

Choosing the Appropriate Outpatient E/M Code

1. History

Complete the following chart by marking the entry in the farthest right column which best describes the History of Present Illness (HPI), Review of Systems (ROS), and the Past Family and Social History (PFSH). If one column contains three marks, the type of history is indicated at the bottom of the column. If no column contains three marks, the column containing the mark farthest to the left identifies the type of history. Once the type of history is determined, record it in the appropriate grid in Section 5.

HPI (history of present illness) elements: <input type="checkbox"/> Location <input type="checkbox"/> Severity <input type="checkbox"/> Timing <input type="checkbox"/> Modifying factors <input type="checkbox"/> Quality <input type="checkbox"/> Duration <input type="checkbox"/> Context <input type="checkbox"/> Associated signs and symptoms	<input type="checkbox"/> Brief (1-3)	<input type="checkbox"/> Brief (1-3)	<input type="checkbox"/> Extended (4 or more)	<input type="checkbox"/> Extended (4 or more)
ROS (review of systems): <input type="checkbox"/> Constitutional <input type="checkbox"/> Ears, nose, mouth, throat <input type="checkbox"/> GI <input type="checkbox"/> Integumentary <input type="checkbox"/> Endo <input type="checkbox"/> Eyes <input type="checkbox"/> Card/vasc <input type="checkbox"/> Musculo <input type="checkbox"/> Neuro <input type="checkbox"/> Psych <input type="checkbox"/> Hem/lymph <input type="checkbox"/> Resp <input type="checkbox"/> All immuno <input type="checkbox"/> All others negative	<input type="checkbox"/> None	<input type="checkbox"/> Pertinent to problem (1 system)	<input type="checkbox"/> Extended (2-8 systems))	<input type="checkbox"/> Complete**
PFSH (past medical, family, social history) areas: <input type="checkbox"/> Past history (the patient's past experiences with illnesses, operations, injuries, and treatments) <input type="checkbox"/> Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk.) <input type="checkbox"/> Social history (an age appropriate review of past and current activities.)	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Pertinent (1 history area)	<input type="checkbox"/> Complete* (2 or 3 history areas)
* Complete PFSH: 2 hx areas: a) Estab pts, office (outpt) care, domiciliary care: home care b) Emergency dept c) Subseq nursing facility care 3 hx areas: a) New pts, office (outpt) care: domiciliary care, home care b) Consultations c) Initial hospital care d) Hospital observation e) Comprehensive nursing facility assessments	PROBLEM FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPREHENSIVE

** 10 or more systems, or some systems with statement "all others negative"

2. Examination

Use the following grid to determine the type of examination. Note that the "General Multi-System Exam" section on the front page of the ACR template corresponds to the organ systems and body areas. The "Joint Exam" and "Spine Exam" sections on the back page of the ACR template correspond to the single organ system exam for the musculoskeletal system. Once the type of examination is determined, record it in the appropriate grid in Section 5.

Body areas: <input type="checkbox"/> Head, including face <input type="checkbox"/> Chest, breasts, axillae <input type="checkbox"/> Abdomen <input type="checkbox"/> Back, including spine <input type="checkbox"/> Neck <input type="checkbox"/> Genitalia, groin, buttocks <input type="checkbox"/> Each extremity	<input type="checkbox"/> 1 body area or system	<input type="checkbox"/> Up to 7 systems	<input type="checkbox"/> Up to 7 systems (in more detail than Expanded Problem Focused)	<input type="checkbox"/> 8 or more systems OR Complete exam of single system
Organ systems: <input type="checkbox"/> Constitutional (e.g., vitals, gen app) <input type="checkbox"/> Ears, nose, mouth, throat <input type="checkbox"/> Resp <input type="checkbox"/> Musculo <input type="checkbox"/> Psych <input type="checkbox"/> Eyes <input type="checkbox"/> Cardiovascular <input type="checkbox"/> GU <input type="checkbox"/> Skin <input type="checkbox"/> Hem/lymph/imm <input type="checkbox"/> Neuro	PROBLEM FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPREHENSIVE

3. Medical Decision Making

Medical Decision Making involves calculating the number of diagnoses or treatment options, amount and/or complexity of data reviewed, and the level of risk. Use the following tables to calculate these factors and record the results in the table labeled "Final Result for Complexity." When the final result for complexity is determined, record it in the appropriate grid in Section 5.

3.a. Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum numbers in two categories.)

A	B X	C =	D
Problem(s) Status	Number	Points	Result
Self-limited or minor (stable, improved or worsening)	<i>Max = 2</i>	1	
Est problem (to examiner): stable, improved		1	
Est. problem (to examiner): worsening		2	
New problem (to examiner): no additional workup planned	<i>Max = 1</i>	3	
New problem (to examiner): add. workup planned		4	
TOTAL			

Multiply the number in columns B & C and put the product in column D.
Enter a total for column D.
Bring total to **Line B** in 3.d. Final Result for Complexity (table on reverse side)

3.b. Amount and/or Complexity of Data Reviewed

For each category of 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	

Bring total to **Line B** in 3.d. Final Result for Complexity (table on reverse side)

See Reverse Side to Complete Medical Decision Making

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Medical Decision Making (Continued)

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk on **Line C** in 3.d. Final Result for Complexity (table below).

3.c. Risk of Complications and/or Morbidity or Mortality

Level of Risk	Presenting Problem(s) or Number of Diagnoses and/or Complications	Diagnostic Procedure(s) Ordered and/or Amount of Data to be Obtained or Reviewed	Management Options Selected
<i>Minimal</i>	<ul style="list-style-type: none"> One self limited or minor problem (e.g., rash or oral ulcers) 	<ul style="list-style-type: none"> Laboratory tests requiring venipuncture Chest X-ray Plain X-rays of hands and/or feet Urinalysis Non-invasive diagnostic procedures (e.g., EKG, ultrasound) 	<ul style="list-style-type: none"> Rest Splints Sunscreen
<i>Low</i>	<ul style="list-style-type: none"> Two or more self-limited or minor problems or symptoms One stable chronic illness (e.g., well controlled OA, gout) Acute uncomplicated illness or injury (e.g., simple sprain) 	<ul style="list-style-type: none"> MRI/CT Skin biopsies 	<ul style="list-style-type: none"> Physical Therapy Occupational Therapy Tendon Injection OTC Drugs TENS Unit
<i>Moderate</i>	<ul style="list-style-type: none"> One or more chronic illnesses with mild exacerbation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis (e.g., septic joint) Acute illness with systemic symptoms (e.g., pyelonephritis, pneumonitis, colitis) Acute complicated injury (e.g., vertebral compression fracture) 	<ul style="list-style-type: none"> Diagnostic endoscopies with no identified risk factors Muscle biopsy Arthroscopy Arthrocentesis Data to be obtained/reviewed requiring at least 10 minutes of physician time 	<ul style="list-style-type: none"> One or Two Prescription Drugs Joint Injections
<i>High</i>	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function (e.g., progressive severe RA) An abrupt change in neurologic status (e.g., seizure, TIA, weakness, sensory loss) 	<ul style="list-style-type: none"> Renal/lung biopsy Diagnostic endoscopies with identified risk factors Discography Data to be obtained and reviewed requiring at least 20 minutes of physician time 	<ul style="list-style-type: none"> Elective major surgery with identified risk factors Emergency major surgery Administration of controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to deescalate care because of poor prognosis Parenteral drug therapy requiring intensive monitoring and observation

3.d. Final Result for Complexity

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

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

5. Determining Level of Service

Complete this table by recording results from previous tables to determine the level of service for office encounters with new patients, established patients and consults.

	New Office/Consults					Established Office				
	Requires 3 components within a column (or choose lowest column)					Requires 2 components within a column (or choose lowest column)				
History	PF	EPF	D	C	C	<i>Minimal problem that may not require presence of physician</i>	PF	EPF	D	C
Examination	PF	EPF	D	C	C		PF	EPF	D	C
Complexity of medical decision	SF	SF	L	M	H		SF	L	M	H
Level	I (99201 or 99241)	II (99202 or 99242)	III (99203 or 99243)	IV (99204 or 99244)	V (99205 or 99245)	I (99211)	II (99212)	III (99213)	IV (99214)	V (99215)

4. If Counseling and Coordination of Care Constitute More than 50 % of the Visit Time:

If counseling and coordination of care dominate the encounter, time *may* be used to determine the level of service. Documentation should refer to prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

Documentation should:

- Reveal total face-to-face time
- Describe the content of counseling or coordinating care
- Reveal that more than half the time of the encounter was spent counseling and coordinating care.

If these criteria are met, the following times for the entire visit (not just time spent in counseling or coordination of care) correspond with these code levels:

New Patient (9920_)

- Level 1: 10 minutes
- Level 2: 20 minutes
- Level 3: 30 minutes
- Level 4: 45 minutes
- Level 5: 60 minutes

Established Patient (9921_)

- Level 1: 5 minutes
- Level 2: 10 minutes
- Level 3: 15 minutes
- Level 4: 25 minutes
- Level 5: 40 minutes

New or Est. Consult (9924_)

- Level 1: 15 minutes
- Level 2: 30 minutes
- Level 3: 40 minutes
- Level 4: 60 minutes
- Level 5: 80 minutes