{ Start from the presenting problem to get to the right code faster. }

Coding FROM THE

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Evaluation and management (E/M) coding isn't hard; it just seems that way. It seems hard because it's typically taught "from the top down" – with all the bits and pieces of history, then all the exam bullet points, and then all the elements of decision making. This approach tends to involve convoluted lists of requirements for all the different levels of all three areas. The complexity of this approach is one of the reasons physicians may not be coding properly, both because it leads to confusion and because that confusion increases our fear of audit, often resulting in our coding at a level lower than appropriate.

The problem may arise from the mistaken assumption that a SOAP note represents the elements of a typical visit in chronological order and that the *Documentation Guidelines for Evaluation and Management Services* follow that order: Subjective = history, Objective = exam and Assessment and Plan = decision making. In fact, however, decision making is going on throughout the visit. It starts with the chief complaint, the nurse's notes and your impression of the patient the moment you enter the room, and it permeates and shapes the visit, guiding the history, the exam and any further evaluation that's warranted.

In an attempt to simplify the coding process and increase coding accuracy, we suggest evaluating the note in a new way, starting from the "bottom," with medical decision making. More specifically, we recommend that you start with the presenting problem, which is relegated to the decision making section at the end of the guidelines even though it's the logical beginning of the visit.

Let the presenting problem guide a tentative code selection; if the history and physical support that code, make that the code for the visit. It may seem risky to ignore the rest of what the guidelines have to say about decision making, but we would argue that it is not. The presenting problem, after all, is what the whole visit responds to, and there's naturally a strong correlation between the nature of your patient's problem and the way you deal with that problem. Assuming that you document the visit properly, there's a similarly strong correlation between the problem and the note and between the problem and the code. Although the presenting problem alone cannot substantiate a coding level, it leads you to an evaluation and plan that typically meet the rest of the requirements for the code without difficulty.

If you are dubious about the correlation between presenting problem and code, try reviewing the coding for several of your recent visit notes to see how well the correlation holds in your practice. First, evaluate your note against the documentation guidelines or a coding reference to determine the proper code. [One coding reference, the *FPM* "Pocket Guide to the 1997 E/M Documentation Guidelines," was mailed with the print version of this issue in the same plastic wrapper.] Second, code the same note again, using just the presenting problem or problems and the approach outlined in this article. We think you'll find a close relationship.

Seeing the bottom-up approach in action

Take a look at "From the presenting problem to the code" on page 24. The tables show how the requirements for 99213-99215 and 99203-99205 look if you start from the presenting problem, assume that the other decision-making requirements are met and work toward the exam

and history. As an example of how the model can be implemented, consider the following vignette:

You see a 22-year-old man, an established patient, who complains of new-onset, acute low-back pain. Since this is a new problem of uncertain diagnosis, you can infer a moderate complexity of decision making, and the visit can be coded 99214, assuming that your documented history and exam are commensurate with the problem. The chief complaint of back pain often necessitates a review of multiple elements of the history as well as a multisystem review and detailed physical. In other words, a "99214-level problem" is likely to require a 99214-level workup, and the final code is likely to be 99214.

Using the 99215 visit as a base, it is easy to remember the other five most frequently used E/M codes.

Level V. The presenting problems characteristic of a 99215 are one or more chronic illnesses with *severe* exacerbation or a *severe* side effect of treatment, an illness posing a threat to life or function, or an abrupt neurological status change such as a TIA or seizure. To substantiate this level of coding with the history and physical, *either* of the following is sufficient:

- A history that includes at least four elements of the history of present illness, or HPI (location, quality, severity, duration, timing, context, modifying factors and associated symptoms), at least one item each from the past history, family history and social history (PFSH) and at least a 10-system review of systems (ROS).
- A comprehensive exam – either a general multisystem exam or a complete single-organ-system exam.

For a 99205 code, the characteristic problem is the same as for a 99215, but *both* the above history and physical exam components are needed.

Level IV. For a 99214 visit, the presenting problem will involve one chronic illness with exacerbation, two or more stable chronic illnesses, a new problem with an uncertain diagnosis (e.g., breast lump or back pain), an acute illness with systemic symptoms or an acute complicated injury. To substantiate this level of coding, *either* of the following is sufficient:

- A history that includes at least four HPI elements; at least one item from either the past medical history (a medication list or allergy list qualifies), social history *or* family history; and at least a two-system ROS.
- An exam of the affected area and related organ systems.

(As you can see, a large percentage of patients seen by family physicians qualify for the 99214 level of service.)

For a 99204 visit, the medical-decision-making criteria are the same as for a 99214, while the history and physical criteria are the same as for a 99215. *Both* the history and physical are required.

Level III. The presenting problem characteristic of a 99213 visit consists of one stable chronic illness, two or more self-limited illnesses or an acute uncomplicated illness. Substantiation of this level of coding requires *either* of the following:

- A history that includes at least one HPI element and a review of systems pertinent to the problem.
- An expanded problem-focused physical exam.

For a 99203 visit, the medical decision making is the same as for a 99213, but *both* the history and physical components of the 99203 must have the elements of a 99214.

Noting the patterns in the coding table can help you remember its structure:

- The 9921x series requires history *or* exam.
- The 9920x series requires history *and* exam.
- Requirements for 99205 are the same as for 99215 except that all three elements are needed.
- 99204 combines the presenting problem (and decision making) of 99214 with the history and physical of 99215.
- 99203 combines the presenting problem (and decision making) of 99213 with the history and physical of 99214.
- All require four HPI elements except 99213.

Coding trends

Although 99213 continues to be the most widely used code in family medicine, 99214s are becoming more common. The increase may stem from the fact that patients

Bottom Up

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FROM THE PRESENTING PROBLEM TO THE CODE

The table shows how E/M codes can be based on the presenting problem. Background colors indicate where the same requirements for decision making, history or exam are found in multiple codes, and red text is used to emphasize where a 9920x code differs from the 9921x code to its left.

99215

Decision Making (presenting problem)

- ≥ 1 Chronic illness with severe exacerbation, progression or side effects of treatment
- Acute or chronic illness/injury threatening life or function (MI, pulmonary embolism, respiratory distress)
- Abrupt neurologic status change (TIA, seizure, weakness, sensory loss)

Plus ...

History	OR	Exam
HPI: 4 elements ROS: 10 systems PFSH: 3 of 3*		Comprehensive (general multisystem or complete single organ system)

99205

Decision Making (presenting problem)

- ≥ 1 Chronic illness with severe exacerbation, progression or side effects of treatment
- Acute or chronic illness/injury threatening life or function (MI, pulmonary embolism, respiratory distress)
- Abrupt neurologic status change (TIA, seizure, weakness, sensory loss)

Plus ...

History	AND	Exam
HPI: 4 elements ROS: 10 systems PFSH: 3 of 3		Comprehensive (general multisystem or complete single organ system)

99214

Decision Making (presenting problem)

- 1 Chronic illness with exacerbation
- ≥ 2 Chronic stable illnesses
- New problem of uncertain diagnosis
- Acute illness with systemic symptoms
- Acute complicated injury

Plus ...

History	OR	Exam
HPI: 4 elements ROS: 2-9 systems PFSH: 1 of 3		Detailed (affected area and related organ system)

99204

Decision Making (presenting problem)

- 1 Chronic illness with exacerbation
- ≥ 2 Chronic stable illnesses
- New problem of uncertain diagnosis
- Acute illness with systemic symptoms
- Acute complicated injury

Plus ...

History	AND	Exam
HPI: 4 elements ROS: 10 systems PFSH: 3 of 3		Comprehensive (general multisystem or complete single organ system)

99213

Decision Making (presenting problem)

- ≥ 2 Self-limited problems
- 1 Stable chronic illness
- Acute uncomplicated illness (cystitis, sprain)

Plus ...

History	OR	Exam
HPI: 1-3 elements ROS: Pertinent		Expanded problem focused

99203

Decision Making (presenting problem)

- ≥ 2 Self-limited problems
- 1 Stable chronic illness
- Acute uncomplicated illness (cystitis, sprain)

Plus ...

History	AND	Exam
HPI: 4 elements ROS: 2-9 systems PFSH: 1 of 3		Detailed (affected area and related organ system)

* The documentation guidelines require only 2 of 3 here, but since this is the only difference between the requirements for 99215 and for a 99205, we're opting for consistency and ease of memorization.

Key: HPI: History of present illness; PFSH: Past, family and social history; ROS: Review of systems

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are coming in with more complicated problems, particularly because of the rise in elderly patients with multiple chronic diseases. It may also reflect the growing use of electronic medical record systems with coding capabilities. Whatever the cause, it seems likely that today's coding distribution better reflects the realities of practice and that family physicians have been undercoding visits. But don't just assume that your practice is part of the trend toward more accurate coding. You need to understand E/M coding inside and out. The appendix to the CPT manual provides a number of scenarios showing application of various E/M codes. Reviewing these will reinforce proper levels of coding for common types of visits.

What first attracted you to a career in medicine probably wasn't the chance to do E/M documentation and coding. But that doesn't make it less important. Better coding leads to better payment and a healthier practice. We hope our bottom-up approach helps you improve both the speed and the accuracy of your coding. FPM

Send comments to **fpmedit@aafp.org.**

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