4

Codes and Documentation for Evaluation and Management Services

The evaluation and management (E/M) codes were introduced in the 1992 update 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 obvious 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 reporting your services. Psychiatrists frequently ask, "Under what clinical circumstances would you use the office or other outpatient service E/M codes in lieu of the psychiatric evaluation and psychiatric therapy codes?" The decision

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 coordination 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 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
Office or outpatient services	
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
Nursing facility discharge services	99315–99316
Annual nursing facility assessment	99318
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
Basic life and/or disability evaluation services	99450
Work-related or medical disability evaluation services	99455–99456

[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

Level of history is achieved when all four of the four criteria for each element are completed for that level.	LEVELS			
	Problem focused	**Expanded problem focused**	**Detailed**	**Comprehensive**
ELEMENT	**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			
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)	One to five elements identified by a bullet	At least six elements identified by a bullet	At least nine elements identified by a bullet	*All* elements identified by a bullet
Musculoskeletal • Assessment of muscle strength and tone • 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**

Source. Centers for Medicare and Medicaid Services 1997 Guidelines for Documentation of Evaluation and Management Services.

- *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.

QUESTIONS AND ANSWERS

Q. *Who may use E/M codes?*

A. Psychiatrists and appropriately licensed nurses and physician assistants may use the E/M codes.

Q. *Is a unit treatment team conference on an inpatient unit a service for which one may code?*

A. Treatment team conferences can be coded for but should be considered part of overall coordination of care. The time spent providing that service is a component of the total unit/floor time. Team conferences should not be coded as a separate service but rather as a component of the total services provided to the patient on any given day.

Q. *If I have a patient in the hospital whom I see for rounds in the morning and again when I am called to the ward in the afternoon because of a problem, do I code for two subsequent hospital care visits?*

A. No. One code should be selected that incorporates all of the hospital inpatient services provided that day.

Q. *What are the documentation requirements associated with inpatient and outpatient consultations?*

A. The request for the consultation must be documented in the patient's medical record. The consultant's opinion and any services that are performed also must be documented in the patient's medical record and communicated in writing to the requesting physician.

Q. *What codes should be used for psychiatric services provided in partial hospital settings, residential treatment facilities, and nursing homes?*

A. The codes for partial hospitalization services are the same as those used for hospital inpatient settings (99221–99239). The codes for residential treatment services are the same as those used for nursing facility services (99301–99316).

Q. *When would I use the pharmacological management code (90862) rather than one of the E/M outpatient codes?*

A. Your decision should be based on which code most accurately reports the services provided. Code 90862 is valued slightly less in relative value units than 99213, but 90862 is used specifically for psychopharmacological management. Code 99213 denotes more general medical services and might include consideration of comorbid medical conditions.

Q. *Is it necessary for the provider to record the examination him- or herself or can a checklist be used for the patient to record past history?*

A. A checklist is acceptable if the clinician provides a narrative report of the important positive and relevant negative findings. Abnormal findings should be described in the report. A notation of an abnormal finding without a description is not sufficient.

Q. *Can a checklist be used for an ROS?*

A. Yes, but pertinent positive and negative findings that are relevant to the presenting problem must be commented on by the examining clinician. Failure to document the appropriate number of systems for each level of service is the most common reason for downcoding by claims auditors, resulting in a lower level of reimbursement.

Q. *Now that Medicare no longer pays for consultation codes, how do I code for a consultation request from a colleague and what are the reporting requirements?*

A. When you are 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. It is still necessary to report back to the referring physician, but it is not necessary to write a report. The report can be done by telephone or the patient record can be sent to the referring physician.

Q. *Is it permissible to use a template or checklist to record the mental status examination?*

A. Yes.

Q. *If my mode of practice for inpatient services is to have an internist or family practitioner do a medical history and a physical examination and I then do the psychiatric evaluation and mental status examination within a 24-hour period, how can we code so we will both be paid?*

A. The typical way to code for this situation is to have the internist or family practitioner use a new patient E/M code and a medical diagnosis code and for the psychiatrist use a hospital service code for first day and a psychiatric diagnosis code.

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Appendix E

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 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 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 healthcare 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:
   - 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 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 ser-

vices, 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 components, 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 illness the details of mother's pregnancy and the infant's status at birth; social history 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. 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)
- Past, family, and/or social history (PFSH)

The extent of HPI, ROS, and PFSH that is obtained and documented is dependent 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 (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 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 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
- 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 illness 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 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. [*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 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 12 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 **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 EXAMINATION *(CONTINUED)*	
SYSTEM/ BODY AREA	**ELEMENTS OF EXAMINATION**
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	
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 resolved 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. 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 Complexity of Data to Be Reviewed

The amount and complexity of data to be reviewed are 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 (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 procedure on an urgent basis should be documented or implied.*

The table on p. 128 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.**

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 describe 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 F

Vignettes for Evaluation and Management Codes

OFFICE VISIT, NEW PATIENT

99203 A 27-year-old woman with a history of depression who is visiting the area is seen in an initial office visit. She is currently under treatment in her hometown. History taking focuses on a review of her past psychiatric history, present illness, and interval history since her last visit to her treating psychiatrist. Her medication history is reviewed, as is her side-effect history. A mental status examination focuses on her current affective state, ability to attend and concentrate, and insight. A prescription for an antidepressant is provided, along with education on its use and side effects.

Explanation for code choice: Although a new patient to the examining psychiatrist, this patient has an existing treatment source. The psychiatrist obtains a detailed history and performs a detailed mental status examination. (A detailed history requires a detailed [two to nine elements] review of symptoms.) The provision of a prescription requires medical decision making of low complexity.

99205 A 38-year-old man brought by his parents for evaluation of paranoid delusions and alcohol abuse is seen in an initial office visit. History taking focuses on the family history of mental illness. The past medical and psychiatric history, history of present illness, and social history of the patient are taken. The results of a mental status examination reveal a poorly groomed individual, poor eye contact, no spontaneity to speech, flat affect, no hallucinations, paranoid delusions about the police, no suicidal/homicidal ideation, and intact cognitive status. The patient has no history of current medical problems. The patient denies alcohol use. The parents are interviewed and provide a history of the patient that includes at least 5 years of binge drinking. Routine blood studies are ordered. The patient's vital signs are taken. A prescription for a neuroleptic is

given, and education about medication is provided to the patient and the parents. Referrals to a dual-diagnosis treatment program and Alcoholics Anonymous are made.

Explanation for code choice: This initial evaluation requires complex medical decision making because of the psychotic symptoms in the context of alcohol abuse. The psychiatrist must complete a comprehensive history and examination. The comprehensive history includes a complete review of systems.

OFFICE VISIT, ESTABLISHED PATIENT

99213 A 42-year-old male established patient with a history of bipolar II disorder, last seen 2 months prior, is seen for an office visit. Interval history taking focuses on the presence/absence of symptoms, the patient's level of social/vocational function, and the patient's adherence to the medication regimen. A mental status examination focuses on the patient's affective state. The patient's lithium blood level is reviewed. The side effects of the medication are reviewed, and prescriptions for the same medications are provided.

Explanation for code choice: In order to make a decision about medications, the psychiatrist must do an expanded problem-focused history and examination. An expanded problem-focused history includes one to three elements of a review of systems. The actual medical decision to continue the medication regimen is of low complexity.

HOSPITAL INPATIENT SERVICES—INITIAL HOSPITAL CARE

99221 A 32-year-old woman is seen for initial hospital care. The woman had been discharged from the same psychiatric unit 3 days earlier after a 5-day stay precipitated by threats of suicide in the context of alcohol intoxication. The patient had received diagnoses of adjustment disorder with depressed mood and suicidal ideation, alcohol abuse, and mixed personality disorder with borderline features. Her interval history revealed that the patient had returned home after discharge from the hospital and within 24 hours became involved in verbally violent arguments with her husband, drank an unspecified amount of vodka, and threatened to kill him. Her blood alcohol level in the emergency department is 160 mg/dL. The results of a physical examination are within normal limits, as are the results of the remainder of the laboratory studies. The results of a toxicology screening are negative. The mental status examination reveals a patient who is crying, angry, and accusing her husband of infidelity. She is difficult to redirect, and her affect is labile and irritable. Her mood is depressed. She shows no psychotic symptoms and is cognitively intact. She demonstrates little to no insight. The patient is admitted to the hospital voluntarily. The social work staff is asked to provide an evaluation of the husband and the family situation. Discharge planning is begun.

Explanation for code choice: The lowest level of initial hospital care is appropriate because this is a readmission with no change in the history database and because the medical decision making is straightforward.

99222 A 40-year-old man discharged 12 days before the current admission with a diagnosis of schizophrenia had been given instructions to attend follow-up visits at an outpatient clinic to monitor his neuroleptic medication. He now presents with auditory hallucinations and paranoid ideation with violent thoughts toward his neighbors. His interval history reveals that he never attended the outpatient clinic and that he immediately discontinued taking the neuroleptic medication after discharge. The patient's brother reports that the patient's symptoms reappeared 4 days before the current admission. The patient also has a history of diabetes mellitus controlled by oral medications and had discontinued taking his diabetes medication. A mental status examination reveals a poorly groomed individual with auditory hallucinations that are threatening toward the patient and paranoid delusions that involve neighbors trying to hurt him. He admits to violent thoughts toward his neighbors and states that he might have to harm or kill them. He appears to be cognitively intact. A physical examination reveals a moderately obese individual. The results of his laboratory studies are normal except for an elevated glucose level. The results of repeat finger-stick tests indicate glucose levels above 400 mg/dL. A new neuroleptic regimen is begun for the patient. The treatment team devises a strategy to help the patient's family assist him in adhering to this regimen after discharge.

Explanation for code choice: Although this case is also a readmission, the nature of the presenting problem involves psychotic symptoms, violent thoughts, and symptomatic diabetes. The level of history taking and examination are comprehensive, and the medical decision making is moderately complex.

99223 Initial psychiatric hospital services are provided for a 17-year-old female transferred from the medical intensive care unit after treatment for ingestion of a large amount of acetaminophen and aspirin. Her family history reveals that her mother and a maternal uncle have been treated for depression. The patient has been doing poorly in school for 6 months and has been experimenting with drugs and alcohol. She has been rebellious at home, and 2 months ago she reported that she might be pregnant. One week before her admission, her boyfriend of 1 year left her for another schoolmate. She has no history of significant medical or surgical problems. Her last menstrual period was 3 weeks ago. The patient is admitted voluntarily. A mental status examination reveals a barely cooperative, sullen teenager whose speech is not spontaneous but is logical and coherent. She shows no psychotic symptoms. The patient refuses to comment on current suicidal thoughts or ideation. She is cognitively intact. The results of a physical examination and laboratory tests are all within normal limits. The social work staff is asked to assess the patient's family situation. The patient is placed on close observation as a suicide precaution.

Explanation for code choice: Suicidal behaviors always require highly complex medical decision making supported by a comprehensive history and comprehensive mental status examination. Be sure to complete a full review of systems.

99223 Initial hospital care is provided for a 35-year-old woman with a 3-month history of withdrawn, bizarre behavior. Two days before her admission she became disorganized and aggressive toward her family and started talking to herself. Her

family history reveals a maternal grandfather with a diagnosis of schizophrenia. The patient had two prior episodes of psychosis and had received a diagnosis of schizophrenia. She dropped out of treatment 5–6 months ago, and since then she has not taken any medications. There are no current medical or surgical problems. The patient is admitted involuntarily. The results of a mental status examination reveal the patient to be uncooperative and poorly groomed and to make poor eye contact. Her speech is rambling and tangential. The patient appears to be responding to internal stimuli and is easily distracted and blocked. Her affect is flat and blunted. The patient is oriented to time, place, and person. The results of a physical examination and laboratory tests are within normal limits. The patient is placed on every-15-minute observation status. She is assessed for neuroleptic treatment. The social work staff is asked to assess the family situation. The occupational therapy/recreational therapy staff is asked to assess the patient's ability to perform activities of daily living.

Explanation for code choice: This is an example of a typical admission for a patient with a major psychiatric disorder and severe acute symptoms. The history and mental status examination must be comprehensive. A complete review of systems is required, and the medical decision making is highly complex.

99223 Initial hospital care is provided for an 8-year-old boy whose parents requested admission because of a 1-week history of repeated attempts to cut and hit himself. The patient's family history reveals that his father is in treatment for bipolar disorder. The patient is the second of three children. The siblings are reported to be doing well. The parents admit to having recent marital problems for which they have sought counseling. The patient is described as generally well behaved but moody with a bad temper. His schoolwork has been deteriorating for the past 3 months, and there have been reports of minor behavioral misconduct. One week before admission, the parents denied the patient a puppy. Since then he has been out of control and has been cutting, scratching, and hitting himself. A mental status examination reveals a withdrawn, depressed-appearing child who answers all questions with yes or no. He is cognitively intact. A physical examination reveals scratches and bruises over the patient's arms and legs. The results of laboratory studies are within normal limits. The social work staff is asked to begin a family assessment. The patient is placed on close observation.

Explanation for code choice: The out-of-control self-harm behavior requires highly complex medical decision making supported by a complete review of systems and a comprehensive history and examination.

99223 Initial hospital care is provided for a 75-year-old man with a 2-month history of depression, a 2-week history of auditory hallucinations, and recent suicidal ideation. The patient has a history of diabetes mellitus and is dehydrated. The psychiatric history focuses on past history of episodes of depression, family history of depression, and the patient's current social support system. A mental status examination reveals poor grooming, poor eye contact, lack of spontaneity, slowed speech, psychomotor retardation, depressed affect, present suicidal ideation with no plan, and auditory hallucinations telling the patient that he is no good. The patient is cognitively intact. The patient is admitted voluntarily. A medical consul-

tation is requested. Complete blood count, SMA-12, and thyroid laboratory tests are ordered. The patient and the family are instructed about the probable need for electroconvulsive therapy. The consent process for electroconvulsive therapy is explained, and signatures are obtained. Exploration of discharge placement is begun. The patient is placed on close observation as a suicide precaution.

Explanation for code choice: Severe depression with psychotic symptoms and suicidal ideation in an elderly patient requires a comprehensive history and examination as well as a complete review of systems. Treatment considerations, taking into account medical comorbidities and including electroconvulsive therapy, demand highly complex medical decision making.

HOSPITAL INPATIENT SERVICES—SUBSEQUENT HOSPITAL CARE

99231 A 14-year-old female admitted for depression and suicidal ideation is seen in a subsequent hospital visit. The patient has been in the hospital for 12 days and is behaviorally stable. Her condition is improving. The attending psychiatrist interviews the patient; meets with the treatment team; reviews notes prepared by nursing, occupational therapy/recreational therapy, and social work staff; writes an order for as-needed medication for headache; and writes the daily progress note.

Explanation for code choice: This level of subsequent hospital care is appropriate because the patient is stable and approaching discharge. The medical decision making for this day's work is straightforward.

99232 A 36-year-old man admitted for hallucinations and delusions and now in his third hospital day is seen for a subsequent hospital visit. The attending psychiatrist interviews the patient, takes an interval history, does a mental status examination, and then meets with the treatment team. The team reviews notes prepared by nursing, occupational therapy/recreational therapy, and social work staff. The attending psychiatrist orders an increase in the patient's neuroleptic medication. The attending psychiatrist discusses discharge planning with social work staff, talks with the patient's mother by phone, and writes the daily progress note.

Explanation for code choice: This example of subsequent hospital care is typical of a mid-hospital-course day of work. The history and examination are at the expanded problem-focused level, and the medical decision making is moderately complex. The expanded problem-focused history requires one to three elements of a review of systems.

99233 A 72-year-old man admitted for depression with suicidal ideation and paranoid delusions is seen for a subsequent hospital visit. The patient is in his seventh hospital day. The attending psychiatrist interviews the patient and does a mental status examination, noting minor changes in orientation. The attending psychiatrist meets with the treatment team and reviews notes prepared by nursing, occupational therapy/recreational therapy, and social work staff. Although the patient is taking antidepressants, the team does not believe the patient has shown

progress. His sleep and appetite are poor, and he must be encouraged to shower and groom. The attending psychiatrist reviews discharge planning with social work staff and writes the daily progress note. Later the same day the attending psychiatrist is notified that the patient has become combative with staff and is confused and disoriented. The attending psychiatrist returns to the unit and orders as-needed lorazepam and open-door seclusion. The patient's vital signs are taken, and a modest increase in temperature is observed. The attending psychiatrist orders a medical consultation and an evaluation for the fever and prepares an addendum to the progress note.

Explanation for code choice: The reason the highest level of subsequent hospital care is recommended in this case is the abrupt change in mental state requiring a return to the unit and a detailed evaluation of the situation, with a detailed examination and medical decision making of high complexity. Although the subsequent hospital care codes require only two of the three key components, it is not a bad idea to do a detailed (two to nine elements) review of systems when using these codes.

OFFICE OR OTHER OUTPATIENT CONSULTATIONS

Note: As of January 1, 2010, Medicare does not reimburse for these codes. See Chapter 4 for alternative coding.

99244 A 7-year-old boy referred by his pediatrician is seen in an initial office consultation. The patient was referred because of his short attention span, easy distractibility, and hyperactivity. The history taken during the parents' interview focuses on the patient's family history and psychosocial context, the mother's pregnancy, the patient's early childhood development, and the parents' description of the onset and progression of the symptoms and behaviors. The mental status examination focuses on the patient's affective state, ability to attend and concentrate during the evaluation and observation, and behavior during the session. The patient is scheduled for neuropsychological testing and a return visit with his parents.

Explanation for code choice: The consultation requires a comprehensive history and examination. The medical decision making is moderately complex. Do not forget that a review of systems is required.

99245 An 81-year-old woman referred by her internist is seen in an initial office consultation for evaluation of her mental state. Her family had reported her activity as being markedly decreased and that she was having difficulty maintaining independent self-care. The patient's history reveals that she has congestive heart failure and chronic obstructive pulmonary disease that is in fair control. She had two episodes of depression in her 50s and was treated successfully with antidepressants. The patient reports feelings of general malaise, loss of interest, trouble sleeping, decreased appetite, and problems with memory over a 4-week period. The patient denies awareness of an inability to maintain her home or independent self-care. A mental status examination reveals a poorly groomed, cooperative woman

with moderate psychomotor retardation and no speech abnormalities. She appears sad and expresses feelings of depression and has flat affect. Her Mini-Mental State Examination score is 25 of 30 points, with poor recall, attention and concentration deficits, and distortion of figure drawing. A family member is interviewed and confirms most of the history. Neuropsychological testing is ordered, and the patient's case is discussed with the referring physician.

Explanation for code choice: This case involves mental disorder with significant comorbid medical conditions. The medical decision making is highly complex, supported by a comprehensive history and examination. The history must include a complete review of systems.

INITIAL INPATIENT CONSULTATIONS

> **Note:** As of January 1, 2010, Medicare does not reimburse for these codes. See Chapter 4 for alternative coding.

99253 An initial hospital consultation is provided for a 35-year-old woman referred by obstetrics/gynecology staff after she had a normal vaginal delivery and had asked to talk to a psychiatrist about feelings of depression. A review of her chart reveals an uncomplicated neonatal course and a normal delivery of a healthy baby girl. History taking focuses on symptom onset and progression and the patient's current family/social context. The patient reports that her husband is out of work and is drinking and arguing with her frequently. Two other children are doing well. A mental status examination reveals a cooperative, friendly individual with normal speech, moderately depressed mood (which she relates to her marital stress), full affect, and no psychotic or anxiety symptoms. She is cognitively intact. Her insight is fair, and her judgment is intact. Her desire for marital counseling is supported, and she is given a referral for this service.

Explanation for code choice: This consultation for a medically stable patient required a detailed history and examination. The medical decision making is of low complexity. The history must include a detailed review of systems (two to nine elements).

99254 An initial hospital consultation is provided for a 19-year-old female referred by department of medicine staff after treatment for ingestion of acetaminophen and alcohol. A review of her chart reveals that symptomatic management was used to treat ingestion of alcohol (her blood alcohol level was 120 mg/dL) and a nonlethal amount of acetaminophen. The patient has no history of medical or surgical problems. History provided by the patient includes a recent breakup with her boyfriend of 3 years, loss of her job, and fighting with her mother. Her family history includes alcohol abuse by the father and two brothers. The patient reports that she has experimented with street drugs, has used alcohol regularly since age 16 years, and has had a history of binge drinking. There is no history of blackouts or delirium tremens. The patient has no current legal problems. A mental status examination reveals a cooperative individual with good eye con-

tact. She asks "When can I get out of here?" and states "I did a stupid thing." The patient is remorseful, and her affect is bright, with a moderate level of depression. She is cognitively intact. She expresses concerns about her boyfriend and states that she probably needs some counseling. She agrees to treatment of alcohol abuse. The patient is cleared for discharge and given a referral to a community psychiatry program for dually diagnosed patients.

Explanation for code choice: The suicide attempt was committed impulsively, and the patient is remorseful and ready for outpatient follow-up. A detailed history and examination are performed, and medical decision making is moderately complex. The history must include a complete review of systems.

99255 An initial hospital consultation is provided for an 82-year-old man referred by department of medicine staff because of bizarre behavior that resulted in his requiring a sitter. The patient has high blood pressure, renal insufficiency, congestive heart failure, and chronic obstructive pulmonary disease. He is taking 12 medications, including as-needed lorazepam and haloperidol for "behavioral control." Notes prepared by nursing staff indicate that the patient has periods of lucidity intermixed with confused, uncooperative behavior, usually in the evenings. The patient began receiving antibiotics in the previous 12 hours for a urinary tract infection. The social worker reports that the patient lives with his wife and was in good health and maintained a wide range of activities before this admission. The wife reports some slippage in the patient's memory, but the patient denies that there are any problems whatsoever. The mental status examination reveals the patient to be resting in his hospital bed and receiving intravenous fluids and intranasal oxygen. The patient is irritable, and his irritability increases during the course of the evaluation. He denies any psychological symptoms. The patient knows who he is and where he is but does not know the day, the date, or the month. He cannot do serial 7s. The patient reports having had a visit by several of his children the night before, but nursing staff report no such visit took place. The findings are reviewed with the nursing staff and the attending physician. Lorazepam is discontinued, and orientation strategies are discussed with the nursing staff and the attending physician.

Explanation for code choice: This case is typical for an acute geriatric medical admission: multiple comorbidities and multiple medications complicated by delirium. The consulting psychiatrist must do a comprehensive history and examination. The medical decision making is highly complex. The history must include a complete review of systems.

Appendix G

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

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A CMS Contracted Agent

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.

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