EVALUATION AND MANAGEMENT
Coding and Documentation Reference Guide

1 HISTORY

HPI (History of Present Illness): Characterize HPI by considering either the Status of chronic conditions or the number of elements recorded. ☐ 1 condition ☐ 2 conditions OR ☐ 3 conditions ☐ Location ☐ Severity ☐ Timing ☐ Modifying factors ☐ Quality ☐ Duration ☐ Context ☐ Associated signs and symptoms	☐ Status of 1–2 chronic conditions ☐ Brief (1–3)	☐ Status of 1–2 chronic conditions ☐ Brief (1–3)	☐ Status of 3 chronic conditions ☐ Extended (4 or more)	☐ Status of 3 chronic conditions ☐ Extended (4 or more)
ROS (Review of Systems): ☐ Constitutional (wt loss, etc.) ☐ Ears, nose, mouth, throat ☐ GI ☐ Integumentary (skin, breast) ☐ Endo ☐ Eyes ☐ Card/vasc ☐ GU ☐ Neuro ☐ Hem/lymph ☐ Musculo ☐ Psych ☐ All/immuno ☐ Resp	N/A	☐ Pertinent to problem (1 system)	☐ Extended (Pert and others) (2–9 systems)	☐ Complete (Pert and all others) (10 systems)
PFSH (Past, Family, Social History): ☐ 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)	N/A	N/A	☐ Pertinent (1 history area)	☐ *Complete (2 or 3 history areas)
*Complete PFSH: 2 history areas: a) established patients – office (outpatient) care, domiciliary care, home care; b) emergency department; c) subsequent nursing facility care; and, d) subsequent hospital care. 3 history areas: a) new patients – office (outpatient) care, domiciliary care, home care; b) consultations; c) initial hospital care; d) hospital observation; and, e) initial nursing facility care.	PROBLEM-FOCUSED	EXP. PROBLEM-FOCUSED	DETAILED	COMPREHENSIVE
	Final History requires all 3 components above met or exceeded			

2 EXAMINATION

CPT Exam Description	95 Guideline Requirements	97 Guideline Requirements	CPT Type of Exam
Limited to affected body area or organ system	One body area or organ system	1–5 bulleted elements	PROBLEM-FOCUSED EXAM
Affected body area or organ system and other symptomatic or related organ systems	2–7 body areas and/or organ systems	6–11 bulleted elements	EXPANDED PROBLEM-FOCUSED EXAM
Extended exam of affected body area or organ system and other symptomatic or related organ systems	2–7 body areas and/or organ systems	12–17 bulleted elements for 2 or more systems	DETAILED EXAM
General multi-system	8 or more body areas and/or organ systems	18 or more bulleted elements for 9 or more systems	COMPREHENSIVE EXAM
Complete single organ system exam	Not defined	See requirements for individual single system exams	

3 MEDICAL DECISION-MAKING

Instructions for Using TrailBlazer's MDM Coding Method

Coding Medical Decision-Making (MDM) begins with separately coding the three distinct components of MDM. Two of the three components determine the final level of MDM complexity documented in a record of Evaluation and Management (E/M) service. These components are:

1. Number of diagnoses and/or management options.
2. Amount and/or complexity of data reviewed or ordered.
3. Risk of complication and/or mortality.

The TrailBlazer MDM coding method corresponds directly to the components above as follows:

- Section A corresponds to number of diagnoses and/or management options.
- Section B corresponds to amount and/or complexity of data reviewed or ordered.
- Section C corresponds to risk of complication and/or mortality.

Code each component separately using respective Tables A–C, then compare results from Tables A–C to requirements in Table D to determine the overall MDM level.

Section A

Coding Number of Diagnoses or Management Options – Use the Tables A.1 and A.2 on page 2 to determine the numbers of diagnoses or management options.

Note: In all cases, the information in the clinical record (history and physical) must clearly support diagnostic impressions. Diagnostic impressions listed but not supported elsewhere in the clinical record must not be included in the problem list for coding purposes.

3 MEDICAL DECISION-MAKING (continued)

Determine total points for each diagnosis or problem and associated management options using Tables A.1 and A.2. Use the larger of the two "Totals" for Section D. Final Assignment of Medical Decision Making Type.

Table A.1 Number of Diagnoses

A "problem" is defined as definitive diagnosis or, for undiagnosed problems, a related group of presenting symptoms and/or clinical findings.		Points
Each new or established problem for which the diagnosis and/or treatment plan is evident with or without diagnostic confirmation		1
Each new or established problem for which the diagnosis and/or treatment plan is not evident	2 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	2
	3 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	3
	4 or more plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	4
	Total Points	

Table A.2 Management Options

Important Note: These tables are not all inclusive. The entries are examples of commonly prescribed treatments and the point values are illustrative of their intended quantifications. Many other treatments exist and should be counted when documented.		Points
Do not count as treatment option's notations such as: Continue "same" therapy or "no change" in therapy (including drug management) if specified therapy is not described (record does not document what the current therapy is nor that the physician reviewed it).		0
Drug management, per problem. Includes "same" therapy or "no change" in therapy if specified therapy is described (i.e., record documents what the current therapy is and that the physician reviewed it). Dose changes for current medications are not required; however, the record must reflect conscious decision-making to make no dose changes in order to count for coding purposes.	≤3 new or current medications per problem	1
	>3 new or current medications per problem	2
Open or percutaneous therapeutic cardiac, surgical or radiological procedure; minor or major		1
Physical, occupational or speech therapy or other manipulation		1
Closed treatment for fracture or dislocation		1
IV fluid or fluid component replacement, or establish IV access when record is clear that such involved physician decision-making and was not standard facility "protocol"		1
Complex insulin prescription (SC or combo of SC/IV), hyperalimentation, insulin drip or other complex IV admix prescription		2
Conservative measures such as rest, ice/heat, specific diet, etc.		1
Radiation therapy		1
Joint, body cavity, soft tissue, etc injection/aspiration		1
Patient education regarding self or home care		1
Decision to admit to hospital		1
Discuss case with other physician		1
Other		1
Total Points		

Section B

Coding Amount and/or Complexity of Data Reviewed or Ordered – Determine total points for amount and/or complexity of data reviewed or ordered using Table B. Use the "Total Points" for Section D. Final assignment of Medical Decision Making Type.

Table B Data Reviewed or Ordered

		Point Value
Order and/or review medically reasonable and necessary clinical laboratory procedures. Note: Count laboratory panels as one procedure.	1–3 procedures	1
	≥4 procedures	2
Order and/or review medically reasonable and necessary diagnostic imaging studies in Radiology section of CPT.	1–3 procedures	1
	≥4 procedures	2
Order and/or review medically reasonable and necessary diagnostic procedures in Medical section of CPT.	1–3 procedures	1
	≥4 procedures	2
Discuss test results with performing physician.		1
Discuss case with other physician(s) involved in patient's care or consult another physician (i.e., true consultation meaning seeking opinion or advice of another physician regarding the patient's care). This does not include referring patient to another physician for future care.		1
Order and/or review old records. Record type and source must be noted. Review of old records must be reasonable and necessary based on the nature of the patient's condition. Practice- or facility protocol-driven record ordering does not require physician work thus should not be considered when coding E/M services. Perfunctory notation of old record ordering/review solely for coding purposes is inappropriate and counting such is not permitted.	Order/review without summary	1
	Order/review and summarize	2
Independent visualization and interpretation of an image, EKG or laboratory specimen not reported for separate payment. Note: Each visualization and interpretation is allowed one point.		1
Review of significant physiologic monitoring or testing data not reported for separate payment (e.g., prolonged or serial cardiac monitoring data not qualifying for payment as rhythm electrocardiograms).		1
	Total Points	

3 MEDICAL DECISION-MAKING (continued)

Section C

Use Table C.1 to determine the highest level or risk associated with each of the following: presenting problems, diagnostic procedure(s) ordered/performed, management options(s) chosen. Then use Table C.2 to determine the "final risk," which is the highest of the three risks from Table C.1. The "final risk" from Table C.2 is used for Section D. Final Assignment of Medical Decision Making Type.

Table C.1 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	• Laboratory tests requiring venipuncture • Chest X-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well-controlled hypertension or non-insulin 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 tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• 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., 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 • Dee needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath • Obtain fluid from body cavity, e.g., lumbar procedure, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One 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.

Table C.2 Risk of Complication and/or Mortality (see Table C.1)

Nature of the presenting illness	Minimal	Low	Moderate	High
Risk conferred by diagnostic options	Minimal	Low	Moderate	High
Risk conferred by therapeutic options	Minimal	Low	Moderate	High
Final Risk determined by highest of 3 components above				

Section D

Final Assignment of Medical Decision Making Type

1. Line A – Use Total Diagnosis Points or the Total Management Option Points from Section A (Tables A.1 and A.2).
2. Line B – Use Total Points from Section B (Table B).
3. Line C – Use highest level of risk from Section C (Table C.2).
4. Choose final Type of Medical Decision Making. Final Type Requires 2 of the 3 MDM Components below be met or exceeded.

Table D Final Assignment of Medical Decision Making Type

A. Number of diagnoses or management options	1 Point – Minimal	2 Points – Limited	3 Points – Multiple	≥4 Points – Extensive
B. Amount and complexity of data reviewed/ordered	≤1 Point – None/Minimal	2 Points – Limited	3 Points – Multiple	≥4 Points – Extensive
C. Risk	Minimal	Low	Moderate	High
Type of medical decision-making	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Final Medical Decision-Making requires 2 of 3 components above met or exceeded				

4 LEVEL OF SERVICE

OUTPATIENT, CONSULTS (OUTPATIENT AND INPATIENT) AND ER

	New Office/Consults/ER						Established Office			
	Requires 3 components within shaded area						Requires 2 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) 15 Outpt cons (99241) 20 Inpat cons (99251) ER (99281)	20 New (99202) 30 Outpt cons (99242) 40 Inpat cons (99252) ER (99282)	30 New (99203) 40 Outpt cons (99243) 55 Inpat cons (99253) ER (99283)	45 New (99204) 60 Outpt cons (99244) 80 Inpat cons (99254) ER (99284)	60 New (99205) 80 Outpt cons (99245) 100 Inpat cons (99255) 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			Subsequent Inpatient/Follow-up		
	Requires 3 components within shaded area			Requires 2 components within shaded area		
History	D or C	C	C	PF interval	EPF interval	D interval
Examination	D or C	C	C	PF	EPF	D
Complexity of Medical Decision	SF/L	M	H	SF/L	M	H
Average Time (minutes) (Observation care has no average time)	30 Init hosp (99221) Observ care (99218)	50 Init hosp (99222) Observ care (99219)	70 init hosp (99223) Observ care (99220)	15 Subsequent (99231)	25 Subsequent (99232)	35 Subsequent (99233)
Level	I	II	III	I	II	III

NURSING FACILITY

	Annual Assessment/Admission			Subsequent Nursing Facility			
	Old Plan Review	New Plan	Admission				
	Requires 3 components within shaded area			Requires 2 components within shaded area			
History	D/C	C	C	PF interval	EPF interval	D interval	C interval
Examination	D/C	C	C	PF	EPF	D	C
Complexity of Medical Decision	SF	M	M	SF	L	M	H
No Average Time Established (Confirmatory consults and ER have no average time)	(99304)	(99305)	(99306)	(99307)	(99308)	(99309)	(99310)
Level	I	II	III	I	II	III	IV

DOMICILIARY (REST HOME, CUSTODIAL CARE) AND HOME CARE

	New					Established			
	Requires 3 components within shaded area					Requires 2 components within shaded area			
History	PF	EPF	D	C	C	PF interval	EPF interval	D interval	C
Examination	PF	EPF	D	C	C	PF	EPF	D	C
Complexity of Medical Decision	SF	L	M	M	H	SF	L	M	H
Average Time (minutes)	20 Domiciliary (99324) 20 Home care (99341)	30 Domiciliary (99325) 30 Home care (99342)	45 Domiciliary (99326) 45 Home care (99343)	60 Domiciliary (99327) 60 Home care (99344)	75 Domiciliary (99328) 75 Home care (99345)	15 Domiciliary (99334) 15 Home care (99347)	25 Domiciliary (99335) 25 Home care (99348)	40 Domiciliary (99336) 40 Home care (99349)	60 Domiciliary (99337) 60 Home care (99350)
Level	I	II	III	IV	V	I	II	III	IV

PF = Problem focused • EPF = Expanded problem focused • D = Detailed • C = Comprehensive • SF = Straightforward • L = Low • M = Moderate • H = High