Selection of Evaluation and Management Service Codes
1995 E&M Guidelines

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Evaluation and Management Services
99201-99499
Documentation Tips

• Provide specific and descriptive documentation

• Thorough documentation facilitates the rendition of high quality patient care for payors, the medical record is also used to provide documentation of the site of service, the medical necessity of the service, and that the service documented was the service billed and paid for.

• An appropriately documented medical record can reduce many of the “hassles” associated with claims processing and, if necessary, serve as a legal document to verify the care provided

• Good documentation is the key to correct coding of E/M services
General Documentation Principles for All Types of Services

- The medical record should be complete and legible

- The documentation of each encounter should include:
  - The reason for the encounter and relevant history, physical exam findings and prior diagnostic test results
  - An assessment, clinical impression or diagnosis
  - A plan for care
  - The date and legible signature of the physician

- If not documented, the rationale for ordering diagnostic or other services should be easily inferred
General Documentation Principles for All Types of Services

- Past and present diagnoses should be accessible to the treating and/or consulting provider
- Appropriate health risk factors should be identified
- The patient’s progress, response to and changes in treatment and revisions in the diagnosis should be documented
- 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
Practice Pointer:

Remember proper selection of the level of E/M service is dependent on satisfaction on two or three key components.
Performance and documentation of one component at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level E/M service.
What is an E&M service?

E&M services (visits) include the following

- Examination
- Evaluation
- Consultation
- Treatments
- Conferences
- Counseling with patient/family
- Preventive Medicine

- Critical Care
- Emergency Room
- Home Care
- Nursing Home
- Custodial Care
- Hospice
- Assisted Living
<table>
<thead>
<tr>
<th>Categories of E&amp;M Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Office or Outpatient</td>
</tr>
<tr>
<td>• Hospital Observation</td>
</tr>
<tr>
<td>• Hospital Inpatient</td>
</tr>
<tr>
<td>• Observation/Inpatient same day</td>
</tr>
<tr>
<td>• Consultations</td>
</tr>
<tr>
<td>• Emergency Room</td>
</tr>
<tr>
<td>• Critical Care</td>
</tr>
<tr>
<td>• Nursing Facility</td>
</tr>
<tr>
<td>• Domiciliary/Rest Home/Custodial</td>
</tr>
</tbody>
</table>

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care Oversight</td>
</tr>
<tr>
<td>• Home</td>
</tr>
<tr>
<td>• Prolonged</td>
</tr>
<tr>
<td>• Case Management</td>
</tr>
<tr>
<td>• Preventive Medicine</td>
</tr>
<tr>
<td>• Non-Face to Face</td>
</tr>
<tr>
<td>• Special E&amp;M services</td>
</tr>
<tr>
<td>• Newborn Care</td>
</tr>
<tr>
<td>• Neonatal Critical Care</td>
</tr>
<tr>
<td>• Other</td>
</tr>
</tbody>
</table>
Components of an E&M Code

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of presenting problem
- Time
Key Components

History
Examination
Medical Decision Making

As a general rule these are the first components considered when selecting a level of E&M code

Of course, there are exceptions to every rule.
Contributing Factors

- Counseling
- Coordination of Care
- Nature of Presenting Problem

These components are not required for E&M services but may be used in certain circumstances.
For visits in which counseling and/or coordination of care dominates the provider/patient and/or family encounter (i.e., takes up more than 50 percent of the time), time is considered the key or controlling factor to qualify for a particular level of E/M service.

For time-based codes, the total length of time of the encounter must be clearly documented in the medical record, and the record should describe the counseling and/or other activities to coordinate care.
Documenting Time

Critical Care time:
The time spent caring for your patient, bedside, reviewing labs/x-rays, discussing care with nursing staff, and discussing care options with family members

Counseling time: (not psychotherapy services)
The total time of the visit must be documented along with the time spent counseling.

Example: Visit 35m Counseling time 20m
- This section will instruct you on how to select the level of each of the 3 key components.

- This will allow you to successfully select the appropriate code for billing purposes.

- The goal is to select the appropriate code based on location of where the patient was seen, and the level of the visit, using the key components as a guide.
1st you need to select the location of where the patient is being seen.

- Office or Outpatient
- Hospital Observation
- Hospital Inpatient
- Emergency Room
- Nursing Facility
- Domiciliary/Rest Home/ Custodial
Once you determine the location that you are using for billing then decide if the patient is a “new” or “established”.

**There is no distinction between new and established patients in the Emergency Dept.**
New Patient Guidelines

• A new patient is someone that has not received any professional services from you, the physician, or a physician in the same practice of the same specialty.

• To meet the coding levels for new patient visits, 3 of the 3 elements (history, exam and medical decision-making) must be adequately documented.
To meet the coding levels for established patient visits, only 2 of the 3 key components (history, exam and medical decision-making) must be adequately documented.

Examples:

- History & Exam
- Exam & MDM
- History & MDM
Step by Step

- **Location**: Doctors office
- **Type of patient**: Established patient
- **Code set**: 99211-99215

This is an example of an established patient in the office.
What’s next?

- Once you determine the code set that you are using for coding the documentation you must select the levels of each key component.

- Keeping in mind that new patients require all 3 key components and established patients only use 2 of the 3.

- History
- Exam
- Medical Decision Making
What is the “History”? 

- History is broken down into the following:
  - Chief Complaint (CC)
  - History of Present Illness (HPI)
  - Review of Systems (ROS); and
  - Past, family and/or Social history (PFSH)

- The patient’s history is subjective and should be in the patient’s own words.

This is the “S” of the S.O.A.P note
Documentation Tips:

- The chief complaint, review of systems and PFSH may be listed as separate elements of the history, or they may be included in the HPI.

- ROS and/or PFSH obtained during an earlier encounter does not need to be re-documented if there is evidence that the provider reviewed and updated the previous information.

- ROS and/or PFSH may be documented by ancillary staff or on a form completed by the patient. However, the provider must notate that he/she reviewed and has confirmed such information as documented by others.

- If the provider is unable to obtain the history due to the patient’s condition, that fact must be reflected in the documentation.
The Chief Complaint (CC) is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return or other factor that is the reason for the encounter.

The Medical Record should always clearly reflect the chief complaint
The History of Present Illness (HPI) is a chronological description of the development of the patient’s present illness from the first sign and/or symptom, or from the previous encounter to the present. It includes:

- Location (e.g. where the problem is located)
- Quality (e.g. sharp, dull, stabbing, etc...)
- Severity (e.g. on a scale of 1-10)
- Duration (e.g. how long the symptom has been present)
- Timing (e.g. how long it lasts and when it occurs)
- Context (e.g. improved upon walking)
- Modifying factors (e.g. tends to improve with ice)
- Associated signs/symptoms (e.g. visible swelling, redness)
**Brief and Extended HPI** are distinguished by the amount of detail needed to accurately characterize the clinical problem

** A **Brief HPI** will consist of one to three elements of the HPI

** An **Extended HPI** will consist of at least 4 elements
The Review of Systems (ROS) is an inventory of body systems which is obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

This is NOT a listing of medical problems or conditions.
Recognized Systems for the ROS

- Constitutional symptoms (e.g. fever)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal

- Integumentary (skin or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/(and Lymphatic)
- Allergic/Immunologic
Problem Focused/Pertinent ROS

Inquires about the system directly related to the problems identified in the HPI

Documentation Tip:
The patient’s positive responses and pertinent negatives for the system which relates to the problem must be documented
Extended Problem Focused ROS

Inquires about the system directly related to the problem/s identified in the HPI, and a limited number of additional systems

Documentation Tip:

The patient’s positive responses and pertinent negatives for 2 to 4 systems must be documented for an extended ROS.
Inquires about all the systems directly related to the problem identified in the HPI, plus all additional body systems.

Documentation Tip:
- At least 10 organ systems must be reviewed for a complete ROS. Those systems with positive or pertinent negative responses must be individually documented.
- For the remaining systems a notation indicating “all other systems are negative” is permissible.
- In the absence of such a notation, at least 10 systems must be individually documented.
Past, Family and/or Social History (PFSH)

The PFSH consists of a review of three areas:

- **Past History**: The patient’s past experience with illnesses, operations, injuries and treatment

- **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**: An age appropriate review of past and current activities

“Unobtainable” is not acceptable documentation, something must be documented.
Pertinent PFSH

- A review of the history area(s) directly relating to the problem(s) identified in the HPI

Documentation Tip:

For a “pertinent PFSH,” at least 1 specific item from any of the 3 history areas (past history, family history, social history) must be documented
A “complete PFSH” is a review of 2 or all 3 of the PFSH areas, depending on the category of E/M service.

A review of all 3 history areas is required for services that, by their nature, include a comprehensive assessment of the patient.

A review of 2 of the 3 areas is sufficient for all other services.
Unable to obtain history

• If the patient is unable to give you any part of the history component due to their condition you must document that condition.

Examples:
“unable to obtain history pt is unconscious”
“unable to obtain history pt is a poor historian”
“unable to obtain history pt is on a vent and sedated”
“obtained partial history from “sister” pt is confused”
Using the History Table

- Select how many components you have in each section
- You must have 3 components of the same level to get the overall level
- You can choose a lower level if the 3 components selected aren’t equal (see example)

Example:
Extended HPI
Complete ROS
Pertinent PFSH

You would select a Detailed level for the History Component
## Deciding the level of History

<table>
<thead>
<tr>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family, and/or Social History (PFSH)</th>
<th>Type of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>1-3 elements</td>
<td>Problem Pertinent</td>
<td></td>
<td>Extended Problem Focused</td>
</tr>
<tr>
<td></td>
<td>System directly related to the HPI</td>
<td>N/A</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
<td>Detailed</td>
</tr>
<tr>
<td>4 or more elements</td>
<td>System directly related to problem in HPI and 1-8 additional</td>
<td>At least 1 item from any 3 history areas</td>
<td></td>
</tr>
<tr>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>4 or more elements (location, severity, timing, modifying factors, quality, duration, context, associated signs/symptoms)</td>
<td>System directly related to problem in HPI at least 10 additional (constitutional, CV, Resp., GU, Skin, Psych, Allergic, EENMT, GI, MS, Neuro, Endocrine, Hematologic/Lymph</td>
<td>1 item from 2 or 3 history areas. If the patient is NEW all 3 must be documented (past history, family history, social history)</td>
<td></td>
</tr>
</tbody>
</table>

You have to lower the complete on the ROS to get 3 in a row.
Examination Component

• The Objective part of the E&M code selection

To count vital signs as an exam component you must have 3 of the 7 vitals listed

This is the “O” in the S.O.A.P note
## Examination: Organ Systems

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Genitourinary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>Ears, nose, mouth &amp; throat</td>
<td>Skin</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Neurological</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Psychiatric</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Hematologic/lymphatic/immunologic</td>
</tr>
</tbody>
</table>
To qualify for a given level of examination, the following content and documentation requirements must be met:

- **Problem Focused Examination** – must include documentation of exam of 1 body area or system (relevant affected area)

- **Expanded Problem Focused Examination** - must include documentation of exam of 2-4 body areas or systems including the affected area

- **Detailed Examination** - must include documentation of exam of 5-7 body areas or systems, including affected area

- **Comprehensive Examination** - must include documentation of exam of 8 or more body areas or systems
MDM refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the following:

- Number of possible diagnoses and/or the number of management options to be considered

- The amount of data and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed or obtained

- The risk of significant complications, morbidity, and/or mortality as well as co-morbidities associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.
## Number of Diagnoses and/or Treatment Options

Add up the points to get a total.

<table>
<thead>
<tr>
<th>Problems to Exam Physician</th>
<th>Number X</th>
<th>Points = Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>1</td>
<td>Max = 2</td>
</tr>
<tr>
<td>Est. problem (to examiner); stable, improved</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); worsening</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>3</td>
<td>Max = 3</td>
</tr>
<tr>
<td>New problem (to examiner); addtnl. workup planned</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed.

A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity 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 being reviewed.

The physician who ordered the test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation, this is also an indication of the complexity of data being reviewed.
If a diagnostic service is ordered, planned, scheduled or performed at the time of the E/M encounter, the type of service must be documented.

The review of lab, radiology and/or other diagnostic tests should be documented. An entry such as “WBC elevated” or “chest x-ray unremarkable” is acceptable.

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

The results of discussion of diagnostic services with the physician who performed or interpreted the study should be documented.
Amount and/or Complexity of Data

<table>
<thead>
<tr>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45</strong></td>
</tr>
</tbody>
</table>
The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s) and the possible management options.
Co-morbidities/underlying diseases or other factors that increase the complexity of the medical decision making by increasing the risk of complications, morbidity, and or mortality must be documented.

If a surgical or invasive diagnostic procedure is performed, ordered, planned or scheduled at the time of the E/M service, the type of the procedure must be documented.

The referral for, or decision to perform, a surgical or invasive diagnostic procedure on an urgent basis must be documented or implied.
<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, tinea corporis</td>
<td>• Laboratory test requiring venipuncture, chest x-rays, EKG-EEG, urinalysis, ultrasound, KOH prep</td>
<td>• Rest, gargles, elastic bandages, superficial dressings</td>
</tr>
<tr>
<td>LOW</td>
<td>• Two or more self-limited or minor problems, one stable chronic illness, e.g. well controlled hypertension or non-insulin dependent diabetes, cataract, BPH, acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain</td>
<td>• Psychological tests not under stress, e.g. pulmonary function tests, non-cardiovascular imaging studies with contrast, e.g. barium enema, superficial needle biopsies, clinical laboratory tests requiring arterial puncture, skin biopsies</td>
<td>• Over the counter drugs, minor surgery with no identified risk factors, physical therapy, occupational therapy, IV fluids without additives</td>
</tr>
<tr>
<td>MODERATE</td>
<td>• 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 diagnosis, e.g. lump in breast, acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis, acute complicated injury, e.g. head injury with brief loss of consciousness</td>
<td>• Psychologic tests under stress, e.g. 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, e.g. arteriogram, cardiac cath, obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis</td>
<td>• 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</td>
</tr>
<tr>
<td>HIGH</td>
<td>• One or more chronic illness with severe exacerbation, progression, or side effects of treatment, 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, peritonitis, acute renal failure, an abrupt change in neurologic status, e.g. seizure, TIA, weakness, or sensory loss</td>
<td>• Cardiovascular imaging studies with contrast with identified risk factors, cardiac electrophysiological tests, diagnostic endoscopies with identified risk factors, discography</td>
<td>• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors, emergency major surgery (open, percutaneous or endoscopic), parental controlled substances, drug therapy requiring intensive monitoring for toxicity, decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
High Risk Medication

- Drugs that have a narrow therapeutic window and a low therapeutic index may exhibit toxicity at concentrations close to the upper limit of the therapeutic range and may require intensive clinical monitoring.

- Administration of cytotoxic chemotherapy is always considered high risk under management options when monitoring of blood cell counts is used as a surrogate for toxicity.

- The table on the next slide lists examples of drugs that may need to have drug levels monitored for toxicity. This is not an all exclusive list.

- On medical review, to consider therapy with one of these drugs as a high risk management option, we would expect to see documentation in the medical record of drug levels obtained at appropriate intervals.
### Table of Risk

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Drugs in that Category</th>
<th>Treatment Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac drugs</td>
<td>Digoxin, digitoxin, quinidine, procainamide, amiodarone</td>
<td>Congestive heart failure, angina, arrhythmias</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Aminoglycosides (gentamicin, tobramycin, amikacin) Vancomycin, Chloramphenicol, cubicin, zyvox</td>
<td>Infections with bacteria that are resistant to less toxic antibiotics</td>
</tr>
<tr>
<td>Antiepileptics</td>
<td>Phenobarbital, phenytoin, valproic acid, carbamazepine, ethosuximide, sometimes gabapentin, lamotrigine</td>
<td>Epilepsy, prevention of seizures, sometimes to stabilize moods</td>
</tr>
<tr>
<td>Bronchodilators</td>
<td>Theophylline, caffeine</td>
<td>Asthma, Chronic obstructive pulmonary disorder (COPD), neonatal apnea</td>
</tr>
<tr>
<td>Immunosuppressants</td>
<td>Cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil, azathioprine</td>
<td>Prevent rejection of transplanted organs, autoimmune disorders</td>
</tr>
<tr>
<td>Anti-cancer drugs</td>
<td>All cytotoxic agents</td>
<td>Multiple malignancies</td>
</tr>
<tr>
<td>Psychiatric drugs</td>
<td>Lithium, valproic acid, some antidepressants (imipramine, amitriptyline, nortriptyline, doxepin, desipramine)</td>
<td>Bipolar disorder (manic depression), depression</td>
</tr>
<tr>
<td>Protease inhibitors</td>
<td>Indinavir, ritonavir, lopinavir, saquinavir, atazanavir, nelfinavir</td>
<td>HIV/AIDS</td>
</tr>
</tbody>
</table>
Results for MDM

You must have 2 of 3 components in the same column. You may go lower than your highest selected if you don’t have 2 in the same category.

<table>
<thead>
<tr>
<th>Final Result for Complexity</th>
<th>2 of 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Number diagnoses or management options</td>
<td>≤ 1</td>
</tr>
<tr>
<td>B Amount and complexity of data</td>
<td>≤ 1 Minimal or low</td>
</tr>
<tr>
<td>C Highest risk</td>
<td>Minimal</td>
</tr>
<tr>
<td>Type of decision making</td>
<td>STRAIGHT FORWARD</td>
</tr>
</tbody>
</table>

Example: If you have 3 pts in diagnoses and management options, but only low in the level of risk, you must choose the low as your MDM.
Decision Making Tips

Remember that decision-making is only one element in determining the level of service.

A high level of decision making does not automatically qualify for a higher level code.
This is an example of an established patient in the office.
Other E&M Services

There are other E&M services that are provided to a patient, they may include the following:

- Discharging a patient from an inpatient setting
- Critical Care coding
- Observation Admission and Discharge
- Yearly nursing home assessments
- ER visits

*Check the CPT book for specific code set instruction.*
Discharging a Patient

• When discharging a patient from an inpatient setting you may bill the following CPT code:
  99238 (<30m)-99239 (>30m)

• The physician must personally document that the patient is to be discharged

• CPT code 99217 is used for all hospital observation discharges

• If over 30 minutes time is spent in discharge management, the time must be clearly documented by the attending
• Critical care time must be clearly documented by the attending physician

• The attending may not use time spent teaching, or the resident’s time in his total

• The medical necessity of the critical care service must be clearly documented

• Clearly document the critical system that you are responsible for and are taking care of
Quick E&M Coding

The following slides are just a quick reference to the most used E&M codes. They are used to serve as a guide in selecting the correct level of service.

These slides are not all inclusive.
You should refer to the CPT book for specific guidelines.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>History</th>
<th>Exam</th>
<th>Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Straight-Forward</td>
<td><strong>History</strong>: Chief Complaint &amp; HPI 4 elements</td>
<td><strong>Exam</strong>: Limited exam of affected body area or organ system</td>
<td><strong>Medical Decision Making</strong>: Diagnosis, Management options minimal amount of complexity, straight-forward</td>
</tr>
<tr>
<td>99202</td>
<td>Low</td>
<td><strong>History</strong>: Chief Complaint, HPI 4 elements and 2-9 ROS</td>
<td><strong>Exam</strong>: 2-4 body areas Limited exam of affected body area and other related system</td>
<td><strong>Medical Decision Making</strong>: Diagnosis, Management options minimal amount of complexity, straight-forward</td>
</tr>
<tr>
<td>99203</td>
<td>Extended</td>
<td><strong>History</strong>: Chief Complaint, HPI 4 elements and 2-9 ROS,1 PFSH</td>
<td><strong>Exam</strong>: 5-7 body areas Limited exam of affected body area and other related system</td>
<td><strong>Medical Decision Making</strong>: Diagnosis/management options limited amount/complexity low decision making</td>
</tr>
<tr>
<td>99204</td>
<td>Moderate</td>
<td><strong>History</strong>: Chief Complaint, HPI 4 elements and 10 ROS or more, 2 or 3 PFSH</td>
<td><strong>Exam</strong>: 8 or more systems</td>
<td><strong>Medical Decision Making</strong>: Diagnosis/management options multiple, moderate complexity and moderate risk</td>
</tr>
<tr>
<td>99205</td>
<td>High</td>
<td><strong>History</strong>: Chief Complaint, HPI 4 elements and 10 ROS or more, 2 or 3 PFSH</td>
<td><strong>Exam</strong>: 8 or more systems</td>
<td><strong>Medical Decision Making</strong>: Diagnosis/management options extensive amount/high &amp; high risk</td>
</tr>
<tr>
<td>Code</td>
<td>Category</td>
<td>History, Exam and Medical Decision Making</td>
<td>Notes</td>
<td></td>
</tr>
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</tr>
<tr>
<td>99211</td>
<td>Straight-Forward</td>
<td>No key elements required. Problem severity does not require physician presence, service is provided under physician’s supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td>Low</td>
<td>Chief Complaint, 1-2 HPI elements, Brief exam of affected body area, Diagnosis, Management options minimal amount of complexity, straight-forward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>Extended</td>
<td>Chief Complaint, HPI 1-3 elements and 1 ROS, 2-4 body areas Limited exam of affected body area and other related system, Diagnosis/management options limited amount/complexity low decision making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td>Moderate</td>
<td>Chief Complaint, HPI 4 elements and 2-9 ROS, 5-7 body areas, Diagnosis/management options multiple, moderate complexity and moderate risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td>High</td>
<td>Chief Complaint, HPI 4 elements and 10 ROS or more, 2 or 3 PFSH, &amp; 3 Past Medical history/Family history areas, Diagnosis/management options extensive amount/high &amp; high risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>History:</td>
<td>Exam:</td>
<td>Medical Decision Making:</td>
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<tr>
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<tr>
<td>99221</td>
<td>Straight-Forward</td>
<td>Chief Complaint, HPI 4 elements and 2-9 ROS, 1 PFSH</td>
<td>5-7 body areas Limited exam of affected body area and other related system</td>
<td>Diagnosis/management options limited amount/complexity low decision making</td>
</tr>
<tr>
<td>99222</td>
<td>Moderate</td>
<td>Chief Complaint, HPI 4 elements and 10 ROS or more, 2 or 3 PFSH</td>
<td>8 or more body areas</td>
<td>Diagnosis/management options limited amount/complexity moderate and moderate risk</td>
</tr>
<tr>
<td>99223</td>
<td>Extended</td>
<td>Chief Complaint, HPI 4 elements and 10 ROS or more, 2 or 3 PFSH</td>
<td>8 or more body areas</td>
<td>Diagnosis/management options limited amount/complexity high, high decision making, high risk</td>
</tr>
</tbody>
</table>
## Hospital Observation Admission Coding Guide (3 of 3 required)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>History: Chief Complaint, HPI 4 elements and 2-9 ROS, 1 PFSH</th>
<th>Exam: 2-7 body areas Limited exam of affected body area and other related system</th>
<th>Medical Decision Making: Diagnosis/management options limited amount/complexity low decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99218</td>
<td>Straight-Forward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99219</td>
<td>Moderate</td>
<td>History: Chief Complaint, HPI 4 elements and 10 ROS or more, 2 or 3 PFSH</td>
<td>Exam: 8 or more body areas</td>
<td>Medical Decision Making: Diagnosis/management options limited amount/complexity moderate and moderate risk</td>
</tr>
<tr>
<td>99220</td>
<td>Extended</td>
<td>History: Chief Complaint, HPI 4 elements and 10 ROS or more, 2 or 3 PFSH</td>
<td>Exam: 8 or more body areas</td>
<td>Medical Decision Making: Diagnosis/management options limited amount/complexity high, high decision making, high risk</td>
</tr>
</tbody>
</table>
Sources

- “Principles of CPT® Coding” 6th Edition published by the AMA
- “CPT 2010” Professional Edition published by the AMA
- Palmetto GBA at www.palmettogba.com
- www.AMA.com
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