


CPT® E/M CODE REQUIREMENTS			
Level of Service (LOS) is ultimately dependent on medical-decision-making (MDM). Generally, the single highest point score on the Table of Risk will be the LOS limiting factor.			
MDM3 - TABLE OF RISK - USE SINGLE HIGHEST POINT			
Points	Risk of illness / injury	Risk of testing	Risk of treatment
4	Chronic + severe exacerbation/ treatment side effect Life / function threatening - Mult trauma, MI, PE, acute resp failure - psych + threat to self / others - peritonitis, acute renal failure Neuro change, AMS, seizure, TIA, weakness, sens loss	CVS imaging + risk Cardiac electrophysiologic test Diagnostic endoscopy + risk Discography	Elective major surgery + risk Emergency major surgery Parenteral controlled Rx Rx therapy + toxicity monitor Poor prognosis - De-escalate care DNR decision
3	Chronic + mild exac/tx side effect 2 stable chronic illnesses Undiagnosed new problem - breast lump Acute, systemic sx - colitis, pneumonitis, pyelonephritis Complicated injury - head injury brief LOC	Stress tests Diagnostic endoscopy, no risk Deep needle / incision biopsy CVS imaging, no risk factors Get body cavity fluid - LP, thoracentesis	Rx management IV fluids + additives Minor surgery + risk factors Elective major surg, no risk Therapeutic nuclear med Closed fx/dislocation no manipulation
2	2 self-limited / minor 1 Stable chronic - HTN, DM, BPH Acute, uncomplicated - cystitis, rhinitis, sprain	Non-cardiac contrast test, BE Superficial needle biopsies Arterial puncture labs Skin biopsies	OTC medications IV fluids no additives PT / OT Minor surgery, no risk
1	1 Self-limited / minor - cold, insect bite, tinea	Lab, x-ray, EKG, or US Non-stress tests, PFTs	Rest, gargle Bandage, ace
Day of Discharge 99217 Observation discharge DOS is not the same as admission DOS Hospital discharge, total time for all DOS services 99238 < 30 min 99239 > 30 min			
Time dependent codes - Total time for date of service (DOS) Time is for counseling, critical care, telephone, and prolonged service only.			
Critical Care NOT an ICU code, use anywhere. Physician cannot leave patient bedside. Document time & critical conditions 99291 30-74 min 99292 additional 30 min after 74		Prolonged Care Face-to-face 99354 OP 30-74 99355 OP +30 99356 IP 30-74 99357 IP +30 NOT face-to-face 99358 30-74 99359 +30	
Included services: chest x-rays (71010, 71015, 71020), interpretation of cardiac output (93561-62), pulse oximetry (94760-62), blood gases, data stored in computers (ECGs, BPs, hematologic data 99090); gastric intubation (43752, 91105); temporary transcutaneous pacing (92953); ventilator management (94002-94004, 94656, 94660); vascular access (36000, 36410, 36415, 36540, 36591, 36600)		Established patients only Unrelated to an E/M within 7 days Day of Discharge* 99441 5-10 min 99442 11-20 min 99443 21-30 min *Telephone services	
Services not included in Critical Care 92950 Management of CPR 76937 Ultrasound vascular access needs image & procedure note in record			
DON'T FORGET TO DOCUMENT THESE IMPORTANT CONDITIONS			
<div><div><div>• Acute esophageal/gas- tric/duodenal/peptic/ gastrojejunal ulcer</div><div>• Acute paranoid reaction</div><div>• All arrhythmias</div><div>• Atrial (fib)/flutter</div><div>• Bi/tri-fascicular block</div><div>• Bile duct obstruction</div><div>• Bipolar disorder</div><div>• Bowel hemorrhage</div><div>• Bowel obstruction</div></div><div><div>• (Chronic) DVT</div><div>• Continuous chemical dependency</div><div>• Crohn's</div><div>• Diverticulitis</div><div>• DKA, HHS</div><div>• Drug withdrawal</div><div>• Encephalopathies</div><div>• Esophageal varices</div><div>• Gangrenous hernia</div><div>• Hemiparesis</div><div>• Hydrocephalus</div></div><div><div>• Hypoaldosteronism/ adrenalism/pituitarism</div><div>• Ileus/gastroparesis</div><div>• Intestinal impaction</div><div>• Mechanical/infectious G-tube complication</div><div>• Nephrosis</div><div>• Obstructed hernia</div><div>• Pericardial tamponade</div><div>• Pericarditis</div><div>• Peripheral autonomic neuropathy</div></div><div><div>• Peritonitis</div><div>• Radiation/toxic gastroenteritis/colitis</div><div>• Rectal abscess</div><div>• Specified schizophrenia</div><div>• Sprue</div><div>• Ulcer with perforation</div><div>• Ulcerative colitis</div><div>• Urethral stone</div><div>• V tach</div></div></div>			

CPT® E/M CODE REQUIREMENTS												
Physicians must document patient's complaint and 2 of 3 MDM sections. An established patient = same billing group + same physician or same specialty/subspecialty within 3 yrs. Established patients need 2 of 3 (History [Hx] / exam / MDM). No physician service is needed for 99211.												
New Office	99201	99202				99203			99204	99205		
Established	99212		99213				99214			99215*		
ED	99281		99282	99283			99284			99285*		
Consult	OP	99241	99242			99243			99244	99245		
	IP	99251	99252			99253			99254	99255		
	CMS OP	Use office codes above, new or established patient										
	CMS IP	99499	99499	<Unlisted code submit notes		99221			99222	99223		
Initial Observation						99218			99219	99220		
Initial Observation, discharge same date						99234			99235	99236		
Initial Hospital Subsequent						99221			99222	99223		
Observation				99224		99225			99226			
Hospital				99231		99232			99233			
HPI	1	1	1	1	4	4	4	4	4	4		
ROS		1	1	1	2	2	2	2	10/caveat**			
PFSH					1	1	1	1	2*/3	2*/3		
Exam or 1 system	1	2	2	2	6	6	6	6	8	8		
MDM1	1	1	limited		2	3	1	2	3	4	3	4
MDM2					2	3		2	3	4	3	4
MDM3	1	1	2		3	1	1	2	3	4	3	4
HPI 4 points - document Pt condition prevents Hx						PFSH *only 2 for codes			Counseling			
Location		Duration		Modifying factors		Past			99285 & 99215			
Quality		Timing		Associated signs & symptoms		Family			Subsequent hospital			
Severity		Context		Assoc comorbid conditions		Social			= interval hx			
ROS		Exam		MDM1 - sum of points								
10**Pertinent +/- "all other systems negative"		Const- VS/appearance		Presenting problem SOI								
Constitutional		Eyes		1 1 Self limited / minor illness / injury								
Eyes		ENT, Mouth		2 2 Self limited / minor illness / injury								
ENT, Mouth		CVS		2 1 Established / worse illness / injury								
CVS		Respiratory		4 2 Established / worse illness / injury								
Respiratory		GI or abdomen		3 New illness / injury no workup								
GI		GU/Genital+groin+butt		4 New illness / injury workup needed								
GU		MS		MDM2 - sum of points								
MS		Skin		Document summary of following in notes								
Skin / breast		Neurological		1 Lab								
Neurological		Psychiatric		1 ECG								
Psychiatric		Hem/lymph/immune		1 Rad								
Endocrine		Head & face		2 Image read by me & documented								
Hem / lymph		Neck		2 Old record reviewed & summarized								
Allergic / Immun		Chest + breast + axilla		2 Identify non-patient historian								
		Back + spine		2 Documented discussion with consultant								
		Extremity										
Document diseases, not signs / symptoms, & link them to underlying causes. If in doubt, document 'suspect,' 'possible,' 'likely,' 'probable' disease. Document a disease for each abnormal test.												

	THE PHYSICIAN DOCUMENTATION IMPROVEMENT POCKET GUIDE, SECOND EDITION
Pamela P. Bensen, MD, MS, FACEP For Pocket Guide Instructions, visit: www.hcpro.com/downloads/10530 This guide should accompany documentation education to acquaint the user with basic clinical documentation concepts to support medical necessity, severity of illness (SOI), quality reporting, and correct ICD-9-CM coding.	
DOCUMENTATION TIPS	
History & Physical (H&P) - Reason for Admission/Surgery Indicate acuity, even when it is obvious: congenital, chronic, acute, acute on chronic, acute exacerbation. Detail pathology requiring admission or surgery. List every diseases/conditions POA that is 'suspected,' tested for, treated, monitored, or medicated (prior to & after admission) & link with underlying causes. Document significance & interdependence of coexisting conditions requiring equal attention.	
Present on Admission (POA) = Hospital Acquired Condition (HAC), if not in H&P <div>Foreign object retained after surgery DVT & PE post orthopedic procedures Manifestations of poor glycemic control Vascular cath infection/clot/etc Pneumothorax with venous cath Falls/trauma, fx, dislocations, intracranial injuries, crush injuries, burns, electrical shock</div> <div>Air embolism Blood incompatibility Cath associated UTI Stage 3/4 pressure ulcers</div> <div>Surgical site infection post: • CABG - Mediastinitis • Orthopedic procedures • Obesity bariatric surgery • CIED Procedures</div>	
Before signing orders, think: Does the patient have a pressure ulcer (where)? What is causing the anemia, ↑WBC, pneumonia? Is there R heart failure with the Cor pulmonale? Is pulmonary edema cardiogenic or non-cardiogenic? Is cardiac dysfunction heart failure or not? Is there acute/chronic osteomyelitis?...?...? Remember SOI counts!	
PROGRESS & DAILY POST-OP NOTES	
Document a disease for every positive test/finding & indicate its significance. Show logical progression of conditions, resolution looks good. If no improvement, note additional conditions, alternative care considered, level of service discussions, and end-of-stay / life planning. Document: New conditions as unexpected or expected and inherent-to or complication-of procedure/tx • post-op confusion/acute delirium probable toxic (anesthetic/narcotic) encephalopathy • atrial fibrillation integral to CABG • vomiting & abd distention is from unexpected ileus from narcotics (or expected w bowel surgery) Post-op conditions, like ileus, fever, atelectasis, anemia, may be coded as complications unless physician documents 'expected consequence' of condition/surgery/Rx. Document: if 'acute blood loss anemia' is disease related (from GI bleed or hip/pelvic fx) if red/inclurated wound is expected wound infection from peritonitis present at surgery	
Signs/symptoms? Chest pain AMS, altered Syncope	Document 'suspected' disease! Uncertainty is OK for inpatients! Probable accelerated angina, pleurisy, GERD, costochondritis... Encephalopathy suspected due to...anoxia, metabolic disorder, sepsis, toxin, trauma Suspect arrhythmia/orthostatic hypotension/TIA/autonomic neuropathy...
Sick patient? Hypotension? Document 'shock' cardiogenic/septic/hypovolemic. Consider SIRS, document if non-infectious (from trauma, burns, pancreatitis) or from infection. If sepsis, document if it is due to a condition requiring surgery. Multi-organ failure conveys less SOI than a list of failed organs plus severity & acuity of conditions: 'acute respiratory failure' & 'acute renal failure' with 'severe acute blood loss anemia'	
DISCHARGE SUMMARY	
Single most important part of record Short story of the patient's illness onset through discharge plus plans for future care Summation of all conditions, diseases, findings, treatments, and course of events Convincing closing argument for patient's maximum SOI during admission.	
SURGICAL CONSIDERATIONS	
Complications: Indicate if surgical procedure is needed to treat a previous surgical complication, failure of care, or late effect of medical treatment. Surgery + serious coexisting medical conditions: Acute blood loss anemia, atelectasis, ileus, AML, shock, SIRS, sepsis, coma, acute respiratory/renal failure, and stroke increase SOI. Malnutrition is the most important predictor of surgical morbidity & mortality (SOI). If cachectic, morbidly obese get a dietary consult, and document results with specific BMI. Trauma: Pathological fractures are due to osteoporosis/penia/myelitis or tumor. Document loss of consciousness & duration. Multiple trauma: list all injuries (ruptured spleen, rib & pelvic fractures); 'possible' organ (lung) contusions; respiratory failure in order of decreasing severity Op notes: Codes come from procedure narratives; document all procedures, intra-op tests, pathology found, extraordinary circumstances, unexpected findings, tissue removed, abscesses drained, implanted devices (stents/prostheses). Record if intraoperative lacerations/bleeding are 'inherent-to' or 'complication-of' the underlying condition or the procedure. Document everything that increases op time & if lysed adhesions were 'usual' or 'excessive.'	

CLINICAL INDICATORS				
When uncertain of diagnosis, use possible..., probable..., suspected..., likely... If uncertain at discharge, document uncertainty in last note & discharge summary				
Acidosis	Labs might include pH < 7.35, pCO2 > 45, HCO3 < 18, anion gap > 12 Document as uncompensated or compensated & respiratory, metabolic, or mixed			
	<u>Primary</u>	<u>Compensatory response</u>		
Metabolic acidosis	↓ pH ≡ PaCO2	↓ pH ≡ ↓ HCO3 ↑ PaCO2		
Respiratory acidosis	↓ pH ≡ ↑ PaCO2	↓ pH ≡ ↑ HCO3 ↑ PaCO2		
Acute blood loss anemia	20% ↑ HCT			
Acute exacerbation COPD/asthma	Awaken at night w/ symptoms, ↓ exercise tolerance, ↑ therapy/inhalers ↑ Frequency/duration of cough, wheezing, SOB Yellow sputum, antibiotics, hemoptysis Change in oxygen status, BiPAP/↑ pO2 need ↓ pO2 > 10 mm Hg from base (see respiratory failure)			
Acute renal failure	SCr ↑ 0.3 mg/dl in 48 hrs KDIGO criteria			
Acute Kidney Injury	SCr ↑ 1.5 x base in 7 days Urine output < 0.5 ml/kg/h for 6 hrs			
Acute respiratory failure	Patient in respiratory distress & needs close monitoring, but ICU & vent not necessary, recovery is possible pH ≤ 7.35 & pCO2 ≥ 50 or pO2 < 55 (sat < 88%) & FiO2 > 28%			
Alkalosis	Labs might include pH > 7.45, pCO2 < 28, HCO3 > 28, anion gap < 12 Document as uncompensated or compensated and respiratory, metabolic, or mixed			
	<u>Primary</u>	<u>Compensatory response</u>		
Metabolic alkalosis	↑ pH ≡ PaCO2	↑ pH ≡ ↑ HCO3 ↑ PaCO2		
Respiratory alkalosis	↑ pH ≡ ↓ PaCO2	↑ pH ≡ ↓ HCO3 ↓ PaCO2		
Chronic kidney disease CKD + stage	Stage GFR	1 > 90	2 60–89	3 30–59
		4 15–29	5 < 15	
Chronic respiratory failure	Usually on home O2 for chronic hypoxemia (Partially) compensated respiratory acidosis pO2 < 55 (O2sat < 88%) or pCO2 > 50			
Continuous/daily use chemical dependency	Addiction/obsession to use despite severe consequences. Cessation causes withdrawal symptoms.			
CVA or Stroke	Sx > 24 hrs or CT/MRI positive			
Cerebral embolism/thrombosis no infarction	Sx 1–24 hrs and CT/MRI negative			
TIA	Sx < 1 hr and CT/MRI negative			
Debridement	<p>Excisional debridement- surgical removal or cutting away of devitalized tissue or slough. May be performed by a nurse, therapist, physician assistant, or physician in OR or at bedside. Coding requires “depth” of tissue removed (skin/fascia/muscle/bone) & instrument description.</p> <p>Nonexcisional debridement- non-operative brushing, irrigating, scrubbing, or washing of devitalized tissue, necrosis or slough, includes snipping of tissue followed by Hubbard tank therapy.</p> <p>Sharp debridement & maggot therapy are non-excisional debridement.</p> <p>Escharotomy- other incision of skin and SQ tissue.</p>			
Diabetes mellitus	FBS > 126/symptoms + RBS > 200/2-hr PPBS > 200			
Uncontrolled DM	FBS > 126, RBS > 200, HgbA1c > 7.0			
Diabetic complications	Coma, neurogenic bladder, gangrene, ulcer, retinopathy, autonomic neuropathy, nephrosis, CKD (include stage)			
Diabetic keto acidosis	Mild DKA	Moderate	Severe	HHS
HHS (Hyperosmolar/hyperglycemic state)	BS	> 250	> 250	> 250
	pH	7.25–7.3	7–7.25	< 7
	HCO3	15–18	10–15	< 10
	UA/S ketones	Positive.....	
	S Osmolality	Variable.....	
	Anion gap	> 10	> 12	> 12
	Patient	Alert	...Drowsy	...Stupor/coma...

Encephalopathy		Global brain dysfunction 2° anoxia, HTN, metabolic (acid/alkalosis/uremia), sepsis, toxin (drug/EtOH), trauma		
Heart failure	Not CHF!	Document: acute, chronic, or acute on chronic and systolic, diastolic, or both		
		Chronic	Acute findings similar in all 3 types	
Systolic HF EF < 40%	Cx-ray Cardiomegaly	PND, NVD	BNP	
Heart can't contract 2° cardiomyopathies, pulmonary HTN, myocarditis	S3 gallop	Rales	< 100 - No HF	
	ECHO Dilated	Acute Pul edema	< 300 - Suggests HF	
		↑ BNP	> 400 - Mild	
		CVP > 16cm	> 600 - Moderate	
		HJR, Pul edema	> 900 - Severe	
		Visceral congestion		
		Cardiomegaly at autopsy		
		↑ Wt > 4.5kg in 5 days requiring CHF Tx		
Both - Any EF	Combination			
Hypercoagulable syndrome	Virchow's triad			
Hypercoagulability	1° - Factor V Leiden, Protein C/Protein S deficiency			
	2° - Estrogen, cancer, pregnancy			
Stasis	Debility, illness, surgery, travel			
Thrombophlebitis	DVT, phlegmasia cerulea dolens (severe DVT), PE			
HTN				
Pre-hypertension	120-139 or 80-89			
Benign/essential	140-159 or 90-99			
Accelerated HTN	160-179 or 100-109 + vague symptoms (headache or dizziness)			
Malignant HTN	>180 or >120 + organ failure			
Malnutrition	Morbid obesity with specific BMI value if > 40			
	Cachexia with BMI < 19 Confirm w/ dietary consult			
Myelodysplasia	↓ RBC, ↓ WBC, ↓ platelet with dysplastic bone marrow			
Myocardial infarction	Troponin >99th percentile + sx/sy			
Pancytopenia	↓ RBC, ↓ WBC, and ↓ platelets			
Pathological fracture	Osteoporosis/penia, tumor, atraumatic (minimal trauma)			
Pneumonia	Document if 'sepsis', 'acute respiratory failure', 'acute interstitial pneumonitis' is present. Justify antibiotics & treatments, document 'suspected' underlying organism (use facility antibiogram)/cause.			
Presumptive organism	Presumptive Rx	Gram (-)	Aspiration	
Anaerobes	Clindamycin/ Imipenem + Flagyl	Bacteroides	Anaerobes	
Gram (-) rods, anaerobes	Zosyn/Unasyn	Prevotella	Anaerobic strep	
MRSA, other gm (+)	Zyvox	Porphyromonas	Bacteroides	
Gram (-) rods	Gentamycin/Tobramycin	Fusobacterium	Prevotella	
Anaerobes, gm(-) rods	Primaxin	Chlamydomphilia	Fusobacterium	
Enterococci, Staph	Vancomycin	Mycoplasma	S. aureus	
Aureus				
Pseudomonas	Fortaz/Maxipime	Klebsiella	Legionella	
Mycoplasma, Legionella	Erythromycin/Doxycycline	Legionella	Gram (+)	
Fungus	Amphotericin/fluconazole		Staph	
Acid Fast Bacillus	INH, Rifampin, Ethambutol		Strep	
Aspiration Pneumonia (Clindamycin/ Imipenem) Consider aspiration if...				
Aspiration hx	Debilited	Esop strictures	Nursing home resident	Seizures
(+)BA swallow	Deconditioning	ET tube/trach	Multiple sclerosis	Stroke/TIA
Alcoholism	Diverticula	Feeding tube	Myasthenia gravis	TE fistula
AMS/dementia	Drug overdose	Gastrostomy	NG tube	Trauma
Analgesics	Elderly	GERD	Parkinsonism	UGI endoscopy
Anesthesia	Dysphagia	Head trauma	PPSIs	Vomiting
Bronchoscopy	Elderly	Immunocompromised	Recumbency	
Critical illness/ICU	Esop neoplasm			
Precipitous drop in HCT 20% ↓ HCT, is NOT a complication				
SIRS - Systemic Inflammatory Response Syndrome				
Sick patient plus 2 of	WBC >12K or < 4K	T >100.4° F (101° F) or < 96° F		
	>10% bands	P >90 (100)		
		R >20		
Sepsis	SIRS 2° infection, (+)BC (bacteremia) adds validity but not required			
Severe sepsis	SBP + organ failure			
Septic shock	SBP < 90 or down 40 mmHg from base 2° sepsis, resistant >1hr to fluid resuscitation. Possibly: Dopamine used, lactic acidosis, oliguria, AMS, and/or cardiac/limb ischemia 2° ↓BP/↓CO			
Ventricular Tachycardia	3 PVCs in succession			

SEVERITY OF ILLNESS ICD-9-CM TERMS		
Patient severity of illness (SOI) is conveyed to quality organizations and payers through ICD-9-CM codes assigned by a coder who reads the medical record. Coding rules dictate what codes are assigned to which medical terms.		
Nonspecific	↑SOI	↑↑ SOI
ACS, angina	Accelerated/decubitus angina	MI
Altered mental status	Dementia with acute confusional state	Coma
Altered	(Senile) dementia + behavioral changes (Pre)senile/vascular dementia w delirium/ delusion/depression	Brain death
AMS	Acute delirium/dementia	Encephalopathy
Anemia	Acute/chronic blood loss anemia; precipitous drop in HCT Specific types of anemia	Specified aplastic anemia
Anemia 2° chemo	Aplastic anemia; pancytopenia	Drug induced pancytopenia
Cachexic	(Mild/moderate) malnutrition; Cachexia with BMI< 19	Severe malnutrition
CVS	Cardiomyopathy	Cardiogenic shock
CHF/fluid overload	Chronic systolic/diastolic HF	Acute systolic/diastolic HF
Cholecystitis	Chronic cholecystitis	Acute cholecystitis
COPD/asthma	Acute exacerbation COPD/asthma	Acute respiratory failure
Cystitis	Urosepsis/UTI	Sepsis due to UTI
End stage COPD on home O2	Chronic respiratory failure	Acute respiratory failure
Esophagitis	Acute esophagitis	
Fever	Non-infectious SIRS	Non-infectious SIRS + organ failure
Fracture of ...	Pathological fx 2° osteoporosis/penia/tumor	
GI	GI bleed/ulcer/hematemesis	Specified site of bleed
Hepatitis	Specified chronic hepatitis	Specified acute hepatitis
		Hepatic encephalopathy
HIV Positive		AIDS
Hypertensive urgency	Accelerated HTN	
HTN emergency, crisis	Malignant HTN requires a documented organ failure	
Infection	Bacteremia; thrush Specified/suspected infections	Septicemia/sepsis
Influenza		Influenza d/t avian/H1N1 virus with pneumonia
Kidney disease	CKD 4-5, acute renal failure or kidney injury	ESRD
Obesity	Morbid obesity, give specific BMI if > 40; obesity hypoventilation syndrome	
Pancreatitis	Chronic pancreatitis	Acute pancreatitis
Pleural effusion	Pleural effusion due to X	
(Post-Op) anemia	Acute blood loss anemia Precipitous drop in HCT	
Pulmonary embolus	Chronic pulmonary embolus	Acute pulmonary embolus
Seizure	Specific seizure, grand mal, focal, post traumatic, etc.	
TIA	Cerebral embolism/thrombosis no infarction	Stroke/CVA
Troponemia/leak/bump		(non)STEMI
Ulcer	Ulcer lower limb/thigh/calf/ankle/heel/midfoot Cellulitis; skin ulcer; gangrene of ulcer	Stage 3/4 pressure ulcer w/ site
↓Decreased= Hypo...		
↑Increased= Hypo...		
ICD-10-CM documentation changes		
Trimesters rather than weeks		
Left, right, bilateral, dominant hand/arm		
Initial visit, subsequent visit, sequellae		
Urosepsis - has no code, so stop using the word		
Complication - document condition & link to procedure, expected consequence of X, unexpected consequence of X, or expected complication of X D/T Y		
Asthma - mild intermittent, moderate persistent, severe persistent; with acute exacerbation; with status		
Gustilo open fracture classification (types I, II and III); routine healing or delayed healing; nonunion or malunion		
AMI - STEMI or nonSTEMI; anterior or inferior; which arteries?		
Angioplasty- body part, approach, device (stent) & drug eluting?		
CVA hemorrhagic or occlusive, thrombus or embolus, artery		