# EVALUATION AND MANAGEMENT CODING FOR NEUROLOGY OUTPATIENT

| | DOCUMENTATION REQUIREMENTS OF NEW and ESTABLISHED PATIENTS<br><br>For new patients, one must document: 1) History, 2) Exam and 3) Medical Decision Making (MDM). For established patients, *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. | **New** | | | **Established** | | |
|---|---|---|---|---|---|---|---|
| | | High<br>99205 | Mod<br>99204 | Low<br>99203 | High<br>99215 | Mod<br>99214 | Low<br>99213 |
| **HISTORY** | **Chief Complaint** | 1 | 1 | 1 | 1 | 1 | 1 |
| | **History of Present Illness**<br>☐ Location ☐ Quality ☐ Severity ☐ Duration<br>☐ Timing ☐ Context ☐ Modifying factors ☐ Associated signs and symptoms | ≥4 | ≥4 | 1 | ≥4 | ≥4 | 1 |
| | **PFSH**<br>☐ Past Medical History ☐ Family History ☐ Social History<br><br>**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 | 2 | 1 | 0 |
| | **ROS**<br>☐ Constitutional ☐ Eyes ☐ ENT ☐ Cardiac / Vascular ☐ Respiratory<br>☐ GI ☐ GU ☐ Skin ☐ Musculoskeletal ☐ Neurologic<br>☐ Psychiatric ☐ Endocrine ☐ Hematologic ☐ Allergies / Immunologic<br><br>**Note**: Permissible to document some systems with a statement "all others negative”. ROS does not need to be re-recorded if the physician reviewed and updated the previous information. Document any new ROS information or note there has been no change. | ≥10 | ≥10 | 2-9 | ≥10 | 2-9 | 1 |
| **EXAM** | • General appearance of patient<br>• Measurement of any three of the following seven vital signs:<br>(sitting or standing BP, supine BP, pulse, respiration, temperature, height, weight)<br>• Document 1 of the following: (carotid arteries, auscultation of heart, peripheral vascular system)<br>• Orientation to time, place and person<br>• Attention span and concentration<br>• Recent and remote memory<br>• Language<br>• Fund of knowledge<br>• Ophthalmoscopic examination of optic discs and posterior segments<br>• 2nd cranial nerve<br>• 3rd, 4th and 6th cranial nerves<br>• 5th cranial nerve<br>• 7th cranial nerve<br>• 8th cranial nerve<br>• 9th cranial nerve<br>• 11th cranial nerve<br>• 12th cranial nerve<br>• Muscle tone in upper and lower extremities with notation of any atrophy or abnormal movements<br>• Muscle strength in upper and lower extremities<br>• Examination of reflexes in upper and lower extremities with notation of pathological reflexes<br>• Examination of sensation<br>• Test coordination<br>• Examination of gait and station | All | All | 12 | All | 12 | 6 |
| **MDM** | **MEDICAL DECISION MAKING**<br>(see back of sheet for determination of MDM) | High | Mod | Low | High | Mod | 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. The average total times (face-to-face with patient and/or family) for the common E/M outpatient codes and average Medicare reimbursements are listed below.

| **New Patients** | | **Established Patients** | |
|---|---|---|---|
| High [Level 5] 99205 ($ 194) | 60 minutes | High [Level 5] 99215 ($ 134) | 40 minutes |
| Mod [Level 4] 99204 ($ 155) | 45 minutes | Mod [Level 4] 99214 ($ 99) | 25 minutes |
| Low [Level 3] 99203 ($ 99) | 30 minutes | Low [Level 3] 99213 ($ 66) | 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 |
|---|---|---|---|
| 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<br>• ≥= 1 chronic illnesses with severe exacerbation, progression or side effect of Rx<br>• Decision for DNR or de-escalate care because of poor prognosis |
| | Diagnostic Procedures | • Angiogram • Myelogram |
| | Management Options | • Drug therapy that requires monitoring for toxicity • Parenteral controlled substances<br>• 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<br>• ≥= 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 |

**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 (not just the report impression) | 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: | | | |

**Legal disclaimer**: the information above reviews the most common outpatient visit codes used by neurologists (levels 3, 4, and 5). If the history, exam and MDM do not fit these levels, one needs to use either level 1 or 2. The details of these levels are provided in the 1997 CMS guidelines. (Updated 12/14/10).