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

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

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
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.

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

MA/Cr = 28, LDL 77, HgbA1c 6.8

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
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<td>$80.53</td>
</tr>
<tr>
<td>99215</td>
<td></td>
<td>$117.21</td>
</tr>
</tbody>
</table>

50%

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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
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:

Patient complains of stabbing intermittent chest pain which began 8 hours ago while watching TV. The pain is rated as 8/10 in severity, is worse with exertion and is associated with SOB and nausea.
Status of Three Chronic Problems

Hypertension

Dyslipidemia

The patient’s HTN and dyslipidemia remain stable on current medications. DM has been somewhat difficult to control lately with occasional sugars in the high 200’s.

Diabetes

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
- Ear, 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.
PF SH

- 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 PF SH may be completed by the physician, ancillary staff or by having the patient fill out a questionnaire.

<table>
<thead>
<tr>
<th>History</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFSH RO SH PI H</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Brief</td>
</tr>
<tr>
<td>Detailed</td>
</tr>
<tr>
<td>Comp</td>
</tr>
</tbody>
</table>

The history should be recorded in a purpose-driven manner to ensure compliance while avoiding time-wasting over-documentation.
A problem such as PFSH often involves symptoms and complaints that require a brief HPI. This usually requires one to three HPI elements.
Expanded Problem Focused History

CC: Chest pain
Interval History
ROS

One HL

An expanded ROS. No evidence of difference between prob lem focused history.
A detailed history of three or more complaints, your past medical history, the past medical history of three or more relatives, and any other relevant information.
## Comprehensive History

- **CC:** Exertion
- **Interval:**
- **PMH:**
- **ROS:**
- **FH:**
- **SH:**

*A comprehensive past medical, family, and social history*

<table>
<thead>
<tr>
<th>Comp</th>
<th>History</th>
</tr>
</thead>
</table>

Redacted Version
History Tips and Shortcuts

1. You need support success.
2. The physical member. However, it includes mental health. A permanent member.
3. You don’t have to be there, but the inter%
4. A Companion pertinent information indicated at least 10 care carriers.
5. When do you dictate a note and make a social history? For details to add at.
6. If the patient information contain relevant,
7. At least three inpatient or outpatient care.
8. Only 2 of office patient.
9. PFHs and official progress notes the elements of.
10. When uses allocated if you make a setup.
11. Prolonged direct care either the devices, in physician.

30 minutes additional for M Visit at the first addition codes are
Physical Exam

- 1997 Physical Exam
- 15 Organ Systems and 59 bullets

<table>
<thead>
<tr>
<th>Exam</th>
<th>Bullets</th>
</tr>
</thead>
<tbody>
<tr>
<td>PF</td>
<td>1 - 5</td>
</tr>
<tr>
<td>EPF</td>
<td>6 - 11</td>
</tr>
<tr>
<td>Detailed</td>
<td>12</td>
</tr>
<tr>
<td>Comp</td>
<td>18</td>
</tr>
</tbody>
</table>

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., buble frmitus)
- Auscultation of the lungs

Cardiovascular
- Palpation of the heart (P/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 nails (e.g., clubbing, cyanosis, ischemia)

Examination of the joints, bones, and muscles for 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

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

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
A problem focused exam is one that focuses on specific systems. It is difficult to give you one bullet description of the exam. Here is a sample of a problem focused exam:

**Problem Focused Exam**

**Vitals:** 125/75, 1

**General:** NAD, c

**Physical Exam:**

**PF**

Level 1
Vitals: 125/7
General: NA
Lungs: Clea
CV: RRR, no P
Abd: Soft, n
Ext: No perip

An expanded physical exam was performed on systems. Here, a brief description of listening to the next bullet for assessment of the syste

Lev
<table>
<thead>
<tr>
<th></th>
<th>Physical Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A detailed examination involves getting one bullet for the general and examining the rest of the system. Each for listed with one bullet for association of the details.</td>
</tr>
</tbody>
</table>
## Comprehensive Exam

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Constitutional</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three vital signs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Eyes** |   |   |   |   |   |   |
| Inspection |   |   |   |   |   |   |
| Examination |   |   |   |   |   |   |

| **Ears, Nose, Mout** |   |   |   |   |   |   |
| External appearance |   |   |   |   |   |   |
| Examination |   |   |   |   |   |   |

| **Neck** |   |   |   |   |   |   |
| Examination |   |   |   |   |   |   |
| Examination |   |   |   |   |   |   |

| **Respiratory** |   |   |   |   |   |   |
| Assessment |   |   |   |   |   |   |
| Auscultation |   |   |   |   |   |   |

Level 4 and 5
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

"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."

Determining the MDM

<table>
<thead>
<tr>
<th>Number of Diagnoses</th>
<th>Data Reviewed</th>
<th>Risk</th>
<th>Level of MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Straight-Forward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MDM Complexity</th>
<th>Problems</th>
<th>Data</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight Forward</td>
<td>1</td>
<td>1</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low</td>
<td>2</td>
<td>2</td>
<td>Low</td>
</tr>
</tbody>
</table>
### Points for Data Reviewed

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

“Data points” are reviewed during data collection.

Risk is stratified and/or managed according to the table on element of risk.
### Table of Risk

<table>
<thead>
<tr>
<th>Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedures</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis</td>
<td>• Laboratory tests&lt;br&gt;• Chest X-rays&lt;br&gt;• EKG/EEG&lt;br&gt;• Urinalysis&lt;br&gt;• Ultrasound/Echocardiogram&lt;br&gt;• KOH prep</td>
<td>• Rest&lt;br&gt;• Gargles&lt;br&gt;• Elastic bandages&lt;br&gt;• Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>• Two or more self-limited or minor problems&lt;br&gt;• One stable chronic illness, e.g., well controlled HTN, DM2, cataract&lt;br&gt;• Acute uncomplicated injury or illness, e.g., cystitis, allergic rhinitis, sprain</td>
<td>• Physiologic tests not under stress, e.g., PFTs&lt;br&gt;• Non-cardiovascular imaging studies with contrast, e.g., barium enema&lt;br&gt;• Superficial needle biopsy&lt;br&gt;• ABG&lt;br&gt;• Skin biopsies</td>
<td>• Over the counter drugs&lt;br&gt;• Minor surgery, with no identified risk factors&lt;br&gt;• Physical therapy&lt;br&gt;• Occupational therapy&lt;br&gt;• IV fluids, without additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>• One or more chronic illness, with mild exacerbation, progression, or side effects of treatment&lt;br&gt;• Two or more stable chronic illnesses&lt;br&gt;• Undiagnosed new problem, with uncertain prognosis, e.g., lump in breast&lt;br&gt;• Acute illness, with systemic symptoms, e.g., pyleonephritis, pleuritis, colitis&lt;br&gt;• Acute complicated injury, e.g., head injury, with brief loss of consciousness</td>
<td>• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test&lt;br&gt;• Diagnostic endoscopies, with no identified risk factors&lt;br&gt;• Deep needle, or incisional biopsies&lt;br&gt;• Cardiovascular imaging studies, with contrast, with identified risk factors, e.g., arteriogram, cardiac catheterization&lt;br&gt;• Obtain fluid from body cavity, (e.g., LP or thoracentesis)</td>
<td>• Minor surgery, with identified risk factors&lt;br&gt;• Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors&lt;br&gt;• Prescription drug management&lt;br&gt;• Therapeutic nuclear medicine&lt;br&gt;• IV fluids, with additives&lt;br&gt;• Closed treatment of fracture or dislocation, without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>• One or more chronic illness, with severe exacerbation, progression, or side effects of treatment&lt;br&gt;• One 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&lt;br&gt;• An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss</td>
<td>• Cardiovascular imaging, with contrast, with identified risk factors&lt;br&gt;• Cardiac EP studies&lt;br&gt;• Diagnostic endoscopies, with identified risk factors&lt;br&gt;• Discography</td>
<td>• Elective major surgery (open, percutaneous, endoscopic), with identified risk factors&lt;br&gt;• Emergency major surgery (open, percutaneous, endoscopic)&lt;br&gt;• Parenteral controlled substances&lt;br&gt;• Drug therapy requiring intensive monitoring for toxicity&lt;br&gt;• Decision not to resuscitate, or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MDM Complexity</th>
<th>Problems</th>
<th>Data</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight Forward</td>
<td>1</td>
<td>1</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Moderate</td>
<td>2</td>
<td>2</td>
<td>Low Moderate</td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>4</td>
<td>High</td>
</tr>
</tbody>
</table>

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

The overall MDM is determined by the highest level among the Complexity, Problems, and Data. This ensures that the risk is adequately considered, even if the other two areas are lower.

Redacted Version
Clinical Correlation

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

<table>
<thead>
<tr>
<th>Problems/DDx</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self limited or minor (Max 2)</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SF</th>
<th>MDM</th>
<th>Prob Pts</th>
<th>Data Pts</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>0 - 1</td>
<td>Min</td>
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</tbody>
</table>
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.

Risk

<table>
<thead>
<tr>
<th>Risk</th>
<th>Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Mod</td>
<td>Mod</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

Clinical Correlation

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

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

<table>
<thead>
<tr>
<th>Problems/DDx</th>
<th>Pts</th>
<th>MDM</th>
<th>Prob Pts</th>
<th>Data Pts</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self limited or minor (Max 2)</td>
<td>1</td>
<td>SF</td>
<td>1</td>
<td>0 - 1</td>
<td>Min</td>
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<tr>
<td>Established</td>
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<td></td>
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<tr>
<td>Established</td>
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<tr>
<td>New problem</td>
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<tr>
<td>New problem</td>
<td></td>
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</tbody>
</table>

Acuity of care involves:
Risk corresponds to the acuity of the illness; may also include acute status or IV concomitant...

Data points often require sources of data of...
Putting it All Together

<table>
<thead>
<tr>
<th>Hx</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>Exam</th>
<th>Bullets</th>
<th>MDM</th>
<th>Dx</th>
<th>Data</th>
<th>Risk</th>
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</thead>
<tbody>
<tr>
<td>PF</td>
<td>Brief</td>
<td>None</td>
<td>None</td>
<td>PF</td>
<td>1 - 5</td>
<td>SF</td>
<td>1</td>
<td>1</td>
<td>Min</td>
</tr>
<tr>
<td>EPF</td>
<td>Brief</td>
<td>1</td>
<td>None</td>
<td>EPF</td>
<td>6 - 11</td>
<td>Low</td>
<td>2</td>
<td>2</td>
<td>Low</td>
</tr>
</tbody>
</table>

Once you have completed the above steps, the next step is to ensure that your data is perfectly accurate. Redacted Version

Redacted Version
You have diabetes (DM)

The MA/Cr is 28, LDL is 77, HgbA1c is 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?
In this exam, problems of...
In this case, you:

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

<table>
<thead>
<tr>
<th>MDM Complexity</th>
<th>Problems</th>
<th>Data</th>
<th>Risk</th>
</tr>
</thead>
</table>

Here, Since mode

In this case, solely on

Redacted Version
Selecting the Target Code

Established Office Patients

In this section, we will discuss...

about $88.00
<table>
<thead>
<tr>
<th>BriefEPF</th>
<th>ExtDet</th>
<th>BriefPF</th>
<th>ExtComp</th>
<th>HPI</th>
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<tbody>
<tr>
<td>99214</td>
<td>2 out</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In this example, key components of qualifying allows you to find the minimum having to...
Requires two out of three qualifying key components

<table>
<thead>
<tr>
<th>Target Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

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

<table>
<thead>
<tr>
<th>Problems/DDx</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self limited or minor (M)</td>
<td></td>
</tr>
<tr>
<td>Established problem, stable</td>
<td></td>
</tr>
<tr>
<td>Established problem, worsening</td>
<td></td>
</tr>
<tr>
<td>New problem, no additional planned</td>
<td></td>
</tr>
<tr>
<td>New problem, additional planned</td>
<td></td>
</tr>
</tbody>
</table>
## Data Reviewed Points

<table>
<thead>
<tr>
<th>Risk</th>
<th>Presenting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>- One self-limited or minor problem, e.g., cold, tinea corporis.</td>
</tr>
<tr>
<td>Low</td>
<td>- Two or more self-limited or minor problems.</td>
</tr>
<tr>
<td></td>
<td>- One stable chronic problem.</td>
</tr>
<tr>
<td></td>
<td>- Acute or chronic illness, e.g., cystitis, rhinitis, sprain.</td>
</tr>
<tr>
<td></td>
<td>- One chronic illness exacerbation.</td>
</tr>
<tr>
<td></td>
<td>- Two stable chronic problems.</td>
</tr>
<tr>
<td></td>
<td>- Undiagnosed new problem with uncertain prognosis.</td>
</tr>
<tr>
<td>Moderate</td>
<td>- One or more chronic problems with severe exacerbation.</td>
</tr>
<tr>
<td></td>
<td>- Acute or chronic injury, which poses threat to an organ or bodily function.</td>
</tr>
<tr>
<td>High</td>
<td>- An abrupt change in neurological status.</td>
</tr>
</tbody>
</table>
### Calculating the Overall MDM

<table>
<thead>
<tr>
<th>MDM Complexity</th>
<th>Problems</th>
<th>Data</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight Forward</td>
<td>1</td>
<td>0 - 1</td>
<td>Minimal</td>
</tr>
</tbody>
</table>

Redacted Version
In this case, we know that we already have compliance. This time, we decided to go for the
CC: F/

Interval:

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. Stric
  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?
Calculating the Overall MDM

<table>
<thead>
<tr>
<th>MDM Complexity</th>
<th>Problems</th>
<th>Data</th>
<th>Risk</th>
</tr>
</thead>
</table>

Selecting the Target Code

Admission H&Ps
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

Peter R. Jensen, MD, CPC
Online and On-site
Physician-to-Physician E/M Coding Education
1-888-U-EM-CODE
pjensen@emuniversity.com
Practical E/M Coding Education
www.EMuniversity.com