RT Welter Hospital Services E/M Coding Calculator

		HISTORY	EXAM	MEDICAL DECISION - MAKING (MDM)	Floor Time*
IP Admit	**OBSERV**	**Initial Hospital Services: Initial evaluation by admitting physician.** ***REQUIRES 3/3 COMPONENTS*** ***Work of other E/M today by you is rolled into the admit. State when history cannot be obtained and why.***			**Not for Residents**
99221-AI	**99218**	*Detailed:* **CC, HPI X 4** qualifiers, **ROS x 2-9** systems & **1** pertinent Med., Family or Social Hx	*Detailed:* Novitas **4x4**	**SF | Low Complexity**	30 mins
99222-AI	**99219**	*Comprehensive:* **CC, HPI x 4** qualifiers, **ROS x 10+ & ALL 3 PFSH**.	*Comprehensive:* Novitas **8**x1	**Moderate MDM**	50 mins
99223-AI	**99220**			**High Complexity MDM**	70 mins
IP visit	**OBSERV**	**Subsequent Hospital Services: Daily visits.** ***REQUIRES 2/3 COMPONENTS: One must be MDM*** ***One code for a full day service. Note each time patient is seen, indicate time as appropriate.***			
99231	**99224**	*Problem Focused:* **CC, HPI x 1-3** qualifiers	*Problem Focused:* Novitas **1**x1	**SF | Low Complexity**	15 mins
99232	**99225**	*Expanded Problem Focused:* **CC, HPI x 1-3** qualifiers & **ROS x 1** system	*Expanded Problem Focused:* Novitas **2**x1	**Moderate MDM**	25 mins
99233	**99226**	*Detailed:* **CC, HPI X 4** qualifiers, **ROS x 2-9** systems	*Detailed:* Novitas **4x4**	**High Complexity MDM**	35 mins
IP visit	**OBSERV**	**Discharge Day Management:** ***Time MUST be documented.***			
99238-DC	**99217 DC**	Discharge Day Management: Including summary, exam, instructions and paperwork. Must document time spent on discharge service in record.			≤ 30 mins
99239-DC					≥ 31 mins
IP or Observation		**Admit/Discharge Same day:** ***REQUIRES 3/3 COMPONENTS***			
99234		*Detailed:* **CC, HPI X 4** qualifiers, **ROS x 2-9** systems & **1** pertinent Med., Family or Social Hx	*Detailed:* Novitas **4x4**	**SF | Low Complexity**	40 mins
99235		*Comprehensive:* **CC, HPI x 4** qualifiers, **ROS x 10+ & ALL 3 PFSH**.	*Comprehensive:* Novitas **8**x1	**Moderate MDM**	50 mins
99236				**High Complexity MDM**	55 mins
Prolonged Services: ***Assign for inpt/observ w/other timed E/M Code. Record time and reason for addt'l service. MCare requires F2F; other payors - floor time. Time-based reporting cannot be documented by residents. Must be assigned with parent code.***					
+ 99356		Additional time beyond timed E/M today (1st Hour)		30-74 mins	
+ 99357		Code for each additional 30 minutes today		each addt'l 30 mins	
Critical Care: ***You are managing patient during time reported. No History or Exam required. Document system failure, your action & time involved directing care.***					
99291		Critical Care, evaluation and management of critically ill or critically injured patient.; first 30-74 minutes.		30-74 mins	
+ 99292		Code for each additional 30 minutes today.		each addt'l 30 mins	

HPI Qualifiers:
1. Timing
2. Location
3. Signs/Sxs
4. Quality
5. Severity
6. Context
7. Duration
8. Modifing Factor

When managing multiple chronic problems, the ***incoming status of 3 or more chronic conditions*** may be documented instead of 4 qualifiers.

Detailed Exam:
4 systems OR 4 areas

**** Time-based reporting documentation requirements:***

1) Document and code total duration of floor-time spent dedicated to the patient.
2) Document that greater than 50% of the unit/floor time was devoted to counseling/ coordination of care.
3) Document content/detail of discussion/coordination that occurred.

Time-based reporting cannot be captured by residents.

Only "Medically Necessary" History and/or Exam are counted.

When selecting the level of service for todays encounter: 1) Consider the information in the table below paired with your documented MDM to select code based on complexity. 2) Use front of calculator to assure supportive history and/or exam are documented.

Complexity:	Examples of Presenting Problem(s):	Data Ordered/Reviewed:
SF | Low Complexity MDM:	**99221/99231/99218/99224/99234** **1-2 problems stable/improved today** **Stable, resolving, no need for treatment, discharge soon**	Order/review labs **&** diagnostic radiology **OR** Discussion of case with another provider
Moderate MDM:	**99222/99232/99219/99225/99235** At least **3 problems** w/management by you TODAY ***OR*** At least **1 new significant problem w/WU** and/or tx by you ***OR*** At least **1 problem worsening w/management of other problems** today.	Order/review labs **OR** diagnostic radiology **&** Discussion of case with another provider
High Complexity MDM:	**99223/99233/99220/99226/99236** Severe exacerbation, life-threatening, GI Bleed, Stroke, Cardiac issues, etc. Significant new problem(s) worsening.	Order/review labs **&** diagnostic radiology **&** Discussion of case with another provider

A well-written note provides clear evidence of the nature of presenting illness(es).

Medical Decision Making (MDM) Reminders:

Include all conditions evaluated and/or managed in every assessment. Record Clarity related to new problems. Identify status of all problems addressed. Identify when history is obtained from another source. Document discussion with others. Note labs/studies reviewed.

Admit Coding Reminders:

Code selection is based on inpatient versus observation admit - document accordingly. Admit code includes all Hx, exam, MDM performed in all POS by you on same day. Attending or Teaching Physician (TP) my choose E/M code based on key components or detailed evidence of floor time.

Daily Visit Reminders:

Code selection is based on inpatient versus observation admit - document accordingly. One E/M "daily visit" code assigned per day. Multiple visits by same-group, same-specialty may be combined for code selection. Group member clinicians should make a practice of documenting floor time as it may become necessary later in day for code assignment. Discharge codes are status and time dependent - document accordingly. Any new history information since last encounter should be documented *(interval history)* .

Prolonged Service Coding Reminders:

Reserved for attending or Teaching Physicians only. Record all time & activities. May be combined throughout same date by same group specialty. Resident time is NEVER considered. Assign with Admit or Daily E/M visit where detailed floor time is recorded in the record. Documented reason for addt'l time - Medicare requires this "floor time" to be face to face (F2F).

Critical Care Service Coding Reminders:

Only appropriate when patient is in a 'significant systems failure', regardless of location in facility. Full documented time/activity devoted to patient. Time need *NOT* be F2F.

Teaching Physician (TP) Reminders:

Attending/Teaching physician may select the admit code based on a combination of their component work (Hx, Exam, MDM) OR a combination of Resident/TP work. TP must record performance of "key/critical" history/exam/data review. Reference & support the work of the Resident. Identify your management of the patient.

****See Novitas, your local MAC or CMS 1995 Guidelines for more details.***