E/M versus Eye Codes – Choices for 2019
Part I - E/M Codes ©

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INTRODUCTION

In 2010 the inpatient and outpatient consultation codes were eliminated by Medicare as usable codes although they still appear in the 2019 CPT (Current Procedural Terminology) book) and may be honored by other insurers. In order to help you navigate through the available codes – and to keep you on the path of compliance while optimizing reimbursement - the following three part series is presented. Part I gives an overview of the E/M requirements; in Part II the overview of the Eye Codes is given and in Part III an algorithm guide for making "The Choice" is presented. All guidelines are based on those of Medicare.

BACKGROUND OF E/M AND EYE CODES

Most ophthalmologists prefer using the Eye Codes, believing they are easier to use and more audit-proof. Not necessarily so! If you use only eye codes, not only are you punishing yourself financially, but you also may be found to be up coding or down coding when audited. For example, the intermediate eye code for established patients (CPT code 92012) is not always suitable for coding frequent follow-ups such as follow-up examination for corneal abrasion. (The correct code for healing corneal abrasion often usually is E/M code 99212).

CMS (Center for Medicare and Medicaid Services) wants you to code correctly – to neither up code nor down code. There has been an ongoing increase of various Medicare audits triggered by the different audit agencies and this promises to intensify.

Let's first take a look at the requirements for the E/M codes.

E/M CODES

The new E/M codes were first established in 1994/1995 with the examination requirements for single organ systems (such as eyes) being enacted in 1997. The original document, "Documentation Guidelines for Evaluation and Management Services" jointly issued by the AMA and HCFA (now CMS) may be found at:
http://www.cms.hhs.gov/medlearn/emdoc.asp.
It was – and remains – difficult to learn the first time around, but it has its advantages in that it is very black and white compared to the eye codes which are very gray. It behooves you to master them. If used properly with a forced entry form or electronic medical records for chart documentation it becomes easy to master. More on the chart examination forms later!

E/M codes are defined by seven components, the first three of which are used in conjunction with each other to determine the codes for outpatient office visits that are leveled from one to five, with five being the highest. These three components are: History, Examination and Medical Decision Making.

History – The First Key Component

The First Key Component, History, is organized with four component parts – three of which contain the term "history", thus abetting the confusion. They are: Chief Complaint, History of the Present Illness, ROS (Review of Systems) and PFSH (Past History, Family History, and Social History). If you think of it as a corporate chart— with History-The First Key Component being Chairperson of the Board and the four components as Vice-presidents — you will understand it better. [A training CD with Power Point Presentation is available for purchase on my website]

Chief Complaint (CC). The chief complaint is the **reason for the encounter**, and as such may be in the patient's words or may be the history taker's documentation of the dialogue. This varies significantly from what physicians are taught in medical school, namely, that the chief complaint must be in the patient's own words.

Medicare does **not** cover services performed for annual checkups, routine visits, screenings, refractions or eyeglasses. If your chart note states that the patient's reason for coming in today is any of the following - "glasses aren't good", "routine checkup", "annual check" or "no real complaints" – then that automatically makes the service non covered - one that the patient must pay for and for which the practice may not bill Medicare. If you self-audited last week's charts would you pass or would you be refunding money to Medicare?

The CC may be performed by ancillary personnel, or by the physician if combined with the HPI as described next.

History of the Present Illness (HPI). The HPI is composed of 8 elements that I commonly refer to as the brain-killers. They are: location, duration, timing, quality, context, severity, modifying factors, associated signs and symptoms.

The HPI is leveled into Brief and Extended, Brief having 1-3 elements described and Extensive having 4+ elements described. Why is this so important?

In order for a new patient encounter to ultimately qualify as an E/M level 4 or 5 for the History portion, you must have an extended HPI – 4 or more elements must be qualitatively described. If you only describe 3 elements then the entire encounter drops to a level 2 and for a new patient, for example, you will have lost $89.38/$132.27 respectively on a national average.

You must address the 8 elements and cannot repeat the same ones for credit. For example, with a complaint of blurry vision you cannot count both occasional tearing and itching as two additional elements. They both are examples of associated signs and symptoms. The information in the CC and HPI may be combined as long as the HPI is performed by the physician.

Here is a bad example turned into a good example:
CC: Patient complaining of red eye with associated pain in the right eye. This example serves as the CC only.

CC: Patient complaining of pain and redness in the right eye x 1 day. Sudden onset. Very severe. Also has nausea and abdominal pains. This example combines the CC and HPI.

Note: The HPI **must be performed by the physician or non physician practitioner (NPP).** An HPI performed by ancillary personnel **cannot be counted** and would render the encounter non-billable.

>   ***Review of Systems (ROS) and Past, Family, Social History (PFSH).*** The ROS and PFSH are basically inventories – you are taking an inventory of organ systems in the ROS and of the various pertinent occurrences in PFSH. It's pretty much the same as taking inventory of your closet or an art collection.

>   The systems are: Constitutional; Eyes; Ears, Nose, Mouth, Throat; Cardiovascular; Respiratory; Gastrointestinal; Genitourinary; Musculoskeletal; Integumentary (skin and/or breast); Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; and Allergic/Immunologic.

>   **In order to be compliant with the proper chart documentation according to the 1997 guidelines (the ones we use in ophthalmology) you must note whether *each* system has been inventoried and whether or not it is normal or abnormal. If there is a problem, then that problem must be described.**

>   Chart documentation problems occur when the history taker **fails to note normal or abnormal for each system** and only notes the abnormalities. Most EMRs are noncompliant in this regard. An entry of "denies x" is not sufficient.

>   One of the biggest problems I have encountered is when the practice's history form uses disease entities, rather than organ systems. Thyroid and diabetes both belong in endocrine and cancer is not an organ system at all!

>   For the PFSH you must ask one question for each category in order for that category to be considered inventoried.

>   Both the ROS and PFSH are leveled. To bill the higher level codes (Levels 4 and 5) you must inventory 10 or more organ systems for the ROS and each of the three categories in the HPI. *See Figures 3 and 4 for numerical requirements.*

Examination – The Second Key Component
>   **T**he Examination requirements are shown in Figure 1. Each bullet identifies an element that must be **performed by the physician** if that element is to be counted toward the level of the examination. No substitutions allowed – you cannot take elements from other single organ systems and count them as eye examination elements. **There are 14 elements, each identified by a bullet**. At the highest levels all 14 have to be performed and I advise documenting **both** in Neurologic/Psychiatric.. The 12 elements under eye are in a box with a shaded border and the two elements in Neurologic/Psychiatric are in a box with an unshaded border.

>   Furthermore, the **physician or NPP** who must perform any element that is being counted toward the level of the examination for billing purposes.

At the bottom of the chart (Fig. 1) you will find the leveling of the examination based on the number of elements performed and documented.

Here are some of the documentation problems I frequently encounter when auditing:

- Confrontation visual fields not addressed; if not done – state the reason
- Primary gaze alignment is not "versions full" – you must address the primary gaze measurement
- No reason given when IOP not measured
- Pupils not dilated and the two elements (optic nerve and posterior segment) still being counted toward the level of the exam – with no explanation why. It has to be a medical contraindication – not that it's a sunny day!
- Neurological/Psychiatric elements missing or only one is documented, so when auditing I have no way of knowing if the second one was performed– that is why I advise documenting both
- Dilating drops not on chart
- Failure to check off normal findings for each eye, particularly when there is a problem in the other eye
- Failure to *describe* the abnormality
- Failure to perform all 14 elements by *subspecialists* who feel they are entitled to bill higher level because of subspecialty training. This is especially true in retina and plastics. In retina, you cannot double dip and count an extended ophthalmoscopy as the basic elements of optic disc and posterior segment and also as the separate diagnostic test, extended ophthalmoscopy.

Medical Decision Making – The Third Key Component

Medical Decision Making is the most difficult of the three key components in E/M coding to master, mainly because it is less quantitative than the other two key components - History and Examination. **In its simplest form Medical Decision Making is one of four adjectives – straightforward, low, moderate and high.** It is rather intuitive – acute glaucoma is best described as high where as conjunctivitis is best described as low.

These are the four categories of Medical Decision Making: Straightforward, Low Complexity, Moderate Complexity and High Complexity. The complex method used for determining the level of Medical Decision Making is given below and used by Medicare as is the basis for audit guidelines. The selection of the proper category for the encounter you are coding is calculated using Tables A, B and C (Figure 2).

The two tasks that seem the most troublesome for ophthalmologists are defining chronic illnesses and deciding the level of surgery. Let's look at chronic illnesses first.

Chronic Illness selection. The chronic illnesses should be the *current ones that are being treated by the ophthalmologist*, such as glaucoma, cataracts, and recurrent corneal erosion. *Incidental problems should not be counted just to enhance the level of risk*. The level is also influenced by the state of the illness - whether it is stable, improving, or worsening. A subconjunctival hemorrhage is considered minimal risk; a +3 nuclear sclerosis that is causing Activities of Daily Living difficulties, with a decision made to schedule surgery on that visit, would be moderate risk. A stable glaucoma would be low risk; a

glaucoma that is not in control and requires change of medicine would be moderate risk. A patient presenting with acute glaucoma is considered high risk.

Level of Surgery selection. When minor or major surgery is selected as the management option there are four different types: two for minor and two for major. They are: Minor Surgery with no identified risk factors; Minor Surgery with identified risk factors; Major Surgery with no identified risk factors; Major Surgery with identified risk factors. The fifth classification is Emergency Major Surgery and is always considered High Risk.

What is meant by "risk factors" is not what a risk management agent would define as such. The intended meaning is there is the likelihood or probability that a complication or unfavorable outcome would occur with *that* given surgery in *that* given patient. You are coding for the office visit, not the surgery.

Do not to be confused with the fact that there are "risks" inherent in all surgery. Rather, this is the likelihood that *this* patient has a greater chance than average of not doing well. Thus, a patient with a standard cataract who is scheduled for surgery would fall into the moderate risk category (elective major surgery with no identified risk factors) whereas a patient who previously lost an eye secondary to an expulsive hemorrhage during cataract surgery, and who also has had glaucoma surgery in the remaining eye complicated by a severe chronic uveitis would be in the high risk category (elective major surgery with identified risk factors) when that patient is scheduled to have the second eye operated upon.

When selecting the level of risk – think outcomes. What is the chance/likelihood that this patient will or will not have a good result. Keep in mind you are coding for that particular office visit.

High Risk. Some ophthalmologists think they never have circumstances defined as high risk whereas others firmly believe that everything they do qualifies as high risk. Obviously, neither is correct. Some clinical examples of high risk that would fit into the "Presenting Problems" category are perforating corneal ulcer and acute glaucoma. All emergency surgery (repair of ruptured globe) qualifies for the adjective "high". If the adjectives urgent and emergent apply it probably is high; however, there are not too many examples.

Selecting the Level of Risk. Use Figure 2 to select your level of risk. Medical Decision Making consists of three tables in the top table called The Summary Table. Two of these you will actually use: Table A —Number of Diagnoses and Treatment Options and Table C (Table of Risk). Table B, The Number of Diagnoses or Treatment Options, may only be applicable to Neuro-ophthalmology —so for the rest of you circle the column on the far left on the Summary table (Table B) and then forget it.

For Table A read the instructions (see the Tips that follow) and calculate the number of points. Totals of 4 or over would get the far right box in the row for Table A circled.

The level of risk is selected from the **Table of Risk (***See page 2 of Figure 2)***. It is definitely official and has been since 1997**, so ignore those seminars that say something different. The Levels of Risk (*Minimal, Low, Moderate and High*) are found in the first column to the left. The next three columns respectively are entitled: Presenting Problem(s), Diagnostic Procedure(s) Ordered and Management Option(s) Selected. Pick the box with the *highest level in **any** of the three columns*. The highest level is your level of risk.

Scenarios: 1) new patient with acute glaucoma would be High Risk based on the 2nd bullet point in the box adjacent to High under the Presenting Problems column; 2) established patient presenting for follow-up of early cataract with no other diagnoses would be Low Risk based on the 2nd bullet on the adjacent box to Low also under Presenting Problems column; 3) established patient presenting with new problems diagnosed as cataract with difficulty in performing ADL (activities of daily living) and is scheduled for cataract surgery would be Moderate Risk based on the 2nd bullet under the Management Option(s) Selected located across from Moderate.

Next step, for Example 1, on the Summary Table, circle "High" (Table C: the box on the 3rd row on the far right). On Table A you should have selected New Problem (to examiner); additional workup planned (4 points, Extensive) and circle in Summary Table. Both boxes are in the same column; this equals High Complexity Medical Decision Making. Transfer this to the appropriate column in Figure 3 for a new patient or Figure 4 for an established patient. Note (*see Figure 3*) for **new patients** all 3 key components have to be at the **same level** and for **established patients use only the Key Components of Examination and Medical Decision Making (***see Figure 4)* (excepting neuro-ophthalmology).

CPT Code Selection. (Figures 3 & 4). Always **keep medical** necessity in mind—medical necessity for the **visit** and medical necessity for **each element within the visit.**

For new patients use Figure 3 and for established patients use Figure 4. **The Three Key Components** are listed in the columns to its right as designated in the top of each column. The requirements for *each* code level for *each* key component is listed under that specific E/M code. For new patients **all three Key Components must be at the same level.** If one key component is lower, then the entire level of the service drops to the lowest level. For established patients if both key components are at the same level that becomes the level; if one is lower the final level is the lower level.

Case Examples using Figures 3 and 4. The examples are the same clinically as described above in *Selecting the Level of Risk.* Assumption: all calculations for the Three Key Components performed as described in this paper. Figures 5, 6 & 7 are filled out worksheets.

Case 1. Use Figure 3 since it is a new patient. History = Comprehensive; Examination = Comprehensive; Medical Decision Making = High; therefore, E/M code = 99205.

Case 2. Use Figure 4 since it is an established patient. Exam = Detailed [Lids/Adnexa + all elements in slit lamp + conjunctiva + optic nerve and posterior segment IOP]; Medical Decision Making = Low; therefore, E/M code = 99213.

Case 3. Use Figure 4 since it is an established patient. Exam = as above = Detailed; Medical Decision Making = Moderate; therefore, E/M code = 99214.

See calculation examples for the above three cases using the charts at the end of the paper (Figures 5, 6 & 7). All charts except those from CMS (Figures 1 & 2) are copyrighted by Riva Lee Asbell.

FORCED ENTRY CHART

   The secret of facilitating proper chart documentation is a good forced entry chart and a version of my chart can be downloaded from my web site www.RivaLeeAsbell.com. When using a chart such as this, **all elements of the history and examination must be checked off as being either negative or positive/ normal or abnormal.** Do not use squiggly lines. This is the first step to electronic medical records – all of which are based on this system. It is easy and fast and enables you to access all levels of coding.

   Most of you are now using EMR. **Do not set automatic "negative" or "normal" defaults** – it becomes quite obvious that this is what has transpired during an audit, leading the auditor to question the entire chart documentation and even whether the work was performed.

   Do not set automatic carry forwards of ROS/PFSH. Notate that it was reviewed and any changes from the baseline study. This is a waste of effort and makes for unnecessary chart documentation that is especially cumbersome when printing the chart.

PEARLS AND PITFALLS
   ● There is only one Table of Risk, and that is the generic Table of Risk to be used by all specialties. **There is no ophthalmology Table of Risk sanctioned by Medicare**. Note that the **word "referral" does not appear in the document** – you do not receive credit for referring a patient. **Barton C. McCann, MD who headed up the original 1997 E/M project for CMS (then known as HCFA) personally gave me strict instructions during a private meeting to teach this information as above.** Recent (2019) national ophthalmic society webcasts have stated that there is no official Table of Risk…there is one, and it will remain in place until these specific E/M guidelines are rescinded or modified. Some specialties, including ophthalmology, have erroneously issued revised Tables of Risk.
   ● Note the parenthetical comment "to the examiner" in Table A. This refers to **the examiner** and not the practice. In a group practice, if a retina subspecialist is referred a retinal detachment patient for evaluation and treatment, this is considered a new problem to the examiner.
   ● When coding encounters for established patients, be sure to use both Table A and Table C.
   ● Requesting a consultation is not an activity that can be counted under Amount and Complexity of Data.
   ● These audit forms are the basis for audit sheets used by Medicare – use them for your own internal self audits.
   ● The HPI is to be performed **only by the physician or NPP.**
   ● **Any examination element** that is counted in determining the level of the examination **must be performed or repeated by the physician**.
   ● **All 14 elements** need to be performed **and** documented, including both elements listed in the Neurologic/Psychiatric box. In the real world, there would be no way for an auditor to ascertain that both were performed unless both were present in the chart documentation. Another blooper made in other courses.

Figure 1
Page 1

EVALUATION & MANAGEMENT CODES
EYE EXAMINATION

System/Body Area	Elements of Examination
Constitutional	
Head and Face	

Eyes	•Test visual acuity (does not include determinations of refractive error)
	•Gross visual field testing by confrontation
	•Test ocular motility including primary gaze alignment
	•Inspection of bulbar and palpebral conjunctiva
	•Examination of ocular adnexa including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular nodes
	•Examination of pupils, irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology
	•Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film
	•Slit lamp examination of anterior chambers including depth, cells, and flare
	•Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus
	•Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)
	
	Ophthalmic examination through dilated pupils (unless contraindicated) of
	   • Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer
	   • Posterior segments including retina and vessels (eg, exudates and hemorrhages)

Ears, Nose, Mouth And Throat	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	
Extremities	
Skin	

Neurological/ Psychiatric	Brief assessment of mental status including
	   •Orientation to time, place, and person
	   •Mood and affect (eg, depression, anxiety, agitation)

Figure 1
Page 2

CONTENT AND DOCUMENTATION REQUIREMENTS

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 every box with a shaded border and _document_ at least 1 element in every box with an unshaded border

RLA note: the instructions under Comprehensive were written and presented at Training the Trainers before the Single Organ System for Eye Examinations were in effect. Once the audits began it was evident that an auditor would have to see documentation for both elements in order to give credit for both.

Figure 2
Page 1

SUMMARY TABLE
MEDICAL DECISION MAKING
Final Result for Level of Medical Decision Making
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.

Table A	**Number of Diagnoses or Management Options**	<1 Minimal	2 Limited	3 Multiple	> 4 Extensive
Table B	**Amount & Complexity of Data**	<1 Minimal or Low	2 Limited	3 Multiple	> 4 Extensive
Table C	**Highest Risk**	Minimal	Low	Moderate	High
Type of Decision Making		Straightforward	Low Complexity	Moderate Complexity	High Complexity

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS
TABLE A

A	B x	C =	D
Problem(s) Status	Number	Points	Result
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Established problem (to examiner); stable, improved		1	
Established problem (to examiner); worsening		2	
New problem (to examiner); no additional work-up planned	Max = 1	3	
New problem (to examiner); additional work-up planned		4	

Total

AMOUNT AND/OR COMPLEXITY OF DATA REVIEWED
TABLE B

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 the 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

Figure 2
Page 2

TABLE C   TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Option(s) Selected
Minimal	● One self-limited or minor problem, eg, cold, insect bite, tinea corporis	● Laboratory tests requiring venipuncture ● Chest x-rays ● EKG/EEG ● Urinalysis ● Ultrasound, eg, echocardiography ● KOH prep	● Rest ● Gargles ● Elastic bandages ● Superficial dressings
Low	● Two or more self-limited or minor problems ● One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH ● Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	● Physiologic tests not under stress, eg, pulmonary function tests ● Non-cardiovascular imaging studies with contrast, eg, barium enema ● Superficial needle biopsies ● Clinical laboratory tests requiring arterial puncture ● Skin biopsies	● Over-the-counter drugs ● Minor surgery with no identified risk factors ● Physical therapy ● Occupational therapy ● IV fluids without additives
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, eg, lump in breast ● Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis ● Acute complicated injury, eg, head injury with brief loss of consciousness	● Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test ● Diagnostic endoscopies with no identified risk factors ● Deep needle or incisional biopsy ● Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization ● Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	● Minor surgery with identified risk factors ● Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ● Prescription drug management ● Therapeutic nuclear medicine ● IV fluids with additives ● Closed treatment of fracture or dislocation without manipulation
High	● 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, eg, 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, eg, seizure, TIA, weakness, sensory loss	● Cardiovascular imaging studies with contrast with identified risk factors ● Cardiac electrophysiological tests ● Diagnostic Endoscopies with identified risk factors ● Discography	● 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

Figure 3

EVALUATION & MANAGEMENT CODES Office Visits - New Patient REQUIRES *ALL THREE* KEY COMPONENTS TO BE AT THE SAME LEVEL					
Code/ Components	99201	99202	99203	99204	99205
NATURE OF PRESENTING PROBLEM	Self-limited or Minor Severity	Low to Moderate Severity	Moderate Severity	Moderate to High Severity	Moderate to High Severity

HISTORY	<u>Problem Focused</u>
	
	CC
	Brief HPI
	  (1-3 elements)
	
	No ROS
	
	No PFSH
		<u>Expanded Problem Focused</u>
		
		CC
		Brief HPI
		  (1-3 elements)
		
		Problem Pertinent ROS (1 system)
		
		No PFSH
			<u>Detailed</u>
			
			CC
			Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions)
			
			Extended ROS (2-9 systems)
			
			Problem Pertinent PFSH (1 element)
				<u>Comprehensive</u>
				
				CC
				Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions)
				
				Complete ROS (10+ systems)
				
				Complete PFSH (3/3 elements)
					<u>Comprehensive</u>
					
					CC
					Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions)
					
					Complete ROS (10+ systems)
					
					Complete PFSH (3/3 elements)

EXAMINATION	<u>Problem Focused</u> 1-5 elements	<u>Expanded Problem Focused</u> At least 6 elements	<u>Detailed</u> At least 9 elements	<u>Comprehensive</u> 14 elements Requires Mental Status Assessment	<u>Comprehensive</u> 14 elements Requires Mental Status Assessment
MEDICAL DECISION MAKING [Numbers refer to points transferred from Medical Decision Making Charts]	<u>Straightforward</u> $\leq$ 1 Diagnosis or Management Options $\leq$ 1 Amount and Complexity Of Data Risk = Minimal	<u>Straightforward</u> $\leq$ 1 Diagnosis or Management Options $\leq$ 1 Amount and Complexity Of Data Risk = Minimal	<u>Low Complexity</u> 2 Diagnoses or Management Options 2 Amount and Complexity Of Data Risk = Low	<u>Moderate Complexity</u> 3 Diagnoses or Management Options 3 Amount and Complexity Of Data Risk =Moderate	<u>High Complexity</u> $\geq$ 4 Diagnoses or Management Options $\geq$ 4 Amount and Complexity Of Data Risk = High

Figure 4

EVALUATION & MANAGEMENT CODES Office Visits - Established Patient REQUIRES *TWO OF THREE* OF THE KEY COMPONENTS TO BE AT THE SAME LEVEL					
Code/Component	99211	99212	99213	99214	99215
NATURE OF PRESENTING PROBLEM	Minimal Severity	Self-limited or Minor Severity	Low to Moderate Severity	Moderate to High Severity	Moderate to High Severity
HISTORY	Evaluation and Management Code does not require the presence of a physician	**Problem Focused** CC Brief HPI (1-3 elements) No ROS No PFSH	**Expanded Problem Focused** CC Brief HPI (1-3 elements) Problem Pertinent ROS (1 system) No PFSH	**Detailed** CC Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions) Extended ROS (2-9 systems) Problem Pertinent PFSH (1 element)	**Comprehensive** CC Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions) Complete ROS (10+ systems) Complete PFSH (2/3 elements)
EXAMINATION		**Problem Focused** 1-5 elements	**Expanded Problem Focused** At least 6 elements	**Detailed** At least 9 elements	**Comprehensive** 14 elements Requires Mental Status Assessment
MEDICAL DECISION MAKING [Numbers refer to points trans- ferred from Medical Decision Making Charts]		**Straightforward** $\leq$1 Diagnosis or Management Options $\leq$1 Amount of Data Risk = Minimal	**Low Complexity** 2 Diagnoses or Management Options 2 Amount of Data Risk = Low	**Moderate Complexity** 3 Diagnoses or Management Options 3 Amount of Data Risk = Moderate	**High Complexity** $\geq$4 Diagnoses or Management Options $\geq$4 Amount of Data Risk = High

Figure 5
Page 1

Case #1

SUMMARY TABLE
MEDICAL DECISION MAKING
Final Result for Level of Medical Decision Making
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.

Table A	Number of Diagnoses or Management Options	≤1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
Table B	Amount & Complexity of Data	≤1 Minimal or Low	2 Limited	3 Multiple	≥ 4 Extensive
Table C	Highest Risk	Minimal	Low	Moderate	High
Type of Decision Making		Straightforward	Low Complexity	Moderate Complexity	High Complexity

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS
TABLE A

A		B x	C =	D
Problem(s) Status		Number	Points	Result
Self-limited or minor (stable, improved or worsening)		Max = 2	1	
Established problem (to examiner); stable, improved			1	
Established problem (to examiner); worsening			2	
New problem (to examiner); no additional work-up planned		Max = 1	3	
New problem (to examiner); additional work-up planned		1	4	4

Total **4**

AMOUNT AND/OR COMPLEXITY OF DATA REVIEWED
TABLE B

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 the 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 0

Figure 5

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Case # 1					
EVALUATION & MANAGEMENT CODES **Office Visits - New Patient** **REQUIRES *ALL THREE* KEY COMPONENTS TO BE AT THE SAME LEVEL**					
Code/ Components	99201	99202	99203	99204	**99205**
NATURE OF PRESENTING PROBLEM	**Self-limited or Minor Severity**	**Low to Moderate Severity**	**Moderate Severity**	**Moderate to High Severity**	**Moderate to High Severity**

HISTORY	<u>**Problem Focused**</u>
	
	**CC
	Brief HPI
	  (1-3 elements)**
	
	No ROS
	
	No PFSH
		<u>**Expanded Problem Focused**</u>
		
		**CC
		Brief HPI
		  (1-3 elements)**
		
		Problem Pertinent ROS (1 system)
		
		No PFSH
			<u>Detailed</u>
			
			**CC
			Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions)**
			
			Extended ROS (2-9 systems)
			
			Problem Pertinent PFSH (1 element)
				<u>Comprehensive</u>
				
				**CC
				Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions)**
				
				Complete ROS (10+ systems)
				
				Complete PFSH (3/3 elements)
					<u>**Comprehensive**</u>
					
					**CC
					Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions)**
					
					Complete ROS (10+ systems)
					
					Complete PFSH (3/3 elements)

EXAMINATION	<u>**Problem Focused**</u> **1-5 elements**	<u>**Expanded Problem Focused**</u> **At least 6 elements**	<u>Detailed</u> **At least 9 elements**	<u>Comprehensive</u> **14 elements Requires Mental Status Assessment**	<u>**Comprehensive**</u> **14 elements Requires Mental Status Assessment**
MEDICAL DECISION MAKING [Numbers refer to points trans-ferred from Medical Decision Making Charts]	<u>**Straightforward**</u> **≤ 1 Diagnosis or Management Options** **≤ 1 Amount and Complexity Of Data** **Risk = Minimal**	<u>**Straightforward**</u> **≤ 1 Diagnosis or Management Options** **≤ 1 Amount and Complexity Of Data** **Risk = Minimal**	<u>Low Complexity</u> **2 Diagnoses or Management Options** **2 Amount and Complexity Of Data** **Risk = Low**	<u>Moderate Complexity</u> **3 Diagnoses or Management Options** **3 Amount and Complexity Of Data** **Risk =Moderate**	<u>**High Complexity**</u> **≥ 4 Diagnoses or Management Options** **≥ 4 Amount and Complexity Of Data** **Risk = High**

Figure 6
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Case #2

SUMMARY TABLE
MEDICAL DECISION MAKING
Final Result for Level of Medical Decision Making
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.

Table A	Number of Diagnoses or Management Options	<u><1</u> Minimal	**2 Limited**	3 Multiple	<u>></u> 4 Extensive
Table B	Amount & Complexity of Data	<u><1</u> **Minimal or Low**	2 Limited	3 Multiple	<u>></u> 4 Extensive
Table C	Highest Risk	Minimal	**Low**	Moderate	High
Type of Decision Making		Straightforward	**Low Complexity**	Moderate Complexity	High Complexity

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS
TABLE A

A		B x	C =	D
Problem(s) Status		Number	Points	Result
Self-limited or minor (stable, improved or worsening)		Max = 2	1	
Established problem (to examiner); stable, improved			1	
Established problem (to examiner); worsening		1	2	2
New problem (to examiner); no additional work-up planned		Max = 1	3	
New problem (to examiner); additional work-up planned			4	
			Total	2

AMOUNT AND/OR COMPLEXITY OF DATA REVIEWED
TABLE B

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 the 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 0	

Figure 6
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Case #2 EVALUATION & MANAGEMENT CODES Office Visits - Established Patient REQUIRES *TWO OF THREE* OF THE KEY COMPONENTS TO BE AT THE SAME LEVEL					
Code/Component	99211	99212	99213	99214	99215
NATURE OF PRESENTING PROBLEM	Minimal Severity	Self-limited or Minor Severity	Low to Moderate Severity	Moderate to High Severity	Moderate to High Severity
HISTORY Not used as one of the key components	Evaluation and Management Code does not require the presence of a physician	<u>Problem Focused</u> CC Brief HPI (1-3 elements) No ROS No PFSH	<u>Expanded Problem Focused</u> CC Brief HPI (1-3 elements) Problem Pertinent ROS (1 system) No PFSH	Detailed CC Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions) Extended ROS (2-9 systems) Problem Pertinent PFSH (1 element)	Comprehensive CC Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions) Complete ROS (10+ systems) Complete PFSH (2/3 elements)
EXAMINATION		<u>Problem Focused</u> 1-5 elements	<u>Expanded Problem Focused</u> At least 6 elements	<u>Detailed</u> At least 9 elements	<u>Comprehensive</u> 14 elements Requires Mental Status Assessment
MEDICAL DECISION MAKING [Numbers refer to points trans-ferred from Medical Decision Making Charts]		<u>Straightforward</u> ≤1 Diagnosis or Management Options ≤1 Amount of Data Risk = Minimal	<u>Low Complexity</u> 2 Diagnoses or Management Options 2 Amount of Data Risk = Low	<u>Moderate Complexity</u> 3 Diagnoses or Management Options 3 Amount of Data Risk = Moderate	<u>High Complexity</u> ≥4 Diagnoses or Management Options ≥4 Amount of Data Risk = High

Figure 7
Page 1

Case #3

SUMMARY TABLE
MEDICAL DECISION MAKING
Final Result for Level of Medical Decision Making
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.

Table A	Number of Diagnoses or Management Options	<1 Minimal	2 Limited	3 Multiple	> 4 Extensive
Table B	Amount & Complexity of Data	<1 Minimal or Low	2 Limited	3 Multiple	> 4 Extensive
Table C	Highest Risk	Minimal	Low	Moderate	High
	Type of Decision Making	Straightforward	Low Complexity	Moderate Complexity	High Complexity

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS
TABLE A

A	B x	C =	D
Problem(s) Status	Number	Points	Result
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Established problem (to examiner); stable, improved		1	
Established problem (to examiner); worsening		2	
New problem (to examiner); no additional work-up planned	Max = 1	3	
New problem (to examiner); additional work-up planned		4	4
		Total	4

AMOUNT AND/OR COMPLEXITY OF DATA REVIEWED
TABLE B

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 the 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	0

Figure 7

Page 2

Case #3					
EVALUATION & MANAGEMENT CODES					
Office Visits - Established Patient					
REQUIRES *TWO OF THREE* OF THE KEY COMPONENTS TO BE AT THE SAME LEVEL					
Code/Component	99211	99212	99213	99214	99215
NATURE OF PRESENTING PROBLEM	Minimal Severity	Self-limited or Minor Severity	Low to Moderate Severity	Moderate to High Severity	Moderate to High Severity
HISTORY **Not used as one of the key components**	Evaluation and Management Code does not require the presence of a physician	**Problem Focused** CC Brief HPI (1-3 elements) No ROS No PFSH	**Expanded Problem Focused** CC Brief HPI (1-3 elements) Problem Pertinent ROS (1 system) No PFSH	**Detailed** CC Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions) Extended ROS (2-9 systems) Problem Pertinent PFSH (1 element)	**Comprehensive** CC Extended HPI (4+ elements or status of at least 3 chronic or inactive conditions) Complete ROS (10+ systems) Complete PFSH (2/3 elements)
EXAMINATION		**Problem Focused** 1-5 elements	**Expanded Problem Focused** At least 6 elements	**Detailed** At least 9 elements	**Comprehensive** 14 elements Requires Mental Status Assessment
MEDICAL DECISION MAKING [Numbers refer to points trans-ferred from Medical Decision Making Charts]		**Straightforward** <1 Diagnosis or Management Options <1 Amount of Data Risk = Minimal	**Low Complexity** 2 Diagnoses or Management Options 2 Amount of Data Risk = Low	**Moderate Complexity** 3 Diagnoses or Management Options 3 Amount of Data Risk = Moderate	**High Complexity** >4 Diagnoses or Management Options >4 Amount of Data Risk = High