What Are Evaluation and Management Guidelines?

Evaluation and Management guidelines, also known as E/M coding, are documentation practices initially established by the US in 1995 to standardize medical documentation and billing Medicare. Because Medicare is such a large player in the medical industry, E/M coding has become the standard for medical billing throughout the country. [1]

The billing format largely utilizes the Evaluation and Management coding section of the Current Procedural Terminology codes, or CPT codes. CPT is created and maintained by the American Medical Association (a brief overview of CPT codes in the Appendix). E/M codes cover most standard check-ups, diagnoses, and medical care.[2] The table below shows the divided sections. Please note that even if one section has a wider range than others, wiggle room is added in the ranges so that more codes can be added as they are needed.

Table 1

Fields and Code Ranges of E/M Codes[3]

Field	Code Range	Field	Code Range
Office or other outpatient services	9920 – 99213	Hospital observation services	99217 – 99220
Hospital inpatient services	99221 – 99239	Consultation	99241 – 99255
Emergency department services	99281 – 99288	Critical care services	99291 – 99292
Nursing facility services	99304 – 99318	Domiciliary, rest home (boarding home), or custodial care services	99324 – 99337
Domiciliary, rest home (assisted living), or home care plan oversight service	99339 – 99340	Home services	99341 – 99350
Prolonged services	99354 – 99360	Case management services	99363 – 99368
Care plan oversight services	99441 – 99444	Special evaluation and management services	99450 – 99457
Newborn care services	99460 – 99456	Inpatient neonatal intensive, and pediatric/neonatal critical, care services	99466 – 99480

[1] *CMS Roadmaps Overview for Quality Measurement*, 1
[2] *Medical Billing and Coding Certification*, 178
[3] *5.11: CPC Exam: Evaluation and Management*

While the Guidelines were established in 1995, new guidelines were created in 1997 because some felt that the 1995 requirements for a general examination weren't specific enough.[4] The 1997 guidelines did not replace the 1995 guidelines, though. Either could be used depending on the encounter or standards of the office. Then, in 2018 the Centers for Medicare & Medicaid Services announced several revisions to the E/M guidelines that would allow doctors to focus more on patients and less on paperwork.[5] These new guidelines go into effect January 1, 2021, giving all outpatient or office services one year to change over. The sections below go over what the 1995 and 1997 guidelines are along with the 2020 changes to the way physicians document the diagnosis, management, and treatment of patients.

1995 Guidelines

The guidelines use seven components to identify the level of E/M service provided by the healthcare worker. These are:

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of the presenting problem
- Time

Of these seven, the first three (history, examination, and medical decision making) are key components when determining the E/M services.[6] These components are so important that the guidelines *only* go into detail about how to document these three components, essentially leaving the rest to the physician's discretion.

History

When documenting history, a qualified healthcare professional should document using these four elements:

- Chief complaint or CC
- History of present illness or HPI
- Review of systems or ROS
- Past, family, and/or social history or PFSH

The chief complaint must always be documented to the same extent each time. The extent of the documentation of the other three elements is up to the physician to decide. This should be based on the nature of the presenting problem(s) and clinical judgment.

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[4] *Understand how to apply the 1995 and 1997 Documentation Guidelines*
[5] *Major Changes Are Coming to E/M Visits in 2021: Will You Be Ready?*
[6] *1995 Documentation Guidelines for Evaluation and Management Services, 3*

Table 2

Extent of Elements in a Given History[7]

Type of History	Chief Complaint	History of Present Illness	Review of Systems	Past, Family, and/or Social History
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

In the case of frequent patients or follow-up care, the history need only add anything that happens between visits. This means that there may not be anything to add to the PFSH than what is already given and may be ignored for the purposes of billing.

Chief Complaint

The chief complaint should be a concise statement describing the reason for the encounter. This could be a symptom or problem reported by the patient or even just a note about a follow-up or referral.[8]

History of Present Illness

This part of the history should document a description of the present illness from the first sign or from the previous encounter to the present. As seen on the table, there are two types of HPI used in documentation. The first, called brief, only documents one of the elements in an HPI. The second, extended, documents four or more elements. The elements are:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms[9]

Review of Systems

A review of systems takes inventory of the patient's body systems. For documentation, the Centers for Medicare and Medicaid Services only recognize the following systems:

- Constitutional symptoms
- Eyes
- Ears, Nose, Mouth Throat

[7] *Evaluation and Management Services Guide, 7*
[8] *1995 Documentation Guidelines for Evaluation and Management Services, 5*
[9] *1995 Documentation Guidelines for Evaluation and Management Services, 6*

- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

There are three types of ROS that may be used:

- Problem pertinent, which focuses on reviewing the system directly related to the problem.
- Extended, which adds a limited number (maximum of nine) of additional systems in addition to the immediate system.
- Complete, which adds at least ten other systems in addition to the immediate system.[10]

Past, Family, and/or Social History

This section reviews three areas:

- The patient's past medical history (illnesses, operations, injuries, etc.)
- The patient's family medical history (close relatives' hereditary conditions)
- The patient's social history (sexual history or history of exposure to contagions)

A PFSH may either be pertinent or complete. A pertinent PFSH reviews the history areas only related to the identified problem. A complete PFSH reviews two or all three areas. For instance, on a follow-up visit or a regular patient, if there is no change in the family medical history, it would be unnecessary to add anything to it.[11]

Examination

How to exactly document an examination is a little vague—and part of the reason the 1997 guidelines were created. To perform an examination, the physician must look at a requisite number of body areas and/or organ systems. The body areas are:

- Head, including the face
- Neck
- Chest, including the breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity.

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[10] *1995 Documentation Guidelines for Evaluation and Management Services, 7 – 8*

[11] *1995 Documentation Guidelines for Evaluation and Management Services, 8*

The organ systems are:

- Constitutional (vitals and appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic.

The extent of the examinations range from just a single body area to general multi-system or complete single organ examination. The only real requirement of the number of systems is that a general multi-system examination should have 8 or more of the 12 organ systems.[12] The rest is up to the physician's discretion.

Medical Decision Making

Medical decision making or MDM refers to the complexity of diagnosing and/or selecting management options for the patient. This sounds more complicated than it really is. MDM is supposed to take into account the number of diagnoses, the amount and complexity of data, and the risk of complications and morbidity. The table below shows the level of MDM based on those three categories. To qualify for a specific level of MDM, two of the three factors must be met.

Table 3

Level of Medical Decision Making[13]

Level of MDM	Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Number of Diagnoses or Management Options

This section essentially refers to the amount of problems addressed in the encounter. These can be new problems (diagnoses) or old problems (management) like trying new medications for high blood

[12] *1995 Documentation Guidelines for Evaluation and Management Services,* 9 – 10
[13] *1995 Documentation Guidelines for Evaluation and Managements Services,* 11

pressure or diabetes. The smaller the problem or the fewer the problems addressed, the less complex this section is.[14]

Amount and/or Complexity of Data to Be Reviewed

Data refers to the types of diagnostic testing ordered or reviewed. This can be ordering blood work and going over the test results. It specifically refers to results reviewed, tests ordered, and performed *during* this encounter. Tests performed at other times should be billed separately.[15]

Risk of Complications and/or Morbidity or Mortality

This section refers to any risks associated with problem(s), diagnostic procedure(s), and management options present to the patient. Taking a chest x-ray or an ultrasound would be a minimal risk procedure. An example of a high-risk complication would be elective major surgery or acute renal failure as a presenting problem.[16]

1997 Guidelines

The 1997 guidelines are almost exactly the same. These new guidelines changed how to document the history of present illness and the documentation of the examination. While the history of present illness is really only a minor change, the changes to the documentation of the examination are huge. Instead of going over every part of these guidelines, two are presented below as examples: the history of present illness and the documentation of the examination.

History of Present Illness

History of present illness hasn't changed its function; it is still a description of the development of the patient's present problem over time. It still needs to include the same elements. Even a brief HPI is the same. The change comes from the extended HPI. For this one, the medical record should describe at least four elements of the present illness, *or the status of at least three chronic or inactive conditions.*[17] Instead of just the present illness, other chronic or inactive conditions may be used instead to create an extended HPI. This could be more useful for a general checkup instead of a visit for a specific problem.

Documentation of the examination

Almost everything has changed to properly document an examination. First, there are no established body areas, but a new list of organ systems. The organ systems recognized under these guidelines are:

- Cardiovascular
- Ears, Nose, Mouth, and Throat
- Eyes
- Genitourinary (female)
- Genitourinary (male)
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurological
- Psychiatric

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[14] *1995 Documentation Guidelines for Evaluation and Management Services,* 11 – 12
[15] *1995 Documentation Guidelines for Evaluation and Management Services,* 12 – 13
[16] *1995 Documentation Guidelines for Evaluation and Management Services,* 14
[17] *Evaluation and Management Services Guide,* 7

- Respiratory
- Skin

There are still the same levels for examinations, but the levels are now divided according to general multi-system examinations and single organ system examinations. The guidelines note that any physician, regardless of specialty may perform a general multi-system examination or a single organ system examination. Which makes sense. Usually a primary care physician looks at a system *before* referring a patient to a specialist. The table below shows the difference by level.

Table 4

Examination Level for Multi-System and Single Organ System Examinations[18]

Examination Level	General Multi-System Examination	Single Organ System Examination
Problem Focused	Includes performance and documentation of one to five elements (listed in the table as bullet points) in one or more organ systems/body areas.	Includes performance and documentation of one to five elements (listed in the table as bullet points), in any box of that system's examination table (see below).
Expanded Problem Focused	Includes performance and documentation of at least six elements (listed in the table as bullet points) in one or more systems/body areas.	Includes performance and documentation of at least six elements (listed in the table as bullet points) in any box of that system's examination table.
Detailed	Includes *at least* six organ systems or body areas. For each, at least two elements (listed in the table as bullet points) must be performed and examined. Or instead there can be at least 12 elements (as bullet points) in only two or more systems/areas.	Excepting eye and psychiatric examinations, this should include performance and documentation of at least 12 elements (listed in the table as a bullet) in any box of that system's examination table.
Comprehensive	Includes at least nine organ systems/body areas. All elements (listed in the table as bullet points) of each system/area should be performed, unless there are specific directions that limit the examination. However, a minimum of two elements in each system/area is only expected.	Include performance of all elements (listed in the table as bullet points) in all boxes of that system's examination table. Documentation of every element in each box with a shaded border is expected and at least one element belonging to a box in an unshaded border is expected.

[18] *1997 Documentation Guidelines for Evaluation Management Service,* 11 – 12

Notice that both the multi and single organ examinations talk about bullet points from tables. That's because there are specific tasks that must be performed to consider the encounter a proper examination for each system in a multi-system examination or in a single organ system examination. While a physician can assess other things specific to those systems, these requirements *must* be met for the purposes of billing. Below is an example of some of the requirements of a general multi-system examination.

Table 5

Example of General Multi-System Examination Requirement[19]

System/Body Area	Elements of Examination
Constitutional	● Measurement of **any three** of the following seven vital signs: 1. sitting or standing blood pressure, 2. supine blood pressure, 3. pulse rate and regularity, 4. respiration, 5. temperature, 6. and height, 7. weight (may be taken by ancillary staff) ● General appearance of patient
Eyes	● Inspection of conjunctivae and lids ● Examination of pupils and irises ● Ophthalmoscopic examination of optic discs
Ears, Nose, Mouth, and Throat	● External inspection of ears and nose ● Otoscopic examination of external auditory canals and tympanic membranes ● Assessment of hearing ● Inspection of nasal mucosa, septum, and turbinates ● Inspection of lips, teeth, and gums ● Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils, and posterior pharynx

The single organ system examinations are a little different. Each system has a specific table that the physician uses to perform and document certain elements. There are elements listed for almost every system/body area for each single system examination. However, the physician does not necessarily need

[19] *1997 Documentation Guidelines for Evaluation and Management Services,*13

to use them all, just as many as they feel is necessary for that specific examination. Below is only one of the tables as an example. The gray-shaded systems are required in their entirety when making a comprehensive examination.[20]

Table 6

Elements of a Cardiovascular Examination[21]

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three** of the following seven vital signs: 1. sitting or standing blood pressure, 2. supine blood pressure, 3. pulse rate and regularity, 4. respiration, 5. temperature, 6. and height, 7. Weight (may be taken by ancillary staff) • General appearance of patient
Head and Face	
Eyes	• Inspection of conjunctivae and lids
Ears, Nose, Mouth, and Throat	• Inspection of teeth, gums, and palate • Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	• Examination of jugular veins • Examination of thyroid
Respiratory	• Assessment of respiratory effort • Auscultation of lungs
Cardiovascular	• Palpation of heart • Auscultation of heart including sounds, abnormal sounds, and murmurs • Measurement of blood pressure in two or more extremities when indicated Examination of: • Carotid arteries • Abdominal aorta • Femoral arteries • Pedal pulses • Extremities for peripheral edema and/or varicosities
Chest (Breasts)	
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presences of masses or tenderness • Examination of liver and spleen

[20] *1997 Documentation Guidelines for Evaluation and Management Services,* 10 – 12
[21] *1997 Documentation Guidelines for Evaluation and Management Services,* 18 – 19

	• Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
Genitourinary (Abdomen)	
Lymphatic	
Musculoskeletal	• Examination of the back with notations of kyphosis or scoliosis • Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs • Assessment of muscle strength and tone with notation of any atrophy and abnormal movements
Extremities	• Inspection and palpation of digits and nails
Skin	• Inspection and/or palpation of skin and subcutaneous tissue
Neurological/Psychiatric	Brief assessment of mental status including: • Orientation to time, place, and person • Mood and affect

Using Both Guidelines

In most practices, healthcare professionals should only use either the 1995 guidelines or the 1997 guidelines. For encounters after September 2013, physicians may use the 1997 guidelines for the extended history of present illness with the other elements from the 1995 guidelines. No other combinations may be used.[22]

2020 Changes

In an effort to let healthcare professionals focus on patients, further changes were made to the evaluation and management guidelines at the end of 2019 to take into full effect beginning in 2021. This gave the healthcare system time to adjust and train in preparation. The main changes come to documenting medical history and how to determine billing.

Changes to Documenting History

The amount of history necessary is now up to the physician.[23] This means that if the patient is new, the physician may decide to request a more comprehensive and in-depth medical history. If the patient is a regular with a chronic condition, the physician may decide to only record the changes or lack thereof.

Changes to Billing

The previous guidelines focused on what the physician or other healthcare professionals were supposed to document during an encounter for billing. Because some of the guidelines were very specific in what should be documented, they also gave the bare minimum of what should be performed in an encounter. The 1997 guidelines were very, very explicit on what needed to be documented and what needed to be

[22] *FAQ on 1995 & 1997 Documentation Guidelines for Evaluation & Managements Services*
[23] *CPT Evaluation and Management Office or Other Outpatient and Prolonged Services Code and Guideline Changes, 3*

done to reach a specific level of care. Now what is documented and what is done is left largely up to the physicians. Billing is now determined by either time or medical decision making.[24]

Time

To a degree, time has been implicit in how billing worked. Certain things were expected for each level of care and that meant it should take approximately so many minutes to complete the encounter. Now, the physician or other healthcare worker may use the amount of time to determine the billing for the encounter. Time is divided up into four intervals: 15 – 29 minutes, 30 – 44 minutes, 45 – 59 minutes, and 60 – 74 minutes. An encounter that lasts 75 minutes or longer is considered a prolonged service and charged differently.[25]

What to Count as Time?

For the most part, the total time includes both face-to-face time and non-face-to-face time for the encounter. This time isn't only the physician's time, but other healthcare professionals involved in the encounter. This includes the following:

- Preparing to see the patient
- Obtaining and/or reviewing separately obtained medical history
- Performing medically appropriate examination and/or evaluation
- Counseling and educating the patient, their family, or their caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other healthcare professionals, unless it's separately reported
- Documenting clinical information either electronically or by hand
- Independently interpreting results (when not separately reported) and communicating the results
- Care coordination (when not separately reported)

Reporting Services Separately

Not everything needs to be reported as time. In the list given above, both interpreting the results and care coordination count as time *except* when separately reported. Anything that is an identifiable procedure or service with a specific CPT code that is performed on the date may be reported separately instead of within time.[26]

Medical Decision Making

Instead of billing the encounter according to time, the physician may want to charge based on medical decision making instead. This version of medical decision making has some changes when compared to the 1995 guidelines. One thing does stay the same: to achieve a specific level of medical decision making, two of the three elements must be met. The levels and elements of medical decision making are:

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[24] *CPT Evaluation and Management Office or Other Outpatient and Prolonged Services Code and Guideline Changes*, 6

[25] *CPT Evaluation and Management Office or Other Outpatient and Prolonged Services Code and Guideline Changes*, 9 – 10

[26] *CPT Evaluation and Management Office or Other Outpatient and Prolonged Services Code and Guideline Changes*, 2 – 3

Table 7

Levels and Elements of Medical Decision Making[27]

Level of MDM	Elements of MDM		
	Number and Complexity of Problems	Amount/Complexity of Data	Risk of Complication/Morbidity/Mortality of Patient Management
Straightforward	Minimal	Minimal or none	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

Number and Complexity of Problems

When the table refers to problems, it means the reason the patient came in. It can be any disease, condition, illness, injury, symptom, sign, finding, complaint, or anything addressed during the encounter. The diagnosis does not need to be established at the time of the encounter. For instance, the problem addressed in the encounter could just be a checkup to see how the patient's new medication is working for their high blood pressure. The high blood pressure would be the problem addressed for that encounter.

Minimal. This level has a single self-limited problem. A self-limited problem will run a definite course and is unlikely to alter the health status of the patient.[28]

Low. This level has two or more self-limited problems, one stable chronic illness, or one acute, uncomplicated injury. A stable chronic illness is a problem that will last a year or until the death of the patient, like diabetes. An acute, uncomplicated injury is a recent problem with low-risk morbidity. A simple sprain would be an acute, uncomplicated injury.

Moderate. A moderate level would need a chronic illness with some sort of minor complication, two stable chronic illnesses or more, an undiagnosed new problem with an uncertain prognosis, an acute illness with systemic symptoms, or an acute complicated injury. A minor complication is one where the chronic illness is getting worse but does not require hospital care. An undiagnosed new problem is a newer problem that has a high probability resulting in death if further action isn't taken. A breast lump or newly found goiter, for example. An acute illness with systemic symptoms is one that has a high risk of death without any treatment. An acute, complicated injury is one that needs an evaluation of other body systems not directly related to the injury, an extensive injury, or an injury where the treatment options increase the risk of death.

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[27] *CPT Evaluation and Management Office or Other Outpatient and Prolonged Services Code and Guideline Changes, 7 – 8*

[28] *CPT Evaluation and Management Office or Other Outpatient and Prolonged Services Code and Guideline Changes, 3*

High. This level either includes one or more chronic illnesses with a severe complication or an acute injury/chronic illness that poses a threat to life or bodily function. A severe complication is one that the progression of the illness or the side effects of treatment have a high risk of death.[29]

Amount/Complexity of Data

Data is divided into three categories. Category 1 contains a review of test results, ordering tests, or a request for an assessment requiring an independent historian. Category 2 is receiving a second opinion by another physician or other qualified healthcare professional and is not separately reported. Category 3 is a discussion of management or test interpretation with an outside physician or qualified healthcare professional that is not separately reported. Each level requires that the data meets one or more of the categories.

Minimal or none. This section has no real complex data.

Limited. The data qualifies for this section by either meeting the standards for category 1 or 2.

Moderate. The data must fall into one of the three categories.

High. The data falls into at least two of the three categories.[30]

Risk of Complication/Morbidity/Mortality of Patient Management

This one is fairly straightforward. Anything in treatment of the problem that could harm the patient increases the level of this section. For instance, the moderate level would be like prescription drug management or the diagnosis/treatment of the problem is severely hampered by health or social pressure (including money). A high-risk level would involve major emergency surgery or monitoring highly toxic medicine.[31]

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[29] *CPT Evaluation and Management Office or Other Outpatient and Prolonged Services Code and Guideline Changes,* 4

[30] *CPT Evaluation and Management Office or Other Outpatient and Prolonged Services Code and Guideline Changes,* 7 – 8

[31] *CPT Evaluation and Management Office or Other Outpatient and Prolonged Services Code and Guideline Changes,* 8

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Appendix

Current Procedural Terminology

Current Procedural Terminology, or CPT, is a set of codes created by the American Medical Association. They were created originally in 1966 as a way to standardize the language of

medical professionals.[32] Over the years it has grown from just medical terminology about procedures and diseases to *the* system of terminology and documentation for healthcare professionals. Let's go over briefly what is within this set of terminology.

What's in CPT?

The American Medical Association divides the CPT into three separate categories, Category I, Category II, and Category III. Below is a brief description of each category.

Category I

This is by far the biggest category and chances are what most healthcare professionals are going to use. It contains most medical, administrative, and procedural categories. It is divided into six sections, Evaluation and Management, Anesthesiology, Surgery, Radiology, Pathology and Laboratory, and Medicine.

Evaluation and Management

It contains codes for medical documentation and services rendered. Doctor's office visits, nursing homes, home care, and preventative medicine are included in this section. It also contains specific standards and practices on how to bill patients. Even within Category I, healthcare professionals will be using these codes the most, as they contain general care.[33]

Anesthesiology

This section is all about sedations. This includes general, local, and conscious sedation.[34]

Surgery

These surgical codes are divided up by which body system is operated on.[35]

Radiology

This section is focused on the use of all types of radiation in the medical field. This applies to medical imagine, like x-rays, ultrasound, and other diagnostic radiology tests, but also nuclear medicine.[36]

Pathology and Laboratory

Pathology and Laboratory includes all specialized lab work and tests. It also includes lab consultations.[37]

Medicine

This section is for treatment, rehabilitation, medicine distribution, and therapy. It also includes codes for products, not just services.[38]

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[32] *Current Procedural Terminology: History, Structure, and Relationship to valuation for the Neuroradiologist,* 1972
[33] *Medical Billing and Coding Certification*, 49
[34] *Medical Billing and Coding Certification,* 156
[35] *Medical Billing and Coding Certification,* 50
[36] *Medical Billing and Coding Certification,* 160
[37] *Medical Billing and Coding Certification,* 208
[38] *Medical Billing and Coding Certification,* 162

Category II

Category II is a set of alphanumeric codes that help define some of the procedures found in Category I and Category III. As they help the other sections, this one is not required for use nor can it be used to replace codes from the other categories.

For instance, say that a patient was in a car accident and an x-ray of their chest was taken. That x-ray would use a radiology code from Category I. A healthcare professional can supplement that with a 3006F to note that the x-ray was documented and reviewed.[39]

Category III

These codes are for new technology and experimental procedures. While there is a code in Category I for unlisted procedures, using these helps governmental agencies gather data on how a new procedure or technology is widely-used or working properly.[40]

[39] *Medical Billing and Coding Certification,* 52
[40] *Medical Billing and Coding Certification,* 53