Chapter Five

EVALUATION AND MANAGEMENT

Evaluation and Management (E/M) services describe face-to-face visits which are rendered by clinical providers. These visits are reported either by time spent with the patient or by the level of evaluation performed on a patient and the site of service in which the evaluation took place. The physician performs and reports E/M codes and it is his documentation that must support the level of service for which he bills. Only the provider is aware of what he actually does when performing an evaluation of a patient and only the provider is able to appropriately transfer the "language" of the evaluation he performs (dictation) into its numeric coding equivalent. The coder is, however, responsible to make sure that the provider's definition of what he has performed is accurate, that his documentation indeed meets the level of service reported, and, if other services were performed in addition to the E/M on the same date of service, that the appropriate modifiers are utilized for all services provided including the E/M service.

This chapter focuses on a variety of issues in E/M coding scenarios where the coder will be directly responsible to ensure that the provider maintains accuracy, consistency and compliance in the reporting of these services.

The key components for determining what E/M code to report include location of service, status of patient (new or established) and level of service documented. Time and counseling/coordination of care criteria are additional measures used to determine E/M code selection.

A **new** patient is a patient who has not received any professional services (regardless of the site of service) from the physician or another physician within the same group in the same specialty within the past **three** years.

An **established** patient is a patient who has received professional services (regardless of site of service) from the physician or another physician within the same group in the same specialty within the past three years.

To determine the key components required for documentation purposes to choose a particular level of service, refer to the three bullets listed under each level of service and follow the guidelines as listed for each component.

Time based codes require that the total time of the encounter be documented in the medical record. Where the time is not documented in the medical record, the time-based codes may not be used.

When **counseling and coordination of care dominate over 50%** of the entire encounter of the patient, the time must be documented and the level of service is chosen based on the time indicated in the level of service descriptor. The documented time is utilized in lieu of the three key components to determine the appropriate overall level of service.

No distinction is made between new or established patients presenting to the ER or for initial consultative services, nursing facility services, and counseling and/or risk factor reduction codes.

Evaluation and Management Code Sections Defined

Office or Other Outpatient Services (99201-99215) codes are used to report services provided in the physician's office or other outpatient facility (i.e.: E/R).

Hospital Observation Services (99217-99226) codes are used to report services provided to patients designated as "observation status" in a hospital. The common time frames for the patient in observation status is not less than 12 hours, an average stay of 23 hours, and not more than 48 hours. These services are billed per calendar day of the patient designated as "observation status". These codes are utilized for patients admitted to observation on one date of service and discharged from observation on a different date of service.

Hospital Inpatient Services (99221-99239) codes are used to report evaluation and management services provided to hospital inpatient services. These codes are also utilized for services provided to patients in a partial hospital setting. The initial inpatient codes are utilized for admissions to the hospital (H&P). The subsequent hospital codes are used for all follow-up visits after the initial admit to the inpatient settings.

Observation or Inpatient Care Services (99234-99236) codes are used to report services provided to patients who are admitted to observation status or inpatient hospital care and discharged on the same date of service.

Hospital Discharge Services (99238-99239) codes are used to report the total duration of time spent by a physician for final hospital discharge of a patient. The codes include, as appropriate, final exam of the patient, discussion of the hospital stay (even if the time spent by the physician on that date is not continuous), instructions for continuing care to all relevant care givers, and preparation of discharge records, prescriptions and referral forms. The discharge codes are used for patients admitted to the inpatient setting on one date of service and discharged on a different date of service.

Office or Other Outpatient Consultations (99241-99245) codes are used to report consultations provided to patients in the physician's office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, custodial care, or emergency department. As of 2010, Medicare no longer recognizes consult codes for payment. Refer to codes 99201-99215 for accurate reporting to Medicare.

A **consultation** is a service provided by a physician whose opinion or advice regarding the treatment of a patient is requested by another physician or appropriate source.

Physicians providing consultative services may initiate diagnostic or therapeutic services. The physician providing the consultation must document who requested the consult be done and a copy of the medical record must be forwarded to the physician who requested the consult be done.
Consultations requested by the patient or the patient's family and not requested by another physician is not reported using these codes.

Initial Inpatient Consultations (99251-99255) codes are used to report consultations to patients in the inpatient hospital setting, residents of nursing facilities, or patients in a partial hospital setting. As of 2010, Medicare no longer recognizes consultation codes for payment. Refer to codes 99221-99223 to report correctly to Medicare.

As of 2010 Medicare no longer recognizes CPT codes for consultations. Many private payers have followed Medicare's guidance; however, many still recognize reporting for consultation codes.

Emergency Department Services (99281-99285) codes are used to report services provided in the emergency department. An emergency department is a hospital-based facility providing services for unscheduled episodic visits to patients who present for immediate medical attention. The facility must be available 24 hours a day.

Other Emergency Services (99288) code is used in physician directed emergency care, advanced life support where the physician is located in the hospital emergency or critical care department, and is in two-way voice communication with ambulance or rescue personnel outside the hospital.

Critical Care Services (99291-99292) codes are used to report services provided to patients who are unstable, critically ill or critically injured. These codes are time-based codes and the time must be documented in order to utilize them.

There are certain services that are inclusive of critical care services. These services are listed in the critical care subsection guidelines under E/M.

Nursing Facility Services (99304-99318) codes are used to report services provided to patients in Skilled Nursing Facilities, Intermediate Care Facilities, or Long-term Care Facilities. These codes should also be used to report services provided to patients in a psychiatric residential treatment facility for psychiatric care. The codes 99304-99306 cover the initial care. Codes 99307-99310 are used for follow-up visits where the patient is being treated for a medical condition. Nursing facility discharge codes are reported using codes 99315-99316. Annual nursing facility assessments are reported using code 99318.

Domiciliary, Rest Home, or Custodial Care Services (99324-99340) codes are used to report E/M services provided in a facility which provides room and board as well as other personal assistance services. The facilities services do not include a medical component.

Home Services (99341-99350) codes are used to report services provided to patients in a private residence.

Prolonged Services (99354-99416) codes are used to report services provided in the inpatient or outpatient setting that is beyond the usual services. These codes are time-based codes and may not be used as standalone codes. The service is provided in addition to other physician E/M services.

Physician Standby Services (99360) code is used to report physician standby services requested by another physician where the physician is on standby to determine if his services are required for treatment. If the physician participates in treating the patient, the standby code is not used. An example of the use of this code would be a neonatologist who presents to the hospital and remains on standby to possibly treat a neonate who may need to be evaluated for problems due to the mother's complicated birth.

Case Management Services (99366-99368) codes are used to report medical conferences with other physicians participating in the care of a particular patient and telephone calls. Medical conference codes are based on time and the telephone calls are based on the complexity of the call.

Care Plan Oversight (99374-99380) codes are used to report physician time spent working on the treatment plans of patients in nursing homes, hospice care, and home health care. These codes are time-based codes and are billed in thirty-day intervals per day.

Preventative Care Services (99381-99397) codes are used to report preventative services provided to infants, children, adolescents, and adults. The codes are based on the age of the patient and on the status of whether the patient is new or established.

Counseling and/or Risk Factor Reduction (99401-99429) codes are used to report services provided to patients for the purpose of promoting health and preventing illness or injury. An example of this type of service would be a visit of a patient who is at high risk for a heart attack due to obesity. The visit would address a weight loss program for the patient.

Telephone and Online Medical Services (99441-99444) codes are used to report telephone calls, conference calls and online assistance for patients by providers.

Interprofessional Telephone/Internet Assessment and Management Service (99446-99449) codes are reported for services provided by a consulting physician coordinating the care of the patient through telephone and internet communication. Consultative services are documented and results forwarded to the referring physician or other qualified provider. These codes are time-based codes.

Basic Life and/or Disability Exam (99450) code is used to report life or disability exams prior to insurance certificates being issued.

Work Related or Medical Disability Evaluation Services (99455-99456) codes are used to report services provided to patients for IME's and disability assessments performed by the treating physician (99455) and by a physician other than the treating physician (99456).

Newborn Care Services (99460-99465) codes are used to report E/M services rendered to newborns. These codes include initial and subsequent care of newborn as well as attendance and resuscitation services.

Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services (99466-99486) codes are used to report pediatric critical care transport services as well as critical care services provided to a neonatal or pediatric patient who is critically ill in the inpatient setting.

Complex Chronic Care Coordination Services (99487-99490) codes are used to report services provided to patients in one of the following settings: home, domiciliary, rest home or assisted living facility.

Transitional Care Management Services (99495-99496) codes are used to report transitional care provided to patient moving from inpatient hospital setting to patient community home setting.

Advance Care Planning (99497-99498) codes are used to report face-to-face services for counseling and discussion of future care of a patient with either the patient, patient's family, or surrogate.

Other Evaluation and Management Services (99499) code is used to report E/M service that is not adequately reported utilizing any of the E/M visit codes provided.

Evaluation and Management Modifiers

-21 Prolonged Evaluation and Management (E/M) services - Use only with highest level of care code for the category when the face-to-face or floor/unit service provided is prolonged or otherwise greater than that usually required for the highest-level code within an E/M category.

-24 Unrelated E/M Service by the Same Physician During a Postoperative Period – The physician may indicate that an E/M service was provided during the postoperative period of a procedure for a reason unrelated to the procedure.

-25 Significant, Separately Identifiable E/M Service by the Same Physician on the Same Date of Service of a procedure or Other Service – The physician may need to indicate that on a day that a procedure or service was performed a separate and identifiable E/M service was provided.

-27 Multiple Outpatient Hospital Evaluation and Management Encounters on the Same Date – Utilized for E/M codes reported in the outpatient hospital setting when more than one is reported for the same date of service. This modifier should never be used by physicians to report multiple E/M codes on same date for professional services.

-32 Mandated Service – Services provided which have been mandated by a third-party payer or Peer Review Organization.

-52 Reduced Service – Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician. The meaning of the service is not changed; a portion of the service is not performed (only preventative services). For Preventive Medicine E/M codes modifier 52 will be considered valid to report an annual women's exam when other systems usually included in an age appropriate preventive exam are not addressed.

-57 Decision for Surgery – An E/M service that resulted in the initial decision to perform surgery. This modifier is used only when the procedure is a major surgery requiring "preoperative" clearance. The modifier is utilized only when the decision for surgery is the day of or the day before the surgical procedure.

-95 Telemedicine Service – Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System. The symbol for telemedicine is a star.

Evaluation and Management Documentation Guidelines

Proper documentation of services by providers has been a primary focus of CMS and other payers for some time now. Evaluation and management services provided by physicians and non-physician practitioners must meet certain documentation criteria so that the appropriate level of service is chosen accurately. Nurses seeing patients in office settings may only code for an established patient visit and only when the physician or other clinical provider does not see the patient on the same date. If the nurse is the only person to see the established patient in an office setting, the nurse may report code 99211 for the service.

Physicians, practitioners and other provider types may use any of the E/M code categories, regardless of their specialty area unless described otherwise by the code.

There are seven elements that are used in defining the level of service for E/M. These elements are:

- **History**
- **Exam**
- **Medical decision making**
- **Counseling**
- **Coordination of care**
- **Nature of presenting problem**
- **Time**

Of the elements listed above, there are three **key** components, which are history, exam and medical decision-making. Each component is broken into further classifications and a point system in each category is utilized to obtain the correct overall level of service.

Counseling, coordination and nature of presenting problem are called **contributory** elements. Although important factors in the evaluation of a patient, it is not required that counseling and coordination of care services be provided at every patient encounter.

The time factor is utilized for time-based E/M services. Discharge from the hospital and critical care services are examples of E/M services that are billed utilizing time.

New patient or new problem visits (those E/M services where there is no differentiation between new and established patient are considered new i.e.: ER services) require that three of three key components be met on the same level to justify use of the overall level chosen (per documentation).

Established patient visits require that two of the three key components be met on the same level to justify use of the overall level chosen (per documentation).

There are two sets of E/M documentation guidelines that are used to determine the appropriate level of service for visits: 1995 guidelines and 1997 guidelines. The differences are discussed within each key component listed below.

The guidelines for reporting E/M levels of service are different for professional services (physicians) versus outpatient hospital technical services (facility). Differences are discussed separately below.

E/M Level of Service Determination for Professional Services

The **three key components** are broken down into further sub-classifications, which provide the reporting mechanism justifying the level of service indicated on the claim.

History: The history portion of the E/M includes the following elements in determining the overall level of service. The history requires 3 of 3 key categories be met to choose a particular level of overall history of the patient.

- Chief Complaint
- History of Present Illness
- Review of Systems
- Past, Family, and Social History

The **HPI** requires a description of the illness for which the patient is being seen. The following factors must be reviewed and described within the HPI to account for the appropriate level within the HPI: location, duration, severity, quality, associations, modifying factors, timing, and context.

The difference for the history component between 1995 and 1997 guidelines lies within the reporting of the HPI. In 1995 guidelines, the HPI requires a detailed review of four of seven factors related to the HPI; whereas, in 1997 guidelines, the provider may document the status of three chronic illnesses in order to meet the highest level of HPI within the category.

The **review of systems** portion of the history requires a review of one or more of the following systems as it relates to the problem that the patient is presenting with: constitutional, eye, ENT, cardiovascular, respiratory, allergies, GI, GU, skin, neurology, psychiatric, endo, heme, and musculoskeletal.

PFSH covers the patient past, family and social history that may be contributing factors of the condition for which the patient has presented.

The overall level of documented history requires that all three of three components of the HPI, ROS and PFSH must be documented on the same level to report that specific level of service.

The E/M services recognize four levels of history that are defined as follows:

Problem focused – equivalent to a new patient level one service and an established patient level one or two service.

Expanded Problem Focused – equivalent to a new patient level two service and an established patient level two or three service.

Detailed – equivalent to a new patient level three service and an established patient level four service.

Comprehensive – equivalent to a new patient level four or five and an established patient level five.

Exam: The exam is broken down into organ systems and body areas.

In 1995 guidelines, a combination of body systems and areas must be reviewed to determine the appropriate exam level. 1997 guidelines require that a specific number of bullets within the body system be documented in order for the particular level of service to be chosen.
The following body systems are recognized:

- Eyes
- Ears, Nose, Mouth & Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal

- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

The following body areas are recognized for the 1995 guidelines:

- Head, including face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, & buttocks
- Back
- Each extremity

The E/M services recognize four levels of exam that are defined as follows:

Problem focused – equivalent to a new patient level one service and an established patient level one or two service.

Expanded Problem Focused – equivalent to a new patient level two service and an established patient level two or three service.

Detailed – equivalent to a new patient level three service and an established patient level four service.

Comprehensive – equivalent to a new patient level four or five and an established patient level five.

Medical Decision Making: Diagnosis/management options
Amount and/or complexity of work
Risk factor

The **diagnosis/management options** cover the number of diagnoses and management options for which the patient is diagnosed and the management options that the provider refers the patient for (i.e.: testing, medication, etc).

The **amount and complexity of work** covers the preparation for a visit and/or follow-up work required including obtaining, reviewing and analyzing of medical records, diagnostic tests and other patient information.
The **risk factors** relate to documentation of the risk factors, complications and/or mortality and morbidity rate for the patient's presenting problem.

Two of three components of medical decision making must be documented to report a specific level of service.
The E/M services recognize four levels of medical decision making that are defined as follows:

Straightforward – equivalent to a new patient level one service and an established patient level one or two service.

Low Complexity – equivalent to a new patient level two service and an established patient level two or three service.

Moderate Complexity – equivalent to a new patient level three service and an established patient level four service.

High Complexity – equivalent to a new patient level four or five and an established patient level five.

History and Exam Differences in 1995 vs. 1997 E/M Guidelines

HPI

- ✓ 1995 documentation guidelines – should describe four or more elements of the present HPI or associated comorbidities.
- ✓ 1997 documentation guidelines – should describe at least four elements of the present HPI or the status of at least three chronic or inactive conditions.

Exam

1995 Guidelines

The 1995 documentation guidelines count the number of overall body organs and body areas that are reviewed and documented by the provider to determine the appropriate exam level of service. There are **seven body areas** (head: including face, neck, chest: including breasts and axilla, abdomen, genitalia, groin and buttocks, back and each extremity) and **eleven body systems** (eyes, ENT, cardiovascular, respiratory, GI, GU, musculoskeletal, skin, neurologic, psychiatric, and hematologic, lymphatic and immunologic systems) that are recognized for 1995 exam. There are no specific requirements or bulleted elements within these body areas and body systems that are required to be documented by the provider within these body areas and systems as there is with the 1997 guidelines. The provider simply needs to address the body areas and systems to count the appropriate exam
level. A PF examination should include findings in 1-2 organ systems, EPF should include 2-5 organ systems, detailed should include 5-7 organ systems and comprehensive should include eight or more organ systems. In 2017, the EPF and detailed examination requirements were updated.

1997 Guidelines

A **general multi-system examination** involves the examination of one or more organ systems or body areas, as depicted in the exam categories and descriptions in the following table. The exam types may be problem focused, expanded problem focused, detailed or comprehensive as determined by the presenting problem of the patient.

TYPE OF EXAMINATION	DESCRIPTION
Problem Focused	Include performance and documentation of one to five elements identified by a bullet in one or more organ system(s) or body area(s)
Expanded Problem Focused	Include performance and documentation of at least six elements identified by a bullet

	in one or more organ system(s) or body area(s).
Detailed	Include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet is expected. Alternatively, may include performance and documentation of at least twelve elements identified by a bullet in two or more organ systems or body areas.
Comprehensive	Include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by bullet is expected.

A **single organ system examination** involves a more extensive examination of a specific organ system, as depicted in the chart below.

TYPE OF EXAMINATION/DESCRIPTION	
Problem Focused	Include performance and documentation of one to five elements identified by a bullet, whether in a box with a shaded or unshaded border.
Expanded Problem Focused	Include performance and documentation of at least six elements identified by a bullet, whether in a box with a border.
Detailed	Examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet, whether in a box with a shaded or unshaded border. Eye and psychiatric examinations include the performance and documentation of at least nine elements identified by a bullet, whether in a box with a shaded or unshaded border.
Comprehensive	Include performance of all elements identified by a bullet, whether in a shaded or unshaded box.

Documentation of every element in each box with a shaded border and at least one element

Both types of examinations may be performed by any physician, regardless of specialty.

Some important points that should be kept in mind when **documenting general multi-system and single organ system examinations** (in both the 1995 and the 1997 documentation guidelines) are:

- ✓ Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is not sufficient.
- ✓ Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.
- ✓ A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

The OIG provided a report in May 2012 that discussed the coding trends of E/M services reported to Medicare and the increase of the percentage of higher levels of E/M services reported with the use of EMR systems to assist in providing documentation assistance. The report states that, since EMR systems have been instituted in the healthcare environment, providers are misusing EMR systems and therefore, levels of E/M services have steadily increased (the report references the mandate of ACA electronic medical records in 2010 as starting point of the data collection).

The report also points to abuse of 'cut and paste' functions as the cause of these incorrect code assignments. When providers (including nurses, scribes and other clinical providers entering data into the EMR system) see established patients, many times they will forward data from previous notes so that they do not have to retype the ROS, past history or current medication list. This process creates errors in documentation and the same wording in every note without changes can trigger an audit trail. These are issues that the OIG report focused on and continues to have on the OIG Workplan each year since 2010. The OIG Compliance Work Plan continues to monitor E/M levels for professional services as well.

OIG CODING TRENDS OF MEDICARE EVALUATION AND MANAGEMENT SERVICES

Figure 1: Percentage of E/M Codes Billed for Established Patient Office Visits From 2001 to 2010

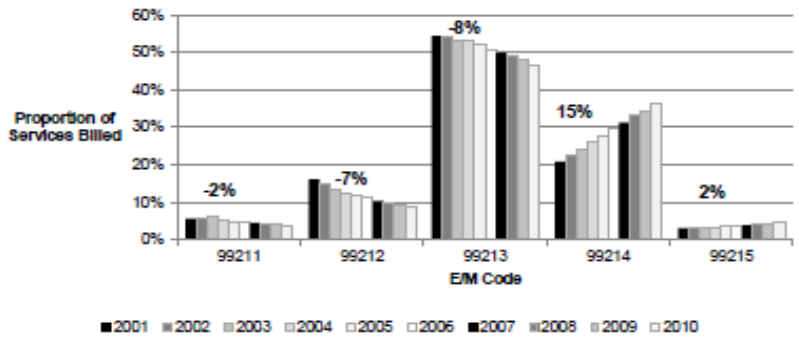
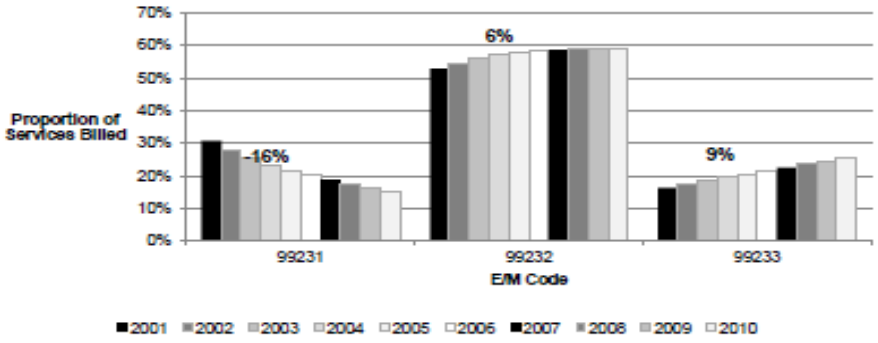
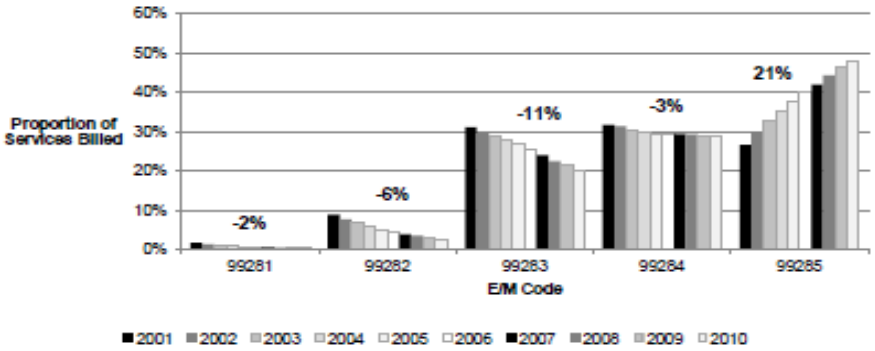


Figure 2: Percentage of E/M Codes Billed for Subsequent Inpatient Hospital Care From 2001 to 2010



Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

Figure 3: Percentage of E/M Codes Billed for Emergency Department Visits From 2001 to 2010



*Percentages do not sum to zero because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

AMA Changes to E/M Reporting Coming in 2021

There are a number of changes coming to reporting guidelines for E/M in 2021 that will impact accurate code assignment for office visit E/M code ranges 99201-99205 (New Patient) and 99211-99215 (Established Patient). These changes include:

- Deletion of level 1 new patient office visit code 99201
- Development of new guidelines for code range 99202-99215
- Changes in how to score various components of history and exam for both new and established office visit codes 99202-99215
- Changes to the definitions/categories of medical decision-making component for 99201-99215
- Changes to the previously defined "typical" times associated with each E/M office visit code to overall face-to-face time spent with patient by the treating provider
- Development of 15-minute incremental code (s) for Prolonged Service code to better represent additional physician/QHP time. The time for prolonged services is changed to a single 15-minute increment code and would only be reported with codes 99205 and 99215 and only when time was the primary basis for code selection.

Main changes in determining E/M code levels starting 2021

Documentation of the history and exam will still need to be provided in the patient record for each visit, however, the point system for the amount of history and the number of elements examined will no longer be a factor for determining the overall E/M level of service.

The key basis for code selection in 2021 will be determined solely on the level of MDM performed *or* the **"total"** (not typical) time spent performing the E/M service. The typical times currently used will be changed to new total time components for each level of service.

The time component for current Prolonged Service time-based codes for Office or Other Outpatient Visits 99354 1st hour and 99355 each additional 30 minutes (direct face-to-face service) have been updated as well to better reflect prolonged time spent during the face-to-face visit by the rendering provider. The incremental time for these codes will be in 15-minute intervals in lieu of the current 1st hour and each additional hour incremental time. Likely there will be only one code to report each 15-minute time frame above and beyond the face-to-face time represented by codes 99205 and 99215 (the highest levels of service for New and Established Office or Other Outpatient Visit E/M codes).

Note that these proposed changes are made by the AMA and considered only for CPT coding. Payers may have different models to calculate the E/M code levels. Upon creation of these new guidelines proposed by the AMA, CMS concurred and partnered with the AMA to incorporate these changes in the 2019 CMS Physician Fee Scheduled Proposed Rule released in August 2019. Be sure to confirm how other individual payers will be implementing any E/M changes that begin in 2021.

The new AMA guidelines for MDM & calculation of time are shown in the table below.

2021 MDM & Time Changes Table

CPT Year	Medical Decision Making			Time
2019	**Number of Diagnosis or management options**	**Amount and/or complexity of data reviewed**	**Risk of complications and/or morbidity or mortality**	**Typical time (includes face-to-face, counseling and coordination of care)**
2021	**Number and complexity of problems addressed**	**Amount and/or complexity of data reviewed and analyzed**	**Risk of complications and/or morbidity or mortality of patient management**	**Total time**

E/M Level of Service Determination for Outpatient Hospital Facility Services

The level of service for E/M charges in the outpatient hospital setting are determined utilizing a **level of risk** of the patient and the testing required to determine diagnosis and treatment options for the level of risk. Each individual hospital is responsible for developing a point system that justifies the level of service being reported for the hospital component. The level of service reported by the hospital (technical) does not have to match the level of service reported by the provider (professional services).

While each hospital develops their own E/M level of service criteria, there is a guide that provides recommendations for standard reporting of E/M codes in the emergency room and clinic areas of the hospital outpatient setting. The guide is
a joint effort between the American Hospital Association and American Health Information Management Association and was written in June of 2003 when the reporting of E/M first came about in the hospital setting.

 For additional information from CMS on current 2019 E/M coding Guidelines visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html.