EVALUATION AND MANAGEMENT CODING FOR NEUROLOGY HOSPITAL ADMISSIONS

DOCUMENTATION REQUIREMENTS FOR HOSPITAL ADMISSIONS

For initial hospital care, one must document: 1) History, 2) Exam and 3) Medical Decision Making (MDM). For subsequent daily care, *one only needs to document two of the three* (**2/3 Rule**). *Determine the level of MDM first, and use that level to determine the E/M code*. Then, refer to the requirements below of what History and/or Exam must be documented for the level of the E/M Code. The day of discharge code (see below) is time based.

		Initial Care			Subsequent Daily Care		
		High 99223	Mod 99222	Low 99221	High 99233	Mod 99232	Low 99231
HISTORY	**Chief Complaint**	1	1	1			
	History of Present Illness ☐ Location ☐ Quality ☐ Severity ☐ Duration ☐ Timing ☐ Context ☐ Modifying factors ☐ Associated signs and symptoms	≥4	≥4	≥4	≥4	1	1
	PFSH ☐ Past Medical History ☐ Family History ☐ Social History **Note**: PFSH does not need to be re-recorded if the physician reviewed and updated the previous information. Document any new PFSH information or note there has been no change.	3	3	1	0	0	0
	ROS ☐ Constitutional ☐ Eyes ☐ ENT ☐ Cardiac / Vascular ☐ Respiratory ☐ GI ☐ GU ☐ Skin ☐ Musculoskeletal ☐ Neurologic ☐ Psychiatric ☐ Endocrine ☐ Hematologic ☐ Allergies / Immunologic **Note**: May document some systems with a statement "all others negative". ROS does not need to be re-recorded if previous information is reviewed and updated. Document any new ROS or note there has been no change, and refer to reviewing original ROS.	≥10	≥10	2-9	2-9	1	0
EXAM	• Measurement of any three of the following seven vital signs: (sitting or standing BP, supine BP, pulse, respiration, temperature, height, weight) • General appearance of patient • Ophthalmoscopic examination of optic discs and posterior segments • Document 1 of the following: (carotid arteries, auscultation of heart, peripheral vascular system) • Examination of gait and station • Muscle strength in upper and lower extremities • Muscle tone in upper and lower extremities with notation of any atrophy or abnormal movements • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language • Fund of knowledge • 2nd cranial nerve • 3rd, 4th and 6th cranial nerves • 5th cranial nerve • 7th cranial nerve • 8th cranial nerve • 9th cranial nerve • 11th cranial nerve • 12th cranial nerve • Examination of sensation • Examination of reflexes in upper and lower extremities with notation of pathological reflexes • Test coordination	All	All	12	12	6	1
MDM	**MEDICAL DECISION MAKING** (see back of sheet for determination of MDM; STF = straightforward)	High	Mod	STF or Low	High	Mod	STF or Low

CODING BY TIME

If the total time is documented and counseling and coordinating care required more than 50% of the encounter, then time may be used to determine the level of service. Documentation may refer to prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, or risk reduction. Time spent is face to face time with the patient, and also includes time spent on the floor/unit rendering services for patient (e.g., reviewing the chart, writing notes, talking to family and staff, etc.). The average total times for E/M hospital admission codes and average Medicare reimbursements are listed below.

Initial Care (face to face and on the floor/unit)		Subsequent Daily Care (face to face and on the floor/unit)		Discharge Day	
High 99223 ($195)	70 minutes	High 99233 ($101)	35 minutes	Simple 99238 ($69)	< 30 minutes
Mod 99222 ($132)	50 minutes	Mod 99232 ($70)	25 minutes	Extended 99239 ($101)	> 30 minutes
Low 99221 ($98)	30 minutes	Low 99231 ($39)	15 minutes		

MEDICAL DECISION MAKING

Determine the levels of 1) Risk, 2) Diagnosis/Management Options, and 3) Amount/Complexity of Data from the tables below. The MDM is determined by taking the lower of the two highest of the three categories.

LEVEL	RISK	DIAGNOSIS/MANAGEMENT OPTIONS	AMOUNT/COMPLEXITY OF DATA
STRAIGHTFORWARD	Minimal	Minimal	Minimal
LOW	Low	Limited	Limited
MODERATE	Moderate	Multiple	Moderate
HIGH	High	Extensive	Extensive

RISK LEVEL: The highest item in any category determines the risk.

HIGH RISK	Presenting Problem	• Any abrupt change in neurologic status • ≥= 1 chronic illnesses with severe exacerbation, progression or side effect of Rx • Decision for DNR or de-escalate care because of poor prognosis
	Diagnostic Procedures	• Angiogram Myelogram • tPA
	Management Options	• Drug therapy that requires monitoring for toxicity • Parenteral controlled substances • Elective major surgery with risk factors • Any emergency surgery
MODERATE RISK	Presenting Problem	• Undiagnosed new problem with uncertain prognosis • Two or more stable chronic illnesses • ≥= 1chronic illnesses with mild exacerbation, progression or side effect of Rx
	Diagnostic Procedures	• Lumbar puncture • CT / MRI (with contrast) • EMG • Autonomic Studies
	Management Options	• Prescription drug therapy • IV fluids with additives • Elective major surgery with no risk factors
LOW RISK	Presenting Problem	• One stable chronic illness
	Diagnostic Procedures	• CT / MRI (no contrast) • EEG
	Management Options	• PT, OT • OTC drugs
STF	Presenting Problem	• One self limited or minor problem
	Diagnostic Procedures	• Blood test • Chest XR • Ultrasound
	Management Options	• Rest • Bandage

DIAGNOSIS &/OR MANAGEMENT OPTIONS: Sum all items below and then determine the level based on the Total Points

Does the patient have:	NUMBER	POINTS	SCORE
Self-limited or minor (stable, improved or worsening)	max = 2	1	
Established problem; stable, improved or resolving	any	1	
Established problem, inadequately controlled worsening or failing to change	any	2	
New problem to you, no additional work-up planned	max = 3	3	
New problem to you, additional work-up planned	any	4	
LEVEL BASED ON TOTAL POINTS: MINIMAL - 1 Point; LIMITED - 2 Points; MULTIPLE - 3 Points; EXTENSIVE ≥4 Points:			

AMOUNT/COMPLEXITY OF DATA TO REVIEW: Sum all items below and then determine the level based on the Total Points

Have you reviewed, ordered or call for:	NUMBER	POINTS	SCORE
Clinical laboratory test	max = 1	1	
Radiology test	max = 1	1	
Medical diagnostic test	max = 1	1	
Discussed the test results with performing or interpreting physician	any	1	
Directly visualized imaging (CT, MRI), EEG tracing, or EMG data done by another physician	any	2	
Decision to obtained old records and/or obtain history from someone other than the patient	any	1	
Reviewed and summarized old records or history from source other than the patient	any	2	
LEVEL BASED ON TOTAL POINTS: MINIMAL - 1 Point; LIMITED - 2 Points; MODERATE - 3 Points; EXTENSIVE ≥4 Points:			