Evaluation and Management Coding Advisor

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

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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...
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.

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.

Determining the Level of Service for Office or Other Outpatient E/M Services

Effective January 1, 2021, the AMA and CMS adopted new guidelines and code descriptions for reporting E/M codes for new and established office or other outpatient services (99202–99215). Note that 99201 has been deleted and is no longer valid for dates of service after December 31, 2020.

Per CMS CY2020 Physician Fee Schedule (PFS) Final Rule and CPT guidelines, the history and examination will no longer be used to select the code level for these services. These services will include a medically appropriate history and/or physical examination, the number of body systems/areas examined or reviewed as part of the history and examination will no longer apply. The history and examination are still required and
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 SNO-CAMP 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.

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 (99202–99215)

New Patient (99202–99205)

**QUICK COMPARISON**

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>Medical Decision Making</th>
<th>History</th>
<th>Exam</th>
<th>Time Spent on Date of Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>Straightforward</td>
<td>Medically appropriate</td>
<td>Medically appropriate</td>
<td>15–29 min.</td>
</tr>
<tr>
<td>99203</td>
<td>Low</td>
<td>Medically appropriate</td>
<td>Medically appropriate</td>
<td>30–44 min.</td>
</tr>
<tr>
<td>99204</td>
<td>Moderate</td>
<td>Medically appropriate</td>
<td>Medically appropriate</td>
<td>45–59 min.</td>
</tr>
<tr>
<td>99205</td>
<td>High</td>
<td>Medically appropriate</td>
<td>Medically appropriate</td>
<td>60–74 min.</td>
</tr>
</tbody>
</table>

**GENERAL GUIDELINES**

- Code selection is based on MDM or total time, including face-to-face and non-face-to-face time spent on the date of the encounter.
- History and physical examination elements are not required for code level selection for office and other outpatient services. However, a medically appropriate history and/or physical examination should still be documented. The nature and degree of the history and/or physical examination is determined by the treating physician or other qualified healthcare professional reporting the service.
- Clinical staff may collect information pertaining to the history and exam and the patient and/or caregiver may provide information directly (e.g., by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting provider.
- Total time for these services includes total face-to-face and non-face-to-face time personally spent by the physician or other qualified healthcare professional on the day of the encounter.
- Physician or other qualified healthcare professional time may include the following activities:
  - preparing to see the patient (e.g., review of tests)
  - obtaining and/or reviewing separately obtained history
  - performing a medically appropriate examination and/or evaluation
  - counseling and educating the patient/family/caregiver
  - ordering medications, tests, or procedures

**QUICK TIP**

Medical necessity is still the overarching criterion for selecting a level of service in addition to the individual requirements of the E/M code.
Chapter 6: Hospital Services
(99217–99239)

Initial Hospital Observation and Discharge Services
(99217–99220)

QUICK COMPARISON

Hospital Observation Services—Initial Care and Discharge

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>Medical Decision Making¹</th>
<th>History¹</th>
<th>Exam¹</th>
<th>Counseling and/or Coordination of Care</th>
<th>Time Spent at Bedside and on Patient’s Floor or Unit (avg.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99217</td>
<td></td>
<td>Observation care discharge day management</td>
<td></td>
<td></td>
<td>N/A.</td>
</tr>
<tr>
<td>99218</td>
<td>Straightforward or low complexity</td>
<td>Detailed or comprehensive</td>
<td>Detailed or comprehensive</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>30 min.</td>
</tr>
<tr>
<td>99219</td>
<td>Moderate complexity</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>50 min.</td>
</tr>
<tr>
<td>99220</td>
<td>High complexity</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>70 min.</td>
</tr>
</tbody>
</table>

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.
Chapter 7: Consultations
(99241–99255)

Office or Other Outpatient Consultations (99241–99245)

QUICK COMPARISON

Consultations—Office or Other Outpatient, New or Established Patient

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>Medical Decision Making¹</th>
<th>History¹</th>
<th>Exam¹</th>
<th>Counseling and/or Coordination of Care</th>
<th>Time Spent Face to Face (avg.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>Straightforward</td>
<td>Problem focused</td>
<td>Problem focused</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>15 min.</td>
</tr>
<tr>
<td>99242</td>
<td>Straightforward</td>
<td>Expanded problem focused</td>
<td>Expanded problem focused</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>30 min.</td>
</tr>
<tr>
<td>99243</td>
<td>Low complexity</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>40 min.</td>
</tr>
<tr>
<td>99244</td>
<td>Moderate complexity</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>60 min.</td>
</tr>
<tr>
<td>99245</td>
<td>High complexity</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>80 min.</td>
</tr>
</tbody>
</table>

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.

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

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Chapter 8: Other Hospital-Based Services (99281–99292)

Emergency Department Services, New or Established Patient (99281–99288)

### Quick Comparison

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>Medical Decision Making1</th>
<th>Problem2 Severity</th>
<th>History2</th>
<th>Exam</th>
<th>Counseling and/or Coordination of Care</th>
<th>Time Spent Face to Face (avg.2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>Straight-forward</td>
<td>Minor or self-limited</td>
<td>Problem focused</td>
<td>Problem focused</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>N/A</td>
</tr>
<tr>
<td>99282</td>
<td>Low complexity</td>
<td>Low to moderate</td>
<td>Expanded problem focused</td>
<td>Expanded problem focused</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>N/A</td>
</tr>
<tr>
<td>99283</td>
<td>Moderate complexity</td>
<td>Moderate</td>
<td>Expanded problem focused</td>
<td>Expanded problem focused</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>N/A</td>
</tr>
<tr>
<td>99284</td>
<td>Moderate complexity</td>
<td>High; requires urgent evaluation</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>N/A</td>
</tr>
<tr>
<td>99285</td>
<td>High complexity</td>
<td>High; poses immediate/significant threat to life or physiologic function</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Consistent with problems and patient’s or family’s needs</td>
<td>N/A</td>
</tr>
<tr>
<td>99288*</td>
<td>Physician direction of EMS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

2 Typical times have not been established for this category of services.

3 NOTE: The severity of the patient’s problem, while taken into consideration when evaluating and treating the patient, does not automatically determine the level of E/M service unless the medical record documentation reflects the severity of the patient’s illness, injury, or condition in the details of the history, physical examination, and medical decision making process. Federal auditors will “downcode” the level of E/M service despite the nature of the patient’s problem when the documentation does not support the E/M code reported.

4 Code 99288 is used to report two-way communication with emergency medical services personnel in the field.
Chapter 12: Other E/M Services
(99366–99457)

Medical Team Conferences (99366–99368)

QUICK COMPARISON

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>Intent of Service</th>
<th>Provider</th>
<th>Presence of Patient</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99366</td>
<td>To plan and coordinate</td>
<td>Nonphysician member of interdisciplinary team</td>
<td>Patient and/or family present</td>
<td>30 min.</td>
</tr>
<tr>
<td>99367</td>
<td>To plan and coordinate</td>
<td>Physician member of interdisciplinary team</td>
<td>Patient and/or family not present</td>
<td>30 min.</td>
</tr>
<tr>
<td>99368</td>
<td>To plan and coordinate</td>
<td>Nonphysician member of interdisciplinary team</td>
<td>Patient and/or family not present</td>
<td>30 min.</td>
</tr>
</tbody>
</table>

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.
- These codes should not be reported for the same time reported for 99424–99427, 99439, 99487, 99489, or 99490–99491.

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.
Chapter 18: Coding and Compliance

QUICK COMPARISON

Ongoing Compliance Investigations

<table>
<thead>
<tr>
<th>E/M Service</th>
<th>Compliance Issue</th>
<th>Investigating Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>E/M codes reported during the global period</td>
<td>E/M services bundled into the global surgical package not provided</td>
<td>Office of Inspector General (OIG), recovery audit contractors (RAC)</td>
</tr>
<tr>
<td>Use of modifiers during the global surgery period</td>
<td>Modifiers used inappropriately to report E/M services that are bundled into the global surgical package</td>
<td>Office of Inspector General (OIG), recovery audit contractors (RAC)</td>
</tr>
<tr>
<td>Inappropriate E/M code level selection</td>
<td>Selecting codes that do not have appropriate supporting documentation for that level of service</td>
<td>Centers for Medicare and Medicaid Services (CMS), Comprehensive Error Rate Testing (CERT) Program</td>
</tr>
<tr>
<td>Initial preventive physical examination (IPPE)</td>
<td>Misuse due to the likelihood that non-Medicare patients may have already received the preventive services listed under the IPPE</td>
<td>Office of Inspector General (OIG), recovery audit contractors (RAC)</td>
</tr>
<tr>
<td>Assigning new patient E/M codes</td>
<td>More than one new patient E/M service reported for the same beneficiary within a three-year period</td>
<td>Recovery audit contractors (RAC)</td>
</tr>
<tr>
<td>High level subsequent nursing facility care codes</td>
<td>Higher levels of care reported but not supported by documentation</td>
<td>Centers for Medicare and Medicaid Services (CMS), Medicare Administrative Contractor (MAC)—National Government Services (NGS)</td>
</tr>
<tr>
<td>Anesthesia care package and billing E/M codes separately</td>
<td>Unbundling of E/M services in anesthesia claims</td>
<td>Recovery audit contractors (RAC)</td>
</tr>
<tr>
<td>Critical care and emergency department (ED) services</td>
<td>Inappropriate use of critical care codes</td>
<td>Office of Inspector General (OIG), recovery audit contractors (RAC)</td>
</tr>
<tr>
<td>Observation services</td>
<td>Duplication of observation codes and other E/M services</td>
<td>Recovery audit contractors (RAC)</td>
</tr>
<tr>
<td>Pulmonary diagnostic procedures with E/M services</td>
<td>Overpayments associated with E/M services and diagnostic pulmonary procedures</td>
<td>Recovery audit contractors (RAC)</td>
</tr>
</tbody>
</table>

E/M CODES REPORTED DURING THE GLOBAL PERIOD

General Guidelines

- CMS established a national definition for a global surgical package to ensure consistent payment for the same services across all carrier regions.
- CMS defined the global surgical package to include:
  - preoperative visits
  - intraoperative services
  - complications following surgery
    - does not require a return trip to the operating room
  - postoperative visits related to recovery
  - postsurgical pain management provided by the surgeon
Appendix A: Physician E/M Code
Self-Audit Forms

Note: For 2022, the forms contained in this appendix will also be available as a downloadable PDF.

EVALUATION AND MANAGEMENT SERVICES WORKSHEET
The following worksheet may be used to collect the necessary data when auditing a medical record for office and other outpatient services (99202-99205 and 99212-99215).

Note: For definitions and details regarding each MDM element, refer to chapter 2 and chapter 5 of this publication.

Example 1: Office and Other Outpatient Services Audit Worksheet

<table>
<thead>
<tr>
<th>Record Number</th>
<th>DOS billed</th>
<th>Attending Signed</th>
<th>Yes ☐ No ☐</th>
<th>DOS Rendered</th>
</tr>
</thead>
<tbody>
<tr>
<td>E/M Billed</td>
<td>E/M Documented</td>
<td>E/M Mod Billed</td>
<td>E/M Mod Doc</td>
<td></td>
</tr>
</tbody>
</table>

**Incident to:**
When a yes is answered for all of the following, the service may be billed as incident to under Medicare guidelines.

- Is the NPP an employee of the practice? ☐ ☐
- If this is a new patient, did the physician participate in the patient’s care? ☐ ☐
- Was direct personal supervision by the physician provided for in-office encounters? ☐ ☐
- Does the physician have an active part in the ongoing care of the patient? ☐ ☐

**Shared Services:**
For a service to be considered shared, all of the following questions must have an answer of yes.

- Are the NPP and physician employed by the same practice? ☐ ☐
- Are the clinically relevant portions of the E/M service documented by the physician? ☐ ☐
- Is there documentation from the physician for this encounter? ☐ ☐
- Is the physician documentation tied to the NPP’s documentation? ☐ ☐

**History**
Was a medically appropriate history documented? Yes ☐ No ☐

**Examination**
Was a medically appropriate exam documented? Yes ☐ No ☐