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Evaluation and Management Coding Advisor

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

2020

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Contents

Changes to E/M Coding and Documentation Under the CY 2019 Physician Fee Schedule Final Rule

The 2019 PFS proposed rule included multiple E/M coding, documentation, and payment changes to help ease administrative burdens faced by physicians that were to take effect January 1, 2019. After the comment period and taking into account the feedback received from multiple stakeholders, CMS will implement the following changes in 2019 and 2021.

Beginning January 1, 2019, the following changes apply to office/outpatient visits (99201–99215) for Medicare beneficiaries:

- Ancillary staff, and/or the patient, may document the chief complaint and history in the medical record (including the history of present illness), eliminating the need for physicians to document or re-document the information. Physicians must document their review and confirmation of the information and supplement the information as needed.
- For established office or outpatient encounters physicians may choose to document only the parts of the history and physical exam that have changed since the last encounter, instead of re-recording a list of defined elements. Physicians will perform clinically relevant and medically necessary elements of the physical exam and may indicate their review of and update previous data as necessary.
- The requirement to document medical necessity of a home visit in lieu of an office visit is no longer necessary.

Beginning January 1, 2021, CMS will implement the following payment, coding, and additional documentation changes to office/outpatient visits (99201–99215):

- E/M office/outpatient visit levels 2, 3, and 4 will be consolidated into a single payment rate. The payment rate for a level 5 office/outpatient visit will be retained to account for the care of more complex patients.
- Providers may continue to use the current 1995 or 1997 guidelines for documenting visit levels 2 through 5, or they may choose to use the level of medical decision making (MDM) only or time. To use time, the provider must demonstrate the medical necessity of the encounter and document the total time spent face to face with the patient.
- A minimum supporting documentation standard will apply to E/M office/outpatient levels 2 through 4. If documented using the current framework or MDM only, providers will only have to meet history, exam, and/or MDM documentation requirements for a level 2 service.

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

Chapter 6: Hospital Services (99217–99239)

Initial Hospital Observation and Discharge Services (99217–99220)

Quick Comparison

Hospital Observation Services—Initial Care and Discharge

E/M Code	Medical Decision Making[1]	History[1]	Exam[1]	Counseling and/or Coordination of Care	Time Spent at Bedside and on Patient's Floor or Unit (avg.)
99217		Observation care discharge day management			N/A.
99218	Straightforward or low complexity	Detailed or comprehensive	Detailed or comprehensive	Consistent with problems and patient's or family's needs	30 min.
99219	Moderate complexity	Comprehensive	Comprehensive	Consistent with problems and patient's or family's needs	50 min.
99220	High complexity	Comprehensive	Comprehensive	Consistent with problems and patient's or family's needs	70 min.

1 Key component. All three components (history, exam, and medical decision making) are required for selecting the correct code.

General Guidelines

- Hospital observation services codes are used to report services provided to patients designated as under "observation status" in a hospital.
- Three codes (99218, 99219 and 99220) describe "initial observation care, per day, with the evaluation and management of a patient." CPT® code selection depends on the level of complexity of the service, as defined by the three key components—history, examination and medical decision making.
- Code 99217 is used to discharge a patient from observation status when the discharge occurs on a date other than the initial date of observation. The patient does not need to be physically located in an observation unit, but does need to have a status of "observation" and not "inpatient." All of the observation codes describe "counseling and/or coordination of care with other providers or agencies"
- Codes 99218, 99219 and 99220 are appropriate for use by the supervising physician or other qualified healthcare professional whenever the patient has been designated as outpatient hospital

Key Point

Observation status admissions may be to a specified observation area or to another hospital floor. The location of the bed is not as important as the patient's designated status of "observation" versus "inpatient."

Subsequent Hospital Observation Services (99224–99226)

QUICK COMPARISON

Hospital Observation Services—Subsequent Care[1]

E/M Code [3]	Medical Decision Making[2]	History[2]	Exam[2]	Counseling and/or Coordination of Care	Time Spent Face to Face/Floor/ Unit (avg.)
99224	Straightforward or low complexity	Problem focused interval	Problem focused	Consistent with problems and patient's or family's needs	15
99225	Moderate complexity	Expanded problem focused interval	Expanded problem focused	Consistent with problems and patient's or family's needs	25
99226	High complexity	Detailed interval	Detailed	Consistent with problems and patient's or family's needs	35

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 observation services, at least two of the three components (history, exam, and medical decision making) are needed to select the correct code.
3 These codes are resequenced and are included in the CPT book following code 99220.

GENERAL GUIDELINES

- Hospital observation services codes are used to report services provided to patients designated under "observation status" in a hospital.
- Three codes (99224, 99225, and 99226) describe "subsequent observation care, per day, with the evaluation and management of a patient." CPT code selection depends on the level of complexity of the service, as defined by the three key components—history, examination, and medical decision making.
- Codes 99224–99226 are appropriate for any subsequent visit to a patient that has been designated as observation status. The patient does not need to be physically located in an observation unit but does need to have a status of "observation" and not "inpatient."
- Use 99224–99226 for any observation service/visit provided to a patient on a calendar day that is different from the date that the patient was designated as "observation status," admission, or discharge.
- For reporting these services, unit/floor intraservice time includes both bedside services and those services rendered while on the hospital unit. Unit/floor time includes chart review, patient examination, record documentation, and communication with the patient's family and facility staff.
- It is important to remember that hospitals have their own guidelines regarding how long a patient can remain in observation status. Many hospitals do not allow a patient to remain in observation for longer than 23 hours, although Medicare guidelines under the outpatient prospective payment system (OPPS) allow for payment of up to 48 hours of observation, for certain conditions.

- When a patient receives observation services for a minimum of eight hours and is discharged from observation status (or inpatient hospital status) on the same date, see codes 99234–99236.

Issues in This Code Range

- Frequently history and decision making are the most contributory components in this code range. Given that a patient will have had a complete history and physical on admission to observation, the subsequent exam is often limited to the affected area
- These codes are also one of the few code sets where an interval history is described. The specific elements of these histories are not defined in CPT or federal guidelines, but the labels of each level are suggested. A problem-focused interval history would focus on HPI since the last visit. The expanded problem-focused version would include some ROS. The detailed version would simply have more of the above in each area, but again as limited by what has occurred since the last visit.
- Also remember that floor/unit time can be counted towards these codes when applicable. Extra time spent reviewing labs or looking at films (not for them) can count towards the level of service.
- According to the Medicare guidelines, outpatient observation services are classified as acute services and usually do not exceed one day (24 hours). Some patients may require a second day of outpatient observation (48 hours or two calendar days). And, in some rare and exceptional cases, an outpatient observation placement may span more than 48 hours. Providers billing 99224–99226 should pay close attention to the number of days a patient was held in observation. Unless the provider has requested an exception to the denial of services, Medicare will deny all observation services after the third day.
- When a patient's condition worsens after the initial day of observation and the provider feels that an inpatient admission is warranted, the provider must admit the patient to inpatient status. Extended days on an observation unit are not a substitute for a medically appropriate inpatient admission.

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.

Chapter 9: Residential Care Services (99304–99340)

Nursing Facility Services (99304–99318)
Initial Nursing Facility Care (99304–99306)

QUICK COMPARISON

Nursing Facility Services—Comprehensive Nursing Facility Assessments

E/M Code	Medical Decision Making[1]	Problem Severity	History[1]	Exam[1]	Counseling and/or Coordination of Care	Time Spent[2] Face to Face (avg.)
99304	Straightforward or of low complexity	Low severity	Detailed or comprehensive	Detailed or comprehensive	Consistent with problems and patient's or family's needs	25 min.
99305	Moderate complexity	Moderate severity	Comprehensive	Comprehensive	Consistent with problems and patient's or family's needs	35 min.
99306	High complexity	High severity	Comprehensive	Comprehensive	Consistent with problems and patient's or family's needs	45 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 CPT® codes to report initial nursing facility care provided in a hospital observation unit, office, nursing facility, domiciliary/non-nursing facility or the patient's home.
- Use these codes to report initial E/M services provided in a psychiatric residential treatment center.
- Per CPT guidelines, initial nursing facility assessments must be performed by a physician.
- Consider assigning the appropriate consultation code instead of these codes when an opinion or advice was provided about a patient for a specific problem at the request of another physician/qualified healthcare professional or other appropriate source.

Chapter 12: Other E/M Services (99366–99457)

Medical Team Conferences (99366-99368)

Quick Comparison

Medical Team Conferences

E/M Code	Intent of Service	Provider	Presence of Patient	Time
99366	To plan and coordinate	Nonphysician member of interdisciplinary team	Patient and/or family present	30 min.
99367	To plan and coordinate	Physician member of interdisciplinary team	Patient and/or family not present	30 min.
99368	To plan and coordinate	Nonphysician member of interdisciplinary team	Patient and/or family not present	30 min.

General Guidelines

- A minimum of three healthcare professionals of different specialties or disciplines who provide direct care to the patient must participate.
- Participants must have performed a face-to-face evaluation or treatment of the patient in the prior 60 days.
- Physician's report team conferences with the patient present using the appropriate E/M code and time as the key controlling factor if counseling and coordination of care dominate the service.
- Only one person per specialty may report participation in the team conference.
- Time is calculated based upon the review of the individual patient and ends at the conclusion.
- Time does not include record keeping or generation of reports.
- Time is not reported concurrently with any other billable service.
- The services are reported as face-to-face if the patient is present for any part of the service.
- Team conference services of less than 30 minutes are not reported.
- Team conferences are not reported if part of a contractual agreement of a facility or organization.
- Each participant must document his or her participation and care recommendations.

✓ Quick Tip

Healthcare professionals may include PT, OT, speech-language pathologists, social workers, dietitians, nurse practitioners, physician assistants, discharge coordinators, and other appropriate ancillary healthcare providers.

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

Note: For 2019, 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/2019EMCAForms
Password: o360emca19

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 D: 1997 Evaluation and Management Documentation Guidelines

1997 DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?
Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical recordchronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- The ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time
- Communication and continuity of care among physicians and other healthcare professionals involved in the patient's care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations
- Collection of data that may be useful for research and education

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?
Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- The site of service
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided
- That services provided have been accurately reported

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.