Statistically, the overwhelming majority of patient office visits are billed at E/M Levels 2, 3 or 4. Determining which billing level is correct for a particular patient encounter can often be a problem. This is particularly the case because many physicians mistakenly believe that the E/M level of service is determined by the amount of time spent with the patient. In fact, it is not the time but the content of the physician chart documentation that determines the level of billing.

Any E/M level of service submitted for payment must be substantiated by documentation of the key components of history, physical examination and medical decision making. For established patients, two of these three key components must be met or exceeded to validate the level of service billed. The following case study illustrates how a particular patient visit could be billed at Level 2, 3 or 4 depending upon physician documentation.

Case Study

A sixty-eight year old established patient with a past medical history of hypertension presents to a physician’s office with a chief complaint of nausea and vomiting for four days. The patient was recently discharged from the hospital and started on Sinemet 25/100 2 tabs TID for a new onset of Parkinson’s disease. In addition to nausea and vomiting, the patient also complains of dull abdominal pain and decreased desire to eat or drink.

Taking note of these complaints, the physician asks if the patient has experienced any acute neurological changes, such as dizziness, headaches, seizures, recent falls or blurry vision, or has had any fever since his recent discharge. Patient denies having any of these additional symptoms, but does mention that he has some difficulty walking.

The physician then performs a physical examination, noting that the patient is a sixty-eight year old male, in no apparent distress. Vital signs are BP 130/80, P 80, T 98. The lungs are found to be clear to auscultation and percussion. Heart rate was regular with no arrhythmia or murmur. Abdomen was palpated and noted to be soft, without tenderness or distention, with positive bowel sounds present.

After examining the patient, the physician’s assessment is that the nausea and vomiting are due to an inability to tolerate the initial dosage of Sinemet. The patient is instructed to decrease his Sinemet from 2 tabs to 1 tab three times a day, drink plenty of fluids, and continue taking his antihypertensive medication since his blood pressure has been stable and well controlled.

Unless symptoms persist, the patient is to return to the office in two weeks for follow-up. The patient’s neurologist, Dr. Banks, will be advised of the results of this encounter.

E/M Level 2, 3 or 4?

What E/M level of service should be billed for this encounter? How does the physician documentation in the patient record translate into the appropriate E/M code assignment?

The following sample patient records are all based on the patient encounter outlined above. These examples are designed to illustrate how the same visit, when documented in different ways, will result in different E/M levels of service. As you will see, the presence or absence of explicit, thorough and accurate physician documentation has a direct impact on E/M code assignment. In order to fully understand the distinctions between the levels, each example should be read carefully and thoroughly before proceeding to the next one.

The examples include case analyses explaining how the 3 key components of history, physical examination and medical decision making are evaluated in determining the appropriate E/M level of service under both the 1995 and 1997 HCFA guidelines. The patient’s history, at the very minimum, must include a chief complaint along with a history of present illness (HPI). The elements of an HPI include a description of the chief complaint’s location, quality, severity, timing, duration, context, modifying factors and associated signs and symptoms. The physical examination must conform to either the 1995 examination guidelines or the 1997 general multi-system/single specialty examination formats. In addition, to support a given level of service, medical decision making must be sufficiently documented in terms of the complexity of establishing a diagnosis, the number and severity of the conditions evaluated and the associated risk to the patient.

(See “Documentation Requirements for Established Patient Office Visits for E/M Levels 2, 3 & 4” and “1997 General Multi-System Examination.”)

By comparing each sample patient record to the corresponding case analysis, you will understand that the completeness of your documentation of at least 2 of the 3 key components determines the level of billable service. The differences in documentation from example to example are printed in bold, underlined type. Depending upon the physician documentation, this patient encounter would be billed at either Level 2, Level 3 or Level 4.
PATIENT RECORD: EXAMPLE #1

Chief Complaint: Nausea and vomiting
HPI: Nausea and vomiting with abdominal pain for 4 days. On Sinemet for new onset of Parkinson’s.
PMH: HTN, Parkinson’s
Meds: HCTZ, Sinemet 25/100 2 Tab TID
PE: 68 year old male
   Abd: soft, NT/ND, + BS
Imp: Nausea and vomiting due to Sinemet, Parkinson’s, HTN
Plan: Decrease Sinemet to 25/100 1 Tab TID
   D/W Dr. Banks, pt’s neurologist
   Encourage PO.
   Continue HTN meds.
   Return to office in 2 weeks.

CASE ANALYSIS: LEVEL 2 E/M CODE 99212

History: Problem Focused
In this case, the physician documented the chief complaint and 3 HPI elements (location: abdominal; duration: 4 days; and context: nausea and vomiting due to Sinemet). However, the physician has failed to document the review of systems (patient’s denial of a recent history of dizziness, headaches, seizures, blurry vision or fever). Regardless of the amount of documentation in other areas, without a “review of systems” the level of history cannot rise above the problem focused level. Had the documentation been complete, the physician could claim credit for reviewing 3 systems (neurological, eyes and constitutional).

Physical Examination:
1995 Problem Focused: Only 1 organ system/body area (gastrointestinal) is documented. Exam was not extended to include other related organ systems.
1997 Problem Focused: Only 1 element (palpation of abdomen) was documented from the general multi-system examination. One to five documented elements from the 1997 format is considered a problem focused examination.

Decision Making: Moderate Complexity
Number of diagnoses to consider: Multiple (nausea/vomiting, hypertension, Parkinson’s disease).
Risk to patient: Moderate (adverse effects of treatment and prescription drug management).
Data to review: None.

Commentary:
In this case, the documentation supports only a Level 2 service. Even though there is decision making of moderate complexity, the lack of thorough documentation of the other 2 key components (history and physical examination) prevents billing at a higher level of service.

Note: Had the physician performed and documented a review of just one pertinent body system, the history component would have become Expanded Problem Focused. With an Expanded Problem Focused history and decision making of moderate complexity, the documentation would have supported a Level 3 service.

PATIENT RECORD: EXAMPLE #2

Chief Complaint: Nausea and vomiting
HPI: Nausea and vomiting with dulldr abdominal pain and decreased P.O. intake for 4 days. On Sinemet for new onset of Parkinson’s.
PMH: HTN, Parkinson’s
Meds: HCTZ, Sinemet 25/100 2 Tab TID
PE: WNNWD 68 year old male NAD
   VS: 130/80  80  98
   Resp: CTA & P
   Heart: RRR
   Abd: soft, NT/ND, + BS
Imp: Nausea and vomiting due to Sinemet, Parkinson’s, HTN
Plan: Decrease Sinemet to 25/100 1 Tab TID
   D/W Dr. Banks, pt’s neurologist
   Encourage PO. Continue HTN meds.
   Return to office in 2 weeks.

CASE ANALYSIS: LEVEL 3 E/M CODE 99213

History: Problem Focused
The HPI in this example has been extended to include the elements of quality (dull) and associated signs and symptoms (decreased P.O. intake), in addition to the 3 elements documented in Example 1 (location, duration and context). However, failure to document a review of systems again results in the history remaining at the problem focused level. Had the physician documented the patient’s denial of dizziness, headaches, seizures, blurry vision or fever (a review of 3 systems), this record would have supported a detailed history.

Physical Examination:
1995 Expanded Problem Focused: A limited examination of the affected organ system (gastrointestinal) and 3 other related organ systems (constitutional, respiratory, cardiovascular) was documented. This qualifies as an expanded problem focused examination under the 1995 guidelines.
1997 Expanded Problem Focused: Six elements from the 1997 general multi-system exam were documented: constitutional (2), respiratory (2), cardiovascular (1), gastrointestinal (1). Six to eleven elements are required for an Expanded Problem Focused exam.

Decision Making: Moderate Complexity
Number of diagnoses to consider: Multiple (nausea/vomiting, hypertension, Parkinson’s disease).
Risk to patient: Moderate (adverse effects of treatment and prescription drug management).
Data to review: None.

Commentary:
Since only 2 of the 3 key components are needed to validate the level of service, the low level history can be eliminated and the 2 highest components (i.e., expanded problem focused examination and moderate medical decision making) can be used to support billing a Level 3 service.
CASE ANALYSIS: LEVEL 4 E/M CODE 99214

History: Detailed
This detailed history includes 4 or more HPI elements (location, quality, duration, context, and associated signs and symptoms); a review of at least 2 systems: neurological (denial of headache, seizures, blurry vision), constitutional (denial of fever), and eyes (denial of blurry vision); and 1 pertinent area of past medical, social or family history (PMFSHx).

Note: The significance of documenting all components of the history (i.e., HPI, ROS and PMFSHx) is illustrated in this example. This history without a ROS would only be problem focused (see Example 2).

Physical Examination:
1995 Expanded Problem Focused: A limited examination of the affected organ system (gastrointestinal) and 3 other related organ systems (constitutional, respiratory, cardiovascular) was documented. This qualifies as an expanded problem focused examination under the 1995 guidelines.

1997 Expanded Problem Focused: Six elements from the 1997 general multi-system exam were documented: constitutional (2), respiratory (2), cardiovascular (1), gastrointestinal (1). Six to eleven elements are required for an Expanded Problem Focused exam.

Decision Making: Moderate Complexity
Number of diagnoses to consider: Multiple (nausea/vomiting, hypertension, Parkinson’s disease).
Risk to patient: Moderate (adverse effects of treatment and prescription drug management).
Data to review: None.

Commentary:
This is an example of a well documented encounter that includes all of the necessary elements to support a detailed history. Since the 2 highest of the 3 key components can be used to support the level of service, the exam component can be eliminated. The detailed history and moderate complexity decision making support billing at Level 4.