“Simplified” E&M Coding

New						
IP: 9922x				1	2	3
OP: 9920x		1	2	3	4	5
Established (Best 2/3)						
IP: 9923x	Hist/Exam	1	2	3		
	MDM	1			2	3
OP: 9921x	Hist/Exam	2	3	4	5	
	MDM		2	3	4	5
History						
CC		Y	Y	Y	Y	Y
HPI		1	1	4	4	4
ROS			1	2	10	10
PFSH				1	3	3
Exam						
Systems		1	2	2 (detailed)	8	8
MDM (Best 2/3)						
Problem points		0	0	2	3	4
Data points		0	0	2	3	4
Risk		Min	Min	Low	Mod	High

Medical Decision Making (MDM)

Problems	Points	**Data Ordered/Reviewed**	Points
Self-limiting (max 2)	1	Labs	1
Established, improved	1	Rads	1
Established, worse	2	Invasive testing	1
New, no further eval	3	D/w provider	1
New, needs eval	4	Review images	2
Risk	Problem	Tests Ordered	Management Selected
Minimal	1 self-limited	Labs CXR US	RICE
Low	2 self-limited 1 stable chronic 1 acute uncomplicated	Simple biopsies Imaging w/ contrast Simple physio tests	OTC PT/OT Minor surgery
Moderate	1 worse chronic 2 stable chronic Acute systemic illness Acute complicated injury Undiagnosed new problem	Stress tests Simple endoscopy Complex bx CV imaging Taps	Major surgery Prescription drugs IVF w/ additives
High	1 severely worse chronic Threat to life or function Acute change in neuro status	Endoscopy w/ risk factors CV imaging w/ risk factors	Major surg w/ risk factors Emergency major surgery IV controlled substances Intensive mon for toxicity Palliative care

Instructions & Explanation

Evaluation and management services are based on time (not addressed by this document) or on the specific evaluation and management performed and documented. E&M coding is based on three components: the history, physical exam, and medical decision making (MDM). Each component itself has several sections. Abstracting a note to find the appropriate E&M CPT or HCPCS billing code requires evaluating each section for the quantity of appropriate information

The History section includes chief complaint, history of present illness, review of systems, and past medical, surgical, family, and social history. The table notes that all levels of service require a chief complaint and a number of observations in the HPI; some additionally require a number of systems reviewed and a number of components of the prior history documented. The appropriate number of items must be documented for all sections for a given column to apply; choose the right-most column that applies.

The Exam component is the simplest, and requires a given number of systems documented for the column to apply. However, the third column labeled "2 (detailed)" requires "more detail" for the systems. No, nobody seems to know what that means, but S/NT/ND probably isn't it. Choose the right-most column that applies.

The MDM component is most complex. Unlike the other two, not all criteria need to be fulfilled, but the column that includes the best 2 out of 3 sections is used. Those three sections include Problems (add up the points for each documented problem per the table), Data (add up the points for all data documented as reviewed per the table), and Risk (find the cell closest to the bottom of the table for any of the Risk columns that applies and use that Risk category). Choose the right-most column of the table which includes or is to the left of at least 2 of the section values; for instance, if a note has 1 point for Problems, 2 points for Data, and High Risk, the 3rd (middle) column applies.

Finally, note the header category number for each column chosen. Note that for "established" patients (a.k.a. "subsequent" E&M), the History & Exam values don't match up with the MDM values, and that the values aren't the same for inpatients & outpatients; be sure to choose the right row. For new patients, use the lowest number obtained; for established patients, the second lowest number (i.e., the best 2 out of 3). Prepend the first 4 digits of the CPT code as given in the first column.

Example

You're admitting a patient with a small bowel obstruction. She has abdominal pain, and you appropriately document its severity, location, timing, and provoking and palliating factors. You obtain a full past medical, surgical, family, and social history, but only document the constitutional and gastrointestinal systems on ROS. You perform a full head-to-toe physical exam that includes 8 systems. You document her normal labs, and review the CT report, including its findings in your note. You decide to admit her for nonoperative management and give her IV fentanyl for breakthrough pain.

To code, note that the History section is limited by the brief (2 systems) review of systems; choose only the third column for that. Choose the 5th column ("8") for Exam. As this is a new problem requiring further evaluation, it gets 4 points for Problems; reviewing the labs and CT report gets a total of 2 points for Data; ordering a parenteral controlled substance (IV fentanyl) places the Risk at High. This allows you to choose the 5th MDM column.

Since this is a new inpatient, we use the first row of the table; a new patient also means choosing the lowest number. Therefore, we choose the 1, and bill for 99221, then weep as you realize that if only you'd performed a complete (appropriate) review of systems you could have coded 99223.

Tips & Tricks

- Seeing a follow-up patient in the office? Any note you leave at all is billable as 99211; there are no specific requirements
- Seeing an ill patient on a subsequent day of hospitalization? They don't need an extensive note to justify an appropriate 99233 bill. The easiest to me is detailed examination of 2 systems, 4 identified stable problems, and the ongoing need for IV pain medication. Even the simplest of ICU patients (who don't require 30 minutes of critical care time) tend to apply.
- Don't forget the formal review of systems on initial evaluation. Besides increasing your billing, it's good medicine. If your patient has palpitations or unintended weight loss, shouldn't you know about it?
- Finally, while you should document everything you do to ensure it's being properly recognized, remember that your billing is designed to reflect your documentation, not the other way around. Pertinent negatives are, well, pertinent—but never include medically unnecessary information to increase your billing. Put another way, an uncomplicated URI doesn't require a GU exam just because you're trying to list 8 systems.

Disclaimer

I'm not a professional coder, it's just an interest along with my practice. Medical coding & billing is a complex topic, and this document may contain errors. Do not rely solely upon this document for legal coding & billing advice.

Version

This is version 20160906, released on that date.

Version 20160906 added the prose from the 2nd page on, and modified the table to use two rows for each of the inpatient/outpatient subsequent care headers.

An initial version was not released to the public but given in hardcopy to a few surgeons.

Contact & Source

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