BASICS of E/M CODING

ASSIGNING THE CORRECT E/M CODE TO YOUR CLAIMS

A HANDBOOK FOR PHYSICIAN OFFICES

August 2009
THE PURPOSE of this HANDBOOK
(What it is & What it is not)

MSSNY and the county medical societies of New York State are constantly seeking ways to bring value to our members. This handbook is to be used as a resource by office staff tasked with billing and claims submissions. Our hope is that it will help offices operate more efficiently and effectively.

While this is no substitute for formal and extended training in E/M coding and claims submission, The Basics of E/M Coding Handbook gives essentials and offers resources for reference and further information.

This 2009 edition is a first effort, and no doubt suggestions for additions and changes will be incorporated in subsequent editions. Suggestions to improve this handbook are welcomed.

For questions regarding this handbook (or to learn more about review services) please contact: Frances Scott, Empire State Medical, Scientific & Educational Foundation, phone: (800) 437-2234 or by e-mail: fscott@esmsef

This handbook contains basics of E/M coding and claims submission. Office staff should be aware that this Handbook does not contain specialty specific codes or submission information. That information is best obtained from specialty societies and insurers.

CONTRIBUTORS:

MSSNY Coding Educational Task Force Members 2008

MSSNY expresses its appreciation and thanks to task force members who offered their time, talents and expertise in the research and writing of this handbook:

Frances Scott, RHIA – Director of Operations, Empire State Medical, Scientific and Educational Foundation, Inc. – Primary author of the Handbook

Beth Sassano, CPC, CCS-P, ACMCS, LPN – CEO, Cardiovascular Group of Syracuse Project consultant

Jim Coulthart – MSSNY Outreach Representative – Task Force Leader

ADDITIONAL RESOURCES

Acknowledgements and thanks are extended to the following for providing resource materials:

Michael Schoppmann, Esq. – Kern Augustine Conroy & Schoppmann, P.C.
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Sample E/M Coding Reference Forms

- EVALUATION AND MANAGEMENT GUIDELINES FOR NEW AND ESTABLISHED PATIENT – OFFICE VISIT

- EVALUATION AND MANAGEMENT GUIDELINES FOR NEW AND ESTABLISHED PATIENT – CONSULTATION

- EVALUATION AND MANAGEMENT- Coding and Documentation Reference Guide
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Helpful References
Helpful Websites

Appendix C
Articles from TrailBlazer Health Enterprises
- *E&M Coding – The Five-Step Process*
- *Medical Necessity for Evaluation and Management Services*
- *Documentation Requirements for CPT Code 99211*
- *Tips for Preventing Most Common Evaluation and Management (E/M) Service Coding Errors*
- *Tips for Preventing Coding Errors with Specific Evaluation and Management (E/M) Codes*

Appendix D
Medical Records – Fact Sheet

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**Note:** Frequently used items may be copied and laminated for office staff use
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DEFINITION AND PURPOSE OF EVALUATION AND MANAGEMENT (E/M) CODES

The E/M codes were designed to classify services provided by physicians in evaluating patients and managing their medical care. The codes incorporate the key and contributing components of a physician's service to determine the level of services that the physician provides. The code is then used for reimbursement of those services.¹

E/M codes are categorized according to site and/or type of service provided (office, outpatient, consultation, emergency department). Within these categories, the codes are then subdivided according to initial versus subsequent care. Within these categories, the codes are then listed based on the key components of service provided.

Categories of Evaluation and Management Codes:

<table>
<thead>
<tr>
<th>Office or Other Outpatient Services</th>
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</tr>
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<tbody>
<tr>
<td>New Patient</td>
<td>99201-99205</td>
</tr>
<tr>
<td>Established Patient</td>
<td>99211-99215</td>
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<table>
<thead>
<tr>
<th>Hospital Observation Services</th>
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<tbody>
<tr>
<td>Observation Care Discharge Services</td>
<td>99217</td>
</tr>
<tr>
<td>Initial Observation Care</td>
<td>99218-99220</td>
</tr>
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<table>
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<tr>
<th>Hospital Inpatient Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Hospital Care</td>
<td>99221-99223</td>
</tr>
<tr>
<td>Subsequent Hospital Care</td>
<td>99231-99236</td>
</tr>
<tr>
<td>Hospital Discharge Services</td>
<td>99238-99239</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consultations</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Office or Other Outpatient Consultations</td>
<td>99241-99245</td>
</tr>
<tr>
<td>Inpatient Consultations</td>
<td>99251-99255</td>
</tr>
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<table>
<thead>
<tr>
<th>Emergency Department Services</th>
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<tbody>
<tr>
<td>Initial Hospital Care</td>
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<tr>
<td>Subsequent Hospital Care</td>
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</tr>
<tr>
<td>Hospital Discharge Services</td>
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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Inpatient Pediatric Critical Care</td>
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<td>Inpatient Neonatal Critical Care</td>
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</tr>
<tr>
<td>Continuing Intensive Care Services</td>
<td>99298-99300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nursing Facility Services</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Initial Nursing Facility Care</td>
<td>99304-99306</td>
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<tr>
<td>Subsequent Nursing Facility Care</td>
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<tr>
<td>Nursing Facility Discharge Services</td>
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<tr>
<td>Other Nursing Facility Services</td>
<td>99318</td>
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</table>

<table>
<thead>
<tr>
<th>Domiciliary, Rest Home (eg, Boarding Home) or Custodial Care Service</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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<td>99324-99328</td>
</tr>
<tr>
<td>Established Patient</td>
<td>99334-99337</td>
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</table>

<table>
<thead>
<tr>
<th>Domiciliary, Rest Home (eg, Assisted Living Facility) or Home Care Plan Oversight Services</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Home Services</th>
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</thead>
<tbody>
<tr>
<td>New Patient</td>
<td>99341-99345</td>
</tr>
<tr>
<td>Established Patient</td>
<td>99347-99350</td>
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</table>
Prolonged Services
- Prolonged Physician Service With Direct (Face-to-Face) Patient Contact…………………………………… 99354-99357
- Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact…………………………………… 99358-99359
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Newborn Care……………………………………………………………………… 99431-99440

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- Telephone Services…………………………………………………… 99441-99443
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Special Evaluation and Management Services
- Basic Life and/or Disability Evaluation Services…………………… 99450
- Work Related or Medical Disability Evaluation Services………… 99455-99456

Other Evaluation and Management Services……………………………………… 99477-99499

As you can see, E/M codes always begin with the digits “99”. The format of the subsections is generally the same throughout. In the CPT book, you will find the code number listed followed by a description of the code including the site and/or type of service provided. You will then find the content of the service listed with a description of the key components and contributing components to the service. Finally, a description of the nature of the presenting problem is provided along with an estimated time generally required for the physician to complete the service. See example below:

| 99201 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components: |
|       | - a problem focused history; |
|       | - a problem focused examination; and |
|       | - straightforward medical decision making. |

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
IMPORTANCE OF MEDICAL RECORD DOCUMENTATION

Concise medical record documentation is critical to providing quality care to patients and to receiving accurate and timely reimbursement from payers. The patient medical record should reflect chronological documentation of the care the patient received including pertinent facts, findings, observations, examinations, tests, treatments and outcomes. “If it isn’t documented, it hasn’t been done” is a saying often heard in the health care arena.

Payers require documentation that shows services are consistent with insurance coverage provided to the patient. Payers may require documentation to validate:

• The site of the service;
• The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
• That services furnished have been accurately reported.

To ensure that medical record documentation is adequate, the following principles should be followed:

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:
   • Reason for the encounter and relevant history, physical examination
   • Findings and prior diagnostic test results;
   • Assessment, clinical impression or diagnosis;
   • Plan for care; and
   • Date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented.

7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
DEFINITIONS OF COMMONLY USED TERMS

New patient: a patient who has not received any professional services from the physician, or another physician of the same specialty from the same group practice, within the past three years.

Established patient: a patient who has received professional services from the physician, or another physician of the same specialty from the same group practice, within the past three years.

Consultation: a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

Chief complaint: a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter. The chief complaint is usually stated in the patient’s own words and therefore may be in layman’s terms.

Concurrent care: the provision of similar services to the same patient by more than one physician on the same day.

Family history: refers to a review of significant medical events in the patient’s family, such as the health status or cause of death of parents, siblings, and children. Any diseases of family members that relate to the chief complaint of the patient or that place the patient at risk are included in family history.

History of Present Illness: a chronological description of the development of the patient’s present illness, from the first sign and/or symptom to the present. Included in the family history is a description of the location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms.

COMMON ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>CC</td>
<td>Chief Complaint</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>E/M</td>
<td>Evaluation and Management</td>
</tr>
<tr>
<td>GME</td>
<td>Graduate Medical Education</td>
</tr>
<tr>
<td>HPI</td>
<td>History of Present Illness</td>
</tr>
<tr>
<td>ICD-9-CM</td>
<td>International Classification of Diseases, 9th Revision, Clinical Modification</td>
</tr>
<tr>
<td>PFSH</td>
<td>Past, Family and/or Social History</td>
</tr>
<tr>
<td>ROS</td>
<td>Review of Systems</td>
</tr>
</tbody>
</table>
DOCUMENTATION OF E/M SERVICES

To appropriately determine the appropriate level of service for a patient's visit, it is necessary to first determine if the patient is new or already established. The physician then uses the presenting illness as a guide and his or her clinical judgment about the patient's condition to determine the extent of key elements to be performed. The seven components in defining the level of E/M services are:

- History
- Examination
- Medical Decision Making

- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time

Key Components

Contributing Components

KEY COMPONENTS

HISTORY

There are four types of History, each based on the physician's clinical judgment and the nature of the patient's presenting problem. The elements of History include some or all of the following:

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family and/or Social History (PFSH)

The four types of History considering these elements are:

Problem-Focused: includes chief complaint and a brief history of the present illness or problem.

Expanded Problem-Focused: includes chief complaint, brief history of the present illness and a problem-pertinent system review.

Detailed: includes chief complaint, extended history of present illness, problem-pertinent system review extended to include a review of a limited number of additional systems, pertinent past, family and/or social history directly related to the patient’s problems.

Comprehensive: includes chief complaint, extended history of present illness, review of systems directly related to the problem(s) identified in the history of present illness, plus a review of all additional body systems, and complete past, family and social history.
Chief Complaint (CC)

The chief complaint (CC) is a concise statement that describes the symptom, problem, condition, diagnosis or reason for the patient encounter. The CC is generally stated in the patient’s own words.

History of Present Illness (HPI)

The history of present illness (HPI) is a chronological description of the development of the patient’s illness from the first sign and/or symptom or from the previous encounter, to the present. There are 8 elements of the HPI. Listed below are the elements and suggested adjectives to illustrate how to document the element.

<table>
<thead>
<tr>
<th>Element</th>
<th>Question/Adjective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>What site? abdomen, chest leg</td>
</tr>
<tr>
<td>Severity</td>
<td>How bad? intolerable, minimal, 0/10 scale, slight</td>
</tr>
<tr>
<td>Timing</td>
<td>When? 2 hours after eating, 1 hour after waking, AM/PM</td>
</tr>
<tr>
<td>Quality</td>
<td>Describe? burning, dull, puffy, pus-filled, radiating, color</td>
</tr>
<tr>
<td>Duration</td>
<td>Since when? for 2 days, since prescription started</td>
</tr>
<tr>
<td>Context</td>
<td>Why/What was patient doing? when walking, due to fall</td>
</tr>
<tr>
<td>Modifying Factors</td>
<td>Relief? Improves when sitting, worse after eating</td>
</tr>
<tr>
<td>Associated Signs &amp; Symptoms</td>
<td>What else? rash with blistering, nausea and vomiting, congestion</td>
</tr>
</tbody>
</table>

There are two types of HPI’s:

Brief: this includes documentation of one to three HPI elements.

Extended: this includes documentation of at least four HP elements or the status of at least three chronic or inactive conditions.

Example:

Patient presented with chest pain for 1 day.

In this example, a Brief HPI (≤3 elements) was performed.

Location: “chest”
Duration: “1 day”
Example:
Patient presented with severe chest pain, noted to be 8 on a scale of 0/10. Pain occurred one hour after eating breakfast. Pain was described as dull, radiating to left arm. Pain has lasted 6 hours and is partially relieved with rest. Patient was exercising when pain started.

In this example, an Extended HPI (≥4 elements) was performed:

Location: “chest”
Severity: “8/10, severe”
Timing: “1 hour after breakfast”
Quality: “dull, radiating to arm”
Duration: “6 hours”
Context: “exercising”
Modifying Factors: “partially relieved with rest”
Associated Signs and Symptoms: none documented

Review of Systems (ROS)

A Review of Systems (ROS) is an inventory of body systems obtained by asking a series of questions to identify signs and/or symptoms that the patient may be experiencing or has experienced. The patient’s positive responses and pertinent negative responses should be documented.

For purposes of the ROS, the following systems are recognized:

- Constitutional symptoms (ie, fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic
There are three types of ROS considering these systems:

**Problem pertinent:** ROS inquires about the system directly related to the patient’s problem identified in the HPI.

<table>
<thead>
<tr>
<th>Example: (one system reviewed – GI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC: Stomach ache</td>
</tr>
</tbody>
</table>

**Extended:** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. (2-9 organ systems must be reviewed.)

<table>
<thead>
<tr>
<th>Example: (two systems reviewed – GI, Constitutional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC: Stomach ache/abdominal pain</td>
</tr>
<tr>
<td>ROS: Patient with stomach pain. Patient has bloating, nausea, vomiting and diarrhea. He had fever and 10 pound weight loss in last 8 days.</td>
</tr>
</tbody>
</table>

**Complete:** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems. (At least 10 organ systems must be reviewed.)

<table>
<thead>
<tr>
<th>Example: (10 systems reviewed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC: Stomach ache/abdominal pain</td>
</tr>
<tr>
<td>ROS:</td>
</tr>
<tr>
<td>Constitutional – Fever to 101, weight loss 10 pounds</td>
</tr>
<tr>
<td>ENT – no complaints, no sore throat</td>
</tr>
<tr>
<td>Cardiovascular – some associated chest pain, some palpitations</td>
</tr>
<tr>
<td>Respiratory – no shortness of breath</td>
</tr>
<tr>
<td>GI – diarrhea, no blood in stool, abdomen soft/tender</td>
</tr>
<tr>
<td>GU – no burning or frequency of urination</td>
</tr>
<tr>
<td>Musculoskeletal – Steady gait, muscle strength good, joint pain</td>
</tr>
<tr>
<td>Integumentary (Skin) – warm, clammy</td>
</tr>
<tr>
<td>Neurologic – denies any numbness, tingling or tremors</td>
</tr>
<tr>
<td>Psychiatric – Mood okay, no depression, no memory loss</td>
</tr>
</tbody>
</table>
Past, Family and/or Social History (PFSH)

The Past, Family and/or Social History (PFSH) consists of review in three areas:

- Past history (patient’s past illnesses, operations, injuries, treatments)
- Family history (a review of the medical events in the patient’s family including diseases which may be hereditary or place the patient at risk)
- Social history (age appropriate review of past and current activities)

There are two types of PFSH considering these elements:

**Pertinent:** a review of the history area(s) directly related to the problem(s) identified in the HPI

At least one specific item from any of the three history areas must be documented for a pertinent PFSH. iii

**Complete:** a review of two or all three of the PFSH history areas, depending on the category of E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: iii

- office or other outpatient services – established patient
- emergency department
- domiciliary care – established patient
- home care – established patient

At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: iii

- office or other outpatient services – new patient
- hospital observation services
- hospital inpatient services – initial care
- consultations
- comprehensive nursing facility assessments
- domiciliary care – new patient
- home care – new patient

**Pertinent PFSH:** Review of history directly related to the problem identified in the HPI.

**Example:** One area documented (past history)

HPI: Follow-up visit following cardiac catheterization
Past History: Patient returns to office for follow-up of CABG done in 2000. A recent cardiac catheterization showed 60% occlusion of the vein graft to obtuse marginal artery.
Complete: Review of two or all three of PFSH history areas (dependent on category of the E/M service).

Example: Two areas documented (past and family history – office visit-established patient)

**HPI:** Follow-up visit following cardiac catheterization
Past History: Patient returns to office for follow-up of CABG done in 2000. A recent cardiac catheterization showed 60% occlusion of the vein graft to obtuse marginal artery.
Family History: Both maternal grandparents positive for coronary artery disease, grandfather deceased at 69. Paternal grandmother positive for diabetes, hypertension. Mother with diabetes and hypertension. Father deceased at age 50 due to heart attack.

**Helpful Hints:**
- A ROS and/or PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physician use a common record. The review and update may be documented by:
  - Describing any new ROS and/or PFSH information or noting there has been no change in the information; and
  - Noting the date and location of the earlier ROS and/or PFSH.
- The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.
EXAMINATION

The examination may involve a single organ system or multiple organ systems. The extent of the exam performed is based on the physician’s clinical judgment, the patient’s history and the nature of the presenting problem. The level of examination and E/M service is based on the following recognized Body Areas and Organ Systems:

<table>
<thead>
<tr>
<th>Body Areas</th>
<th>Organ Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, including the face</td>
<td>Eyes</td>
</tr>
<tr>
<td>Neck</td>
<td>Eyes, nose, mouth and throat</td>
</tr>
<tr>
<td>Chest, including the breasts and axillae</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Genitalia, groin, buttocks</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Back, including spine</td>
<td>Genitourinary</td>
</tr>
<tr>
<td>Each extremity</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td></td>
<td>Skin</td>
</tr>
<tr>
<td></td>
<td>Neurologic</td>
</tr>
<tr>
<td></td>
<td>Psychiatric</td>
</tr>
<tr>
<td></td>
<td>Hematologic/Lymphatic/Immunologic</td>
</tr>
</tbody>
</table>

The content and documentation requirements for each type and level of examination are summarized and described in detail in the 1997 Documentation Guidelines for Evaluation and Management Services. Whether using the 1997 Guidelines or the 1995 Guidelines, the coder should reference the detailed descriptions in the 1997 Guidelines.

The level of E/M service is based on 4 types of examination which are defined as follows:

**Problem Focused:** a limited examination of the affected body area or organ system.

**Expanded Problem Focused:** a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

**Detailed:** an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

**Comprehensive:** a general multi-system examination or complete examination of a single organ system.
**Single Organ System Examination:**

The elements required for a single organ system examination are well defined in the 1997 Documentation Guidelines for Evaluation and Management Services (Please reference the 1997 Guidelines for the defined elements and bulleted items):

**Problem Focused:**
Should include performance and documentation of one to five elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

**Expanded Problem Focused:**
Should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

**Detailed:**
Examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

Eye and psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

**Comprehensive:**
Should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in each box with an unshaded border is expected.

**General Multi-System Examination:**

The elements required for a general multi-system examination are well defined in the 1997 Documentation Guidelines for Evaluation and Management Services (Please reference the 1997 Guidelines for the defined elements and bulleted items):

**Problem Focused:**
Should include performance and documentation of one to five elements identified by a bullet (•) in 1 or more organ system(s) or body area(s).

**Expanded Problem Focused:**
Should include performance and documentation of at least six elements identified by a bullet (•) in one or more organ system(s) or body area(s).

**Detailed:**
Should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet (•) is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet (•) in two or more organ systems or body areas.
**Comprehensive:** Should include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet (•) should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by a bullet is expected.

**Helpful Hints:**

- Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.

- Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ(s) should be described.

- A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s). For example:
  - Chest – Clear
  - Heart – WNL
  - Abdomen – WNL
  - Lymph Nodes – No enlargement

**Example:**

The following is an example of the Content and Documentation Requirements as defined in the 1997 *Documentation Guidelines for Evaluation and Management Services* for the Cardiovascular System:

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>• Palpation of heart (eg, location, size, thrills)</td>
</tr>
<tr>
<td></td>
<td>• Auscultation of heart with notation of abnormal sounds murmurs</td>
</tr>
<tr>
<td></td>
<td>Examination of:</td>
</tr>
<tr>
<td></td>
<td>• carotid arteries (eg, pulse amplitude, bruits)</td>
</tr>
<tr>
<td></td>
<td>• abdominal aorta (eg, size, bruits)</td>
</tr>
<tr>
<td></td>
<td>• femoral arteries (eg, pulse amplitude, bruits)</td>
</tr>
<tr>
<td></td>
<td>• pedal pulses (eg, pulse amplitude)</td>
</tr>
<tr>
<td></td>
<td>• extremities for edema and/or varicosities</td>
</tr>
</tbody>
</table>
The following chart illustrates the elements of the cardiovascular system/body area for both a general multi-system examination and a single organ system examination:

<table>
<thead>
<tr>
<th>SYSTEM/ BODY AREA</th>
<th>GENERAL MULTI-SYSTEM EXAMINATION</th>
<th>SINGLE ORGAN SYSTEM EXAMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>Palpation of heart (eg, location, size, thrill). Auscultation of heart with notation of abnormal sounds and murmurs. Examination of: • Carotid arteries (eg, pulse amplitude, bruits); • Abdominal aorta (eg, size, bruits); • Femoral arteries (eg, pulse amplitude, bruits); • Pedal pulses (eg, pulse amplitude); and • Extremities for edema and/or varicosities</td>
<td>Palpation of heart (eg, location, size and forcefulness of the point of maximal impact; thrill; lifts; palpable S3 of S4) Auscultation of heart including sounds, abnormal sounds, and murmurs. Measurement of blood pressure in two or more extremities when indicated (eg, aortic dissection, coarctation). Examination of: • Carotid arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay); • Abdominal aorta (eg, size, bruits); • Femoral arteries (eg, pulse amplitude, bruits); • Pedal pulses (eg, pulse amplitude); and • Extremities for peripheral edema and/or varicosities.</td>
</tr>
</tbody>
</table>
**MEDICAL DECISION MAKING**

There are four recognized types of Medical Decision Making used in assigning the level of E/M service code:  
- straight-forward  
- low complexity  
- moderate complexity  
- high complexity

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option to be determined by considering the following:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The following chart illustrates the elements required for each level of medical decision making. Below the chart is a discussion/definition of each of the elements. To quality for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

<table>
<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of complications and/or morbidity or mortality</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td><strong>Straightforward</strong></td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td><strong>Low Complexity</strong></td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td><strong>Moderate Complexity</strong></td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td><strong>High Complexity</strong></td>
</tr>
</tbody>
</table>
Number of Diagnoses or Management Options

The number of diagnoses and/or management options that must be considered is based on the following:

• the number and types of problems addressed during the encounter
• the complexity of establishing a diagnosis
• the management decisions that are made by the physician

Decision making with respect to a diagnosed problem is generally easier than that for an identified but undiagnosed problem. An indicator for the number of possible diagnoses may be the number and type of diagnostic tests performed. Problems that are improving or resolving are generally less complex than those which are worsening or failing to change as expected. The need to seek advice from other health practitioners is another indicator of diagnostic or management problems.

Helpful Hints: ii

- For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.
  - For a presenting problem with an established diagnosis, the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.
  - For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as “possible”, “probable”, or “rule out” (R/O) diagnoses.
- The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies and medications.
- If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.

Amount and/or Complexity of Data to be Reviewed

The amount and/or complexity of data to be reviewed is dependent on the types of diagnostic testing ordered or reviewed. Factors that affect the amount and complexity of data to be reviewed include:

• A decision to obtain and review old medical records is an indication of the amount of data to be reviewed
• A decision to obtain history from sources other than the patient is an indication of the amount of data to be reviewed
• Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data to be reviewed
• The decision by the physician who ordered the test to personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation is an indication of the complexity of data to be reviewed.

**Helpful Hints:**

- If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray should be documented.

- The review of lab, radiology and/or other diagnostic tests should be documented. An entry in a progress note such as “WBC elevated” or “chest x-ray unremarkable” is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the results.

- A decision to obtain old records or a decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.

- Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of “Old records reviewed” or “additional history obtained from family” without elaboration is insufficient.

- Discussion about the results of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.

- The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.

**Risk of Significant Complications, Morbidity and/or Mortality**

The risk of significant complications, morbidity and/or mortality is based on the risks associated with:

- the presenting problem(s)
- the diagnostic procedure(s)
- the possible management options.

The assessment of risk of the presenting problem(s) is based on:

- the risk related to the disease process anticipated between the present encounter and the next one.

The assessment of risk of selecting diagnostic procedures and management options is based on:

- the risk during and immediately following any procedures or treatment.

The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s) or management option(s)) determines the overall risk.
The level of risk of significant complications, morbidity and/or mortality is:

- minimal
- low
- moderate
- high

**Helpful Hints:**

- Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity and/or mortality should be documented.

- If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of E/M encounter, the type of procedure, eg, laparoscopy, should be documented.

- If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.

- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

The table on the following page may be helpful in determining whether the risk of significant complications, morbidity and/or mortality is minimal, low, moderate or high. This table is taken from the 1995 and 1997 Documentation Guidelines for E/M Services.
<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| Minimal       | • One self-limited or minor problem, eg, cold, insect bite, tinea corporis | • Laboratory tests requiring venipuncture  
• Chest x-rays  
• EKG/EEG  
• Urinalysis  
• Ultrasound, eg, echocardiography  
• KOH prep | • Rest  
• Gargles  
• Elastic bandages  
• Superficial dressings |
| Low           | • Two or more self-limited or minor problems  
• One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH  
• Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain | • Physiologic tests not under stress, eg, pulmonary function tests  
• Non-cardiovascular imaging studies with contrast, eg, barium enema  
• Superficial needle biopsies  
• Clinical laboratory tests requiring arterial puncture  
• Skin biopsies | • Over-the-counter drugs  
• Minor surgery with no identified risk factors  
• Physical therapy  
• Occupational therapy  
• IV fluids without additives |
| Moderate      | • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment  
• Two or more stable chronic illnesses  
• Undiagnosed new problem with uncertain prognosis, eg, lump in breast  
• Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis  
• Acute complicated injury, eg, head injury with brief loss of consciousness | • Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test  
• Diagnostic endoscopies with no identified risk factors  
• Deep needle or incisional biopsy  
• Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization  
• Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis | • Minor surgery with identified risk factors  
• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors  
• Prescription drug management  
• Therapeutic nuclear medicine  
• IV fluids with additives  
• Closed treatment of fracture or dislocation without manipulation |
| High          | • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
• Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure  
• An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss | • Cardiovascular imaging studies with contrast with identified risk factors  
• Cardiac electrophysiological tests  
• Diagnostic Endoscopies with identified risk factors  
• Discography | • Elective major surgery (open, percutaneous or endoscopic) with identified risk factors  
• Emergency major surgery (open, percutaneous or endoscopic)  
• Parenteral controlled substances  
• Drug therapy requiring intensive monitoring for toxicity  
• Decision not to resuscitate or to de-escalate care because of poor prognosis |
CONTRIBUTING COMPONENTS

The contributing components defining the level of E/M service code assignment include:

- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time

In those cases where counseling and/or coordination of care dominate (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor in selecting the correct level of E/M service.

If the E/M level of service is reported based on counseling and/or coordination of care, the medical record should clearly document the total length of time of the encounter and the documentation should clearly describe the counseling and/or activities undertaken to coordinate the care.

The average time guidelines for E/M service codes are as follows: i

<table>
<thead>
<tr>
<th>Established Patient:</th>
<th>New Patient:</th>
<th>Consultation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211 – 5 minutes</td>
<td>99201 – 10 minutes</td>
<td>99241 – 15 minutes</td>
</tr>
<tr>
<td>99212 – 10 minutes</td>
<td>99202 – 20 minutes</td>
<td>99242 – 30 minutes</td>
</tr>
<tr>
<td>99213 – 15 minutes</td>
<td>99203 – 30 minutes</td>
<td>99243 – 40 minutes</td>
</tr>
<tr>
<td>99214 – 25 minutes</td>
<td>99204 – 45 minutes</td>
<td>99244 – 60 minutes</td>
</tr>
<tr>
<td>99215 – 40 minutes</td>
<td>99205 – 60 minutes</td>
<td>99245 – 80 minutes</td>
</tr>
</tbody>
</table>

Example:

Mr. Jones presented back to his physician with recurring abdominal pain. The patient is known to have colitis. Dr. Smith talked to the patient about his diet. Dr. Smith spent 15 minutes counseling the patient on the importance of diet specifically lowering his intake of carbohydrates, lactose products, caffeine and spicy foods. Dr. Smith then spent 10 minutes discussing the option of surgery with Mr. Jones, offering the pros and cons. Dr. Smith ordered an x-ray and set it up for the patient to go that afternoon to have the x-ray done. Dr. Smith spent 25 minutes counseling the patient and coordinating his care.

In this case, time was the key factor in the visit. Based on the fact that 25 minutes were spent counseling/coordinating care, code 99214 is assigned.

i CPT/HCPCS for Physician Office Coding, Therese M. Jorwic, RHIA, CCS, Published by the American Health Information Management Association, 2000.
ii 1995 Documentation and Guidelines for Evaluation & Management Services
iii 1997 Documentation Guidelines for Evaluation and Management Services
iv Evaluation and Management Services Guide, Published by the Medical Learning Network
# Evaluation and Management Guidelines for New and Established Patient - Office Visit

**PT Name:**

**DOS:**

**Billed Code:**

**Audit Code:**

### Chief Complaint:
(Symptom, problem, condition, diagnosis, physician recommended return or other reason for encounter. Must be listed for all encounters)

### History

**HPI:**

1. **Chief:**
2. **Extended:**
3. (97 allied 2nd Chronic Condition to equal expanded)
   - Location Q: Quality B: Severity D: Duration T: Timing C: Center M: Modifying factors A: Associated signs and symptoms

**ROS:**

**Past Personal:**

1. **Positive:**
2. **Extended:**
3. (97 allied 2nd Chronic Condition to equal expanded)
   - Location Q: Quality B: Severity D: Duration T: Timing C: Center M: Modifying factors A: Associated signs and symptoms

**Familial History:**

1. **Positive:**
2. **Extended:**
3. (97 allied 2nd Chronic Condition to equal expanded)
   - Location Q: Quality B: Severity D: Duration T: Timing C: Center M: Modifying factors A: Associated signs and symptoms

### Examination

**PFH:**

1. **Nick:**
2. **PEPP:** (Pertinent any 1 of 3) (Complete New and All Established Pt - 2 of 3)
3. (97 allied 2nd Chronic Condition to equal expanded)
4. 

**Past:**

1. **Physical:**
2. **Past History:**
3. (97 allied 2nd Chronic Condition to equal expanded)
4. Anomalous or Hemorrhage

**Primary:**

1. **Present:**
2. **Established:**
3. (97 allied 2nd Chronic Condition to equal expanded)
4. Review of systems and examination and any other significant findings

**Physical:**

1. **Past:**
2. **Present:**
3. (97 allied 2nd Chronic Condition to equal expanded)
4. Pertinent findings

**Medications:**

1. **Present:**
2. **Established:**
3. (97 allied 2nd Chronic Condition to equal expanded)
4. All medications

## Medical Decision Making

### Diagnosis/Primary Problems or Management Options

<table>
<thead>
<tr>
<th>A</th>
<th>X</th>
<th>B</th>
<th>C</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Complexity of Care

1. Document Review of literature, laboratory, other diagnostic test(s), EKG, ECG, PFT, O2 Sat, etc.
2. Document all relevant findings from review of medical record, X-rays, etc. (If applicable)
3. Document results of discussion with referring physicians, other physicians, or other staff with the physician who performed the exam

### Risk of Significant Maternal or Morbidity

1. Document any other factors that increase the complexity of medical decision making
2. Document additional procedures performed at the time of the encounter
3. Document any other factors that increase the complexity of medical decision making

### Timing and Coordination of Care Factor

1. Document the time of total encounter time counseling or coordination of care
2. Document the time in determining the level of care

### Setting

1. Number of Diagnosis or management options
2. Amount and/or complexity of data to be reviewed
3. Risk of complications, morbidity or mortality

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Limited</th>
<th>Multiple</th>
<th>Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
</tr>
</tbody>
</table>

### Type of Encounter

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Limited</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(4)</td>
</tr>
</tbody>
</table>

### Time to Next Visit

- 1st Visit: 01/13
- 2nd Visit: 02/14
- 3rd Visit: 03/15
- 4th Visit: 04/16
- 5th Visit: 05/17

### Additional Information

- Straightforward (01/12)
- Low Complexity (02/13)
- Moderate Complexity (03/14)
- High Complexity (04/15)
### Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>- One self-limited or minor problem, e.g. cold, insect bite, tissue corporis</td>
<td>- Laboratory tests requiring Ventrilcure chest X-rays</td>
<td>- Rest, Gargles, Elastic bandages, Superficial dressings</td>
</tr>
<tr>
<td>99211</td>
<td>- One stable chronic illness, e.g. well controlled hypertension or non-insulin dependent diabetes, cataract, BPH</td>
<td>- EKG/EEG, Ultrasound, 2-D echocardiography</td>
<td></td>
</tr>
<tr>
<td>Minor 99201</td>
<td>- Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple, sprain</td>
<td>- Ultrasound, 2-D echocardiography</td>
<td></td>
</tr>
<tr>
<td>Low 99212 – 13</td>
<td>- Two or more self-limited or minor problems</td>
<td>- Physiologic tests not under stress, e.g. pulmonary function tests</td>
<td>- Over the counter drug, Analgesics with no identified risk factors, Physical therapy, Occupational therapy, IV fluids without additives</td>
</tr>
<tr>
<td></td>
<td>- One stable chronic illness, e.g. well controlled hypertension or non-insulin dependent diabetes, cataract, BPH</td>
<td>- Non-cardiovascular imaging studies with contrast, e.g. barium enema</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple, sprain</td>
<td>- Superficial needle biopsy, Clinical laboratory tests requiring arterial puncture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Ultrasound, 2-D echocardiography</td>
<td>- Skirt bleepies</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>- One or more chronic illnesses 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, Blood transfusion, Anticoagulant, Endoscopic, with no identified risk factors</td>
</tr>
<tr>
<td>99202 – 00</td>
<td>- Undiagnosed new problem with uncertain prognosis, e.g. lump in breast</td>
<td>- Diagnostic endoscopies with no identified risk factors</td>
<td>- Over the counter drug, Analgesics with no identified risk factors, Physical therapy, Occupational therapy, IV fluids without additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>- Two or more stable chronic illnesses</td>
<td>- Deep needle or incisional biopsy</td>
<td>- Prescription drug management, Therapeutic nuclear medicine, IV fluids with additives, Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>99204 – 14</td>
<td>- Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonia, cellulitis</td>
<td>- Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram, cardiac catheterization</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>- Acute complicated injury, e.g. head injury with brief loss of consciousness</td>
<td>- Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis</td>
<td></td>
</tr>
<tr>
<td>Low 99205 – 15</td>
<td>- One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>- Cardiovascular imaging studies with contrast and no identified risk factors</td>
<td>- Elective major surgery, Appendectomy, Endoscopic, with no identified risk factors, Emergency surgery, Appendectomy, Endoscopic, General anesthesia, Pain management</td>
</tr>
<tr>
<td></td>
<td>- Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g. Multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, Progressive severe rheumatoid arthritis, Psychiatric illness with potential threat to self or others, peritonitis, acute renal failure</td>
<td>- Diagnostic endoscopies with identified risk factors, Endoscopic, Diagnostic endoscopies with identified risk factors, Endoscopic, Cardiac electrophysiological tests</td>
<td>- Decision not to resuscitate or to discontinuance care because of poor prognosis</td>
</tr>
<tr>
<td></td>
<td>- An abrupt change in neurologic status, e.g. seizure, TIA, weakness or sensory loss</td>
<td>- Angiography</td>
<td></td>
</tr>
</tbody>
</table>

### Code Determination

**New Patient:** Column must meet or exceed **all three** elements identified. (Select the column with the lowest level indicated.)

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Examination</th>
<th>Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211 (10)</td>
<td>Problem Focused Hx</td>
<td>Expanding P F Hx</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99212 (20)</td>
<td>Expanding P F Hx</td>
<td>Detailed Hx</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99213 (30)</td>
<td>Comprehensive Hx</td>
<td>Comprehensive Exam</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99214 (40)</td>
<td>Comprehensive Hx</td>
<td>Comprehensive Exam</td>
<td>Straightforward</td>
</tr>
</tbody>
</table>

(X) indicates AMA's approximate face-to-face time associated with the level noted.

**Established Patient:** Column must meet or exceed **two or three** elements identified. (Select column with 2/3 met or exceeded.)

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Examination</th>
<th>Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215 (5)</td>
<td>N/A</td>
<td>Problem Focused Hx</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99216 (10)</td>
<td>Problem Focused Hx</td>
<td>Expanding P F Hx</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99217 (15)</td>
<td>Expanding P F Hx</td>
<td>Detailed Hx</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99218 (20)</td>
<td>Comprehensive Hx</td>
<td>Comprehensive Exam</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99219 (30)</td>
<td>Comprehensive Hx</td>
<td>Comprehensive Exam</td>
<td>Straightforward</td>
</tr>
</tbody>
</table>

**Comments:**

---

- **Minimal** level of risk includes self-limited or minor problems such as cold, insect bite, or tissue corporis.
- **Minor** level includes one stable chronic illness or well-controlled hypertension. Diagnostic procedures might include laboratory tests or imaging studies.
- **Low** level includes two or more self-limited or minor problems, along with one stable chronic illness. Management options range from rest and analgesics to more extensive care.
- **Moderate** level includes one or more chronic illnesses with mild exacerbation, along with additional issues like lumps or systemic symptoms.
- **High** level includes severe exacerbation or severe side effects of treatment, requiring more comprehensive care.

- **New Patient** criteria require meeting all three elements, while **Established Patient** criteria require meeting two or three elements.

- **Code Determination** involves selecting the column with the lowest level indicated for new patients, and at least 2/3 of the elements for established patients.
**EVALUATION AND MANAGEMENT GUIDELINES FOR NEW AND ESTABLISHED PATIENT – CONSULTATION**

**History:**

- **HPI:** Brief: (1-3) (Extended: 1-4)
  - Location, quality, severity, duration, timing, relief, modifying factors, associated signs and symptoms
- **ROS:**
  - U: (Problem Presenting 1) (Extended: 2-6) (Complete: 1-10)
  - 1: Cardiac
  - 2: Head
  - 3: Ear/New
  - 4: CV
  - 5: Respiratory
  - 6: GI
  - 7: Skin
  - 8: Musculoskeletal
  - 9: Integumentary
  - 10: Neurologic
  - 11: Psychiatric
  - 12: Endocrine
  - 13: Hemat-Lymph
  - 14: Allergy
  - V: All others negative

**PFH:** (No: PFE) [Patient: any 1 of 2] (Complete: New Patient/All) [Established: any 2 of 2]

- **Medication:**
  - **History Type:**
    - **Problem Focused:**
      - 0-41/61 FF-01
    - **Expanded Prob Focused:**
      - 0-42/61 FF-02
    - **Detailed:**
      - 0-43/61 FF-63
    - **Comprehensive:**
      - 0-44/61 FF-55

**Examination:**

- **10/8 Guidelines:** See definitions below. **“PT Guidelines – see asterisk(s)”**
  - **Problem Focused:** Limited exam of affected body area or organ system on only the body areas or systems regarding problem (1)
  - **Extended Exam:** Limited exam of affected body area or organ system and other symptoms or related system (2–7)

**Medical Decision-Making:**

- **Diagnosis/Presenting Problems or Management Options**
  - **A** (Diagnosis): Presentation of problem or diagnosis
  - **A** (Conditions): Supporting conditions
  - **B** (Evidence/Procedure): Evidence/Procedure for diagnosis
  - **C** (Result): Result of procedure
  - **D** (EFactor): Evidence/Procedure for differential diagnosis
  - **E** (Diagnosis): Diagnosis
  - **F** (Diagnosis): Clinical implications
  - **G** (Diagnosis): Management options

- **Compartment Data:**
  - **1.** Document: Review of abnormal findings, abnormalities, or other diagnostic tests (e.g., EEG, ECG, PFT, Gastrointestinal, etc.)
  - **2.** Document: Relevant findings from review of abnormal tests (e.g., EEG, ECG, PFT, Gastrointestinal, etc.)

- **Comprehensive:**
  - **A** (Diagnosis): Presentation of problem or diagnosis
  - **B** (Conditions): Supporting conditions
  - **C** (Evidence/Procedure): Evidence/Procedure for diagnosis
  - **D** (Result): Result of procedure
  - **E** (Diagnosis): Diagnosis
  - **F** (Diagnosis): Clinical implications
  - **G** (Diagnosis): Management options

- **Compartment Data:**
  - **1.** Document: Review of abnormal findings, abnormalities, or other diagnostic tests (e.g., EEG, ECG, PFT, Gastrointestinal, etc.)
  - **2.** Document: Relevant findings from review of abnormal tests (e.g., EEG, ECG, PFT, Gastrointestinal, etc.)

- **Risks of Significant Complications, Morbidity, or Mortality:**
  - **A** (Diagnosis): Presentation of problem or diagnosis
  - **B** (Conditions): Supporting conditions
  - **C** (Evidence/Procedure): Evidence/Procedure for diagnosis
  - **D** (Result): Result of procedure
  - **E** (Diagnosis): Diagnosis
  - **F** (Diagnosis): Clinical implications
  - **G** (Diagnosis): Management options

- **Compartment Data:**
  - **1.** Document: Review of abnormal findings, abnormalities, or other diagnostic tests (e.g., EEG, ECG, PFT, Gastrointestinal, etc.)
  - **2.** Document: Relevant findings from review of abnormal tests (e.g., EEG, ECG, PFT, Gastrointestinal, etc.)

- **Coding and Documentation of Care Factor:**
  - **A** (Diagnosis): Presentation of problem or diagnosis
  - **B** (Conditions): Supporting conditions
  - **C** (Evidence/Procedure): Evidence/Procedure for diagnosis
  - **D** (Result): Result of procedure
  - **E** (Diagnosis): Diagnosis
  - **F** (Diagnosis): Clinical implications
  - **G** (Diagnosis): Management options

- **Number of Diagnosis:**
  - **A** (Diagnosis): Presentation of problem or diagnosis
  - **B** (Conditions): Supporting conditions
  - **C** (Evidence/Procedure): Evidence/Procedure for diagnosis
  - **D** (Result): Result of procedure
  - **E** (Diagnosis): Diagnosis
  - **F** (Diagnosis): Clinical implications
  - **G** (Diagnosis): Management options

- **Amount及/also? Risk of complications & mortality:**
  - **A** (Diagnosis): Presentation of problem or diagnosis
  - **B** (Conditions): Supporting conditions
  - **C** (Evidence/Procedure): Evidence/Procedure for diagnosis
  - **D** (Result): Result of procedure
  - **E** (Diagnosis): Diagnosis
  - **F** (Diagnosis): Clinical implications
  - **G** (Diagnosis): Management options

- **Type of Decision-Making:**
  - **A** (Diagnosis): Presentation of problem or diagnosis
  - **B** (Conditions): Supporting conditions
  - **C** (Evidence/Procedure): Evidence/Procedure for diagnosis
  - **D** (Result): Result of procedure
  - **E** (Diagnosis): Diagnosis
  - **F** (Diagnosis): Clinical implications
  - **G** (Diagnosis): Management options

- **Time of Decision-Making:**
  - **A** (Diagnosis): Presentation of problem or diagnosis
  - **B** (Conditions): Supporting conditions
  - **C** (Evidence/Procedure): Evidence/Procedure for diagnosis
  - **D** (Result): Result of procedure
  - **E** (Diagnosis): Diagnosis
  - **F** (Diagnosis): Clinical implications
  - **G** (Diagnosis): Management options
### Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One self-limited or minor problem, e.g. cold, insect bite, linea corporis</td>
<td>Laboratory tests requiring Venipuncture chest x-rays</td>
<td>Rest, Gargles, Blister bandages,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EKG/ESCC, Urinalysis, Ultrasound, eg. echocardiography, X-ray 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, eg. pulmonary function tests, Non-cardiovascular imaging studies with contrast, eg. barium enema</td>
<td>Over-the-counter drug, Minor surgery with no identified risk factors, Physical therapy,</td>
</tr>
<tr>
<td></td>
<td>One stable chronic illness, e.g. well controlled hypertension or non-insulin dependent diabetes, cataract, BPH</td>
<td></td>
<td>IV fluids without additives</td>
</tr>
<tr>
<td></td>
<td>Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple scalp injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low To</td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Physiologic tests under stress, eg. cardiac stress test, furosemide administration, a diagnostic endoscopy with no identified risk factors, Deep needle or incisional biopsy, Cardiovascular imaging studies with contrast and no identified risk factors, eg. angiogram, cardiac catheterization, Obtain fluid from body cavity, eg. lumbar puncture, thoracentesis, pleurocentesis</td>
<td>Minor surgery with no identified risk factors, Effective 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</td>
</tr>
<tr>
<td>Moderate</td>
<td>Two or more stable chronic illnesses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Undiagnosed new problem with uncertain prognosis, eg. lump in breast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms, e.g. pneumonia, pneumothorax, cellulitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury, e.g. head injury with brief loss of consciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate To</td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute or chronic illness or injuries that pose a threat to life or bodily function, eg. Multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, Progressive severe rheumatoid arthritis, Psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, An abrupt change in neurologic status, eg. seizure, TIA, weakness or sensory loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>Cardiovascular imaging studies with contrast with identified risk factors, Cardiac electrophysiologic tests, Diagnostic endoscopy with identified risk factors, Discography</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**EVALUATION AND MANAGEMENT**

**Coding and Documentation Reference Guide**

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**HISTORY**

<table>
<thead>
<tr>
<th>HPI (History of Present Illness): Characterize HPI by considering either the Status of chronic conditions or the number of elements recorded.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 condition</td>
</tr>
<tr>
<td>Location</td>
</tr>
<tr>
<td>Status of 1-2 chronic conditions</td>
</tr>
<tr>
<td>Brief (1-3)</td>
</tr>
</tbody>
</table>

**ROS (Review of Systems):**

- Constitutional
- Cardiac, chest, heart
- GI
- Integumentary
- Endocrine
- Eyes, vision
- Musculo
- Reproductive

**PFSH (Past, Family, Social History):**

- Past history: the patient's past experiences with illnesses, operations, injuries and treatments
- Family history: a review of medical events in the patient's family, including diseases that may be hereditary or may have affected the patient at risk
- Social history: a review of past and current activities

*Complete PFSH: 2 history areas: a) the patient's office (patient care); b) emergency department; c) hospital; d) outpatient facility care; e) hospital. 3 history areas: a) the patient's office (patient care); b) emergency department; c) hospital; d) outpatient facility care.

**EXAMINATION**

<table>
<thead>
<tr>
<th>CPT Exam Description</th>
<th>95 Guideline Requirements</th>
<th>97 Guideline Requirements</th>
<th>CPT Type of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to affected body area or organ system</td>
<td>One body area or organ system</td>
<td>1-5 bulleted elements</td>
<td>PROBLEM-FOCUSED EXAM</td>
</tr>
<tr>
<td>Affected body area or organ system and other symptomatic or related organ systems</td>
<td>2-7 body areas or organ systems</td>
<td>6-11 bulleted elements</td>
<td>EXPANDED PROBLEM-FOCUSED EXAM</td>
</tr>
<tr>
<td>Extended exam of affected body area or organ system and other symptomatic or related organ systems</td>
<td>2-7 body areas or organ systems</td>
<td>12-17 bulleted elements</td>
<td>DETAILED EXAM</td>
</tr>
<tr>
<td>General multi-system</td>
<td>8 or more body areas or organ systems</td>
<td>18 or more bulleted elements</td>
<td>COMPREHENSIVE EXAM</td>
</tr>
<tr>
<td>Complete single organ system exam</td>
<td>Not defined</td>
<td>See requirements for individual single organ exams</td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL DECISION-MAKING**

**Instructions for Using TrailBlazer’s MDM Coding Method**

Coding Medical Decision-Making (MDM) begins with separately coding the three distinct components of MDM. Two of the three components determine the final level of MDM complexity documented in a record of Evaluation and Management (E&M) service. These components are:

1. Number of diagnoses and/or management options.
2. Amount and/or complexity of data reviewed or ordered.
3. Risk of complications and/or mortality.

The TrailBlazer MDM coding method corresponds directly to the components above as follows:

- Section A corresponds to number of diagnoses and/or management options
- Section B corresponds to amount and/or complexity of data reviewed or ordered
- Section C corresponds to risk of complications and/or mortality

Code each component separately using respective Tables A-C. Then compare results from Tables A-C to requirements in Table D to determine the overall MDM level.

**Section A**

**Coding Number of Diagnoses or Management Options** – Use the Tables A1 and A2 on page 2 to determine the number of diagnoses or management options.

**Note:** In all cases, the information in the clinical record (history and physical) must clearly support diagnostic impressions. Diagnostic impressions listed but not supported elsewhere in the clinical record must not be included in the problem list for coding purposes.
### MEDICAL DECISION-MAKING (continued)

Determine total points for each diagnosis or problem and associated management options using Tables A.1 and A.2. Use the larger of the two "Total" for Section B, Final Assignment of Medical Decision Making Type.

<table>
<thead>
<tr>
<th>Table A.1 Number of Diagnoses</th>
<th>Table A.2 Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &quot;problem&quot; is defined as definitive diagnosis or, for undiagnosed problems, a related group of presenting symptoms and/or clinical findings.</td>
<td>Important Note: The entries are examples of commonly prescribed treatments and the point values are illustrative of their intended qualifications. Many other treatments exist and should be counted when documented.</td>
</tr>
<tr>
<td>Each new or established problem for which the diagnosis and/or treatment plan is evident with or without diagnostic confirmation</td>
<td>Points</td>
</tr>
<tr>
<td>2 plausible differential diagnoses, complications or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation</td>
<td>2</td>
</tr>
<tr>
<td>3 plausible differential diagnoses, complications or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation</td>
<td>3</td>
</tr>
<tr>
<td>4 or more plausible differential diagnoses, complications or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation</td>
<td>4</td>
</tr>
<tr>
<td>Total Points</td>
<td>Points</td>
</tr>
</tbody>
</table>

#### Section B

Coding Amount and/or Complexity of Data Reviewed or Ordered – Determine total points for amount and/or complexity of data reviewed or ordered using Table B. Use the "Total Points" for Section D, Final Assignment of Medical Decision Making Type.

<table>
<thead>
<tr>
<th>Table B Data Reviewed or Ordered</th>
<th>Point Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order and review medically reasonable and necessary clinical laboratory procedures. Note: Count laboratory panels as one procedure.</td>
<td>1-3 procedures 2</td>
</tr>
<tr>
<td>Order and review medically reasonable and necessary diagnostic imaging studies in Radiology section of CPT.</td>
<td>&gt;3 procedures 2</td>
</tr>
<tr>
<td>Order and review medically reasonable and necessary diagnostic procedures in Medical section of CPT.</td>
<td>1-3 procedures 1</td>
</tr>
<tr>
<td>Discuss test results with performing physician.</td>
<td>1</td>
</tr>
<tr>
<td>Discuss case with other physician(s) involved in patient's care or consult another physician (i.e., true consultation meaning seeking opinion or advice of another physician regarding the patient's care). This does not include referring patient to another physician for future care.</td>
<td>1</td>
</tr>
<tr>
<td>Review old records. Record type and source must be noted. Review of old records must be reasonable and necessary based on the nature of the patient's condition. Perfunctory notation of old record ordering of testing for coding purposes is inappropriate and counting such is not permitted.</td>
<td>Order/review without summary 1</td>
</tr>
<tr>
<td>Independent visualization and interpretation of an image, EKG or laboratory specimen not reported for separate payment. Note: Each visualization and interpretation is allowed one point.</td>
<td>1</td>
</tr>
<tr>
<td>Review of significant physiology, monitoring or testing data not reported for separate payment (e.g., prolonged or serial cardiac monitoring data not qualifying for payment as rhythm electrocardiograms).</td>
<td>1</td>
</tr>
</tbody>
</table>

Total Points

Revised January 2008
Section C

Use Table C.1 to determine the highest level or risk associated with each of the following: presenting problem(s), diagnostic procedure(s) ordered, performed, management option(s) chosen. Then use Table C.2 to determine the "final risk", which is the highest of the three risks from Table C.1. The "final risk" from Table C.2 is used for Section D. Final Assignment of Medical Decision Making Type.

Table C.1 Risk of Complications and/or Morbidity or Mortality

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</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, skin burns</td>
<td>Laboratory tests requiring venipuncture</td>
<td>Rest</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Goggles</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Elastic bandages</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems</td>
<td>Laboratory tests requiring venipuncture</td>
<td>Over-the-counter drugs</td>
</tr>
<tr>
<td></td>
<td>One stable chronic illness, e.g., well-controlled hypertension or non-insulin dependent diabetes, infection, BPH</td>
<td>Physical tests under stress, e.g., pulmonary function tests</td>
<td>Minor surgery with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, sprain</td>
<td>Non-cardiovascular imaging studies with contrast, e.g., barium enema</td>
<td>Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prescription drug management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic illnesses with mild exacerbation, progression or side effects of treatment</td>
<td>Physiologic tests under stress, e.g., cardiac stress test, fatal 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>Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>Deep needle or incisional biopsy</td>
<td>Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms, e.g., pneumonia, pneumothorax, colitis</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors, e.g., angiogram cardiac cath</td>
<td>Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, splenectomy</td>
<td>IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic illnesses with severe exacerbation, progression or side effects of treatment</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors</td>
<td>Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, pneumonia, acute renal failure</td>
<td>Cardiac electrophysiological tests</td>
<td>Emergency major surgery (open, percutaneous or endoscopic)</td>
</tr>
<tr>
<td></td>
<td>An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss</td>
<td>Diagnostic endoscopies with identified risk factors</td>
<td>Parenteral controlled substances</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discography</td>
<td>Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>

Table C.2 Risk of Complication and/or Mortality (see Table C.1)

<table>
<thead>
<tr>
<th>Nature of the presenting illness</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk conferred by diagnostic options</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Risk conferred by therapeutic options</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

Final Risk determined by highest of 3 components above

Section D

Final Assignment of Medical Decision Making Type

1. Line A – Use Total Diagnostic Points or the Total Management Option Points from Section A (Tables A.1 and A.2).
2. Line B – Use Total Points from Section B (Table B).
3. Line C – Use highest level of risk from Section C (Table C.2).
4. Choose final Type of Medical Decision Making. Final Type Requires 2 of the 3 ICDM Components below met or exceeded.

Table D Final Assignment of Medical Decision Making Type

<table>
<thead>
<tr>
<th>Type of medical decision-making</th>
<th>Straightforward</th>
<th>Low Complexity</th>
<th>Moderate Complexity</th>
<th>High Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Number of diagnoses or management options</td>
<td>1 Point – Minimal</td>
<td>2 Points – Limited</td>
<td>3 Points – Multiple</td>
<td>4 Points – Extensive</td>
</tr>
<tr>
<td>B Amount and complexity of data reviewed/ordered</td>
<td>≤1 Point – None/Minimal</td>
<td>2 Points – Limited</td>
<td>3 Points – Multiple</td>
<td>4 Points – Extensive</td>
</tr>
<tr>
<td>C Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

Final Medical Decision Making requires 2 of 3 components above met or exceeded

Revised January 2008
### LEVEL OF SERVICE

#### Outpatient, Consults (Outpatient and Inpatient) and ER

<table>
<thead>
<tr>
<th>History</th>
<th>New Office/Consult/ER</th>
<th>Established Office</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PF: PF</td>
<td>EPF</td>
</tr>
<tr>
<td>Examination</td>
<td>PF: ER</td>
<td>EPF: EPF</td>
</tr>
<tr>
<td>Average Time (minutes)</td>
<td>10 New (90210) 10 Outl. care (90210) 50 Inpat. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210) 20 New (90210) 50 Outl. care (90210)</td>
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#### Inpatient

<table>
<thead>
<tr>
<th>History</th>
<th>Initial Hospital/Observation</th>
<th>Subsequent Inpatient/Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D or C</td>
<td>C</td>
</tr>
<tr>
<td>Examination</td>
<td>D or C</td>
<td>C</td>
</tr>
<tr>
<td>Complexity of Medical Decision</td>
<td>SF</td>
<td>M</td>
</tr>
<tr>
<td>Average Time (minutes) (Observation care has no average time)</td>
<td>30 Int. hosp (90231) 50 Int. hosp (90231) 70 Int. hosp (90231)</td>
<td>15 Subsequent (90231) 25 Subsequent (90231) 35 Subsequent (90231)</td>
</tr>
</tbody>
</table>

#### Nursing Facility

<table>
<thead>
<tr>
<th>History</th>
<th>Annual Assessment/Admission New Plan Admission Subsequent Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Old Plan Review</td>
</tr>
<tr>
<td>Examination</td>
<td>DJC</td>
</tr>
<tr>
<td>Complexity of Medical Decision</td>
<td>SF</td>
</tr>
<tr>
<td>No Average Time Established (Consultatory consults and ER have no average time)</td>
<td>(90304) (90305) (90306) (90307) (90308) (90309) (90310)</td>
</tr>
</tbody>
</table>

#### Domiciliary (Rest Home, Custodial Care) and Home Care

<table>
<thead>
<tr>
<th>History</th>
<th>New</th>
<th>Established</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PF</td>
<td>EPF</td>
</tr>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
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<tr>
<td>Complexity of Medical Decision</td>
<td>SF</td>
<td>L</td>
</tr>
<tr>
<td>Average Time (minutes)</td>
<td>20 Domiciliary (90310) 20 Home care (90341) 30 Domiciliary (90310) 30 Home care (90342) 45 Domiciliary (90310) 45 Home care (90343) 60 Domiciliary (90310) 60 Home care (90344) 75 Domiciliary (90310) 75 Home care (90345) 15 Domiciliary (90310) 15 Home care (90346) 25 Domiciliary (90310) 25 Home care (90347) 40 Domiciliary (90310) 40 Home care (90348) 60 Domiciliary (90310) 60 Home care (90349)</td>
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</tbody>
</table>

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

1995 Documentation Guidelines for Evaluation and Management Services
1997 Documentation Guidelines for Evaluation and Management Services

CPT Assistant (American Medical Association)
Official source for directives on CPT coding

CPT® Code Book (American Medical Association)

CPT/HCPCS Coding and Reimbursement for Physician Services, Lynn Kuehn, MS, RHIA, CCS-P,
(American Health Information Management Association)

Part B Answer Book – Medicare Billing Rules from A – Z
Medicare Claims Processing Manual
National Correct Coding Initiative

HELPFUL WEBSITES

http://www.cms.hhs.gov (Centers for Medicare and Medicaid)
http://www.cms.hhs.gov/MLNProducts/ (Medicare Learning Network)
www.mssny.org (Medical Society of the State of New York)
www.ahima.org (American Health Information Management Association)
www.nyhima.org (New York Health Information Management Association)
www.aapc.com (American Academy of Procedural Coders)
www.ngs.com (NGS American – Medical Benefit Administrators)
www.trailblazerhealth.com (Trail Blazer Health – Source for Medicare Information)
http://cms.hhs.gov/MedicalReviewProcess (Billing - Medical Review Process)
http://cms.hhs.gov/NationalCorrectCodInitEd (National Correct Coding Initiative)
http://cms.hhs.gov/CoverageGenInfo (Medicare coverage - General Information)
http://cms.hhs.gov/PhysicianFeeSched (Medicare Physician Fee Schedule)
http://cms.hhs.gov/MedicalReviewProcess (Medical Review Process - Billing)
http://cms.hhs.gov/mcd/search.asp? (Medicare Coverage Database)
http://cms.hhs.gov/apps/pfslookup (Medicare Physician Fee Schedule Look Up)
The Five-Step Process

1. Determine that the service is medically necessary.
2. Provide the service needed in order to properly meet the patient’s needs.
3. Document the service provided.
4. Select the most appropriate CPT/HCPCS code for the medically necessary service that was provided and properly documented.
5. Submit the service to Medicare that was medically necessary and documented.

Check Your Records for the Following:

- Records are legible; reasonable clinicians will easily recognize all abbreviations and symbols.
- The patient’s name and the date of service appear on every page of the record (including the back side of double-sided forms).
- The date of service on the record matches the date of service on the claim.
- The medical record clearly indicates the identity and professional credentials of all people who contributed to the service and/or the record, and who contributed which portion(s) of the service and/or record.
- Information in the record clearly supports all diagnoses reported on the claim.
- Information in the record clearly demonstrates all of the work described by the code(s) and/or modifiers reported on the claim were performed.
- All procedures reported are clearly documented.
- Evaluation and Management (E/M) services reported on the same day as a procedure are clearly documented, medically necessary, significant and separate from the procedure.
- The record of services performed “incident to” a physician service demonstrates the link between the employee’s work and the physician’s service.
- The record of services split/shared by a physician and non-physician practitioner demonstrates the face-to-face encounter and contribution to patient management by each practitioner involved.
Medical Necessity for Evaluation and Management Services

1. Federal law requires that all expenses paid by Medicare, including expenses for Evaluation and Management (E/M) services, are "medically reasonable and necessary."

   - Medical necessity of E/M services is generally expressed in two ways: frequency of services and intensity of service (CPT level).
   - Medicare’s determination of medical necessity is separate from its determination that the E/M service was rendered as billed.
   - Medicare determines medical necessity largely through the experience and judgment of clinician coders along with the limited tools provided in CPT and by CMS.
   - At audit, Medicare will deny or downcode E/M services that, in its judgment, exceed the patient’s documented needs.

2. Information used by Medicare is contained within the medical record documentation of history, examination and medical decision-making. Medical necessity of E/M services is based on the following attributes of the service that affected the physician’s documented work:

   - Number, acuity and severity/duration of problems addressed through history, physical and medical decision-making.
   - The context of the encounter among all other services previously rendered for the same problem.
   - Complexity of documented comorbidities that clearly influenced physician work.
   - Physical scope encompassed by the problems (number of physical systems affected by the problems).
Tips for Correct Coding of E/M Services Based on Medical Necessity

1. Identify all the presenting complaint(s) and/or reason(s) for the visit for which physician work occurred.
   - Demonstrate clearly the history, physical and extent of medical decision-making associated with each problem.
   - Demonstrate clearly how physician work (expressed in terms of mental effort, physical effort, time spent and risk to the patient) was affected by comorbidities or chronic problems listed.

2. Ensure the nature of the patient’s presentation corresponds to CPT’s contributory factors of nature of the presenting problem and/or patient’s status descriptions for the code reported. For instance:
   - 99231 – “Usually the patient is stable, recovering or improving.”
   - 99232 – “Usually the patient is responding inadequately to therapy or has developed a minor complication.”
   - 99233 – “Usually the patient is unstable or has developed a significant complication or a significant new problem.”

3. Utilize Clinical Examples in CPT Appendix C.
   - The clinical examples are believed by CPT to represent the physician work that is reasonable and necessary in order to provide appropriate patient care in the specified clinical circumstances of the example.
   - Understand that Medicare expects actual documentation of services similar to the ones in the examples to also satisfy CMS documentation requirements to demonstrate that the service billed was provided.
Documentation Requirements for CPT Code 99211

CPT code 99211© is used to report a low-level Evaluation and Management (E/M) service. The CPT book defines code 99211 as:

"Office or other outpatient visits for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services."

Code 99211 requires a face-to-face patient encounter; however, when billed as an "incident to" service, the physician’s service may be performed by ancillary staff and billed as if the physician personally performed the service. For such instances, all billing and payment requirements for "incident to" services must be met.

As with all services billed to Medicare, code 99211 services must be reasonable and necessary for the diagnosis or treatment of an illness or injury. Unlike the other E/M CPT codes, the CPT book does not specify completion of particular levels of work for code 99211 in terms of key components or contributory factors. Also, unlike the other E/M codes, CMS did not provide documentation requirements for code 99211 in the “E/M Documentation Guidelines.”

CPT code 99211 describes a service that is a face-to-face encounter with a patient consisting of elements of both evaluation and management. The evaluation portion of code 99211 is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information (historical information and/or physical data) between the provider and the patient. The management portion of code 99211 is substantiated when the record demonstrates influence by the service of patient care (medical decision-making, provision of patient education, etc.). Documentation of all code 99211 services must be legible and include the identity and credentials of the individual who provided the service.

For code 99211, services performed by ancillary staff and billed by the physician as an "incident to" service, the documentation should also demonstrate the “link” between the non-physician service and the precedent physician service to which the non-physician service is incidental. Therefore, documentation of code 99211 services provided "incident to" should include the identity and credentials of both the individual who provided the service and the
supervising physician. Documentation of a code 99211 service provided "incident to" should also indicate the supervising physician's involvement with the patient care as demonstrated by one of the following:

- Notation of the nature of involvement by the physician (the degree of which must be consistent with clinical circumstances of the care).
- Documentation from other dates of service that establishes the link between the services of the two providers.
- Medicare has reviewed numerous claims on which 99211 was reported inappropriately. All 99211 services for which supporting documentation does not demonstrate that an E/M service was performed and was necessary as outlined in this document will be denied upon review.

Among other things, code 99211 should not be used to bill Medicare:

- For phone calls to patients.
- Solely for the writing of prescriptions (new or refill) when no other E/M is necessary or performed.
- For blood pressure checks when the information obtained does not lead to management of a condition or illness.
- When drawing blood for laboratory analysis or when performing other diagnostic tests, whether or not a claim for the venipuncture or other diagnostic study test is submitted separately.
- Routinely when administering medications, whether or not an injection (or infusion) code is submitted on the claim separately.
- For performing diagnostic or therapeutic procedures (especially when the procedure is otherwise usually not covered/not reimbursed or payment is bundled with payment for another service), whether or not the procedure code is submitted on the claim separately.

The table below contains elements that would constitute adequate documentation of a code 99211 service in selected clinical circumstances:

<table>
<thead>
<tr>
<th>Clinical Circumstance</th>
<th>Adequate Documentation for Code 99211</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure check</td>
<td>1. Blood pressure and other vital signs recorded.</td>
</tr>
<tr>
<td></td>
<td>2. Clinical reason for checking blood pressure recorded (i.e., follow up to previous abnormal finding, symptoms suggestive of abnormal blood pressure, etc.)</td>
</tr>
<tr>
<td></td>
<td>3. Current medications listed (with notation of level of compliance).</td>
</tr>
<tr>
<td></td>
<td>4. Indication of doctor's evaluation of the clinical information obtained and his management recommendation.</td>
</tr>
<tr>
<td></td>
<td>5. Identity and credentials of provider(s) as listed in text above.</td>
</tr>
<tr>
<td>Clinical Circumstance</td>
<td>Adequate Documentation for Code 99211</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Prescription refill or injection/infusion  | 1. Reason for the visit. A physician visit is not necessary to routinely provide stable patients with an ongoing medication supply. Therefore, the documentation for code 99211 or any other E/M code in this circumstance must demonstrate a need for clinical evaluation and management (for instance, symptoms or signs reported that are significant enough to necessitate evaluation).  
2. Current medications listed (with notation of level of compliance).  
3. Indication of doctor’s evaluation of the clinical information obtained and his management recommendation.  
4. Identity and credentials of provider(s) as listed in text above.                                                                                      |
| Prothrombin time evaluation for patients on chronic warfarin anticoagulation | 1. Reason for the visit. A physician visit is not routinely necessary to draw blood for prothrombin time or other laboratory tests. Therefore, the documentation for code 99211 or any other E/M code in this circumstance must demonstrate a need for clinical evaluation and management. In this case, services that would serve to demonstrate that evaluation and management was performed include an evaluation of significant new symptoms (such as excessive bruising or hemorrhage). Alternatively, for patients who have no new clinical concerns, documentation that contemporaneous laboratory values were obtained, reviewed, and used to guide current and/or future therapy documents that a separately payable E/M service has been performed.  
2. Current medications listed (with notation of level of compliance).  
3. Indication of doctor’s evaluation of the information about signs/symptoms and laboratory test result and his management recommendation.  
4. Identity and credentials of provider(s) as listed in text above.                                                                                      |
Part B Tips for Preventing Most Common Evaluation and Management (E/M) Service Coding Errors

History

1. Indicate clearly the chief complaint and/or reason for the visit.
   Do not limit the chief complaint to “follow-up” without identifying the problem(s) being followed.

2. Describe the history of the present illness fully and in such a way that the nature of the presenting problem is clear.
   - The documentation guidelines specify elements that must be recorded about the present illness. Higher-level services require four or more elements or a description of the status of three or more chronic problems.
   - Medical necessity of an Evaluation and Management (E/M) encounter is often visualized only when viewed through the prism of its characteristics captured in specific History of Present Illness (HPI) elements.

3. Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services.
   - Do not use the term “non-contributory.”
   - Record information about all three realms to document “complete” PFSH for the following services: new patient or initial services in office and inpatient hospital, observation, domiciliary and home, as well as consultations and comprehensive Nursing Facility (NF) assessments.
   - Do not record unnecessary information solely to meet requirements of a high-level service when the nature of the visit dictates a lower-level service to have been medically appropriate.

4. Record the Review of Systems (ROS) appropriate for the clinical circumstance of the encounter. Expansive ROS is unnecessary for lower-level services.
   - Document an ROS for the system(s) related to the presenting problem. It is required for all levels of systemic review (meaning that it is required for all codes except the least codes in all code families).
   - Record positives and pertinent negatives.
     - Never note the system(s) related to the presenting problem as “negative.”
     - Use notations such as “normal” or “negative” only for systems not related to the presenting problem.
     - When using “negative” notation, always identify which systems were queried and found to be “negative.”
   - Do not count physical observations as ROS (count them as Physical Examination).
• Do not record unnecessary information solely to meet requirements of a high-level service when the nature of the visit dictates a lower-level service to have been medically appropriate.

Physical Examination

1. Understand the difference between “Expanded Problem-Focused (EPF)” and “Detailed” examination under 1995/1997 guideline requirements.
   • The difference is not the number of systems examined. Two to seven systems are required for both examinations.
   • The difference is the detail in which the examined systems are described.

2. Always examine the system(s) related to the presenting problem and do not describe it as “normal” or “negative.”

   Use “normal,” “negative” and “WNL” notations only to describe unaffected or asymptomatic organ systems.

3. Code the physical examination considering the clinical circumstances of the encounter. Do not code based on excessive and unnecessary information recorded solely to meet the requirements of a high-level service when the nature of the visit dictates a lower-level service to have been medically appropriate.

Medical Decision-Making (MDM)

1. Record relevant impressions, tentative diagnoses, confirmed diagnoses and all therapeutic options chosen related to every problem for which E/M is clearly demonstrated in the record of the other key components.

   Do not count existent old diagnoses unless the record clearly demonstrates their presence increased physician work related to the encounter.

2. Document all diagnostic tests ordered, reviewed and independently visualized as part of the work of the encounter.

   Do not code MDM based solely on the severity of or number of presenting problems; decision-making also encompasses the numbers of and risk associated with diagnostic tests ordered/performed as well as the complexity of and risk associated with therapeutic options chosen.

3. Summarize old records or other outside information reviewed and incorporated into decision-making.

4. Beware of templates that overestimate decision-making. Understand the logic of templates and/or computer programs used for E/M service coding.
Tips for Preventing Coding Errors With Specific Evaluation and Management (E/M) Codes

1. High-level services and the “comprehensive” codes: Understand CPT code requirements.
   - All codes in the following code sets require three of three key components documented according to CMS guidelines to meet published CPT definitions:
     - New patient office services.
     - Initial hospital services.
     - Initial consultations (inpatient and outpatient).
     - Emergency department services.
     - Comprehensive nursing facility assessments.
   - All of the following codes require not just three of three, but also require comprehensive history and comprehensive examination:
     - 99204 and 99205 (New patient office services).
     - 99222 and 99223 (Initial hospital services).
     - 99244 and 99245 (Office consultations).
     - 99254 and 99255 (Initial in-patient consultations).

2. Emergency Department Services: Pay attention to the unique record kept in most Emergency Departments (EDs). Multiple individuals, including hospital staff, contribute to the ED service and the ED record, but Part B must not pay the physician for services rendered by hospital staff.
   - Physician coding should be based on the physician’s personal Evaluation and Management (E/M) work (or work shared by a physician and non-physician practitioner in the same group).
   - All history obtained and recorded by triage and other hospital nursing staff must be specifically repeated by the physician and either re-recorded or annotated with specific comments, additions and/or corrections and notation of the elements of work personally performed by the physician.

3. Subsequent Hospital Services.
   - Pay attention to medical necessity. When coding, strongly consider CPT’s “nature of the presenting problem” contributory factors and/or other patient status descriptions.
     - 99231 – “Usually the patient is stable, recovering or improving.”
     - 99232 – “Usually the patient is responding inadequately to therapy or has developed a minor complication.”
     - 99233 – “Usually the patient is unstable of has developed a significant complication or a significant new problem.”
   - Pay attention to CPT key component requirements. Because of the nature of hospital record-keeping, the following deficiencies are very common:
     - History components are often documented to be no more detailed than Problem-Focused (PF) or Expanded Problem-Focused (EPF).
     - Examinations are rarely documented higher than EPF.
4. **Consultations:** Before coding a consultation, ask and answer these questions about the service. If the answer is "No" to any of the questions, do not report the service as a consultation.

- Did you receive a request for an opinion from another physician?
- Does your documentation of the service clearly demonstrate who made the request and the nature of the opinion requested?
- Have you provided a written report of your opinion/advice to the referring physician?
- Though the referring physician may have asked for a “consultation,” should the E/M service you provided truly be reported as a consultation?
  - Will your opinion be used by, and in some manner affect, the requesting physician’s own management of the patient?
  - Will the referring physician be involved in subsequent decision-making about the problem for which the referral has been made?
  - For preoperative “consultations,” is the service requested specifically for preoperative clearance that is medically necessary considering the patient’s condition and the procedure planned?

Never report separately payable services to Medicare when the service was rendered solely for completion of the mandatory preoperative or preadmission History and Physical (H&P) (when payment for the H&P has been made, or will be made, to the operating surgeon as part of the global payment for the surgical procedure).

5. **Critical Care:** Before coding critical care, ask and answer the following questions about the service. If the answer is "No" to any of these questions, do not report the service as critical care.

- Does the record demonstrate work performed during the encounter that is more intense than the work of other E/M codes of the same time duration?
- Does the record demonstrate the patient has acute impairment of one or more vital organ systems and has a high probability of imminent or life-threatening deterioration?
- Does the physician’s documentation demonstrate all of the following?
  - Direct personal management.
  - Frequent personal assessment and manipulation (not generally a once-daily visit).
  - High-complexity decision-making to assess, manipulate and support vital system function(s) to treat single or multiple organ system failure and/or to prevent further life-threatening deterioration.
  - Interventions of a nature that failure to initiate these interventions on an urgent basis would likely result in sudden clinically significant or life-threatening deterioration in the patient’s condition.
- What about the time spent providing critical care?
  - Is it specifically recorded?
  - Is it reasonable considering the documented work provided?
  - Does it exclude time spent performing procedures for which separate payment is made?
  - If it includes time spent with family, was the family member operating as a surrogate decision-maker because the patient is unable to make decisions?
APPENDIX D

LEGAL CONSIDERATIONS REGARDING MEDICAL RECORDS
MEDICAL RECORDS

FACT SHEET

I. CREATION OF A MEDICAL RECORD

1. Must physicians create a medical record for all patients?

Yes. The Education Law requires physicians to maintain a medical record which accurately reflects the evaluation and treatment of each patient.

*(Education Law § 6530 (32))*

2. What should the medical record contain?

Physicians must prepare legible, contemporaneous, permanent treatment records which reflect the actual treatment or services rendered. Such record should contain patient information regarding the examination, health assessment or treatment of a patient.

*(Public Health Law § 18 (1)(e))*

Generally, the following is recommended to be contained within a patient's medical record:

A. Information sufficient to identify the patient;

B. The date of each patient visit;

C. The patient’s chief complaint or reason for each visit;

D. The patient’s pertinent medical history as appropriate to each visit, and findings obtained from any physical examination conducted that day;

E. A recording of any progress of a patient, including patient response to treatment;

F. Any diagnostic impressions made for each visit;

G. A notation of all medication dispensed, administered or prescribed, with the precise dosage and drug regimen for each medication dispensed or prescribed;

H. Presence and identity of chaperone;

I. Time spent with patient, when appropriate;

J. Physician's or provider's identity, if service is provided in multi-provider setting;

K. Any information regarding suggested actions to be taken that were nonetheless disregarded by the patients;
L. Information regarding any advance directive for healthcare for an adult or emancipated minor. Inquiry and documentation of this information must also be included on the routine intake history form for a new patient who is a competent adult or emancipated minor. In addition, the treating doctor shall request and document this information when providing treatment for a significant illness, a life-threatening emergency, or where surgery is anticipated with use of general anesthesia;

M. Documentation of the patient’s consent to perform any procedure;

N. Prominent display of allergies or adverse reaction to any medication on every page of the record;

O. A statement as to whether or not the patient is expected to return for further treatment, the treatment planned, and the time frames for return appointments;

P. A notation as to any referral for consultation to another provider or practitioner, a statement as to the reason for, and the results of such consultations; and

Q. A chart entry giving the medical necessity for any ancillary diagnostic procedure.

Corrections and additions can be made, provided that each change is clearly identified as such, dated and initialed by the physician.

In a corporation practicing medicine, each report, diagnosis, prognosis and prescription shall be signed by the physician responsible for such report, diagnosis, prognosis or prescription.

(Business Corporation Law § 1504(c); 18 NYCRR 540.7(10))

The physician must also maintain information that is not patient information, as identified by the Public Health Law. Such information includes:

A. personal notes and observation of a healthcare professional not disclosed to any other person after January 1, 1987.

B. examination records for the patient from another practitioner.

C. confidential data disclosed to the practitioner by other persons.

(Public Health Law § 18 (1)(e))

3. What are a physician's obligations to provide medical records at the request of the patient?

A healthcare provider is required, within 10 days of a written request, to provide a qualified person with an opportunity to inspect a patient’s medical records. A qualified person means the patient, the parent or guardian of a minor patient, or a qualified personal representative of the patient. If the practitioner does not have space available
to permit the inspection of patient information, the practitioner may, in the alternative, furnish a qualified person a copy of such information within ten days.

Upon the request of any qualified person, a healthcare provider shall furnish to such person, within a reasonable time, a copy of any patient information requested which the person is authorized to inspect.

(Public Health Law § 18 (1)(g) and (2))

If applicable, subjective information in the records shall be provided to the patient, unless, in the exercise of the physician’s professional judgment, the provider believes that the patient’s mental or physical condition will be adversely affected upon being made aware of such information. In that case, the subjective information shall be provided upon request, along with a notice setting forth the reasons for the original refusal to the patient’s attorney, another licensed health care professional, the patient’s health insurance carrier, or a governmental reimbursement program.

(Public Health Law § 17 and 18 (3))

4. **May a physician withhold medical records on the basis that the patient owed money to the physician for services rendered?**

No. A qualified person shall not be denied access to patient information solely because of inability to pay.

(Public Health Law § 17 and 18 (2)(e))

5. **May a physician charge for copying costs of medical records?**

Yes. A medical provider may impose a charge for the copying of medical records, not exceeding the costs incurred by such provider, which shall not exceed $.75 per page. A provider may not impose a charge for copying an original mammogram when the original has been furnished to any qualified person, provided that any charge for furnishing an original mammogram shall not exceed the documented costs associated therewith.

(Public Health Law § 18 (2)(e))

6. **How long must physicians retain patient medical records?**

Regulations require that treatment records be retained for the following durations:

A. For adults: for at least six years from the date of the most recent entry. (MSSNY recommends retaining records for seven years.)

B. Records of Minors and Obstetrical Records: for at least six years from the date of the most recent entry, or until one year after the minor reaches the age of eighteen years, whichever is later.
In addition, regulations mandate that physicians maintain records relating to billings made to patients and third-party carriers for professional services.

*(Education Law § 6530 (32))*

**HMO Requirements**
Physicians must also be aware of and comply with requirements regarding retention of medical records as stated in any HMO or managed care agreements they have signed. Generally, HMO agreements require the physician to retain copies of medical records of HMO enrollees for a period longer than that required by law. For minor patients they typically require that records be retained for at least three years after the minor reaches the age of 18.

**MEDICARE:** MSSNY recommends that physicians maintain all Medicare patient records for ten years to protect themselves in the event there is a Federal False Claims Act investigation.

7. **How should a physician respond to a subpoena for medical records?**

When a physician is served with a subpoena to produce medical records, the subpoena must be accompanied by the patient’s signed HIPAA-compliant authorization. The subpoena must also contain a notice to the recipient in bold-face type that the records need not be supplied without an accompanying authorization. If the physician is unsure how to respond to the subpoena, the physician must be aware that HIPAA rules must always be followed – no exceptions.

*(CPLR § 3122(a))*

Physicians should ALWAYS consult with an attorney specializing in health law before responding to any subpoena or request for medical records.

No one should EVER alter a requested or subpoenaed medical record in an attempt to provide clarification or justification.

**II. TERMINATION OF PRACTICE OR EMPLOYMENT**

What should be done with medical records upon a physician’s leave of absence, death, retirement or relocation?

It is professional misconduct for a physician to abandon or neglect a patient who is under or in need of immediate professional care, without making reasonable arrangements for the continuation of such care, and for a practitioner to abandon a group practice, hospital, clinic or other health care facility, without providing reasonable notice and under circumstances which seriously impair the delivery of professional care to patients. It is also professional misconduct to fail to maintain patient records in accordance with statutory guidelines.
If a physician takes a leave of absence from a practice, dies, retires or relocates, he/she must inform the patients that he/she will no longer be available to provide them with treatment and provide them with a referral for alternate treatment whether it is a referral to another practitioner or a local medical society. The physician must also take steps that the medical records are maintained in such a way that they can be accessed by the patients and he/she must inform the patients where these medical records are kept and how the patient can obtain a copy of his/her medical record.

(Education Law § 6530 (30) and (32))

III. DISPOSITION OF RECORDS
How should medical records be destroyed?

Medical records, whether paper or electronic, must be stored and destroyed in compliance with HIPAA requirements. For paper records, cabinets that contain protected documents must be locked, and the documents must be shredded prior to disposal. For electronic records, procedures must be implemented to either address the final disposition of electronic protected health information and/or the hardware or electronic media on which it is stored, or to remove such protected electronic health information from electronic media before the media is made available for re-use. In summary, procedures must be implemented for all protected health information to prevent the unauthorized, unnecessary and inadvertent disclosure of protected information. Records must be destroyed to the point where no one can later retrieve them and misuse them.

(45 CFR Parts 160, 162, 164)

IV. RISK MANAGEMENT OF A MEDICAL RECORD

It is vital for the practitioner to be mindful that there are many individuals, that do not have clinical training, who review medical records including the attorneys who defend them and who file lawsuit(s) against them, managed care company personnel and law enforcement personnel. Medical records are not only reviewed in furtherance of patient care, but are also reviewed in the context of managed care audits, medical malpractice cases, professional licensure investigations and law enforcement investigations as well as in many other countless circumstances. Therefore, in addition to complying with the law, a prudent practitioner will also be sure to document accordingly.

The practitioner must bear in mind that while the primary purposes of a medical record are to document the care provided to a patient and to ensure the continuity of care, the medical records may well be reviewed by a number of individuals for other purposes. Medical records may be reviewed by managed care companies, in connection with medical malpractice or licensing actions and in connection with criminal investigations. It is crucial that all information necessary to justify any treatment provided be fully documented in the record. The medical record must be documented keeping in mind the maxim, “If it has not been documented it has not been done”.