THE UNIVERSITY OF CHICAGO | UChicago Medicine | Office of Corporate Compliance

UCHICAGO MEDICINE
Evaluation & Management Documentation Guidelines

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Questions:

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E/M BACKGROUND

- **Medical Necessity:** Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.
- **3 key components to determining level of service**: History, Examination, and Medical Decision Making.
- **Time based codes:** When counseling and/or coordination of care dominates (more than 50%) of the encounter with the patient and/or family (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility)**,** then time can be used to supplement the 3 key components when identifying service level. Documentation of discussion/coordination of care can include prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction and/or discussion with another health care provider.

  Documentation requirements include:

  - The total **Teaching Physician** time spent with the patient;
  - The time spent counseling the patient and/or coordinating patient care; and
  - The subject matter of the counseling and/or coordination of care.

  Acceptable documentation of the Teaching Physician's participation could read: "Total time spent was [xx] minutes. Greater than 50% was spent counseling (patient) on (summarize subject of counseling [e.g., surgical and non-surgical options for treatment of the patient's condition.])."
- **E/M Patient Types**
  - **New:** One who has not received professional services from the physician or another physician of the same specialty in the same group within the past 3 years.
  - **Established:** One who has received professional services from the physician or another physician of the same specialty in the same group within the past 3 years.
  - **Outpatient:** A patient who has not been admitted to a health care facility
    - ⇒ New Outpatient Service Codes: 99201, 99202, 99203, 99204, 99205 (3/3 components)
    - ⇒ Established Outpatient Service Codes: 99211, 99212, 99213, 99214, 99215 (2/3 components)
  - **Inpatient:** A patient who has been admitted to a health care facility
    - ⇒ Initial Inpatient Service Codes: 99221, 99222, 99223 (3/3 components)
    - ⇒ Subsequent Hospital Care Service Codes: 99231, 99232, 99233 (2/3 components)

E/M BACKGROUND

Hospital Discharge Services Codes (when a patient is discharged on a different date from the initial inpatient admission date)

- 99238 - 30 minutes or less (Documentation of time is required)
- 99239 - More than 30 minutes (Documentation of time is required)

Observation or Inpatient Care Services (when a patients is admitted and discharged on the same date of service)

- 99234, 99235, 99236 (3/3 components)

Observation Codes

- **Observation is appropriate** for patients whose stay will either NOT cross 2 midnights, or do not meet the inpatient necessity criteria in your current clinical judgment; to observe, monitor or assess the patient.
- **Observation is not appropriate** if it's not reasonable and necessary for the diagnosis or treatment of the patient; for social reasons, or non-medically necessary stays; for services provided after medically necessary observation has ended and the patient is awaiting transportation.
- **Documentation must reflect** the patient is in the care of a physician as documented in the medical record by outpatient registration, discharge and other appropriate progress notes that are timed, written and signed by the physician; and that the physician assessed the patient risk to determine that the patient would benefit from observation care.
- **Hospital Observation Service Codes for patients admitted and discharged on different dates of service:** When the patient is receiving outpatient observation services, only the attending physician of record, who is primarily responsible for the patient, uses the observation codes. When the attending of record is a member of a same-specialty group, other group members providing coverage may also bill the subsequent and discharge observation codes.
  - 99218-99220 Initial Observation Care
  - 99224-99226 Subsequent Observation Care
  - 99217 Observation Care Discharge (when discharge date is different from the initial date of observation status)
- Services performed on a consultative basis by other specialty providers are billed with the correlative outpatient visit codes (Initial care: 99201-99205, Subsequent care: 99211-99215). Services performed on a consultative basis by other specialty providers are billed with the correlative outpatient visit codes (Initial care: 99201-99205, Subsequent care: 99211-99215). The use of a modifier is not indicated in either billing scenario.

3 Golden Rules for Teaching Physicians when billing

1. Teaching Physician must personally perform or observe resident perform key portion of E/M service billed
2. Teaching Physician must document presence and participation in service
3. Teaching Physician must attest to the documentation of resident

Modifiers

- 24- Unrelated E/M in Post OP
- 25- Significant, Separately Identifiable E/M service by the same physician on the procedure day/minor procedure
- 27- Multiple Outpatient Hospital E/M Encounters on the Same Day
- 52- Reduced Services
- 53- Discontinued Procedure
- 57- Decision for Surgery (Major Procedure)
- 59- Service distinct/independent from other services on the same day
- 79- Unrelated procedure or service in Post Op
- GC- Supervision of Resident
- GE- PCE Resident Service

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Section 1 - HISTORY: Refer to the data section (below) in order to quantify. Circle the entry farthest to the RIGHT in the table, which best describes the history of present illness (HPI), review of system (ROS), and past medical, family, social history (PFSH). If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the LEFT, identifies the type of history. After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 4, Level of Service. CHIEF COMPLAINTS REQUIRED FOR ALL HISTORY LEVELS.				
1. HPI ELEMENTS: • Location • Timing • Quality • Context • Severity • Modifying Factors • Duration • Associated Signs and Symptoms	Brief (1-3)	Brief (1-3)	Extended (4 or more)	Extended (4 or more)
HPI Status of Chronic Conditions: 3 conditions	N/A	N/A	Status of 3 chronic conditions	Status of 3 chronic conditions
2. REVIEW OF SYSTEMS: • All/immuno • GU • Constitutional (weight loss, etc.) • Musc/Skeletal • Eyes • Integumentary (skin, breast) • Ears-nose-mouth-throat • Neuro • Cardiovascular • Psych • Respiratory • Endo • GI • Hem lymph • All others negative	None	Pertinent to Problem (1 system)	Extended (2-9)	Complete (10 or more systems, or some systems with statement "all others negative")
3. PFSH: • Past history (patient's past experiences with illnesses, operations, injuries and treatments) • Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) • Social history (an age-appropriate review of past and current activities) *Note: For subsequent hospital and nursing facility E/M services, only an interval history is necessary. It is unnecessary to record information about the PFSH.*	None	None	Pertinent to Problem (1 history area)	Complete **2 history areas:** a) Established patients-office (outpatient) care; b) Emergency dept. **3 history areas:** a) New patients –office (outpatient) care, b) Initial hospital care; c) Hospital observation;
FINAL RESULTS	**PROBLEM FOCUSED**	**EXPANDED PROBLEM FOCUSED**	**DETAILED**	**COMPREHENSIVE**

Section 2 - EXAMINATION: Refer to table below in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 4, Level of Service. ***NOTE: Choose either the 1995 or 1997 rules, but not both.***				
EXAMINATION	**Calculation - Choose either the 1995 or 1997 rules to calculate result.**			
	1995 RULES			
	One body area or system	**2-4 areas or systems**	**5-7 areas or systems**	**8 or more systems only**
	1997 RULES			
	1-5 bullets (1 or more body areas or system)	**6 bullets (1 or more body areas or system)**	**12 bullets in 2 or more body areas/systems or 2 bullets in 6 or more body areas or systems (except eye and psych exams which are 9 bullets)**	**2 bullets in 9 or more body areas or systems; or complete single organ system**
FINAL RESULTS	**PROBLEM FOCUSED**	**EXPANDED PROBLEM FOCUSED**	**DETAILED**	**COMPREHENSIVE**

Section 3 - MEDICAL DECISION MAKING: Complete Tables A, B, C and D to determine type of Medical Decision Making.

Table A. NUMBER OF DIAGNOSES OR TREATMENT OPTIONS
For each row in Column A, multiply the number in column B with the points in column C and put the product in column D. Enter a total for column D.(note the maximum number in two of the categories).

A. Problem (s) Status	B. Number	C. Points	D. Results
• Self-limited or minor (stable, improved, or worsening)	Max = 2	1	
• Est. problem (to patient); stable, improved		1	
• Est. problem (to patient); worsening		2	
• New problem (to patient; no additional workup planned	Max = 1	3	
• New problem (to patient); add workup planned		4	
		Total	

Table B. AMOUNT AND/OR COMPLEXITY OF DATA REVIEWED
For each category or reviewed data identified, circle the number in the Points column. Total the points.

Reviewed Data	Points
• Review and/or order of clinical lab tests	1
• Review and/or order of tests in the radiology section of CPT	1
• Review and/or order of tests in the medicine section of CPT	1
• Discussion of test results with performing physician	1
• Decision to obtain old records and/or obtain history from someone other than patient	1
• Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
• Independent visualization of image, tracing or specimen itself (not simply review of report)	2
Total	

Table D. FINAL RESULT FOR COMPLEXITY TABLE
Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the second circle form the left. After completing this table circle the type of decision making with the appropriate grid in Section 4, Level of Service.

A	Number of Diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Amount and/or Complexity of Data Reviewed	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
C	Highest Risk	Minimal	Low	Moderate	High
	TYPE OF DECISION MAKING	**STRAIGHT FORWARD**	**LOW COMPLEXITY**	**MODERATE COMPLEXITY**	**HIGH COMPLEXITY**

Section 3 - MEDICAL DECISION MAKING:

Table C. Risk of Complications and/or Morbidity or Mortality - This table is a guide to assign risk factors. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Table D "Final Result for Complexity".

Risk Level	Presenting Problem	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• 1 self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Lab tests requiring venipuncture • Chest X-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• 2 or more self-limited or minor problems • 1 stable chronic illness (e.g., well controlled hypertension) • Noninsulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function test • Noncardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical lab tests requiring arterial puncture • Skin biopsies	• Over the counter drugs • Minor surgery w/no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• 1 or more chronic illness with mild exacerbation, progression, or side effects of treatment • 2 or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac catheter • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic with no identified risk factors) • Prescription drug management (continuation & new prescription) • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic with identified risk factors) • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Section 4 - Level of Service										
ABBREVIATIONS:	**PF (Problem Focused)**	**EPF (Expanded Problem Focused)**		**D (Detailed)**	**C (Comprehensive)**	**SF (Straightforward)**		**L (Low)**	**M (Moderate)**	**H (High)**
Outpatient and Emergency Room (ER)										
	New Office/ER- Requires three components with shaded area					**Established Office- Requires two components within shaded area**				
History	PF ER: PF	EPF ER: EPF	D ER: EPF	C ER: D	C ER: C	Minimal problem that may not require presence of physician	PF	EPF	D	C
Examination	PF ER: PF	EPF ER: EPF	D ER: EPF	C ER: D	C ER: C		PF	EPF	D	C
Complexity of medical decision	SF ER: SF	SF ER: L	L ER: M	M ER: M	H ER: H		SF	L	M	H
Average time (minutes) (ER has no average time)	10 New (99201) ER (99281)	20 New (99202) ER (99282)	30 New (99203) ER (99283)	45 New (99204) ER (99284)	60 New (99205) ER (99285)	5 (99211)	10 (99212)	15 (99213)	25 (99214)	40 (99215)
LEVEL	**I**	**II**	**III**	**IV**	**V**	**I**	**II**	**III**	**IV**	**V**

Inpatient						
	Initial Hospital/Observation- Requires three components within shaded area			**Subsequent Hospital/Observation- Requires two components within shaded area**		
History	D/C	C	C	PF interval	EPF interval	D interval
Examination	D/C	C	C	PF	EPF	D
Complexity of medical decision	SF/L	M	H	SF/L	M	H
Average time (minutes) (Initial observation care has no average time)	30 Init hosp (99221) Observation care (99218)	50 Init hosp (99222) Observation care (99219)	70 Init hosp (99223) Observation care (99220)	15 Subsequent (99231) Observation (99224)	25 Subsequent (99232) Observation (99225)	35 Subsequent (99233) Observation (99226)
LEVEL	**I**	**II**	**III**	**I**	**II**	**III**

Section 4 - Level of Service					
Outpatient Consultation for new or established patient: **Requires three components within shaded area***					
History	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
Examination	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
Complexity of medical decision making	Straightforward	Straightforward	Low	Moderate	High
Average Time (minutes)	**15**	**30**	**40**	**60**	**80**
LEVEL	**I (99241)**	**II (99242)**	**III (99243)**	**IV (99244)**	**V (99245)**
Inpatient Consultation for new or established patient: **Requires three components within shaded area***					
History	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
Examination	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Comprehensive
Complexity of medical decision making	Straightforward	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Average Time (minutes)	**20**	**40**	**55**	**80**	**110**
LEVEL	**I (99251)**	**II (99252)**	**III (99253)**	**IV (99254)**	**V (99255)**

Effective January 1, 2010 Medicare stopped recognizing consultation CPT codes. However, they are still an American Medical Association CPT code and recognized by non-Medicare Payors. To accommodate providers who use consultation codes, the UCMC billing system automatically cross-walks the consultation codes to the appropriate code for Medicare Payors.