



The Basic Course

A Clinical Approach to Accurate and Ethical
E/M Coding and Documentation

Redacted Version

Peter R. Jensen, MD, CPC
www.EMuniversity.com

Redacted Version



The Basic Course

**A Clinical Approach to Accurate and Ethical
E/M Coding and Documentation**



Peter R. Jensen, MD, CPC

Goals

- Understand the key components of documentation
- Improve documentation compliance
- Save time by streamlining the documentation
- Learn to select the correct level of care
- Keep the focus on patient care

Repeated Version

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.

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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?

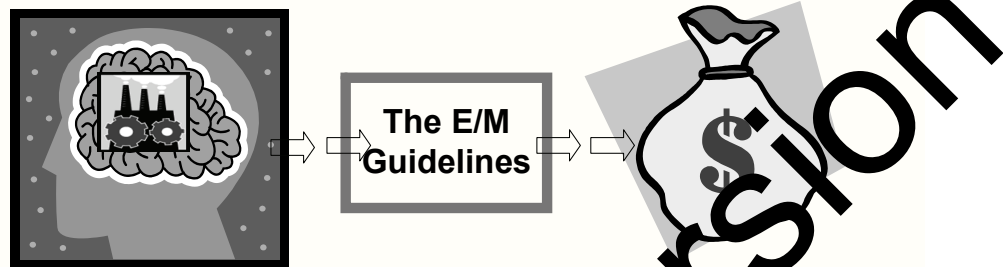
E/M Coding

- 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
99212	\$36.82
99213	\$51.63
99214	\$80.53
99215	\$117.21

↑ 50%

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

Repealed Version

History

- CC
 - HPI
 - ROS
 - PFSH
- Problem Focused
 - Expanded Problem Focused
 - Detailed
 - Comprehensive

Levels of History

History	HPI	ROS	PFSH
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 an 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

If there are no somatic complaints, the 1997 E/M guidelines state that an extended HPI may be completed by commenting on the status of three or more chronic or inactive problems.

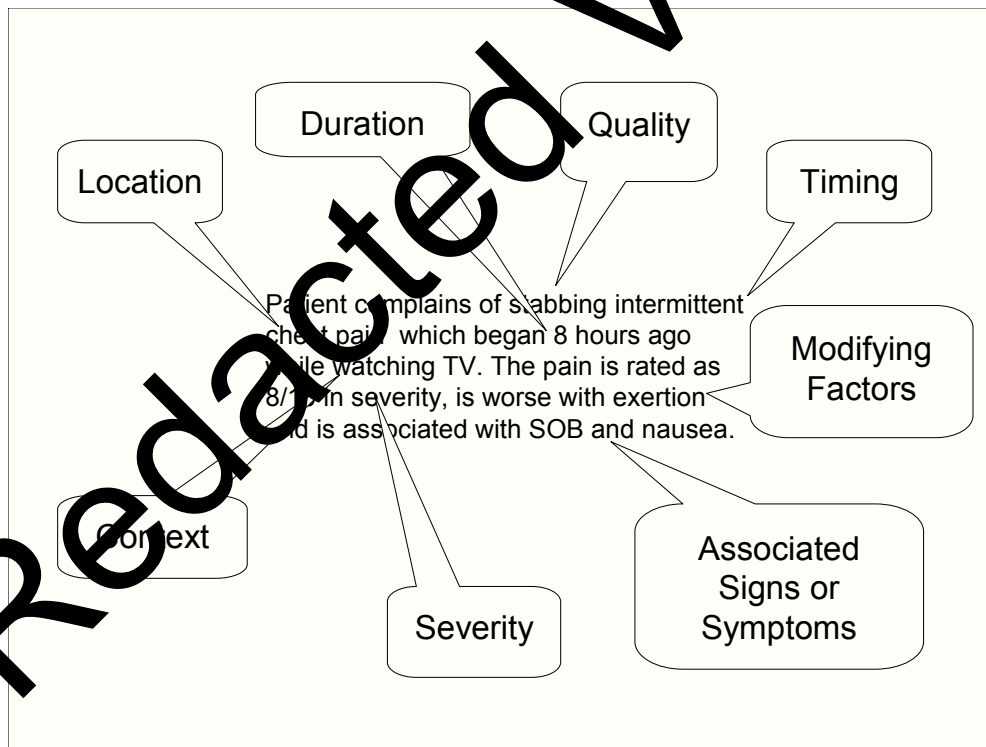
Levels of HPI

Brief HPI

- Requires only one to three HPI elements

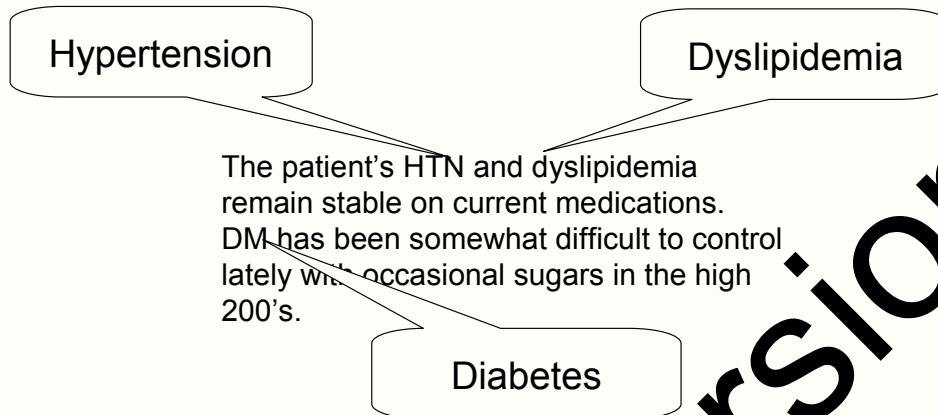
Extended HPI

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



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

Status of Three Chronic Problems



If there are no somatic complaints, an Extended HPI may be completed 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.

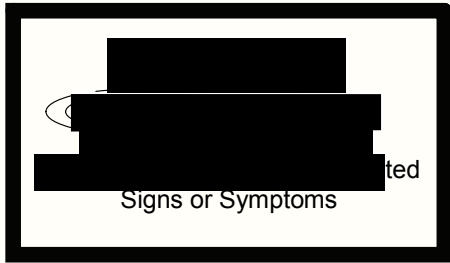
Levels of History

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

The history should be recorded in a purpose-driven manner to ensure compliance while avoiding time-wasting over-documentation.

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One HPI Element
Location

Requires one to
three HPI Elements



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Expanded Problem Focused History

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History Tips and Shortcuts

1. You need a patient history and physical examination. You need a patient history and physical examination. You need a patient history and physical examination.
2. The physician must be present for the history and physical examination. However, the physician may be present for the history and physical examination and include the patient in the examination. The physician may also mention the patient's medical history and physical examination. The physician may also mention the patient's medical history and physical examination.
3. You don't need a patient history and physical examination. You don't need a patient history and physical examination. You don't need a patient history and physical examination.
4. A Complicated History and Physical Examination is a patient history and physical examination that is at least 10 minutes long. A Complicated History and Physical Examination is a patient history and physical examination that is at least 10 minutes long. A Complicated History and Physical Examination is a patient history and physical examination that is at least 10 minutes long.
5. When documenting a patient history and physical examination, the physician should include the patient's medical history and physical examination. When documenting a patient history and physical examination, the physician should include the patient's medical history and physical examination. When documenting a patient history and physical examination, the physician should include the patient's medical history and physical examination.
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7. At least one physician should be present for the patient history and physical examination. At least one physician should be present for the patient history and physical examination. At least one physician should be present for the patient history and physical examination.
8. Only 2 physicians can be present for the patient history and physical examination. Only 2 physicians can be present for the patient history and physical examination. Only 2 physicians can be present for the patient history and physical examination.
9. PFSH E/M is a patient history and physical examination. PFSH E/M is a patient history and physical examination. PFSH E/M is a patient history and physical examination.
10. When using a patient history and physical examination, the physician should use a patient history and physical examination. When using a patient history and physical examination, the physician should use a patient history and physical examination. When using a patient history and physical examination, the physician should use a patient history and physical examination.
11. Prolonged History and Physical Examination is a patient history and physical examination that is at least 30 minutes long. Prolonged History and Physical Examination is a patient history and physical examination that is at least 30 minutes long. Prolonged History and Physical Examination is a patient history and physical examination that is at least 30 minutes long.

Physical Exam

- 1997 Physical Exam
- 15 Organ Systems and 59 bullets

Exam	Bullets
PF	1 - 5
EPF	6 - 11
Detailed	12
Comp	18

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
- Otoscope 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 (MI)
- 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 hands (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

Problem Focused Exam

Constitution	
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General: NAD, c

Physical Exam
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Level 4 and

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

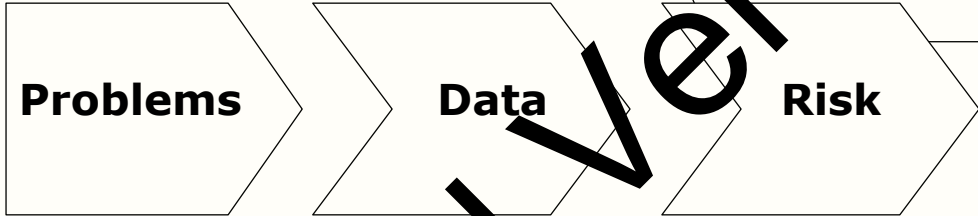
The 1995 exam rules are included here for the sake of completeness. We recommend using the 1997 physical exam rules because they are less open to individual interpretation and therefore more likely to stand up against an audit.

Medical Decision-Making

- Straightforward
- Low Complexity
- Moderate Complexity
- High Complexity

Cognitive Labor
+
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 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.”



Determining the MDM

Number of Diagnoses	Data Reviewed	Risk	Level of MDM
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

MDM Points

MDM Complexity	Problems	Data	Risk
Straight Forward	1	1	Minimal
Low	2	2	Low

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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

“Data points” are reviewed during

Risk is stratified and/or managed to the table on element of risk

Table of Risk

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

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 qualify 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

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SF Complexity MDM

Clinical Correlation

You see an otherwise healthy patient with a cold and recommend increased fluid intake and plenty of rest.

Problems/DDx	Pts	MDM	Prob Pts	Data Pts	Risk
Self limited or minor (Max 2)	1	SF	1	0 - 1	Min

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Low Complexity MDM

Clinical Correlation

You see a patient with OA which is no longer controlled on Tylenol. You recommend Motrin 800 mg PO TID, prn.

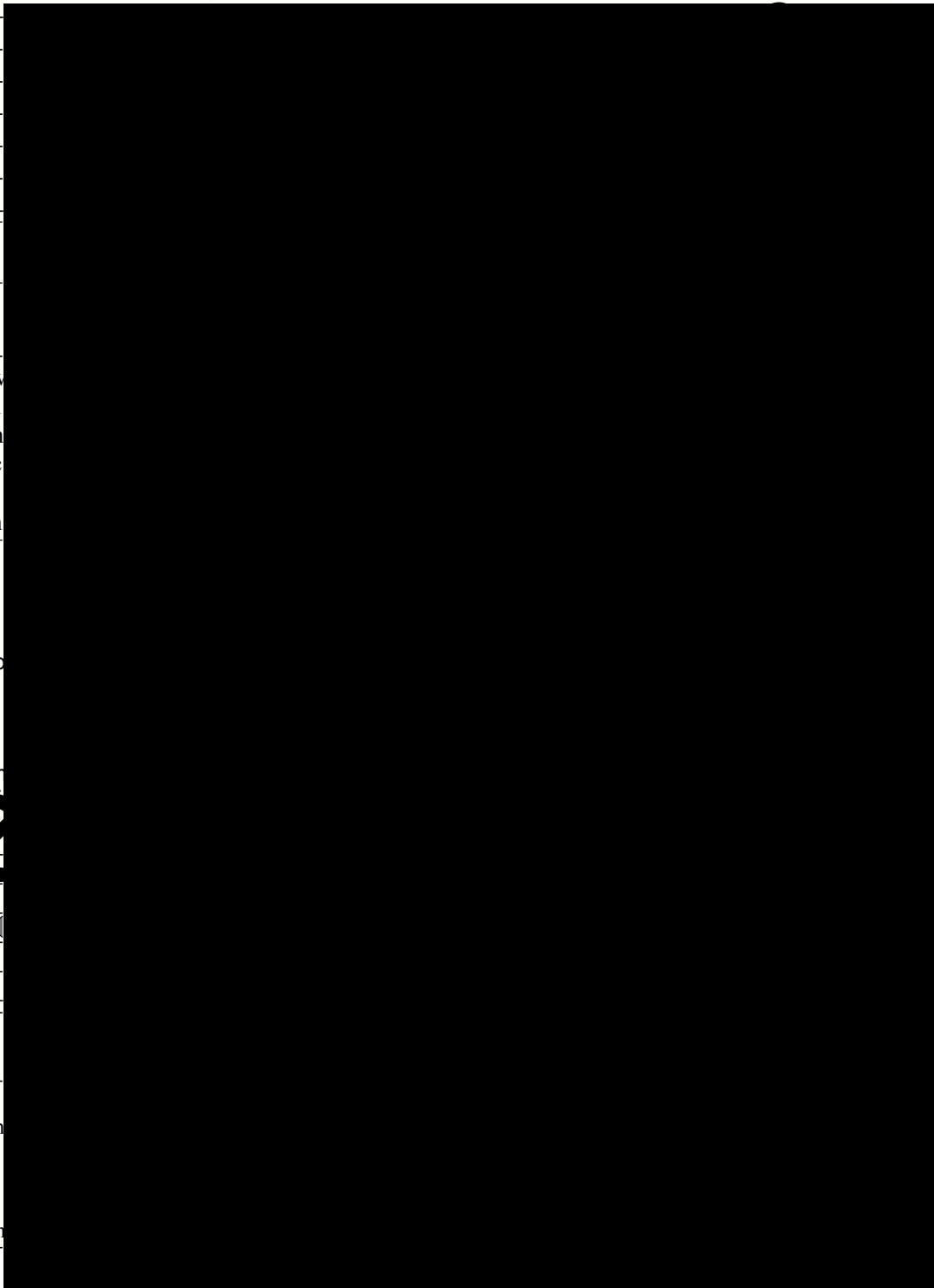
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Moderate Complexity MDM

Clinical Correlation

You see a patient with stable HTN who also has dyslipidemia which is not controlled on current medications. You increase simvastatin from 20 to 40 mg PO QD.

Problems/DDx	Pts
Self limited or minor (Max 2)	1
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MDM	Prob Pts	Data Pts	Risk
SF	1	0-1	Min

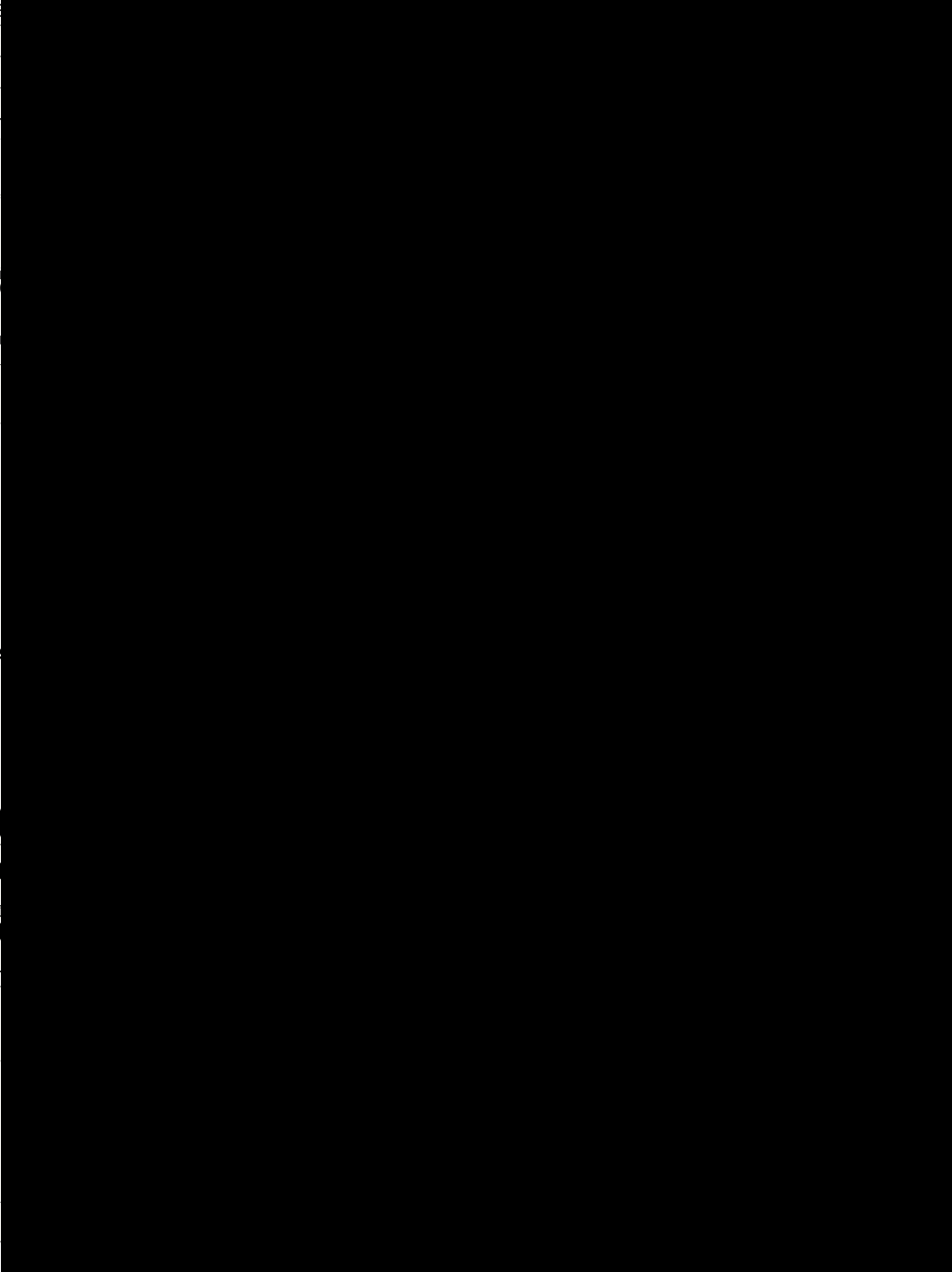
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High Complexity MDM

Clinical Correlation

You admit a patient with CAD and DM to the hospital with CHF exacerbation requiring IV diuretics.

Problems/DDx	Pts
Self limited or minor (Max 2)	1
Established	
Established	
New problem	
New problem	

MDM	Prob Pts	Data Pts	Risk
SF	1	0 - 1	Min

Risk	Pres
High	<ul style="list-style-type: none"> •One or more severe exacerbations •Acute or chronic condition which poses a risk to bodily function •An abrupt change in status

Acuity of care is

Risk corresponds to severity of illness; may also include status or IV con

Data points after sources of

MDM	Pro
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High	

Risk	Pres
High	<ul style="list-style-type: none"> •One or more severe exacerbations •Acute or chronic condition which poses a risk to bodily function •An abrupt change in status

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Putting it All Together

Hx	HPI	ROS	PFSH	Exam	Bullets	MDM	Dx	Data	Risk
PF	Brief	None	None	PF	1 - 5	SF	1	1	Min
EPF	Brief	1	None	EPF	6 - 11	Low	2	2	Low
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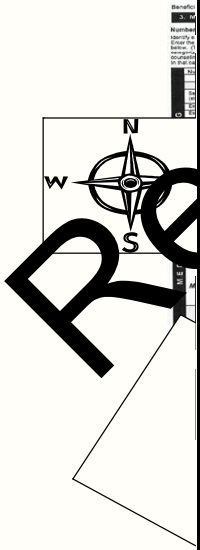
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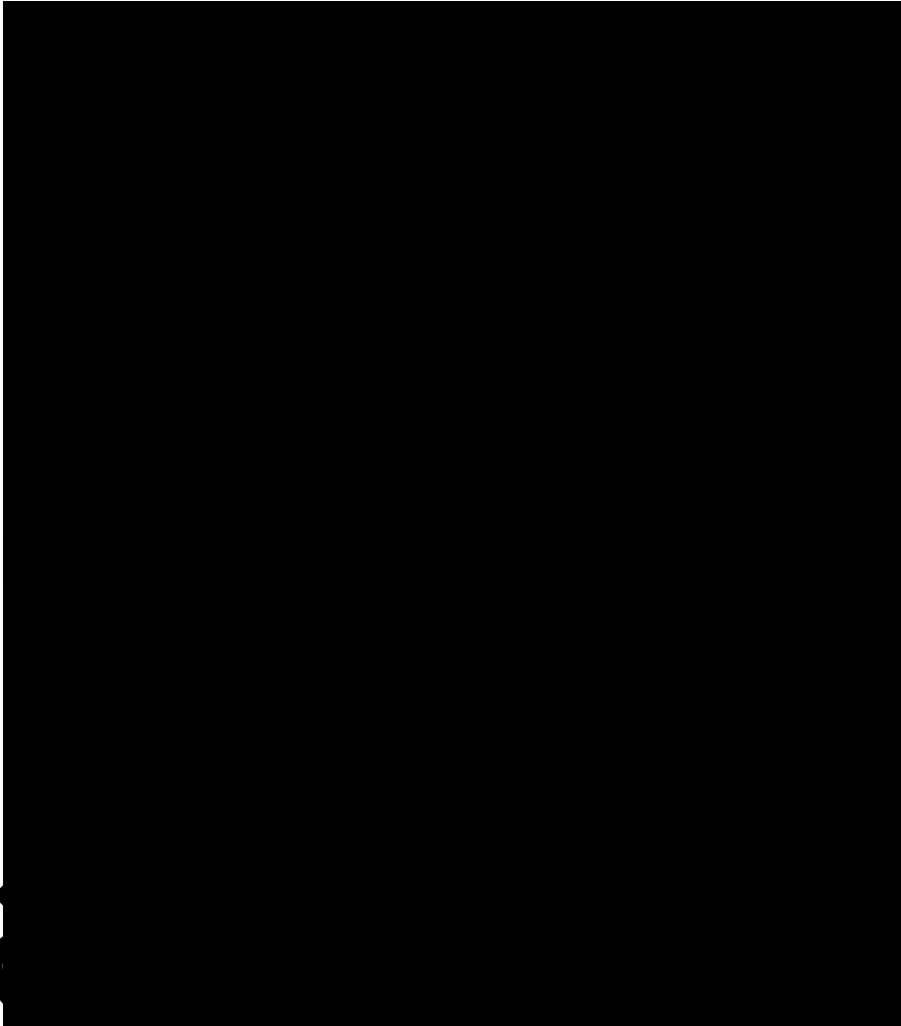
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Rational Physician Coding



- You
DM
- The

Rec

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?

Step 1

Step 2

M

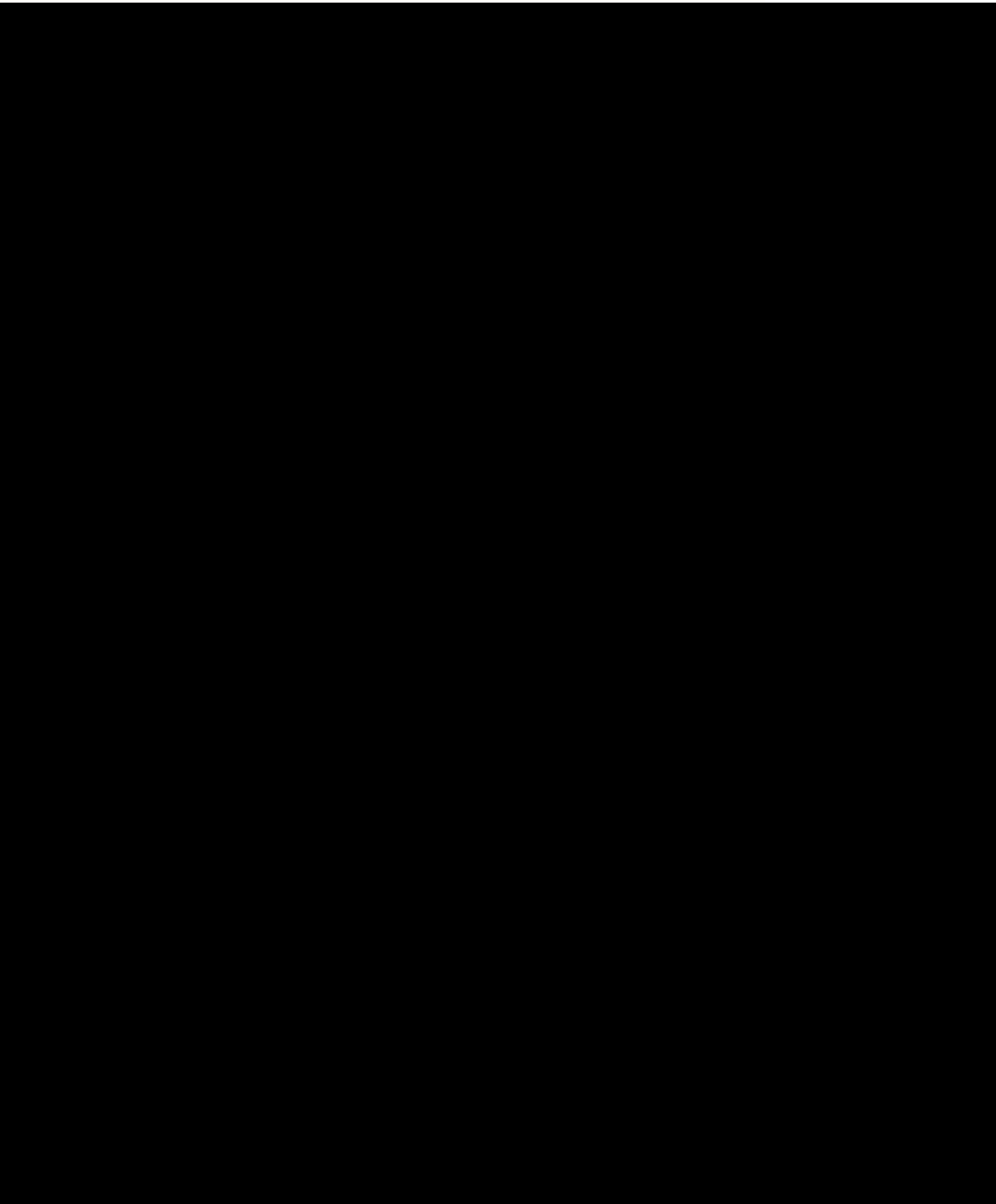
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In this exam
problems of

Data Reviewed Points

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In this case, you

Risk			
Minimal	<ul style="list-style-type: none"> •One probl tinea 		
Low	<ul style="list-style-type: none"> •Two mino •One •Acu illnes rhinit 		
Moderate	<ul style="list-style-type: none"> •One 		
High	<ul style="list-style-type: none"> •One with severe exacerbation, •Acute or chronic illness or injury, which poses a threat to life or bodily function •An abrupt change in neurological status 	contrast, with identified risk factors <ul style="list-style-type: none"> •Cardiac EP studies •Diagnostic endoscopies, with identified risk factors 	substances <ul style="list-style-type: none"> •Drug therapy requiring intensive monitoring for toxicity •Obtain DNR or de-escalate care

This encounter qualifies as being of moderate risk based on the presence of two stable chronic illnesses.

Calculating the Overall MDM

MDM Complexity	Problems	Data	Risk

Here,
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Selecting the Target Code

Established Office Patients

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E/M Code
99214

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Hx	HPI
PF	Brief
EPF	Brief
Det	Ext
Comp	Ext

Target
992

2

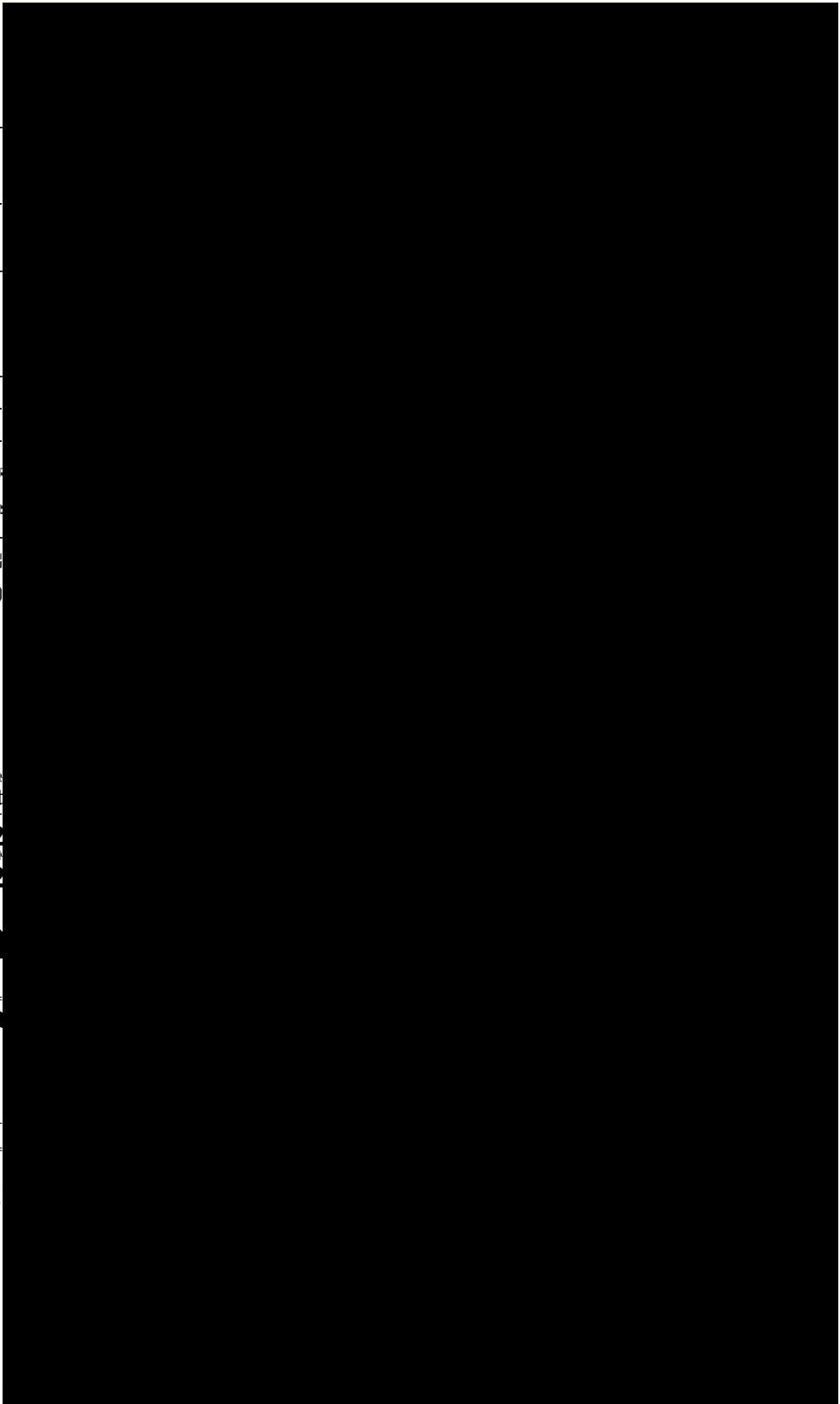
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Which
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Recd



CC: F/U

Interval
is stable
remains

PFSH is

ROS

Vitals: 12

General:

Lungs: C

CV: RRR

Abd: Sof

Ext: No

Assessm

- 1. Well co
- 2. Well C
- 3. Stable
- 4. Underl

Plan

- 1. Contin
- 2. Rehar
- 3. Also c
- 4. Reten

Requires two out of three qualifying key components

Target Code	History	Exam	MDM
-------------	---------	------	-----

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.
- You notice an empty bag of potato chips on the tray table.

$$\begin{array}{r|l} 138 & 101 \\ \hline 3.1 & 23 \end{array} \left\{ \begin{array}{l} 10 \\ 124 \\ 0.8 \end{array} \right. \quad \left\{ \begin{array}{l} 12 \\ 36 \end{array} \right.$$

BNP is 1450

- 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 review the CXR, replete K+, change the patient to a 2 gram sodium diet, and order labs and repeat CXR for the a.m. You also change pt to IV Bumex.
- What's the correct code and documentation if total time spent is 18 minutes?

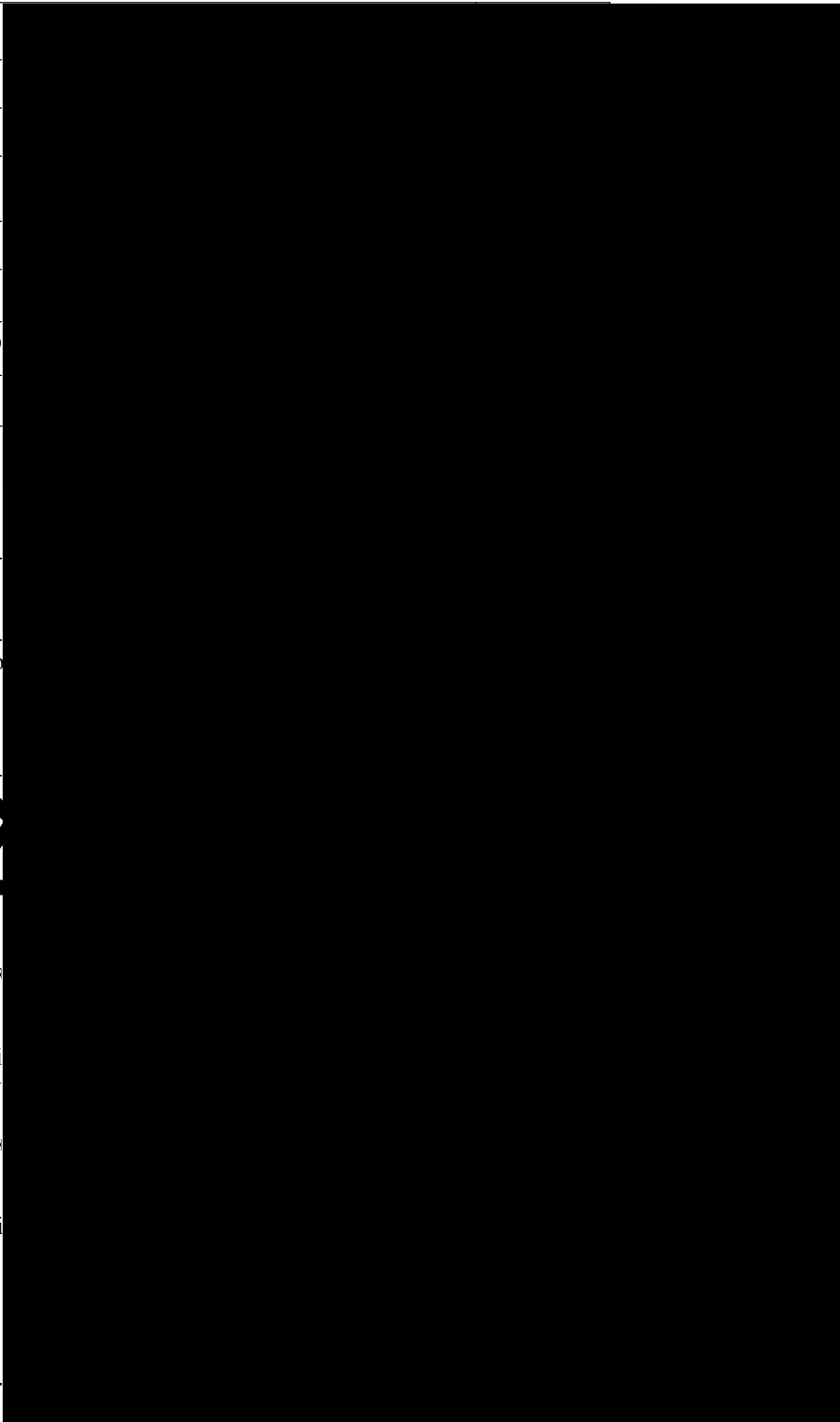
Problem Points

Problems/DDx	Points
Self limited or minor (M	[REDACTED]
Established problem, st	
Established problem, w	
New problem, no additi planned	
New problem, additiona planned	

Data Reviewed Points

Review/order
Review/order
Review/order (LHC, PFTs)
Discussion of
Independent r
Decision to ob
Review and s

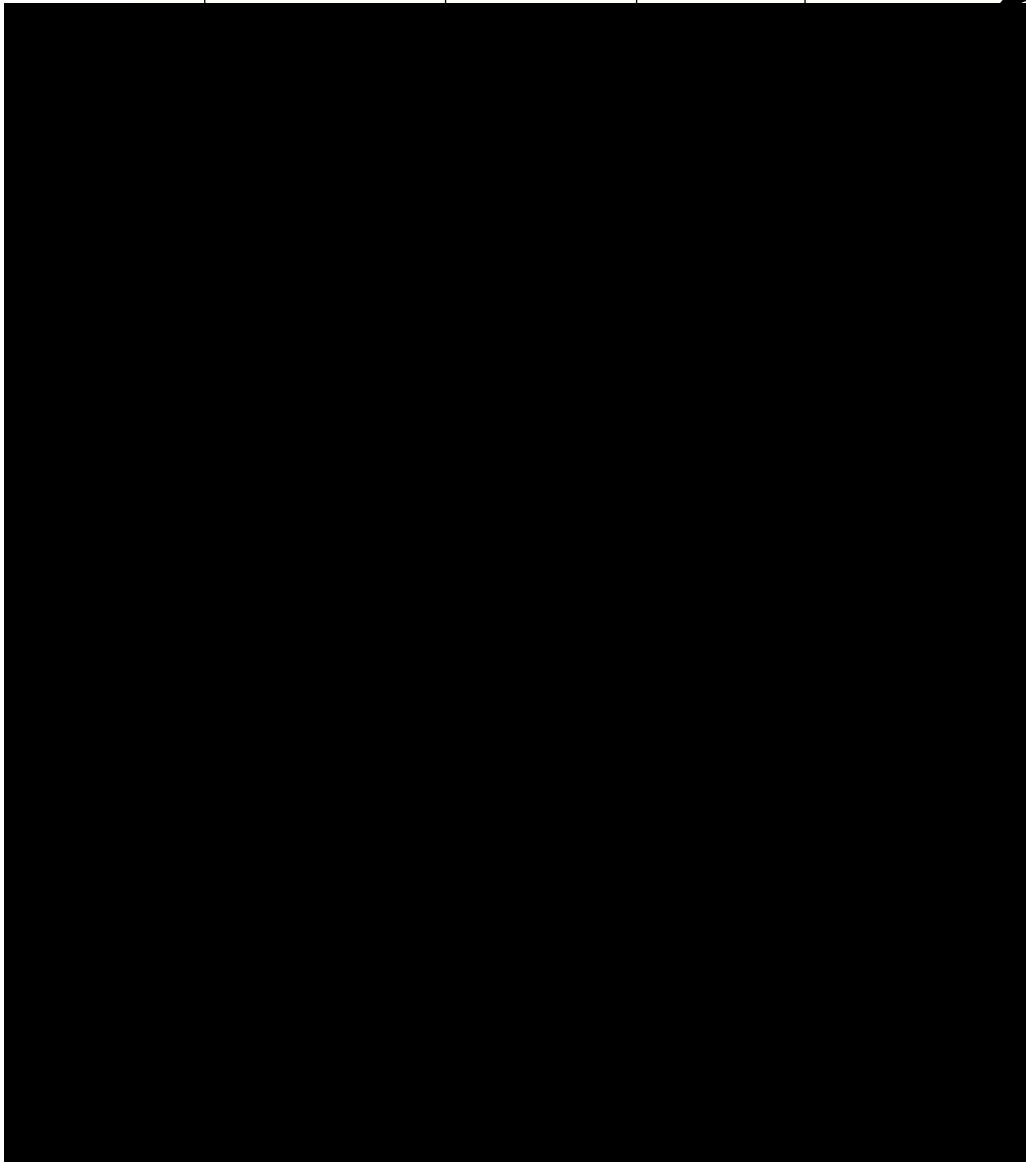
Risk	Presenting
Minimal	<ul style="list-style-type: none"> •One self-limited o problem, e.g., cold tinea corporis.
Low	<ul style="list-style-type: none"> •Two or more self minor problems •One stable chro •Acute complic illness, e.g., cysti rhino, spi
Moderate	<ul style="list-style-type: none"> •One chronic illne exacerbation, •Two stable chroni •Undiagnosed new uncertain prognosi
High	<ul style="list-style-type: none"> •One or more chro with severe exacer •Acute or chronic i injury, which pose or bodily function •An abrupt change neurological status



Required

Calculating the Overall MDM

MDM Complexity	Problems	Data	Risk
Straight Forward	1	0 - 1	Minimal



CC: F/

Interva

Vitals:

Gener

Neck:

Lungs:

CV: R

Abd: S

Ext: 2+

Skin:

Assess

1. Dec

2. Poo

3. Mild

4. Stab

Plan

1. D/C

2. Start

3. tric

4. Rep

5. Rep

6. Rep

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?

Problem Points

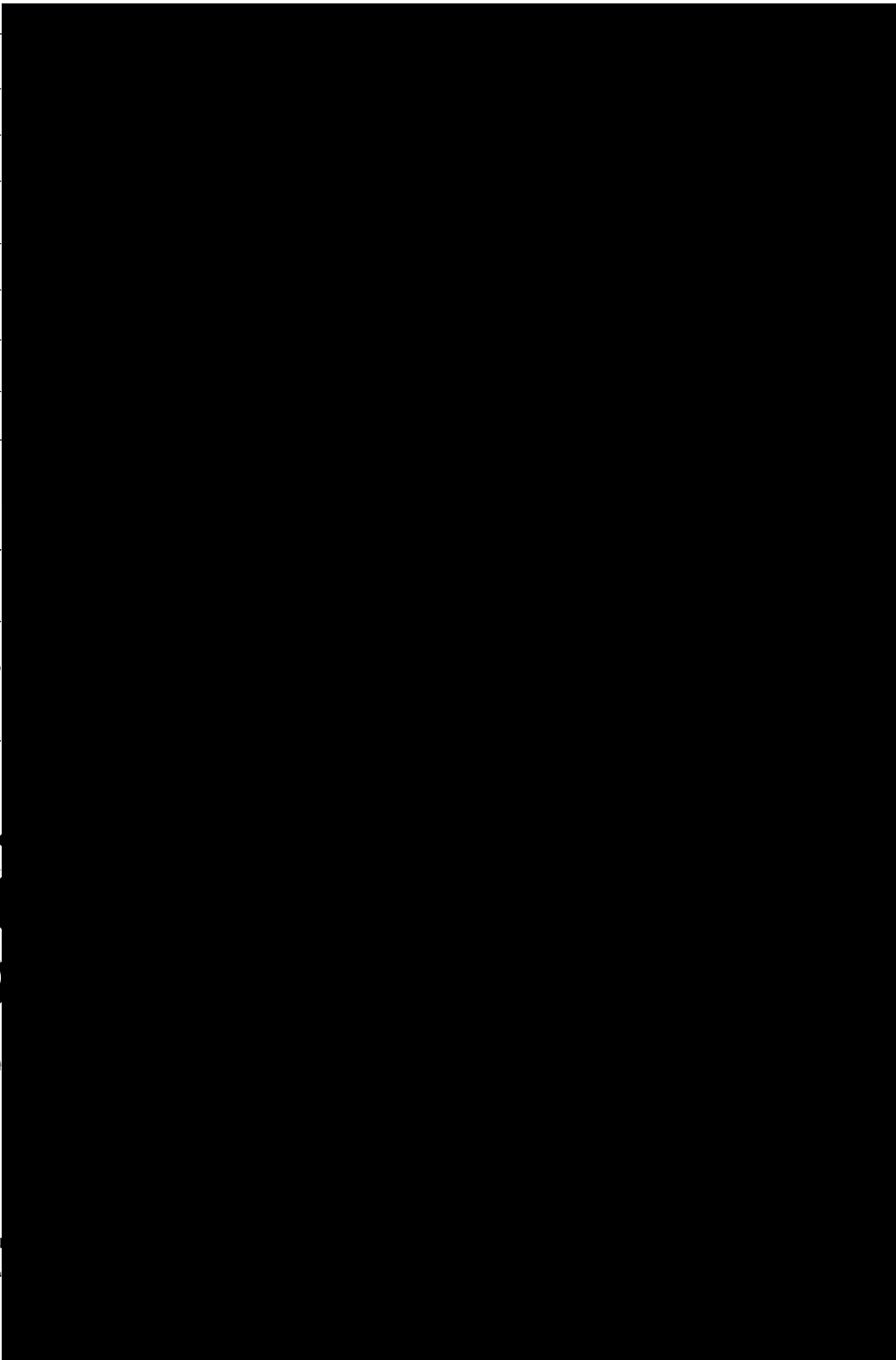
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Data Reviewed Points

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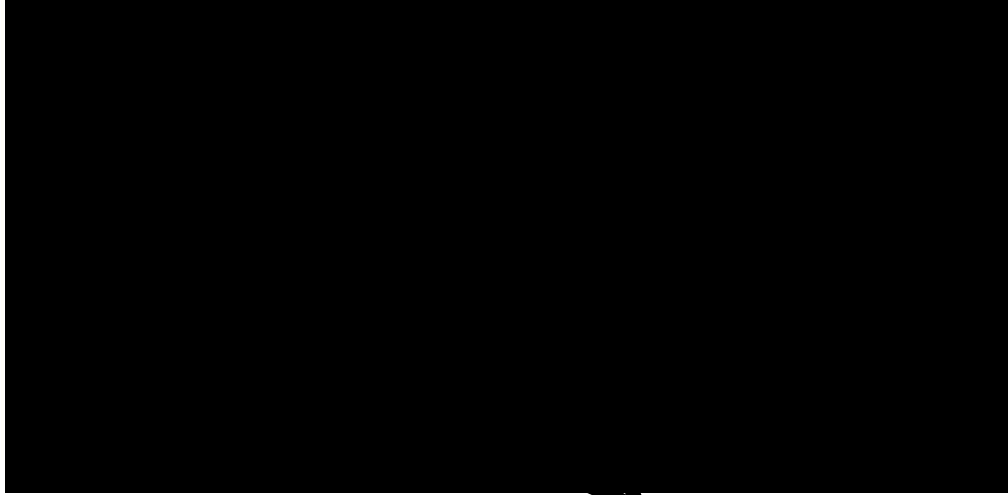
Risk	
Minimal	<ul style="list-style-type: none"> •O pro tin
Low	<ul style="list-style-type: none"> •T mi •O •A illn rh
Moderate	<ul style="list-style-type: none"> •O xa •T U un
High	<ul style="list-style-type: none"> •O wit •A inj or •A neu

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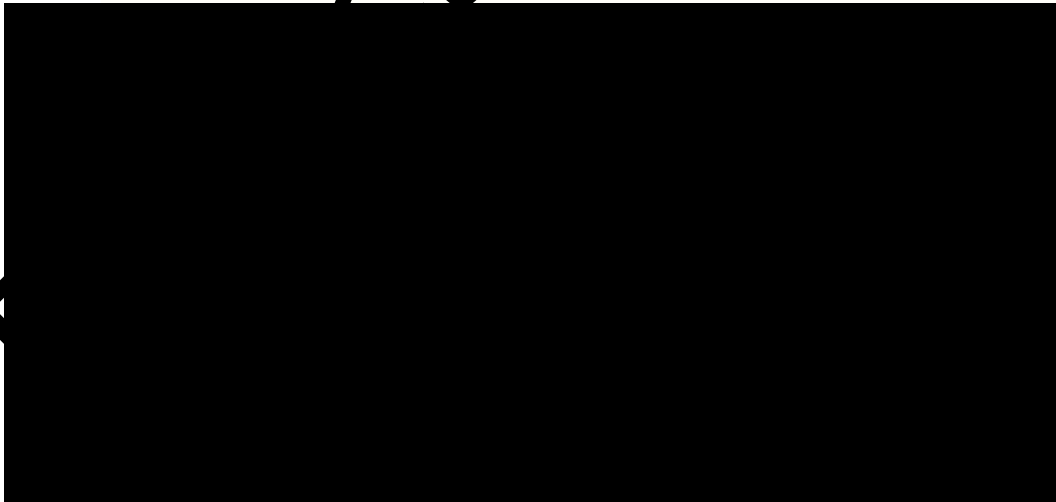
Calculating the Overall MDM

MDM Complexity	Problems	Data	Risk
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Selecting the Target Code

Admission H&Ps



E/M Cod

99223

- Mo
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enc
- Rei
abo

E/M Cod

99233

Hx	PI
PF	Brief
EPI	Brief
Det	Ext
Comp	Ext

REC

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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



E/M UNIVERSITY

Peter R. Jensen, MD, CPC

Online and On-site
Physician-to-Physician E/M
Coding Education

1-888-U-EM-CODE

pjensen@emuniversity.com

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