Rational Physician Coding for Hospitalist E/M Services

Peter R. Jensen, MD, CPC
www.EMuniversity.com
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.
- BP is 160/90, edema has worsened and patient c/o orthopnea and SOBAR requiring 2 liters NC O2.
- Echo report from yesterday shows an EF of 25%.
- You look at the CXR, replace the K+, change the patient to a strict 2 gram sodium diet, and order labs and repeat CXR for the a.m. You also change the diuretics to IV Bumex.
- Time spent is 25 minutes
- How much is this encounter worth?

BNP is 1450

\[
\begin{array}{c|c|c|c}
138 & 101 & 10 \\
3.1 & 23 & 0.8 \\
\end{array} \\
\begin{array}{c|c|c|c}
124 & 12 & 36 \\
\end{array} \\
\text{BNP is 1450}
\]
Goals

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

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>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>$36.00</td>
</tr>
<tr>
<td>99232</td>
<td>$64.00</td>
</tr>
<tr>
<td>99233</td>
<td>$91.00</td>
</tr>
</tbody>
</table>

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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
We think of the key components as being random, but they’re really not……

This is how auditors look at the E/M guidelines. They view the history, physical exam and medical decision-making in very concrete terms.
Our challenge is to find some way to translate our cognitive labor into the abstruse language of the E/M guidelines without wasting time on over-documentation or getting distracted from our real job of taking care of patients.

Rational Physician Coding teaches you to consider the MDM first in order to identify a target code for each encounter. Then you can perform and document the history and exam in a purpose-driven manner to ensure that these elements are congruent with the level of care selected.
Rationale
1. Calculate
2. Identify
3. Perform

Primacy of Medical Decision-Making

\[ \text{MDM} = \text{key} \]

Problems → Data → Risk
The Importance of Medical Necessity

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

The quote above is taken directly from the Medicare carrier manual and it points out the fact that there must be sufficient medical necessity to support the intensity of the history and exam performed and documented. The key component of medical decision-making can act as an objective index of care by verifying that the visit is medically necessary.
## 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>
<tr>
<td>Moderate</td>
<td>3</td>
<td>3</td>
<td>Moderate</td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>4</td>
<td>High</td>
</tr>
</tbody>
</table>

The few vague terms will "volun...
Problem Points

<table>
<thead>
<tr>
<th>Problems/DDx</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self limited or minor (Max 2)</td>
<td>1</td>
</tr>
<tr>
<td>Established problem, stable</td>
<td>1</td>
</tr>
<tr>
<td>Established problem, worsening</td>
<td>2</td>
</tr>
<tr>
<td>New problem, no additional work-up planned</td>
<td>3</td>
</tr>
<tr>
<td>New problem, additional work-up planned</td>
<td></td>
</tr>
</tbody>
</table>

Points for Data Reviewed

<table>
<thead>
<tr>
<th>Data Reviewed</th>
<th>Points</th>
</tr>
</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>1</td>
</tr>
<tr>
<td>Independent review of image, tracing, or specimen</td>
<td>2</td>
</tr>
<tr>
<td>Decision to obtain old records</td>
<td>1</td>
</tr>
</tbody>
</table>
## 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</td>
<td>• Rest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Chest X-rays</td>
<td>• Gargles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• EKG/EEG</td>
<td>• Elastic bandages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Urinalysis</td>
<td>• Superficial dressings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ultrasound/Echocardiogram</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• KOH prep</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>• Two or more self-limited or minor problems</td>
<td>• Physiologic tests not under stress, e.g., PFTs</td>
<td>• Over the counter drugs</td>
</tr>
<tr>
<td></td>
<td>• One stable chronic illness, e.g., well controlled HTN, DM2, cataract</td>
<td>• Non-cardiovascular imaging studies with contrast, e.g., barium enema</td>
<td>• Minor surgery, with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Acute uncomplicated injury or illness, e.g., cystitis, allergic rhinitis, sprain</td>
<td>• Superficial needle biopsy</td>
<td>• Physical therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ABG</td>
<td>• Occupational therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Skin biopsies</td>
<td>• 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</td>
<td>• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test</td>
<td>• Minor surgery, with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Two or more stable chronic illnesses</td>
<td>• Diagnostic endoscopies, with no identified risk factors</td>
<td>• Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>• Undiagnosed new problem, with uncertain prognosis, e.g., lump in breast</td>
<td>• Deep needle, discisional biopsies</td>
<td>• Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td>• Acute illness, with systemic symptoms, e.g., pyelonephritis, pleuritis, colitis</td>
<td>• Cardiac EP studies</td>
<td>• IV fluids, with additives</td>
</tr>
<tr>
<td></td>
<td>• Acute complicated injury, e.g., head injury, with brief loss of consciousness</td>
<td>• Cardiovascular imaging, with contrast, with identified risk factors</td>
<td>• 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</td>
<td>• Diagnostic endoscopies, with identified risk factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 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</td>
<td>• Discography</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is the table of risk. The rules of categories above are the following:

- **Minimal**: Presenting problems are self-limited or minor, e.g., cold, insect bite, tinea corporis.
- **Low**: Presenting problems are two or more self-limited or minor problems, or one stable chronic illness, e.g., well-controlled HTN, DM2, cataract. Management options include physiologic tests not under stress, e.g., PFTs, and selected diagnostic procedures such as chest X-rays, EKG/EEG, urinalysis, and ultrasound/Echocardiogram.
- **Moderate**: Presenting problems are one or more chronic illnesses, with mild exacerbation, progression, or side effects of treatment. Management options include physiologic tests under stress, e.g., cardiac stress test, and selected diagnostic procedures such as diagnostic endoscopies with no identified risk factors.
- **High**: Presenting problems are one or more chronic illnesses, with severe exacerbation, progression, or side effects of treatment. Management options include selected diagnostic procedures such as cardiovascular imaging with contrast, and selected management options such as non-treatment or resuscitation, with potential threat to others or self.
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</td>
<td>2</td>
<td>2</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>3</td>
<td>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.
There are four levels of history based on the documentation of the HPI, ROS and elements of past medical, family and social history.
HPI

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

Elements of HPI

- Location
- Duration
- Timing
- Quality
- Severity
- Context
- Modifying factors
- Associated signs or symptoms
Example of an extended HPI using all eight of the HPI elements.

**Levels of HPI**

- **Brief HPI**
  - Requires only one to three HPI elements

- **Extended HPI**
  - Requires four HPI elements or the status of three chronic or inactive problems
What if the patient has no complaints?

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

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

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 supplement
2. The physical member
   However, and included also means a permanent
3. You do it, but the example, “the interest
4. A Certain pertinence indication indicates at least 10 care cards
5. When dictating and making the entries, For details to add a
6. If the patient obtain Re
7. At least in complete, inpatient, and inpatient care
8. Only 2 office p
9. PFSH ER officially progress notes moments of
10. When use allotted

You Must
11. Prolong direct, either the services, in the physical visit the first 30 minutes of the first additional codes and
# 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., tracheal frumitus)
- Auscultation of the lungs

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

Chest (Breasts)
- Inspection of the breasts
- Palpation of the breasts and axillae

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

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

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

Musculoskeletal
- Examination of gait and station
- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, ischemia)
- Examination of the joints, bones, and muscles of one or more of the following six areas:
  1. Head and neck
  2. Spine, ribs, and pelvis
  3. Right upper extremity
  4. Left upper extremity
  5. Right lower extremity
  6. Left lower extremity

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

Lymphatic
- Palpation of lymph nodes two or more areas
  - Neck
  - Axillae
  - Groin
  - Other

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

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.

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

1. Why
2. What
3. Is

Redacted Version

Accounte
allowed c
This add
Three le
99231
99232
99233
Requires
compone
Hospital Progress Notes

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>PF</td>
<td>PF</td>
<td>SF/Low</td>
<td>15</td>
</tr>
<tr>
<td>99232</td>
<td>EPF</td>
<td>EPF</td>
<td>Moderate</td>
<td>25</td>
</tr>
<tr>
<td>99233</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High</td>
<td>15</td>
</tr>
</tbody>
</table>

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

BNP is 1450

![Image of calculation]

Redacted Version
### Data Reviewed Points

<table>
<thead>
<tr>
<th>Data Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenteral controlled substances</td>
<td></td>
</tr>
<tr>
<td>Drug therapy requiring intensive monitoring for toxicity</td>
<td></td>
</tr>
<tr>
<td>Obtain DNR or de-escalate care</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular imaging, with contrast, with identified risk factors</td>
<td></td>
</tr>
<tr>
<td>Cardiac EP studies</td>
<td></td>
</tr>
<tr>
<td>Diagnostic endoscopies, with identified risk factors</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Obtain DNR or de-escalate care</td>
<td></td>
</tr>
</tbody>
</table>

### Risk vs. Presence

<table>
<thead>
<tr>
<th>Risk</th>
<th>Presence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One self-problem, tinea corporis</td>
</tr>
<tr>
<td>Low</td>
<td>Two or minor problems, one stable, acute upper respiratory illness, rhinitis, one acute exacerbation, two subacute illnesses, uncertain</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic illness, with severe exacerbation, or injury, which poses a threat to life or bodily function, an abrupt change in neurological status</td>
</tr>
<tr>
<td>High</td>
<td>Cardiovascular imaging, with contrast, with identified risk factors, cardiac EP studies, diagnostic endoscopies, with identified risk factors, parenteral controlled substances, drug therapy requiring intensive monitoring for toxicity, obtain DNR or de-escalate care</td>
</tr>
</tbody>
</table>
Calculating the Overall MDM

If you speak a language other than English, you would need to code

Redacted Version
## Selecting the Target Code

### Hospital Progress Notes

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>90221</td>
<td>PF</td>
<td>PF</td>
<td>SF/Low</td>
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</tr>
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<td>90222</td>
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<td>EPF</td>
<td>Mod</td>
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<tr>
<td>99233</td>
<td>Det</td>
<td>Det</td>
<td>High</td>
<td>35</td>
</tr>
</tbody>
</table>

2 out of 3 key components must qualify

---

- **Least frequently used code**
- Reimbursement is about $78.00
Ethical Documentation
**Rational Documentation**

2 out of 3 key components must qualify

<table>
<thead>
<tr>
<th>Target Code</th>
<th>HPI</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99233</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High</td>
</tr>
</tbody>
</table>

**CC: F/U CHF**

**HPI: The patient...**

**History**

<table>
<thead>
<tr>
<th>History</th>
<th>Detailed</th>
<th>Extended</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
</tbody>
</table>
Plan:

Decision-Making

Assessment:

Physical Exam

Constitutional

Eyes

ENMT

Chest/Breasts

Musculoskeletal

Neurologic

Psychiatric

GI GU

Lungs

Skin

Musculoskeletal

Neurologic

Psychiatric

Vitals: 160/90, 18, 82, 98.6
General: NAD, well nourished WM looks stated age
Vitals: 160/90, 18, 82, 98.6
General: NAD, well nourished WM looks stated age

Redacted Version
CC: F/U HTN and DM2

Patient states he feels generally “lousy.”

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

This exam includes 12 bullets:

- Th
- Ge
- Ex
- Au
- Per
- Au
- Pal
- Ex
- Ex
- Au
- Ex

CXR was reviewed and showed worsening pulmonary vascular congestion

<table>
<thead>
<tr>
<th>MDM</th>
<th>Prob Pts</th>
<th>Data Pts</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>SF</td>
<td>≤ 1</td>
<td>≤ 1</td>
<td>Min</td>
</tr>
<tr>
<td>Low</td>
<td>≥ 2</td>
<td>≥ 2</td>
<td>Low</td>
</tr>
</tbody>
</table>

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>99233</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High</td>
</tr>
<tr>
<td>Target</td>
<td>9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remember, the new components of the exam and their explanation.

On the other hand, care need to be taken up to the indication medically necessary.

The next page is ending.”
CC: F/U HTN

Interval History
HTN is poorly controlled, and he has increased his chest pain.

ROS
CV: +
Pulm: Lungs: Bibas.
CV: RRR, no RPE
Ext: 2+ edema

Assessment
1. Decomp
2. Poorly controlled HTN
3. Mild hypokalemia
4. Stable CAD

Plan
1. D/C PO Levo
2. Start IV Bu
3. Strict low salt
4. Replete K
5. Repeat replete K
6. Repeat CX
Admission H&Ps

- Accounted for $1.3 billion in allowed charges in 2021.
- This adds another $1.2 billion.
- Three levels are available:
  - 99221
  - 99222
  - 99223
- Requires 3 out of 3 key components.

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>Description</th>
<th>Comp</th>
<th>Comp</th>
<th>Complexity</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99222</td>
<td>Comp</td>
<td>Comp</td>
<td>Moderate</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>99223</td>
<td>Comp</td>
<td>Comp</td>
<td>High</td>
<td>70</td>
<td></td>
</tr>
</tbody>
</table>

3 out of 3 key components must qualify
Admission H&P

- You are on ER backup and asked to admit a 68 year old diabetic male with HTN and dyslipidemia who presents with chest pain.
- After reviewing the EKG, CXR and labs, you decide to admit the patient to a monitored bed in the CCU and consult cardiology.
- The chest pain improves with IV MSO4. You also order labs.
- Total time: 7 minutes
- What is the diagnosis?
### Data Reviewed Points

<table>
<thead>
<tr>
<th>Data Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review/order clinical lab tests</td>
<td></td>
</tr>
<tr>
<td>Review/order X-rays</td>
<td></td>
</tr>
<tr>
<td>Review/order tests in the medicine section (echo, EKG, LHC, PFTs)</td>
<td></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></td>
</tr>
<tr>
<td>Review and summation of old records</td>
<td></td>
</tr>
</tbody>
</table>

### Risk

<table>
<thead>
<tr>
<th>Risk</th>
<th>Presenting Problems</th>
<th>Diagnostic Procedures</th>
<th>Management Options</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, Chest X-rays, EEG/EEG, Echocardiogram</td>
<td>Rest, Gargles, Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems</td>
<td>Physiologic tests not under stress, e.g., PFTs, Non-cardiovascular imaging</td>
<td>Over the counter drugs, Minor surgery, with no risk factors</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>
<tr>
<td>Low</td>
<td>2</td>
<td>2</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>3</td>
<td>Mod</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

Selecting the Target Code

<table>
<thead>
<tr>
<th>Admission H&amp;Ps</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Det</td>
<td>SF/Low</td>
<td>30</td>
</tr>
<tr>
<td>Comp</td>
<td>Mod</td>
<td>50</td>
</tr>
<tr>
<td>Comp</td>
<td>High</td>
<td>70</td>
</tr>
</tbody>
</table>

3 out of 3 key components must qualify
<table>
<thead>
<tr>
<th>E/M Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99223</td>
<td>Comp</td>
<td>Comp</td>
<td>High</td>
<td>70</td>
</tr>
</tbody>
</table>

Time requirements:
- Most frequently used code
- Reimbursed about $1

3 out of 3 key components must qualify:
- History
- Exam
- MDM

For comprehensive codes, patients must be seen in any systems and must perform a comprehensive exam of NINE systems.
<table>
<thead>
<tr>
<th>ROS</th>
<th>FH: Father and has A</th>
<th>PMH: HT</th>
<th>SH: Quit smoking</th>
<th>HPI: The patient sometimes has crushing chest pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tar 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CC:** Chest pain as "crushing chest pain".
This question is asking you to identify each of the following items. The following items are included:

- Physical exam
- Constitutional
- Eyes
- ENMT
- Neck
- Chest/Breasts
- CV
- GI GU
- Lungs
- Vital
- Gen
- Eye
- HE
- NEC
- Lung
- CV:
- Abd:
- Ext:
- Skin
- Psych

- Exam of neck
- Exam of thyroid

- Auscultation of lungs
- Assessment of respiratory effort
- Assessment of affect
- Assessment of orientation
Medical Decision-Making

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

Assessment
1. USA v
2. Stable
3. Stable

Plan
1. F/U e
2. Admit
3. Start
4. Sliding
5. Consult cardiology

<table>
<thead>
<tr>
<th>Target Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99223</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This example qualifies for medical decision making due to the complexity of the patient's medical condition.

- Four EKG findings
- Four CXR findings
- High complexity medical condition

Note: Even if we observe four EKG findings, four CXR findings, and a high complexity MDM, in order to qualify for the code, we must also have a stable patient.
CC: Chest pain

HPI: The patient presents with "crushing" and 8 out of 10 in intensity, associated with nausea and IV MOS4 in the ER.

Complete ROS:
- “crushing” and 8 out of 10 in intensity
- nausea
- IV MOS4

Additional findings:
- Patients stated age
- RLA
- Constitutional
- no thyroid abnormalities
- MCL
- tender neck, no masses or HSM
- esophagus, ulcer, nodules
- pitting or effusion
- Lab results:
  - 101 14
  - 88 24
  - 0.8

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

5. Consult cardiology

Requires three 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>99223</td>
<td>Comp</td>
<td>Comp</td>
<td>High</td>
</tr>
</tbody>
</table>
### Inpatient Consult Services

- **12,**
- **Ac**
- **8.4**
- **Find**

3 out of 3 key components must qualify

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99251</td>
<td>PF</td>
<td>PF</td>
<td>SF</td>
<td>20</td>
</tr>
<tr>
<td>99252</td>
<td>EPF</td>
<td>EPF</td>
<td>SF</td>
<td>40</td>
</tr>
<tr>
<td>99253</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
<td>55</td>
</tr>
<tr>
<td>99254</td>
<td>Comp</td>
<td>Comp</td>
<td>Mod</td>
<td>80</td>
</tr>
<tr>
<td>99255</td>
<td>Comp</td>
<td>Comp</td>
<td>High</td>
<td>110</td>
</tr>
</tbody>
</table>

Redacted Version
The Three “R”s

- Table
- Redacted Version

Types of Consults

- Inpatient Consults
- Outpatient
- Confirmator
- Follow-up Consult

Confirmation
Inpatient vs. Outpatient Consults

- Inpatient Consults
  - 3 out of 3 key components must qualify

Consult Documentation

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>PF</td>
<td>PF</td>
<td>SF</td>
<td>15</td>
</tr>
<tr>
<td>99242</td>
<td>EPF</td>
<td>EPF</td>
<td>SF</td>
<td>30</td>
</tr>
<tr>
<td>99243</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
<td>40</td>
</tr>
<tr>
<td>99244</td>
<td>Comp</td>
<td>Comp</td>
<td>Mod</td>
<td>60</td>
</tr>
<tr>
<td>99245</td>
<td>Comp</td>
<td>Comp</td>
<td>High</td>
<td>80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E/M Code</th>
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<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99251</td>
<td>PF</td>
<td>PF</td>
<td>SF</td>
<td>20</td>
</tr>
<tr>
<td>99252</td>
<td>EPF</td>
<td>EPF</td>
<td>SF</td>
<td>40</td>
</tr>
<tr>
<td>99253</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
<td>55</td>
</tr>
<tr>
<td>99254</td>
<td>Comp</td>
<td>Comp</td>
<td>Mod</td>
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</tr>
<tr>
<td>99255</td>
<td>Comp</td>
<td>Comp</td>
<td>High</td>
<td>110</td>
</tr>
</tbody>
</table>

3 out of 3 key components must qualify
Inpatient Consult

- You are consulted for hyperglycemia in an 84 year old post-op hip replacement patient.
- She has stable hypertension and CAD, but her diabetes has been poorly controlled and she complains of significant hip pain.

\[
\begin{array}{c|c|c}
136 & 101 & 14 \\
3.8 & 24 & 336 \\
\hline
12 & 37 & \end{array}
\]

- After ordering routine labs, you adjust the patient's scheduled insulin and add sliding scale coverage.
- You are asked to see the patient in 6 hours.
- You are told to order a CT scan.
- Time = 24 hours.
- What’s your plan?

New problem, additional work-up planned | 4

Total Points = 4
## Data Points

<table>
<thead>
<tr>
<th>Decision to obtain old medical records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent review of medical records</td>
</tr>
<tr>
<td>Review and summation of patient data</td>
</tr>
<tr>
<td>Discussion of test results</td>
</tr>
<tr>
<td>Review/order tests in LHC, PFTs</td>
</tr>
</tbody>
</table>

### Risk Levels

**Minimal**
- One self-limited or minor problem, e.g., cold, tinea corporis.

**Low**
- Two or more self-limited or minor problems
- One stable chronic problem
- Acute or chronic illness, e.g., cystitis, rhinitis, sprain

**Moderate**
- One chronic illness exacerbation
- Two stable chronic problems
- Undiagnosed new problem with uncertain prognosis
- One or more chronic problems with severe exacerbation
- Acute or chronic illness, injury, which poses threat to bodily function
- An abrupt change in neurological status

**High**
- One or more chronic illnesses
- Two or more chronic illnesses
- Acute or chronic illness, injury, which poses threat to bodily function
- An abrupt change in neurological status
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</td>
<td>2</td>
<td>2</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate High</td>
<td>3</td>
<td>3</td>
<td>Mod</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

Selecting the Target Code

3 out of 3 key components must qualify
### 99255

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99255</td>
<td>Comp</td>
<td>Comp</td>
<td>High</td>
<td>110</td>
</tr>
</tbody>
</table>

3 out of 3 key components must qualify

- Time requirements:
  - Third most frequently used code for the encounter
  - Reimbursed about $19

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99255</td>
<td>Comp</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3 out of 3 key components must qualify

<table>
<thead>
<tr>
<th>Type</th>
<th>ROS</th>
<th>PFSH</th>
<th>1</th>
<th>2 – 9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief</td>
<td>None</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Det</td>
<td>Ext</td>
<td>1</td>
<td></td>
<td>1/3</td>
<td></td>
</tr>
<tr>
<td>Comp</td>
<td>Ext</td>
<td>2</td>
<td>10</td>
<td>3/3</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>History</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comp</td>
<td>Extended</td>
<td>10</td>
<td>3/3</td>
</tr>
</tbody>
</table>

Reason for HPI:

HPI: This patient is nominally controlled on insulin. She comes in for a routine check-up.

PMH: peripheral neuropathy

SH: Marital status

FH: Father died of heart disease at age 50. One sibling is alive and well.

ROS:

Target

992

Extended

Redacted Version

Complete

Review of Systems

Complete

Redacted Version

Reviewed by: [Signature]
<table>
<thead>
<tr>
<th>Physical Exam</th>
<th>Constitutional</th>
<th>Eyes</th>
<th>ENT</th>
<th>Neck</th>
<th>Lungs</th>
<th>CV</th>
<th>GI</th>
<th>GU</th>
<th>Chest/Breasts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

Vitals: 120/80, 28, 111, 98.6
General: Elderly C;

- General appearance
- Eyes
- External app
- Exam of oral cavity
- Neck
- Exam of nodes
- Exam of thyroid
- Auscultation of lungs
- Percussion of lungs
- Assessment of judgment/insight

50
This example qualifies as being of high complexity medical decision-making.

Assessment:
1. U
2. S
3. S
4. P

Plan:
1. I
2. S
3. C
4. S
5. R
6. C

Target Code | History  | Data Pts  | MDM
---|---|---|---
99255 | Comp | 0 - 1 | High

Note: This example is redacted.
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
- Eliminates E/M coding anxiety
- 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