Evaluation and Management Coding Advisor

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

SAMPLE

optumcoding.com

Contents

Changes to E/M Coding by the CPT® Editorial Panel for 2023 and a Summary of the 2021 Changes v

Chapter 1: An Introduction and Overview of E/M Coding 1
Origin and Development of Evaluation and Management Codes 1
Telehealth Services 4
Temporary Expansion of Telehealth Services Due to Covid-19 Public Health Emergency 15
About This Book 16
Physician or Other Qualified Healthcare Professional 17
Contents 18
How to Use *Evaluation and Management Coding Advisor* 20
Knowledge Assessment Chapter 1 23

Chapter 2: The Building Blocks of E/M Coding 25
Levels of E/M Services 25
Determining the Level of Service for Office or Other Outpatient E/M Services 25
Component Sequence and Code Selection 35
Key Components 38
Contributory Components 58
Modifiers Used with E/M Codes 61
Selecting an E/M Code 63
Knowledge Assessment Chapter 2 63

Chapter 3: The Elements of Medical Documentation 67
Principles of Documentation 68
Evaluating Your Documentation 69
The SOAP Format 69
The SNOCAMP Format 70
Audit Considerations in Documentation 72
Over-Documenting the Encounter 73
Electronic Health Records 76
Knowledge Assessment Chapter 3 80

Chapter 4: Adjudication of Claims by Third-Party Payers and Medicare 83
Medically Necessary Services 83
Documentation Policy Under the Medicare Program 87
Teaching Physician Documentation 88
Temporary Expansion of the Primary Care Exception Due to Covid-19 Public Health Emergency (PHE) 91
Incident-to Services 95
Quality Payment Program 100
Comprehensive Error Rate Testing (CERT) Program 102
Knowledge Assessment Chapter 4 105

Chapter 5: Office or Other Outpatient Services (99202–99215) 107
New Patient (99202–99205) 107
Quick Comparison 107
General Guidelines 107
Issues in This Code Range 109
Established Patient (99211–99215) 121
Quick Comparison 121
General Guidelines 121
Issues in This Code Range 123
Knowledge Assessment Chapter 5 135

Chapter 6: Hospital Services (99217–99239) 137
Initial Hospital Observation and Discharge Services (99217–99220) 137
Quick Comparison 137
General Guidelines 137
Issues in This Code Range 139
Subsequent Hospital Observation Services (99224–99226) 148
Quick Comparison 148
General Guidelines 148
Issues in This Code Range 149
Initial Hospital Care (99221–99223) 156
Quick Comparison 156
General Guidelines 156
Issues in This Code Range 157
Subsequent Hospital Care and Hospital Discharge Services (99231–99239) 166
Quick Comparison 166
General Guidelines 166
Issues in This Code Range 168
Knowledge Assessment Chapter 6 180

Chapter 7: Consultations (99241–99255) 183
Office or Other Outpatient Consultations (99241–99245) 183
Quick Comparison 183
General Guidelines 183
Inpatient Consultations (99251–99255) 198
Quick Comparison 198
General Guidelines 198
Knowledge Assessment Chapter 7 211

Chapter 8: Other Hospital-Based Services (99281–99292) 213
Emergency Department Services, New or Established Patient (99281–99288) 213
Quick Comparison 213

SAMPLE

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

General Guidelines ... 214
Issues in This Code Range ... 215
Critical Care Services (99291–99292) ... 229
Quick Comparison ... 229
General Guidelines ... 229
Knowledge Assessment Chapter 8 ... 234

Chapter 9: Residential Care Services (99304–99340) ... 237
Nursing Facility Services (99304–99318) ... 237
Initial Nursing Facility Care (99304–99306) ... 237
Quick Comparison ... 237
General Guidelines ... 237
Issues in This Code Range ... 238
Subsequent Nursing Facility Care, Discharge, and Annual Nursing Assessment (99307–99318) ... 247
Quick Comparison ... 247
General Guidelines ... 247
Issues in This Code Range ... 248
Domiciliary, Rest Home, or Custodial Care Services—New Patient (99324–99328) ... 256
Quick Comparison ... 256
General Guidelines ... 256
Domiciliary, Rest Home, or Custodial Care Services—Established Patient (99334–99337) ... 263
Quick Comparison ... 263
General Guidelines ... 263
Domiciliary, Rest Home (e.g., Assisted Living Facility), or Home Care Plan Oversight Services (99339–99340) ... 269
Quick Comparison ... 269
General Guidelines ... 269
Knowledge Assessment Chapter 9 ... 270

Chapter 10: Home Services (99341–99350) ... 273
New Patient (99341–99345) ... 273
Quick Comparison ... 273
General Guidelines ... 273
Established Patient (99347–99350) ... 280
Quick Comparison ... 280
General Guidelines ... 280
Issues in This Code Range ... 281
Knowledge Assessment Chapter 10 ... 286

Chapter 11: Prolonged Physician Services (99354–99359, 99415–99416, 99417, 99360) ... 287
Prolonged Service with Direct Patient Contact (99354–99357) ... 287
Quick Comparison ... 287
General Guidelines ... 287
Special Instructions for Prolonged Physicians Services ... 289
Prolonged Service Without Direct Patient Contact (99358–99359) ... 292
Quick Comparison ... 292
General Guidelines ... 292
Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision (99415–99416) ... 294
Quick Comparison ... 294
General Guidelines ... 294
Prolonged Service With or Without Direct Patient Contact (99417) ... 296
Quick Comparison ... 296
General Guidelines ... 296
Standby Services (99360) ... 298
Quick Comparison ... 298
Documentation Requirements ... 298
Knowledge Assessment Chapter 11 ... 299

Chapter 12: Other E/M Services (99366–99457) ... 301
Medical Team Conferences (99366–99368) ... 301
Quick Comparison ... 301
General Guidelines ... 301
Care Plan Oversight Services (99374–99380) ... 302
Quick Comparison ... 302
General Guidelines ... 303
Preventive Medicine Services (99381–99429) ... 307
Quick Comparison ... 307
General Guidelines ... 308
Issues in This Code Range ... 309
Non-Face-to-Face Physician Services (99441–99443, 99421–99423) ... 310
Quick Comparison ... 310
General Guidelines ... 310
Quick Comparison ... 311
General Guidelines ... 311
Interprofessional Telephone/Internet/Electronic Health Record Consultations (99446–99452) ... 312
Quick Comparison ... 312
General Guidelines ... 312
Digitally Stored Data Services/Remote Physiologic Monitoring and Physiologic Monitoring Treatment Services (99453–99454, 99091, 99473–99474, 99457–99458) ... 314
Quick Comparison ... 314
General Guidelines ... 314
Special Evaluation and Management Services (99450–99456) ... 316
Quick Comparison ... 316
General Guidelines ... 316
Issues in This Code Range ... 317
Knowledge Assessment Chapter 12 ... 318

Chapter 13: Newborn and Pediatric Services (99460–99486) ... 319
Newborn Care Services (99460–99465) ... 319
Quick Comparison ... 319
General Guidelines ... 319
Issues in This Code Range ... 319
Pediatric Critical Care Patient Transport (99466–99467 and 99485–99486) ... 320

SAMPLE

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

Quick Comparison 320
General Guidelines 320
Inpatient Neonatal and Pediatric Critical Care (99468–99476) 323
Quick Comparison 323
General Guidelines 323
Initial and Continuing Intensive Care Services (99477–99480) 326
Quick Comparison 326
General Guidelines 326
Knowledge Assessment Chapter 13 327

Chapter 14: Care Plan and Care Management Services (99483–99494) 329
Cognitive Assessment and Care Plan Services (99483) 329
Quick Comparison 329
General Guidelines 329
Issues in This Code Range 330
Care Management Services (99490, 99439, 99491, 99437, 99487, 99489, 99424–99427) 331
Quick Comparison 331
General Guidelines 331
Behavioral Health Intervention Services (99492–99494, 99484) 337
Quick Comparison 337
General Guidelines 337
Knowledge Assessment Chapter 14 340

Chapter 15: Transitional Care Management Services (99495–99496) 343
Quick Comparison 343
General Guidelines 343
Knowledge Assessment Chapter 15 345

Chapter 16: Advance Care Planning (99497–99498) 347
Quick Comparison 347
General Guidelines 347
Knowledge Assessment Chapter 16 348

Chapter 17: HCPCS G Codes and Evaluation and Management Services 349
Medicare Covered Care Plan Oversight Services (G0179–G0182) 349
Quick Comparison 349
General Guidelines 350
Preventive Medicine Services (G0402, G0438–G0439) 352
Quick Comparison 352
General Guidelines 352
Telehealth Follow-up Inpatient Consultation Services (G0406–G0408) 355
Quick Comparison 355
General Guidelines 355
Telehealth ED or Initial Inpatient Consultation Services (G0425–G0427) 357
Quick Comparison 357
General Guidelines 357
Behavioral Screenings and Intervention (G0442–G0444) 361
Quick Comparison 361
General Guidelines 361
Issues in This Code Range 362
Care Management Services (G0506) 363
Quick Comparison 363
General Guidelines 363
Critical Care Telehealth Consultations (G0508–G0509) 364
Quick Comparison 364
General Guidelines 364
Prolonged Service With or Without Direct Patient Contact (G2212) 365
Quick Comparison 365
General Guidelines 365
Knowledge Assessment Chapter 17 366

Chapter 18: Coding and Compliance 369
Quick Comparison 369
E/M Codes Reported During the Global Period 369
Use of Modifiers During the Global Surgery Period 372
Inappropriate E/M Code Selection 374
Initial Preventive Physical Exam (IPPE) 375
Assigning New Patient E/M Codes 376
High-Level Subsequent Nursing Facility Care Codes 378
Anesthesia Care Package and Billing E/M Codes Separately 378
Critical Care and Emergency Department (ED) Services 379
Observation Services 381
Pulmonary Diagnostic Procedures with E/M Services 383
Knowledge Assessment Chapter 18 384

Chapter 19: Knowledge Assessments with Answers 387
Chapter 1 Questions and Answers......................... 387
Chapter 2 Questions and Answers......................... 388
Chapter 3 Questions and Answers......................... 391
Chapter 4 Questions and Answers......................... 393
Chapter 5 Questions and Answers......................... 396
Chapter 6 Questions and Answers......................... 397
Chapter 7 Questions and Answers......................... 399
Chapter 8 Questions and Answers......................... 400
Chapter 9 Questions and Answers......................... 401
Chapter 10 Questions and Answers....................... 403
Chapter 11 Questions and Answers....................... 404
Chapter 12 Questions and Answers....................... 405
Chapter 13 Questions and Answers....................... 407
Chapter 14 Questions and Answers....................... 408
Chapter 15 Questions and Answers....................... 410
Chapter 16 Questions and Answers....................... 411
Chapter 17 Questions and Answers....................... 412
Chapter 18 Questions and Answers....................... 413

SAMPLE

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

Glossary **417**

Appendix A: Physician E/M Code Self-Audit Forms **431**

Appendix B: Crosswalk for 1995 and 1997 E/M Documentation Guidelines **449**

Appendix C: 1995 Evaluation and Management Documentation Guidelines **461**

Appendix D: 1997 Evaluation and Management Documentation Guidelines **473**

Index **501**

SAMPLE

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

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.

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.

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

SAMPLE

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

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.

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

SAMPLE

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

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.

SAMPLE

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

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

SAMPLE

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

Chapter 5: Office or Other Outpatient Services (99202–99215)

New Patient (99202–99205)

QUICK COMPARISON

Office or Other Outpatient Services—New Patient

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

SAMPLE

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.

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

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.

SAMPLE

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."

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

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.

SAMPLE

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.

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

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

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

QUICK COMPARISON

Emergency Department Services, New or Established Patient

E/M Code	Medical Decision Making[1]	Problem[3] Severity	History[1]	Exam[1]	Counseling and/or Coordination of Care	Time Spent Face to Face (avg.)[2]
99281	Straight-forward	Minor or self-limited	Problem focused	Problem focused	Consistent with problems and patient's or family's needs	N/A
99282	Low complexity	Low to moderate	Expanded problem focused	Expanded problem focused	Consistent with problems and patient's or family's needs	N/A
99283	Moderate complexity	Moderate	Expanded problem focused	Expanded problem focused	Consistent with problems and patient's or family's needs	N/A
99284	Moderate complexity	High; requires urgent evaluation	Detailed	Detailed	Consistent with problems and patient's or family's needs	N/A
99285	High complexity	High; poses immediate/ significant threat to life or physiologic function	Comprehensive	Comprehensive	Consistent with problems and patient's or family's needs	N/A
99288[4]	Physician direction of EMS					N/A

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.

SAMPLE

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

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.
- 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.

SAMPLE

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

Chapter 18: Coding and Compliance

QUICK COMPARISON

Ongoing Compliance Investigations

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

SAMPLE

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

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.

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

Record Number			DOS billed	
Attending		Signed Yes ❑ No ❑	DOS Rendered	

E/M Billed	**E/M Documented**	**E/M Mod Billed**	**E/M Mod Doc**

Incident to:			
When a yes is answered for **all** of the following, the service may be billed as incident to under Medicare guidelines.		**Yes**	**No**
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 ❑

SAMPLE

© 2021 Optum360, LLC
CPT © 2021 American Medical Association. All Rights Reserved.