



Rational Physician
Coding for E/M
Services

Redacted Version

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

Redacted Version

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

Redacted 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.

139	101	12	12
4.6	23	124	36
		0.8	

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?

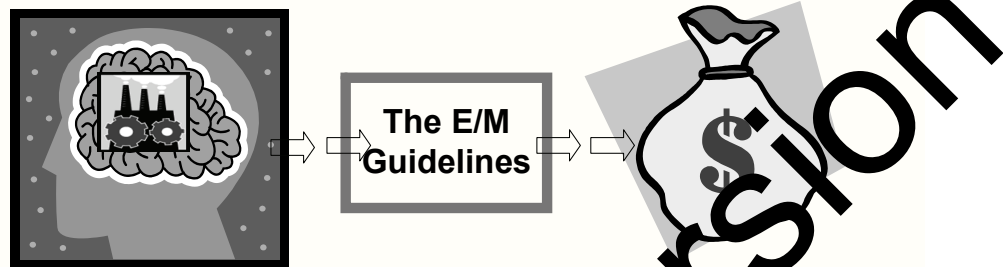
E/M Coding

- 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%

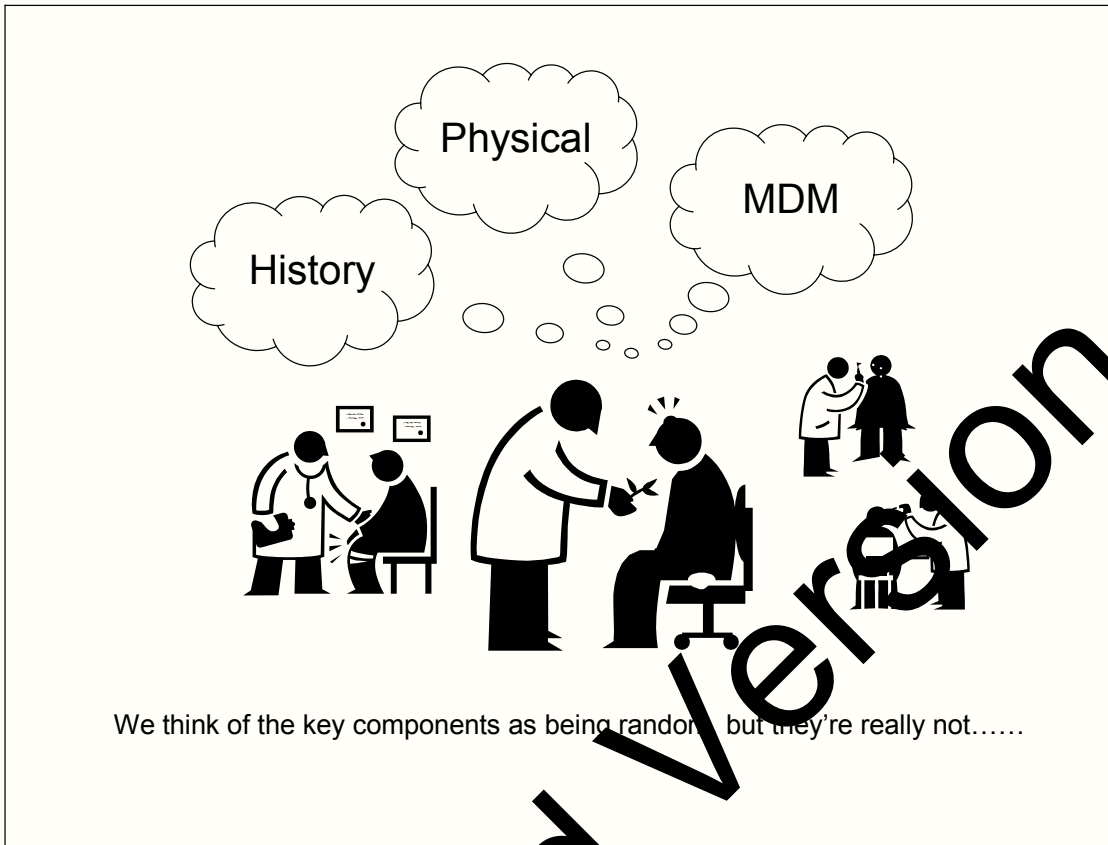
E/M = Cognitive Labor



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Repealed Version



3. Medical Decision Making

Outpatient, Consults (OUTPATIENT, INPATIENT & CONFIRMATORY) and ER

Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the history and physical examination. Enter the number in each of the categories in Grid below. (There are maximum number in two categories for each problem.) If the encounter is about counseling/coordination of care, and duration of visit is that code, enter 1 in the last box.

Number of Diagnoses or Treatment Options	Problem Focused				Expanded Problem Focused				Detailed Comprehensive			
	A	B	C	D	E	F	G	H	I	J	K	L
1												
2												
3												
4												
5												
6												
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16												
17												
18												
19												
20												

Problem Focused
Expanded Problem Focused
Detailed Comprehensive

Problem Focused
Expanded Problem Focused
Detailed Comprehensive

History

Physical

MDM

Final Result for Complexity

4. Time

Initial Hospital Observation

Subsequent Hospital Follow-up

Subsequent Nursing Facility

Home Care and Home Care

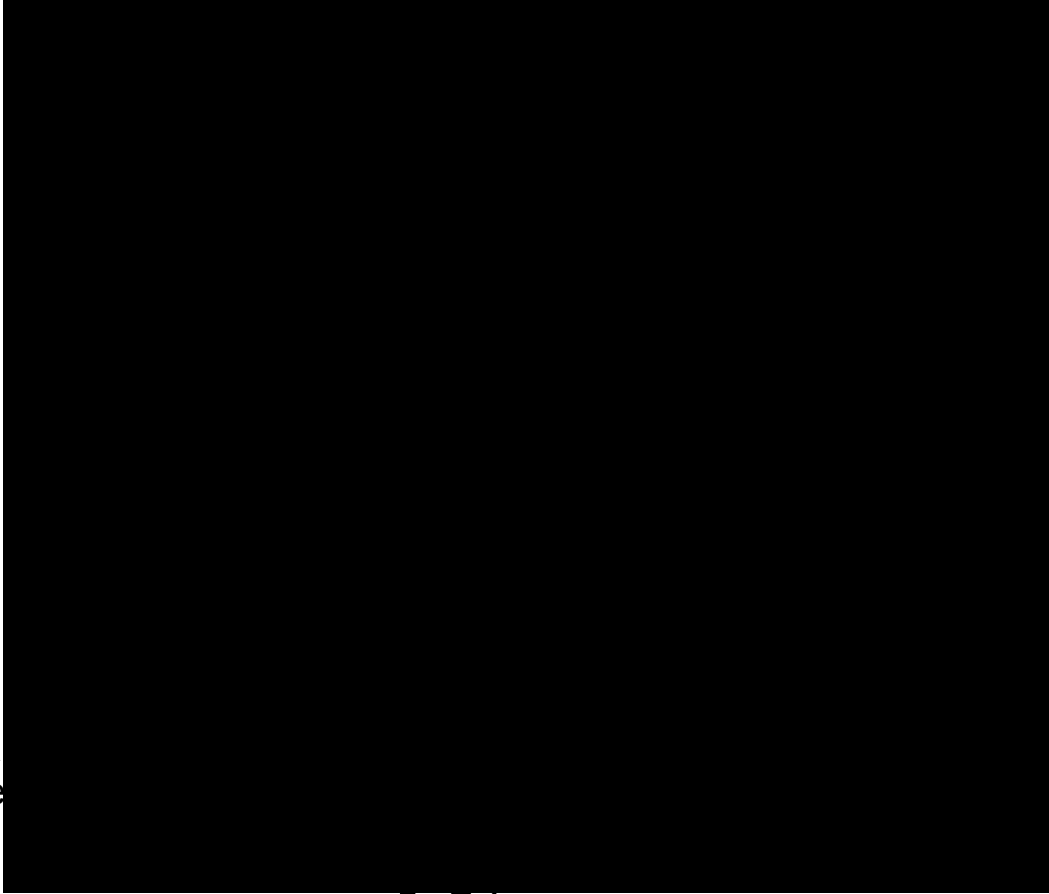
Established

Level I II III IV V

PF = Problem focused, EPF = Expanded problem focused, D = Detailed, C = Comprehensive, SF = Straightforward, L = Low, M = Moderate, H = High

This is how auditors look at the E/M guidelines. They view the history, physical exam and medical decision-making in very concrete terms.

Step 1

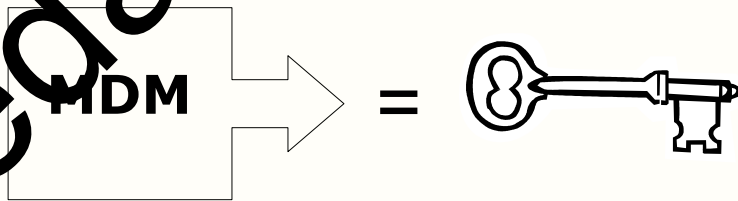


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Primacy of Medical Decision-Making



Redacted

The Importance of Medical Necessity

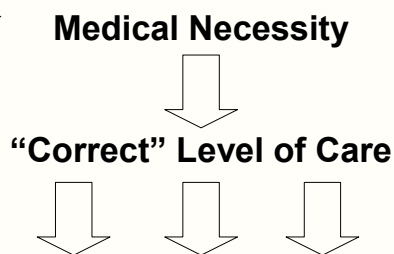
“Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not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



The quote above points out the fact that documentation should support the intent of the service. The key component of the index of medical care based on the

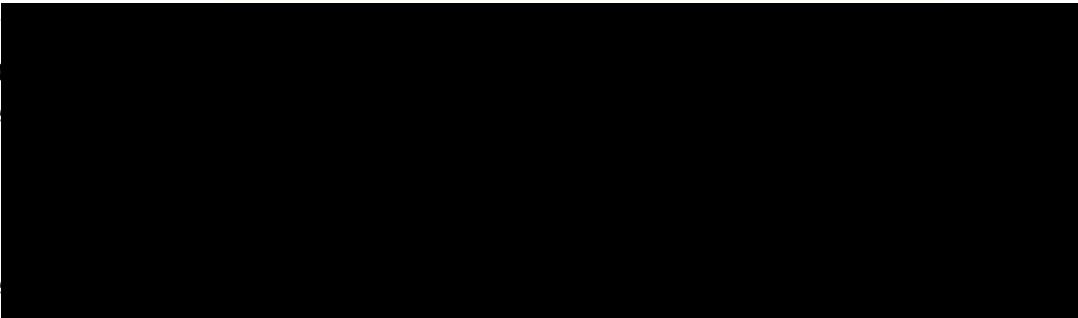


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The Secret of True E/M Compliance

If you provide the service, you should document the medical necessity of the service.



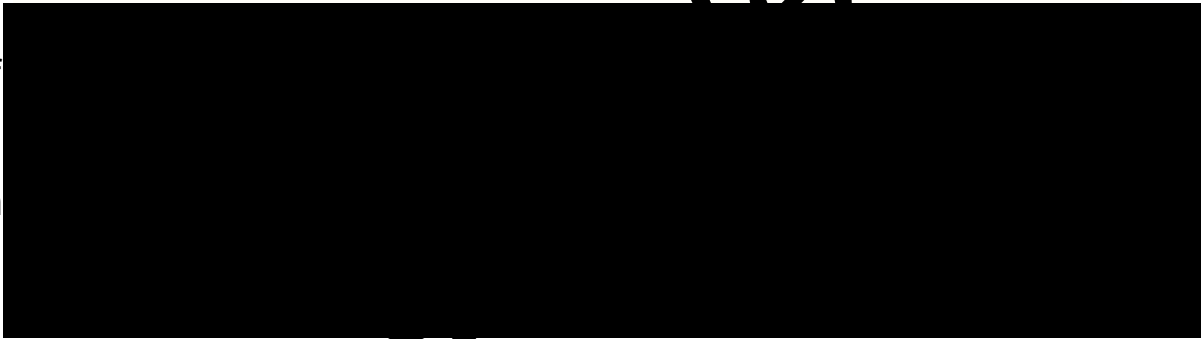
or you can find the service in the code book.

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

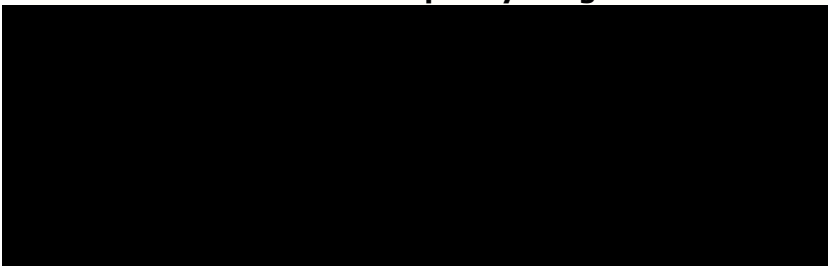
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MDM Complexity	Problems	Data	Risk
Straight Forward	1	1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4	4	High

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

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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

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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, NETs)	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 re [REDACTED] S.
 If you [REDACTED]
 blood [REDACTED]
 findin [REDACTED]

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, decisional biopsies • Cardiovascular imaging studies, with contrast, with no identified risk factors, arteriogram, cardiac catheterization • Obtain fluid from body cavity, (e.g., LP or thoracentesis) 	<ul style="list-style-type: none"> • Elective major 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

This is the official table of risk for both the 1995 and 1997 E/M guidelines. The rules

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 MDM is determined by the highest level of MDM complexity that meets the criteria. Only the highest level of MDM complexity is used to determine the overall MDM. This is based on the highest level of MDM complexity that meets the criteria, even if it is not the highest level of MDM complexity.

Requirements

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.

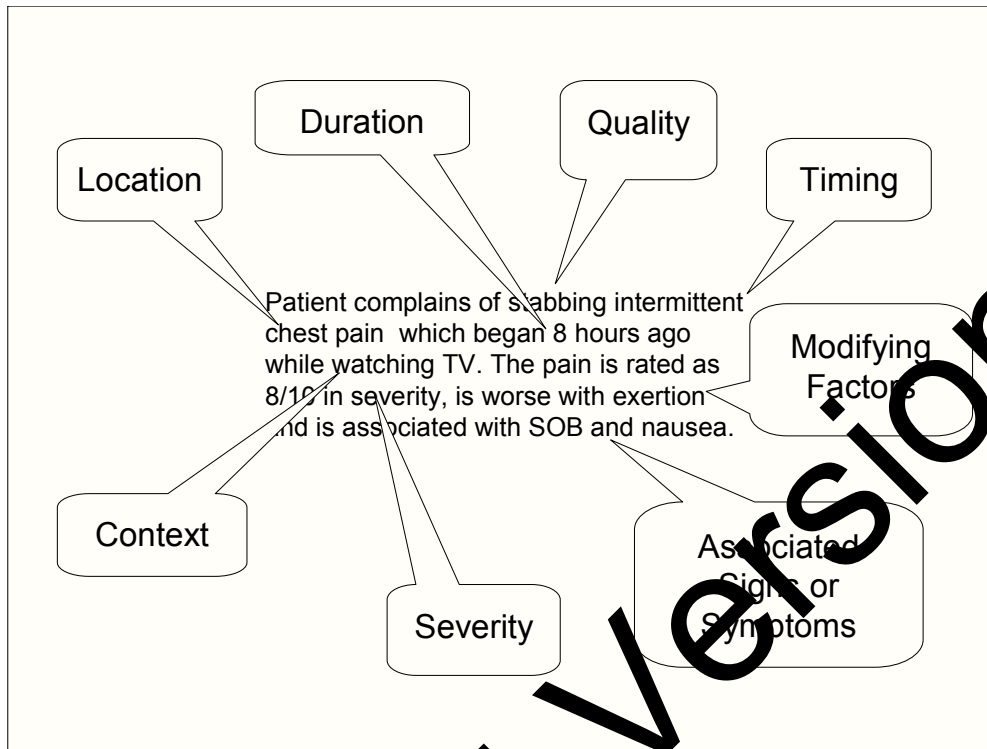
HPI

- A narrative of the patient's symptoms or illnesses since onset or since the previous encounter
- Every level of history requires 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

Redacted Version



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.

- 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
PE	Brief	None	None
EPE	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 (99231)--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 allowed 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

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
- 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 (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

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

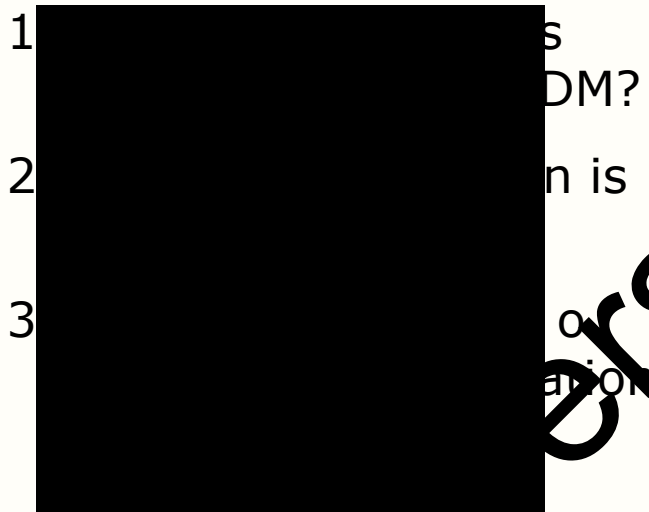
Expanded Problem Focused: a limited exam of the affected body area or organ system and other symptomatic or related organ systems

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



Established Office Patients

- Accounted for \$11,155,924,872 in 2004
- 39
- Five
- 99
- 99
- 99
- 99
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- 99
- TW



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.

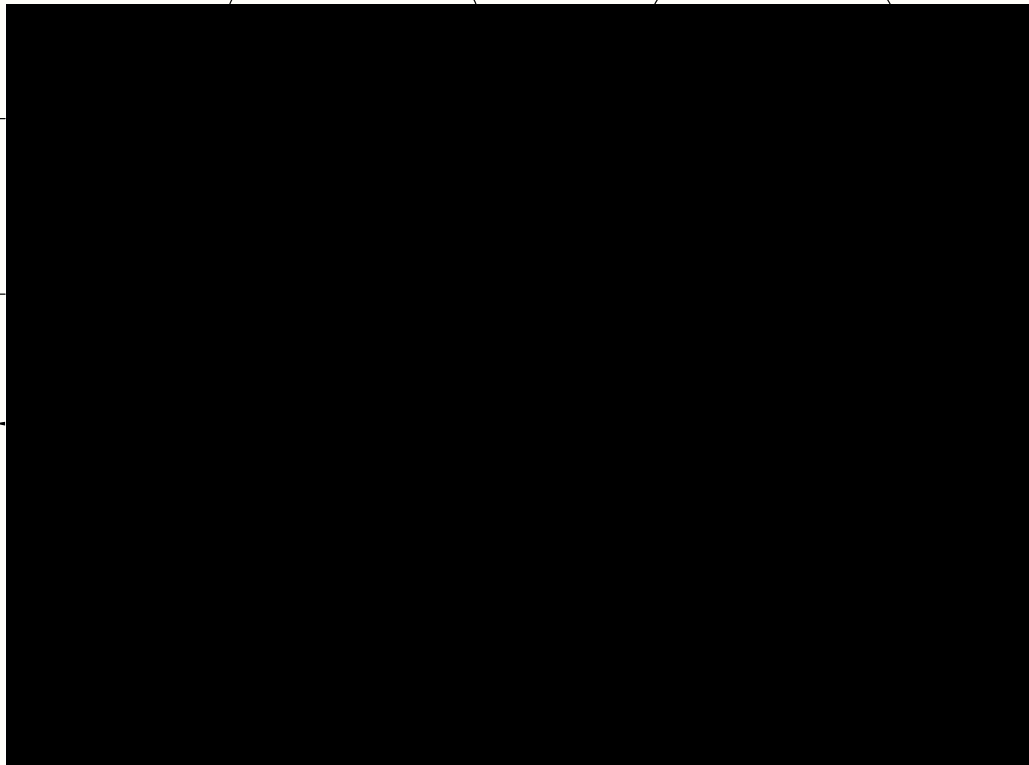
$$\begin{array}{r|l} 139 & 101 \\ \hline 4.6 & 23 \end{array} \begin{array}{l} 12 \\ 124 \\ 0.8 \end{array} \quad \begin{array}{l} 12 \\ 36 \end{array}$$

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?

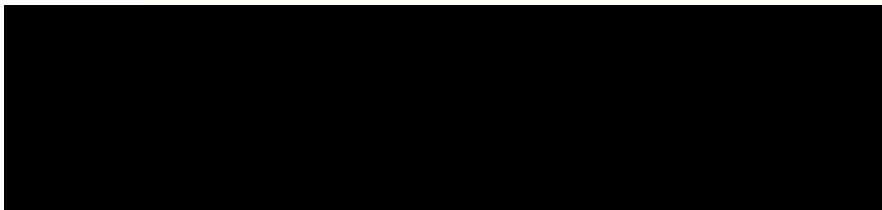
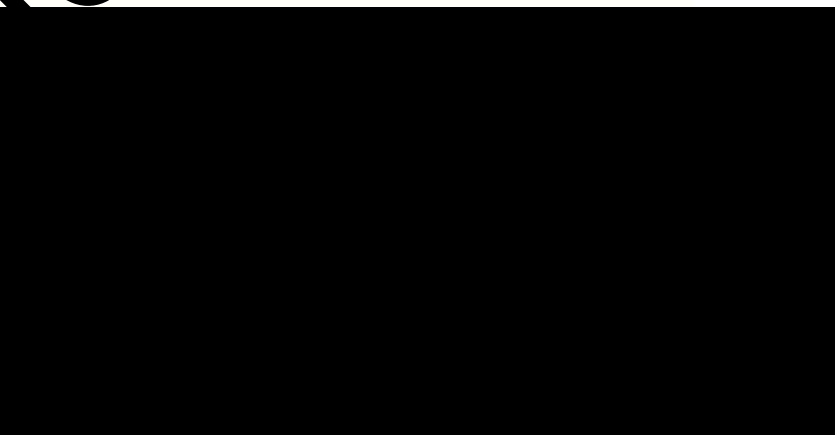


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Problem Points

P	
Self limited or	
Established p	
Established p	
New problem, planned	
New problem, planned	



Points = 3

ne three stable or im-

Data Reviewed Points

Data Reviewed	Points
Review/order clinical lab tests	1 <input checked="" type="checkbox"/>
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

Total Points = 1

In this case, you would only get one data point for reviewing and/or ordering labs.

Risk	Presenting Problems	Diagnostic Procedures	Management Options
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 • ECG/ECG, Echocardiogram 	<ul style="list-style-type: none"> • Rest • Gargles • Superficial dressings
Low	<ul style="list-style-type: none"> • Two or more self-limited or minor problems • One stable chronic illness • Acute uncomplicated injury or illness, e.g., cystitis, allergic 	<ul style="list-style-type: none"> • Physiologic tests not under stress, e.g., PFTs • Non-cardiovascular imaging studies with contrast • ABG 	<ul style="list-style-type: none"> • Over the counter drugs • Minor surgery, with no risk factors • PT/OT • IV fluids, without



Selecting the Target Code

Established Office Patients

E/M Code	History	Exam	MDM	Time
99211	No	MD	Presence	Required
99212	PF	PF	SF	10

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99214

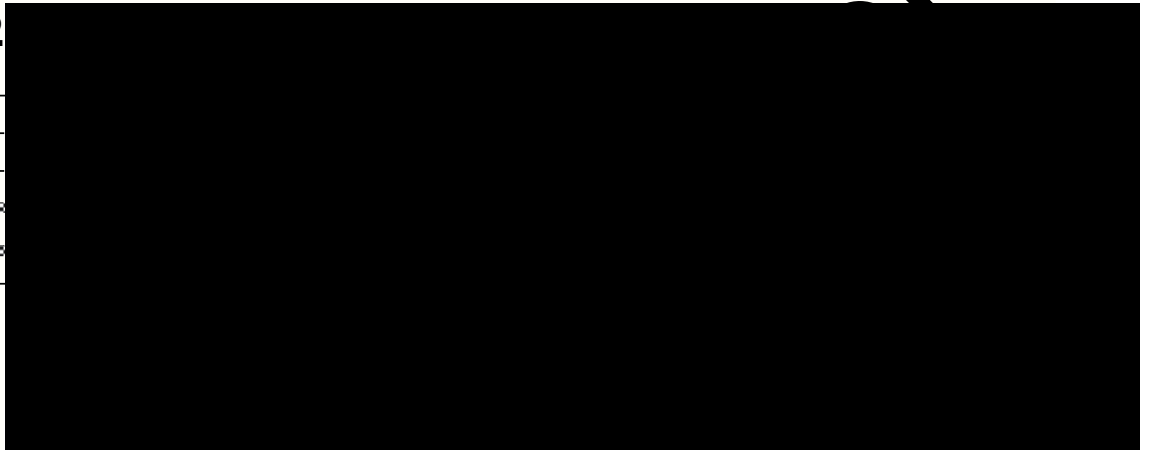
E/M Code	History	Exam	MDM	Time
99214	Det	Det	Mod	25

99214

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

2

Hx
PF
EPF
Det
Comp



Target Code	History	Exam	MDM
99214	Detailed	Detailed	Moderate

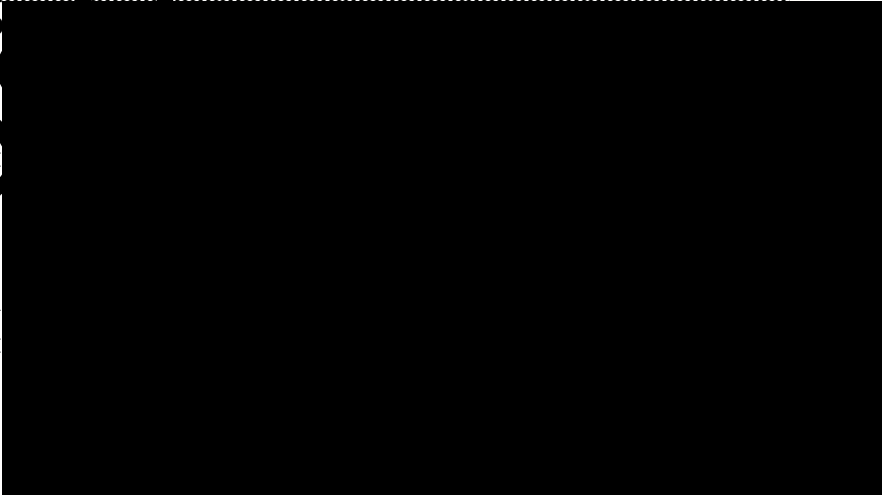
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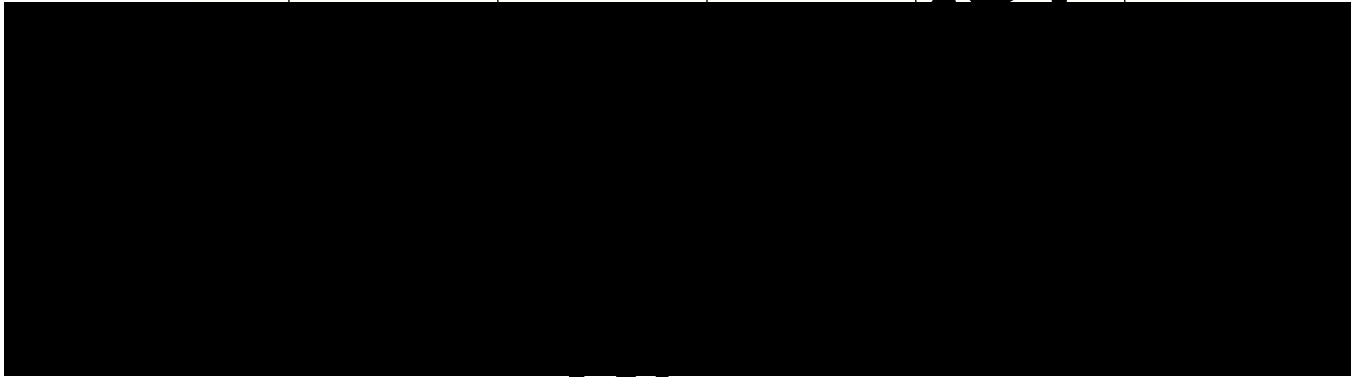
Ethical Documentation

Purpose-Driven Documentation


99214
 Detailed History
~~Detailed Exam~~
 Moderate MDM

2 out of 3 key components must qualify

Target Code	History	Exam	MDM
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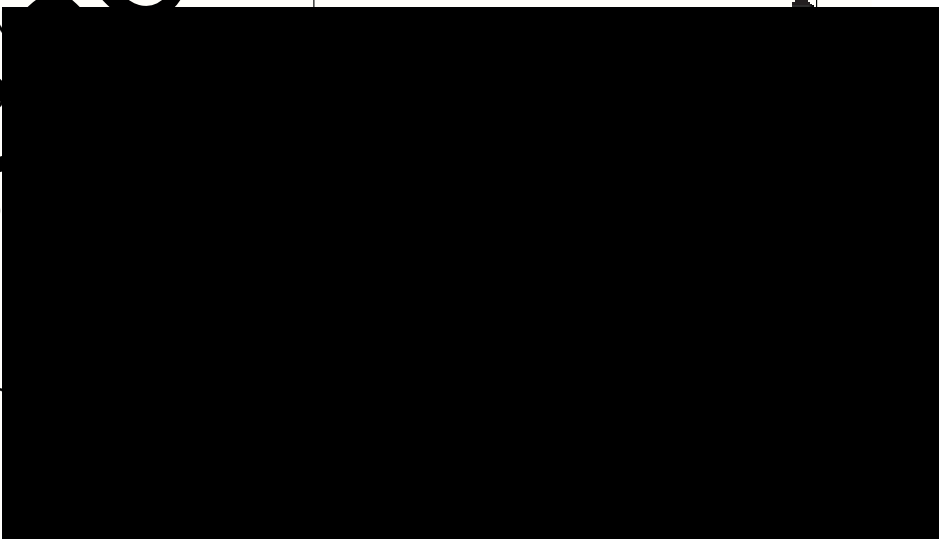
History	XPI	ROS	PFSH
Detailed	Extended <input type="checkbox"/>	2 - 9 <input checked="" type="checkbox"/>	1/3 <input checked="" type="checkbox"/>

CC: F/U HTN

Interval histo
 current medi
 symptomatic
 remains stab

PFSH is rem

ROS: CV:
 Neur



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
<div style="background-color: black; width: 100%; height: 100%;"></div> <p>stated age</p> <p>s AT LEAST 12 from ANY organ</p>					Chest/Breasts
					Skin
					Musculoskeletal
					Neurological
					Psychiatric
Target Code	History	Exam	MDM		
99214	Detailed <input checked="" type="checkbox"/>	Detailed <input type="checkbox"/>	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

135/85/25
46/23/0.8
12/36

HGBA1c = 6.8
LDL = 77
MA/Cr = 28

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

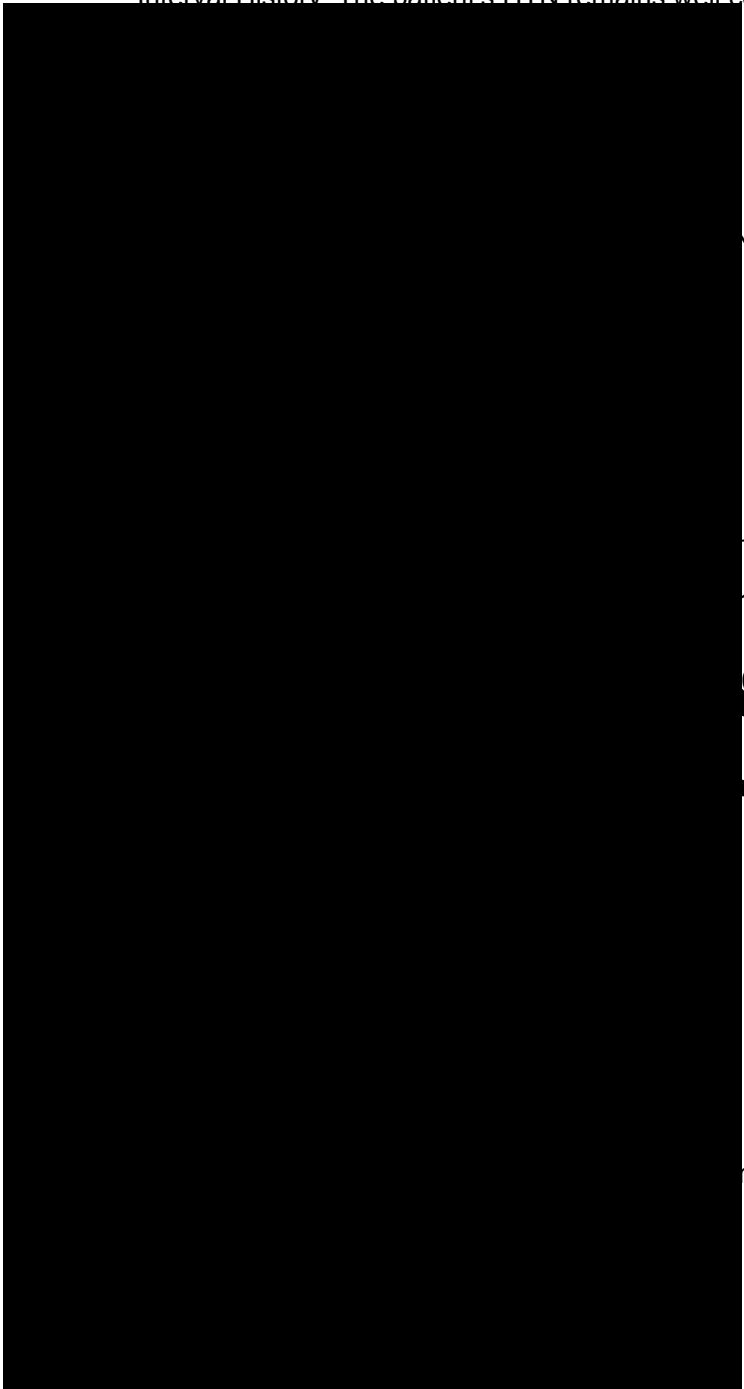
C on return
therapy

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

 99214

CC: F/U HTN and DM2

Interval History: The patient's HTN remains well controlled on cur



Statu

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- As

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MD
SF
Low
Mod
High

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MDM du
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matter th

Requires two out of three qualifying key components

Target Code	History	Exam	MDM
99214	Detailed	Detailed 	Moderate

Alternative Ending



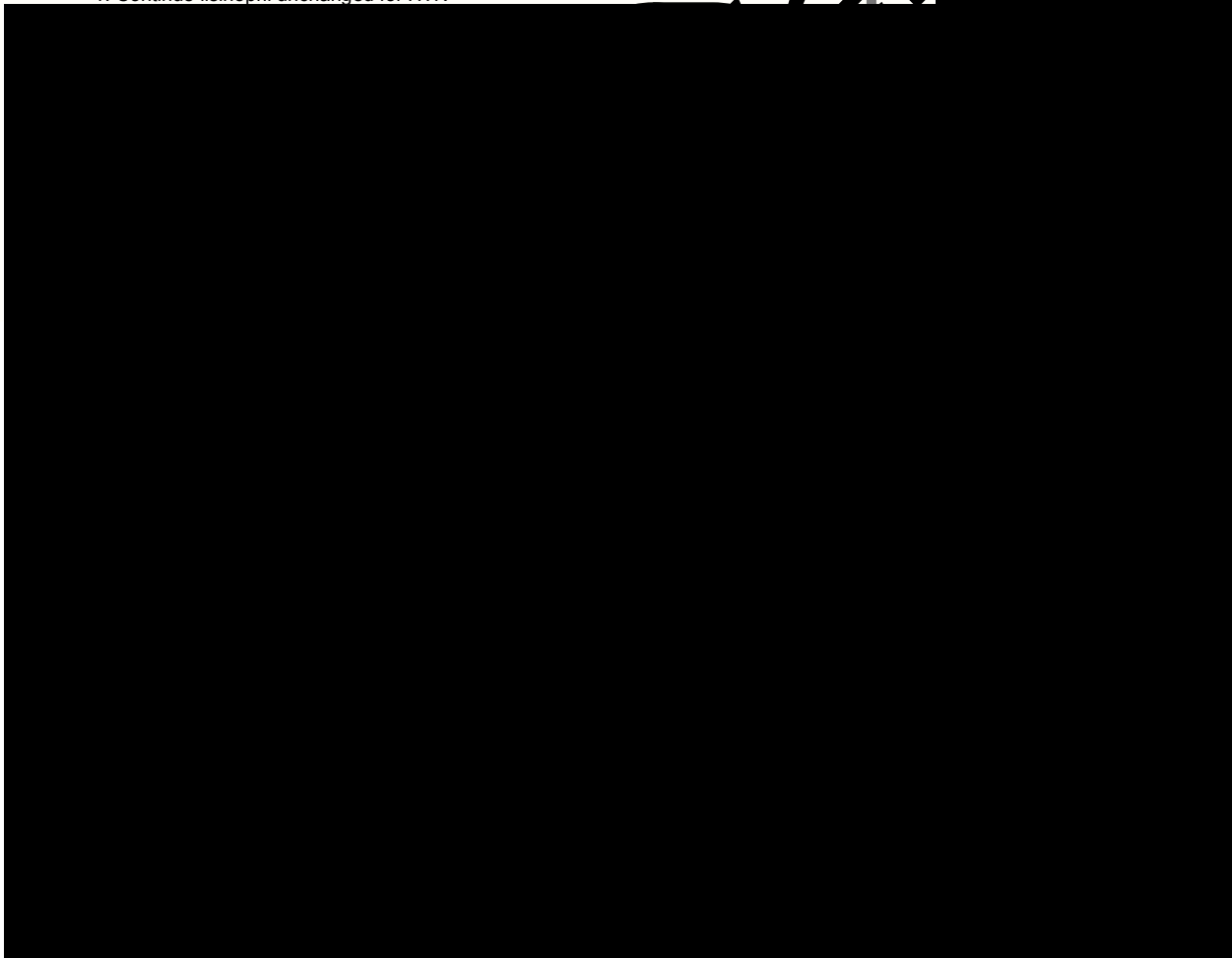
current medications. Diabetes is stable as well, with no
mia remains stable on statin therapy.



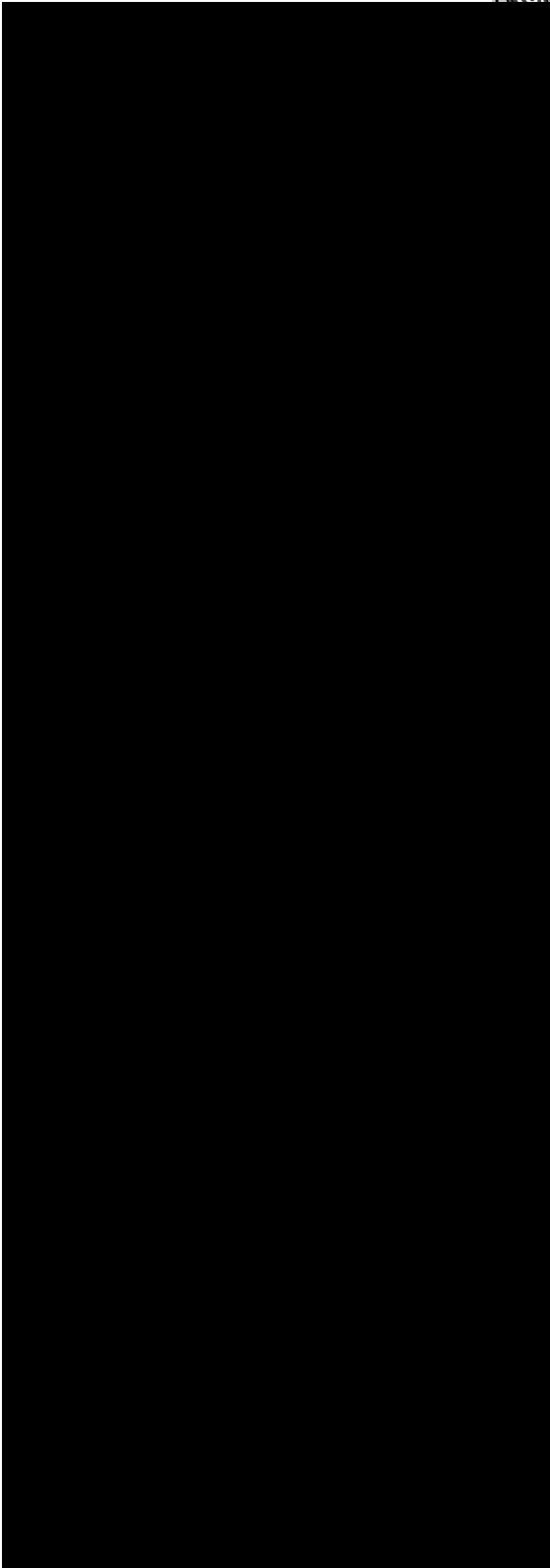
- Assessment
1. Well controlled DM2
 2. Well controlled HTN
 3. Stable dyslipidemia

- Plan
1. Continue lisinopril unchanged for HTN

Re
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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
 - 99231
 - 99232
 - 99233
- Req
com



Hospital Progress Notes

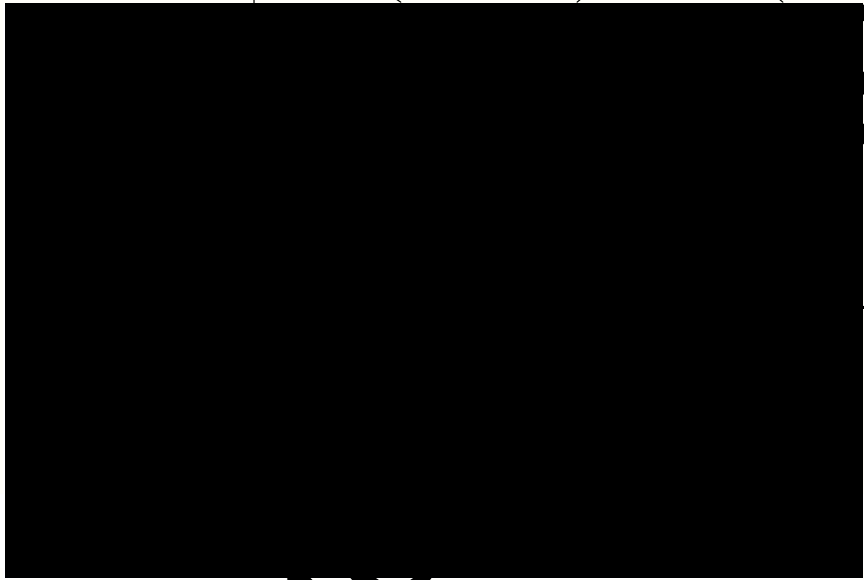
E/M Code	History	Exam	MDM	Time
99231	PF	PF	SF/Low	15
99232	EPF	EPF	Moderate	25
99233	Detailed	Detailed	High	35

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.

138 | 101 | 10
 124 | 12
 36



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Problem Points

Problems/DD	
Self limited or minor (Max	
Established problem, stab	
Established problem, wors	
New problem, no addition planned	
New problem, additional w planned	

Total Points = 6

Data Reviewed Points

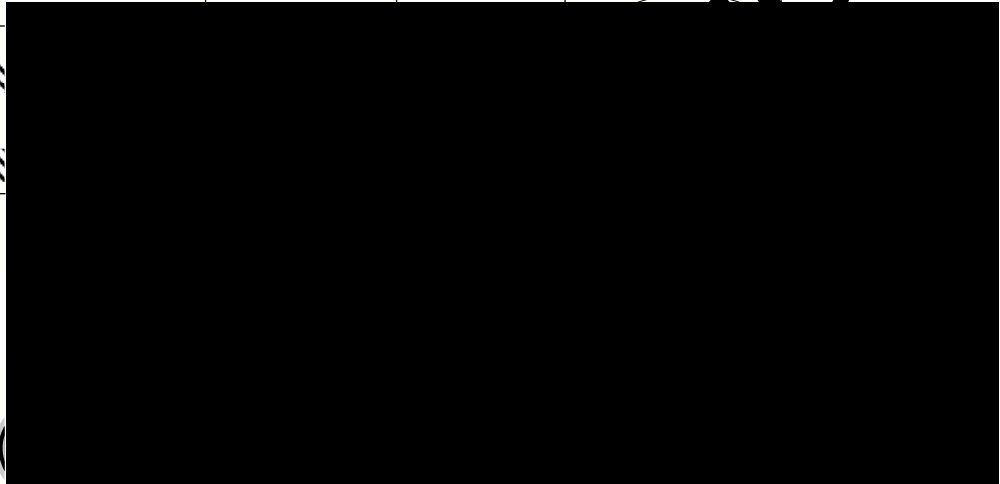
Data Reviewed	Points
Review/order clinical lab tests	
Review/order X-rays	
Review/order tests in the medicine section (echo, EKG, LHC, PFTs)	
Discussion of test results with performing MD	
Independent review of image, tracing, or specimen	
Decision to obtain old records	
Review and summation of old records	

Total Points =

Risk	Presenting Problems	Diagnostic Procedures	Options
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, Echocardiogram 	<ul style="list-style-type: none"> • Rest • Gargles • Superficial dressings
Low	<ul style="list-style-type: none"> • Two or more self-limited or minor problems • One stable chronic illness • Acute uncomplicated injury • Illness, e.g., cystitis, allergic rhinitis, sinusitis 	<ul style="list-style-type: none"> • Physiologic tests not under stress, e.g., PFTs 	<ul style="list-style-type: none"> • Over the counter drugs • Minor surgery, with no
Moderate	<ul style="list-style-type: none"> • One chronic illness, with exacerbation, • Two stable chronic illnesses • Undiagnosed new problem • Uncertain prognosis 		
High	<ul style="list-style-type: none"> • One or more chronic illnesses with severe exacerbation, • Acute or chronic illness or injury, which poses a threat to organ or bodily function • An abrupt change in neurological status 	<ul style="list-style-type: none"> • Diagnostic endoscopies, with identified risk factors 	<ul style="list-style-type: none"> • toxicity • Obtain DNR or de-escalate care

Calculating the Overall MDM

MDM Complexity	Problems	Data	Risk
Straight Forward	1	0 - 1	Minimal
Low	2	2	Low



Hospital Progress Notes

History	Exam	MDM	Time
PF	PF	SF/Low	15
PF	EPF	Low	25
Det	Det	High	35

2 out of 3 key components must qualify



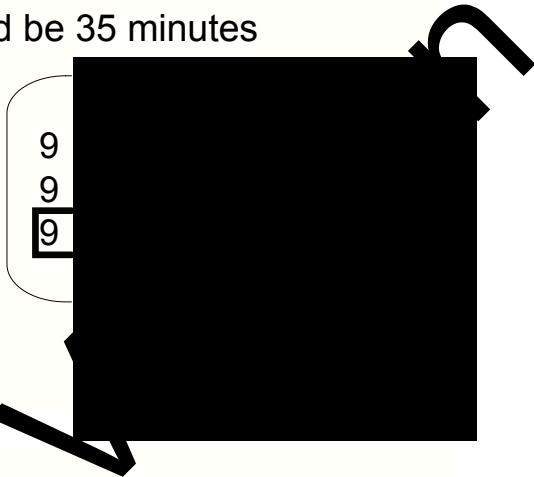
99233

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

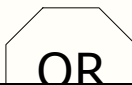


99233

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

2 out of 3 key components must qualify

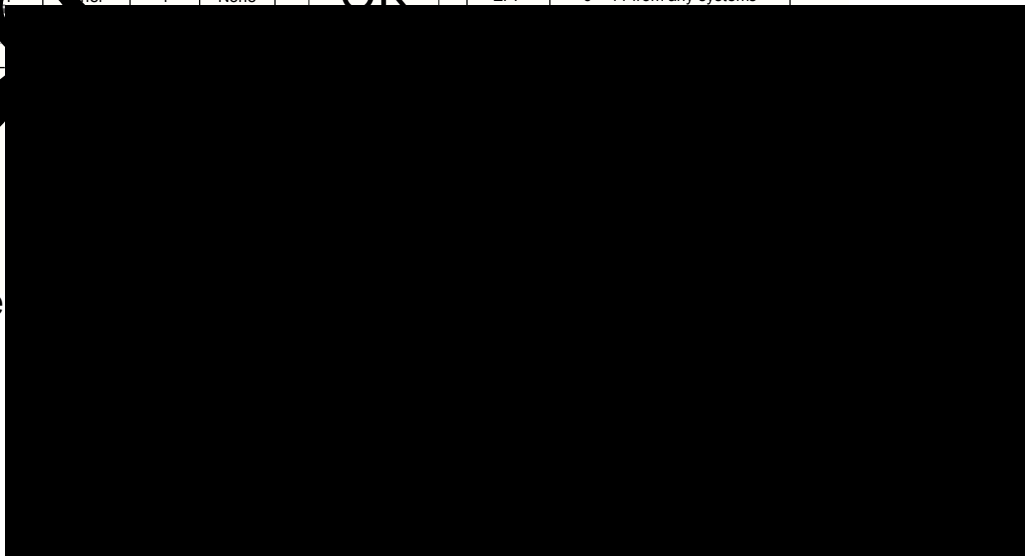
	UPL	OS	PFSH
PF	Brief	None	None
EPF	Brief	1	None




Exam	Bullets
PF	1 – 5 from any systems
EPF	6 – 11 from any systems

Redacted

In this case, we AND that we al perform and do addition to our how the docum of the history.



Rational Documentation

 **99233**
~~Detailed History~~
Detailed Exam
High Complexity MDM

2 out of 3 key components must qualify

History

History	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Detailed	Exam <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

CC: F/U CHF

HPI: The patient

Target Code
99233

C	1	2	nal	Eyes	ENMT	3	4	5	6	7	8	9	10	GU
													Chest/Breasts	
													11	
													Musculoskeletal	
													12	
													Neurologic	
													Psychiatric	
													MDM	
													High	

Medical Decision-Making

BNP 1450
 $\frac{138}{71} \times \frac{101}{24} \times \frac{10}{0.8} \times \frac{12}{36}$

Echo: Report showed EF 25%

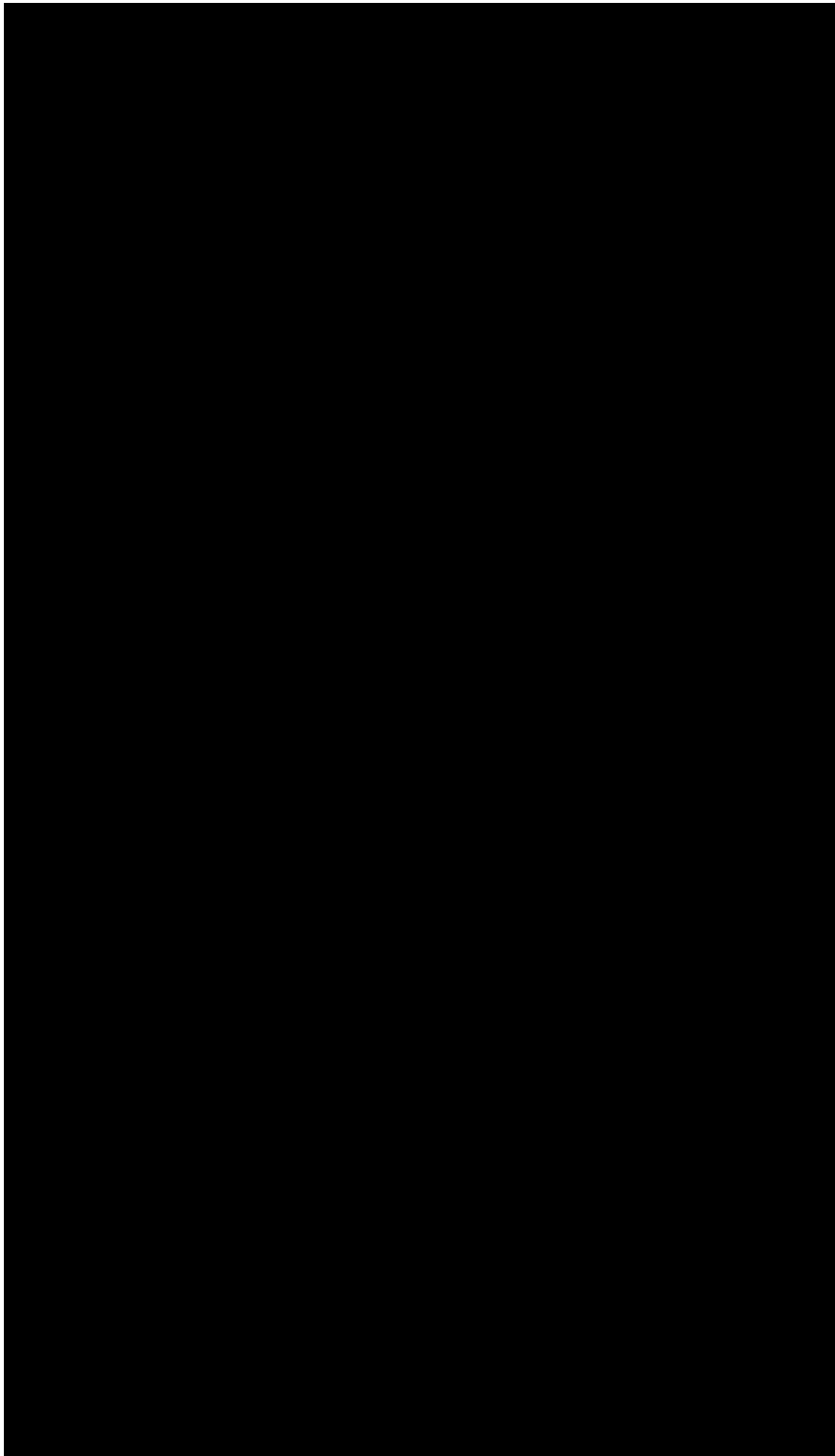
CXR was reviewed and

Assessment:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

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

CC: F/U HTN and DM2



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SH and theref
level of history

This exam incl
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cultation of ne
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ation of skin

Qualifies as a

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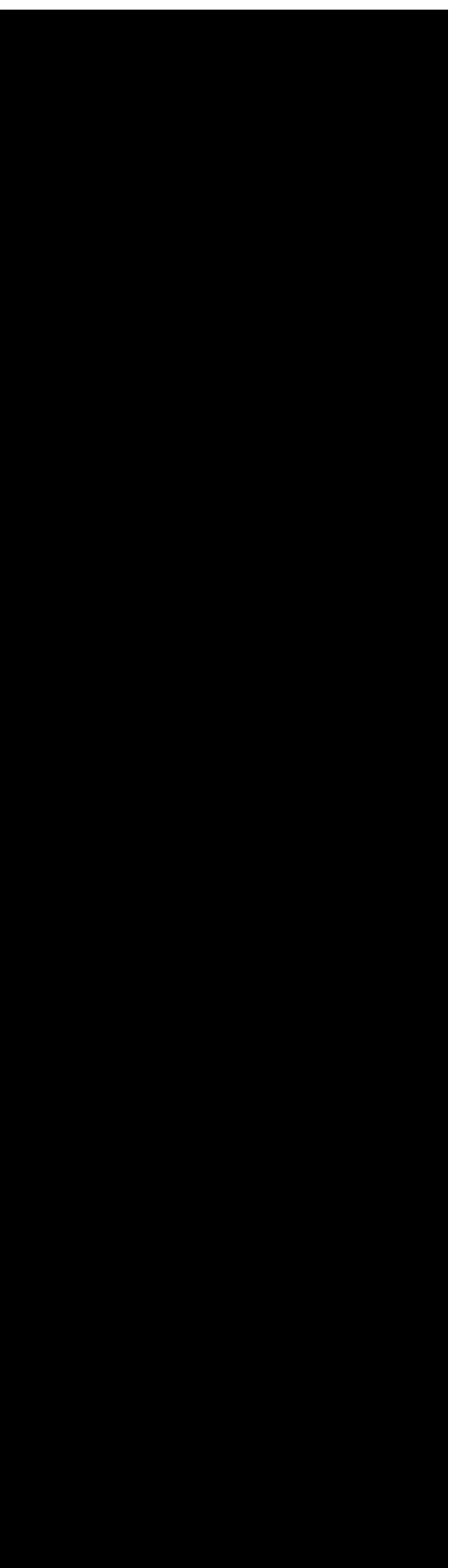
showed worse
stion

MDM	Prob
SF	≤
Low	2
Mod	3
High	≥

Require

M qualifies as
e presence of
four or more d
moderate.

ey compone



Target Code	History	Exam
99233	Detailed ✕	Detailed

99233

CC: CHF

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

Vitals: 1
General
Neck: F
Lungs:
CV: RR
Abd: Sof
Ext: 2+
Skin: W

Assess
1. Deco
2. Poorl
3. Mild
4. Stabl

Plan
1. D/C P
2. Start
3. Strict
4. Reple
5. Repe
6. Repe

Target

99

Remem
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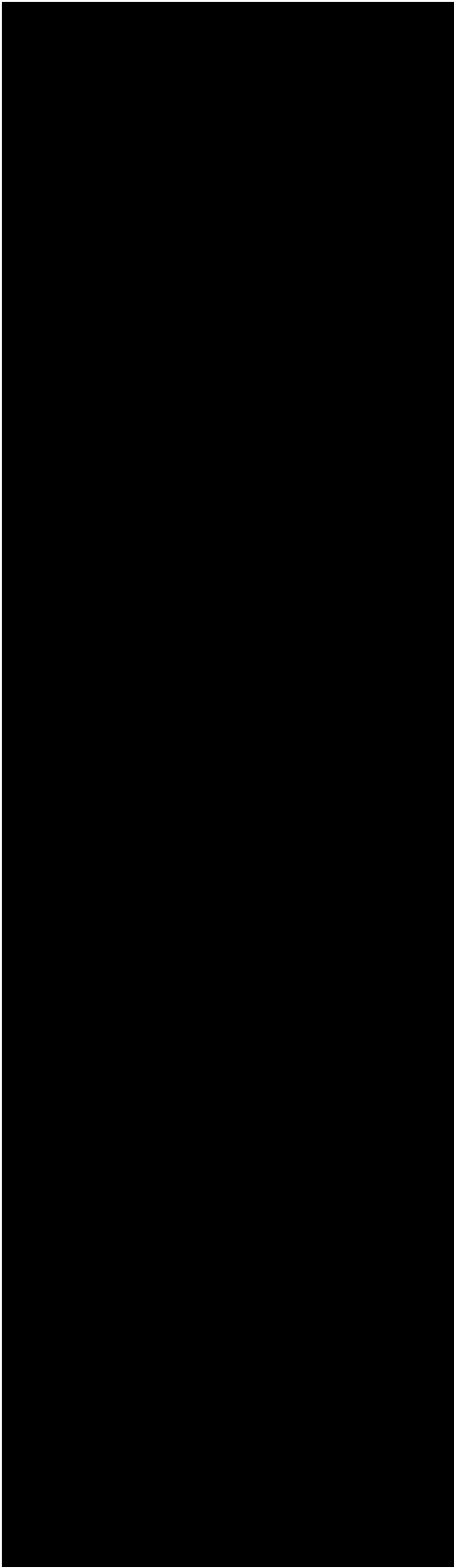
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99233

Status of Three Chronic Problems
CHF, HTN, CAD



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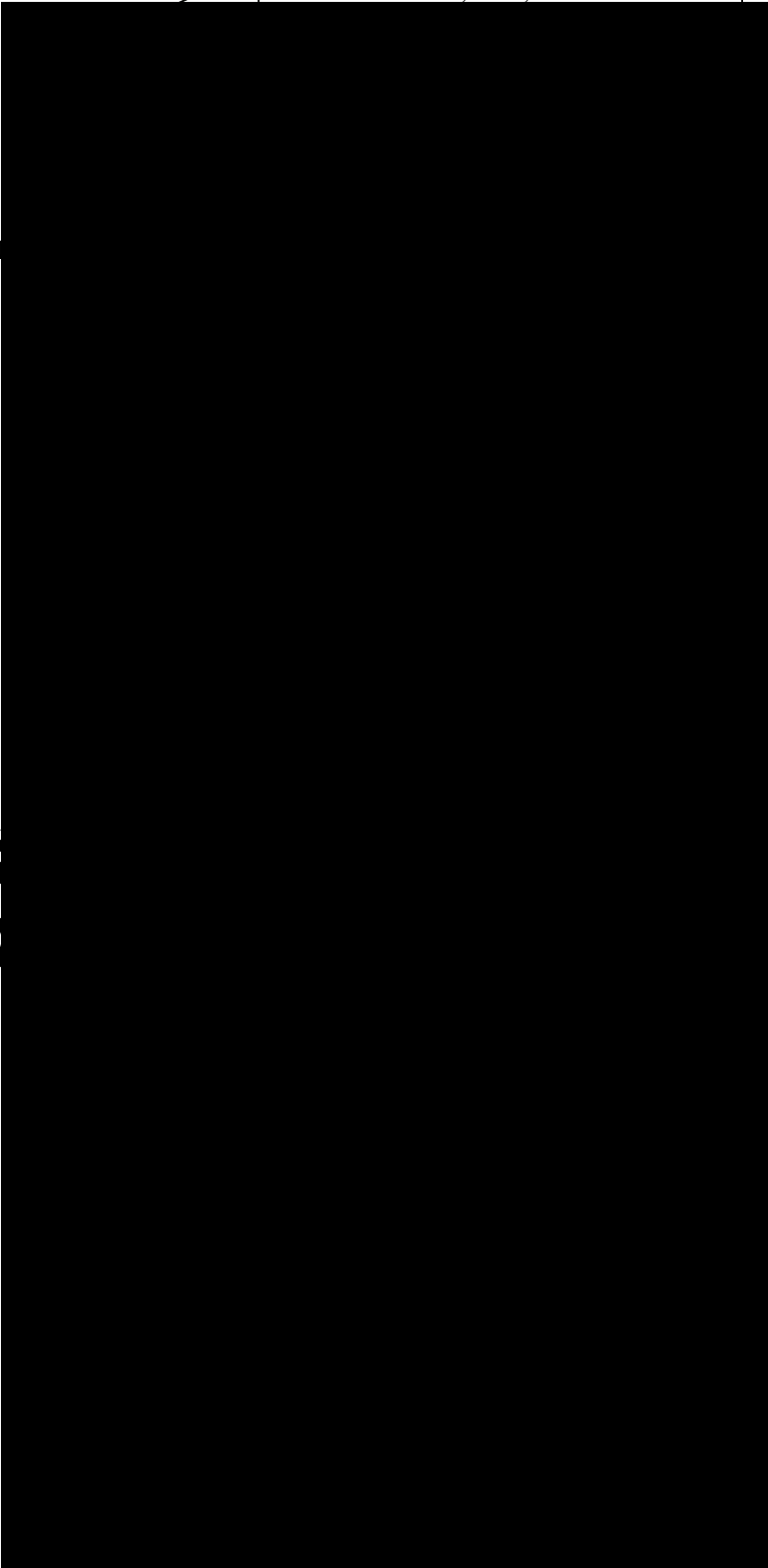
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99233



Admission H&Ps

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Documentation: Admission H&Ps

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

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
- After reviewing the chart you decide to admit him to the CCU bed in the CCU
- The chest physical exam is clear, also order ABG
- Total time spent on the case is 15 minutes
- What is the total number of points for this case?

Problem Points

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

Total Points = 7

Redacted

Data Reviewed Points

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

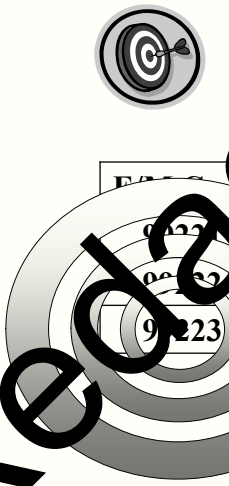
Total

Risk	Presenting Problems	Diagnostic Procedures	Management Options
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 • ECG/EEG, Echocardiogram 	<ul style="list-style-type: none"> • Rest • Gargles • Superficial dressings
Low	<ul style="list-style-type: none"> • Two or more self-limited or minor problems • One stable chronic illness • 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 • ABG • Skin biopsies 	<ul style="list-style-type: none"> • Over the counter drugs • Minor surgery, with no risk factors • PT/OT • IV fluids, without additives
Moderate	<ul style="list-style-type: none"> • One chronic illness, with mild exacerbation, • Two stable chronic illnesses • Undiagnosed neurological condition with uncertain prognosis 	<ul style="list-style-type: none"> • Cardiac stress test • Cardiovascular imaging 	<ul style="list-style-type: none"> • Prescription drug management
High	<ul style="list-style-type: none"> • One or more chronic illnesses with severe exacerbation • Acute or chronic injury, which poses a threat to life or bodily function • An abrupt change in neurological status 		

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



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

- Most f
used
encou
- Reimb
about

E/M Code
99233

3

Hx	HP
PF	rief
EPF	rief
De	Ext
Com	Ext

Read

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.

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

CC:

HPI:
as "c
som

PMH

SH:

FH:
and

R

99223	Comp <input checked="" type="checkbox"/>	Comp	High
-------	--	------	------

- Qualifies for an extended HPI because four or more HPI elements were recorded. In this case, the following seven elements were used:

- Qualifies three com
- At least 1 other sys

This

1	2	3	4	5	6	7	8	9	10	11	12	13	14	GU
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----

Vitals: 140/75, 108,
 General: Anxious a
 Eyes: anicteric scler
 HENT: AT/NC; oro
 Neck: Trachea mid
 Lungs: Clear to aus
 CV: RRR, no MRG
 Abd: Soft, non-tend
 Ext: No digital cyan
 Skin: Normal temp
 Psych: Appropriate

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

This qualifies as a comprehensive exam because at least two bullets from each of nine differ
 The following bull

- Constitutional
 - Three vital
 - General ap
- Eyes
 - Exam of scler
 - Exam of p
- HENT
 - External a
 - Exam of or
- Neck
 - Exam of n
 - Exam of th
- Lungs
 - Auscultatio
 - Assessmen

Medical Decision-Making

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

Assessment

1. U
2. S
3. S

Plan

1. F
2. A
3. S
4. S
5. C

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

This example
making due

-
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Note: Even
complexity
order to qu



CC: Chest pain

HPI: The patient presents with

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y voltage;

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SAP

red bed in

3. ASA, PPI, NTP, sq hepari

4. Sliding scale insulin

5. Consult cardiology

Requires three out of three qualifying key components

Target Code	History	Exam	MDM
99223	Comp	Comp	High

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
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Coding Education

1-888-U-EM-CODE

pjensen@emuniversity.com

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