CPT Coding and E/M Documentation Training Resources

Background Material

- **E/M Services Guide-AACAP**

- **E/M Coding Review**

- **Examples for Evaluation and Management Codes-AACAP**

- **Counseling and Coordination of Care E/M Progress Note**

- **Templates, Outpatient & Inpatient-Stein, S.P.**

- **Outpatient E/M Progress Note Template-Based on the Elements**

- **Selected Sections from the CPT Primer for Psychiatrists-APA**

- **Frequently Asked Questions: 2013 CPT Coding Changes-APA AMA's Coding and Documentation Principles** ·

- **Selected Sections from the 2011 Procedure Coding Handbook for Psychiatrists, Fourth Edition.**

  o **Chapter 4 - Codes and Documentation for Evaluation and Management Services (Selected sections)**

  o **1997 CMS Documentation Guidelines for Evaluation and Management Services (Abridged and Modified for Psychiatric Services)**

  o **Most Frequently Missed Items in Evaluation and Management (E/M) Documentation**

- **E/M Documentation Auditor's Form**

Evaluation and Management Services Guide
Coding by Key Components

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History

Chief Complaint (CC)	History of present illness (HPI)	Past, family, social history (PFSH)	Review of systems (ROS)
Reason for the visit	Location; Severity; Timing; Quality; Duration; Context; Modifying Factors; Associated signs and symptoms	Past medical; Family medical; Social	Constitutional; Eyes; Ears, Nose, Mouth, and Throat; Cardiovascular; Respiratory; Genitourinary; Musculoskeletal; Gastrointestinal; Skin/Breast; Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; Allergic/Immunologic

CC	HPI	PFSH	ROS	History Type
Yes	*Brief* (1-3 elements or 1-2 chronic conditions)	N/A	N/A	*Problem focused* (PF)
			Problem pertinent (1 system)	*Expanded problem focused* (EPF)
	Extended (4 elements or 3 chronic conditions)	*Pertinent* (1 element)	*Extended* (2-9 systems)	*Detailed* (DET)
		Complete (2 elements (est) or 3 elements (new/initial))	*Complete* (10-14 systems)	*Comprehensive* (COMP)

Examination

System/body area	Examination
Constitutional	• 3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight • General appearance
Musculoskeletal	• Muscle strength and tone • Gait and station
Psychiatric	• Speech • Thought process • Associations • Abnormal/psychotic thoughts • Judgment and insight • Orientation • Recent and remote memory • Attention and concentration • Language • Fund of knowledge • Mood and affect

Examination Elements	Examination type
1-5 bullets	*Problem focused* (PF)
At least 6 bullets	*Expanded problem focused* (EPF)
At least 9 bullets	*Detailed* (DET)
All bullets in Constitutional and Psychiatric (shaded) boxes and 1 bullet in Musculoskeletal (unshaded) box	*Comprehensive* (COMP)

Med Dec Making

Medical Decision Making Element	Determined by
Number of diagnoses or management options	Problem points chart
Amount and/or complexity of data to be reviewed	Data points chart
Risk of significant complications, morbidity, and/or mortality	Table of risk

Problem Points

Category of Problems/Major New symptoms	Points per problem
Self-limiting or minor (stable, improved, or worsening) (max=2)	1
Established problem (to examining physician); stable or improved	1
Established problem (to examining physician); worsening	2
New problem (to examining physician); no additional workup or diagnostic procedures ordered (max=1)	3
New problem (to examining physician); additional workup planned*	4
*Additional workup does not include referring patient to another physician for future care	

Evaluation and Management Services Guide
Coding by Key Components

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
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Medical Decision Making

Data Points

Categories of Data to be Reviewed (max=1 for each)	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
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	2
Independent visualization of image, tracing, or specimen itself (not simply review report)	2

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem	Venipuncture; EKG; urinalysis	Rest
Low	Two or more self-limited or minor problems; One stable chronic illness; Acute uncomplicated illness	Arterial puncture	OTC drugs
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis; Acute illness with systemic symptoms		Prescription drug management
High	One or more chronic illnesses with severe exacerbation, progression, or side effects; Acute or chronic illnesses that pose a threat to life or bodily function		Drug therapy requiring intensive monitoring for toxicity

	Problem Points	Data Points	Risk	Complexity of Medical Decision Making
2/3 elements must be met or exceeded:	0-1	0-1	Minimal	*Straightforward*
	2	2	Low	*Low*
	3	3	Moderate	*Moderate*
	4	4	High	*High*

CPT Codes

New Patient Office
(requires 3 of 3)

CPT Code	History	Exam	MDM
99201	PF	PF	Straightforward
99202	EPF	EPF	Straightforward
99203	DET	DET	Low
99204	COMP	COMP	Moderate
99205	COMP	COMP	High

Established Patient Office
(requires 2 of 3)

CPT Code	History	Exam	MDM
99211	N/A	N/A	N/A
99212	PF	PF	Straightforward
99213	EPF	EPF	Low
99214	DET	DET	Moderate
99215	COMP	COMP	High

Initial Hospital/PHP
(requires 3 of 3)

CPT Code	History	Exam	MDM
99221	DET	DET	Straightforward
99222	COMP	COMP	Moderate
99223	COMP	COMP	High

Subsequent Hospital/PHP
(requires 2 of 3)

CPT Code	History	Exam	MDM
99231	PF	PF	Straightforward
99232	EPF	EPF	Moderate
99233	DET	DET	High

Evaluation and Management Coding Review

New Patient vs. Established Patient Codes vs. Psychiatric Diagnostic Eval Codes

- New Patient Codes
    - Not allowed for County Employed Medical Providers
    - Not recommended for CBO's, instead use:
- Psychiatric Diagnostic Evaluation with Medical Component (may add Interactive Complexity for communication difficulties—not for interpretation) - or -
- Established Patient Codes

Path I: Counseling & Coordination of Care (CCC)

- This is the majority of Psychiatry services provided in Community MH—medication management + supportive psychotherapy (coded as E/M CCC—not E/M + Psychotherapy Add-on).
- Must Document:
    - > 50% of face-to-face time was spent providing "Counseling or Coordination of Care".
    - Specify which of the six topic areas was discussed: Prognosis, Test Results, Compliance/Adherence, Education, Risk Reduction, Instructions.
    - Detail the discussion of each topic area explored.

Path II: Documenting by the Elements (level of complexity is determined by the two highest scores of History, Psychiatric Exam and Medical Decision Making):

- *History (History score requires all 4 areas)*
    - Chief Complaint
    - History of Present Illness (HPI), score *either*:
        - Status of 1 - 3 chronic conditions being treated, or
        - Number of HPI elements: location, quality, severity, timing, context, modifying factors, associated signs & symptoms, and duration
    - Past Medical/Mental Health, Past Family and Social History. PFSH = number of areas documented. May refer to prior Progress Note (PN) and indicate no change—or add updates.
    - Review of Systems with symptoms. ROS = number of areas documented of: Constitutional ; Eyes, Ears, Nose, Mouth & Throat; Cardiovascular; Respiratory; Genitourinary; Musculoskeletal; Gastrointestinal; Skin/Breast; Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; Allergic/Immunologic. May refer to prior Progress Note (PN) and indicate no change—or add updates.
- *Psychiatric Exam (Exam requires total of all documented bullets)*
    - Number of bullets for:
        - 3/7 Vital Signs, General Appearance, Muscle Strength and Tone, Gait and Station, speech, thought process, associations, abnormal/psychotic thoughts, judgment and insight, orientation, recent and remote memory, attention and concentration, language, fund of knowledge, and/or mood and affect
- *Medical Decision Making (MDM is established by the highest two of the three areas)*
    - Number of Problems Points: Diagnoses or Treatment Options (score per guides)
    - Number of Data Points (score per guides)
    - Risk of Complications and/or Morbidity or Mortality (rate per guides)

OUTPATIENT E/M FOR ESTABLISHED PATIENTS: REQUIRES TWO OF THREE ELEMENTS:

Established	99211	99212	99213	99214	99215
HISTORY					
Chief Complaint	N/A	Required	Required	Required	Required
History of Present Illness	N/A	1 – 3 Elements or 1 – 2 Chronic Cond's	1 – 3 Elements or 1 – 2 Chronic Cond's	4 Elements or 3 Chronic Cond's	4 Elements or 3 Chronic Cond's
ROS	N/A	N/A	1 System	2 – 9 Systems	10 – 14 Systems
PFSH	N/A	N/A	N/A	1 Of 3 Elements	2 of 3 Elements
PHYSICAL EXAMINATION					
1997 CMS Guidelines	N/A	1 – 5 Bulleted Elements	6 – 8 Bulleted Elements	9 or more Elements	All in Psych & Constitutional & 1 or 2 in Musculoskeletal
MEDICAL DECISION MAKING – REQUIRES TWO OF THREE BELOW					
Problem Pts	N/A	0 – 1	2	3	4
Data Pts	N/A	0 – 1	2	3	4
Risk	N/A	Minimal	Low	Moderate	High

EXAMPLES OF MINIMUM # OF NEEDED ELEMENTS FOR EACH CODE CIRCLED BELOW (HOWEVER, THERE ARE MANY OTHER POSSIBLE COMBINATIONS TO REACH THE INDICATED LEVEL OF COMPLEXITY):

Established	99211	99212	99213	99214	99215
HISTORY					
Chief Complaint	N/A	Required	Required	Required	Required
History of Present Illness	N/A	1 – 3 Elements or 1 – 2 Chronic Cond's	1 – 3 Elements or 1 – 2 Chronic Cond's	4 Elements or 3 Chronic Cond's	4 Elements or 3 Chronic Cond's
ROS	N/A	N/A	1 System	2 – 9 Systems	10 – 14 Systems
PFSH	N/A	N/A	N/A	1 Of 3 Elements	2 of 3 Elements
PHYSICAL EXAMINATION					
1997 CMS Guidelines	N/A	1 – 5 Bulleted Elements	6 – 8 Bulleted Elements	9 or more Elements	All in Psych & Constitutional & 1 or 2 in Musculoskeletal
MEDICAL DECISION MAKING – REQUIRES TWO OF THREE BELOW					
Problem Pts	N/A	0 – 1	2	3	4
Data Pts	N/A	0 – 1	2	3	4
Risk	N/A	Minimal	Low	Moderate	High

Evaluation and Management (E/M) Patient Examples
Office, Established Patient

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IMPORTANT

The sample progress notes below meet criteria for the specified E/M code, but do ***not*** necessarily meet criteria for the multiple other purposes (e.g., clinical, legal) of documentation. For illustration, the documentation meets requirements specified by the codes for the exact levels of each of the 3 key components. In practice, criteria for these codes may be met by documenting only 2 of 3 of the key components at or above the level required by the code.

SERVICES SHOULD ALWAYS BE MEDICALLY NECESSARY.

99213	*Office visit for a 9-year-old male, established patient, with ADHD. Mild symptoms and minimal medication side effects.*	*Office visit for a 27-year-old female, established patient, with stable depression and anxiety. Intermittent moderate stress.*	
HISTORY — CC	9-year-old male seen for follow up visit for ADHD. Visit attended by patient and mother; history obtained from both.	27-year-old female seen for follow up visit for depression and anxiety. Visit attended by patient.	**HISTORY:** *Expanded Problem Focused*
HPI	Grades are good (associated signs and symptoms) but patient appears distracted (quality) in class (context). Lunch appetite poor but eating well at other meals. **HPI scoring**: 3 elements = *Brief*	Difficulty at work but coping has been good. Minimal (severity) situational sadness (quality) and anxiety when stressed (context). **HPI scoring**: 3 elements = *Brief*	
PFSH	N/A	N/A	
ROS	Psychiatric: denies depression, anxiety, sleep problems **ROS scoring**: 1 system = *Problem-pertinent*	Psychiatric: no sadness, anxiety, irritability **ROS scoring**: 1 system = *Problem-pertinent*	
EXAM — Const	Appearance: appropriate dress, comes to office easily	Appearance: appropriate dress, appears stated age	**EXAM:** *Exp. Problem Focused*
MS	N/A	N/A	
Psych	Speech: normal rate and tone; Thought content: no SI/HI or psychotic symptoms; Associations: intact; Orientation: x 3; Mood and affect: euthymic and full and appropriate **Examination scoring**: 6 elements = *Expanded problem-focused*	Speech: normal rate and tone; Thought content: no SI/HI or psychotic symptoms; Associations: intact; Orientation: x 3; Mood and affect: euthymic and full and appropriate; Judgment and insight: good **Examination scoring**: 7 elements = *Expanded problem-focused*	
MEDICAL DECISION MAKING	**Problem 1**: ADHD **Comment**: Relatively stable; mild symptoms **Plan**: Renew stimulant script and increase dose; Return visit in 2 months	**Problem 1**: Depression **Comment**: Stable **Plan**: Renew SSRI script at the same dose; Return visit in 3 months **Problem 2**: Anxiety **Comment**: Stable **Plan**: Same dose of SSRI	**MEDICAL DECISION MAKING:** *Low Complexity*
Prob	**Problem scoring**: 1 established problem, stable (1); total of 1 = *Minimal*	**Problem scoring**: 2 established problems, stable (1 for each = 2); total of 2 = *Limited*	
Data	**Data scoring**: Obtain history from someone other than patient (2); total of 2 = *Limited*	**Data scoring**: None = *Minimal*	
Risk	**Risk scoring**: Chronic illness with mild exacerbation, progression, or side effects; and Prescription drug management = *Moderate*	**Risk scoring**: Two stable chronic illnesses; and Prescription drug management = *Moderate*	

Evaluation and Management (E/M) Patient Examples

99214	*Office visit for a 13-year-old male, established patient, with depression, anxiety, and anger outbursts.*	*Office visit for a 70-year-old male, established patient, with stable depression and recent mild forgetfulness.*	
HISTORY — CC	13-year-old male seen for follow up visit for mood and behavior problems. Visit attended by patient and father; history obtained from both.	70-year-old male seen for follow up visit for depression. Visit attended by patient and daughter; history obtained from both.	**HISTORY:** *Detailed*
HPI	Patient and father report increasing (timing), moderate (severity) sadness (quality) that seems to be present only at home (context) and tends to be associated with yelling and punching the walls (associated signs and symptoms) at greater frequency, at least once per week when patient frustrated. Anxiety has been improving and intermittent, with no evident trigger (modifying factors). **HPI scoring**: 6 elements = *Extended*	Patient and daughter report increasing distress related to finding that he has repeatedly lost small objects (e.g., keys, bills, items of clothing) over the past 2-3 months (duration). Patient notices intermittent (timing), mild (severity) forgetfulness (quality) of people's names and what he is about to say in a conversation. There are no particular stressors (modifying factors) and little sadness (associated signs and symptoms). **HPI scoring**: 6 elements = *Extended*	
PFSH	Attending 8th grade without problem; fair grades **PFSH scoring**: 1 element: social = *Pertinent*	Less attention to hobbies **PFSH scoring**: 1 element: social = *Pertinent*	
ROS	Psychiatric: no problems with sleep or attention; Neurological: no headaches **ROS scoring**: 2 systems = *Extended*	Psychiatric: no problems with sleep or anger; Neurological: no headaches, dizziness, or weakness **ROS scoring**: 2 systems = *Extended*	
EXAM — Const	Appearance: appropriate dress, appears stated age	Appearance: appropriate dress, appears stated age	**EXAM:** *Detailed*
MS	N/A	Muscle strength and tone: normal	
Psych	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: x 3; Attention and concentration: good; Mood and affect: euthymic and full and appropriate ; Judgment and insight: good **Examination scoring**: 9 elements = *Detailed*	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: x 3; Attention and concentration: unable to focus on serial 7s; Mood and affect: euthymic and full and appropriate; Recent and remote memory: mild struggle with telling history and remembered 1/3 objects **Examination scoring**: 10 elements = *Detailed*	
MEDICAL DECISION MAKING	**Problem 1**: Depression **Comment**: Worsening; appears associated with lack of structure **Plan**: Increase dose of SSRI; write script; CBT therapist; Return visit in 2 weeks **Problem 2**: Anxiety **Comment**: Improving **Plan**: Patient to work with therapist on identifying context **Problem 3**: Anger outbursts **Comment**: Worsening; related to depression but may represent mood dysregulation **Plan**: Call therapist to obtain additional history; consider a mood stabilizing medication if no improvement in 1-2 months	**Problem 1**: Depression **Comment**: Stable; few symptoms **Plan**: Continue same dose of SSRI; write script Return visit in 1 month **Problem 2**: Forgetfulness **Comment**: New; mildly impaired attention and memory **Plan**: Brain MRI; consider referral to a neurologist if persists	**MEDICAL DECISION MAKING:** *Moderate Complexity*
Prob	**Problem scoring**: 2 established problems, worsening (2 for each problem = 4); 1 established problem, improving (1); total of 5 = *Extensive*	**Problem scoring**: 1 established problem, stable (1); 1 new problem with additional workup (4); total of 5 = *Extensive*	
Data	**Data scoring**: Obtain history from other (2); Decision to obtain history from other (1); total of 3 = *Multiple*	**Data scoring**: Order of test in the radiology section of CPT (1); Obtain history from other (2); total of 3 = *Multiple*	
Risk	**Risk scoring**: One or more chronic illnesses with mild exacerbation, progression; and Prescription drug management = *Moderate*	**Risk scoring**: Undiagnosed new problem with uncertain prognosis; and Prescription drug management = *Moderate*	

Evaluation and Management (E/M) Patient Examples

99215	Office visit for an established adolescent patient with history of bipolar disorder treated with lithium; seen on urgent basis at family's request because of severe depressive symptoms.	Office visit for a 25-year-old male, established patient with a history of schizophrenia, who has been seen bi-monthly but is complaining of auditory hallucinations.	
HISTORY — CC	17-year-old male seen for urgent visit for depression. Visit attended by patient and parents; history obtained from all 3.	25-year-old male seen for follow up visit for schizophrenia. Visit attended by patient.	**HISTORY:** *Comprehensive*
HPI	Patient doing well until 2 days ago (timing) when, for no apparent reason (context), he refused to leave his bed and appeared extremely (severity) and continuously depressed (quality); he is sleeping more and eating little (associated signs and symptoms). **HPI scoring**: 5 elements = *Extended*	The patient reports doing well until 1 week ago (duration) when he stayed up all night to finish a term paper (context). He has slept poorly (severity) since (timing) and, 2 days ago, began hearing fairly continuous voices (quality) telling him that people plan to shoot him. Attention and organization were good up until this past week (associated signs and symptoms). **HPI scoring**: 6 elements = *Extended*	
PFSH	Stopped attending school; family history of suicide is noted from patient's initial evaluation **PFSH scoring**: Family and social (2 elements) = *Complete*	Doing well in third year of graduate school. Chart notes no family psychiatric history. **PFSH scoring**: Family and social (2 elements) =*Complete*	
ROS	Psychiatric: no problems with anxiety or anger; Neurological: no headaches; All other systems reviewed and are negative. **ROS scoring**: All systems = *Complete*	Psychiatric: denies symptoms of depression or mania; Neurological: no headaches; All other systems reviewed and are negative. **ROS scoring**: All systems = *Complete*	
EXAMINATION — Const	VS: BP (sitting) 120/70, P 90 and regular, R 20; Appearance: appropriate dress, appears stated age	VS: BP (sitting) 115/70, P 86 and regular, Ht 5'10", Wt 180 lbs; Appearance: appropriate dress, appears stated age	**EXAMINATION:** *Comprehensive*
MS	Gait and station: normal	Gait and station: normal	
Psych	Speech: sparse and slow; Thought process: logical; Associations: intact; Thought content: hopelessness, thinks of suicide, no HI or psychotic symptoms; Orientation: x 3; Attention and concentration: impaired; Mood and affect: depressed and constricted; Judgment and insight: poor; Fund of knowledge: good; Recent and remote memory: good; Language: able to repeat phrases **Examination scoring**: All elements of constitutional and psychiatric and 1 element of musculoskeletal = *Comprehensive*	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: auditory hallucinations and paranoid ideation, no SI/HI; Orientation: x 3; Attention and concentration: impaired; Mood and affect: euthymic and full and appropriate; Judgment and insight: good; Fund of knowledge: good; Recent and remote memory: good; Language: able to repeat phrases **Examination scoring**: All elements of constitutional and psychiatric and 1 element of musculoskeletal = *Comprehensive*	
MEDICAL DECISION MAKING	**Problem 1**: Bipolar disorder **Comment**: Major relapse **Plan**: Continue current dose of Lithium for the moment **Problem 2**: Suicidality **Comment**: New **Plan**: Refer to hospital; confer with hospitalist once patient is admitted	**Problem 1**: Psychosis **Comment**: Major relapse **Plan**: Increase dose of antipsychotic; write script; hold off on hospital admission as patient historically very adherent; return for visit in 1 day **Problem 2**: Insomnia **Comment**: Sleep deprivation may have triggered the psychosis relapse **Plan**: Change to a more powerful hypnotic; write script **Problem 3**: ADHD **Comment**: Appears stable **Plan**: Continue same dose of non-stimulant medication	**MEDICAL DECISION MAKING:** *High Complexity*
Prob	**Problem scoring**: 1 established problem, worsening (2); 1 new problem (3); total of 5 = *Extensive*	**Problem scoring**: 1 established problem, stable (1); 2 established problems, worsening (2 for each problem = 4); total of 5 = *Extensive*	
Data	**Data scoring**: Obtain history from other (2); total of 2 = *Limited*	**Data scoring**: None = *Minimal*	
Risk	**Risk scoring**: Chronic illness with severe exacerbation; and Illness that poses a threat to life = *High*	**Risk scoring**: Chronic illness with severe exacerbation = *High*	

INPATIENT PSYCHIATRIC PROGRESS NOTE
COUNSELING AND/OR COORDINATION OF CARE

Patient's Name: _____**Date of Visit:**_____

Interval History: _____

_____

_____

_____

Interval Psychiatric Assessment/ Mental Status Examination: _____

_____

_____

_____

Current Diagnosis: _____

Diagnosis Update: _____

Current Medication(s)/Medication Change(s) – No side effects or adverse reactions noted or reported ☐

_____

_____

_____

Lab Tests: Ordered ☐   Reviewed ☐ : _____

_____

Counseling Provided with Patient / Family / Caregiver (circle as appropriate and check off each counseling topic discussed and describe below:

☐ Diagnostic results/impressions and/or recommended studies   ☐ Risks and benefits of treatment options

☐ Instruction for management/treatment and/or follow-up   ☐ Importance of compliance with chosen treatment options

☐ Risk Factor Reduction   ☐ Patient/Family/Caregiver Education   ☐ Prognosis

_____

_____

_____

_____

Coordination of care provided with (check off as appropriate and describe below):

Coordination with: ☐ Nursing Staff ☐ Treatment Team ☐ Social Work ☐ Physician/s ☐ Family ☐ Caregiver

_____

_____

_____

_____

Additional Documentation (if needed):_____

_____

Duration of face to face visit with patient and floor time (in minutes):_____   **CPT Code** _____

Greater than 50% of patient time and floor time spent providing counseling and/or coordination of care: ☐

Justification for Continued Stay (record must include documentation to support justification for continued stay):
☐ A. Continued danger to self and/or others.
☐ B. Continued behavior intolerable to patient or society.
☐ C. High probability of A or B recurring if patient were to be discharged, and imminent re-hospitalization likely.
☐ D. Recovery depends on use of modality, but patient unwilling or unable to cooperate.
☐ E. Major change of clinical conditions required extended treatment.
☐ F. Has a general medical condition (other than mental disorder) requiring hospital care and due to psychological aspects, patient
      cannot be managed as well on non-psychiatric unit.
☐ ALC

Psychiatrist's Signature:_____**Date**:_____

OUTPATIENT/OFFICE PSYCHIATRIC PROGRESS NOTE
COUNSELING AND/OR COORDINATION OF CARE

Patient's Name: _____ **Date of Visit:** _____

Interval History: _____

_____

_____

_____

Interval Psychiatric Assessment/ Mental Status Examination:

_____

_____

_____

Current Diagnosis: _____

Diagnosis Update: _____

Current Medication(s)/Medication Change(s) – No side effects or adverse reactions noted or reported ☐

_____

_____

Lab Tests: Ordered ☐   Reviewed ☐ : _____

Counseling Provided with Patient / Family / Caregiver (circle as appropriate and check off each counseling topic discussed and describe below:

☐ Diagnostic results/impressions and/or recommended studies   ☐ Risks and benefits of treatment options

☐ Instruction for management/treatment and/or follow-up   ☐ Importance of compliance with chosen treatment
options

☐ Risk Factor Reduction   ☐ Patient/Family/Caregiver Education   ☐ Prognosis

_____

_____

_____

_____

Coordination of care provided (with patient present) with (check off as appropriate and describe below):

Coordination with: ☐ Nursing ☐ Residential Staff ☐ Social Work ☐ Physician/s ☐ Family ☐ Caregiver

_____

_____

Additional Documentation (if needed): _____

_____

Duration of face to face visit w/patient : _____ min. **Start Time** _____ **Stop Time** _____ **CPT** _____

Greater than 50% of face to face time spent providing counseling and/or coordination of care: ☐

Psychiatrist's Signature: _____ **Date:** _____

Evaluation and Management Progress Note—Based on the Elements

Client Name:_____ **PSP#:**_____ **Date:**_____	
EM Code:_____ **Face-to-Face EM Time:**_____ **Total Time:**_____	
EM Code Psychotherapy Add-on:_____ **Face-to-Face Therapy Time:**_____	
EM Code Interactivity Complexity Add-on (only with Psychotherapy add-on):_____	

Two of three criteria for: (I-III) History, Exam and/or Medical Decision Making must be met. **Score the key.**

1. HISTORY:

Hx of Present Illness (HPI): Past Medical, Family & Social Hx (PFSH), and Review of Systems (ROS)

Chief Complaint/Reason for Encounter (Required):

A. HPI. History of Present Illness:

Elements: Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, & Associated Signs and Symptoms. If unable to gather from client or others, indicate and describe condition preventing collection.
 One – three elements = Brief; Four or more elements = Extended.

OR Status of Chronic Conditions:

One – two conditions = Brief; Three or more conditions = Extended.

Describe HPI and/or Status of Chronic Conditions:

B. PFSH. Past Medical History, Family History & Social History (MAY BE COLLECTED BY STAFF OR FROM CLIENT INFORMATION FORM IF REIVEWED—INDICATE SO BY PRESCRIBER):

Elements Completed: One element = Pertinent; Two elements for Established (Three for New Client) Client = Complete .

Past Medical Hx: ___**Check if no change (or updates below) and see note dated ___/___/___ for detail.**

Diagnoses: Medications:

Surgeries: Allergies:

Family History: ___**Check if no change (or updates below) and see note dated ___/___/___ for detail.**

Social History: ___**Check if no change (or updates below) and see note dated ___/___/___ for detail.**

C. Review of Systems & Active Medical Problems History (MAY BE COLLECTED BY STAFF OR FROM CLIENT INFORMATION FORM IF REIVEWED BY—INDICATE SO BY PRESCRIBER):

# of systems completed: One = Problem Pertinent; Two – nine = Extended; Ten or > = Complete.

Systems:	Document Notes if Positive:

___Check if no change (or see changes indicated below) and see note dated ___/___/___ for detail

1. Constitutional   pos___ neg ___
2. Eyes   pos___ neg ___
3. Ears/Nose/Mouth/Throat pos___ neg___
4. Cardiovascular   pos___ neg___
5. Respiratory   pos___ neg___
6. Gastrointestinal   pos___ neg___
7. Genitourinary   pos___ neg___
8. Muscular   pos___ neg___
9. Integumentary   pos___ neg___
10. Neurological   pos___ neg___
11. Endocrine   pos___ neg___
12. Hemotologic/Lymphatic pos___ neg___
13. Allergies/Immune   Pos___ neg___

TOTAL # OF SYSTEMS:_____

2. PSYCHIATRIC SPECIALITY EXAMINATION

Number of Bullets completed: 1-5 = Prob. Focused (PF); 6-8 = Expanded Prob. Focused (EPF); 9 = Detailed, all (just one in Musc.)= Comprehensive.

--Vital Signs (any 3 or more of the 7 listed in this box):
Blood Pressure: (Sitting/Standing) _____ (Supine) _____ Height_____ Weight_____
Temp_____ Pulse (Rate/Regularity) _____ Respiration _____

--General Appearance and Manner (E.g., Development, Nutrition, Body Habitus, Deformities, Attention to Grooming, etc.):

--Musculoskeletal: __Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) (note any atrophy or abnormal movements):

(and/or) __Examination of gait and station:

-- Speech: Check if normal: ___rate __volume __articulation __coherence __spontaneity

Abnormalities; e.g., perseveration, paucity of language:

--Thought processes: Check if normal: __associations __processes __abstraction __computation
Indicate abnormalities:

--Associations (e.g., loose, tangential, circumstantial, intact):

--Abnormal or psychotic thoughts (e.g., hallucinations, delusions, preoccupation with violence (V/I), homicidal (H/I), or suicidal ideation (S/I), obsessions):

S/I: __ Present__ Absent   H/I: __Present __ Absent   V/I: __Present __ Absent

--Judgment and insight:

--Orientation:
--Memory (Recent/Remote):
--Attention/Concentration:
--Language:
-- Fund of knowledge: __intact __inadequate
--Mood and affect: **TOTAL BULLETS:_____**
Other Findings—*not a countable bullet* (e.g. cognitive screens, personality, etc.):

3. MEDICAL DECISION MAKING
Two of three criteria must be met: 1.) Data; 2.) Diagnosis/Problems; and 3.) Risk

A. **Data Reviewed:**	Points:	Description:
___ Review and/or order of clinical lab tests	1 POINT	**DESCRIBE:**
___Review and/or order of tests in the radiology section of CPT	1 POINT	**DESCRIBE:**
___Review and/or order of tests in the medicine section of CPT	1 POINT	**DESCRIBE:**
___Discussion of test results with performing provider	1 POINT	**DESCRIBE:**
___Decision to obtain old records and/or obtain history from someone other than client	1 POINT	**DESCRIBE:**
___Review and summarization of old records and/or obtaining history from someone other than client and/or discussion of case with another health care provider	2 POINT	**DESCRIBE:**
___Independent visualization of image, tracing, or specimen itself (not simply review report)	2 POINT	**DESCRIBE:**
	DATA TOTAL POINTS: _____	

B. Diagnosis/Problem (ARE ADDRESSED DURING ENCOUNTER TO ESTABLISH DX OR FOR MGT DECISION MAKING):

Indicate Status and points for each:

-Self-limiting or minor (stable, improved, or worsening) (1 point: max=2 Dx/Problem)

-Established problem (to examining provider); stable or improved (1 point)

-Established problem (to examining provider); worsening (2 point)

-New problem (to examining provider); no additional workup or diagnostic procedures ordered (3 point: max=1 Dx/Problem)

-New problem (to examining provider); additional workup planned*(4 point)

*Additional workup does not include referring client to another provider for future care

Axis I-V: Status: Points___ Plan (RX, Lab, etc.):	Axis I-V: Status: Points___ Plan (RX, Lab, etc.):
Axis I-V: Status: Points___ Plan (RX, Lab, etc.):	Axis I-V: Status: Points___ Plan (RX, Lab, etc.):
Axis I-V: Status: Points___ Plan (RX, Lab, etc.):	Axis I-V: Status: Points___ Plan (RX, Lab, etc.):

DIAG/PROBLEMS TOTAL POINTS: _____

C. Risk

Minimal -One self-limited or minor problem. **OR REST W/O RX**

Low   - Two or more self-limited or minor problems; One stable chronic illness; Acute uncomplicated. **OR OTC DRUGS**

Moderate -One or > chronic illnesses with mild exacerbation, progression, or side effects; Two or more stable chronic illnesses
            or Undiagnosed new problem with uncertain prognosis; Acute illness with systemic symptoms   **OR RX**

High   - One or more chronic illnesses with severe exacerbation, progression, or side effects;
            Acute or chronic illnesses that pose a threat to life or bodily function **OR RX REQUIRING INTENSIVE MONITORING**

Indicate Highest Risk Level and Describe:

Psychotherapy Add-on: ___ Supportive, ___ CBT, ___Behavior-modifying, ___Psychoeducational

Describe (Note must be thorough enough to stand on its own.):

_____   _____

    Medical Provider's Name (Print)   Signature   Date

         USE ALTERNATE FORM IF COUNSELING/COORDINATION IS > 50% OF TIME.

Evaluation and Management Progress Note—Based on the Elements

SCORING KEY

(Circle all results from Progress Notes)

I.   History: (Choose lowest of the three circled to determine History Type)

CC	HPI	PFSH	ROS	HISTORY TYPE
YES	BRIEF	N/A	N/A	PF
YES	BRIEF	N/A	PROBLEM PERTINENT	EPF
YES	EXTENDED	PERTINENT	EXTENDED	DET
YES	EXTENDED	COMPLETE	COMPLETE	COMPREHENSIVE

II.   Psychiatric Exam: (Select one)

PF	EPF	COMPLETE

III.   Medical Decision Making (Select two highest circled to determine MDM Complexity)

Data Points	Dx/Prob Points	Risk	Complexity
0 - 1	0 - 1	Minimal	Straightforward
2	2	Low	Low
3	3	Moderate	Moderate
4	4	High	High

RESULTS: CPT CODES

(Select two highest circled to determine CPT Code)

New Client Office (requires 3 of 3)				Established Client Office (requires 2 of 3)			
CPT Code	History	Exam	MDM	CPT Code	History	Exam	MDM
99201	PF	PF	Straightforward	99211	N/A	N/A	N/A
99202	EPF	EPF	Straightforward	99212	PF	PF	Straightforward
99203	DET	DET	Low	99213	EPF	EPF	Low
99204	COMP	COMP	Moderate	99214	DET	DET	Moderate
99205	COMP	COMP	High	99215	COMP	COMP	High
Initial Hospital/PHP (requires 3 of 3)				Subsequent Hospital/PHP (requires 2 of 3)			
CPT Code	History	Exam	MDM	CPT Code	History	Exam	MDM
99221	DET	DET	Straightforward	99231	PF	PF	Straightforward
99222	COMP	COMP	Moderate	99232	EPF	EPF	Moderate

CPT Primer for Psychiatrists
(Selected Selections)

What is CPT?

Current Procedural Terminology (CPT) was first published by the American Medical Association (AMA) in 1966. The CPT coding system was created to provide a uniform language for describing medical and surgical procedures and diagnostic services that would facilitate more effective communication between clinicians, third-party payers, and patients. The 2013 CPT Manual is the most recent revision of the 4th edition of the book.

How Is the CPT Manual Organized?

The CPT manual is organized to be as user friendly as possible. The following is a quick survey of its contents as it pertains to psychiatry.

Introduction

The short introduction contains valuable information for the clinician on how to use the manual.

Evaluation and Management Codes

Although the rest of the CPT manual is organized according to the numerical order of the codes, the evaluation and management (E/M) codes, 99xxx, are provided in the first code section because they are used by physicians in *all* specialties to report a considerable number of their services. The E/M codes are preceded by tables that indicate the required components for the various E/M codes and fairly extensive guidelines that define the terms used in the code descriptors and provide instructions for selecting the correct level of E/M service.

Major Clinical Sections

Next come the major clinical sections: Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine. Each of these sections is preceded by guidelines. The psychiatry codes, 908xx, are found in the Medicine section. The codes in the Psychiatry subsection cover most of the services mental health professionals provide to patients in both inpatient and outpatient settings.

Psychiatry Codes

The codes most frequently used by psychiatrists can be found in the Psychiatry subsection of the Medicine section of the CPT Manual (codes 90785-90899). In 2013 there were major changes to the Psychiatry codes. A distinction was made between an initial evaluation with medical services done by a physician (90792) and an initial evaluation done by a non-physician (90791). The psychotherapy codes were simplified: There are now three timed codes to be used in all settings (90832- 30 minutes; 90834-45 minutes; 90837- 60 minutes) and parallel add-on codes for psychotherapy (indicated by the + symbol in the CPT Manual) that are to be used by psychiatrists when the psychotherapy is provided in the same encounter as medical evaluation and management (90833 -30 minutes, 90836 - 45 minutes, 90838 – 60 minutes). In lieu of the codes for interactive psychotherapy, there is now an add-on code for interactive complexity (90785) that may be used with any code in the Psychiatry section for which it is appropriate. Another change is that a new code was added for psychotherapy for a patient in crisis (90839). When a crisis encounter goes beyond 60 minutes there is an add-on code for each additional 30 minutes (90840). Code 90862 was eliminated, and psychiatrists now use the appropriate evaluation and management (E/M) code when they do pharmacologic management for a patient. (A new code, add-on code 90863, was created for medication management when done

with psychotherapy by the psychologists in New Mexico and Louisiana who are permitted to prescribe, but this code is **not** to be used by psychiatrists or other medical mental health providers). All of these changes are discussed in detail below.

Interactive Complexity Add-On

90785 - Interactive Complexity -- This add-on code may be used with *Psychiatric Diagnostic Evaluation (90791/90792)* when the encounter is made more complex by the need to involve others along with the patient. It will most frequently be used in the treatment of children. When this add-on is used, documentation must explain what exactly the interactive complexity was (i.e., the need for play equipment with a younger child; the need to manage parents' anxiety; the involvement of parents with discordant points of view).

Psychiatric Diagnostic Evaluation Codes

90791 - Psychiatric Diagnostic Evaluation□□
This code is used for an initial diagnostic interview exam that does not include any medical services. In all likelihood this code will not be used by psychiatrists. It includes a chief complaint, history of present illness, review of systems, family and psychosocial history, and complete mental status examination, as well as the order and medical interpretation of laboratory or other diagnostic studies. In the past most insurers would reimburse for one 90791 (then a 90801) per episode of illness. The guidelines now allow for billing this on subsequent days when there is medical necessity for an extended evaluation (i.e., when an evaluation of a child that requires that both the child and the parents be seen together and independently). Medicare will pay for only one 90791 per year for institutionalized patients unless medical necessity can be established for others.

90792 - Psychiatric Diagnostic Evaluation with Medical Services□□This code is used for an initial diagnostic interview exam for an adult or adolescent patient that includes medical services. It includes a chief complaint, history of present illness, review of systems, family and psychosocial history, and complete mental status examination, as well as the ordering and medical interpretation of laboratory or other diagnostic studies. In the past most insurers would reimburse for one 90792 (then a 90801) per episode of illness. The guidelines now allow for billing this on subsequent days when there is medical necessity for an extended evaluation (i.e., when an evaluation of a child that requires that both the child and the parents be seen together and independently). Medicare will pay for only one 90792 per year for institutionalized patients unless medical necessity can be established for others. Medicare permits the use of this code or the appropriate level of the E/M codes (see below) to denote the initial evaluation or first-day services for hospitalized patients. Medicare also allows for the use of 90792 if there has been an absence of service for a three-year period.

Evaluation and Management Codes

With the elimination of code 90862 and the addition of the add-on codes for psychotherapy when done with evaluation and management (E/M), psychiatrists are now using far more E/M codes than they did in the past. Previously, many psychiatrists just used the E/M codes for their inpatient and nursing facility encounters, but now they must be used for outpatient care as well.

The evaluation and management codes were introduced in 1992 to cover a broad range of services for patients, in both inpatient and outpatient settings. E/M code descriptors provide explicit criteria for selecting codes, and the clinical vignettes given in Appendix C of the CPT Manual provide examples of situations that fulfill these criteria.

Evaluation and management codes cover a family of *general medical services* provided in various settings, i.e., office, hospital, nursing home, emergency department, etc. It is extremely important to read the guidelines to the Evaluation and Management section of the CPT Manual because they explain how to choose the appropriate level of service when using E/M codes.

Level of Service
The level of service for an E/M code encompasses the skill, effort, time, responsibility, and medical knowledge necessary to evaluate, diagnose, and treat medical conditions.

The three key components used in selecting the level of service within each category or subcategory of E/M service are:
- the extent of the history
- the extent of the examination
- the complexity of medical decision making involved

The clinician's ability to determine the appropriate level of service being provided to the patient within each category or subcategory of evaluation and management services is dependent on a thorough understanding of the Definition of Terms (found in the Evaluation and Management Services Guidelines that precede the listing of the E/M codes in the CPT Manual) and the Instructions for Selecting a Level of E/M Service (also in the Guidelines). The brief synopsis that follows is not an adequate substitute for a careful review of these sections of the CPT Manual.

There are three to five levels of service for each category or subcategory of E/M services. Each level of service represents the total work (skill, time, effort, medical knowledge, risk) required of the clinician during an incident of service. For example, outpatient E/M codes are divided by *new patient* and *established patient,* with five levels of service for new patient care (99201-99205) and five for established patient care (99211-99215). Each of the levels is based on the depth of history and examination and complexity of the decision making involved, and the descriptors for the codes provide a typical time for the code as well.

History
There are four levels of history in the E/M codes: problem focused, expanded problem focused, detailed, and comprehensive. The more detailed the history required, the greater the work effort.

Examination
The same four categories define the examination: problem focused, expanded problem focused, detailed, and comprehensive. The more extensive the examination required, the greater the work effort. For psychiatry, a complete mental state examination (single system examination) qualifies as a comprehensive examination.

Decision Making
There are four levels of medical decision making presented in the E/M codes: 1. Straightforward; 2. Low complexity; 3. Moderate complexity; and 4. High complexity. The more complex the medical decision making, the greater the work effort.
The complexity of the medical decision making depends on: the number of diagnoses or management options; the amount and/or complexity of data to be reviewed; and the risk of complications and/or morbidity or mortality.

For example, the lowest level of service a physician would provide for an established patient in an Office or Other Outpatient setting (99212) requires:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making

Average time: 10 minutes

While the highest level of service for an established patient in an Office or Other Outpatient setting (99215) requires:
- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity

Average time: 40 minutes

The clinician selects 99212 or 99215 (or any of the other levels: 99211, which is used by non-physician ancillary staff; 99213, or; 99214) on the basis of the work required (i.e., extent of history and examination, complexity of medical decision making). The average/typical times given for each code are guidelines for the clinician and are not a requirement when using the key components (history, examination, and medical decision making) in selecting the level of service.

Time and Level of Service

Time (as a component in selecting the level of service) has two definitions in the E/M guidelines. The clinician must review these definitions (see CPT 2014, E/M Services Guidelines) in order to fully understand the rationale for the two definitions.

For office and other outpatient visits and office consultations, intraservice time is defined as the *face-to-face* time spent providing services to the patient and/or family members. Time spent pre- and post-service (time that is not face-to-face) is not included in the average times listed for office and outpatient consultation services. The work associated with the pre- and post-encounter time has been calculated into the total work that forms the basis for how each code is reimbursed, and, therefore, the average face-to-face times listed with each E/M code are considered fair proxy for the total work effort.

For inpatient hospital care, hospital consultations, and nursing facility care intraservice time is defined as *unit floor time.* Unit floor time includes all work the clinician performs on behalf of the patient while present on the unit or at the bedside. This work includes direct patient contact, review of chart, writing orders, reviewing test results, writing progress notes, meeting with the treatment team, telephone calls, and meeting with the family. Pre- and post-time work such as reviewing patient records in another part of the hospital has been included in the calculation of total work as described above in the definition of face-to-face time.

There is one final and important twist in using time in the selection of the level of service. When counseling and/or coordination of care (see *Physicians Current Procedural Terminology 2014* , page 10) accounts for more than 50 percent of the patient and/or family encounter unit/floor time, then time becomes the *key factor* in selecting level of service. The clinician makes the selection by matching the time of the encounter (face-to-face or unit/floor) to the typical time listed for the appropriate E/M service. In this instance there is no consideration of the extent of the history, the exam, the medical decision making required, or the nature of the presenting

problem; time is the sole determinant. Remember, that when performing psychotherapy in addition to an E/M service, time may NOT be used to determine the level of E/M service.

Counseling is defined as a discussion with the patient and/or family concerning one or more of the following: diagnostic results, prognosis, risks and benefits of treatment, instructions for management, compliance issues, risk factor reduction, patient and family education. Coordination of care entails discussions about the patient's care with other providers or agencies. These two services are considered contributory factors and although important to E/M service, are not required to be provided at every encounter.

The following are examples of counseling and coordination of care:
A clinician spends 35 minutes on the hospital floor (third hospital day for patient) and over 50 percent of that time was spent in counseling and/or coordination of care. The correct code is 99233 (subsequent hospital care), average time 35 minutes. In this case, history, examination, and medical decision making are no longer the factors that determine the selection of the level of service. Instead, the clinician documents the extent of the counseling/coordination of care in the daily progress note as well as any standard E/M work that was done.

A patient returns to a psychiatrist's office for a medication check. The encounter takes a total of 25 minutes, during which time more than 12.5 minutes is spent explaining to the patient about how a newly prescribed medication works, how to establish a routine so that no doses will be missed, and the possible side-effects of the medication and what to do if they occur. The appropriate E/M code would be 99214 (office or outpatient service for an established patient), based on the 25-minute time rather than on a detailed history and examination and moderately complex medical decision making that would be required to use this code if counseling and coordination had not taken up more than 50 percent of the time.

Documentation
Documentation is an extremely complex issue, an issue we can only touch on here. For example, there may be special documentation requirements for Medicare found in the local Medicare contractor's Local Coverage Determination (LCD) policies; and when psychiatrists use E/M codes for treating Medicare patients, the HCFA (CMS) documentation guidelines should be used (but the clinician must decide whether to use the 1995 or 1997 guidelines—see below); and commercial insurers generally use these guidelines as well, but may have other requirements.

Although accurate documentation of services and procedures is vital for good medicine, documentation has become an increasingly troublesome practical issue for clinicians. It is especially problematic for psychiatrists because of confidentiality issues and the amount of clinical information produced during psychotherapy sessions. Also, documentation for psychotherapy codes is one issue, while documentation for E/M codes is another.

In 1995 the Health Care Financing Administration published documentation guidelines for evaluation and management services. In 1997 revised E/M documentation guidelines were issued. Currently, physicians can choose to base their documentation on either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services. Following either set will fulfill documentation requirements to the satisfaction of the Medicare program, and should be acceptable to private insurers as well. **Generally, psychiatrists will want to use the 1997 guidelines, which allow for a single-system psychiatric exam.**

The Health Insurance Portability and Accountability Act (HIPAA), which went into effect in April 2001, has very specific requirements for the privacy of patient records, and has very clear ramifications for the documentation of psychotherapy. HIPAA distinguishes between psychotherapy notes (notes a therapist may keep about the patient's personal life as distinguished from the patient's medical history and treatment) and the medical record, and holds these personal notes to a higher level of confidentiality. Since 2003, when all physicians were expected to be incompliance with HIPAA, the standard of practice has been that psychotherapy notes be kept so that they can be easily separated from the rest of a patient record.

Reimbursement Issues

It is very important for the clinician to understand that just because a code exists for a service in the CPT Manual, this does not guarantee that an insurance carrier or third-party payer will reimburse for that code. For example, Medicare will not pay for code 90882, Environmental Intervention, nor will it pay for certain codes done on the same day as others. You need to be aware of these exceptions. Clinicians may also find their contracts with managed care organizations specify certain codes that are not reimbursable, or that patients' insurance policies specify certain services that are not covered. It is essential to find out about any of these issues before treatment begins.

The outpatient mental health services limitation under Medicare was eliminated in 2014. Medicare now reimburses for all covered mental health services at 80 per cent just as it does for all other medical services.

RBRVS and Medicare Reimbursement Policies

Medicare generally excludes from payment all non-face-to-face services such as telephone calls (including Skype), environmental interventions, record reviews, and case management, although there may be some variation in local payment policies.

The way to avoid delay of payment or audits because of disputes over use of codes that you're not absolutely certain about is to prospectively negotiate with insurers about the use of any codes that are not unquestionably standard.

Conclusions

Careful, correct coding is vital to the practicing psychiatrist. Take it seriously. Not only will correct coding help achieve prompt and appropriate payment for treatment, it will also provide protection from charges of fraud and abuse. Accurate documentation of the services you have provided, and coded for, is the most certain means of protection against allegations of abusive or fraudulent billing. Accurate documentation is also extremely helpful in defending against malpractice allegations. You need to stay current on coding issues.

- Buy and read the AMA's annually published CPT Manual
- Stay in touch with your District Branch and the APA's Office of Healthcare Systems and Financing about coding and billing issues.
- Psychiatrists who provide services under Medicare must educate themselves on policies specific to Medicare. You want to be sure to read any correspondence sent to you by your Medicare contractor.

You should code and bill for all services rendered regardless of local or national payer policies – the developing database may help change payment policies that negatively affect reimbursement of mental health services.

It is important that you not try to game the reimbursement system by manipulating codes inappropriately. Medicare/Medicaid fraud, and insurance fraud in general, is a serious priority of the Justice Department.

Note: Although psychiatrists are likely to use only the codes within the Psychiatry and E/M sections of the CPT Manual to cover the services they provide, the Manual clearly states in its introduction: **"Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician."**

Frequently Asked Questions: 2013 CPT Coding Changes

APA Office of Healthcare Systems & Financing

The changes to the CPT Psychiatry codes were major. The entire coding framework has changed. The APA has based the answers to these FAQs on its general current understanding of the CPT codes and the information available to it. It is possible that as more information becomes available some the information could be outdated. THIS IS NOT LEGAL ADVICE. Members are advised to seek the advice of attorneys specializing in this area of law if for any legal questions.

Q: I understand there are now two codes to use for a standard initial psychiatric diagnostic evaluation, 90791 and 90792. Why was this done?
A: Previously all mental health clinicians use the same initial evaluation codes, 90801 and 90802, even though nonmedical providers could not provide the medical work that was described in those codes. In 2013, psychiatrists can use code 90792, which indicates medical services were provided, while nonmedical providers will use 90791, which does not include medical services. Medical services may consist of any medical activities such as performing elements of a physical exam or considering writing a prescription or modifying psychiatric treatment based on medical comorbidities.

Q: What is an E/M code?
A: The evaluation and management (E/M) codes are found in the first section of the AMA CPT manual. The first two digits of this code set are 99. The E/M codes are generic in the sense that they can be used by all physicians. They describe general medical services. Code selection is based on whether the patient is new or established, the setting (outpatient, inpatient, nursing facility, etc.), and on the complexity of the service provided, which is based on the nature of the presenting problem. There are specific documentation requirements when using these codes. You can download a list of the most frequently used E/M codes as well as information on the documentation requirements on the APA's webpage for CPT Coding Changes (www.psychiatry.org/cptcodingchanges).

Q: I'd never used the CPT evaluation and management codes before, is there somewhere I can find out about how to use them?
A: You can download the chapter on E/M coding from the book *Procedure Coding for Psychiatrists* (the information on the psychiatry codes in this 2011 book is now obsolete, but the information about the E/M codes is current.) The chapter is available on the APA website at www.psychiatry.org/cptcodingchanges as are a number of webinars dealing with E/M coding. APA also has an online CME course on the CPT code changes available free to members at www.apaeducation.org.

Q: In my outpatient practice I often see patients for medication management and previously used CPT code 90862, which was deleted for 2013. What code will I use in place of 90862?
A: The typical outpatient 90862 is most similar to E/M code 99213. If the patient you are seeing is stable, and really just needs a prescription refill, code 99212 might be a more appropriate crosswalk. If you have a patient with a very complex situation, you might need to use 99214, a higher level E/M code. The E/M codes have documentation guidelines published by the Centers

for Medicare and Medicaid Services (CMS) that explain how to determine which level code to choose. There is a link to this information at http://psychiatry.org/cptcodingchanges.

Q: I am a child psychiatrist and, in the past, generally billed using one of the interactive psychotherapy codes. What do I use now?
A: There is now an add-on code, 90785, that can be used with diagnostic evaluation codes to indicate what is now referred to as "interactive complexity." The concept of interactive complexity has been expanded. See the interactive complexity guide developed by the American Academy of Child and Adolescent Psychiatry at http://psychiatry.org/cptcodingchanges.

Q: If during an evaluation or a follow-up session, meds are NOT prescribed, but the patient is assessed as to whether meds would be appropriate, can we still consider that an E/M?
A: Yes, E/M codes describe any manner of medical work and not just the prescription of medication.

Q: Do you recommend using the E/M new patient codes or 90792?
A: You could use either. There may be times, based and the presenting problem and the complexity of the work performed, when a higher level E/M code may be more appropriate.

Q: What are the times for the various E/M codes for established patients, and is there any reason you couldn't use the 50% counseling and coordination of care for every follow up visit if it applies?
A: Correct coding requires that you choose the code that most closely represents the work performed. If more than 50% of your E/M service involves counseling and coordination of care, you can choose the code on the basis of time. You cannot choose the E/M code on the basis of counseling and coordination of care if you also bill a psychotherapy service for the same visit. *We must also warn you that consistently billing using high level E/M codes on the basis of counseling and coordination of care may often elicit an audit from Medicare or commercial insurers. In fact, Medicare announced that in 2013 it will be auditing claims for 99215 on the basis of frequency.*

Q: What constitutes "counseling and coordination of care"?
A: Counseling, as defined by CPT, is a discussion with a patient and/or family concerning one or more of the following areas:
- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Q: Family members of a man with serious mental illness who is not a patient of mine have asked to see me for assistance with navigating the mental health system on behalf of the patient and for help in dealing with the patient at home. I was thinking of using 90846 and calling it Family Therapy without the patient present, but since the patient is not part of my practice this seems questionable.

A: You are not required to use CPT codes any time you provide medical services, although they are required for billing purposes. This is not a service that would be covered by health insurance, there is really no reason to code for this encounter

Q: What is the difference between a new outpatient E/M visit versus an established outpatient visit; 99201 vs 99211?
A: You only use the new outpatient visit code when this is the first time you've ever treated the patient or it has been more than three years since you or anyone in your practice of the same specialty or subspecialty has seen the patient.

Q: If you are a small psychiatric office and purchasing CPT books, would it be best to purchase AMA CPT or ICD-9-CM VOL 1-3? Bundles are cheaper.
A: We would suggest purchasing the AMA CPT book so you have reference to the complete set of coding guidelines developed for the new codes psychiatrists will be using. The DSM uses ICD diagnostic codes, and the DSM-5 provides both the ICD-9-CM codes, which are in use now, and the ICD-10-CM codes, which will go into effect for use in the U.S. in October, 2014.

Q: Are there visit note templates that have been developed for psychiatrists to easily check off the bullets necessary for E/M coding?
A: Templates are available on the APA website at www.psychiatry.org/cptcodingchanges.

Q: Does 90792 cover deciding and prescribing medications in the session?
A: Yes, that could be one component of the medical service that differentiates 90792 from 90791.

Q: Are there specific requirements for 90792, and are there other codes for new patients beyond 90791 and 90792?
A: The documentation requirements for the 90792 are really the same as the documentation for 90801. The only difference is you will want to be sure to list any of the medical work when billing the 90792. Psychiatrists and others who can bill E/M codes may also choose to bill an initial evaluation with the appropriate E/M code.

AMA's CODING AND DOCUMENTATION PRINCIPLES

- The medical record should be complete and legible.

- The documentation of each patient encounter should include the date; reason for the encounter; appropriate history and physical examination; review of laboratory, x-ray data, and other ancillary services when appropriate; assessment; and plan for care, including discharge plan if appropriate.

- Past and present diagnoses should be accessible to the treating and/or consulting physician.

- The reasons for and results of x-rays, laboratory tests, and other ancillary services should be documented or included in the medical record.

- The patient's progress, including response to treatment, change in treatment, change in diagnosis, and patient noncompliance, should be documented.

- The written plan for care should include, when appropriate, treatments and medications, specifying frequency and dosage; any referrals and consultations; patients/family education; and specific instructions for follow-up.

- The documentation should support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision making.

- All entries to the medical record should be dated and authenticated.

- Physicians' Current Procedural Terminology (CPT)/International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

SELECTED SECTIONS FROM THE 2011 PROCEDURE CODING HANDBOOK FOR PSYCHIATRISTS, FOURTH EDITION

- Codes and Documentation for Evaluation and Management Services
- 1997 CMS Documentation Guidelines for Evaluation and Management Services (Abridged and Modified for Psychiatric Services)
- Most Frequently Missed Items in Evaluation and Management (E/M) Documentation

CPT CODE 1/1/13 CHANGES
FAQ

Q: **Our agency often does both a MH Assessment and a Medication Assessment on the same day for our clients. May we bill for both a 323-90791 *Psychiatric Diagnostic Evaluation* and a 565-90792 *Psychiatric Diagnostic Evaluation with a Medical Component* on the same day by different providers?**

A: Yes

Q: **Our agency sometimes does a MH Assessment with the client and the family of the client separately on the same day by the same provider. May we bill either 323-90791 or 565-90792 twice in the same day by the same provider?**

A: Yes, but only if different "informants" (such as client and family member) are seen in each Psychiatric Diagnostic Evaluation. They must be seen separately and documented as such.

Q: **Clinician's Gateway will no longer accept "0" minutes in the face-to-face fields for some codes. Are we now unable to bill for phone services?**

A: Yes, you may bill. For now, when providing MH Services on the telephone—enter the number of contact minutes into the face-to-face fields. Also, be sure to indicate "telephone" in the "location" field so that only Medi-Cal is billed.

A: **Do we use code 323-90791 (Psychiatric Diagnostic Evaluation) when we complete the Community Functioning Evaluation?**

A: No, use code 324-96151 (Behavioral Evaluation). One advantage to this code is that all disciplines (with appropriate training and experience) may gather the Community Functioning Evaluation (or approved equivalent form) data.

Q: **Now, that Medicare requires that the choice of many billing codes (those with time frames, min-max) be done on the basis of face-to-face time, can we bill for work done exclusively on the phone (e.g. crisis, therapy, etc.)?**

A: Yes, the choice of the code would then be based on the *client contact time* and you would select the location code "telephone". Such claims will bypass Medicare and bill directly to Medi-Cal.

Q: **Medical Providers (MD, DO, NP, PA, CNS) claim medication services on codes that require face-to-face time, how do they bill for medication support on the phone?**

A: Medical Providers (MD, DO, NP, PA, CNS) use a specific County Code of 367 for non-face-to-face medication training and support.

A: For RN/LVN see below.

Q: **RN and LVN's cannot bill Medicare, how do they bill for medication support?**

A: RN/LVN's use a County Code 369 for medication support. It may be face-to-face (f-f) or non- f-f.

Q: Some CPT codes now require a minimum amount of client f-f time, are we unable to bill for those services if our f-f time is below the minimum required?
A: You may not use a CPT code in which the f-f time does not meet the minimum required by the CPT manual (i.e. a minimum of 16" for Individual Psychotherapy). However, if there is another appropriate code (that the service meets) you may claim and chart to that service.

Q: The Crisis Intervention code has been eliminated and replaced with Crisis Therapy (377-90839, 378+90840). We have MHRS and Adjunct staff who used to provide Crisis Intervention services but who are not allowed to do Psychotherapy, may they bill the new "therapy" code?
A: Yes, the definition of Crisis Intervention Services has not changed—only the Code Label. With the appropriate training and experience your staff may provide Crisis Intervention Services—now identified as Crisis Therapy.

Q: In Children's Services we used to use Code 319 for "Collateral Family Therapy". We now see code 413-90846 ("Family Psychotherapy without Patient Present") and code 449-90847 ("Family Psychotherapy with Patient Present") on the Master Code List. Which should we use?
A: Codes 413-90846 and 449-90847 have now been added to the Children's Programs' RU's. These are the codes to now use as they are more specific and map to an approved CPT code for billing purposes.

Q: The Interactive Complexity add-on code 491+90785 is used for 456-90853 Group Psychotherapy. Can it also be used for 455-90849 Multi-Family Group Psychotherapy and/or 391 Group Rehabilitation services?
A: No, the only group related code that the add-on code 491+90785 Interactive Complexity may be used with is code 406-90853 Group Psychotherapy.

Q: The Interactive Complexity add-on code 491+90785 is used for Individual Psychotherapy. Can it also be used for 413-90846 and/or 449-90847 Family Psychotherapy codes?
A: No, Interactive Complexity add-on code may not be used for Family Psychotherapy; however it may be used with Psychiatric Diagnostic Evaluation (323-90791, 565-90792), Group Psychotherapy (456-90853), Individual Psychotherapy (441-90832, 442-90834, 443-90837), and the Individual Psychotherapy add-on codes (465+90833, 467+90836, 468+90838).

Q: May Interactive Complexity 491+90785 be used with all E/M codes?

A: No, 491+90785 Interactive Complexity add-on code may only be used in conjunction with a Primary E/M code which <u>also</u> has a Psychotherapy add-on code (465+90833, 467+90836, 468+90838) associated with it.

Q: May we bill the Psychiatric Diagnostic Evaluation codes 323-90791, or 565-90792 without the client present?
A: Yes, you may review medical records, interview others involved in the client's care and still utilize these codes. If you interview the client on the phone—note that as the location code and you may bill these codes.

Q: How do I enter Interactivity Complexity 491+90785 for billing purposes?
A: In Clinician's Gateway select "present" in the Interactive Complexity Field.
A: For InSyst, select the 491+90785 code and enter one (1) minute for the duration of service as a placeholder.

Q: Clinician's Gateway does not allow me to select multiple 30" Crisis Therapy 378+90840 add-on codes. May we then only bill for the first 1 1/2 hours of crisis?
A: You may bill for the length of service provided, and Clinician's Gateway will bill the appropriate number of 30" Crisis Therapy Add-on's to the Insurer. However, when entering data into the database you total all of the f-f time beyond the first 60 minutes and enter those minutes in the "second f-f minutes" field for the add-on code.

Q: May we use the Psychiatric Diagnostic Evaluation codes 323-90791, or 565-90792, for re-assessment purposes?
A: Yes, these codes may be used for both Initial and re-assessments.

Q: If we provide an E/M service in the field, at school or at a home may we use the E/M codes 99211-99215 which indicate "Office or other outpatient visit"?
A: Yes, also select the appropriate "Location Code" when utilizing these E/M codes (e.g. telephone, field, school, home, etc.).

Q: Clinician's Gateway used to support Co-Staffing of a service. It no longer does for some procedures, may we bill for both of the staff's time?
A: Yes, if each provider writes a separate note and indicates what unique contribution each had, or why a second person was needed (e.g. safety).   If "duplicate entry" is displayed, select the reason.

Q: The CPT manual indicates Interactive Complexity 491+90785, includes: "Use of play equipment, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction". May we claim Interactive Complexity when we have an Interpreter present to overcome the language barriers to therapeutic interventions?

A: No, currently CMS has indicated that the Interactive Complexity code "…should not be used to bill solely for translation or interpretation services as that may be a violation of federal statue".

Q: The CPT manual indicates Interactive Complexity 491+90785, includes: "Use of play equipment, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction". May we claim Interactive Complexity when we utilize play therapy equipment for the majority of the session (sand tray, etc.)?
A: Yes, the use of play equipment throughout the session allows you to claim for Interactive Complexity.

Q: May we choose the time bracketed (min-max) CPT Codes based on total time so that we may be reimbursed for transportation and documentation time as well as f-f time?
A: No, CPT Codes with time-frames (min-max) must be chosen only on the basis of f-f time (or contact time if done on the phone). However, you may claim for your time for transportation and documentation time as below. (Also, see examples, in the Power Point CPT Code Jan 2013 Changes Training.)
A: For Insyst:
   - Choose the appropriate code based on the f-f time and then enter the Total Number of minutes (inclusive of documentation and travel time) even if the time exceeds that listed for the code. Do not choose a code which allows for more time. InSyst will claim to Medicare and Medi-Cal appropriately behind the scenes.
   - If you have needed to choose Crisis Therapy or Psychotherapy add-on codes— add the documentation and travel time to the minutes for the last add-on code (but do not add an additional add-on code for those minutes).
A: For Clinician's Gateway
   - Choose the appropriate code based on the f-f time and enter that time in the "Primary F-f Time field". In the "Primary Clinician Time" field, add the f-f time with the documentation and travel time and enter the Total Time.
   - If add-on codes for Crisis Therapy or Psychotherapy are needed--do not add the documentation time and travel time to the" Primary Clinician Time" field (just enter Primary F-F time). After entering the remaining f-f time in the "2nd FF Time field"-- add the documentation and travel time to the add-on code's f-f time in the" Secondary Total Time Field". (Be sure to also indicate the remaining f-f time in the 2nd FF Time field).
   - See examples, in the Power Point CPT Code Jan 2013 Changes Training.

Q: May we utilize the 690 Mobile Crisis Response Code?
A: No, this code is specific to the "Crisis Response Program's" RU only. As appropriate use the Crisis Therapy Codes: 377-90839 & 378+90840.

Q: May we utilize the "New Patient" E/M codes 545-9, 992(01-05)?

A: CBO's may use these codes if they have not provided Psychiatric Services to the client in the past three years. Alternatively, they may use Psychiatric Diagnostic Evaluation 565-90792 (there is no 3 year limit). County Clinics must use the code Psychiatric Diagnostic Evaluation 565-90792. Any person qualified to use E/M can also use 99212-15 E/M codes.

Q: In a paper record (not Clinician's Gateway note) how do we enter the minutes for crisis when there are multiple add-on codes, do we break them down per code?

A: You do need to indicate every add-on code, but then total the minutes (with f-f time broken out). For example: 128 minutes f-f time, 30 minutes documentation and 60 minutes travel time. Indicate as such:

In Chart:

377-90839,,378+90840, 378+90840

F-F 128", Doc 30", Travel 60", Total 218"

In InSyst:

377-90839   60"

378+90840 30"

378+90840 128"

_____

Q: May we utilize E/M codes that are not in our program's RU such as SNF E/M codes?

A: No, programs may only provide those services authorized in their contract. Contact Provider Relations if you believe you are contracted for a procedure code that is not being accepted in InSyst.

Q: In Clinician's Gateway I received an error statement "problem with form", what does this indicate?

A: Hover your cursor over the red dot for more information. Call the IS help desk if you need additional assistance at 510-567(3)-8160.

Q: Where can I learn more about the 2013 CPT Psychotherapy/Psychiatric Services changes—especially utilizing the E/M Codes?

 A: See below:

        The National Council Resource Page:

        - http://www.thenationalcouncil.org/cs/cpt_codes

        The American Psychiatric Association Resource Page

        - http://www.psych.org/practice/managing-a-practice/cpt-changes-2013/current-procedural-terminology-cpt-code-changes-for-2013

        The AACAP

        - http://www.aacap.org/cs/business_of_practice/reimbursement_for_practitioners

The American Psychological Association

- http://www.apapracticecentral.org/reimbursement/billing/psychotherapy-codes.pdf
- http://www.apapracticecentral.org/reimbursement/billing/index.aspx?__utma=12968039.338271549.1342112804.1359501649.1361380803.10&__utmb=12968039.1.10.1361380803&__utmc=12968039&__utmx=-&__utmz=12968039.1361380803.10.6.utmcsr=google|utmccn=(organic)|utmcmd=organic|utmctr=american psychological association cpt code changes&__utmv=-&__utmk=224931866

The AMA

- http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page?
- The AMA app: EM Quickref (android or apple)
- **AMA Webinar - Psychotherapy/Psychiatric Services**: **CPT® 2013 Changes - Psychotherapy/Psychiatric Services**. This one-hour program discusses the changes made in the Psychotherapy/Psychiatric Services coding section.

HOW TO USE THE TEMPLATES FOR PROGRESS NOTES FOR E/M CODES FOR COUNSELING AND/OR COORDINATION OF CARE

Each template includes the essential documentation required to be included in an inpatient and outpatient progress note when providing an E/M service when the primary service (more than 50% of the service time as defined below) involves counseling and/or coordination of care.

Please note that E/M codes and these templates should never be used when psychotherapy is provided. When psychotherapy is provided, the 908xx psychotherapy codes must be used.

When billing for an E/M service based upon counseling and/or coordination of care, it is imperative that the counseling and/or coordination of care be documented as follows:

- The actual duration of the service time must be included in the progress note. The templates include a specific section to enter the total time.

- For outpatient visits, only face to face time with the patient providing counseling and/or coordination of care constitutes the service time.

- For inpatient visits, the service time includes both face to face patient time and floor time providing counseling and/or coordination of care.

- In addition, a statement must be included in the progress note that: "Greater than 50% of patient face to time spent providing counseling and/or coordination of care" (for outpatient services) or "Greater than 50% of patient time and floor time spent providing counseling and/or coordination of care" (for inpatient services).

- The templates include a statement to be checked off confirming compliance with this requirement.

- The templates also include a place to insert the CPT code selected for the service provided.

The elements of the templates include:

Interval History: Include documentation of new history since last visit.

Interval Psychiatric Assessment/Mental Status Examination: Update mental status of patient and psychiatric assessment

Current Diagnosis: Note the current diagnoses.

Diagnosis Update: Note any changes in diagnosis after visit.

Current Medication(s)/Medication Update: Update medication and note any changes. A box is included to permit a check off to indicate that no side affects or adverse reactions were noted by the psychiatrist or reported by the patient. If there are side affects or adverse reactions noted or reported, include documentation.

Counseling Provided: Circle whether counseling was provided to patient, family and/or caregivers. Check off one or more focuses of counseling and include specific documentation of counseling topics that were checked off.

Coordination of Care Provided: Check off one or more individuals with whom coordination of care was provided and then include documentation of specific coordination of care activities checked off.

Duration: Insert total session time in minutes. Remember that for outpatient services, only face to face time with the patient may be counted for the total session time, but for inpatient services, the session time include both face to face time with the patient and floor time providing counseling and/or coordination of care.

CPT Code: Insert CPT code selected for service provided.

Greater than 50%: Check off when counseling and/or coordination of care exceeded 50% of total session time: patient face to face time for outpatient services and floor time plus patient face to face time for inpatient services) involves counseling and/or coordination of care.

Justification for Continued Stay: This section is only included in the <u>inpatient note</u> and is intended to comply with the requirements of the NYS Medicaid Program to document medical necessity for continued inpatient psychiatric hospitalization. Check off the appropriate justification/s for the continued stay and include specific documentation in the progress note (use the **Additional Documentation** section) for the justification/s selected. (NYSPA extends appreciation to Barry Perlman, M.D., St. Joseph's Hospital, Yonkers, New York, for this element of the inpatient progress note template.)

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Selected Sections from the 2011 Procedure Coding

Handbook for Psychologist, 4th Edition

4

Codes and Documentation for Evaluation and Management Services

The evaluation and management (E/M) codes were introduced in the 1992 up-date to the fourth edition of *Physicians' Current Procedural Terminology* (CPT). These codes cover a broad range of services for patients in both inpatient and outpatient settings. In 1995 and again in 1997, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS) published documentation guidelines to support the selection of appropriate E/M codes for services provided to Medicare beneficiaries. The major difference between the two sets of guidelines is that the 1997 set includes a single-system psychiatry examination (mental status examination) that can be fully substituted for the comprehensive, multisystem physical examination required by the 1995 guideline. Because of this, it clearly makes the most sense for mental health practitioners to use the 1997 guidelines (see Appendix E). A practical 27-page guide from CMS on how to use the documentation guidelines can be found at http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv _guide.pdf. The American Medical Association's CPT manual also provides valuable information in the introduction to its E/M section. Clinicians currently have the option of using the 1995 or 1997 CMS documentation guidelines for E/M services, although for mental health providers the 1997 version is the obvi-ous choice.

The E/M codes are generic in the sense that they are intended to be used by all physicians, nurse-practitioners, and physician assistants and to be used in primary and specialty care alike. All of the E/M codes are available to you for re-porting your services. Psychiatrists frequently ask, "Under what clinical cir-cumstances would you use the office or other outpatient service E/M codes in lieu of the psychiatric evaluation and psychiatric therapy codes?" The decision

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to use one set of codes over another should be based on which code most accurately describes the services provided to the patient. The E/M codes give you flexibility for reporting your services when the service provided is more medically oriented or when counseling and coordination of care is being provided more than psychotherapy. (See p. 44 for a discussion of counseling and coordination of care).

Appendix K provides national data on the distribution of E/M codes selected by psychiatrists within the Medicare program. Please note that although there are many codes available to use for reporting services, the existence of the codes in the CPT manual does not guarantee that insurers will reimburse you for the services designated by those codes. Some insurers mandate that psychiatrists and other mental health providers only bill using the psychiatric codes (90801 – 90899). It is always smart to check with the payer when there are alternatives available for coding.

THE E/M CODES

- E/M codes are used by all physician specialties and all other duly licensed health providers.
- The definitions of *new patient* and *established patient* are important because of the extensive use of these terms throughout the guidelines in the E/M section. **A *new patient* is defined as one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group within the past 3 years. An *established patient* is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group within the past 3 years.** When a physician is on call covering for another physician, the decision as to whether the patient is new or established is determined by the relationship of the covering physician to the physician group that has provided care to the patient for whom the coverage is now being provided. If the doctor is in the same practice, even though she has never seen the patient before, the patient is considered established. There is no distinction made between new and established patients in the emergency department.

    The other terms used in the E/M descriptors are equally as important. The terms that follow are vital to correct E/M coding (complete definitions for them can be found under Steps 4 and 5 later in this chapter):

    - Problem-focused history
    - Detailed history
    - Expanded problem-focused history
    - Comprehensive history

    - Problem-focused examination
    - Detailed examination
    - Expanded problem-focused examination
    - Comprehensive examination

- Straightforward medical decision making
- Low-complexity medical decision making
- Moderate-complexity medical decision making
- High-complexity medical decision making

- E/M codes have three to five levels of service based on increasing amounts of work.
- Most E/M codes have time elements expressed as the time "typically" spent face-to-face with the patient and/or family for outpatient care or unit floor time for inpatient care.
- For each E/M code it is noted that "Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs." *When this counseling and coordination of care accounts for more than 50% of the time spent, the typical time given in the code descriptor may be used for selecting the appropriate code rather than the other factors.* (See p. 44 for a discussion of counseling and co-ordination of care.)
- The 1995 and 1997 CMS documentation guidelines for E/M codes have become the basis for sometimes draconian compliance requirements for clinicians who treat Medicare beneficiaries. Commercial payers have adopted elements of the documentation system in a variable manner. *The fact is that the documentation guidelines cannot be ignored by practitioners.* To do so would place the practitioner at risk for audits, civil actions by payers, and perhaps even criminal charges and prosecution by federal agencies.

SELECTING THE LEVEL OF E/M SERVICE

The following are step-by-step instructions that guide you through the code selection process when providing services defined by E/M codes. Code selection is made based on the work performed.

Step 1: Select the Category and Subcategory of E/M Service

Table 4 – 1 lists the E/M services most likely to be used by psychiatrists. This table provides only a partial list of services and their codes. For the full list of E/M codes [and the coding guidelines] you will need to refer to the CPT manual.

TABLE 4–1. EVALUATION AND MANAGEMENT CODES MOST LIKELY TO BE USED BY PSYCHIATRISTS

CATEGORY/SUBCATEGORY	CODE NUMBERS
New patient	99201–99205
Established patient	99211–99215
Hospital observational services	
Observation care discharge services	99217
Initial observation care	99218–99220
Hospital inpatient services	
Initial hospital care	99221–99223
Subsequent hospital care	99231–99233
Hospital discharge services	99238–99239
Consultations[1]	
Office consultations	99241–99245
Inpatient consultations	99251–99255
Emergency department services	
Emergency department services	99281–99288
Nursing facility services	
Initial nursing facility care	99304–99306
Subsequent nursing facility care	99307–99310
Domiciliary, rest home, or custodial care services	
New patient	99324–99328
Established patient	99334–99337
Home services	
New patient	99341–99345
Established patient	99347–99350
Team conference services	
Team conferences with patient/family[2]	99366
Team conferences without patient/family	99367
Behavior change interventions	
Smoking and tobacco use cessation	99406–99407
Alcohol and/or substance abuse structured screening and brief intervention	99408–99409
Non-face-to-face physician services[3]	
Telephone services	99441–99443
On-line medical evaluation	99444
NEW Interprofessional telephone/internet consultations	99446-99449
Basic life and/or disability evaluation services	99450
Work-related or medical disability evaluation services	99455–99456
Complex chronic care coordination services	99487-99489
Transitional Care Management Services	
Transitional Care management services	99495-99495

[1]Medicare no longer recognizes these codes.
[2]For team conferences with the patient/family present, physicians should use the appropriate evaluation and management code in lieu of a team conference code.
[3]Medicare covers only face-to-face services.

Step 2: Review the Descriptors and Reporting Instructions for the E/M Service Selected

Most of the categories and many of the subcategories of E/M services have special guidelines or instructions governing the use of the codes. For example, under the description of initial hospital care for a new or established patient, the CPT manual indicates that the inpatient care level of service reported by the admitting physician should include the services related to the admission that he or she provided in other sites of service as well as in the inpatient setting. E/M services that are provided on the same date in sites other than the hospital and that are related to the admission should *not* be reported separately.

Examples of Descriptors for CPT Codes Used Most Frequently by Psychiatrists

99221—Initial hospital care, per day, for the evaluation and management of a
patient, which requires these three key components:
- A detailed or comprehensive history
- A detailed or comprehensive examination
- Medical decision making that is straightforward or of low complexity

Counseling and/or coordination of care with other providers or agencies is
provided consistent with the nature of the problem(s) and the patient's and/or
family's needs.

Usually, the problem(s) requiring admission are of low severity. Physicians
typically spend 30 minutes at the bedside and on the patient's hospital floor or
unit.

99222—Initial hospital care, per day, for the evaluation and management of a
patient, which requires these three key components:
- A comprehensive history
- A comprehensive examination
- Medical decision making of moderate complexity

Counseling and/or coordination of care with other providers or agencies is
provided consistent with the nature of the problem(s) and the patient's and/or
family's needs.

Usually, the problem(s) requiring admission are of moderate severity. Physicians
typically spend 50 minutes at the bedside and on the patient's hospital floor or
unit.

99223—Initial hospital care, per day, for the evaluation and management of a
patient, which requires these three key components:
- A comprehensive history
- A comprehensive examination
- Medical decision making of high complexity

Counseling and/or coordination of care with other providers or agencies is
provided consistent with the nature of the problem(s) and the patient's and/or
family's needs.

Usually, the problem(s) requiring admission are of low severity. Physicians
typically spend 70 minutes at the bedside and on the patient's hospital floor or
unit.

Step 3: Review the Service Descriptors and the Requirements for the Key Components of the Selected E/M Service

Almost every category or subcategory of E/M service lists the required level of history, examination, or medical decision making for that particular code. (See the list of codes later in the chapter.)

For example, for E/M code 99223 the service descriptor is "Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components" and the code requires

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Each of these components are described in Steps 4, 5, and 6.

Step 4: Determine the Extent of Work Required in Obtaining the History

The extent of the history obtained is driven by clinical judgment and the nature of the presenting problem. Four levels of work are associated with history taking. They range from the simplest to the most complete and include the components listed in the sections that follow.

The elements required for each type of history are depicted in Table 4 – 2. Note that each history type requires more information as you read down the left-hand column. For example, a problem-focused history requires the documentation of the chief complaint (CC) and a brief history of present illness (HPI), and a detailed history requires the documentation of a CC, an extended HPI, an extended review of systems (ROS), and a pertinent past, family, and/or social history (PFSH).

The extent of information gathered for a history is dependent on clinical judgment and the nature of the presenting problem. Documentation of patient history includes some or all of the following elements.

A. CHIEF COMPLAINT (CC)

The chief complaint is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. It is usually stated in the patient's own words. For example, "I am anxious, feel depressed, and am tired all the time."

B. HISTORY OF PRESENT ILLNESS (HPI)

The history of present illness 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. HPI elements are:

- Location (e.g., feeling depressed)
- Quality (e.g., hopeless, helpless, worried)
- Severity (e.g., 8 on a scale of 1 to 10)
- Duration (e.g., it started 2 weeks ago)

TABLE 4–2. ELEMENTS REQUIRED FOR EACH TYPE OF HISTORY

TYPE OF HISTORY	CHIEF COMPLAINT	HISTORY OF PRESENT ILLNESS	REVIEW OF SYSTEMS	PAST, FAMILY, AND/OR SOCIAL HISTORY
Problem focused	Required	Brief	N/A	N/A
Expanded problem focused	Required	Brief	Problem pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

- Timing (e.g., worse in the morning)
- Context (e.g., fired from job)
- Modifying factors (e.g., feels better with people around)
- Associated signs and symptoms (e.g., loss of appetite, loss of weight, loss of sexual interest)

There are two types of HPIs, *brief* and *extended:*

1. *Brief* includes documentation of one to three HPI elements. In the following example, three HPI elements—location, severity, and duration—are documented:

   - CC: Patient complains of depression.
   - Brief HPI: Patient complains of feeling severely depressed for the past 2 weeks.

2. *Extended* includes documentation of at least four HPI elements or the status of at least three chronic or inactive conditions. In the following example, five HPI elements—location, severity, duration, context, and modifying factors—are documented:

   - CC: Patient complains of depression.
   - Extended HPI: Patient complains of feelings of depression for the past 2 weeks. Lost his job 3 weeks ago. Is worried about finances. Trouble sleeping, loss of appetite, and loss of sexual interest. Rates depressive feelings as 8/10.

C. REVIEW OF SYSTEMS (ROS)

The review of systems is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced. The following systems are recognized:

- Constitutional (e.g., temperature, weight, height, blood pressure)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory

- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

There are three levels of ROS:

1. **Problem pertinent**, which inquires about the system directly related to the problem identified in the HPI. In the following example, one system—psychiatric—is reviewed:
   - CC: Depression.
   - ROS: Positive for appetite loss and weight loss of 5 pounds (gastrointestinal/constitutional).

2. **Extended**, which inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems. In the following example, two systems—constitutional and neurological—are reviewed:
   - CC: Depression.
   - ROS: Patient reports a 5-lb weight loss over 3 weeks and problems sleeping, with early morning wakefulness.

3. **Complete**, which inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of 10) body systems. In the following example, 10 signs and symptoms are reviewed:
   - CC: Patient complains of depression.
   - ROS:
     a. Constitutional: Weight loss of 5 lb over 3 weeks
     b. Eyes: No complaints
     c. Ear, nose, mouth, throat: No complaints
     d. Cardiovascular: No complaints
     e. Respiratory: No complaints
     f. Gastrointestinal: Appetite loss
     g. Urinary: No complaints
     h. Skin: No complaints
     i. Neurological: Trouble falling asleep, early morning awakening
     j. Psychiatric: Depression and loss of sexual interest

D. PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

There are three basic history areas required for a complete PFSH:

1. Past medical/psychiatric history: Illnesses, operations, injuries, treatments

2. Family history: Family medical history, events, hereditary illnesses
3. Social history: Age-appropriate review of past and current activities

The data elements of a textbook psychiatric history, listed below, are substantially more complete than the elements required to meet the threshold for a comprehensive or complete PFSH:

- Family history
- Birth and upbringing
- Milestones
- Past medical history
- Past psychiatric history
- Educational history
- Vocational history
- Religious background
- Dating and marital history
- Military history
- Legal history

The two levels of PFSH are:

1. **Pertinent,** which is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document one item from any of the three history areas. In the following example, the patient's past psychiatric history is reviewed as it relates to the current HPI:

   - Patient has a history of a depressive episode 10 years ago successfully treated with Prozac. Episode lasted 3 months.

2. **Complete.** At least one specific item from two of the three basic history areas must be documented for a complete PFSH for the following categories of E/M services:

   - Office or other outpatient services, established patient
   - Emergency department
   - Domiciliary care, established patient
   - Home care, established patient

   At least one specific item from each of the three basic history areas must be documented for the following categories of E/M services:

   - Office or other outpatient services, new patient
   - Hospital observation services
   - Hospital inpatient services, initial care
   - Consultations
   - Comprehensive nursing facility assessments
   - Domiciliary care, new patient
   - Home care, new patient

Documentation of History. Once the level of history is determined, documentation of that level of HPI, ROS, and PFSH is accomplished by listing the required number of elements for each of the three components (see Table 4 – 3).

TABLE 4–3. PATIENT HISTORY TAKING

ELEMENT	LEVELS			
Level of history is achieved when all four of the four criteria for each element are completed for that level.	Problem focused	Expanded problem focused	Detailed	Comprehensive
	CRITERIA			
Chief complaint (always required): Should include a brief statement, usually in the patient's own words; symptom(s); problem; condition; diagnosis; and reason for the encounter	Chief complaint	Chief complaint	Chief complaint	Chief complaint
History of the present illness: A chronological description of the development of the patient's present illness • Associated signs and symptoms • Context • Duration • Location • Modifying factors • Quality • Severity • Timing	Brief, one to three bullets	Brief, one to three bullets	Extended, four or more bullets	Extended, four or more bullets
Review of systems: An inventory of body systems to identify signs and/or symptoms • Allergic, immunologic • Cardiovascular • Constitutional (fever, weight loss) • Ears, nose, mouth, throat • Endocrine • Eyes • Gastrointestinal • Genitourinary • Hematologic, lymphatic • Integumentary (skin, breast) • Musculoskeletal • Neurological • Psychiatric • Respiratory	None	Pertinent to problem, one system	Extended, two to nine systems	Complete, 10 or more systems or some systems with statement "all others negative"
Past, family, and/or social history: Chronological review of relevant data • Past history: Illnesses, operations, injuries, treatments • Family history: Family medical history, events, hereditary illnesses • Social history: Age-appropriate review of past and current activities	None	None	Pertinent, one history area	Complete, two or three history areas

An ROS and/or PFSH taken during an earlier visit need not be rerecorded if there is evidence that it has been reviewed and any changes to the previous information have been noted. The ROS may be obtained by ancillary staff or may be provided on forms completed by the patient. The clinician must review the ROS, supplement and/or confirm the pertinent positives and negatives, and document the review. By doing so, the clinician takes medical-legal responsibility for the accuracy of the data. If the condition of the patient prevents the clinician from obtaining a history, the clinician should describe the patient's condition or the circumstances that precluded obtaining the history. **Failure to provide and record the required number of elements of the ROS for the level of history designated is the most frequently cited deficiency in audits of clinicians' mental health records.**

See Appendix H for examples of templates that provide a structure that will ensure that the clinician's note and documentation requirements are met. The Attending Physician Admitting Note template for initial hospital case with a complete history qualifies for a comprehensive level of history. The Attending Physician Subsequent Care template for inpatient subsequent care or outpatient established care contains the required elements for three levels of inpatient subsequent care or five levels of outpatient established care.

Step 5: Determine the Extent of Work in Performing the Examination

The mental status examination of a patient is considered a single system examination. The elements of the examination are provided in Table 4 – 4. This definition of what composes a mental status examination was jointly published by the American Medical Association and Health Care Financing Administration (now CMS) in 1997. There are four levels of work associated with performing a mental status examination.

Table 4 – 4 is a summary of the four levels of examination and the number of bullets (elements) required for each level. Template examples for the mental status examination are illustrated in Appendix H. **Failure to provide and record the required number of constitutional elements (including vital signs) is the second most frequently cited deficiency in audits of clinicians' medical records.**

Step 6: Determine the Complexity of Medical Decision Making

Medical decision making is the complex task of establishing a diagnosis and selecting treatment and management options. **Medical decision making is closely tied to the nature of the presenting problem.** A *presenting problem* is a disease, symptom, sign, finding, complaint, or other reason for the encounter having been initiated.

- *Minimal*—A problem that may or may not require physician presence, but the services provided are under physician supervision.
- *Self-limited or minor*—A problem that is transient, runs a definite course, and is unlikely to permanently alter health status.

TABLE 4–4. CONTENT AND DOCUMENTATION REQUIREMENTS FOR THE SINGLE SYSTEM PSYCHIATRIC EXAMINATION

SYSTEM/BODY AREA AND ELEMENTS OF EXAMINATION	CRITERIA			
	One to five elements identified by a bullet	At least six elements identified by a bullet	At least nine elements identified by a bullet	*Perform All* elements identified by a bullet; document all elements in the **shaded areas** (Constitutional and Psychiatric) and at least one element in the musculoskeletal area
Constitutional • Measurement of *any three of the following seven vital signs* (may be measured and recorded by ancillary staff): 1. Sitting or standing blood pressure 2. Supine blood pressure 3. Pulse rate and regularity 4. Respiration 5. Temperature 6. Height 7. Weight • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) **Musculoskeletal** • Assessment of muscle strength and tone, **or** • Examination of gait and station **Psychiatric** *Description of patient's* • Speech, including rate, volume, articulation, coherence, and spontaneity, with notation of abnormalities (e.g., perseveration, paucity of language) • Thought processes, including rate of thoughts, content of thoughts (e.g., logical versus illogical, tangential), abstract reasoning, and computation • Associations (e.g., loose tangential, circumstantial, intact) • Abnormal psychotic thoughts, including hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions • Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability) • Judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) *Complete mental status examination, including* • Orientation to time, place, and person • Recent and remote memory • Attention span and concentration • Language (e.g., naming objects, repeating phrases) • Fund of knowledge (e.g., awareness of current events, past history, vocabulary)				
Level of examination is achieved when the number of criteria specified for a given level is met	Problem focused	Expanded problem focused	Detailed	Comprehensive

- *Low severity*—A problem of low morbidity, no risk of mortality, and expectation of full recovery with no residual functional incapacity.
- *Moderate severity*—A problem with moderate risk of morbidity and/or mortality without treatment, uncertain outcome, and probability of prolonged functional impairment.
- *High severity*—A problem of high to extreme morbidity without treatment, moderate to high risk of mortality without treatment, and/or probability of severe, prolonged functional impairment.

Medical decision making is based on three sets of data:

1. *The number of diagnoses and management options:* As specified in Table 4 – 5, this is the first step in determining the type of medical decision making.

TABLE 4–5. NUMBER OF DIAGNOSES AND MANAGEMENT OPTIONS

	MINIMAL	**LIMITED**	**MULTIPLE**	**EXTENSIVE**
Diagnoses	One established	One established [and] one rule-out or differential	Two rule-out or differential	More than two rule-out or differential
Problem(s)	Improved	Stable Resolving	Unstable Failing to change	Worsening Marked change
Management options	One or two	Two or three	Three changes in treatment plan	Four or more changes in treatment plan

Note. To qualify for a given type of decision making, two of three elements must be met or exceeded.

2. *The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed:* Table 4 – 6 lists the elements and criteria that determine the level of decision making for this set of data.

TABLE 4–6. AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

	MINIMAL	**LIMITED**	**MODERATE**	**EXTENSIVE**
Medical data	One source	Two sources	Three sources	Multiple sources
Diagnostic tests	Two	Three	Four	More than four
Review of results	Confirmatory review	Confirmation of results with another physician	Results discussed with physician performing tests	Unexpected results, contradictory reviews, requires additional reviews

Note. To qualify for a given type of decision making, two of three elements must be met or exceeded.

3. *Risk of complications and/or morbidity or mortality as well as comorbidities:* As with the two previous tables, Table 4 – 7 provides the elements and criteria used to rate this particular data set.

TABLE 4–7. TABLE OF RISK

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	One self-limited problem (e.g., medication side effect)	Laboratory tests requiring venipuncture Urinalysis	Reassurance
Low	Two or more self-limited or minor problems or one stable, chronic illness (e.g., well-controlled depression) or acute uncomplicated illness (e.g., exacerbation of anxiety disorder)	Psychological testing Skull film	Psychotherapy Environmental intervention (e.g., agency, school, vocational placement) Referral for consultation (e.g., physician, social worker)
Moderate	One or more chronic illness with mild exacerbation, progression, or side effects of treatment or two or more stable chronic illnesses or undiagnosed new problem with uncertain prognosis (e.g., psychosis)	Electroencephalogram Neuropsychological Testing	Prescription drug management Open-door seclusion Electroconvulsive therapy, inpatient, outpatient, routine; no comorbid medical conditions
High	One or more chronic illnesses with severe exacerbation, progression, or side effect of treatment (e.g., schizophrenia) or acute illness with threat to life (e.g., suicidal or homicidal ideation)	Lumbar puncture Suicide risk assessment	Drug therapy requiring intensive monitoring (e.g., tapering diazepam for patient in withdrawal) Closed-door seclusion Suicide observation Electroconvulsive therapy; patient has comorbid medical condition (e.g., cardiovascular disease) Rapid intramuscular neuroleptic administration Pharmacological restraint

Source. Modified from CMS 1997 Guidelines for Psychiatry Single System Exam.

DETERMINING THE OVERALL LEVEL OF MEDICAL DECISION MAKING

Table 4 – 8 provides a grid that includes the components of the three preceding tables and level of complexity for each of those three components. The overall level of decision making is decided by placing the level of each of the three components into the appropriate box in a manner that allows them to be summed up to rate the overall decision making as *straightforward, low complexity, moderate complexity,* or *high complexity.*

DOCUMENTATION

The use of templates, either preprinted forms or embedded in an electronic patient record (see Appendix H), is an efficient means of addressing the documentation of decision making. Rather than counting or scoring the elements of the three components and actually filling out a grid like the one in the Table 4 – 8, a template can be constructed in collaboration with the compliance officer of your practice or institution to include prompts that capture the required data necessary to document complexity. Solo practitioners may require the assistance of their specialty association or a consultant to develop appropriate templates.

The templates in Appendix H fulfill the documentation requirements for both clinical and compliance needs. The fifth page of the Attending Physician Admission Note template includes all of the elements necessary for addressing Step 6 of the E/M decision-making process. Similarly, the second page of the daily note for inpatient or outpatient care also includes the elements for documenting medical decision making.

Remember: Clinically, there is a close relationship between the nature of the presenting problem and the complexity of medical decision making. For example:

- Patient A comes in for a prescription refill—straightforward decision making
- Patient B presents with suicidal ideation—decision making of high complexity

TABLE 4–8. ELEMENTS AND TYPE OF MEDICAL DECISION MAKING

	TYPE OF DECISION MAKING			
	Straightforward	Low complexity	Moderate complexity	High complexity
Number of diagnoses or management options (Table 4–5)	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data to be reviewed (Table 4–6)	Minimal or none	Limited	Moderate	Extensive
Risk of complications and/or morbidity or mortality (Table 4–7)	Minimal	Low	Moderate	High

Note.   To qualify for a given type of decision making, two of three elements must be met or exceeded.

Step 7: Select the Appropriate Level of E/M Service

As noted earlier, each category of E/M service has three to five levels of work associated with it. Each level of work has a descriptor of the service and the required extent of the three key components of work. For example:

99223   **Descriptor:** Initial hospital care, per day for the evaluation and management of a patient, which requires these three key components:

- A comprehensive history
- A comprehensive examination
- Medical decision making that is of high complexity

For new patients, the three key components (history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for each level of service for office visits, initial hospital care, office consultations, initial inpatient consultations, confirmatory consultations, emergency department services, comprehensive nursing facility assessments, domiciliary care, and home services.

For established patients, two of the three key components (history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for each level of service for office visits, subsequent hospital care, follow-up inpatient consultations, subsequent nursing facility care, domiciliary care, and home care.

WHEN COUNSELING AND COORDINATION OF CARE ACCOUNT FOR MORE THAN 50% OF THE FACE-TO-FACE PHYSICIAN–PATIENT ENCOUNTER

When counseling and coordination of care account for more than 50% of the face-to-face physician – patient encounter, then time becomes the key or controlling factor in selecting the level of service. Note that counseling or coordination of care must be documented in the medical record. The definitions of counseling, coordination of care, and time follow.

Counseling is a discussion with a patient or the patient's family concerning one or more of the following issues:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of adherence to chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Coordination of care is not specifically defined in the E/M section of the CPT manual. A working definition of the term could be as follows: Services provided by the physician responsible for the direct care of a patient when he or she coordinates or controls access to care or initiates or supervises other healthcare ser-

vices needed by the patient. Outpatient coordination of care must be provided face-to-face with the patient. Coordination of care with other providers or agencies without the patient being present on that day is reported with the case management codes.

TIME

For the purpose of selecting the level of service, time has two definitions.

1. For office and other outpatient visits and office consultations, *intraservice time* (time spent by the clinician providing services with the patient and/or family present) is defined as face-to-face time. Pre- and post-encounter time (non-face-to-face time) is not included in the average times listed under each level of service for either office or outpatient consultative services. The work associated with pre- and post-encounter time has been calculated into the total work effort provided by the physician for that service.

2. Time spent providing inpatient and nursing facility services is defined as *unit/ floor time*. Unit/floor time includes all work provided to the patient while the psychiatrist is on the unit. This includes the following:
    - Direct patient contact (face-to-face)
    - Review of charts
    - Writing of orders
    - Writing of progress notes
    - Reviewing test results
    - Meeting with the treatment team
    - Telephone calls
    - Meeting with the family or other caregivers
    - Patient and family education

Work completed before and after direct patient contact and presence on the unit/floor, such as reviewing X-rays in another part of the hospital, has been included in the calculation of the total work provided by the physician for that service. Unit/floor time may be used to select the level of inpatient services by matching the total unit/floor time to the average times listed for each level of inpatient service. For instance:

99221   **Descriptor:** Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:

- A detailed or comprehensive history
- A detailed or comprehensive examination
- Medical decision making that is straightforward or of low complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

Table 4 – 9 provides an example of an auditor's worksheet employed in making the decision of whether to use time in selecting the level of service. The three questions are prompts that assist the auditor (usually a nurse reviewer) in assessing whether the clinician 1) documented the length of time of the patient encounter, 2) described the counseling or coordination of care, and 3) indicated that more than half of the encounter time was for counseling or coordination of care.

> **Important:** If you elect to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter should be documented and the record should describe the counseling and/or services or activities performed to coordinate care.

TABLE 4–9. CHOOSING LEVEL BASED ON TIME

	YES	NO
Does documentation reveal total time? Time: Face-to-face in outpatient setting; unit/floor in inpatient setting		
Does documentation describe the content of counseling or coordinating care?		
Does documentation suggest that more than half of the total time was counseling or coordinating of care?		

Note.   If all answers are yes, select level based on time.

For examples and vignettes of code selection in specific clinical settings, see Chapter 5.

EVALUATION AND MANAGEMENT CODES MOST LIKELY TO BE USED BY PSYCHIATRISTS AND OTHER APPROPRIATELY LICENSED MENTAL HEALTH PROFESSIONALS

It is vital to read the explanatory notes in the CPT manual for an accurate understanding of when each of these codes should be used.

> **Note:** For each of the following codes it is noted that: "Counseling and/or coordination of care with other providers or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs." As stated earlier, when this counseling and coordination of care accounts for more than 50% of the time spent, the typical time given in the code descriptor may be used for selecting the appropriate code rather than the other factors.

Office or Other Outpatient Services

NEW PATIENT

99201—The three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 10 minutes face-to-face with patient and/or family

99202—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low to moderate severity
Typical time: 20 minutes face-to-face with patient and/or family

99203—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 30 minutes face-to-face with patient and/or family

99204—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity
Typical time: 45 minutes face-to-face with patient and/or family

99205—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Moderate to high severity

Typical time: 60 minutes face-to-face with patient and/or family

ESTABLISHED PATIENT

99211—This code is used for a service that may not require the presence of a physician. Presenting problems are minimal, and 5 minutes is the typical time that would be spent performing or supervising these services.

99212—Two of the three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 10 minutes face-to-face with patient and/or family

99213—Two of the three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Low to moderate severity

Typical time: 15 minutes face-to-face with patient and/or family

99214—Two of the three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 25 minutes face-to-face with patient and/or family

99215—Two of the three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Moderate to high severity

Typical time: 40 minutes face-to-face with patient and/or family

Hospital Observational Services

OBSERVATION CARE DISCHARGE SERVICES

99217—This code is used to report all services provided on discharge from "observation status" if the discharge occurs after the initial date of "observation status."

INITIAL OBSERVATION CARE

99218—The three following components are required:

- Detailed or comprehensive history
- Detailed or comprehensive examination
- Medical decision making of straightforward or of low complexity

Presenting problem(s): Low severity
Typical time: None listed

99219—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate severity

Typical time: None listed

99220—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): High severity
Typical time: None listed

Hospital Inpatient Services

Services provided in a partial hospitalization setting would also use these codes. (With the elimination of the consultation codes as of January 1, 2010, CMS has created a new modifier A1, that is used to denote the admitting physician.)

INITIAL HOSPITAL CARE FOR NEW OR ESTABLISHED PATIENT

99221—The three following components are required:

- Detailed or comprehensive history
- Detailed or comprehensive examination
- Medical decision making that is straightforward or of low complexity

Presenting problem(s): Low severity

Typical time: 30 minutes at the bedside or on the patient' s floor or unit

99222—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate severity

Typical time: 50 minutes at the bedside or on the patient' s floor or unit

99223—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): High severity

Typical time: 70 minutes at the bedside or on the patient' s floor or unit

SUBSEQUENT HOSPITAL CARE

99231—**Two of the three following components are required:**
- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward or of low complexity

Presenting problem(s): Patient usually stable, recovering, or improving
Typical time: 15 minutes at the bedside or on the patient's floor or unit

99232—**Two of the three following components are required:**
- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of moderate complexity

Presenting problem(s): Patient responding inadequately to therapy or has developed a minor complication
Typical time: 25 minutes at the bedside or on the patient's floor or unit

99233—**Two of the three following components are required:**
- Detailed interval history
- Detailed examination
- Medical decision making of high complexity

Presenting problem(s): Patient unstable or has developed a significant new problem
Typical time: 35 minutes at the bedside or on the patient's floor or unit

HOSPITAL DISCHARGE SERVICES

99238—**Time: 30 minutes or less**

99239—**Time: More than 30 minutes**

Consultations

Medicare no longer pays for the consultation codes. When coding for Medicare or for commercial carriers that have followed Medicare's lead, 90801 may be used for both inpatient and outpatient consults. Psychiatrists who choose to use E/M codes to report outpatient consults should use the outpatient new patient codes (99201 – 99205). For inpatient consults, the codes to use are hospital inpatient services, initial hospital care for new or established patients (99221 – 99223). For consults in nursing homes, initial nursing facility care codes should be used (99304 – 99306); if the consult is of low complexity, the subsequent nursing facility codes may be used (99307 – 99310). As with all E/M codes, the selection of the specific code is based on the complexity of the case and the amount of work required. Medicare has created a new modifier, A1, to denote the admitting physician so that more than one physician may use the initial hospital care codes.

OFFICE OR OTHER OUTPATIENT CONSULTATIONS

99241—The three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 15 minutes face-to-face with patient and/or family

99242—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low severity

Typical time: 30 minutes face-to-face with patient and/or family

99243—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 40 minutes face-to-face with patient and/or family

99244—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 60 minutes face-to-face with patient and/or family

99245—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Moderate to high severity

Typical time: 80 minutes face-to-face with patient and/or family

INPATIENT CONSULTATIONS

99251—The three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 20 minutes at the bedside or on the patient' s floor or unit

99252—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making that is straightforward

    Presenting problem(s): Low severity

    Typical time: 40 minutes at the bedside or on the patient's floor or unit

99253—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of low complexity

    Presenting problem(s): Moderate severity

    Typical time: 55 minutes at the bedside or on the patient's floor or unit

99254—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

    Presenting problem(s): Moderate to high severity

    Typical time: 80 minutes at the bedside or on the patient's floor or unit

99255—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

    Presenting problem(s): Moderate to high severity

    Typical time: 110 minutes at the bedside or on the patient's floor or unit

Emergency Department Services

No distinction is made between new and established patients in this setting. There are no typical times provided for emergency E/M services.

99281—The three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

    Presenting problem(s): Self-limited or minor

99282—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

    Presenting problem(s): Low or moderate severity

99283—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of moderate complexity

    Presenting problem(s): Moderate severity

99284—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

    Presenting problem(s): High severity

99285—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

    Presenting problem(s): High severity and pose(s) an immediate and significant threat to life or physiological function

Nursing Facility Services

INITIAL NURSING FACILITY CARE

99304—The three following components are required:

- Detailed or comprehensive history
- Detailed or comprehensive examination
- Medical decision making that is straightforward or of low complexity

    Problem(s) requiring admission: Low severity

    Typical time: 25 minutes with patient and/or family or caregiver

99305—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

    Problem(s) requiring admission: Moderate severity
    Typical time: 35 minutes with patient and/or family or caregiver

99306—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

    Problem(s) requiring admission: High severity
    Typical time: 45 minutes with patient and/or family or caregiver

SUBSEQUENT NURSING FACILITY CARE

99307—Two of the three following components are required:

- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward

   Presenting problem(s): Patient usually stable, recovering, or improving
   Typical time: 10 minutes with patient and/or family or caregiver

99308—Two of the three following components are required:

- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of low complexity

   Presenting problem(s): Patient usually responding inadequately to therapy or has developed a minor complication
   Typical time: 15 minutes with patient and/or family or caregiver

99309—Two of the three following components are required:

- Detailed interval history
- Detailed examination
- Medical decision making of moderate complexity

   Presenting problem(s): Patient usually has developed a significant complication or a significant new problem
   Typical time: 25 minutes with patient and/or family or caregiver

99310—Two of the three following components are required:

- Comprehensive interval history
- Comprehensive examination
- Medical decision making of high complexity

   Presenting problem(s): Patient may be unstable or may have developed a significant new problem requiring immediate physician attention
   Typical time: 35 minutes with patient and/or family or caregiver

NURSING FACILITY DISCHARGE SERVICES

99315—Time: 30 minutes or less

99316—Time: More than 30 minutes

ANNUAL NURSING FACILITY ASSESSMENT

99318—The three following components are required:

- Detailed interval history
- Comprehensive examination
- Medical decision making of low to moderate complexity
   Presenting problem(s): Patient usually stable, recovering, or improving
   Typical time: 30 minutes with patient and/or family or caregiver

Domiciliary, Rest Home, or Custodial Care Services

The following codes are used to report E/M services in a facility that provides room, board, and other personal services, usually on a long-term basis. They are also used in assisted living facilities.

NEW PATIENT

99324—The three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Low severity

Typical time: 20 minutes with patient and/or family or caregiver

99325—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 30 minutes with patient and/or family or caregiver

99326—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity
Typical time: 45 minutes with patient and/or family or caregiver

99327—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): High severity
Typical time: 60 minutes with patient and/or family or caregiver

99328—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Patient usually has developed a significant new problem requiring immediate physician attention
Typical time: 75 minutes with patient and/or family or caregiver

ESTABLISHED PATIENT

99334—Two of the three following components are required:

- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward

    Presenting problem(s): Self-limited or minor

    Typical time: 15 minutes with patient and/or family or caregiver

99335—Two of the three following components are required:

- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of low complexity

    Presenting problem(s): Low to moderate severity

    Typical time: 25 minutes with patient and/or family or caregiver

99336—Two of the three following components are required:

- Detailed interval history
- Detailed examination
- Medical decision making of moderate complexity

    Presenting problem(s): Moderate to high severity

    Typical time: 40 minutes with patient and/or family or caregiver

99337—Two of the three following components are required:

- Comprehensive interval history
- Comprehensive examination
- Medical decision making of moderate to high complexity

    Presenting problem(s): Patient may be unstable or has developed a significant new problem requiring immediate physician attention
    Typical time: 60 minutes with patient and/or family or caregiver

Home Services

These codes are used for E/M services provided to a patient in a private residence, in other words, for home visits.

NEW PATIENT

99341—The three following components are required:

- Problem-focused history
- Problem-focused examination
- Medical decision making that is straightforward

    Presenting problem(s): Low severity

    Typical time: 20 minutes face-to-face with patient and/or family

99342—The three following components are required:

- Expanded problem-focused history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Moderate severity

Typical time: 30 minutes face-to-face with patient and/or family

99343—The three following components are required:

- Detailed history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity
Typical time: 45 minutes face-to-face with patient and/or family

99344—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of moderate complexity

Presenting problem(s): High severity

Typical time: 60 minutes face-to-face with patient and/or family

99345—The three following components are required:

- Comprehensive history
- Comprehensive examination
- Medical decision making of high complexity

Presenting problem(s): Patient unstable or has developed a significant new problem that requires immediate physician attention

Typical time: 75 minutes face-to-face with patient and/or family

ESTABLISHED PATIENT

99347—Two of the three following components are required:

- Problem-focused interval history
- Problem-focused examination
- Medical decision making that is straightforward

Presenting problem(s): Self-limited or minor

Typical time: 15 minutes face-to-face with patient and/or family

99348—Two of the three following components are required:

- Expanded problem-focused interval history
- Expanded problem-focused examination
- Medical decision making of low complexity

Presenting problem(s): Low to moderate severity

Typical time: 25 minutes face-to-face with patient and/or family

99349—**Two of the three following components are required:**

- Detailed interval history
- Detailed examination
- Medical decision making of moderate complexity

Presenting problem(s): Moderate to high severity

Typical time: 40 minutes face-to-face with patient and/or family

99350—**Two of the three following components are required:**

- Comprehensive interval history
- Comprehensive examination
- Medical decision making of moderate to high complexity

Presenting problem(s): Moderate to high severity—patient may be unstable or may have developed a significant new problem requiring immediate physician attention

Typical time: 60 minutes face-to-face with patient and/or family

Case Management Services

MEDICAL TEAM CONFERENCES

99366—**To be used when patient and/or family is present***
Physicians should use the appropriate code from the "Evaluation and Management" section when reporting this service.

99367—**To be used when there is no face-to-face contact with the patient and/or family**

Preventive Medicine Services

COUNSELING RISK FACTOR REDUCTION AND BEHAVIOR CHANGE INTERVENTION

99406—**Time: 3–10 minutes**

99407—**Time: More than 10 minutes**

99408—**Time: 15–30 minutes, includes the administration of an alcohol and/or substance abuse screening tool and brief intervention**

99409—**Time: 30 minutes or more**

NON-FACE-TO-FACE SERVICES

Medicare does not pay for these.

Telephone Services

99441—**Time: 5–10 minutes of medical discussion**

99442—**Time: 11–20 minutes of medical discussion**

99443—Time: 21–30 minutes of medical discussion

On-Line Medical Evaluation

99444—For an established patient, guardian, or healthcare provider; may not have originated from a related E/M service provided within the previous 7 days.

Special Evaluation and Management Services

Medicare does not pay for these.

BASIC LIFE AND/OR DISABILITY EVALUATION SERVICES

99450—The four following elements are required:

- Measurement of height, weight, and blood pressure
- Completion of a medical history following a life insurance pro forma
- Collection of blood sample and/or urinalysis complying with "chain of custody" protocols
- Completion of necessary documentation/certificates

WORK-RELATED OR MEDICAL DISABILITY EVALUATION SERVICES

99455—Work-related medical disability examination done by the treating physician; the five following elements are required:

- Completion of medical history commensurate with the patient's condition
- Performance of an examination commensurate with the patient's condition
- Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment
- Development of future medical treatment plan
- Completion of necessary documentation/certificates, and report

99456—Work-related medical disability examination done by provider other than the treating physician. Must include the same five elements listed for previous code.

This is just a partial list of codes found in the "Evaluation and Management" section of the CPT manual. We advise all psychiatrists and other mental health clinicians to purchase a copy of the manual to ensure access to information on the full range of codes.

[End]

1997 CMS Documentation Guidelines for Evaluation and Management Services (Abridged and Modified for Psychiatric Services)

I. INTRODUCTION

A.   What Is Documentation and Why Is It Important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history, including past and pres- ent illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high-quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his or her healthcare over time;
- communication and continuity of care among physicians and other health- care professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

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

B.   What Do Payers Want and Why?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

II.   GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed here are applicable to all types of medical and surgical services in all settings. For evaluation and management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service, and the patient's status. The general principles listed here may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:

a. reason for the encounter and relevant history, physical examination find- ings, and prior diagnostic test results;
b. assessment, clinical impression, or diagnosis;
c. plan for care; and
d. date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The Current Procedural Terminology (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.

III. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits that consist predominantly of counseling or coordination of care. The three *key* components—history, examination, and medical decision making—appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. Documentation guidelines are identified by the symbol *DG.*

The descriptors for the levels of E/M services recognize seven components that are used in defining the levels of E/M services:

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The first three of these components (i.e., history, examination, and medical decision making) are the key components in selecting the level of E/M services. In the case of visits that consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of E/M service is dependent on two or three key compo- nents, performance and documentation of one component (e.g., examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

These Documentation Guidelines for E/M services reflect the needs of the typical adult population. For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents, and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present ill- ness the details of mother's pregnancy and the infant's status at birth; social his- tory will focus on family structure; and family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child. Al- though not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A.   Documentation of History

The levels of E/M services are based on four types of history (problem focused, expanded problem focused, detailed, and comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS)
- Past, family, and/or social history (PFSH)

The extent of HPI, ROS, and PFSH that is obtained and documented is de- pendent on clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history all three elements in the table must be met. (A CC is indicated at all levels.)

History of present illness (HPI)	Review of systems (ROS)	Past, family, and/or social history	Type of history
Brief	N/A	N/A	Problem focused
Brief	Problem pertinent	N/A	Expanded problem focused
Extended	Extended	Pertinent	Detailed
Extended	Complete	Complete	Comprehensive

DG: The CC, ROS, and PFSH may be listed as separate elements of history or may be included in the description of the history of the present illness.

DG: An ROS and/or a PFSH obtained during an earlier encounter does not need to be re- recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by
- describing any new ROS and/or PFSH information or noting there has been no change in the information; and
- noting the date and location of the earlier ROS and/or PFSH.

DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a

history.

Definitions and specific documentation guidelines for each of the elements of history are listed in the following sections.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words.

DG: The medical record should clearly reflect the CC.

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's pres- ent illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

Brief and *extended* HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).
A *brief* HPI consists of one to three elements of the HPI.

DG: The medical record should describe one to three elements of the present illness.

An *extended* HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

DG: The medical record should describe at least four elements of the present ill- ness or the status of at least three chronic or inactive conditions.

REVIEW OF SYSTEMS (ROS)

An ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.
For purposes of the ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)

- Neurological
- Psychiatric
- Endocrine
- Hematological/Lymphatic
- Allergic/Immunologic

A *problem pertinent* ROS inquires about the system directly related to the problem(s) identified in the HPI.

DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.

An *extended* ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

DG: The patient's positive responses and pertinent negatives for two to nine systems should be documented.

A *complete* ROS inquires about the system(s) directly related to the problem(s) identified in the HPI *plus* all additional body systems.

DG: At least 10 organ systems must be reviewed. 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 experiences with illnesses, operations, injuries, and treatments)
- Family history (a review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk)
- Social history (an age-appropriate review of past and current activities)

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations, and subsequent nursing facility care. A *pertinent* PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.

A *complete* PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient.

DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.

B.   Documentation of Examination

The levels of E/M services are based on four types of examination:

- *Problem focused*—A limited examination of the affected body area or organ system.
- *Expanded problem focused*—A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
- *Detailed*—An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
- *Comprehensive*—A general multisystem examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

These types of examinations have been defined for general multisystem and the following single organ systems:

- Cardiovascular
- Ears, nose, mouth, and throat
- Eyes
- Genitourinary (female)
- Genitourinary (male)
- Hematological/Lymphatic/Immunological
- Musculoskeletal
- Neurological
- **Psychiatric**
- Respiratory
- Skin

A general multisystem examination or a single organ system examination may be performed by any physician regardless of specialty. The type (general multisystem or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s).

The content and documentation requirements for each type and level of examination are summarized here and described in detail in the tables that appear later in this appendix. In the first table (see pp. 123), organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (•) in the right column.

Parenthetical examples "(e.g., ...)" have been used for clarification and to provide guidance regarding documentation. Documentation for each element must satisfy any numeric requirements (such as "Measurement of *any three of the following seven*...") included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as "Examination of *liver* and *spleen*") require documentation of at least one component. It is possible for a given examination to be expanded beyond what is de- fined here. When that occurs, findings related to the additional systems and/or areas should be documented.

DG: *Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.*

DG: *Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.*

DG: *A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*

[DELETED: GUIDELINES FOR "GENERAL MULTI-SYSTEM EXAMINATIONS"]

SINGLE ORGAN SYSTEM EXAMINATIONS

The single organ system examinations recognized by CPT are described in detail. **[*Authors' note:* We are only including the psychiatric examination.]** Variations among these examinations in the organ systems and body areas identified in the left columns and in the elements of the examinations described in the right columns reflect differing emphases among specialties. To qualify for a given level of single organ system examination, the following content and documentation requirements should be met:

- *Problem focused examination*—Should include performance and documen- tation of one to five elements identified by a bullet (•), whether in a box with a *shaded* or *unshaded* border.

- *Expanded problem focused examination*—Should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a *shaded* or *unshaded* border.

- *Detailed examination*—Examinations other than the eye and psychiatric exam- inations should include performance and documentation of at least 12 elements identified by a bullet (•), whether in box with a *shaded* or *unshaded* border.

- Eye and psychiatric examinations should include the performance and doc- umentation of at least nine elements identified by a bullet (•), whether in a box with a *shaded* or *unshaded* border.

- *Comprehensive examination*—Should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documen- tation of every element in each box with a shaded border and at least one el- ement in each box with an *unshaded* border is expected.

CONTENT AND DOCUMENTATION REQUIREMENTS
[DELETED: CONTENT AND DOCUMENTATION REQUIREMENTS FOR GENERAL MULTI-SYSTEM EXAMINATION AND ALL SINGLE-SYSTEM REQUIREMENTS OTHER THAN PSYCHIATRY]

[Single System] PSYCHIATRIC EXAMINATION

SYSTEM/ BODY AREA	ELEMENTS OF EXAMINATION
Constitutional	• Measurement of any **three** of the following **seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (may be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth, and Throat	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	
Skin	
Neurological	
Psychiatric	• Description of speech, including rate, volume, articulation, coherence, and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language) • Description of thought processes, including rate of thoughts; content of thoughts (e.g., logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (e.g., loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts, including hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions • Description of the patient's judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) Complete mental status examination, including • Orientation to time, place, and person • Recent and remote memory • Attention span and concentration • Language (e.g., naming objects, repeating phrases) • Fund of knowledge (e.g., awareness of current events, past history, vocabulary) • Mood and affect (e.g., depression, anxiety, agitation hypomania, lability)

CONTENT AND DOCUMENTATION REQUIREMENTS [for single system psychiatric exam]

LEVEL OF EXAMINATION	PERFORM AND DOCUMENT
Problem focused	**One to five** elements identified by a bullet.
Expanded problem focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a *shaded* border and at least one element in each box with an *unshaded* border.

C.   Documentation of the Complexity of Medical Decision Making

The levels of E/M services recognize four types of medical decision making: straightforward, low complexity, moderate complexity, and high complexity. *Medical decision making* refers to the complexity of establishing a diagnosis and/ or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- the risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The following chart shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or none	Minimal	*Straightforward*
Limited	Limited	Low	*Low complexity*
Multiple	Moderate	Moderate	*Moderate complexity*
Extensive	Extensive	High	*High complexity*

Each of the elements of medical decision making is described below.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician.
Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic

tests employed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need to seek advice from others is another indicator of the complexity of diagnostic or management problems.

DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

- *For a presenting problem with an established diagnosis, the record should reflect whether the problem is a) improved, well controlled, resolving, or re- solved or b) inadequately controlled, worsening, or failing to change as expected.*

- *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible," "probable," or "rule out" (R/O) diagnosis.*

DG: The initiation of, or changes in, treatment should be documented. Treat- ment includes a wide range of management options including patient instruc- tions, nursing instructions, therapies, and medications.

DG: If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.

AMOUNT AND COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed are based on the types of di- agnostic 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 be- ing reviewed. On occasion the physician who ordered a test may personally review the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service (e.g., laboratory work or X-ray) should be documented.

DG: The review of laboratory, radiology, and/or other diagnostic tests should be documented. A simple notation such as "white blood cells elevated" or "chest X- ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.

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

DG: Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement that obtained from the patient

should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "old records reviewed" or "additional history obtained from family" without elaboration is insufficient.

DG: The results of discussion of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.

DG: The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

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.

DG: Comorbidities/Underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

DG: If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure (e.g., laparoscopy) should be documented.

DG: If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.

DG: The referral for or decision to perform a surgical or invasive diagnostic pro- cedure on an urgent basis should be documented or implied.

The table on p. 128 may be used to help determine whether the risk of sig- nificant complications, morbidity, and/or mortality is *minimal, low, moderate,* or *high.* Because the determination of risk is complex and not readily quantifi- able, the table includes common clinical examples rather than absolute mea- sures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. **The highest level of risk in any one category (presenting problem[s], diagnostic procedure[s], or management options) determines the overall risk.**

D. Documentation of an Encounter Dominated by Counseling or Coordination of Care
In the case in which counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

DG: If the physician elects to report the level of service based on counseling and/ or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented, and the record should de- scribe the counseling and/or activities to coordinate care.

TABLE OF RISK
(MODIFIED FOR PSYCHIATRY FROM THE 1997 CMS GUIDELINES)

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	1 self-limited problem (e.g., medication side effect)	Laboratory tests requiring venipuncture Urinalysis	Reassurance
Low	2 or more self-limited or minor problems; or 1 stable chronic illness (e.g., well-controlled depressions); or Acute uncomplicated illness (e.g., exacerbation of anxiety disorder)	Psychological testing Skull film	Psychotherapy Environmental intervention (e.g., agency, school, vocational placement) Referral for consultation (e.g., physician, social worker)
Moderate	1 or more chronic illnesses with mild exacerbation, progression, or side effects of treatment; or 2 or more stable chronic illnesses; or Undiagnosed new problem with uncertain prognosis (e.g., psychosis)	Electroencephalogram Neuropsychological testing	Prescription drug management Open-door seclusion ECT, inpatient, outpatient, routine; no comorbid medical conditions
High	1 or more chronic illnesses with severe exacerbation, progression, or side effect of treatment (e.g., schizophrenia); or Acute illness with threat to life (e.g., suicidal or homicidal ideation)	Lumbar puncture Suicide risk assessment	Drug therapy requiring intensive monitoring (e.g., tapering diazepam for patient in withdrawal) Closed-door seclusion Suicide observation ECT; patient has comorbid medical condition (e.g., cardiovascular disease) Rapid intramuscular neuroleptic administration Pharmacological restraint (e.g., droperidol)

Appendix G

Most Frequently Missed Items in Evaluation and Management (E/M) Documentation

Medicare

Most Frequently Missed Items in Evaluation and Management (E/M) Documentation

History

- History is too brief and lacks the reason for the encounter or minimal documentation of the reason for the encounter.

- Documentation for the Review of Systems is too minimal.

- If billing for a Complete Review of Systems – either must individually document ten (10) or more systems **OR** may document pertinent (some) systems and make the statement in the progress note "all other systems negative."

- Lacks any documentation in support of why elements of the history or the entire history was unobtainable; would also apply to documenting the work done to attempt to obtain history from sources other than the patient if it was unobtainable from the patient.

- Insufficient documentation of the Past, Family and Social history; no reference to dates or any documentation to support obtaining the information.

- If you wish to refer to a Review of Systems and/or a PFSH documented in a progress note of a previous date and update it with today's information (e.g., unchanged from ROS of 1/4/07 except patient has stopped smoking) – you must specifically indicate the previous date you are referring to in today's note and you must include a photocopy of the previous ROS or PFSH you have referred to if you are asked to send documentation for today's note. Make sure your staff is also aware of this if they will photocopy and send documentation to Medicare.

Physical Exam

- Physical exam documentation is too brief.

- 1997 Specialty exams, billed at the comprehensive level, do not meet all of the required elements for that level.

- For the 1995 Comprehensive exam – required to count ONLY organ systems and not body areas; must be eight (8) or more organ systems only.

- Can choose to perform and document either the 1995 or 1997 physical exam but findings show that most physicians do better with documentation based upon the 1995 guidelines.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medical Decision Making

- Lack of sufficient evidence that labs, X-rays, etc., were performed to credit in this section (Amount and/or Complexity of Data Reviewed or in Table of Risk of Complications and/or Morbidity or Mortality).

- Lack of sufficient documentation of items which could be credited to Reviewed Data (Amount and/or Complexity of Data Reviewed) such as the decision to obtain old records or obtain history from someone other than the patient, review and summarization of old records, discussion of case with another health care provider.

- Remember, in this section, need only two (2) elements of the three and need only the highest, single item available and appropriate in one box of the chart for Risk of Complications and/or Morbidity or Mortality.

Time Based Codes

- In choosing a code based upon time for counseling and coordination of care, total time may be documented but there is not quantification that more than 50 percent of the time was spent on counseling and there is also no documentation of what the coordination of care was or what the counseling was.

- No documentation of time for critical care.

- No documentation of time for discharge day management.

General

- Missing the order for a consultation in hospitals and SNFs.

- Illegible documentation.

- Lack of a physician signature on the note.

- Missing patient names.

- Incorrect dates of service.

- Lack of any note for a billed date of service.

- Lack of the required two (2) or three (3) key elements to bill an E/M service.

1997 CMS Documentation Guidelines for Evaluation and Management Services
(Abridged & Modified for Psychiatric Services)

I.Introduction

What Is Documentation and Why Is It Important?
Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health are over time.
- communication and continuity of care among physicians and other health care professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

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

What Do Payers Want and Why?
Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

II.General Principles of Medical Record Documentation
The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.
1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   - reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   - assessment, clinical impression or diagnosis;
   - plan for care; and
   - date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. 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.

III. Documentation of E/M Services

This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits which consist predominately of counseling or coordination of care. The three *key* components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. Documentation guidelines are identified by the symbol •*DG*.

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:
- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (i.e., history, examination and medical decision making) are the key components in selecting the level of E/M services. In the case of visits which consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (eg, examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

These Documentation Guidelines for E/M services reflect the needs of the typical adult population. For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants,

children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. Documentation of History

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:
- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history all three elements in the table must be met. (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	Problem focused
Brief	Problem Pertinent	N/A	Expanded Problem Focused
Extended	Extended	Pertinent	Detailed
Extended	Complete	Complete	Comprehensive

- *DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.*

- *DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician*

updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:
- *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*
- *noting the date and location of the earlier ROS and/or PFSH.*

- *DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*

- *DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.*

Definitions and specific documentation guidelines for each of the elements of history are listed below.

Chief Complaint (CC)
The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words.
- *DG: The medical record should clearly reflect the chief complaint.*

History of Present Illness (HPI)
The 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 the following elements:
• location,
• quality,
• severity,
• duration,
• timing,
• context,
• modifying factors, and
• associated signs and symptoms.

Brief and *extended* HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).
A *brief* HPI consists of one to three elements of the HPI.
- *DG: The medical record should describe one to three elements of the present illness (HPI).*

An *extended* HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

- *DG: The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions.*

Review of Systems (ROS)
An ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized:
• Constitutional symptoms (e.g., fever, weight loss)
• Eyes
• Ears, Nose, Mouth, Throat
• Cardiovascular
• Respiratory
• Gastrointestinal
• Genitourinary
• Musculoskeletal
• Integumentary (skin and/or breast)
• Neurological
• Psychiatric
• Endocrine
• Hematologic/Lymphatic
• Allergic/Immunologic

A *problem pertinent* ROS inquires about the system directly related to the problem(s) identified in the HPI.
- *DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.*

An *extended* ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.
- *DG: The patient's positive responses and pertinent negatives for two to nine systems should be documented.*

A *complete* ROS inquires about the system(s) directly related to the problem(s) identified in the HPI *plus* all additional body systems.
- *DG: At least ten organ systems must be reviewed. 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 ten 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 experiences with illnesses, operations, injuries and treatments);

- family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- social history (an age appropriate review of past and current activities).

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care.

A *pertinent* PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.
- *DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.*

A *complete* PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.
- *DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient.*

- *DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.*

B. Documentation of Examination
The levels of E/M services are based on four types of examination:
- *Problem Focused* -- a limited examination of the affected body area or organ system.
- *Expanded Problem Focused* -- a limited examination of the affected body area or organ system and any ther symptomatic or related body area(s) or organ system(s).
- *Detailed* -- an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
- *Comprehensive* -- a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

These types of examinations have been defined for general multi-system and the following single organ systems:

• Cardiovascular
• Ears, Nose, Mouth and Throat
• Eyes
• Genitourinary (Female)
• Genitourinary (Male)
• Hematologic/Lymphatic/Immunologic
• Musculoskeletal
• Neurological
• **Psychiatric**
• Respiratory
• Skin

A general multi-system examination or a single organ system examination may be performed by any physician regardless of specialty. The type (general multi-system or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s).

The content and documentation requirements for each type and level of examination are summarized below and described in detail in tables [provided below]. In the tables, organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (•) in the right column.

Parenthetical examples, "(eg, ...)", have been used for clarification and to provide guidance regarding documentation. Documentation for each element must satisfy any numeric requirements (such as "Measurement of *any three of the following seven...*") included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as "Examination of *liver* and *spleen*") require documentation of at least one component. It is possible for a given examination to be expanded beyond what is defined here. When that occurs, findings related to the additional systems and/or areas should be documented.

- *DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.*
- *DG: Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.*
- *DG: A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*

[Deleted: guidelines for "General Multi-System Examinations"]

Single Organ System Examinations

The single organ system examinations recognized by CPT are described in detail [we are only including the psychiatric examination] . Variations among these examinations in the organ systems and body areas identified in the left columns and in the elements of the examinations described in the right columns reflect differing emphases among specialties. To qualify for a given level of single organ system examination, the following content and documentation requirements should be met:

- **Problem Focused Examination**--should include performance and documentation of one to five elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- **Expanded Problem Focused Examination**--should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- **Detailed Examination**--examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet (•), whether in box with a shaded or unshaded border.
  Eye and psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- **Comprehensive Examination**--should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in each box with an unshaded border is expected.

Content and Documentation Requirements
[Deleted: content and documentation requirements for General Multi-System Examination and all single-system requirements other than psychiatry]

Psychiatric Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any 3 of the following 7** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth, and Throat	
Neck	
Respiratory	

Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	• Assessment of muscle strength and tone (eg., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	
Skin	
Neurological	
Psychiatric	• Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language) • Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (eg, loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions • Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition) Complete mental status examination including • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases) • Fund of knowledge (eg, awareness of current events, past history, vocabulary) • Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border

C. Documentation of the Complexity of Medical Decision Making

The levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	*Straightforward*
Limited	Limited	Low	*Low Complexity*
Multiple	Moderate	Moderate	*Moderate Complexity*
Extensive	Extensive	High	*High Complexity*

Each of the elements of medical decision making is described below.

Number of Diagnoses or Management Options
The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

- *DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*

- o *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*

- o *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible", "probable", or "rule out" (R/O) diagnosis.*

- *DG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*

- *DG: If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

Amount and/or Complexity of Data to be Reviewed

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. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- *DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray, should be documented.*

- *DG: The review of lab, radiology and/or other diagnostic tests should be documented. A simple notation such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

- *DG: A decision to obtain old records or decision to obtain additional historyfrom the family, caretaker or other source to supplement that obtained from the patient should be documented.*

- *DG: Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*

- ***DG:*** *The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

- ***DG:*** *The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.*

Risk of Significant Complications, Morbidity, and/or Mortality

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.

- ***DG:*** *Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*

- ***DG:*** *If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, eg, laparoscopy, should be documented.*

- ***DG:*** *If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*

- ***DG:*** *The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is *minimal*, *low*, *moderate*, or *high*. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. **The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.**

TABLE OF RISK
(Modified from 1997 Guidelines for Psychiatry)

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	1 self-limited problem (e.g., medication side effect)	Laboratory tests requiring venipuncture; Urinalysis	Reassurance
Low	2 or more self-limited or minor problems; or 1 stable chronic illness	Psychological testing Skull film	Psychotherapy Environmental intervention (e.g., agency, school,

	(e.g., well-controlled depressions); or Acute uncomplicated illness (e.g., exacerbation of anxiety disorder)		vocational placement) Referral for consultation (e.g., physician, social worker)
Moderate	1 or more chronic illness with mild exacerbation, progression, or side effects of treatment; or 2 or more stable chronic illnesses; or Undiagnosed new problem with uncertain prognosis (e.g., psychosis)	EEG Neuropsychological testing	Prescription drug management Open-door seclusion ECT, inpatient, outpatient, routine; no comorbid medical conditions
High	1 or more chronic illnesses with severe exacerbation, progression, or side effect of treatment (e.g., schizophrenia); or Acute chronic illness with threat to life (e.g., suicidal or homicidal ideation)	Lumbar puncture Suicide risk assessment	Drug therapy requiring intensive monitoring (e.g., taperin diazepam for patient in withdrawal) Closed-door seclusion Suicide observation ECT; patient has comorbid medical condition (e.g., cardiovascular disease) Rapid intramuscular neuroleptic administration Phamacologic restraint (e.g., droperidol)

D. Documentation of an Encounter Dominated by Counseling or Coordination of Care

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

- *DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

3. Medical Decision Making

Risk of Complications and/or Morbidity or Mortality Highest level from presenting problem, Dx procedure, **or** Med Mgt Options selected.

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below).

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Med. Management Options
Minimal	• One self-limited or minor problem	• Laboratory tests requiring venipuncture • EKG/EEG • Urinalysis	• Rest
Low	• Two or more self-limited or minor problems • One stable chronic illness • Acute uncomplicated illness		• Over-the-counter drugs
Moderate	• 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 prognosis, • Acute illness with systemic symptoms		• Prescription drug management
High	• One or more chronic illnesses 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 (self//other)		• Drug therapy requiring intensive monitoring for toxicity (Lithium, clozapine--clozaril, carbamazepine--tegetrol, valproate—depakote, sometimes TCA's)

Final Result for Complexity

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

Final Result for Complexity

A	Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Multiple	≥ 4 Extensive
	Type of decision making	STRAIGHT-FORWARD	LOW COMPLEX.	MODERATE COMPLEX.	HIGH COMPLEX.

4. Time

If the physician documents total time *and* suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

Does documentation reveal total time? Time: Face-to-face in outpatient setting / Unit/floor in inpatient setting	☐ Yes	☐ No
Does documentation describe the content of counseling or coordinating care?	☐ Yes	☐ No
Does documentation reveal that more than half of the time was counseling or coordinating care?	☐ Yes	☐ No

If all answers are "yes", select level based on time.

3. Medical Decision Making   ALTERNATE METHODOLOGY

TABLE 4-5. NUMBER OF DIAGNOSES AND MANAGEMENT OPTIONS

	MINIMAL	LIMITED	MULTIPLE	EXTENSIVE
Diagnoses	One established	One established [and] one rule-out or differential	Two rule-out or differential	More than two rule-out or differential
Problem(s)	Improved	Stable Resolving	Unstable Failing to change	Worsening Marked change
Management options	One or two	Two or three	Three changes in treatment plan	Four or more changes in treatment plan

TABLE 4-6. AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

	MINIMAL	LIMITED	MODERATE	EXTENSIVE
Medical data	One source	Two sources	Three sources	Multiple sources
Diagnostic tests	Two	Three	Four	More than four
Review of results	Confirmatory review	Confirmation of results with another physician	Results discussed with physician performing tests	Unexpected results, contradictory reviews, requires additional reviews

TABLE 4-8. ELEMENTS AND TYPE OF MEDICAL DECISION MAKING

	TYPE OF DECISION MAKING			
	Straightforward	Low complexity	Moderate complexity	High complexity
Number of diagnoses or management options (Table 4-5)	Minimal	Limited	Multiple	Extensive
Amount and/or complexity of data to be reviewed (Table 4-6)	Minimal or none	Limited	Moderate	Extensive
Risk of complications and/or morbidity or mortality (Table 4-7)	Minimal	Low	Moderate	High

Risk Level	Presenting Problem	Dx Procedures Ordered	Med Mgt Options
Minimal	-One self-limited or minor problem	-lab tests requiring venipuncture -EKG/EEG -urinalysis	Rest
Low	-2 or more self-limited or minor problems -1 stable chronic illness -Acute uncomplicated illness	-psychological testing -skull film -psychotherapy & environmental interaction (eg. agency/school or vocational placement -referral for consultation	OTC drugs
Moderate	-1 or > chronic illnesses with mild exacerbation, progression or s/e of tx -2 or > stable illnesses -Undiagnosed new problem with uncertain prognosis -Acute illness with systemic symptoms	-neuropsychological testing -open door seclusion -ECT (no co-morbid medical conditons)	Rx Drug mgt.
High	-1 or more illnesses with severe exacerbation, progression, or s/e of tx -Acute or chronic illnesses or injuries that may pose a threat to life or bodily function (self/other) -abrupt change in neurological status	-suicide risk assessment -homicide risk assessment	Drug therapy requiring intensive monitoring for toxicity (Lithium, clozapine, carbamazepine, valproate, sometimes TCA's)

5. LEVEL OF SERVICE

	New Office Requires 3 components within shaded area					Established Office Requires 2 components within shaded area				
History	P	EPF	D	C	C	Minimal problem	PF	EPF	D	C
Examination	P	EPF	D	C	C	that may not require	PF	EPF	D	C
Complexity	S	SF	L	M	H	physician	SF	L	M	H
Time	10"	20"	30"	45"	60"	5"	10"	15"	25"	40"
Code	99201	99202	99203	99204	99205	99211	99212	99213	99214	99215

E/M Documentation Auditor's Instructions

Client: E/M Code: Time: Date of Service:

1. History – MUST INDICATE CHIEF COMPLAINT

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the *RIGHT* in the table, which best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the *LEFT*, identifies the type of history.

After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 5.

	Status of 1-2 chronic conditions		Status of 3 chronic conditions
HPI: Status of chronic conditions: ☐ 1 condition ☐ 2 conditions ☐ 3 conditions OR			*Complete
HPI (history of present illness) elements: ☐ Location (WHERE) ☐ Severity (1-10) ☐ Timing WHEN/OFTEN ☐ Modifying factors (WHAT WORSENS/LESSENS) ☐ Quality (DESCRIBE) ☐ Duration (ONSET TO) ☐ Context WJATWJEM ☐ Associated signs and symptoms (ELSE)	Brief (1-3)		Extended (4 or more)
ROS (review of systems--May be collected by staff or Ct. self-report form if reviewed): ☐ Constitutional ☐ Ears, nose, GI ☐ Integumentary ☐ Endo (wt loss, etc) mouth, throat GU (skin, breast) ☐ Hem/lymph ☐ Eyes ☐ Card/vasc Musculo ☐ Neuro ☐ Algy/immuno ☐ Resp ☐ Psych ☐ All others negative	None Pertinent to problem (1 system)	Extended (2-9 systems)	**Complete
PFSH (past medical, family, social history) areas (collection same as ROS): ☐ Past history (the patient's past experiences with illnesses, operation, injuries and treatments) ☐ Family history (a review of 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)	None	Pertinent 1 history area)	*** Complete (2 or 3 history areas)
	PROBLEM FOCUSED **EXP.PROB. FOCUSED**	**DETAILED**	**COMPRE-HENSIVE**

*Complete Hx   Allow if unable to obtain & describe condition preventing.

**Complete ROS 10 or more, or some systems with statement "all others neg."

***Complete PFSH 2 history areas: a) Established patients - office (outpatient) care; b) Emergency department.

> 3 history areas: a) New patients - office (outpatient) care, domiciliary care, home care; b) Consultations; c) Initial hospital care; d) Hospital observation; e) Initial Nursing Facility Care.
>
> NOTE: Subsequent Hospital & Subsequent Nursing Facility Care E/M services require only an interval history, it is not necessary to record information about the PFSH. Refer to procedure code descriptions.

2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

EXAM	SYSTEM/BODY AREA
• 3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight • General appearance	**Constitutional**
• Muscle strength and tone • Gait and Station	**Musculoskeletal**
• Speech • Thought process • Associations • Abnormal/psychotic thoughts • Judgment and Insight • Orientation • Recent and remote memory • Attention and concentration • Language • Fund of knowledge • Mood and affect	**Psychiatric**
1 – 5 bullets	*PROBLEM FOCUSED EXAM*
At least 6 bullets	*EXPAND PROB FOCS'D EXAM*
At least 9 bullets	*DETAILED EXAM*
All bullets in Constitutional and Psychiatric boxes and 1 bullet in Musculoskeletal box.	*COMPREHENSIVE EXAM*

3. Medical Decision Making

Number of Diagnoses or Treatment Options

Identify each problem or treatment option addressed. Enter the number in each of the categories in Column B in the table below. (There are maximum numbers in two categories.) Do not categorize the problem(s) if the encounter is dominated by counseling/coordinating of care—go to box 4.

Number of Diagnoses or Treatment Options			
A Problem(s) Status	**B** Number	**X C** Points	**= D** Result
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	Max = 1	3	
New prob. (to examiner); add. workup planned		4	
		TOTAL	

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.

Bring total to line A in Final Result for Complexity (table below)

Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the points column. Total the points.

Amount and/or Complexity of Data Reviewed	
Reviewed Data	**Points**
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
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	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
	TOTAL

Bring total to line C in Final Result for Complexity (table below)