• Examination of digits</li> <li>• Palpation of skin</li> </ul>													Musculoskeletal 12	
													<b>Neurologic</b>	
													<b>Psychiatric</b>	
<b>2 out of 3 key components must qualify</b>														

<b>Target Code</b>	<del>H</del>	<b>Exam</b>	<b>MDM</b>
<b>99233</b>	<del>Demanded</del>	<b>Detailed</b> <input checked="" type="checkbox"/>	<b>High</b>

## Medical Decision-Making

BNP 1450

138 | 101 | 10  
 3.1 | 28 | 0.8 | 12 | 36

Assessment:

1. Decompensated CHF
2. Poorly controlled HTN
3. Mild hypokalemia
4. Stable CAD

Plan:

1. D/C PO Lasix
2. Start IV Bumex 2 mg Q 6H
3. Strict low Na+ diet
4. Replete K+ per protocol
5. Repeat renal profile, BNP in a.m.
6. Repeat CXR in a.m.

Echo: Report showed EF 25%

CXR was reviewed and showed worsening pulmonary vascular congestion

MDM	Prob Pts	Data Pts	Risk
SF	1	0 - 1	Min
Low	2	2	Low
Mod	3	3	Mod
High	≥4	≥4	High

Requires two out of three

<b>Target Code</b>	<del>H</del>	<b>Exam</b>	<b>MDM</b>
<b>99233</b>	<del>Demanded</del>	<b>Detailed</b> <input checked="" type="checkbox"/>	<b>High</b> <input checked="" type="checkbox"/>

CC: F/U HTN and DM2

Interval History: The patient states he feels generally "lousy."

This statement contains no elements of HPI, ROS or PFSH and therefore does not qualify for ANY level of history.

Vitals: 160/90, 18, 82, 98.6  
 General: NAD, conversant,  
 Neck: FROM, supple; no JVD  
 Lungs: Bibasilar crackles; clear to percussion  
 CV: RRR, no MRG; normal PMI  
 Abd: Soft, non-tender; no HSM  
 Ext: 2+ edema; no digital cyanosis  
 Skin: Warm and dry; well perfused

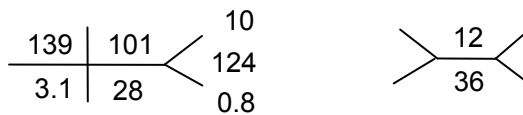
**This exam includes 12 bullets:**

- Three vital signs
- General appearance
- Exam of neck
- Auscultation of lungs
- Percussion of lungs
- Auscultation of heart
- Palpation of PMI
- Exam of the abdomen
- Exam of liver and spleen
- Assessment of lower extremity edema
- Examination of digits
- Palpation of skin

*(Qualifies as a detailed exam)*

**Assessment**

1. Decompensated CHF
2. Poorly controlled HTN
3. Mild hypokalemia
4. Stable CAD



CXR was reviewed and showed worsening pulmonary vascular congestion

**Plan**

1. D/C PO Lasix
2. Start IV Bumex 2 mg Q 6H
3. Strict low Na+ diet
4. Replete K+ per protocol
5. Repeat renal profile and BNP in a.m.
6. Repeat CXR in a.m.

MDM	Prob Pts	Data Pts	Risk
SF	≤ 1	≤ 1	Min
Low	2	2	Low
Mod	3	3	Mod
High	≥ 4	≥ 4	High

Requires 2/3 dimensions

MDM qualifies as being of high complexity based on the presence of four or more problem points and four or more data points, even though risk is only moderate.

Requires two out of three qualifying key components

Target Code	History	Exam	MDM
99233	Detailed ✗	Detailed ✓	High ✓

# 99233

CC: CHF

Interval History: TThe patient' feels generally "lousy."

Vitals: 160/90, 18, 82, 98.6  
 General: NAD, conversant,  
 Neck: FROM, supple; no JVD  
 Lungs: Bibasilar crackles; clear to percuss  
 CV: RRR, no MRG; normal PMI  
 Abd: Soft, non-tender; no HSM  
 Ext: 2+ edema; no digital cyanosis  
 Skin: Warm and dry; well perfused

**Assessment**

1. Decompensated CHF
2. Poorly controlled HTN
3. Mild hypokalemia
4. Stable CAD

**Plan**

1. D/C PO Lasix
2. Start IV Bumex 2 mg Q 6H
3. Strict low Na+ diet
4. Replete K+ per protocol
5. Repeat renal profile and BNP in a.m.
6. Repeat CXR in a.m.



**Detailed History**  
 Requires an extended HPI  
 2 – 9 ROS and ONE element  
 of PFSH

**Detailed Exam**  
 Requires AT LEAST 12 bullets  
 from ANY organ systems

MDM	Prob Pts	Data Pts	Risk
SF	1	0 - 1	Min
Low	2	2	Low
Mod	3	3	Mod
High	≥4	≥4	High

**High Complexity MDM**

Target Code	History	Exam	MDM
99233	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Remember, for hospital progress note, only two out of three qualifying key components must be documented. In the above example, we qualified with the exam and the MDM and we didn't worry about the history.

On the other hand, we could have gone for the history instead of the exam. It's up to the individual examiner to decide which key component would be more medically necessary and informative.

The next page shows how the documentation might look for this "alternative ending."

# 99233

CC: F/U HTN and DM2

**Status of Three Chronic Problems**  
CHF, HTN, CAD

Interval History: The patient's CHF symptoms have worsened due to dietary non-compliance. HTN is poorly controlled as well due to volume overload. CAD remains stable with no active chest pain.

**Two Clinically Relevant ROS**  
Cardiovascular, Pulmonary

ROS CV: + orthopnea, - SSCP/PND  
Pulmonary: + DOE, - cough/hemoptysis/SOBAR

Lungs: Bibasilar crackles  
CV: RRR, no MRG; normal PMI  
Ext: 2+ edema

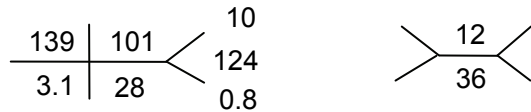
**This exam includes three bullets:**

- Auscultation of lungs
- Auscultation of heart
- Assessment of lower extremity edema

*(Does NOT qualify as a detailed exam)*

**Assessment**

1. Decompensated CHF
2. Poorly controlled HTN
3. Mild hypokalemia
4. Stable CAD



CXR was reviewed and showed worsening pulmonary vascular congestion

**Plan**

1. D/C PO Lasix
2. Start IV Bumex 2 mg Q 6H
3. Strict low Na+ diet
4. Replete K+ per protocol
5. Repeat renal profile and BNP in a.m.
6. Repeat CXR in a.m.

MDM	Prob Pts	Data Pts	Risk
SF	≤ 1	≤ 1	Min
Low	2	2	Low
Mod	3	3	Mod
High	≥ 4	≥ 4	High

Requires 2/3 dimensions

MDM qualifies as being of high complexity based on the presence of four or more problem points and four or more data points, even though risk is only moderate.

Requires two out of three qualifying key components

Target Code	History	Exam	MDM
99233	Detailed <input checked="" type="checkbox"/>	Detailed <input type="checkbox"/>	High <input checked="" type="checkbox"/>

## Admission H&Ps

- Accounted for \$1.3 billion in allowed charges in 2005
- This adds up to 4.4% of E/M spending
- Three levels of care
  - 99221            \$84.00
  - 99222            \$118.00
  - 99223            \$172.00
- Requires documentation of 3 out of 3 key components

## Documentation: Admission H&Ps

<b>E/M Code</b>	<b>History</b>	<b>Exam</b>	<b>MDM</b>	<b>Time</b>
<b>99221</b>	<b>Detailed</b>	<b>Detailed</b>	<b>SF/Low</b>	<b>30</b>
<b>99222</b>	<b>Comp</b>	<b>Comp</b>	<b>Moderate</b>	<b>50</b>
<b>99223</b>	<b>Comp</b>	<b>Comp</b>	<b>High</b>	<b>70</b>

**3 out of 3 key components must qualify**

## Admission H&P

- You are on ER backup and asked to admit a 68 year old diabetic male with HTN and dyslipidemia who presents with chest pain.
- After reviewing the EKG, CXR and labs, you decide to admit the patient to a monitored bed in the CCU and consult cardiology.
- The chest pain improves with IV MSO4. You also order ASA, NTP and sliding scale insulin.
- Total time spent is 50 minutes
- What is the correct code and documentation?

<b>Table A.1 Number of Diagnoses</b>		
A “problem” is defined as a definitive diagnosis or, for undiagnosed problems, a related group of presenting symptoms and/or clinical findings.		PTS
Each new or established problem for which the diagnosis and/or treatment plan is evident		1
<div style="border: 1px solid black; border-radius: 15px; padding: 10px; width: fit-content;"> <p><b>Chest Pain (USA)</b></p> <ul style="list-style-type: none"> <li>• HTN</li> <li>• DM</li> <li>• Dyslipidemia</li> </ul> </div>	2 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	2
	3 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	3 <input checked="" type="checkbox"/>
	4 or more plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	4
	<b>Total Points</b>	

<b>Table A.2 Management Options</b>		<b>PTS</b>
Do not count as treatment option's notations such as: Continue "same" therapy or "no change" in therapy if therapy is not described .		0
Drug management, per problem. Includes "same" therapy or "no change" in therapy if specified therapy is described (i.e., record documents what the current therapy is and that the physician reviewed it). Dose changes for current medications are not required, but the record must reflect conscious decision-making.	≤3 new or current meds per problem	1
	>3 new or current meds per problem	2 <input checked="" type="checkbox"/>
Open or percutaneous therapeutic cardiac, surgical or radiological procedure; minor or major		1
PT/OT, speech therapy or other manipulation		1
Closed treatment for fracture or dislocation		1
IV fluid or fluid component replacement, or establish IV access when record is clear that such involved physician decision-making (not standard "protocol")		1
Complex insulin prescription (SC or combo of SC/IV), TPN, insulin drip or other admixture		2 <input checked="" type="checkbox"/>
Conservative therapy: rest, ice, bandages, diet		1
Radiation therapy		1
Joint, body cavity, soft tissue, etc injection/aspiration		1
Patient education regarding self or home care		1
Decision to admit to hospital		1 <input checked="" type="checkbox"/>
Discuss case with other physician		1
Other – specify		1
<b>Total Points</b>		<b>5</b>



<b>Total TrailBlazer Problem Points</b>	
Diagnosis Points	
Management Points	
<b>Final Problem Points</b>	<b>5</b>



Table B Data Reviewed or Ordered		PTS
Order and/or review labs (Count lab panels as one procedure).	1 – 3 Procedures	1 <input checked="" type="checkbox"/>
	≥ 4 Procedures	2
Order X-rays or review X-ray reports	1 – 3 Procedures	1
	≥ 4 Procedures	2
Order and/or review tests in medical section of CPT.	1 – 3 Procedures	1
	≥ 4 Procedures	2
Discuss test results with performing physician.		1
Discuss case with other physician or consult another physician		1 <input checked="" type="checkbox"/>
Order and/or review old records.	Without summation	1
	With summation	2
Independent visualization and interpretation of an image, EKG or lab specimen (Each visualization and is allowed one point.)		<input checked="" type="checkbox"/> 1 <input checked="" type="checkbox"/>
Review of significant physiologic monitoring or testing data.		1
<b>Total Points</b>		<b>4</b>

Risk	Presenting Problems	Diagnostic Procedures	Management Options
<b>Minimal</b>	<ul style="list-style-type: none"> <li>•One self-limited or minor problem, e.g., cold, insect bite, tinea corporis.</li> </ul>	<ul style="list-style-type: none"> <li>•Laboratory tests</li> <li>•Chest X-rays</li> <li>•EKG/EEG, Echocardiogram</li> </ul>	<ul style="list-style-type: none"> <li>•Rest</li> <li>•Gargles</li> <li>•Superficial dressings</li> </ul>
<b>Low</b>	<ul style="list-style-type: none"> <li>•Two or more self-limited or minor problems</li> <li>•One stable chronic illness</li> <li>•Acute uncomplicated injury or illness, e.g., cystitis, allergic rhinitis, sprain</li> </ul>	<ul style="list-style-type: none"> <li>•Physiologic tests not under stress, e.g., PFTs</li> <li>•Non-cardiovascular imaging studies with contrast</li> <li>•ABG</li> <li>•Skin biopsies</li> </ul>	<ul style="list-style-type: none"> <li>•Over the counter drugs</li> <li>•Minor surgery, with no risk factors</li> <li>•PT/OT</li> <li>•IV fluids, without additives</li> </ul>
<b>Moderate</b>	<ul style="list-style-type: none"> <li>•One chronic illness, with mild exacerbation,</li> <li>•Two stable chronic illnesses</li> <li>•Undiagnosed new problem, with uncertain prognosis</li> </ul>	<ul style="list-style-type: none"> <li>•Cardiac stress test</li> <li>•Cardiovascular imaging studies, with contrast, with no identified risk factors</li> </ul>	<ul style="list-style-type: none"> <li>•Prescription drug management</li> <li>•IV fluids, with additives</li> </ul>
<b>High</b>	<ul style="list-style-type: none"> <li>•One or more chronic illness, with severe exacerbation,</li> <li>•Acute or chronic illness or injury, which poses a threat to life or bodily function <input checked="" type="checkbox"/></li> <li>•An abrupt change in neurological status</li> </ul>	<ul style="list-style-type: none"> <li>•Cardiovascular imaging, with contrast, with identified risk factors</li> <li>•Cardiac EP studies</li> <li>•Diagnostic endoscopies, with identified risk factors</li> </ul>	<ul style="list-style-type: none"> <li>•Parenteral controlled substances <input checked="" type="checkbox"/></li> <li>•Drug therapy requiring intensive monitoring for toxicity</li> <li>•Obtain DNR or de-escalate care</li> </ul>

### Calculating the Overall MDM

MDM Complexity	Problems	Data	Risk
Straight Forward	1	0 - 1	Minimal
Low	2	2	Low
Moderate	3	3	Mod
High	4	4	High

Need 2 out of 3 to qualify for given level of MDM



### Selecting the Target Code

Admission H&Ps

Code	History	Exam	MDM	Time
00221	Det	Det	SF/Low	30
00222	Comp	Comp	High	50
99223	Comp	Comp	High	70

3 out of 3 key components must qualify



# 99223

E/M Code	History	Exam	MDM	Time
99223	Comp	Comp	High	70

**3 out of 3 key components must qualify**

Time required would be 70 minutes

- Most frequently used code for these encounters
- Reimbursement is about \$155.00

99221	4.1%
99222	35.5%
<b>99223</b>	<b>60.4%</b>

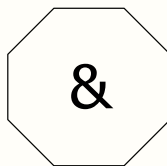


# 99223

E/M Code	History	Exam	MDM	Time
99233	Comp	Comp	High <input checked="" type="checkbox"/>	70

**3 out of 3 key components must qualify**

Hx	HPI	ROS	PFSH
PF	Brief	None	None
EPF	Brief	1	None
Det	Ext	2 – 9	1/3
Comp	Ext	10	3/3



Exam	Bullets
PF	1 – 5 from any systems
EPF	6 – 11 from any systems
Det	12 from any systems
Comp	2 from EACH of NINE systems



For this type of encounter, all three qualifying key components must be documented. This means we don't have a choice: We need to perform and document BOTH the comprehensive history AND the comprehensive exam to maintain compliance.

<b>History</b>	<b>HPI</b>	<b>PFSH</b>	<b>ROS</b>
<b>Comp</b>	<b>Extended</b> <input checked="" type="checkbox"/>	<b>3 out of 3</b> <input checked="" type="checkbox"/>	<b>10</b> <input checked="" type="checkbox"/>

CC: Chest pain

HPI: The patient presents with chest pain which began about two hours ago. Pain described as “crushing” and 8 out of 10 in severity. The pain has been constant since onset and is sometimes associated with nausea and SOB. The pain improved with IV MOS4 in the ER.

PMH: HTN, IRDM, dyslipidemia and gout

Current Medications

Lisinopril 10 mg QD

Lipitor 20 mg QD

70/30 insulin 20 BID

SH: Quit smoking in 1978, social ETOH; married 35 years

FH: Father died at 48 of AMI, mother is alive in her 90’s and has Alzheimer’s; one grown son IGH

ROS: Constitutional: + fatigue, - fevers/chills/anorexia  
 CV: + intermittent lower extremity edema; - PND  
 Pulmonary: - cough/hemoptysis/pleuritic chest pain  
*All other systems reviewed and are negative.*

**3 out of 3 key components must qualify**

<b>Target Code</b>	<b>History</b>	<b>Exam</b>	<b>MDM</b>
<b>99223</b>	<b>Comp</b> <input checked="" type="checkbox"/>	<b>Comp</b>	<b>High</b>

- Qualifies for an extended HPI because four or more HPI elements were recorded. In this case, the following seven elements were used:
  - Location
  - Duration
  - Quality
  - Severity
  - Timing
  - Associated signs or symptoms
  - Modifying factors
- Qualifies for a complete PFSH because at least one element from all three components of PFSH was recorded.
- At least 10 systems were reviewed using the accepted shortcut, “All other systems were reviewed and are negative.”

*This meets all the requirements for a comprehensive history.*

1	2	3	4	5	6	7	8	9	10	11	12	13	14	GU
<p>Vitals: 140/75, 108, 98.6          General: Anxious and agitated, well-nourished WM; looks stated age          Eyes: anicteric sclerae, moist conjunctiva with no lid-lag; PERRLA          HENT: AT/NC; oropharynx clear; MMM; normal hard/soft palate          Neck: Trachea midline; FROM, supple; no thyromegaly          Lungs: Clear to auscultation; normal respiratory effort          CV: RRR, no MRGs, hyperdynamic PMI in the midclavicular line          Abd: Soft, non-tender; no masses or HSM          Ext: No digital cyanosis, but some clubbing          Skin: Normal temperature/turgor/texture; no rash/ulcers/nodules          Psych: Appropriate affect; A&amp;O X 3</p>												<b>Chest/Breasts</b>		
												15	16	
												<b>Musculoskeletal</b>		
												19		
												<b>Neurologic</b>		
												17	18	

Requires AT LEAST 2 bullets from EACH of NINE organ systems

<b>Target Code</b>	<b>History</b>	<b>Exam</b>	<b>MDM</b>
<b>99223</b>	<b>Comp</b> <input checked="" type="checkbox"/>	<b>Comp</b> <input checked="" type="checkbox"/>	<b>High</b>

This qualifies as a comprehensive exam because at least two bullets from each of nine different organ systems were performed and documented. The following bullets were used:

- |   |  |
|---|--|
| <p><b>Constitutional</b></p> <ul style="list-style-type: none"> <li>• Three vital signs</li> <li>• General appearance</li> </ul> <p><b>Eyes</b></p> <ul style="list-style-type: none"> <li>• Exam of sclerae/lids</li> <li>• Exam of pupils/irises</li> </ul> <p><b>ENT</b></p> <ul style="list-style-type: none"> <li>• External appearance of ears/nose</li> <li>• Exam of oropharynx</li> </ul> <p><b>Neck</b></p> <ul style="list-style-type: none"> <li>• Exam of neck</li> <li>• Exam of thyroid</li> </ul> <p><b>Lungs</b></p> <ul style="list-style-type: none"> <li>• Auscultation of lungs</li> <li>• Assessment of respiratory effort</li> </ul> | <p><b>CV</b></p> <ul style="list-style-type: none"> <li>• Auscultation of heart</li> <li>• Palpation of heart</li> </ul> <p><b>Abdomen</b></p> <ul style="list-style-type: none"> <li>• Abdominal Exam</li> <li>• Exam of liver/spleen</li> </ul> <p><b>Skin</b></p> <ul style="list-style-type: none"> <li>• Inspection of skin</li> <li>• Palpation of skin</li> </ul> <p><b>Psych</b></p> <ul style="list-style-type: none"> <li>• Assessment of affect</li> <li>• Assessment of orientation</li> </ul> |
|---|--|

# Medical Decision-Making

EKG showed LVH by voltage, NSR, no diagnostic ST changes  
 CXR was reviewed and showed no infiltrate or effusion

## Assessment

1. USA vs. AMI
2. Stable HTN
3. Stable DM2

$$\frac{136}{3.8} \mid \frac{101}{24} \times \frac{14}{88} \times \frac{12}{36} \times 0.8$$

MDM	Prob Pts	Data Pts	Risk
SF	1	0 - 1	Min
Low	2	2	Low
Mod	3	3	Mod
High	≥4	≥4	High

Requires two out of three

## Plan

1. F/U enzymes ASAP
2. Admit to monitored bed in CCU
3. Start ASA, PPI, NTP and sq heparin, PRN IV MSO4 for CP
4. Sliding scale insulin
5. Consult cardiology

Target Code	History	Exam	MDM
99223	Comp <input checked="" type="checkbox"/>	Comp <input checked="" type="checkbox"/>	High <input checked="" type="checkbox"/>

This example qualifies as being of high complexity medical decision-making due to the presence of:

- Four or more problem points
- Four or more data points
- High risk

Note: Even if we only had moderate risk, we would still qualify for high complexity MDM because only two out of three dimensions are needed in order to qualify for any given level of complexity.

**Seven HPI Elements**  
Location, Duration, Quality, Severity, Timing, Associated Symptoms, Modifying Factors

CC: Chest pain

HPI: The patient presents with chest pain which began about two hours ago. Pain described as "crushing" and 8 out of 10 in severity. The pain has been constant since onset and is sometimes associated with nausea and SOB. The pain improved with IV MOS4 in the ER.

**Complete PFSH**  
At least one element from all three components of past medical, family and social history

PMH: HTN, IRDM, dyslipidemia and gout

SH: Quit smoking in 1978, social ETOH; married 35 years

FH: Father died at 48 of AMI, mother is alive in her 90's and has Alzheimer's; one grown son IGH

**Complete ROS**  
Using the accepted shortcut, "All other systems reviewed and are negative."

ROS: Constitutional: + fatigue, - fevers/chills/anorexia  
CV: + intermittent lower extremity edema; - PND  
Pulmonary: - cough/hemoptysis/pleuritic chest pain  
*All other systems reviewed and are negative.*

- Bullets Used**
- Constitutional
    - Three vital signs
    - General appearance
  - Eyes
    - Exam of sclerae/lids
    - Exam of pupils/irises
  - ENT
    - External appearance of ears/nose
    - Exam of oropharynx
  - Neck
    - Exam of neck
    - Exam of thyroid
  - Lungs
    - Auscultation of lungs
    - Assess respiratory effort
  - CV
    - Auscultation of heart
    - Palpation of heart
  - Abdomen
    - Abdominal Exam
    - Exam of liver/spleen
  - Skin
    - Inspection of skin
    - Palpation of skin
  - Psyche
    - Assessment of affect
    - Assessment of orientation
- (Qualifies as a comprehensive exam)

Vitals: 148/75, 24, 108, 98.6

Gen: Agitated, well-nourished WM; looks stated age

Eyes: Anicteric sclerae, no lid-lag; PERRLA

HENT: AT/NC, oropharynx clear; normal hard/soft palate

Neck: Trachea midline; FROM, supple, no thyromegaly

Lungs: CTA; normal respiratory effort

CV: RRR, no MRGs, normal PMI in the MCL

Abd: Soft, non-tender, NABS, no masses or HSM

Skin: Normal temperature/turgor, no rash, ulcers or nodules

Psych: Appropriate affect; A&OX3

EKG shows LVH by voltage; no diagnostic ST changes

CXR was reviewed and showed no infiltrate or effusion

Assessment	136	101	14	12
1. Unstable Angina	3.8	24	88	36
2. Stable HTN			0.8	
3. Stable DM2				

Qualifies as high complexity based on all three dimensions of medical decision-making

MDM	Prob Pts	Data Pts	Risk
SF	≤ 1	≤ 1	Min
Low	2	2	Low
Mod	3	3	Mod
High	≥ 4	≥ 4	High

**Plan**

1. F/U enzymes ASAP
2. Admit to monitored bed in the CCU
3. ASA, PPI, NTP, sq heparin, PRN MSO4
4. Sliding scale insulin
5. Consult cardiology

Requires three out of three qualifying key components

Target Code	History	Exam	MDM
99223	Comp <input checked="" type="checkbox"/>	Comp <input checked="" type="checkbox"/>	High <input checked="" type="checkbox"/>

## Rational Physician Coding

- Determines the highest ethical level of care
- Driven by medical necessity
- Ensures 100% E/M compliance
- Saves time by avoiding over-documentation
- Increases revenue by preventing undercoding
- Focuses on patient care



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