

E/M CODING AND THE DOCUMENTATION GUIDELINES:

Putting It All Together

IT'S TIME TO TEST
YOUR E/M CODING SKILLS.

Last year *FPM* published a series of articles about the “Documentation Guidelines for Evaluation and Management (E/M) Services,” Medicare’s attempt to produce a standard, detailed description of the requirements for coding level 1 through level 5 office visits, which are now at the center of almost all payers’ auditing and compliance initiatives. The *FPM* articles (listed on page 38) reviewed the guidelines for history, exam and medical decision making and how to use them appropriately. This article provides an opportunity to test your coding acumen by applying what you’ve learned to two notes, written by family physicians, that represent some of the most common presenting problems in family medicine. This article also includes the documentation guidelines “at a glance” (page 36) and tips to help you more quickly distinguish between level 3 and level 4 visits, which account for so many of the services that family physicians provide (page 35).

CC: Routine follow-up of diabetes and hypertension (established patient)

S: Patient is a 56-year-old female who comes in for follow-up of her type II diabetes mellitus and hypertension. She denies any low blood sugar reactions. Her last A1C was 6.0 percent. She has had a recent eye exam that was normal. She checks her blood pressure (BP) at home once a week and reports that the systolic runs from 130 to 135 mmHg and the diastolic runs from 80 to 85 mmHg. She continues on metformin 500 mg bid, atenolol 50mg qd and baby aspirin qd. She states she is doing well, stays active and continues to work as an administrative assistant.

O: BP 130/80 mmHg. Weight 115 pounds. Chest clear. Cardiac exam reveals regular rate and rhythm without murmurs, gallops or rubs. Extremities have no cyanosis, clubbing or edema.

A/P: 1. Diabetes under excellent control. Continue current regimen. Will check A1C and lipid panel when patient comes back for follow-up. 2. Hypertension under



good control. Continue current regimen. 3. Return visit in four to six months.

Stop and think: How would you code this visit?

Discussion. The history involves three components, all of which must be satisfied to determine the level of history overall. Let’s start with the history of the present illness (HPI). The 1997 version of the documentation guidelines specifies eight elements that relate primarily to acute problems (location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms OR status of chronic diseases). A brief HPI includes documentation of one to three of these elements and is consistent with E/M codes 99212 and 99213. Since this is a follow-up visit for well-controlled chronic conditions, the HPI doesn’t meet the level of an extended HPI, which requires documentation of four or more of the elements or the status of three or more chronic diseases. The brief HPI limits the history to problem focused (99212) or expanded problem focused (99213). The review of systems (ROS) is the next component to consider and will influence whether the history meets the requirements for 99212

or 99213. Code 99213 requires a problem-pertinent ROS, meaning that only a review of the system directly related to the problem(s) found in the HPI must be documented. In this case, the note addresses blood sugar reactions (endocrine system) and blood pressure readings (cardiovascular system) at home. The note also comments on the patient's recent eye exam, so it can be assumed the physician asked about eye symptoms related to diabetes and hypertension. Some may consider the comments on the patient's well-being ("doing well," "stays active") as review of the constitutional system. Although the review of three or four systems meets the requirements for an extended ROS (2-9 systems), the brief HPI limits the history to expanded problem focused, a level 3 history.

The last history component is the past, family, and social history (PFSH). The patient's current medications (past history) and occupational status (social history) were reviewed. Although these are clinically important, they do not influence the code selection since 99213 does not require documentation of the PFSH.

Next, let's look at the exam. The 1997 version of the documentation guidelines has been adopted by many family physicians and is the basis for templates in most electronic health record systems (EHRs). We'll look at the 1997 multisystem exam for our review. The Centers for Medicare & Medicaid Services has stated that physicians may use the 1995 version of the guidelines if they prefer. Some payers may permit combining the two versions, for instance by adopting the 1997 guidelines for history, which expanded the definition of an extended HPI to include the review of three or more chronic diseases, with the 1995 guidelines for exam, which depend only on the number of organ systems examined and documented and don't define the content of any exam.

The first exam elements noted are blood pressure and weight. Under the 1997 guidelines, at least three vital signs must be docu-

mented to satisfy the requirements for the "Constitutional" exam element. Therefore, while clinically pertinent, the documentation of blood pressure and weight doesn't contribute to the level of the exam. The addition of temperature or pulse rate would have enabled us to consider vital signs for coding purposes.

The note then states "chest clear," which equates to documenting "auscultation of lungs" (one respiratory element). The exam also includes "auscultation of heart" and "examination of extremities for edema and/or varicosities" (two cardiac elements). With three elements documented, the exam is problem focused, which limits the visit code to 99212. To meet the level of exam for code 99213, a minimum of six exam elements (an expanded problem-focused exam) must be documented.

In this example, *medical decision making* will be the determining factor for the level of E/M coding. The decision making elements are the number of diagnosis or management options, the amount and complexity of data reviewed, and the risk of complications, morbidity and mortality. This patient presents with two problems (limited diagnosis/management options), and the physician plans to review two tests (limited data). Prescription medications are involved in the patient's care, which equates to moderate risk despite no changes being made. Although moderate risk is associated with moderate complexity decision making, the diagnosis/management options and data substantiate low complexity decision making. Because two of three components must be met and neither the diagnosis and management options nor the data scores rise to the level of moderate complexity decision making, the documentation supports low complexity decision making.

Putting it all together. Established patient encounters are selected based on two of the three key components (history, exam and medical decision making). In this case, the history and decision making components satisfied the requirements for code 99213.

CC: Shortness of breath (established patient)

S: Patient is a 48-year-old male who presents with a four-week history of intermittent short-

■ To test your coding acumen, try coding the two notes in this article before reading the analysis.

■ The 1997 version of the E/M documentation guidelines is more commonly used than the 1995 version.

■ Some payers allow physicians to combine the two versions of the guidelines.

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THE DIFFERENCE BETWEEN 99213 AND 99214: LESS THAN YOU THINK?

Key components (2 of 3 required, plus medical necessity)	99213	99214	Difference
History	<ul style="list-style-type: none"> • 1 to 3 HPI elements • review of affected system 	<ul style="list-style-type: none"> • 4+ HPI elements (or status of 3 or more chronic diseases) • review of 2 to 9 systems • 1 PFSH element 	<ul style="list-style-type: none"> • 1 HPI element • review of 1 system • 1 PFSH element
Exam	<ul style="list-style-type: none"> • 6 to 11 exam elements 	<ul style="list-style-type: none"> • 12+ exam elements 	<ul style="list-style-type: none"> • 1 exam element
Medical decision making	<ul style="list-style-type: none"> • low risk (e.g., OTC meds) • limited diagnoses or management options 	<ul style="list-style-type: none"> • moderate risk (e.g., prescription meds) • multiple diagnoses or management options 	<ul style="list-style-type: none"> • 1 prescription • 1 established problem that is uncontrolled or 1 undiagnosed problem

ness of breath that has been occurring more frequently over the last week or so. He primarily gets the symptoms at night when he lies down. He states that he has to gasp for breath, but after sitting up for awhile the symptoms usually subside. He is then able to go to sleep without difficulty. He does not get the symptoms during the day, and it is not related to exertion.

He denies cough, nasal congestion, chest pain, abdominal pain and anxiety. He reports frequent eructation and burning. He reports his weight has increased 10 pounds over the last six months. He admits to eating a bedtime snack every night and also drinks large amounts of caffeine, citrus juices and tomato-based products. He had uncomplicated arthroscopic knee surgery five weeks ago and has been taking ibuprofen 800 mg tid until last week when he cut back to 600 mg bid. He has been taking an aspirin a day. He is on no other medications. He does not smoke or use alcohol.

O: BP 120/80 mmHg. Pulse 88. Weight 265 pounds. Patient is well developed and well nourished. Mood and affect are appropriate. Pupils equally round and reactive to light. Pharynx without redness. Thyroid not palpable. Chest clear. Cardiac: normal S1 S2, no murmurs or gallops. Abdomen soft, with mild epigastric tenderness. Liver/spleen not palpable. Active bowel sounds. Skin warm and dry. Extremities without edema or redness. Pedal pulses 2+ bilaterally. ECG: normal sinus rhythm, no acute ST-T wave changes. O2 saturation 98-99%. CXR revealed no abnormalities.

A/P: Probable gastroesophageal reflux disease. Stop all NSAIDs. Tylenol as needed for knee pain. Limit night-time snacks and

avoid acid-producing foods. Prilosec OTC 20 mg qd for two weeks. Return to office in two weeks or sooner if no resolution of symptoms. Await formal CXR interpretation.

Stop and think: How would you code this visit?

Discussion. The history includes notations on duration, timing, context, modifying factors and associated signs and symptoms of the present illness. This equates to an extended HPI (four or more elements). The ROS is extended (2-9 systems required), as it includes a review of the respiratory, ENT, cardiovascular, gastrointestinal, psychiatric and constitutional systems. Finally, the note also includes documentation of the past history (surgery and medications) and social history (alcohol/tobacco use). Each of these three areas (HPI, ROS and PFSH) meets the requirements for a detailed history associated with code 99214.

Again, we'll use the 1997 guidelines and the general multisystem exam to evaluate the exam documentation. Three vital signs are noted (one element) as are the general appearance of the patient (one element), eyes (one element), pharynx (one element), examination of the thyroid (one element) and auscultation of lungs (one element). The cardiac exam consists of auscultation, examination of extremities and pedal pulses (three elements). The abdominal exam includes palpation and notation of liver and spleen (two elements). There is a notation of bowel sounds, but this is not included as an exam element in the guidelines. There is also a comment regarding inspection of the skin (one element) and mood and affect (one element). Adding up all these elements results in an examination that

Being familiar with the difference between 99213 and 99214 requirements is important.

The summary (above) of the differences between the two codes can be useful.

NEW PATIENT

Code	History	Exam	Decision Making	Time
99201	PF	PF	S	10 min.
99202	EPF	EPF	S	20 min.
99203	D	D	LC	30 min.
99204	C	C	MC	45 min.
99205	C	C	HC	60 min.
3 of 3 required				

ESTABLISHED PATIENT

Code	History	Exam	Decision Making	Time
99211	—	—	—	5 min.
99212	PF	PF	S	10 min.
99213	EPF	EPF	LC	15 min.
99214	D	D	MC	25 min.
99215	C	C	HC	40 min.
2 of 3 required				

History

	HPI elements	ROS systems	PFSH elements
PF	1-3	—	—
EPF		1	—
D	> 3 (OR 3 or more	2-9	1
C	chronic diseases)	> 9	2 (estab.) 3 (new)
3 of 3 required			

HPI: Location, Quality, Severity, Duration, Timing, Context, Modifying factors, Associated signs and symptoms OR Status of chronic diseases

ROS: Constitutional, Eyes, ENT/mouth, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin/breasts, Neurologic, Psychiatric, Endocrine, Hematologic/lymphatic, Allergic/immuno

PFSH: Past, Family, Social history

KEY TO ABBREVIATIONS

- | | |
|--------------------------------------------|----------------------------------------------|
| ASSMT: Assessment | LC: Low complexity |
| C: Comprehensive | MC: Moderate complexity |
| D: Detailed | PALP: Palpation |
| EPF: Expanded problem-focused | PF: Problem-focused |
| EX: Examination | PFSH: Past, family and social history |
| HC: High complexity | ROS: Review of systems |
| HPI: History of the present illness | S: Straightforward |
| INSP: Inspection | |

Exam

	Systems/Areas	Bulleted elements
PF	1+	1-5
EPF	1+	6-11
D	2+	12+
C	9+	18+

Note: For the comprehensive exam, all bulleted elements in the 9+ systems/areas examined must be performed.

General Multisystem Exam

CONSTITUTIONAL

- Any three vital signs
- General appearance of patient

EYES

- INSP of conjunctivae & lids
- EX of pupils & irises
- Ophthalmoscopic EX of optic discs & posterior segments

EARS, NOSE, MOUTH & THROAT

- External INSP of ears & nose
- Otoscope EX of external auditory canals & tympanic membranes
- ASSMT of hearing
- INSP of nasal mucosa, septum & turbinates
- INSP of lips, teeth & gums
- EX of oropharynx: oral mucosa, salivary glands, hard & soft palates, tongue, tonsils & posterior pharynx

NECK

- EX of neck
- EX of thyroid

RESPIRATORY

- ASSMT of respiratory effort
- Percussion of chest
- PALP of chest
- Auscultation of lungs

CARDIOVASCULAR

- PALP of heart
- Auscultation of heart with notation of abnormal sounds & murmurs

EX of:

- Carotid arteries
- Abdominal aorta
- Femoral arteries
- Pedal pulses
- Extremities for edema &/or varicosities

CHEST (BREASTS)

- INSP of breasts
- PALP of breasts & axillae

GASTROINTESTINAL (ABDOMEN)

- EX of abdomen with notation of presence of masses or tenderness
- EX of liver & spleen

- EX for presence or absence of hernia
- EX of anus, perineum & rectum, including sphincter tone, presence of hemorrhoids & rectal masses
- Obtain stool sample for occult blood test when indicated

GENITOURINARY

Male:

- EX of the scrotal contents
- EX of the penis
- Digital rectal EX of prostate gland

GENITOURINARY

Female:

Pelvic EX, including:

- External genitalia & vagina
- Urethra (masses, tenderness, scarring)
- Bladder
- Cervix
- Uterus
- Adnexa/parametria

LYMPHATIC

PALP of lymph nodes in two or more areas:

- Neck
- Axillae
- Groin
- Other

MUSCULOSKELETAL

- EX of gait & station
 - INSP &/or PALP of digits & nails
- EX of joint(s), bone(s) & muscle(s) of one or more of the following six areas:
- 1) head & neck; 2) spine, ribs & pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; & 6) left lower extremity. The EX of a given area includes:
 - INSP &/or PALP with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
 - ASSMT of range of motion with notation of any pain, crepitation or contracture
 - ASSMT of stability with notation of any dislocation, subluxation or laxity
 - ASSMT of muscle strength & tone with notation of any atrophy or abnormal movements

SKIN

- INSP of skin & subcutaneous tissue
- PALP of skin & subcutaneous tissue

NEUROLOGIC

- Test cranial nerves with notation of any deficits
- EX of deep tendon reflexes with notation of pathological reflexes
- EX of sensation

PSYCHIATRIC

- Description of patient's judgment & insight
- Brief ASSMT of mental status, including:
- Orientation to time, place & person
 - Recent & remote memory
 - Mood & affect

Decision making

	Dx/Mx options score	Data score	Risk
S	1 (minimal)	1 (minimal/none)	Minimal
LC	2 (limited)	2 (limited)	Low
MC	3 (multiple)	3 (moderate)	Moderate
HC	4 (extensive)	4 (extensive)	High
2 of 3 required			

Quantifying risk of complications, morbidity, mortality

Risk Level	Examples
Minimal	<p>Problems: One self-limited/minor problem</p> <p>Dx procedures: Venipuncture, CXR, EKG, UA, US, echo, KOH prep</p> <p>Mx options: Rest, gargles, elastic bandages, superficial dressings</p>
Low	<p>Problems: >1 self-limited/minor problem, one stable chronic illness, acute uncomplicated illness/injury</p> <p>Dx procedures: Pulmonary function tests, barium enema, superficial needle biopsy, arterial puncture, skin biopsy</p> <p>Mx options: OTC drugs, minor surgery (no risk factors), PT, OT, IV fluids w/o additives</p>
Moderate	<p>Problems: 1+ chronic illnesses w/ mild Rx side effects; >1 stable chronic illness; new problem, no Dx, (e.g., breast lump); acute illness w/ systemic Sx (e.g., pyelonephritis); acute complicated injury (e.g., head injury w/ brief loss of consciousness)</p> <p>Dx procedures: Cardiac stress test, fetal contraction stress test, Dx endoscopy w/ no risk factors, deep needle or incisional biopsy, arteriogram, lumbar puncture, thoracentesis</p> <p>Mx options: Minor surgery w/ risk factors, Rx drugs, IV fluids w/ additives, closed Mx of fracture/dislocation w/o manipulation</p>
High	<p>Problems: 1+ chronic illnesses w/ severe Rx side effects; potentially life-threatening problems (e.g., acute MI, progressive severe RA, potential threat of suicide); abrupt neuro. change (e.g., seizure, TIA, weakness or sensory loss)</p> <p>Dx procedures: Dx endoscopy w/ risk factors</p> <p>Mx options: Parenteral controlled substances, Rx needing intensive monitoring for toxicity, DNR decision</p>

Note: For a more complete table of risks, see Medicare's "Documentation Guidelines for Evaluation and Management Services" at <http://go.cms.gov/p1QFP5>.

would be considered detailed (12+ elements) and satisfies the requirement for code 99214.

Putting it all together. Since only two of the three key components must be met to determine the code for this established patient encounter, the requirements for 99214 are satisfied based on the history and examination. However, medical necessity (as reflected in the medical decision making) always should be considered. According to the *Medicare Claims Processing Manual*, medical necessity is the “overarching criterion for payment in addition to the individual requirements of a CPT code.”

Although this patient presents with a single complaint and a differential diagnosis is not explicitly noted, several diagnosis and management options were considered. Some potential diagnoses can be assumed based on the tests ordered (chest X-ray for respiratory and ECG for cardiac). Others might be suggested by the history or derived from experience. For example, in addition to a GI condition, an anxiety or thyroid disorder might also be included in the differential for this patient. This would result in multiple diagnosis/management options. Several diagnostic tests were performed and reviewed (ECG, O2 saturation and chest X-ray) with plans to review a final chest X-ray report (extensive data). Finally, the level of risk may be evaluated based on the fact that over-the-counter medications were prescribed and the patient presented with an acute illness with systemic symptoms that would need to be reassessed within a few weeks (low risk). This combination of components would lead most reviewers to consider the decision making for this encounter to be of moderate complexity. This supposition further supports reporting code 99214 for this encounter.

Once you're familiar with the guidelines, a brief summary like the one on the previous pages can be a good quick reference.

Documentation that would support 99214 for an established patient may support only 99203 for a new patient.

The right clinical templates, history forms and coding tools can ease your coding burden considerably.

RECENT *FPM* ARTICLES ABOUT THE E/M DOCUMENTATION GUIDELINES

These and other articles about E/M documentation from the *FPM* archives can be accessed online at <http://www.aafp.org/fpm/medicare>.

“Documenting History in Compliance With Medicare’s Guidelines.” Moore KJ. March/April 2010:22-27.

“Exam Documentation: Charting Within the Guidelines.” Moore KJ. May/June 2010:24-29.

“Thinking on Paper: Documenting Decision Making.” Edsall RL, Moore KJ. July/August 2010:10-15.

What about new patient encounters?

Levels of service for new patient encounters must meet or exceed the established patient requirements for all three key components. Generally this results in a lower level of service for new patients as compared to established patients even when the documentation is nearly identical. For illustration, imagine the patient in the previous case was new rather than established. The documentation would support coding 99203 for the encounter.

To report code 99204, a comprehensive history and exam must be documented and decision making must be of moderate complexity. For this encounter, the ROS must cover at least 10 systems and a notation about family history must be added. A comprehensive multisystem exam (1997 guidelines) requires documentation of at least two specific elements from each of nine body areas and/or organ systems, and the requirement is not satisfied by this note. By the 1995 guidelines, a comprehensive exam requires that eight or more organ systems be evaluated, which this documentation supports. However, because a comprehensive history was not documented, 99203 is the correct code.

Making it work

It’s one thing to audit a clinical note in the quiet of your living room and quite another to choose a level of service during a busy afternoon in the clinic. Using clinical templates, history forms for new patients and coding tools can ease the process of effectively coding and documenting your patient encounters. (The *FPM* Toolbox, at <http://www.aafp.org/fpmttoolbox>, includes many such resources.)

Many EHRs offer coding suggestions for E/M services. Although this can be a useful tool for checking coding, it should not substitute for the physician’s code selection. Depending on the logic built into the EHR, these suggestions may be higher or lower than the encounter warrants.

For most family physicians, simply being familiar with the differences between level 3 and level 4 services will enable you to solve the majority of your daily coding dilemmas. The key is to document carefully and code for what you document. Good luck. 

Send comments to fpmedit@aaafp.org.