E/M Coding for Neurology
American Academy of Neurology

E/M Services and Their Levels
- There are many different types of Evaluation and Management (E/M) services, 3-5 levels of service for each type
- Site of service: outpatient, inpatient, emergency department, etc.
- New or established patient
- Visit or consult
- Initial encounter or follow-up
- There are three key components of E/M codes used to determine the level of service:
  - History
  - Physical examination
  - Medical decision making
  - Each of the key components contains several elements - the more that are documented, the higher the level of service

Current E/M Documentation Rules
- The AMA CPT manual doesn’t detail key aspects of the E/M documentation guidelines
- Documentation guidelines for E/M services can be downloaded at: http://www.cms.hhs.gov/mlnproducts/01_overview.asp
- You may currently use either the 1995 or 1997 E/M documentation guidelines from HCFA (now CMS)
- Most neurologists prefer the 1997 guidelines, which contain a neurologic single system exam, over the 1995 rules

How to Select a Level of E/M
- Identify the category and subcategory of service
- Review the reporting instructions for the selected category or subcategory
- Review the level of E/M service descriptors and examples in the selected category or subcategory
- Determine the level of history obtained
- Determine the extent of examination performed
- Determine the complexity of medical decision making
- Select the appropriate level of E/M service

Site of Service
- Office/outpatient
  - A patient is considered an outpatient until inpatient admission to a health care facility occurs
- Inpatient
  - “Observation status” is a special category
- Emergency department
- Nursing facility
- Others

New and Established Patients I
- New patient: one who has not received any professional services from a physician, or another physician of the same specialty who belongs to the same group practice, within the past three years
  - “Professional services” are face-to-face services performed by a physician and reported with a specific CPT code(s)
  - Subspecialties of neurology (i.e. epilepsy, stroke) are not recognized as separate specialities for this purpose, unless they have different tax ID numbers
- All other patients are established patients
New and Established Patients II

- No distinction is made between new and established patients in the emergency department or with consultations
- If a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available

Consultations: Definition

- A consultation is an E/M service provided by a physician whose opinion and/or advice regarding E/M of a specific problem is requested by another physician or other appropriate source
- The request and need for the consultation must be documented in the patient's medical record
- The consultant's opinion and any services ordered or performed must be documented in the patient's medical record
- A physician consultant may initiate diagnostic and/or therapeutic services at the same or a subsequent visit
- The consulting physician must communicate his/her opinion and/or advice to the requesting physician or other appropriate source by written report

Consultations: Comments

- A consultation is a one-time visit
- There is no differentiation of new versus established patients
- A referral to assume the ongoing care of a patient is not a consultation (e.g., a referral from an emergency room)
- Use outpatient consultation codes for patients seen in the emergency room or under “observation status”
- Some carriers are stricter than CPT standards, requiring that the request be documented both in the consultant's and the requesting physician's files

Consultations: Follow-up

- Sometimes, after an initial office consultation, the physician may undertake ongoing care of that patient
- The established patient codes are used for these subsequent outpatient visits
- If an additional request for an opinion regarding the same or a new problem is received from the attending physician, the office consultation codes can be used again

Patients Admitted to the Hospital

- The admission note of the attending physician is coded as an initial hospital visit
- If a patient is admitted to the hospital in the course of an office encounter, and the physician sees the patient in the office and the hospital on the same day, all E/M services provided by that physician are considered part of the initial hospital care
- Follow-up visits by the attending physician are coded as subsequent hospital visits

Discharge Day Management

- The discharge day encounter is coded as hospital discharge day management
- These codes are for the attending physician to report all services on the day of discharge - final examination, discussion, instructions, record preparation
- Time need not be continuous
Consults on Hospital Patients
- Use inpatient consultation codes, even if you had seen the same patient prior to this hospitalization
- If a consultant follows the inpatient on subsequent days, those visits are subsequent hospital visits - the same codes as used by the attending
- A follow-up consultation code is used when you stop seeing the inpatient for awhile (i.e. if you sign off), and are asked later in the same hospitalization to provide another consultation

Prolonged Services
- These codes are used when a physician provides prolonged service involving direct patient contact that is beyond the usual service
- They are reported in addition to the appropriate E/M code for the work-up
- There are different codes for outpatient and inpatient settings
- Documentation of the reason for the prolonged service must be included in the record

Critical Care Codes
- Critical care is the direct delivery by a physician of medical care for a critically ill or critically injured patient
- Coded by total duration of time per 24 hours
- The time may be discontinuous throughout the day
- These codes are meant to reflect time at bedside/in unit delivering critical care to an unstable patient, not routine consults on, and not daily follow-ups of, patients in an ICU
- These codes are being overused and are being audited closely

Counseling and Coordination of Care
- Counseling is a discussion with patient and/or family or other caregiver about diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment) options; instructions for management (treatment) and/or follow-up; compliance; risk factor reduction; and patient and family education
- Coordination of care is arranging for care with other health care providers

Level of E/M Service Descriptors
- Key components:
  - History
  - Examination
  - Medical decision making
- Contributory factors:
  - Counseling
  - Coordination of care
  - Nature of presenting problem
  - Time

Documentation of History
- The levels of E/M services are based on four types of history:
  - Problem focused
  - Expanded problem focused
  - Detailed
  - 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)
History Taking: Comments

- The CC, ROS and PFSH may be listed as separate elements of history, or included in the HPI.
- A ROS and/or PFSH obtained during an earlier encounter does not need to be re-recorded if there is documentation that the physician reviewed and updated the previous information by:
  - Describing any new information or noting there has been no change.
  - Noting the date and location of the earlier ROS and/or PFSH.
- The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient, as long as there is a notation from the physician supplementing or confirming the information recorded by others.
- 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.

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.
- 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 may include the following elements, depending on level of service:
  - Location
  - Quality
  - Severity
  - Duration
  - Timing
  - Context
  - Modifying factors
  - Associated signs and symptoms.

Review of Systems (ROS)

- A 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.
- 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.

Systems Reviewed in the ROS

- 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
- 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)
- 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 include subsequent hospital care and follow-up inpatient consultations.
Types of History

<table>
<thead>
<tr>
<th>Chief Complaint (CC) plus all of these elements:</th>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family, and/or Social History (PFSH)</th>
<th>Type of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief (1-3)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused</td>
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<tr>
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<td>N/A</td>
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<td>Extended (2, 9)</td>
<td>Pertinent (0-1)† ‡</td>
<td>Detailed</td>
<td>Detailed</td>
</tr>
<tr>
<td>Extended (4*)</td>
<td>Complete (10)</td>
<td>Complete (2-3)†</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

* Or the status of at least three chronic or inactive conditions
† 0 for subsequent hospital care or follow-up inpatient consultations
‡ 2 for office/outpatient, established patient or emergency department; 3 for all others

A “Comprehensive” Neuro History

- **(To qualify as a consult)** Asked to see patient by Dr. Jones.
- **(CC)** Seizure this AM.
- **(At least 4 facts in HPI)** 55 year old man. 2 days s/p CABG, was recovering well. On Demerol, antibiotics, Glucotrol, Prograf. Unwitnessed onset in ICU. Loaded with fosphenytoin 1500 mg IV. Slow to awaken.
- **(ROS by reference)** ROS: no relevant changes since Dr. Jones’s admission note.

Extent of Examination

- Problem focused
  - Limited exam of affected area or organ system
- Expanded problem focused
  - Limited exam of affected area or organ system and other symptomatic or related organ system(s)
- Detailed
  - Extended examination of affected body area(s) and other symptomatic or related organ system(s)
- Comprehensive
  - General multi-system examination or a complete examination of a single organ system

Examination: Body Areas

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

Examination: Organ Systems

- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Single System Examinations

- Content and documentation requirements for ten single organ system examinations were published in 1997
- Each examination fulfills the physical examination requirements of E/M procedure coding
- These single organ system examinations are considered to be the work equivalent of a general multi-system medical examination
The Neurology Single System Examination
- Body areas and organ systems to be examined are:
  - Constitutional
  - Eyes
  - Cardiovascular
  - Musculoskeletal
  - Neurological
- The individual elements of the examination are identified by bullets (•) in the guidelines.

Elements and Documentation
- There are 25 individual elements in the neurologic single system examination
- The organization or sequence of the documentation is not specified
- The items do not have to be specifically labeled
- Bulleted items cannot be grouped
  - It is not sufficient to state, for example, “Cranial nerves are normal.”

Constitutional Elements
- Measurement of any three of the following seven vital signs (which may be measured and recorded by ancillary staff):
  - Sitting or standing blood pressure, supine blood pressure, pulse rate and regularity, respiration, temperature, height, weight
- Note the general appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Eyes
- Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

Cardiovascular
- Examination of carotid arteries (e.g., pulse amplitude, bruits)
- Auscultation of heart with notation of abnormal sounds and murmurs
- Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)

Musculoskeletal
- Examination of gait and station
- Muscle strength in upper and lower extremities
- Muscle tone in upper and lower extremities (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation, tardive dyskinesia)
Neurological

- Higher integrative functions
- Cranial nerves
- Sensation
- Reflexes
- Coordination

Evaluation of Higher Integrative Functions

- Orientation to time, place and person
- Recent and remote memory
- Attention span and concentration
- Language (e.g., naming objects, repeating phrases, spontaneous speech)
- Fund of knowledge (e.g., awareness of current events, past history, vocabulary)

Cranial Nerves: Overview

- Each cranial nerve except the first and tenth must be documented by at least one observation
- The parentheses following each cranial nerve provide some examples of observations that meet the guidelines
- One does not have to name the individual cranial nerves even though appropriate observations need to be written

Cranial Nerves

- 2nd cranial nerve (e.g., visual acuity, visual fields, fundi)
- 3rd, 4th and 6th cranial nerves (e.g., pupils, eye movements)
- 5th cranial nerve (e.g., facial sensation, corneal reflexes)
- 7th cranial nerve (e.g., facial symmetry, strength)
- 8th cranial nerve (e.g., hearing with tuning fork, whispered voice and/or finger rub)
- 9th cranial nerve (e.g., spontaneous or reflex palate movement)
- 11th cranial nerve (e.g., shoulder shrug strength)
- 12th cranial nerve (e.g., tongue protrusion)

Sensation, Reflexes, Coordination

- Examination of sensation (e.g., by touch, pin, vibration, proprioception)
- Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (e.g., Babinski)
- Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

Levels of Neurological Exam

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>One to five elements identified by a bullet</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>At least six elements identified by bullet</td>
</tr>
<tr>
<td>Detailed</td>
<td>At least twelve elements identified by a bullet</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Perform and document all elements identified by a bullet, except for the three cardiovascular elements All three cardiovascular elements must be performed but only one element need be documented</td>
</tr>
</tbody>
</table>
A “Comprehensive” Neuro Exam

1. Healthy male.
2. VS: 120/85, HR 72, RR 16
3. HEENT: Fundi ok, no carotid bruits.
4. MS: Awake, oriented, attentive; speech, knowledge, recent and remote memory normal.
5. CN: Visual fields and EOMs full; facial sensation and power normal; palate/tongue midline; sternocleidomastoid normal.
7. Reflexes: DTRs x 4 extremities; toes downgoing.
8. Sensation: Normal pin all 4 extremities.

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 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.
  - 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.

Number of Diagnoses or Management Options

- Based on:
  - The number and types of problems addressed during the encounter.
  - The complexity of establishing a diagnosis.
  - 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.

Amount and/or Complexity of Data to be Reviewed I

- Document diagnostic service(s) (tests or procedures) that are ordered, planned, scheduled, or performed at the time of the E/M encounter.
- Document the review of lab, radiology and/or other diagnostic tests by a notation about the test results or by initialing and dating the report containing the results.
- Document a decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient.

Amount and/or Complexity of Data to be Reviewed II

- Document relevant findings from the review of old records, and/or the receipt of additional history.
- Document the results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study.
- Document the direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician.

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).
  - The possible management options.
- The highest level of risk in any one category determines the overall risk.
“High Risk” Presenting Problems

- One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
- Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure
- An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss

“High Risk” Diagnostic Procedures

- Cardiovascular imaging studies with contrast with identified risk factors
- Cardiac electrophysiological tests
- Diagnostic endoscopies with identified risk factors
- Discography

“High Risk” Management Options

- Elective major surgery (open, percutaneous or endoscopic) with identified risk factors
- Emergency major surgery (open, percutaneous or endoscopic)
- Parenteral controlled substances
- Drug therapy requiring intensive monitoring for toxicity
- Decision not to resuscitate or to de-escalate care because of poor prognosis

A Practical Approach to Scoring Medical Decision Making I

- Determine the risk level – high vs. moderate
- High is used when the patient meets any of the following criteria:
  - Chronic illness with severe exacerbation/progression/side effects
  - Risk of mortality or serious morbidity
  - Abrupt neurologic change (e.g. TIA, stroke, seizure)
  - Prescribe high risk medications (e.g. warfarin)
  - Administer parenteral controlled substances
  - Most other neurology visits will be moderate risk

A Practical Approach to Scoring Medical Decision Making II

- For a high level of medical decision making, also describe in your note at least one of these:
  - Extensive number of possible diagnoses and/or the number of management options
  - One new presenting problem needing additional assessment
  - Two continuing problems inadequately controlled
  - Highly complex decision making
  - Extensive amount and/or complexity of data to be reviewed
- For a moderate level, use “multiple” or “moderate” instead of “extensive” or “highly complex”

Complexity of Medical Decision Making (2/3)

<table>
<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of complications and/or mortality</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
An Impression/Plan with Decision Making of “High Complexity”

(Abrupt neuro change, extensive DDx and evaluation)

- **Impression:**
  - Seizure, r/o stroke, metabolic factors, drug effect, intracranial mass/infection
  - Lethargy, likely postictal and drug effects, r/o stroke or other CNS processes

- **Plan:**
  - MRI brain if stable enough, otherwise CT
  - EEG
  - Continue Dilantin 300 mg/QD PO
  - Check Dilantin, Prograf levels, electrolytes, BUN/Creatinine, CBC
  - Substitute MS for Demerol
  - After imaging, will consider LP
  - Will follow

Putting It All Together

- All three key components must be present:
  - Office, new patient
  - Hospital observation services
  - Initial hospital care
  - Office consultations
  - Initial inpatient consultations
  - Confirmatory consultations
  - Emergency department services

- Two of three key components must be present:
  - Office, established patient
  - Subsequent hospital care
  - Follow-up inpatient consultations

When Time is a Factor

- **Face-to-face time:** office and other outpatient visits and office consultations
- **Unit/floor time:** hospital observation services, inpatient hospital care, initial and follow-up hospital consultations, nursing facility
- When counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter, then time is the key controlling factor in level of E/M service determination
- The total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care

Types of History

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<tbody>
<tr>
<td>1-3</td>
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<td>0</td>
<td>Problem Focused</td>
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<tr>
<td>1-3</td>
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<td>0</td>
<td>Expanded Problem Focused</td>
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<tr>
<td>4*</td>
<td>2-9</td>
<td>0-11</td>
<td>Detailed</td>
<td></td>
</tr>
<tr>
<td>4*</td>
<td>10</td>
<td>2-3</td>
<td>Comprehensive</td>
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<td>1-5 Items</td>
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<td>6 Items</td>
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<td>Detailed</td>
<td>12 Items</td>
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<tr>
<td>Comprehensive</td>
<td>23 Items</td>
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Complexity of Medical Decision Making (2/3)

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<td>High</td>
<td>High Complexity</td>
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### Overview of the E/M Codes

- The next several slides summarize documentation requirements for the major families of E/M codes.
- History (all need Chief Complaint)
  - H = number of elements in HPI
  - R = number of systems in ROS
  - P = number of areas in PESH
- Exam = number of bullets
- Decision Making = level of decision making

### Office/Outpatient-New (3/3)

<table>
<thead>
<tr>
<th>History</th>
<th>Exam</th>
<th>Decision Making</th>
<th>Time (minutes)</th>
<th>Code</th>
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<tbody>
<tr>
<td>H 1-3</td>
<td>1-5</td>
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<td>10</td>
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</tr>
<tr>
<td>H 1-3</td>
<td>R 1</td>
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<td>20</td>
<td>99202</td>
</tr>
<tr>
<td>H 4, R 2, P 1</td>
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<td>low</td>
<td>30</td>
<td>99203</td>
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<tr>
<td>H 4, R 10, P 3</td>
<td>23</td>
<td>moderate</td>
<td>45</td>
<td>99204</td>
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<tr>
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<td>high</td>
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### Office/Outpatient-Consult (3/3)

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<tr>
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### Office/Outpatient-Established (2/3)

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<th>History</th>
<th>Exam</th>
<th>Decision Making</th>
<th>Time (minutes)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H 1-3</td>
<td>1-5</td>
<td>straight-forward</td>
<td>10</td>
<td>99211</td>
</tr>
<tr>
<td>H 1-3</td>
<td>R 1</td>
<td>straight-forward</td>
<td>15</td>
<td>99212</td>
</tr>
<tr>
<td>H 4, R 2, P 1</td>
<td>6</td>
<td>low</td>
<td>15</td>
<td>99213</td>
</tr>
<tr>
<td>H 4, R 10, P 3</td>
<td>12</td>
<td>moderate</td>
<td>25</td>
<td>99214</td>
</tr>
<tr>
<td>H 4, R 10, P 2</td>
<td>23</td>
<td>high</td>
<td>40</td>
<td>99215</td>
</tr>
</tbody>
</table>

### Inpatient-Initial Care (3/3)

<table>
<thead>
<tr>
<th>History</th>
<th>Exam</th>
<th>Decision Making</th>
<th>Time (minutes)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H 4, R 2, P 1</td>
<td>12</td>
<td>straight-forward or low</td>
<td>30</td>
<td>99221</td>
</tr>
<tr>
<td>H 4, R 10, P 3</td>
<td>23</td>
<td>moderate</td>
<td>50</td>
<td>99222</td>
</tr>
<tr>
<td>H 4, R 10, P 3</td>
<td>23</td>
<td>high</td>
<td>70</td>
<td>99223</td>
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</table>

### Inpatient-Initial Consult (3/3)

<table>
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<th>Time (minutes)</th>
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<td>99251</td>
</tr>
<tr>
<td>H 1-3</td>
<td>R 1</td>
<td>straight-forward</td>
<td>40</td>
<td>99252</td>
</tr>
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<td>55</td>
<td>99253</td>
</tr>
<tr>
<td>H 4, R 10, P 3</td>
<td>23</td>
<td>moderate</td>
<td>80</td>
<td>99254</td>
</tr>
<tr>
<td>H 4, R 10, P 3</td>
<td>23</td>
<td>high</td>
<td>110</td>
<td>99255</td>
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</table>
### Inpatient-Subsequent Care (2/3)

<table>
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<th>Time (minutes)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H 1-3</td>
<td>1-5</td>
<td>straight-forward or low</td>
<td>15</td>
<td>99231</td>
</tr>
<tr>
<td>H 1-3 R 1</td>
<td>6</td>
<td>moderate</td>
<td>25</td>
<td>99232</td>
</tr>
<tr>
<td>H 4, R 2, P 0</td>
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<td>35</td>
<td>99233</td>
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</table>

### Inpatient-Follow-up Consult (2/3)

<table>
<thead>
<tr>
<th>History</th>
<th>Exam</th>
<th>Decision Making</th>
<th>Time (minutes)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H 1-3</td>
<td>1-5</td>
<td>straight-forward or low</td>
<td>10</td>
<td>99261</td>
</tr>
<tr>
<td>H 1-3 R 1</td>
<td>6</td>
<td>moderate</td>
<td>20</td>
<td>99262</td>
</tr>
<tr>
<td>H 4, R 2, P 0</td>
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<td>high</td>
<td>30</td>
<td>99263</td>
</tr>
</tbody>
</table>

### Common Errors in E/M Coding

- Failure to document referring physician by name when using consult codes
- Incorrect use of code category for consult, new, established patient
- Insufficient documentation to support complexity of decision making
- Failure of a hospital note to document face-to-face contact

### How to Follow the Guidelines

- Probably best to have templates for each level of service provided in printed or electronic form
- When appointments are scheduled, printed ROS/PFSH templates can be given to office patients to be filled out at home, then reviewed on the day of the visit and re-reviewed on subsequent visits
- An alternative is the use of printed or electronic check lists of the key components and their elements
- Compliance tools are available from several sources