# MEDICAL DECISION MAKING

## TABLE A. Number of Diagnoses or Treatment Options

| Problems to Exam Physician | Number | Points | Result |
|---|---|---|---|
| Self-limited or minor (stable, improved or worsening) | Max = 2 | 1 | |
| Est. problem (to examiner); stable, improved | | 1 | |
| Est. problem (to examiner); worsening | | 2 | |
| New problem (to examiner); no additional workup planned | Max = 1 | 3 | |
| New problem (to examiner); add, workup planned | | 4 | |
| **Total** | | | |

## TABLE B. Risk of Complications and/or Morbidity or Mortality

| Level of Risk | Presenting Problem(s) | Diagnostic Procedure(s) Ordered | Management Options Selected |
|---|---|---|---|
| MINIMAL | • One self-limited or minor problem, e.g., cold, insect bite, tinea corporis | • Lab tests requiring venipuncture<br>• Chest x-rays<br>• EKG/EEG<br>• Urinalysis<br>• Ultrasound, e.g., echo<br>• KOH prep | • Rest<br>• Gargles<br>• Elastic bandages<br>• Superficial dressings |
| LOW | • Two or more self-limited or minor problems<br>• One stable chronic illness, e.g., well-controlled hypertension or non-insulin-dependent diabetes, cataract, BPH<br>• Acute uncomplicated illness or injury, e.g., cystitus, allergic rhinitis, simple sprain | • Physiologic tests not under stress, e.g., pulmonary function tests<br>• Noncardiovascular imaging studies with contrast, e.g., barium enema<br>• Superficial needle biopsies<br>• Clinical lab tests requiring arterial puncture<br>• Skin biopsies | • Over-the-counter drugs<br>• Minor surgery with no identified risk factors<br>• Physical therapy<br>• Occupational therapy<br>• IV fluids without additives |
| MODERATE | • One or more chronic illnesses with mild exacerbation, progression or side effects of treatment<br>• Two or more stable chronic illnesses<br>• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast<br>• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis<br>• 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<br>• Diagnostic endoscopies with no identified risk factors<br>• Deep needle or incisional biopsy<br>• Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac cath<br>• Obtain fluid from body, e.g., lumbar puncture, thoracentesis, culdocentesis | • Minor surgery with identified risk factors<br>• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors<br>• Prescription drug management<br>• Therapeutic nuclear medicine<br>• IV fluids with additives<br>• Closed treatment of fracture or dislocation without manipulation |
| HIGH | • One or more chronic illnesses with severe exacerbation, progression or side effects of treatment<br>• Acute or chronic illness or injuries that may pose a threat to life or body 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<br>• An abrupt change in neurological status, e.g.,seizure, TIA, weakness or sensory loss | • Cardiovascular imaging studies with contrast with identified risk factors<br>• Cardiac electrophysiological tests<br>• Diagnostic endoscopies with identified risk factors<br>• Myelogram | • Elective major surgery (open, percutaneous or endoscopic) with identified risk factors<br>• Emergency major surgery (open, percutaneous or endoscopic)<br>• Parenteral controlled substances<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |

## TABLE C. Amount and/or Complexity of Data to be Reviewed

| Date to be Reviewed | 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 somone other than patient | 1 |
| Review and summarization of old records and/or obtain history from someone other than the patient and/or discussion of case with another healthcare provider | 2 |
| Independent visualization of image, tracing or specimen itself (not simply review of report) | 2 |
| **Total** | |

M-213 (8/16)

# E & M CODES & LEGEND FOR DOCUMENTATION REQUIREMENTS – 1997 GUIDELINES

**KEY**

**History/ Examination**

**PF** - Problem-Focused
**EPF** - Expanded Problem-Focused
**D** - Detailed
**C** - Comprehensive

**Medical Decision Making**

**SF** - Straight-Forward
**LC** - Low Complexity
**MC** - ModerateComplexity
**HC** - High Complexity

## PRIMARY CARE OUTPATIENT CODES

**New Patient (3 out of 3)**

| E/M Code | History | Examination | Medical Decision Making | Average Time |
|---|---|---|---|---|
| 99201 | PF | PF | SF | 10 |
| 99202 | EPF | EPF | SF | 20 |
| 99203 | D | D | LC | 30 |
| 99204 | C | C | MC | 45 |
| 99205 | C | C | HC | 60 |

**Established Patient (2 out of 3)**

| E/M Code | History | Examination | Medical Decision Making | Average Time |
|---|---|---|---|---|
| 99211 | ------- | ------- | Physician Supervised | 5 |
| 99212 | PF | PF | SF | 10 |
| 99213 | EPF | EPF | LC | 15 |
| 99214 | D | D | MC | 25 |
| 99215 | C | C | HC | 40 |

## PRIMARY CARE INPATIENT CODES

**Initial Hospital Care (3 out of 3)**

| E/M Code | History | Examination | Medical Decision Making | Average Time |
|---|---|---|---|---|
| 99221 | D / C | D / C | SF / LC | 30 min |
| 99222 | C | C | MC | 50 min |
| 99223 | C | C | HC | 70 min |

**Subsequent Hospital Care (2 out of 3)**

| E/M Code | History | Examination | Medical Decision Making | Average Time |
|---|---|---|---|---|
| 99231 | PF | PF | SF / LC | 15 min |
| 99232 | EPF | EPF | MC | 25 min |
| 99233 | D | D | HC | 35 min |

**Inpatient Discharge**

| E/M Code | Time |
|---|---|
| 99238 | ≤ 30 min. |
| 99239 | > 30 min. |

## OBSERVATION CODES

**Initial Observation Day [3 out of 3]**

| E/M Code | History | Examination | Medical Decision Making |
|---|---|---|---|
| 99218 | D / C | D / C | SF / LC |
| 99219 | C | C | MC |
| 99220 | C | C | HC |
| 99217 | Discharge next day | | |

**Subsequent Observation Care (2 out of 3)**

| E/M Code | History | Examination | Medical Decision Making | Average Time |
|---|---|---|---|---|
| 99224 | PF | PF | SF / LC | 15 min |
| 99225 | EPF | EPF | MC | 25 min |
| 99226 | D | D | HC | 35 min |

**Observation Same Day Discharge [3 out of 3]**

| E/M Code | History | Examination | Medical Decision Making |
|---|---|---|---|
| 99234 | D / C | D / C | SF / LC |
| 99235 | C | C | MC |
| 99236 | C | C | HC |

## TCU / NURSING HOME CODES

**Initial Care [3 out of 3]**

| E/M Code | History | Examination | Medical Decision Making | Average Time |
|---|---|---|---|---|
| 99304 | D/C | D/C | SF / LC | 30 min |
| 99305 | C | C | MC | 40 min |
| 99306 | C | C | HC | 50 min |

**Subsequent Care [2 out of 3]**

| E/M Code | History | Examination | Medical Decision Making | Average Time |
|---|---|---|---|---|
| 99307 | PF | PF | SF | 15 min |
| 99308 | EPF | EPF | LC | 25 min |
| 99309 | D | D | MC | 35 min |
| 99310 | C | C | HC | 35 min |

## CRITICAL CARE

| | |
|---|---|
| Less than 30 minutes | Approximate E/M |
| 30 - 74 | 99291 x 1 |
| 75 - 104 | 99291x1 99292x1 |
| 1 Hr 31 Min - 2 Hr 14 Min | 99291x1 99292x2 |
| 2 Hr 15 Min - 2 Hr 44 Min | 99291x1 99292x3 |

## EMERGENCY ROOM

| E/M Code | History | Examination | Medical Decision Making |
|---|---|---|---|
| 99281 | PF | PF | SF |
| 99282 | EPF | EPF | LC |
| 98283 | EPF | EPF | MC |
| 99284 | D | D | MC |
| 99285 | C | C | HC |

## HISTORY

| | Number of Elements | | | |
|---|---|---|---|---|
| | CC (chief complaint) | HPI (history of present illness) | ROS (review of systems) | PFSH (past/family/social history) |
| Problem Focused (PF) | + | 1-3 | N/A | N/A |
| Expanded Problem Focused (EPF) | + | 1-3 | 1 | N/A |
| Detailed (D) | + | ≥ 3 | 2-9 | 1-2 |
| Comprehensive (C) | + | 4+ | 10+ | 3 |

## EXAMINATION

**Problem focused (PF)**
**one to five elements** identified by a bullet

**Expanded problem focused (EPF)**
**at least six elements** identified by a bullet

**Detailed (D)**
at least **two elements** identified by a bullet from each of **six systems OR** at least **twelve elements** identified by a bullet in **two** or more **systems**

**Comprehensive (C)**
at least **two elements** identified by a bullet from each of **nine** systems

## FINAL RESULT FOR DECISION MAKING (2 OUT OF 3)

| Type of decision making | A<br>Number of diagnoses or treatment options | B<br>Highest risk | C<br>Amount and complexity of data |
|---|---|---|---|
| Straight Forward [SF] | ≤ 1<br>Minimal | Minimal | ≤ 1<br>Minimal or low |
| Low Complexity [LC] | 2<br>Limited | Low | 2<br>Limited |
| Moderate Complexity [MC] | 3<br>Multiple | Moderate | 3<br>Moderate |
| High Complexity [HC] | ≥ 4<br>Extensive | High | ≥ 4<br>Extensive |

**Transfer the complexity level to the level of service matrix.**

## TIME

If the physician documents total time and documents that counseling or coordinating care dominates (more than 50%) of the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another healthcare provider.

Does documentation equal total time? Time: Face-to-face in outpatient setting / Unit/floor in inpatient setting ☐ Yes ☐ No

Does documentation describe the content of counseling or coordinating care? ☐ Yes ☐ No

Does documentation reveal that more than half of time was counseling or coordinating care? ☐ Yes ☐ No

If all answers are "yes," select level based on time.

**History, examination and medical decision making are considered the key components in selecting a visit code. These service descriptors, NOT TIME, are used to select the correct level of code.**

**TIME becomes a key consideration in selecting a level of code only when counseling or coordination of care accounts for over 50% of the time spent with the patient.**

**MODIFIERS:**

-21 Prolonged E&M

-24 Unrelated E&M by same physician

-25 Signifigant, separately identifiable on day of procedure

-57 Decision for surgery

### HISTORY OF PRESENT ILLNESS ELEMENTS:

Location, Quality, Context, Timing, Severity, Duration, Modifying Factors, Sign(s)

### REVIEW OF SYSTEMS:

Constitutional, Eyes, ENT, Respiratory, Allergy/Immuno, Hematology/Lymph., Cardiovascular, Musculoskeletal, Integumentary, Neurologic, Psychiatric, Endocrine, GU, GI

### PAST FAMILY AND/OR SOCIAL HISTORY (PFSH):

**Past History:** Illneses; Operations; Injuries; Treatments
**Family History:** Review Possible Inherited Diseases and Risk Factors
**Social History:** Age Appropriate Review of Past and Current Activities

### GENERAL MULTI-SYSTEM EXAMINATION

**Constitutional**

General appearance of the patient

**Any three of the *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

| Eyes | Ears | Nose, Mouth and Throat |
|---|---|---|
| Inspection of conjunctivae and lids | External inspection of ears and nose | Inspection of nasal mucosa, septum and turbinates |
| Examination of pupils and irises | Otoscopic examination | Inspection of lips, teeth and gums |
| Ophthalmoscopic exam of optic discs | Assessment of hearing | Examination of oropharnyx |

**Neck**
- Examination of neck
- Examination of thyroid

**Chest (Breasts)**
- Inspection of breasts
- Palpation of breasts and axillae

**Respiratory**
- Assessment of respiratory effort
- Percussion of chest
- Auscultation of lungs

**Cardiovascular**
- Palpation of heart
- Auscultation of heart
- Carotid arteries
- Abdominal aorta
- Femoral arteries
- Pedal pulses
- Extremities for edema

**Gastrointestinal**
- Examination of abdomen with notation of the presence of masses or tenderness
- Examination of liver and spleen
- Presence or absence of hemia
- Examination of anus, perineum and rectum (P/R)
- Stool for occult blood test (when indicated)

**Genitourinary**

| Male | Female |
|---|---|
| Examination of the scrotal contents | Examination of external genitalia |
| Examination of the penis | Examination of urethra |
| Digital rectal examination of the prostate gland | Examination of bladder |
| | Cervix |
| | Uterus |
| | Adnexa/parametria |

**Lymphatic**
- Palpation of lymph nodes in **two or more areas:** Neck. Axillae, Groin, Other

**Skin**
- Inspection of skin and subcutaneous tissue
- Palpation of skin and subcutaneous tissue

**Musculoskeletal**
- Examination of gait and station
- Inspection and/or palpation of digits and nails
- Examination of joints, bones and muscles of **one or more** of the following areas:
  1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity.

**Neurologic**
- Cranial Nerves with notation of any deficits
- Examination of deep tendon reflexes
- Examination of sensation

**The examination of a given area includes:**
- Inspection and/or palpation
- Range of motion
- Stability
- Muscle strength and tone

**Psychiatric**
- Judgement and insight
- Orientation to time, place and person
- Recent and remote memory
- Mood and affect