Appendix I: E/M Codebuilder

(For use with 1995 and 1997 CMS Documentation Guidelines for Evaluation & Management Coding)

Introduction

The evaluation and management (E/M) code reported to a third-party payer must be supported by documentation in the patient’s record (e.g., SOAP or clinic note, diagnostic test results, operative findings). Although providers are responsible for selecting the E/M code from the encounter form, superbill, or chargemaster at the time patient care is rendered, insurance specialists audit records to make sure that the appropriate level of E/M code was reported to the third-party payer.

This E/M CodeBuilder form can be used for that purpose, and it can also be used as a tool to teach appropriate assignment of E/M level codes. To assign a code, just review the documentation in the patient’s record, record your findings (based on the directions provided), and refer to the CPT coding manual to select the E/M code to be reported.

E/M code selection is based on three key components: history, examination, and medical decision making. This E/M CodeBuilder form emphasizes those components. It is important to be aware that contributory components (counseling and coordination of care) also play an important role in selecting the E/M code when documentation in the patient record indicates that counseling or coordination of care dominated the visit. In this situation, the contributory component of time can be considered a key or controlling factor in selecting a level of E/M service (code).

Note:

Time and nature of presenting problem are listed in some E/M code descriptions to assist in determining which code number to report.

Selecting the Level of History

To select the level of history, review the following elements in the patient record. If an element is not documented, it cannot be considered when selecting the level of E/M service code.

- History of present illness (HPI)
- Review of systems (ROS)
- Past, family, and/or social history (PFSH)

History of Present Illness (HPI)

Review the clinic or SOAP note in the patient’s record, and for each documented HPI element (below), enter an X in the box in front of the element on this form. Then, total the Xs and enter that number on the line in front of the Total Score (below). Finally, select the level of HPI based on the total number of elements documented, and enter an X in the appropriate box.
Appendix I

Location: Of pain/discomfort (e.g., is pain diffused/localized or unilateral/bilateral; does it radiate or refer?).

Duration: Of pain/discomfort; length of time condition has persisted (e.g., pain began three days ago).

Quality: A description of the quality of the symptom (e.g., is pain described as sharp, dull, throbbing, stabbing, constant, intermittent, acute or chronic, stable, improving, or worsening?).

Severity: Use of self-assessment scale to measure subjective levels (e.g., on a scale of 1-10, how severe is the pain?), or comparison of pain quantitatively with previously experienced pain.

Timing: Establishing onset of pain and chronology of pain development (e.g., migraine in the morning).

Context: Where was the patient and what was he or she doing when pain began (e.g., was patient at rest or involved in an activity; was pain aggravated or relieved, or does it recur, with a specific activity; did situational stress or some other factor precede or accompany the pain)?

Modifying factors: What has patient attempted to do to relieve pain (e.g., heat vs. cold; does it relieve or exacerbate pain; what makes the pain worse; have over-the-counter drugs been attempted—with what results)?

Associated signs/symptoms: Clinician’s impressions formulated during the interview may lead to questioning about additional sensations or feelings (e.g., diaphoresis associated with indigestion or chest pain, blurred vision accompanying a headache, etc.).

Total Score: Enter the score for number of Xs entered above (representing number of HPI elements), and enter an X in front of the HPI type below:

- Brief HPI (1–3 elements)
- Extended HPI (4 or more elements)

Review of Systems (ROS)

Review the clinic or SOAP note in the patient’s record, and for each documented ROS element (below), enter an X in the box in front of the element on this form. Then, total the Xs and enter that number on the line in front of the Total Score (below). Finally, select the level of ROS based on the total number of elements documented, and enter an X in the appropriate box.

Note:
To properly assess review of systems documentation, have CMS Documentation Guidelines for Evaluation & Management Coding available as you review the patient’s record. (Go to www.cms.hhs.gov and click on Outreach & Education, MLN Educational Web Guides, and Documentation Guidelines for E&M services to print the guidelines and use with this section of the E/M Code Builder.)

- Constitutional symptoms
  - Allergic/Immunologic
  - Cardiovascular
  - Ears, nose, mouth, throat
  - Endocrine
  - Eyes
  - Gastrointestinal
  - Genitourinary

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- Hematologic/Lymphatic
- Integumentary (including skin and breast)
- Musculoskeletal
- Neurologic
- Psychiatric
- Respiratory

Total Score: Enter the score for number of Xs entered above (representing number of ROS elements), and enter an X in front of the ROS type below:

- None
- Problem pertinent ROS (1 body system documented)
- Extended ROS (2–9 body systems documented)
- Complete ROS (all body systems documented)

Past, Family, and/or Social History (PFSH)

Review the clinic or SOAP note in the patient’s record, and for each documented PFSH element (below), enter an X in the box in front of the element on this form. Then, total the Xs and enter that number on the line in front of the Total Score (below). Finally, select the level of PFSH based on the total number of elements documented, and enter an X in the appropriate box.

- Past history (patient’s past experience with illnesses, operations, injuries, and treatments)
- Family history (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, such as alcohol use, occupation, and so on)

Total Score: Enter the score for number of Xs entered above (representing number of PFSH elements), and enter an X in front of the PFSH type below:

- None
- Pertinent PFSH (1 history area documented)
- Complete PFSH (2 or 3 history areas documented)

Level of History

Circle the type of HPI, ROS, and PFSH in the table below (as determined from the entries selected above); then, circle the appropriate Extent of History determined in the table below.

<table>
<thead>
<tr>
<th>HPI</th>
<th>Brief</th>
<th>Brief</th>
<th>Extended</th>
<th>Extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROS</td>
<td>None</td>
<td>Problem Pertinent</td>
<td>Extended</td>
<td>Complete</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>Pertinent</td>
<td>Complete</td>
</tr>
<tr>
<td>EXTENT OF HISTORY</td>
<td>PROBLEM FOCUSED</td>
<td>EXPANDED PROBLEM FOCUSED</td>
<td>DETAILED</td>
<td>COMPREHENSIVE</td>
</tr>
</tbody>
</table>

Selecting the Level of Examination

To select the level of examination, first determine whether a single organ examination (specialist exam such as ophthalmologist) or a general multisystem examination (e.g., family practitioner) was completed.
Single Organ System Examination

Refer to the single organ system examination requirements in the CMS Documentation Guidelines for Evaluation & Management Services, and enter an X in front of the appropriate exam type below.

- PROBLEM FOCUSED EXAMINATION (1–5 elements identified by a bullet)
- EXPANDED PROBLEM FOCUSED EXAMINATION (at least 6 elements identified by a bullet)
- DETAILED EXAMINATION (at least 12 elements identified by a bullet)
- COMPREHENSIVE EXAMINATION (all elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded box)

Note:
For eye and psychiatric examinations, at least nine elements in each box with a shaded border and at least one element in each box with a shaded or unshaded border is documented.

General Multisystem Exam

Refer to the general multisystem examination requirements in the CMS Documentation Guidelines for Evaluation & Management Services. Enter an X in front of the organ system or body area for up to the total number of allowed elements (e.g., up to two elements can be documented for the Neck exam).

- Constitutional (2)
- Cardiovascular (7)
- Chest (breasts) (2)
- Ears, nose, mouth, throat (6)
- Eyes (3)
- Gastrointestinal (5)
- Genitourinary (male–3; female–6)
- Musculoskeletal (6)
- Neck (2)
- Neurologic (3)
- Psychiatric (4)
- Respiratory (4)
- Skin (2)

Total Score: Enter the score for number of Xs entered above (representing number of exam elements), and enter an X in front of the exam type below:

- PROBLEM FOCUSED EXAMINATION (1–5 elements identified by a bullet on CMS Documentation Guidelines for Evaluation & Management Services)
- EXPANDED PROBLEM FOCUSED EXAMINATION (at least 6 elements identified by a bullet on CMS Documentation Guidelines for Evaluation & Management Services)
- DETAILED EXAMINATION (at least 2 elements identified by a bullet from each of 6 organ systems or body areas, or at least 12 elements identified by a bullet in two or more systems or areas, on CMS Documentation Guidelines for Evaluation & Management Services)
- COMPREHENSIVE EXAMINATION (documentation of all elements identified by a bullet in at least 9 organ systems or body areas, and documentation of at least 2 elements identified by a bullet from each of 9 organ systems or body areas, on CMS Documentation Guidelines for Evaluation & Management Services)
Medical Decision Making

Select the appropriate level of medical decision making based upon the following criteria:

<table>
<thead>
<tr>
<th>Number of Diagnoses or Management Options</th>
<th>Amount/Complexity of Data to be Reviewed</th>
<th>Risk of Complications and/or Morbidity/Mortality</th>
<th>Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High complexity</td>
</tr>
</tbody>
</table>

E/M Code Selection

Select the E/M code based on selection of level of history, examination, and medical decision making:

<table>
<thead>
<tr>
<th>History</th>
<th>Problem focused</th>
<th>Expanded problem focused</th>
<th>Expanded problem focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>Problem focused</td>
<td>Expanded problem focused</td>
<td>Expanded problem focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Medical Decision Making</td>
<td>Straightforward</td>
<td>Low complexity</td>
<td>Moderate complexity</td>
<td>Moderate complexity</td>
<td>High complexity</td>
</tr>
</tbody>
</table>

Go to the appropriate E/M category/subcategory, and select the code based upon the information selected above.