2019

Evaluation and Management Coding Advisor

Advanced guidance on E/M code selection for traditional documentation systems

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Contents

Chapter 1: An Introduction and Overview of E/M Coding

The evaluation and management (E/M) service codes, although some of the most commonly used codes by physicians of all specialties, are among the least understood. These codes, introduced in the 1992 CPT® book, were designed to increase accuracy and consistency of use in the reporting of levels of cognitive encounters. This was accomplished by defining the E/M codes based on the degree that certain elements common to cognitive services are addressed or performed and reflected in the medical record documentation. E/M codes have specific elements identified that must be documented to meet the level of care reported.

At the same time the E/M codes were introduced, the American Medical Association (AMA), in conjunction with other organizations, released general documentation guidelines. Over time the link between good patient care and good documentation has been realized. Documentation has gained importance not only for substantiating the services rendered for reimbursement but also for continuity of care with so many providers choosing specialty medicine, an increase in the use of electronic health record systems, the greater specificity found in ICD-10-CM coding, and even litigation support.

Origin and Development of Evaluation and Management Codes

The AMA and the Centers for Medicare and Medicaid Services (CMS) developed the evaluation and management service codes in an effort to provide a more objective framework to represent services provided to patients and more clearly define work performed by the provider. These E/M codes were developed to replace codes that described brief, intermediate, and comprehensive visits in order to classify medical visits not only on the basis of time but also by the site of service, type of patient, and patient status.

Medicare physician payment was originally based on a calculation of the customary, prevailing, and reasonable cost.

In 1985, Congress authorized the development of a Medicare physician fee schedule (MFPS) based on the physician resources expended while rendering a medical service (e.g., skill, knowledge, specialty training, and time). Medicare's resource based relative value scale (RBRVS) measures the resources (i.e., physician work, practice expense, and malpractice expense) expended when physicians perform services and procedures. The resource costs of evaluation and management services were analyzed extensively as part of Medicare's RBRVS study.

Because studies determined that the duration of the face-to-face encounter with the patient was directly linked to the total amount of work, which did not increase proportionately with encounter time, CMS set the relative value

Objectives

This chapter discusses:

- General overview of coding and documentation of evaluation and management (E/M) services
- The history and origin of E/M coding
- Telehealth and E/M coding
- The development of E/M codes
- The definitions of E/M services and the current E/M documentation guidelines pertaining to them
- Audit risks
- Types of documentation issues
- The format of this book

Definitions

customary, prevailing, and reasonable charge, Categories that were the basis for Medicare's reimbursement rates before the resource based relative value scale (RBRVS) was implemented. These rates were based on the lowest charge of the three categories rather than the relative values of each service, which caused wide variations in Medicare payments among physicians and specialties. "Customary" is the term that described a clinician's historical charges while "prevailing" represented the charges of other providers in the same specialty type residing in the same general locality and "reasonable" was the lowest charge of all three categories.

For More Info

Additional information on the *Physicians' Current Procedural Terminology* (CPT®) can be found at https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology.

Chapter 2: The Building Blocks of E/M Coding

The levels of evaluation and management (E/M) services define the wide variations in skill, effort, time, and medical knowledge required for preventing or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent provider work—mostly cognitive work. Because much of this work revolves around the thought process, and involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code appears to be complex, but the system of coding medical visits is actually fairly simple once the requirements for code selection are learned and used.

OBJECTIVES

This chapter discusses:

- The levels of evaluation and management (E/M) services
- Component sequence and code selection
- How to identify elements of the key components
- How to use AMA tables
- How to recognize contributory components
- The relationship between E/M coding and appropriate ICD-10-CM code selection
- Definitions of common terms
- Why documentation of the key and contributing components is important

LEVELS OF E/M SERVICES

Codes for E/M services are categorized by the place of service (e.g., office or hospital) or type of service (e.g., critical care, observation, or preventive medicine services). Many of the categories are further divided by the status of the medical visit (e.g., new vs. established patient or initial vs. subsequent care).

A **new patient** is defined by the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) as one who has *not* received any professional services from a provider of the exact same specialty and subspecialty from the same group practice within the last three years. An **established patient** is defined as one who *has* received a professional service from a provider of the exact same specialty and subspecialty from the same group practice within the last three years. If the patient is seen by a physician who is covering for another physician, the patient will be considered the same as if seen by the physician who is unavailable.

The narrative descriptions for the levels of most E/M services include seven components. The key components—history, examination, and medical decision making—are most often used to select the appropriate level of service code. Information regarding at least two of the three key components for inpatient or outpatient follow-up visits—and all three for consults and inpatient or outpatient initial visits—must be performed and documented in the patient's record to substantiate a particular level of service.

The four remaining components are called "contributory components" and are: nature of the presenting problem, counseling, coordination of care, and time.

The various levels of service for each component are described on the following pages and include requirements under both the 1995 and 1997 E/M guidelines.

Chapter 3: The Elements of Medical Documentation

Medical documentation furnishes the pertinent facts and observations about a patient's health, including past and present history, tests, treatment and medications, and outcomes. The primary purpose of the medical chart is continuity of patient care. An accurate and complete medical chart protects the patient by providing complete information about the patient's history, current health status, and the effectiveness of past and current therapy. An accurate and comprehensive medical chart can also protect the physician, when necessary, in liability actions.

The medical chart also provides the information that supports the ICD-10-CM and CPT®/HCPCS codes used to report the services provided and submitted to various payers for reimbursement. Therefore, it is absolutely essential that the medical record—whether office, emergency department, or hospital—is complete and concise and contains all information regarding the following:

- Reason for the encounter
- Complete details of the information provided by the patient and by the clinician's evaluation of the patient
- Results of diagnostic, consultative, and/or therapeutic services provided to the patient
- Assessment of the patient's conditions
- Plan of care for the patient, including advice from other physician specialists
- Other services, procedures, and supplies provided to the patient
- Time spent with the patient for counseling and/or coordination of care, if applicable

The style and form of medical documentation depends on the provider, as demonstrated by the samples of documentation included in this book. However, it is important that any reader of the medical record be able to understand, from the documentation, the service rendered and medical necessity for the service.

In addition, the medical documentation must be legible and understandable for all providers who care for the patient. If the handwriting of the provider cannot be read, Medicare auditors, as well as other payers, consider the service to be unbillable.

Abbreviations or shorthand used in medical record documentation should be listed on an identification key accessible to all who read the documentation. Abbreviation lists should be specific to the facility or practice and identify abbreviations that have more than one applicable definition.

All entries should be dated and legibly signed according to the *Evaluation and Management Services Guide*, revised by CMS in December 2010. It is recommended that the signature also include credentials (e.g., MD, DO,

OBJECTIVES

This chapter discusses:

- The principles of documentation
- SOAP and SNOCAMP formats
- Common documentation deficiencies
- Electronic health records (EHR) and documentation

QUICK TIP

Documentation should contain only commonly accepted abbreviations. Specialty-specific abbreviations should be approved by the facility HIM department before they are used in documentation.

KEY POINT

Authentication of documentation is the key to identifying the author, credential, and date of service. Addendums should be dated when written and refer to the date they are modifying.

Chapter 4: Adjudication of Claims by Third-Party Payers and Medicare

The following are medical documentation guidelines many third-party payers use when reviewing claims for accuracy of payment or when performing an audit. Many commercial reviews are geared more towards medical necessity than evaluation and management (E/M) documentation guidelines, as many of the third-party payers have not formally adopted federal documentation guidelines. If they have done so, this should be clear in any contracting language relative to chart or service audit activity. Also, be sure you thoroughly examine your provider's manual, as provided by your third-party payers. Often, if a payer requires one set of documentation guidelines over another, the provider manual is where you will find that information. Your contract with that payer typically binds your practice to follow the rules as set forth in the provider's manual.

Although the specific federal guidelines may not be required by any given payer, it is a prudent policy to have providers document to the level of the highest requirements. Some facilities and practices bill E/M codes based on payer type, and have lesser documentation standards for nongovernmental payers. Though legal at this time, because contractual arrangement supersedes general conventions, this may not be the wisest course. Providers should likely be taught one set of coding and documentation requirements for all patients for at least two reasons: 1) Does the practice truly always know what coverage is in effect on a given day, and who secondary payers might be? and 2) It is hard enough for providers to remember one set of rules much less different rules for different payers. Following a single set of coding and documentation requirements is much safer for practices from a compliance perspective.

OBJECTIVES

This chapter discusses:

- Documentation guidelines that payers use
- How documentation supports medical necessity
- Documentation aids

KEY POINT

Using only one set of documentation guidelines helps providers to be consistent in providing an accurate record of the encounter or procedure.

MEDICALLY NECESSARY SERVICES

Appropriate documentation is important to substantiate services as medically necessary. For a service to be deemed medically necessary, most third-party payers expect the service to be medically required and appropriate for diagnosing and treating the patient's condition and consistent with professionally recognized standards of medical care.

Claims reviewed for medical necessity are usually reimbursed based on the medical documentation supporting the level of service selected. If the documentation does not verify the level of service code reported, the third-party payer, upon review of the documentation, may assign a lesser level of service code and pay accordingly.

Many payers may also use background edits that will evaluate the reported diagnoses with the level of E/M service reported. This is not an invitation to over-diagnose the patient as manual review of the documentation will not support a higher level of care. During a chart audit, many payers, as

Chapter 5: Office or Other Outpatient Services (99201–99215)

New Patient (99201–99205)

Quick Comparison

Office or Other Outpatient Services—New Patient

E/M Code	Medical Decision Making[1]	History[1]	Exam[1]	Counseling and/or Coordination of Care	Time Spent[2] Face to Face (avg.)
99201	Straight-forward	Problem focused	Problem focused	Consistent with problems and patient's or family's needs	10 min.
99202	Straight-forward	Expanded problem focused	Expanded problem focused	Consistent with problems and patient's or family's needs	20 min.
99203	Low complexity	Detailed	Detailed	Consistent with problems and patient's or family's needs	30 min.
99204	Moderate complexity	Comprehensive	Comprehensive	Consistent with problems and patient's or family's needs	45 min.
99205	High complexity	Comprehensive	Comprehensive	Consistent with problems and patient's or family's needs	60 min.

1 Key component. For new patients, all three components (history, exam, and medical decision making) must be adequately documented in the medical record to substantiate the level of service reported and are crucial for selecting the correct code.

2 Time is not considered a key element; this information is provided here only as a guideline for assigning the appropriate level of service. Scenarios during which time becomes the critical factor in deciding the appropriate level of service include encounters for counseling and/or coordinating of care, when these services constitute more than 50 percent of the time spent with the patient and/or family. This includes time spent with patient family members or others who will assume responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents, person acting in locum parentis, legal guardian).

General Guidelines

- Use these codes if the patient has not been seen or had a professional service provided by this physician/qualified healthcare professional or any other physician/qualified healthcare professional from the same practice and exact same specialty and subspecialty in the past three years.
- Consider using the appropriate critical care code instead of these codes if the physician/qualified healthcare professional provided constant care to a critically ill patient. Critical care codes are based on the patient's condition, not the site of service, and are selected according to time spent in attending the patient.
- Consider assigning the appropriate consultation code instead of these codes if the provider provided an opinion or advice about a specific problem at the request of another provider or other appropriate source.
- Report only the appropriate initial hospital care, hospital observation, or comprehensive nursing facility assessment code if the patient was

✓ Quick Tip

A new patient is one who has not received professional services during the last three years from:

- This physician/qualified healthcare professional
- A physician/qualified healthcare professional of the exact same specialty and subspecialty in the same group practice

Subsequent Hospital Care and Hospital Discharge Services (99231–99239)

QUICK COMPARISON

Hospital Inpatient Services—Subsequent Care[1]

E/M Code	Medical Decision Making[2]	History[2]	Exam[2]	Counseling and/or Coordination of Care	Time Spent Face to Face (avg.)
99231	Straightforward or low complexity	Problem focused interval	Problem focused	Consistent with problems and patient's or family's needs	15 min.
99232	Moderate complexity	Expanded problem focused interval	Expanded problem focused	Consistent with problems and patient's or family's needs	25 min.
99233	High complexity	Detailed interval	Detailed	Consistent with problems and patient's or family's needs	35 min.
99234	Straightforward or low complexity	Detailed or comprehensive	Detailed or comprehensive	Consistent with problems and patient's or family's needs	40 min.
99235	Moderate complexity	Comprehensive	Comprehensive	Consistent with problems and patient's or family's needs	50 min.
99236	High complexity	Comprehensive	Comprehensive	Consistent with problems and patient's or family's needs	55 min.
99238[3]	Hospital discharge day management				30 minutes or less [3]
99239[3]	Hospital discharge day management				more than 30 minutes [3]

1 All subsequent levels of service include reviewing the medical record, diagnostic studies and changes in patient's status, such as history, physical condition and response to treatment since last assessment.

2 Key component. For subsequent hospital care, at least two of the three components (history, exam, and medical decision making) are needed to select the correct code. Admission and discharge on the same date requires that all three key components (history, exam, and medical decision making) be adequately documented in the medical record to substantiate the level of service reported, as they are crucial for selecting the correct code.

3 These codes are not based on the three key elements of patient history, physical examination, and level of medical decision making. These codes are correctly assigned based on time, as the CPT code description indicates.

GENERAL GUIDELINES

- Use codes 99231–99233 for any inpatient evaluation and management (E/M) services provided after the first inpatient encounter, including reviewing diagnostic studies and noting changes in the patient's status. These codes also are used to report preoperative medical evaluation and/or postoperative care before discharge when these services were provided by a physician other than the surgeon.
- Use codes 99234–99236 for any E/M services provided by the admitting physician to an inpatient *or* an observation patient that is admitted and discharged on the same day.
- Consider assigning the appropriate consultation code instead of these codes when an opinion or advice was provided about a patient for a

Chapter 7: Consultations (99241–99255)

Office or Other Outpatient Consultations (99241–99245)

Quick Comparison

Consultations—Office or Other Outpatient, New or Established Patient

E/M Code	Medical Decision Making[1]	History[1]	Exam[1]	Counseling and/or Coordination of Care	Time Spent Face to Face (avg.)
99241	Straightforward	Problem focused	Problem focused	Consistent with problems and patient's or family's needs	15 min.
99242	Straightforward	Expanded problem focused	Expanded problem focused	Consistent with problems and patient's or family's needs	30 min.
99243	Low complexity	Detailed	Detailed	Consistent with problems and patient's or family's needs	40 min.
99244	Moderate complexity	Comprehensive	Comprehensive	Consistent with problems and patient's or family's needs	60 min.
99245	High complexity	Comprehensive	Comprehensive	Consistent with problems and patient's or family's needs	80 min.

1 Key component. For office or other outpatient consultations, all three components (history, exam, and medical decision making) must be adequately documented in the medical record to substantiate the level of service reported and are crucial for selecting the correct code.

General Guidelines

- Use these CPT® codes if the physician/qualified healthcare professional provided an opinion or gave advice regarding evaluation or management of a specific problem at the request of another physician/qualified healthcare professional or appropriate source. A consultation may also be necessary to determine whether the consultant is willing to accept transfer and ongoing management of the patient's entire care or for management of a specific problem. The consultant may initiate diagnostic or therapeutic services.
- Consultation codes are appropriate in many settings such as the physician's office, or outpatient or other ambulatory facility, hospital observation unit, patient's home, domiciliary/rest home, custodial care facility or emergency department.
- A written report must be sent to the requesting provider or source to be placed in the patient's permanent medical record. Required documentation includes the request for consultation, the need or reason for the consultation, consultant's opinion and any services that were ordered or performed.

Key Point

Medicare and some commercial carriers do not accept CPT consultation codes.

- When a common chart is used, a separate report to the requesting provider does not need to be sent. Examples of a common chart include large multispecialty clinics with electronic medical records.
- Use the appropriate office consultation code if the consultant was asked again for an opinion or advice regarding the same problem or a new problem.
- Assign the appropriate critical care code instead of these codes if the physician provided constant attention to a critically ill patient.
- Assign the appropriate office visit code if the patient or family member and not another physician (or appropriate source) requested the consultation.
- Do not consider the time spent by other staff (e.g., nurse) as part of the face-to-face time.
- Report 99354–99359 for E/M services that run 30 minutes beyond the typical time specified in the code narrative. The time must be clearly documented in the medical record.
- Append modifier 25 to report that a separately identifiable E/M service was performed by the same physician/qualified healthcare professional on the same day as a procedure or service. Only the work involved in the separate E/M service should be considered when determining the correct level of service.
- Use modifier 32 when the services were mandated, such as by a third-party payer, or as a result of a governmental, legislative or regulatory requirement.
- Append modifier 57 to indicate that the decision to perform major surgery has been made.
- Append modifier 95 to indicate that the E/M service was rendered to a patient at a distant site via a real-time interactive audio and video telecommunications system. The communication between the physician or other qualified healthcare professional and the patient should be commensurate with the same key components or requirements of those that would be required if the service had been rendered in a face-to-face setting.
- Report separately the codes for the diagnostic tests or studies performed.
- Codes for high-level E/M services have been targeted in the CERT program as being overutilized. Medical necessity and the level of medical decision making should be verified for all high-level E/M services.
- Follow-up visits initiated by the physician consultant or patient are reported with the appropriate site-of-service codes (e.g., office visits) for established patients. However, if an additional request is documented in the record for an additional opinion or advice for the same or separate problem, the consultation codes may be reported again.
- Transfer-of-care services (for either specific condition or the patient's entire care) are reported with the appropriate new or established patient codes for the site of service.
- Medicare eliminated the use of all consultation codes with the exception of telehealth inpatient consultation G codes. See chapter 17 for more information on G codes. Report outpatient consultations with the appropriate E/M service code for the site of service and new or established patient.

✓ QUICK TIP

Modifiers 25, 32, and 57 are to be appended to the E/M code and not to the codes for the other procedures or services that may be performed.

Appendix A: Physician E/M Code Self-Audit Forms

Note: For 2018, the forms contained in this appendix will also be available as a downloadable PDF. To access the forms, use the following URL and password:

www.optum360coding.com/2018EMCAForms
Password: o360emca18

EXAMPLE 1: 1997 GUIDELINES

Physician offices may want to adopt a checklist like the one below, for providers to use to correctly identify accurate E/M code levels or as a self-audit tool.

Patient name _____

Account number _____ Date of service _____

Providing physician or other qualified healthcare provider_____

Requesting provider's name and UPIN _____

Diagnoses:

1. 3.

2. 4.

Type of Patient:

- ❑ New
- ❑ Established

Type of History (check one only):

- ❑ **Problem focused** (chief complaint, brief history of present problem)
- ❑ **Expanded problem focused** (chief complaint, brief history and system review pertinent to problem)
- ❑ **Detailed** (chief complaint, extended history, extended system review and pertinent past, family and/or social history **or** minimum of three chronic/inactive conditions reviewed.)
- ❑ **Comprehensive** (chief complaint, extended history, complete system review and complete past, family and social history)

Type of Examination-Multisystem[1] (check one only):

- ❑ **Problem focused** (one to five elements, one or more systems/areas)
- ❑ **Expanded problem focused** (at least six elements, one or more systems/areas)
- ❑ **Detailed** (at least two elements in six systems/areas)
- ❑ **Comprehensive** (all elements in 9 systems/areas)

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1 **Change as appropriate to use for single organ system physical examinations**

Appendix B: Crosswalk for 1995 and 1997 E/M Documentation Guidelines

E/M Guidelines Crosswalk		
CPT® Code	**1995 Guidelines**	**1997 Guidelines**
Office or Other Outpatient Services, New Patient		
99201	**History:** CC; brief HPI	**History:** Same
	Exam: Limited exam of affected body area/organ system	**Exam:** one–five bullet elements in one or more organ systems or body areas
	MDM: Dx/management options minimal; amount/complexity data- minimal or none; risk-minimal	**MDM:** Same
99202	**History:** CC; brief HPI; problem pertinent ROS	**History:** Same
	Exam: Limited exam of affected body area/organ system & other related/symptomatic system(s)	**Exam:** Six bullet elements in one or more organ systems or body areas
	MDM: Dx/management options-minimal; amount/complexity data-minimal or none; risk-minimal	**MDM:** Same
99203	**History:** CC; extended HPI; problem-pertinent ROS including review of limited number additional systems; pertinent PFSH directly related to problem(s)	**History**: Same. Document two–nine systems for ROS. PFSH should document one item from any history area
	Exam: Extended exam of affected body area(s)/organ system(s) and other related/symptomatic system(s)	**Exam:** Two bullet elements in at least six organ systems/ body areas OR 12 bullet elements in two or more organ systems/body areas. Single System-Eye or Psychiatric Exams: nine bullet elements are required
	MDM: Dx/management options-limited; amount/complexity data-limited; risk-low	**MDM:** Same
99204	**History:** CC; extended HPI; ROS directly related to problem(s) plus review of all additional systems; complete PFSH	**History:** Same. Document at least four elements of HPI or document at least three chronic/inactive conditions. ROS should document at least 10 organ systems
	Exam: General multisystem exam or complete exam of a single-organ system, basing exam on the seven recognized body areas and/or the 11 recognized organ systems	**Exam:** All bullet elements in at least nine organ systems/body areas. Document no less than two bullet elements in each area/system reviewed. Single-System Exams: Must document all bullet elements in shaded boxes and at least one bullet element in each unshaded box
	MDM: Dx/management options-multiple; amount/complexity data-moderate; risk-moderate	**MDM:** Same
99205	**History:** CC; extended HPI; ROS directly related to problem(s) plus review of all additional systems; complete PFSH	**History:** Same. Document at least four elements of HPI or document at least three chronic/inactive conditions. ROS should document at least 10 organ systems
	Exam: General multisystem exam or complete exam of a single-organ system, basing exam on the seven recognized body areas and/or the 11 recognized organ systems	**Exam:** All bullet elements in at least nine organ systems/body areas. Document no less than two bullet elements in each area/system reviewed. Single-System Exams: Must document all bullet elements in shaded boxes and at least one bullet element in each unshaded box
	MDM: Dx/management options-extensive; amount/complexity data-extensive; risk-high	**MDM:** Same