Presenter

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AHIMA Certified ICD-10 Trainer

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Objective

- Understand the key components of E/M coding
- Learn to select the correct level of care
- Improve documentation compliance
- Optimize coding
- Maximize reimbursement
E/M Guidelines

• Developed by AMA and CMS
• First released in 1995
• Second set released in 1997
• Based on 3 “Key Components”
  – History
  – Physical
  – Medical Decision Making
Determining Level of Service

To determine the appropriate level of service for a patient’s visit, it is necessary to first determine whether the patient is new or already established. The physician then uses the presenting illness as a guiding factor and his or her clinical judgment about the patient’s condition to determine the extent of key elements of service to be performed.

3 Components

– History
– Physical Examination
– Medical Decision Making
E/M Coding

- E/M = Evaluation and Management
- How patient encounters are translated into 5 digit numbers to facilitate billing
- Within each type of encounter there are various levels of care

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>99211</td>
<td>$35.51</td>
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<td>$97.36</td>
</tr>
<tr>
<td>99215</td>
<td>$117.36</td>
</tr>
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</table>

50%
2012 CPT Changes - Decision Tree for New vs. Established Patients

- Received any professional service from the physician or another physician in group of same specialty within last three years?
  - Yes
    - Exact same specialty?
      - Yes
        - Exact same subspecialty?
          - Yes
            - Established
          - No
            - New patient
      - No
        - New patient
  - No
    - New patient
Statistics

New Patient Visits

Visit Count

Established Patient Visits

Visit count

E/M Service

History
- HPI
- ROS
- PFSH

Medical Decision Making
- Amt/complexity of data reviewed
  - Number of Dx/options

Examination
- Associated risks
  - 1995 Guidelines
  - 1997 Guidelines

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History

- HPI - History of Present Illness
- ROS - Review of Systems
- PFSH - Family History Social History
## History

- **CC**
- **HPI**
- **ROS**
- **PFSH**

- Problem Focused
- Expanded Problem Focused
- Detailed
- Comprehensive

<table>
<thead>
<tr>
<th>History</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>PF</td>
<td>Brief (1-3)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>EPF</td>
<td>Brief (1-3)</td>
<td>1</td>
<td>None</td>
</tr>
<tr>
<td>Detailed</td>
<td>Extended (4+ or 3 Chronic)</td>
<td>2-9</td>
<td>1 out of 3</td>
</tr>
<tr>
<td>Comp</td>
<td>Extended (4+ or 3 Chronic)</td>
<td>10</td>
<td>3 out of 3</td>
</tr>
</tbody>
</table>

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HPI

• A narrative of the patient’s symptoms or illnesses since onset or since the previous encounter.
• It is the only component of history that must be personally obtained and documented by the provider.
• Always document the chief complaint for each encounter.

• Location
• Duration
• Quality
• Modifying Factors

• Associated Signs or Symptoms
• Timing
• Context
• Severity

Coding Tip:
Example CC: It may be a symptom or it may be a statement such as “New Pt with Headache” or follow-up DM.
Patient complains of sharp frequent back pain which began 2 weeks ago while lying in bed. The pain is rated as 7 in severity, is worse when lifting up and is associated with SOB and chest pain.

Example of an extended HPI using all eight of HPI elements
The patients’ HTN and dyslipidemia remain stable on current medications. DM has been somewhat difficult to control lately with occasional sugar in the 200’s.

If there are somatic complaints, the 1997 E/M guidelines state that an extended HPI maybe completed by commenting on the status of three or more chronic conditions or inactive problems.
The ROS is an inventory of the body systems obtained through a series of questions seeking to identify signs and symptoms which the patient may be experiencing or has experienced. This information may be completed by staff, physician, or by having the patient fill out a questionnaire.

**Coding Tip:**
- CV: Negative for palpitations
- Resp: Negative for cough
- GI: Negative for diarrhea
- All other systems reviewed and are negative.
PFSH

• Past Medical
  – Previous illnesses, surgeries, immunizations, allergies, current medications

• Family History
  – Health status of parents/siblings/children, including relevant or hereditary diseases

• Social History
  – Marital status, occupation, education, sexual history, tobacco, alcohol, drug abuse

May be completed by staff or by having patient fill out questionnaire.

Coding Tip:
PFSH was obtained during visited on 01/01/xx was review and re-examined with pt today.
Physical Examination

- 1995 Documentation Guidelines for E and M Services
- 1997 Documentation Guidelines for E and M Services
## Physical Exam OP E&M

<table>
<thead>
<tr>
<th>Exam</th>
<th>1997 guidelines</th>
<th>1995 guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>PF</td>
<td>1 – 5 elements from any system</td>
<td>System of complaint</td>
</tr>
<tr>
<td>EPF</td>
<td>6 – 11 elements from any system</td>
<td>2 – 4 systems</td>
</tr>
<tr>
<td>Detailed</td>
<td>12 elements from any organ system</td>
<td>5 – 7 systems</td>
</tr>
<tr>
<td>Comp</td>
<td>2 elements from 9 organ systems</td>
<td>8+ systems (or complete exam of 1 organ system)</td>
</tr>
</tbody>
</table>

1995 Physical Exam

Body Areas
- Head/face
- Neck
- Chest/breasts/axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

Organ System
- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- GI
- GU
- Musculoskeletal
- Skin
- Neuro
- Psychiatric
- Hematologic/lymphatic

Problem Focused: a limited exam of affected body area or organ system

Expanded Problem Focused: a limited exam of the affected body area or organ system and other symptomatic or related organ systems

Detailed: an extended exam of the affected body area or organ system and other symptomatic or related organ system

Comprehensive: a general multi-system exam or complete exam of a single organ system
1997 Physical Examination
15 Organ Systems and 59 bullets

Constitutional
- Vital signs
- General appearance of patient
- Nutrition, Body habitus, Development, Deformities, Grooming

Eyes
- Inspection of conjunctivae and lids
- Exam of pupils and irises
- Ophthalmoscopic exam of optic discs

Ears, Nose, Mouth and Throat
- External inspection of ears and nose
- Otoscopic exam
- Assessment of hearing
- Inspection of nasal mucosa, septum, and turbinates
- Inspection of lips, teeth and gums
- Exam of oropharynx

Neck
- Exam of neck
- Thyroid

Respiratory
- Assessment of effort
- Percussion of chest
- Auscultation of lungs
- Palpation of chest

Cardiovascular
- Palpation of heart
- Auscultation
  - Carotid artery exam
  - Abdominal aorta exam
  - Femoral arteries exam
  - Pedal pulses exam
  - Extremities for edema or varicosities

Chest (Breasts)
- Inspection
- Palpation

Gastrointestinal
- Abdominal exam
- Liver and spleen exam
- Hernia presence or absence
- Anus, perineum, rectum exam
- Stool for occult blood
1997 Physical Examination (continuation)
15 Organ Systems and 59 bullets

Lymphatic
- Neck
- Axilla
- Groin
- Other

Musculoskeletal
- Gait and station
- Inspection, palpation digits and nails
- Exam of bones, joints, muscles and 1 or more
- Inspection or palpation
- Range of motion and presence/absence of pain
- Stability Muscle strength and ton

Neurologic
- Cranial nerves
- Deep tendon reflexes
- Sensation
- Test Coordination

Psychiatric
- Judgment and insight
- Orientation to person, time, place
- Memory, recent and remote
- Mood and affect

Genitourinary

Male
- Scrotal contents
- Penis
- Digital rectal exam of prostate gland

Female
- Pelvic examination
- External genitalia
- Urethra
- Bladder exam
- Cervix
- Uterus
- Adnexa/parametria

1997 Exam Rules
Problem Focused: 1-5 bullets from any organ systems
Expanded Problem Focused: 6 to 11 bullets from any organ system
Detailed: 12 bullets from any organ system
Comprehensive: 2 bullets from EACH of 9 organ systems (18)
Example - New Patient Level 1 99201

Patient is a 12-year-old, white male. He presents today with chief complaint of a painful right heel. He relates it has been painful now for at least several months, with increasing severity. Progressively getting worse. Particularly painful with activity.

PAST MEDICAL HISTORY: Essentially unremarkable.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: Unremarkable. He is a 12-year-old, white male.

REVIEW OF SYSTEMS: Unremarkable.

PHYSICAL EXAMINATION: Upon observation, he has good pulses and good digital hair. He has pain to palpation to the posterior plantar aspect of the right heel.

X-RAYS: X-ray evaluation reveals a flexible cavo foot deformity and open calcaneal apophysis.

A: 1. Sever's calcaneal apophysis, right.

P: Today I have recommended better support, cushioning, and accommodation. Recommended elevation, rest, and ice. Recommended some stretching exercises. Recommended the use of ice packs, with support. Recommended seeing him back in about three weeks for follow-up care.

Dictated, but not edited.

GA:bd0m  revd: 9/2/11

This visit was coded as a level 3 99203. The documentation supports a level 1 99201 because of the Exam.

Less than 6 bullets is a level 1 exam for NP

This exam covers 3 bullets
Medical Decision Making

- Problems

- Data reviewed

- Risk of complications, morbidity, and/or mortality (overall risk).
Medical Decision Making

- Problems
- Data reviewed
- Risk of complications, morbidity, and/or mortality (overall risk).

<table>
<thead>
<tr>
<th>MDM</th>
<th>Problems</th>
<th>Data</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>SF</td>
<td>1</td>
<td>1</td>
<td>Min</td>
</tr>
<tr>
<td>Low</td>
<td>2</td>
<td>2</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>3</td>
<td>Mod</td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>4</td>
<td>High</td>
</tr>
</tbody>
</table>

Need 2 out of 3 to qualify for given level of MDM
HOW IT WORKS
Use these tables to calculate your level of medical decision making. Your assessment of the problems addressed, the data reviewed, and the level of risk will determine the overall level of complexity. Remember that two of three elements are required.

### MEDICAL DECISION MAKING

<table>
<thead>
<tr>
<th>Complexity</th>
<th>Problem points</th>
<th>Data points</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal complexity</td>
<td>1</td>
<td>1</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low complexity</td>
<td>2</td>
<td>2</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate complexity</td>
<td>3</td>
<td>3</td>
<td>Moderate</td>
</tr>
<tr>
<td>High complexity</td>
<td>4</td>
<td>4</td>
<td>High</td>
</tr>
</tbody>
</table>

Note: Two of three required.

### PROBLEMS

<table>
<thead>
<tr>
<th>Problem</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (maximum of 2)</td>
<td>1</td>
</tr>
<tr>
<td>Established problem, stable or improving</td>
<td>1</td>
</tr>
<tr>
<td>Established problem, worsening</td>
<td>2</td>
</tr>
<tr>
<td>New problem, with no additional work-up planned (maximum of 1)</td>
<td>3</td>
</tr>
<tr>
<td>New problem, with additional work-up planned</td>
<td>4</td>
</tr>
</tbody>
</table>

### DATA

<table>
<thead>
<tr>
<th>Test Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review or order clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review or order radiology test (except cardiac catheterization or echo)</td>
<td>1</td>
</tr>
<tr>
<td>Review or order medicine test (PFTs, ECG, cardiac catheterization or echo)</td>
<td>1</td>
</tr>
<tr>
<td>Discuss test with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Independent review of image, tracing or specimen</td>
<td>2</td>
</tr>
<tr>
<td>Review and summation of old records</td>
<td>2</td>
</tr>
<tr>
<td>Risk</td>
<td>Presenting Problem(s)</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Minimal</td>
<td>• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>• Two or more self-limited or minor problems</td>
</tr>
<tr>
<td></td>
<td>• One stable chronic illness, e.g., well controlled HTN, DM2, cataract</td>
</tr>
<tr>
<td></td>
<td>• Acute uncomplicated injury or illness, e.g., cystitis, allergic rhinitis, sprain</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>• One or more chronic illness, with mild exacerbation, progression, or side effects of treatment</td>
</tr>
<tr>
<td></td>
<td>• Two or more stable chronic illnesses</td>
</tr>
<tr>
<td></td>
<td>• Undiagnosed new problem, with uncertain prognosis, e.g., lump in breast</td>
</tr>
<tr>
<td></td>
<td>• Acute illness, with systemic symptoms, e.g., pyelonephritis, pleuritis, colitis</td>
</tr>
<tr>
<td></td>
<td>• Acute complicated injury, e.g., head injury, with brief loss of consciousness</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>• One or more chronic illness, with severe exacerbation, progression, or side effects of treatment</td>
</tr>
<tr>
<td></td>
<td>• Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others, peritonitis, ARF</td>
</tr>
<tr>
<td></td>
<td>• An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The MDM is a Level 4

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# MDM (Choose 2 of 3 Components)

<table>
<thead>
<tr>
<th>MDM Components</th>
<th>99213 (Low)</th>
<th>99214 (Mod)</th>
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</thead>
<tbody>
<tr>
<td>#/Stability of Dx</td>
<td>2 points</td>
<td>3 points</td>
</tr>
<tr>
<td>Minor problem (max of 2) = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Established problem, stable = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Established problem, worsening = 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem, no work up = 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem, work up planned = 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complexity of Data</td>
<td>2 points</td>
<td>3 points</td>
</tr>
<tr>
<td>Review or Order Lab/Rad/Test = 1 each</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss case with other physician = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent Review of image or specimen = 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review and summary of old records = 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Table of Risk (just need 1 from this list)</td>
<td>*OTC drug</td>
<td>*Prescription drug</td>
</tr>
<tr>
<td></td>
<td>*IV fluid</td>
<td>*IV fluid with additive</td>
</tr>
<tr>
<td></td>
<td>*2 minor problems</td>
<td>*Illness with systemic symptoms (flu, pneumonia)</td>
</tr>
<tr>
<td></td>
<td>*OT/PT</td>
<td>*2 Chronic problems, stable</td>
</tr>
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</table>
Time Based Coding

- When you spend more than 50% of your face to face time with the patient counseling or coordinating care, time may be considered the key or controlling factor to qualify for a particular E/M service.

Example:
- You spend 25 minutes face to face with an established patient in the office.
- More than half that time you spend: reviewing diagnostic results or recommended tests, prognosis, risk/benefits of treatment, instructions for management or follow-up, importance of compliance, or risk factor reduction/patient education.
- You can use a Level 4 (99214) code even if you lack the history, exam, MDM elements.

- Physicians in training are NOT allowed to bill based on time alone.

- Documentation should be driven by medical necessity!
The Importance of Medical Necessity

• “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed.”
Documentation Tips

• Saves time by avoiding over-documentation

• Know the documentation required for the target code

• Plan out the key components ahead of time

• Document in purpose-driven manner
2012 CPT Changes - Initial Observation Codes

- CPT has revised the initial observation codes, 99218 – 99220 to include typical times. Previously these codes did not have typical times assigned.

- Code Typical Time
  - 99218 30 minutes
  - 99219 50 minutes
  - 99220 70 minutes

- The typical times assigned to the initial observation codes mirror the times associated with the Hospital Inpatient Services codes (codes 99221 – 99223).
# Documentation Requirements for New Patients

## History

<table>
<thead>
<tr>
<th>Type</th>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
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</thead>
<tbody>
<tr>
<td>CC</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HPI</td>
<td>1-3 elements</td>
<td>1-3 elements</td>
<td>4+ elements (or 3+ chronic diseases)</td>
<td>10+ systems</td>
<td>10+ systems</td>
</tr>
<tr>
<td>ROS</td>
<td>N/A</td>
<td>1</td>
<td>2-9 systems</td>
<td>3 elements</td>
<td>3 elements</td>
</tr>
<tr>
<td>PFSh</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
<td>3 elements</td>
<td>3 elements</td>
</tr>
</tbody>
</table>

## Examination

<table>
<thead>
<tr>
<th>Type</th>
<th>99201</th>
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<th>99203</th>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997 documentation guidelines</td>
<td>1-5 bullets</td>
<td>6-11 bullets</td>
<td>12 or more bullets</td>
<td>12 + elements</td>
<td>2 Bullets from 9 organ systems</td>
</tr>
<tr>
<td>1995 documentation guidelines</td>
<td>1 system</td>
<td>2-4 systems</td>
<td>5-7 systems</td>
<td>8+ systems</td>
<td>8+ systems</td>
</tr>
</tbody>
</table>

## Medical Decision Making

<table>
<thead>
<tr>
<th>Type</th>
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<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>

## Time

Half the total must involve counseling or coordination of care

10 minutes | 20 minutes | 30 minutes | 45 minutes | 60 minutes

Note: Three of three key components – history, exam and medical decision making – are required.

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# Documentation Requirements for Established Patient Visits

<table>
<thead>
<tr>
<th>Code</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
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<tbody>
<tr>
<td><strong>History</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CC</td>
<td>N/A</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HPI</td>
<td>N/A</td>
<td>1-3 elements</td>
<td>1-3 elements</td>
<td>4+ elements (or 3+ chronic diseases)²</td>
<td>4+ elements (or 3+ chronic diseases)²</td>
</tr>
<tr>
<td>ROS</td>
<td>N/A</td>
<td>N/A</td>
<td>Pertinent</td>
<td>2-9 systems</td>
<td>10+ systems</td>
</tr>
<tr>
<td>PFSH</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1 element</td>
<td>2 elements</td>
</tr>
<tr>
<td><strong>Examination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997 documentation guidelines</td>
<td>N/A</td>
<td>1-5 elements</td>
<td>6-11 elements</td>
<td>12 or more elements</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>1995 documentation guidelines</td>
<td>N/A</td>
<td>System of complaint</td>
<td>2-4 systems²</td>
<td>5-7 systems²</td>
<td>8+ systems</td>
</tr>
<tr>
<td><strong>Medical Decision Making</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Half the total must involve counseling or coordination of care

- 5 minutes
- 10 minutes
- 15 minutes
- 25 minutes
- 40 minutes

Note: Two of the three key components – history, exam and medical decision making – are required.
# Overview of Inpatient E/M Leveling

The codes listed in the left hand column require 3 of 3 components be met or exceeded.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type</th>
<th>History</th>
<th>Exam</th>
<th>Medical Decision-Making</th>
<th>Time Based</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PF</td>
<td>EPF</td>
<td>Detailed</td>
<td>Comp</td>
</tr>
<tr>
<td>99221</td>
<td>Initial Hospital Visit</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99222</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99223</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99218</td>
<td>Observation Services</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99219</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99220</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99234</td>
<td>Hospital Observation or Inpatient Care Services</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99235</td>
<td>(Including Same Day Admission and Discharge)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99236</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99251</td>
<td>Inpatient Consultations</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99252</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99253</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99254</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99255</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PF = Problem Focused  EPF = Expanded Problem Focused  C = Comprehensive  S = Straightforward  L = Low  M = Moderate  H = High

PRSS, Inc
Initial Hospital Visits

Codes 99221-99223 are used by the admitting physician to report initial services to hospital inpatients. These codes are often referred to as the “Admit” codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>99221-99223 + 99238-99239</th>
<th>99221-99223 + 99231-99233 + 99238-99239</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>Initial Hospital Visit + Hospital Discharge Day Management</td>
<td>Initial Hospital Visit + Subsequent Hospital Visit + Hospital Discharge Day Management</td>
</tr>
<tr>
<td>Duration of Service</td>
<td>1st calendar day - admitted + 3rd calendar day - discharged</td>
<td>1st calendar day - admitted + 2nd or subsequent calendar days + 3rd calendar day - discharged</td>
</tr>
<tr>
<td>Comments</td>
<td>Code both services</td>
<td>Code all services</td>
</tr>
</tbody>
</table>
E/M Modifiers

- Modifiers may be utilized with CPT and HCPCS codes
- Modifiers may affect payment or may simply add Information
- Evaluation and Management codes may only be modified by E/M modifiers 24, 25, & 57
Modifier 24

• Modifier 24- Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period.

• Example of correct usage:
  – Mrs. Daniels sees Dr. Smith because of a sprained wrist. Three weeks prior, Mrs. Daniels had surgery to repair a fractured leg (major procedure). Submit the visit with CPT modifier 24, indicating service is unrelated to previous diagnosis.
Modifier 25

- Modifier 25- Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of a Procedure or other Service.

Example of correct usage:
- Mr. Daniels sees Dr. Smith for diabetes and an irritated, enlarged cyst, which is examined and excised. Because the excision (minor procedure) was not planned prior to the examination, the E/M service is separately reportable with modifier 25.
Modifier -57

- **Modifier -57** The Decision for Surgery.

- Modifier 57 is a modifier that is appended to an E/M service to indicate that this was the visit at which the physician decided to perform surgery.

- It is only used on procedures with a 90 day global period, per CMS, although this is not a CPT® rule. It is only used the day of or before a major surgical procedure.
• Determines the highest ethical level of care
• Driven by medical necessity
• Ensures 100% E/M compliance
• Increases revenue by preventing under coding
• Focuses on patient care
Tips on Selecting Diagnosis Codes

This information will assist in the selection of diagnosis codes used to bill an E/M service.

Diagnosis codes:

- Describe the condition(s) that prompted the visit and support the medical necessity and level of service coded.
- Must be supported by documentation in the current note.
- Are coded to the highest degree of specificity (Diabetes ICD-9 codes 250.4 through 524.8 requires a manifestation code)
- May be taken from final assessment or chief complaint.
- Can be based on signs/symptoms if unable to make definitive diagnosis during the visit.
- Cannot be coded for conditions documented as “rule out... probable... possible...questionable...”.
- Include secondary conditions affecting treatment during the current visit.
- Diagnosis codes are not assigned when a diagnosis is mentioned in the history and is not addressed, or there is no indication in the current visit note that the diagnosis affected care.

Example: 250.70 Diabetes with peripheral circulatory disorder, Manifestation code 784.4 (gangrene)
Tips on Sequencing Diagnosis Codes

- All diagnosis codes must be sequenced (1,2,3, etc.) on the fee ticket.
- Sequencing on the fee ticket should follow the same sequence as the diagnosis are documented in the current visit note.
- First-listed code:
  - Chief complaint (i.e., diagnosis, condition, problem, or other reason for the visit such as chemotherapy) chiefly responsible for the service provided.
  - If the reason for the visit was for multiple complaints and each was addressed as supported by documentation,
    - The complaint that was most time consuming due to evaluation and/or management is sequenced first; and,
    - The remaining complaints are sequenced thereafter based on evaluation and/or management.
- Additional codes:
  - Newly diagnosed codes that were evaluated and/or treated during the current service.
  - Co-morbid conditions that coexist at the time of the service and influence, require, or affect patient-care or treatment as supported in documentation.
- Selecting a diagnosis without sequencing the code is not acceptable.
Putting it All Together

- History
- Physical Examination
- Medical Decision Making

E and M Building Blocks
Coding Educational Resources

- http://emuniversity.com
- www.prssinconline.com
Thank You