Evaluation and Management Coding Advisor

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

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Chapter 1: Introduction

About This Book

Evaluation and Management Coding Advisor is a reference guide to help providers select the correct code based on work, and to assist staff and compliance personnel in efforts to ensure that their medical record documentation substantiates the level of E/M service code selected. The guide can also be used as a training tool to help staff educate providers regarding the type and detail of documentation that is necessary.

The guide will provide:

- The American Medical Association's definition of the key components of the E/M codes, as found in the CPT book, and the documentation criteria that must be met or exceeded in order to support a particular E/M code. This text will familiarize readers with the basics.
- An analysis of the difference between correct coding and supporting documentation. This includes in-depth discussion of the medical decision making component and should result in an increase in E/M coding accuracy. This will include both AMA revisions and current CMS guidelines.
- A section prior to each range of E/M codes that will outline real-world issues with particular code types.
- Samples of proper medical documentation for both the level of service and the medical necessity for the service. Optum editors will endeavor to provide realistic samples as well as "perfect" notes.
- The potential for decreased audit liability by presenting guidelines for appropriate medical record documentation, including an explanation of the Subjective Objective Assessment Plan (SOAP) format, an alternative documentation format of Subjective, Nature of presenting problem, Objective, Counseling and/or coordination of care, Assessment, Medical decision making, and Plan (SNOCAMP); and examples of supporting documentation and standard abbreviations

In addition to being a resource for solving day-to-day coding and documentation problems, the *Evaluation and Management Coding Advisor* can be used as a teaching tool for in-service education and as a source book for seminars, E/M coding and documentation training programs, and college and university courses.

Evaluation and Management Coding Advisor does not replace the CPT code book, nor does it contain all the E/M coding guidelines created by the AMA. Rather, it is to be used to understand proper code selection and the linkage to medical record documentation.

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Chapter 2: 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 units (RVU) for the work involved in E/M services by using "intraservice" time as the basis for each code.

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.

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Chapter 3: The Building Blocks of E/M Coding

OBJECTIVES

This chapter discusses:

- Determining levels of evaluation and management (E/M) services using MDM or time
- Component sequence and code selection
- The relationship between E/M coding and appropriate ICD-10-CM code selection
- Definitions of common terms

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.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified.

The place of service and service type is defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

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Chapter 4: 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
- Total time personally spent by the provider or OQPH on the date of the encounter

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.

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Chapter 5: Adjudication of Claims by Third-Party Payers and Medicare

OBJECTIVES

This chapter discusses:

- Documentation guidelines that payers use
- How documentation supports medical necessity
- Documentation aids

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 previously stated, will require the decision making to be one of the required elements to help meet medical necessity guidelines.

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Chapter 6: 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.

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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
  - referring and communicating with other healthcare professionals (when not separately reported)
  - documenting clinical information in the electronic or other health record

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.

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Chapter 7: Hospital Services (99221–99239)

Initial Hospital Inpatient or Observation Care (99221–99223)

QUICK COMPARISON

Hospital Inpatient or Observation Care Services—Initial Care, New or Established Patient

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99221	Straightforward or low	Medically appropriate	Medically appropriate	40 min.
99222	Moderate	Medically appropriate	Medically appropriate	55 min.
99223	High	Medically appropriate	Medically appropriate	75 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. 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.
- 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
  - referring and communicating with other healthcare professionals (when not separately reported)
  - documenting clinical information in the electronic or other health record
  - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - care coordination (not separately reported)

CODING AXIOM

Medicare does not accept consultation codes. Use initial hospital care codes to report the first inpatient encounter by a physician. The admitting physician should append modifier AI Principal physician of record, to the initial hospital care code.

KEY POINT

Tests that are results only and are analyzed as part of MDM do not count as an independent interpretation but may count as one item when determining the amount/complexity of data reviewed and analyzed (e.g., dipstick UA, CBC, quick strep test).

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Chapter 8: Consultations (99242–99255)

Office or Other Outpatient Consultations (99242–99245)

Quick Comparison

Consultations—Office or Other Outpatient, New or Established Patient

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99242	Straightforward	Medically appropriate	Medically appropriate	20 min.
99243	Low complexity	Medically appropriate	Medically appropriate	30 min.
99244	Moderate complexity	Medically appropriate	Medically appropriate	40 min.
99245	High complexity	Medically appropriate	Medically appropriate	55 min.

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 site including patient's home or residence 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.
- When a common chart is used, a separate report to the requesting provider does not need to be sent. Examples of a common chart include large multispecialty clinics with electronic medical records.
- Use the appropriate office consultation code if the consultant was asked again for an opinion or advice regarding the same problem or a new problem.
- 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 consultation services.

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Chapter 9: 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	History	Exam	Time Spent Face to Face (avg.)[1]
99281	May not require the presence of a physician	Medically appropriate	Medically appropriate	N/A
99282	Straightforward complexity	Medically appropriate	Medically appropriate	N/A
99283	Low complexity	Medically appropriate	Medically appropriate	N/A
99284	Moderate complexity	Medically appropriate	Medically appropriate	N/A
99285	High complexity			N/A
99288[2]	Physician direction of EMS			N/A

1 Time is not a component for selecting emergency department levels.
2 Code 99288 is used to report two-way communication with emergency medical services personnel in the field.

GENERAL GUIDELINES

- Use these CPT® codes when an unscheduled, episodic evaluation and management (E/M) service was rendered to a patient who needed immediate medical attention. The services must have been provided in a hospital-based facility open 24 hours a day. These codes apply to new and established patients.
- Consider assigning the appropriate consultation code instead of these codes when an opinion or advice was provided about a patient for a specific problem at the request of another physician or other appropriate source.
- Report only the appropriate initial hospital inpatient or observation care (99221–99223), or comprehensive nursing facility assessment code if the patient was admitted to the hospital or a nursing facility on the same day as the emergency department visit.
- Consider assigning the appropriate critical care codes (99291, 99292) instead of these codes if the physician provided constant attention to a critically ill patient.
- Append modifier 25 to report that a separately identifiable E/M service was performed by the same physician/qualified healthcare professional on the same day as a procedure or service. Only the content of the work

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Chapter 20: Knowledge Assessments with Answers

Chapter 2 Questions and Answers

1. What are the methods of documentation mentioned?
   a. Subjective, Objective, Assessment, Plan (SOAP) format
   b. Subjective, Nature of presenting problem, Objective, Counseling and/or coordination of care, Assessment, Medical decision making, and Plan (SNOCAMP)
   c. Who, What, When, Where, Why, and How (5 W and H) format
   d. <u>Both a and b</u>

   Rationale: See chapter 4 for more information on these two formats.

2. How is using a documentation method beneficial?
   a. Using a standardized documentation format expedites the revenue cycle process
   b. Using a standardized documentation format ensures a lower medical malpractice premium
   c. <u>Using a standardized documentation format can help decrease audit liability</u>
   d. Using a standardized documentation format has not been proven to be beneficial

   Rationale: Standardized documentation formats not only decrease audit liability by consistently and uniformly establishing medical necessity and ensuring that all of the appropriate elements are documented but they also help to promote continuity of care and quality of care. When all elements are regularly and reliably documented, the likelihood of omissions and errors greatly diminish and, furthermore, clinicians become more confident and comfortable in their documentation. More detailed, consistent, thorough documentation ensures more appropriate, accurate, and timely billing.

3. Why are E/M services considered the dominant source of revenue for most providers?
   a. <u>They are among the most frequently billed services</u>
   b. They have high reimbursement values
   c. Providers can bill all high levels of care
   d. These services are not monitored

   Rationale: Although the reimbursement amount for E/M services is considered relatively low in comparison to surgical services, the volume of E/M services performed makes them a significant source of revenue for most providers.

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

Note: For 2023, the forms contained in this appendix will also be available as a downloadable PDF. To access the forms, use the following URL and password:

www.optumcoding.com/support/product-updates/
Password: 23EVAL

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 chapters 3 to 11 of this publication.

Example 1: Office and Other Outpatient Services Audit Worksheet

<table>
<tr><td>Record Number</td><td colspan="3"></td><td>DOS billed</td><td colspan="2"></td></tr>
<tr><td>Attending</td><td colspan="2"></td><td>Signed Yes ❑
No ❑</td><td>DOS Rendered</td><td colspan="2"></td></tr>
<tr><td colspan="2">E/M Billed</td><td colspan="2">E/M Documented</td><td>E/M Mod Billed</td><td colspan="2">E/M Mod Doc</td></tr>
<tr><td colspan="7">Incident to:</td></tr>
<tr><td colspan="5">When a yes is answered for all of the following, the service may be billed as incident to under Medicare guidelines.</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="5">Is the NPP an employee of the practice?</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="5">If this is a new patient, did the physician participate in the patient's care?</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="5">Was direct personal supervision by the physician provided for in-office encounters?</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="5">Does the physician have an active part in the ongoing care of the patient?</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="7">Shared Services:</td></tr>
<tr><td colspan="5">For a service to be considered shared, all of the following questions must have an answer of yes.</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="5">Are the NPP and physician employed by the same practice?</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="5">Are the clinically relevant portions of the E/M service documented by the physician?</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="5">Is there documentation from the physician for this encounter?</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="5">Is the physician documentation tied to the NPP's documentation?</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="2">History</td><td colspan="3">Was a medically appropriate history documented?</td><td>Yes ❑</td><td>No ❑</td></tr>
<tr><td colspan="2">Examination</td><td colspan="3">Was a medically appropriate exam documented?</td><td>Yes ❑</td><td>No ❑</td></tr>
</table>

SAMPLE

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