

Essentials for Determining Evaluation & Management (E/M) Codes

Standard Codes for Evaluation & Management (E/M)

Step 1: Determine Whether Patient Has a Diagnosis or Symptom

- If the patient is not sick, use codes for preventive services (99381–99397), counseling (99401–99412), disability evaluation (99450–99469), or evaluation of newborns (99460–99463).
- If patient is sick, use any E/M codes except those listed above. Follow steps 2–7 to determine the correct code.

Step 2: Determine the Location of the Service

- Office or other outpatient services (99201–99215): Physician's office, walk-in clinic, ambulatory health-care center, etc.
- Hospital services (99221–99239): Inpatient, acute care facility
- Observation services (99217–99226 and 99234–99240): Patient admitted to hospital under "observation status"
- Emergency department services (99281–99285): A hospital-based facility, open 24 hours a day, providing unplanned services to patients requiring immediate medical attention
 - Critical care/intermediate care services (99291–99292 and 99477–99480): Direct delivery of medical care for patients with a high likelihood of an impending or life-threatening decline of their condition
- Nursing facility services (99384–99388): Skilled nursing facility (SNF); intermediate care facility (ICF); long-term care facility (LTCF); psychiatric residential treatment center
- Domestic, respite, or custodial care services (99324–99349): Assisted living facility or any other facility providing room, board, and personal assistance services
- Home Services (99348–99349): Physician visited patient at his or her home (private residence)

Step 3: Determine the Relationship Between Physician & Patient

- New or established: An established patient has received professional services from this physician, or another physician of the same specialty within the same practice, during the last three years. A new patient has never seen this physician/another physician of the same specialty in this practice or was last seen by this physician/another physician of same specialty in this practice more than three years ago.
- Initial or subsequent: An initial visit is the first date of service this physician sees this patient and a subsequent visit is one on a later date during this course of treatment
 - These terms are used for services provided for patients in observation care, inpatient care, and nursing facilities
 - Services are reported by the completed day (calendar date) of service

- Consultation services: These services require a requesting physician and a consulting physician. One physician sends a patient to see another physician with a request for advice or recommendations on the patient's care. The services may be inpatient (99251–99255) or outpatient (99241–99245).

NOTE: Medicare will not pay for any consultation codes. For Medicare patients, use other E/M visit codes (such as outpatient or inpatient codes).

Step 4: Determine the Level of History from Documentation

Remember: If it is not documented, it didn't happen!

- History includes four components (not all levels of service include all four components):
 - Chief complaint (CC): The patient's description of why he/she felt the need to see this physician for this visit—could be a sign, symptom, condition, diagnosis, or other health-related concern
 - History of present illness (HPI): Series of questions asked by a physician or ancillary staff about the patient's condition. This includes seven elements: location, quality, severity, timing, context, modifying factors, and associated signs and symptoms

NOTE: Medicare includes an eighth element: education. HPI: Location (where is the pain?), quality (is the pain sharp or dull?), severity (is the pain consistent?), context (is the pain worse when the patient is lying down?), modifying factors (does the pain lessen when the patient takes over-the-counter drugs?), associated signs and symptoms (is the patient nauseated due to the pain?), and duration (how long has the pain been present?).

- Review of systems (ROS): Series of questions to identify signs and/or symptoms the patient may be experiencing now or has experienced in the past. The systems reviewed may include:
 - Constitutional symptoms (fever, weight loss, etc.)
 - Eye
 - Ears, nose, mouth, and throat
 - Cardiovascular
 - Respiratory
 - Gastrointestinal
 - Genitourinary
 - Musculoskeletal
 - Integumentary (skin and/or hair)
 - Neurological
 - Psychiatric
 - Endocrine
 - Hematologic/Lymphatic
 - Allergic/Immunologic
- Past/Family/Social History (PFSH): Stories of experiences concerning the patient's personal and family background. This includes:
 - Patient's history
 - Prior major illnesses and injuries, surgical procedures, and hospitalizations

- Current medications and allergies (drug, food, inhalant, etc.)
- Home/ambulation status (age-appropriate) and dietary/functional status (feeding, eating, etc.)
- Family history
 - Health status (or cause of death) of parents, siblings, and children
 - Specific diseases of family members related to problems identified in the chief complaint, history of present illness (HPI), and/or systems review
 - Diseases of family members that may be hereditary or place the patient at risk
- Social history
 - Marital status and/or living arrangements
 - Current employment
 - Occupational, military, and sexual history
 - Use of drugs, alcohol, and/or tobacco
 - Level of education
 - Other relevant social factors

Responses are often provided by the patient using a form filled out before seeing the physician or by a nurse. The physician must note that the form was reviewed.

- A patient's review of systems (ROS) is not the same as an examination
- The physician may indicate that an organ/system's history is unrelated or non-contributory—these terms (and similar ones) document that the physician addressed or discussed this with the patient or family member. This area can be counted toward the history.

The levels of history are:

Problem-Focused History

- Chief complaint (CC) required
- Brief HPI: Documentation of a limited number (usually 1–3) of elements
- ROS: No ROS is required
- PFSH: No PFSH is required

Expanded Problem-Focused History

- Chief complaint (CC) required
- Brief HPI: Documentation of a limited number (usually 1–3) of elements
- ROS: Review of systems related to the chief complaint
- PFSH: No PFSH is required

Detailed History

- Chief complaint (CC) required
- Extended HPI: Documentation of extended (usually 4 or more) elements
- ROS: Review of an extended number (usually 2–9) of systems directly related to the chief complaint or present illness plus a limited history of additional related systems
- PFSH: One item from past, family, or social history related to patient's current condition

Evaluation And Management Coding Guidelines

Terri Ann Brame

Evaluation And Management Coding Guidelines:

Evaluation and Management Coding Reference Guide - First Edition AAPC, 2020-06-30 Defeat the challenges that threaten your E M claims and compliance success Evaluation and management E M services are the lifeblood of your revenue stream and yet they're the most problematic to report Claim denials remain high E M coding errors in fact rose from 11.9% in 2018 to account for 12.8% of CMS's overall 2019 improper payment rate How much E M revenue are you losing Safeguard your organization from claim denials and audit scrutiny with the Evaluation Management Coding Reference Guide Our experts break down E M coding rules and requirements into simple manageable steps written in everyday language to boost your E M reporting skills Learn how to capture the key components of medical history physical exam and medical decision making and capitalize on real world clinical scenarios to prevent over or under coding The Evaluation Management Coding Reference Guide will help you prep for 2021 E M guideline changes overhauling new and established office and outpatient services and walk you through online digital E M services remote physiologic monitoring and more Master the ins and outs of E M coding CPT guidelines level of service modifiers regulations and documentation guidelines Put an end to avoidable denials and optimize your E M claims for full and prompt reimbursement Benefit from expert tutorials covering the spectrum of E M reporting concepts and challenges Prep for 2021 guideline changes and their impact on your organization Master the ins and outs of E M guidelines in CPT Capture the seven components of E M services Sort out medical decision making coding Avoid the pitfalls of time based coding Nail down specifics for critical care E M services Clear up modifier confusion Understand NPPs rules for same day E M services Take the guesswork out of complexity determinations Get the details on coding surgery and E M together Learn the principles of E M documentation

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Practical Evaluation and Management Coding Christopher L. Taylor,2008-03-14 This guide explains the Evaluation and Management E M coding process used by physicians and regulated by the American Medical Association In four chapters Dr Christopher Taylor establishes a step by step approach to determining the correct CPT code for the most common patient encounters in the office hospital or nursing home Helpful appendices provide E M coding guide templates and additional information *The New Face of Evaluation and Management* Kellie Hall,2025-06-30 Physicians want to care for patients not spend their time documenting in an electronic medical record Physicians are always complaining about the amount of time they spend documenting patient care in support of medical billing through an evaluation and management coding system E M New guidelines were created to lessen the time a physician provider spends on documentation as many of the mandatory elements are no longer a requirement for calculating a code level Previously an E M evaluation and management note required documentation of history exam and medical decision making with required elements in each component to support a level for payment If an element was missing the level of service was not supported therefore the code was lowered resulting in a lower reimbursement for the physician provider The new guidelines eliminated the requirement of History and Exam as part of the calculation of a code level Yes an appropriate history and exam are required this supports good patient care but when it comes to reimbursement they are no longer part of the picture The overall system is not difficult if time is taken to understand the elements and how they are applied in the documentation Documentation is a word game always has been the authors focus is to show what words to use to lessen the time but still convey the complexity of the patient s condition and how the physician provider determines a treatment plan which includes the risk to the patient to satisfy the Coding guidelines initiated by Medicare and American Medical Association This book evaluates the new guidelines and brings them into prospective so physicians providers coders can easily understand how to document and calculate the level of service for reimbursement This is not a cumbersome book or complicated but straight to the point The main goal of the book is to educate physicians nurses and coders on what documentation is really required and what has just become habit over the last 30 years **E&M Coding Clear & Simple** Terri Ann Brame,2013-09-16 This easy to read text breaks these complex codes into manageable bite sized pieces Practice questions and real world case studies help you apply your knowledge and

approach any coding situation with confidence *Auditing Evaluation and Management Coding* Joe Rivet,Sharon Bolarakis,2006 [Evaluation and Management Coding Made Easy](#) Terry Tropin,2020-11-12 Evaluation and Management Coding Made Easy book has now been updated to include the extensive 2021 changes This book simplifies the language of CPT R E M guidelines and places the guidelines into charts for easy reference The book covers Outpatient and inpatient coding Preventive care Other services such as critical care and prolonged services The book also includes a discussion of modifiers and terms used in E M services Forms are included to guide the reader through the step by step process of determining the level of service This book is designed especially for both students and working coders **Evaluation and Management Coding Made Easy** Terry Tropin,2021-11-29 This book simplifies the language of Current Procedural Terminology CPT for Evaluation and Management coding The book includes the updates for 2022 This book was developed by a coding teacher to help both students and working coders The book is updated every year or as needed The book covers The key components history examination and medical decision making Office or other outpatient services Forms to guide the reader through the step by step process to determine level of service Services to patients who are not sick Non Face to Face Services Services based on time Modifiers Definitions of terms CMS 1997 Documentation Guidelines

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opportunity to understand the complexities of documenting any evaluation and management service correctly. Highlighting a variety of settings readers learn about how to document medical history physical examinations medical decision making counseling and or coordination of care as well as intraservice time Clinical examples a clinical scenario and chapter exercises round out coding skills as readers learn to dissect the evaluation and management visit and all its elements [Foundations of Clinical Nurse Specialist Practice](#) Janet S. Fulton, Brenda L. Lyon, Kelly A. Goudreau, 2009-10-16 Designated a Doody's Core Title This comprehensive book addresses pertinent issues for clinical nurse specialists from clinical interventions to nursing care delivery and nursing leadership This is a wonderful addition to the field of nursing Score 100 5 stars Doody's Foundations of Clinical Nurse Specialist Practice serves as a comprehensive textbook and practice reference for graduate level CNS students and practitioners Compiled and edited by experts in the field this book discusses every aspect of Clinical Nurse Specialist practice from its historical foundations to chapters on implementing the business of CNS practice With this book readers will gain essential knowledge on delivering client care to the individual patient the family and the community The text includes major sections on designing and evaluating client care interventions promoting innovation change and diffusion in practice client care delivery and a wealth of information on the business aspects of CNS practice Key topics discussed How to use the Clinical Reasoning Model CRM a clinical inquiry guide for problem solving How to use complex adaptive systems theory to influence change Using population based data analysis to improve patient care outcomes Exploring the business aspects of CNS practice with discussions on economics consultation technology management and billing and reimbursement issues Practice Exemplars on hospital based CNS practice collaborative private practice and entrepreneurship Role Exemplars that range from pediatric bariatric and pain management to psychiatric liaison rehabilitation CNS and Emergency CNS

Physicians Fee & Coding Guide ,2011 **Evaluation and Management Coding Made Easy** Terry Tropin, 2023-11-26 This book includes the 2024 updates for Evaluation and Management E/M codes effective January 1 2024 The book has been significantly revised for this year Also added were new review questions and additional decision trees to make selecting a code even easier Each of the components of an E/M code appropriate history and examination medical decision making and time are described in detail Then each category of code outpatient inpatient observation consultation critical and intensive care preventive services emergency services nursing facility services prolonged services etc is described in detail the modifiers used with these codes and includes a dictionary of terms

Evaluation and Management Coding Made Easy Terry Tropin, 2024-11-26 Evaluation and Management E/M codes have gone through extensive changes in the past few years This book begins with a detailed explanation of medical decision making and how to determine the level of MDM in a specific case It then describes guidelines for each code category office and other outpatients hospital observation patients consultations emergency services critical care services intensive care services nursing facilities home residential services prolonged services preventive services interdisciplinary teams care

management behavioral mental health services electronic online and the new audio video services and remote physiological monitoring services The book takes the guidelines for each category and translates them into plain English and places them into tables and decision trees for easy comparison of related services The book also includes review questions after each chapter a dictionary of terms description of modifiers used with E/M codes and a form that takes the reader step by step through the process of selecting a code Conquer Medical Coding Jean Jurek, Stacey Mosay, Daphne Neris, 2016-01-25

Conquer Medical Coding Take a real world approach to coding that prepares you for the AAPC or AHIMA certification exams and for professional practice in any health care setting The book is also a handy resource you can turn to throughout your career Unique decision trees show you how to logically assign a code It's the only text that breaks down the decision making process into a visual and repeatable process You'll learn exactly how to select the correct ICD 10 CPT and HCPCS codes Each section parallels the Official Coding Guidelines with a special emphasis on commonly used codes A wealth of learning tools and tips along with critical thinking exercises and real life case studies provide the practice you need to master coding Brief reviews of AP and pathophysiology put the codes into perfect context

PEDIATRIC EVALUATION AND

MANAGEMENT , 2023 *Evaluation and Management Coding and Documentation Guide* Jillian H. Kuruc, 2003 **CPT**

2022 E/M Express Reference Tables Pocket Guide - 10 Pack American Medical Association, 2021-09-17 This quick reference guide 10 pack provides a side by side comparison of evaluation and management E/M codes Easy to use each table summarizes the requirements for reporting E/M services and helps the user select and validate proper E/M coding

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