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Evaluation and Management Services Guide
Coding by Key Components

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
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History

Chief Complaint (CC)	History of present illness (HPI)	Past, family, social history (PFSH)	Review of systems (ROS)
Reason for the visit	Location; Severity; Timing; Quality; Duration; Context; Modifying Factors; Associated signs and symptoms	Past medical; Family medical; Social	Constitutional; Eyes; Ears, Nose, Mouth, and Throat; Cardiovascular; Respiratory; Genitourinary; Musculoskeletal; Gastrointestinal; Skin/Breast; Neurological; Psychiatric; Endocrine; Hematologic/Lymphatic; Allergic/Immunologic

CC	HPI	PFSH	ROS	History Type
Yes	*Brief* (1-3 elements or 1-2 chronic conditions)	N/A	N/A	*Problem focused* (PF)
			Problem pertinent (1 system)	*Expanded problem focused* (EPF)
	Extended (4 elements or 3 chronic conditions)	*Pertinent* (1 element)	*Extended* (2-9 systems)	*Detailed* (DET)
		Complete (2 elements (est) or 3 elements (new/initial))	*Complete* (10-14 systems)	*Comprehensive* (COMP)

Examination

System/body area	Examination
Constitutional	• 3/7 vital signs: sitting or standing BP, supine BP, pulse rate and regularity, respiration, temperature, height, weight • General appearance
Musculoskeletal	• Muscle strength and tone • Gait and station
Psychiatric	• Speech • Thought process • Associations • Abnormal/psychotic thoughts • Judgment and insight • Orientation • Recent and remote memory • Attention and concentration • Language • Fund of knowledge • Mood and affect

Examination Elements	Examination type
1-5 bullets	*Problem focused* (PF)
At least 6 bullets	*Expanded problem focused* (EPF)
At least 9 bullets	*Detailed* (DET)
All bullets in Constitutional and Psychiatric (shaded) boxes and 1 bullet in Musculoskeletal (unshaded) box	*Comprehensive* (COMP)

Med Dec Making

Medical Decision Making Element	Determined by
Number of diagnoses or management options	Problem points chart
Amount and/or complexity of data to be reviewed	Data points chart
Risk of significant complications, morbidity, and/or mortality	Table of risk

Problem Points

Category of Problems/Major New symptoms	Points per problem
Self-limiting or minor (stable, improved, or worsening) (max=2)	1
Established problem (to examining physician); stable or improved	1
Established problem (to examining physician); worsening	2
New problem (to examining physician); no additional workup or diagnostic procedures ordered (max=1)	3
New problem (to examining physician); additional workup planned*	4

*Additional workup does not include referring patient to another physician for future care

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Medical Decision Making

Data Points

Categories of Data to be Reviewed (max=1 for each)	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing, or specimen itself (not simply review report)	2

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem	Venipuncture; EKG; urinalysis	Rest
Low	Two or more self-limited or minor problems; One stable chronic illness; Acute uncomplicated illness	Arterial puncture	OTC drugs
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis; Acute illness with systemic symptoms		Prescription drug management
High	One or more chronic illnesses with severe exacerbation, progression, or side effects; Acute or chronic illnesses that pose a threat to life or bodily function		Drug therapy requiring intensive monitoring for toxicity

	Problem Points	Data Points	Risk	Complexity of Medical Decision Making
2/3 elements must be met or exceeded:	0-1	0-1	Minimal	*Straightforward*
	2	2	Low	*Low*
	3	3	Moderate	*Moderate*
	4	4	High	*High*

CPT Codes

New Patient Office
(requires 3 of 3)

CPT Code	History	Exam	MDM
99201	PF	PF	Straightforward
99202	EPF	EPF	Straightforward
99203	DET	DET	Low
99204	COMP	COMP	Moderate
99205	COMP	COMP	High

Established Patient Office
(requires 2 of 3)

CPT Code	History	Exam	MDM
99211	N/A	N/A	N/A
99212	PF	PF	Straightforward
99213	EPF	EPF	Low
99214	DET	DET	Moderate
99215	COMP	COMP	High

Initial Hospital/PHP
(requires 3 of 3)

CPT Code	History	Exam	MDM
99221	DET	DET	Straightforward
99222	COMP	COMP	Moderate
99223	COMP	COMP	High

Subsequent Hospital/PHP
(requires 2 of 3)

CPT Code	History	Exam	MDM
99231	PF	PF	Straightforward
99232	EPF	EPF	Moderate
99233	DET	DET	High

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Evaluation and Management (E/M) Patient Examples

Office, Established Patient

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IMPORTANT

The sample progress notes below meet criteria for the specified E/M code, but do ***not*** necessarily meet criteria for the multiple other purposes (e.g., clinical, legal) of documentation. For illustration, the documentation meets requirements specified by the codes for the exact levels of each of the 3 key components. In practice, criteria for these codes may be met by documenting only 2 of 3 of the key components at or above the level required by the code.

SERVICES SHOULD ALWAYS BE MEDICALLY NECESSARY.

99213		***Office visit for a 9-year-old male, established patient, with ADHD. Mild symptoms and minimal medication side effects.***	***Office visit for a 27-year-old female, established patient, with stable depression and anxiety. Intermittent moderate stress.***	
HISTORY	CC	9-year-old male seen for follow up visit for ADHD. Visit attended by patient and mother; history obtained from both.	27-year-old female seen for follow up visit for depression and anxiety. Visit attended by patient.	**HISTORY:** *Expanded Problem Focused*
	HPI	Grades are good (associated signs and symptoms) but patient appears distracted (quality) in class (context). Lunch appetite poor but eating well at other meals. **HPI scoring**: 3 elements = *Brief*	Difficulty at work but coping has been good. Minimal (severity) situational sadness (quality) and anxiety when stressed (context). **HPI scoring**: 3 elements = *Brief*	
	PFSH	N/A	N/A	
	ROS	Psychiatric: denies depression, anxiety, sleep problems **ROS scoring**: 1 system = *Problem-pertinent*	Psychiatric: no sadness, anxiety, irritability **ROS scoring**: 1 system = *Problem-pertinent*	
EXAM	Const	Appearance: appropriate dress, comes to office easily	Appearance: appropriate dress, appears stated age	**EXAM:** *Exp. Problem Focused*
	MS	N/A	N/A	
	Psych	Speech: normal rate and tone; Thought content: no SI/HI or psychotic symptoms; Associations: intact; Orientation: x 3; Mood and affect: euthymic and full and appropriate **Examination scoring**: 6 elements = *Expanded problem-focused*	Speech: normal rate and tone; Thought content: no SI/HI or psychotic symptoms; Associations: intact; Orientation: x 3; Mood and affect: euthymic and full and appropriate; Judgment and insight: good **Examination scoring**: 7 elements = *Expanded problem-focused*	
MEDICAL DECISION MAKING		**Problem 1**: ADHD **Comment**: Relatively stable; mild symptoms **Plan**: Renew stimulant script and increase dose; Return visit in 2 months	**Problem 1**: Depression **Comment**: Stable **Plan**: Renew SSRI script at the same dose; Return visit in 3 months **Problem 2**: Anxiety **Comment**: Stable **Plan**: Same dose of SSRI	**MEDICAL DECISION MAKING:** *Low Complexity*
	Prob	**Problem scoring**: 1 established problem, stable (1); total of 1 = *Minimal*	**Problem scoring**: 2 established problems, stable (1 for each = 2); total of 2 = *Limited*	
	Data	**Data scoring**: Obtain history from someone other than patient (2); total of 2 = *Limited*	**Data scoring**: None = *Minimal*	
	Risk	**Risk scoring**: Chronic illness with mild exacerbation, progression, or side effects; and Prescription drug management = *Moderate*	**Risk scoring**: Two stable chronic illnesses; and Prescription drug management = *Moderate*	

Evaluation and Management (E/M) Patient Examples

99214	***Office visit for a 13-year-old male, established patient, with depression, anxiety, and anger outbursts.***	***Office visit for a 70-year-old male, established patient, with stable depression and recent mild forgetfulness.***	
HISTORY CC	13-year-old male seen for follow up visit for mood and behavior problems. Visit attended by patient and father; history obtained from both.	70-year-old male seen for follow up visit for depression. Visit attended by patient and daughter; history obtained from both.	**HISTORY:** *Detailed*
HPI	Patient and father report increasing (timing), moderate (severity) sadness (quality) that seems to be present only at home (context) and tends to be associated with yelling and punching the walls (associated signs and symptoms) at greater frequency, at least once per week when patient frustrated. Anxiety has been improving and intermittent, with no evident trigger (modifying factors). **HPI scoring**: 6 elements = *Extended*	Patient and daughter report increasing distress related to finding that he has repeatedly lost small objects (e.g., keys, bills, items of clothing) over the past 2-3 months (duration). Patient notices intermittent (timing), mild (severity) forgetfulness (quality) of people's names and what he is about to say in a conversation. There are no particular stressors (modifying factors) and little sadness (associated signs and symptoms). **HPI scoring**: 6 elements = *Extended*	
PFSH	Attending 8th grade without problem; fair grades **PFSH scoring**: 1 element: social = *Pertinent*	Less attention to hobbies **PFSH scoring**: 1 element: social = *Pertinent*	
ROS	Psychiatric: no problems with sleep or attention; Neurological: no headaches **ROS scoring**: 2 systems = *Extended*	Psychiatric: no problems with sleep or anger; Neurological: no headaches, dizziness, or weakness **ROS scoring**: 2 systems = *Extended*	
EXAM Const	Appearance: appropriate dress, appears stated age	Appearance: appropriate dress, appears stated age	**EXAM:** *Detailed*
MS	N/A	Muscle strength and tone: normal	
Psych	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: x 3; Attention and concentration: good; Mood and affect: euthymic and full and appropriate ; Judgment and insight: good **Examination scoring**: 9 elements = *Detailed*	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: no SI/HI or psychotic symptoms; Orientation: x 3; Attention and concentration: unable to focus on serial 7s; Mood and affect: euthymic and full and appropriate; Recent and remote memory: mild struggle with telling history and remembered 1/3 objects **Examination scoring**: 10 elements = *Detailed*	
MEDICAL DECISION MAKING	**Problem 1**: Depression **Comment**: Worsening; appears associated with lack of structure **Plan**: Increase dose of SSRI; write script; CBT therapist; Return visit in 2 weeks **Problem 2**: Anxiety **Comment**: Improving **Plan**: Patient to work with therapist on identifying context **Problem 3**: Anger outbursts **Comment**: Worsening; related to depression but may represent mood dysregulation **Plan**: Call therapist to obtain additional history; consider a mood stabilizing medication if no improvement in 1-2 months	**Problem 1**: Depression **Comment**: Stable; few symptoms **Plan**: Continue same dose of SSRI; write script Return visit in 1 month **Problem 2**: Forgetfulness **Comment**: New; mildly impaired attention and memory **Plan**: Brain MRI; consider referral to a neurologist if persists	**MEDICAL DECISION MAKING:** *Moderate Complexity*
Prob	**Problem scoring**: 2 established problems, worsening (2 for each problem = 4); 1 established problem, improving (1); total of 5 = *Extensive*	**Problem scoring**: 1 established problem, stable (1); 1 new problem with additional workup (4); total of 5 = *Extensive*	
Data	**Data scoring**: Obtain history from other (2); Decision to obtain history from other (1); total of 3 = *Multiple*	**Data scoring**: Order of test in the radiology section of CPT (1); Obtain history from other (2); total of 3 = *Multiple*	
Risk	**Risk scoring**: One or more chronic illnesses with mild exacerbation, progression; and Prescription drug management = *Moderate*	**Risk scoring**: Undiagnosed new problem with uncertain prognosis; and Prescription drug management = *Moderate*	

Evaluation and Management (E/M) Patient Examples

99215	***Office visit for an established adolescent patient with history of bipolar disorder treated with lithium; seen on urgent basis at family's request because of severe depressive symptoms.***	***Office visit for a 25-year-old male, established patient with a history of schizophrenia, who has been seen bi-monthly but is complaining of auditory hallucinations.***	
HISTORY CC	17-year-old male seen for urgent visit for depression. Visit attended by patient and parents; history obtained from all 3.	25-year-old male seen for follow up visit for schizophrenia. Visit attended by patient.	**HISTORY:** *Comprehensive*
HPI	Patient doing well until 2 days ago (timing) when, for no apparent reason (context), he refused to leave his bed and appeared extremely (severity) and continuously depressed (quality); he is sleeping more and eating little (associated signs and symptoms). **HPI scoring**: 5 elements = *Extended*	The patient reports doing well until 1 week ago (duration) when he stayed up all night to finish a term paper (context). He has slept poorly (severity) since (timing) and, 2 days ago, began hearing fairly continuous voices (quality) telling him that people plan to shoot him. Attention and organization were good up until this past week (associated signs and symptoms). **HPI scoring**: 6 elements = *Extended*	
PFSH	Stopped attending school; family history of suicide is noted from patient's initial evaluation **PFSH scoring**: Family and social (2 elements) = *Complete*	Doing well in third year of graduate school. Chart notes no family psychiatric history. **PFSH scoring**: Family and social (2 elements) =*Complete*	
ROS	Psychiatric: no problems with anxiety or anger; Neurological: no headaches; All other systems reviewed and are negative. **ROS scoring**: All systems = *Complete*	Psychiatric: denies symptoms of depression or mania; Neurological: no headaches; All other systems reviewed and are negative. **ROS scoring**: All systems = *Complete*	
EXAMINATION Const	VS: BP (sitting) 120/70, P 90 and regular, R 20; Appearance: appropriate dress, appears stated age	VS: BP (sitting) 115/70, P 86 and regular, Ht 5'10", Wt 180 lbs; Appearance: appropriate dress, appears stated age	**EXAMINATION:** *Comprehensive*
MS	Gait and station: normal	Gait and station: normal	
Psych	Speech: sparse and slow; Thought process: logical; Associations: intact; Thought content: hopelessness, thinks of suicide, no HI or psychotic symptoms; Orientation: x 3; Attention and concentration: impaired; Mood and affect: depressed and constricted; Judgment and insight: poor; Fund of knowledge: good; Recent and remote memory: good; Language: able to repeat phrases **Examination scoring**: All elements of constitutional and psychiatric and 1 element of musculoskeletal = *Comprehensive*	Speech: normal rate and tone; Thought process: logical; Associations: intact; Thought content: auditory hallucinations and paranoid ideation, no SI/HI; Orientation: x 3; Attention and concentration: impaired; Mood and affect: euthymic and full and appropriate; Judgment and insight: good; Fund of knowledge: good; Recent and remote memory: good; Language: able to repeat phrases **Examination scoring**: All elements of constitutional and psychiatric and 1 element of musculoskeletal = *Comprehensive*	
MEDICAL DECISION MAKING	**Problem 1**: Bipolar disorder **Comment**: Major relapse **Plan**: Continue current dose of Lithium for the moment **Problem 2**: Suicidality **Comment**: New **Plan**: Refer to hospital; confer with hospitalist once patient is admitted	**Problem 1**: Psychosis **Comment**: Major relapse **Plan**: Increase dose of antipsychotic; write script; hold off on hospital admission as patient historically very adherent; return for visit in 1 day **Problem 2**: Insomnia **Comment**: Sleep deprivation may have triggered the psychosis relapse **Plan**: Change to a more powerful hypnotic; write script **Problem 3**: ADHD **Comment**: Appears stable **Plan**: Continue same dose of non-stimulant medication	**MEDICAL DECISION MAKING:** *High Complexity*
Prob	**Problem scoring**: 1 established problem, worsening (2); 1 new problem (3); total of 5 = *Extensive*	**Problem scoring**: 1 established problem, stable (1); 2 established problems, worsening (2 for each problem = 4); total of 5 = *Extensive*	
Data	**Data scoring**: Obtain history from other (2); total of 2 = *Limited*	**Data scoring**: None = *Minimal*	
Risk	**Risk scoring**: Chronic illness with severe exacerbation; and Illness that poses a threat to life = *High*	**Risk scoring**: Chronic illness with severe exacerbation = *High*	

Patient Name: _____ Date: _____

Identifying Data: Source of Info:

HISTORY

CHIEF COMPLAINT/REASON FOR ENCOUNTER:

HPI (*(1-3 elements - Brief; 4+ elements – Extended)*

Elements: Location, Quality, Severity, Duration, Timing, Content, Modifying Factors, Associated Signs & Symptoms

PAST PSYCHIATRIC HISTORY: *(1 history area – Pertinent; 2-3 history areas – Complete)*

PAST MEDICAL HISTORY:

Diagnoses: Medications:

Surgeries: Allergies:

PAST FAMILY, SOCIAL, HISTORY (PFSH):

REVIEW OF SYSTEMS & ACTIVE MEDICAL PROBLEMS **NOTES IF POSITIVE**

(1 system - Problem Pertinent; 2-9 systems – Extended; 10 or more systems or some systems noted as "all others negative"- Complete)

1. Constitutional pos___ neg ___
2. Eyes pos___ neg ___
3. Ears/Nose/Mouth/Throat pos___ neg___
4. Cardiovascular pos___ neg___
5. Respiratory pos___ neg___
6. Gastrointestinal pos___ neg___
7. Genitourinary pos___ neg___
8. Muscular pos___ neg___
9. Integumentary pos___ neg___
10. Neurological pos___ neg___
11. Endocrine pos___ neg___
12. Hemotologic/Lymphatic pos___ neg___
13. Allergies/Immune pos___ neg___

PSYCHIATRIC SPECIALTY EXAMINATION

(1-5 bullets- Problem Focused; at least 6 bullets Expanded Problem Focused; at least 9 bullets - Detailed; all bullets- Comprehensive Exam)

- Vital Signs (any 3 or more of the 7 listed):

Patient personally examined: __ Yes __ No

Blood Pressure: (Sitting/Standing) _____ (Supine) _____

Temp_____ Pulse (Rate/Regularity) _____ Respiration _____Height _____ Weight _____

- General Appearance and Manner: (e.g., development, nutrition, body habitus, deformities, attention to grooming)

- Musculoskeletal: __Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) (note any atrophy or abnormal movements)

  (and/or) __Examination of gait and station

- Speech: Check if normal:___rate__volume__articulation__coherence__spontaneity (note abnormalities; e.g., perseveration, paucity of language)

- Thought processes: Check if normal: __associations__processes__abstraction __computation

- Description of associations (e.g., loose, tangential, circumstantial, intact):

- Description of abnormal or psychotic thoughts (e.g., hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, obsessions):

Suicidal ideation: __ Present__ Absent Homicidal ideation: __Present __ Absent Violent ideation: __Present __ Absent

- Description of patient's judgment and insight:

- Orientation:

- Memory (Recent/Remote):

- Attention/Concentration:

- Language:

- Fund of knowledge: __intact __inadequate

- Mood and affect:

Other Findings (e.g. cognitive screens, etc.):

MEDICAL DECISION MAKING

Need for admission/evaluation:	**Data**
	Medical Records/Labs/Diagnostic Tests Reviewed:
Diagnoses	**Treatment Plan**
Axis I-V:	Intervention/Psychotherapy
	Medication
Rule outs:	
Formulation:	Labs/Radiology/Tests/Consultation
	Other

__Greater than 50% of time spent in counseling/coordination of care (document)

_____ _____ _____

Physician Name (Print) Physician Signature Date and Time

Patient Name: _____Date: _____

HISTORY

CHIEF COMPLAINT/REASON FOR ENCOUNTER:

HPI ***(1-3 elements - Brief; 4+ elements – Extended)***

Elements: Location, Quality, Severity, Duration, Timing, Content, Modifying Factors, Associated Signs & Symptoms

PAST, FAMILY, SOCIAL HISTORY (PFSH) __ Check if no change ***(1 history area – Pertinent; 2-3 history areas – Complete)***

REVIEW OF SYSTEMS & ACTIVE MEDICAL PROBLEMS **NOTES IF POSITIVE**

(1 system - Problem Pertinent; 2-9 systems – Extended; 10 or more systems or some systems noted as "all others negative"- Complete)

1. Constitutional pos___ neg ___
2. Eyes pos___ neg ___
3. Ears/Nose/Mouth/Throat pos___ neg___
4. Cardiovascular pos___ neg___
5. Respiratory pos___ neg___
6. Gastrointestinal pos___ neg___
7. Genitourinary pos___ neg___
8. Muscular pos___ neg___
9. Integumentary pos___ neg___
10. Neurological pos___ neg___
11. Endocrine pos___ neg___
12. Hemotologic/Lymphatic pos___ neg___
13. Allergies/Immune pos___ neg___

PSYCHIATRIC SPECIALTY EXAMINATION

(1-5 bullets- Problem Focused; at least 6 bullets Expanded Problem Focused; at least 9 bullets - Detailed; all bullets- Comprehensive Exam)

- Vital Signs (any 3 or more of the 7 listed):

Patient personally examined: __ Yes __ No

Blood Pressure: (Sitting/Standing) _____ (Supine) _____

Temp_____ Pulse (Rate/Regularity) _____ Respiration _____Height _____ Weight _____

- General Appearance and Manner: (e.g., development, nutrition, body habitus, deformities, attention to grooming)

- Musculoskeletal: __Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) (note any atrophy or abnormal movements)

  (and/or) __Examination of gait and station

- Speech: Check if normal:___rate__volume__articulation__coherence__spontaneity (note abnormalities; e.g., perseveration, paucity of language)

- Thought processes: Check if normal: __associations__processes__abstraction __computation

- Description of associations (e.g., loose, tangential, circumstantial, intact):

- Description of abnormal or psychotic thoughts (e.g., hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, obsessions):

Suicidal ideation: __ Present__ Absent Homicidal ideation: __Present __ Absent Violent ideation: __Present __ Absent

- Description of patient's judgment and insight:
- Orientation:
- Memory (Recent/Remote):
- Attention/Concentration:
- Language:
- Fund of knowledge: __intact __inadequate
- Mood and affect:
- Other Findings (e.g. cognitive screens, etc.):

MEDICAL DECISION MAKING

Diagnoses	**Data**
Axis I-V: Rule outs:	Medical Records/Labs/Diagnostic Tests Reviewed
Formulation	

Problem/Condition	**Treatment Plan**
Problem/Condition: ___New ___Established Status: ___Improving ___Worsening Comorbidities: ___Stable ___Complications/side effects ___Independent management required ___ Interference with management of primary condition(s)	Intervention/Psychotherapy
	Medication
	Labs/Radiology/Tests/Consultation
	Other

__Greater than 50% of time spent in counseling/coordination of care (document)

PSYCHOTHERAPY, if performed, should be documented separately

_____	_____	_____
Physician Name (Print)	Physician Signature	Date and Time