## Contents

### Chapter 1: Introduction ........................................... 1
Origin And Development Of Evaluation And Management Codes ............................................... 1
Physician or Other Qualified Health Care Professional ......................................................... 5
Contents ........................................................................ 6
How to Use Evaluation and Management Coding Advisor ...................................................... 8
Knowledge Assessment ................................................... 11

### Chapter 2: The Building Blocks of E/M Coding .................................................. 13
Levels of E/M Services ................................................ 13
Component Sequence and Code Selection ................................................................. 14
Key Components ................................................................ 17
Contributory Components ................................................ 35
Modifiers Used with E/M Codes ........................................................................ 38
Selecting an E/M Code ............................................................................ 39
Knowledge Assessment ................................................................. 40

### Chapter 3: The Elements of Medical Documentation .................................. 43
Principles of Documentation ............................................... 44
Evaluating Your Documentation ................................................... 45
The SOAP Format ................................................................ 45
The SNOCAMP Format .......................................................... 46
Audit Considerations in Documentation ................................................. 48
Over-Documenting the Encounter ....................................................... 49
Knowledge Assessment ................................................................. 52

### Chapter 4: Adjudication of Claims by Third-Party Payers and Medicare ............ 55
Medically Necessary Services ................................................... 55
Documentation Policy Under the Medicare Program .............................................. 59
Teaching Physician Documentation ......................................................... 60
Incident-to Services .................................................................. 66
Physician Quality Reporting System .................................................... 71
Comprehensive Error Rate Testing (CERT) Program ......................................................... 72
Knowledge Assessment ................................................................. 75

### Chapter 5: Office or Other Outpatient Services (99201–99215) ............... 77
New Patient (99201–99205) ................................................ 77
Quick Comparison .................................................................. 77
General Guidelines ................................................................. 77
Issues in This Code Range ......................................................... 79
Special Notice ........................................................................ 79
Established Patient (99211–99215) ............................................ 93
Quick Comparison .................................................................. 93

### Chapter 6: Hospital Services (99217–99239) .............................................. 109
Initial Hospital Observation and Discharge Services (99217–99220) ................................. 109
Quick Comparison .................................................................. 109
General Guidelines ................................................................. 109
Issues in This Code Range ......................................................... 111
Subsequent Hospital Observation Services (99224–99226) .................................................. 120
Quick Comparison .................................................................. 120
General Guidelines ................................................................. 120
Issues in This Code Range ......................................................... 121
Initial Hospital Care (99221–99223) ................................................ 128
Quick Comparison .................................................................. 128
General Guidelines ................................................................. 128
Issues in This Code Range ......................................................... 129
Subsequent Hospital Care and Hospital Discharge Services (99231–99239) ....................... 138
Quick Comparison .................................................................. 138
General Guidelines ................................................................. 138
Issues in This Code Range ......................................................... 140

### Chapter 7: Consultations (99241–99255) .............................................. 153
Office or Other Outpatient Consultations (99241–99245) ...................................................... 153
Quick Comparison .................................................................. 153
General Guidelines ................................................................. 153
Inpatient Consultations (99251–99255) ......................................................... 168
Quick Comparison .................................................................. 168
General Guidelines ................................................................. 168
Telehealth ED or Initial Inpatient Consultation Services (G0425-G0427) .......................... 182
Quick Comparison .................................................................. 182
General Guidelines ................................................................. 182
Telehealth Follow-up Inpatient Consultation Services (G0406-G0408) ............................ 186
Quick Comparison .................................................................. 186
General Guidelines ................................................................. 186

### Chapter 8: Other Hospital–Based Services (99281–99292) ...................... 189
Emergency Department Services, New or Established Patient (99281–99288) .................... 189
Quick Comparison .................................................................. 189
General Guidelines ................................................................. 190
Issues in This Code Range ......................................................... 191

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Critical Care Services (99291–99292) ................. 205
Quick Comparison ........................................ 205
General Guidelines ...................................... 205

Chapter 9: Residential Care Services
(99304–99340) ............................................. 211
Nursing Facility Services (99304–99318) ........... 211
Initial Nursing Facility Care (99304–99306) ..... 211
Quick Comparison ....................................... 211
General Guidelines ..................................... 211
Issues in This Code Range ............................... 212
Subsequent Nursing Facility Care, Discharge, and
Annual Nursing Assessment (99307–99318) ... 221
Quick Comparison ....................................... 221
General Guidelines ..................................... 221
Issues in This Code Range ............................... 222
Domiciliary, Rest Home, or Custodial Care
Services—New Patient (99324–99328) ......... 230
Quick Comparison ....................................... 230
General Guidelines ..................................... 230
Domiciliary, Rest Home, or Custodial Care
Services—Established Patient
(99334–99337) ............................................. 237
Quick Comparison ....................................... 237
General Guidelines ..................................... 237
Domiciliary, Rest Home (e.g., Assisted Living
Facility), or Home Care Plan Oversight
Services (99339–99340) ................................. 243
Quick Comparison ....................................... 243
General Guidelines ..................................... 243

Chapter 10: Home Services
(99341–99350) ............................................. 245
New Patient (99341–99345) ............................... 245
Quick Comparison ....................................... 245
General Guidelines ..................................... 245
Established Patient (99347–99350) ..................... 252
Quick Comparison ....................................... 252
General Guidelines ..................................... 252
Issues in This Code Range ............................... 253

Chapter 11: Prolonged Physician Services (99354–99359) ............................................. 259
Prolonged Service with Direct Patient Contact
(99354–99357) ............................................. 259
Quick Comparison ....................................... 259
General Guidelines ..................................... 259
Special Instructions for Prolonged Physicians
Services ..................................................... 259
Prolonged Service Without Direct Patient
Contact (99358–99359) ................................. 264
Quick Comparison ....................................... 264
General Guidelines ..................................... 264

Chapter 12: Other E/M Services (99363–99456) ............................................. 267
Anticoagulant Management (99363–99364) .... 267
Quick Comparison ....................................... 267
General Guidelines ..................................... 267
Medical Team Conferences (99366–99368) .... 269
Quick Comparison ....................................... 269
General Guidelines ..................................... 269
Care Plan Oversight Services (99374–99380) .... 270
Quick Comparison ....................................... 270
General Guidelines ..................................... 272
Preventive Medicine Services (99381–99429) .... 275
Quick Comparison ....................................... 275
General Guidelines ..................................... 276
Issues in These Code Ranges ............................ 277
Initial Preventive Physical Exam and Annual
Wellness Visit ............................................. 277
Non-Face-to-Face Physician Services
(99441–99444) ............................................. 281
Quick Comparison ....................................... 281
General Guidelines ..................................... 281
Interprofessional Telephone/Internet Consultations
(99446–99449) ............................................. 282
Quick Comparison ....................................... 282
General Guidelines ..................................... 282
Special Evaluation and Management Services
(99450–99456) ............................................. 284
Quick Comparison ....................................... 284
General Guidelines ..................................... 284
Issues in This Code Range ............................... 285

Chapter 13: Newborn and Pediatric Services
(99460–99486) ............................................. 287
Newborn Care Services (99460–99465) .............. 287
Quick Comparison ....................................... 287
General Guidelines ..................................... 287
Issues in This Code Range ............................... 287
Critical Care Pediatric Patient Transport
(99466–99467, and 99485–99486) .................... 288
Quick Comparison ....................................... 288
General Guidelines ..................................... 288
Neonatal and Pediatric Inpatient Critical Care
(99468–99476) ............................................. 291
Quick Comparison ....................................... 291
General Guidelines ..................................... 291
Intensive Critical Care—Initial and Continuing
(99477–99480) ............................................. 294
Quick Comparison ....................................... 294
General Guidelines ..................................... 294

Chapter 14: Care Management Services
(99487–99490) ............................................. 295
Quick Comparison ....................................... 295
General Guidelines ..................................... 295
<table>
<thead>
<tr>
<th>Chapter 15: Transitional Care Management Services (99495–99496)</th>
<th>299</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quick Comparison</td>
<td>299</td>
</tr>
<tr>
<td>General Guidelines</td>
<td>299</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 16: Advance Care Planning</th>
<th>303</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quick Comparison</td>
<td>303</td>
</tr>
<tr>
<td>General Guidelines</td>
<td>303</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 17: Electronic Health Records</th>
<th>305</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>305</td>
</tr>
<tr>
<td>Defining an EHR</td>
<td>305</td>
</tr>
<tr>
<td>Health Information Technology for Economic and Clinical Health (HITECH) Act</td>
<td>309</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>313</td>
</tr>
<tr>
<td>Certified Suppliers</td>
<td>322</td>
</tr>
<tr>
<td>EHR Documentation of Encounters</td>
<td>323</td>
</tr>
<tr>
<td>Electronic Health Record Templates</td>
<td>324</td>
</tr>
<tr>
<td>Sample Templates</td>
<td>328</td>
</tr>
<tr>
<td>EHR Encoders</td>
<td>329</td>
</tr>
<tr>
<td>Brief Review of Evaluation and Management Coding</td>
<td>329</td>
</tr>
<tr>
<td>Post-Implementation</td>
<td>331</td>
</tr>
<tr>
<td>Coding Changes</td>
<td>332</td>
</tr>
<tr>
<td>Education</td>
<td>333</td>
</tr>
<tr>
<td>Data Capture</td>
<td>334</td>
</tr>
<tr>
<td>Summary</td>
<td>334</td>
</tr>
<tr>
<td>Knowledge Assessment</td>
<td>335</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 18: Knowledge Assessments with Answers</th>
<th>339</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 1 Questions and Answers</td>
<td>339</td>
</tr>
<tr>
<td>Chapter 2 Questions and Answers</td>
<td>340</td>
</tr>
<tr>
<td>Chapter 3 Questions and Answers</td>
<td>343</td>
</tr>
<tr>
<td>Chapter 4 Questions and Answers</td>
<td>344</td>
</tr>
<tr>
<td>Chapter 17 Questions and Answers</td>
<td>347</td>
</tr>
</tbody>
</table>

| Glossary                                                  | 351 |

| Appendix A: Physician E/M Code Self-Audit Forms           | 365 |

| Appendix B: Crosswalk for 1995 and 1997 E/M Documentation Guidelines | 379 |

| Appendix C: 1995 Evaluation and Management Documentation Guidelines | 393 |

| Appendix D: 1997 Evaluation and Management Documentation Guidelines | 405 |

| Index                                                      | 433 |
99203

**DOCUMENTATION REQUIREMENTS**

Medial Decision Making: low
- Limited number of diagnoses or management options considered
- Limited amount and complexity of data reviewed
- Low risk of complications or morbidity or mortality

Problem Severity: moderate
- Moderate risk of morbidity without treatment
- Moderate risk of mortality without treatment
- Uncertain outcome or increased probability of prolonged functional impairment or increased probability of prolonged functional impairment

History: detailed
- Chief complaint
- Extended history of present illness (four or more HPI elements or the status of three chronic problems)
- Extended system review (two to nine systems)
- Pertinent past, family, and/or social history (one of the history areas)

Examination: detailed
- 1995: two to seven organ systems or body areas with an extended exam of affected area(s)
- 1997: at least two bullet (•) elements from at least six organ systems or body areas, OR at least 12 bullet (•) elements from two or more organ systems or body areas. Eye and psychiatric single-system exams must include at least nine bullet (•) elements.

**Code Indicators** (from tables of risk—including some AMA indicators in italic)

**Presenting Problem(s)**
- Two or more self-limited or minor problem(s)
- One stable chronic illness (e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH)
- Acute uncomplicated illness or injury (e.g., cystitis, allergic rhinitis, simple sprain)

**Management Options**
- Physical therapy, rest or exercise, diet, stress management
- Over the counter drugs, medication management with minimal risk
- Minor surgery, with no identified risk factors
- Occupational therapy
- IV fluids, without additives

**Counseling and/or coordination of care**
- As appropriate for the problem

**Time Spent Face to Face (average)**
- 30 minutes
Sample Documentation—99203

Level III Initial Office Visit

Reason for visit: “Something is really wrong”

HPI: This 18-year-old white female complains of vaginal itching, burning, and pain for three days, getting “worse and worse.” She tried an OTC preparation, but it provided little relief. She has never had a GYN exam before and is apprehensive. She has been sexually active for three years, has had four partners and “always” uses condoms for protection. Past history unremarkable. She denies use of tobacco, drugs, or alcohol except for a “beer or two” on weekends. She is a university student, lives in the dorms, works part time at the university. No known allergies. Menses regular, lasting three to four days, normal flow; LMP 10 days ago. No history of STD or previous GU infections. Review of systems otherwise within normal limits.

Physical exam: Vital signs: T: 97.8, R: 18, P: 76, BP: 116/78. Abdomen: no organomegaly, no masses or tenderness. External genitalia, red and irritated with a foul-smelling creamy discharge oozing from the vagina; no lesions noted. No adnexal tenderness or ovarian masses. Uterus 8 cm. Cervix firm, pink no discharge from os. Rectal negative. Pap smear deferred. Gram stain of vaginal discharge negative for GC. Wet mount + clue cells. KOH prep revealed no yeast or hyphae.

Impression: Bacterial vaginitis.

Plan: The patient was reassured, and her condition was explained. She was given an RX for metronidazole gel intravaginally BID x five days, and was also instructed that her partner should be treated concurrently. GC culture and VDRL sent.

(Single organ system—genitourinary-female)

Level III Initial Office Visit

History: 41-year-old male complaining of pain, stiffness, “clicking” and swelling of both knees that is of gradual onset but seems to be getting worse. He cannot pinpoint when he first noticed a problem, but it was several months before his move here six months ago. He first noted pain in his knees after exercise but notes that exercise also makes the stiffness better. He occasionally gets nonradiating backache, especially after lifting and doing yard work, but sometimes it happens for no apparent reason. Over-the-counter preparations such as Advil with rest and heat help his back and used to make his knees feel better, but lately they seem worse. He notes no paresthesias from his back. Past history is otherwise noncontributory. He notes no problems with gait or stability.

Physical Exam: Well-developed, somewhat obese white male. Height 5’10”, weight 205 pounds. BP 130/92. Gait and station are normal. Back appears normal; no kyphosis or scoliosis; no tenderness upon palpation of the lumbar area. Flexes to 90 degrees. Leg lengths even and joints symmetrical. Knees are nontender and are not erythemic or warm. Full range of motion. No back pain on straight leg raising. McMurray’s negative. There is moderate crepitation noted on movement of the knees. Hip movement is normal and the patient reports no pain. Muscle strength, pulses and reflexes are all within normal limits. Babinski is negative. Normal response to touch and pinprick.

Impression:
1. Osteoarthritis, bilateral knees.

Plan: Discussion with the patient regarding osteoarthritis, treatment options and nature of the condition. Patient instructed in the importance of daily exercise including stretching exercises to avoid further damage to the joints. Importance of weight reduction in management of DJD was also strongly stressed. Patient was instructed to use aspirin to relieve knee and back pain, and was given a referral for physical therapy evaluation and instructions on exercises and activities to help manage his condition. The patient was instructed to return in four months for follow-up and to call sooner if there are any problems. The patient was advised to contact his PCP for hypertension follow up.

(Single organ system—musculoskeletal)

The 1995 guidelines indicate that two to seven organ systems or body areas are required. For a detailed exam, at least one of those systems needs to be in more detail as in this example.