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 evaluation and management (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 (AMA) guidelines for accurate E/M code selection and the documentation criteria necessary to support each 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, 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.

Physician or Other Qualified Healthcare Professional

The AMA's CPT book advises coders that the procedures and services listed throughout the book are for use by any qualified physician or other qualified healthcare professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase "physician or other qualified healthcare professional" was adopted to identify a healthcare provider other than a physician. This type of provider is further described in the CPT book as an individual "qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable)" who performs a professional service within his/her scope of practice and independently reports that professional service." The professionals within this definition are separate from "clinical staff." The CPT book defines clinical staff as "a person who works under the supervision of a physician or other qualified healthcare professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not

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Telehealth technology requirements:

- “Interactive telecommunications system” is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant-site physician or practitioner, including video-enabled phones.
- CMS is allowing some telehealth services to be provided using audio-only communications technology (telephones or other audio-only devices). These include telephone E/M services, certain counseling behavioral healthcare, and educational services, to name a few. Medicare will continue to reimburse codes 99441–99443 for practitioners who can independently bill for E/M services. These CPT codes can be used for new and established patients. Reimbursement for these codes increased to align with the payment rates for levels two to four established office E/M services (99212–99214).

Through December 31, 2023, the CPT telehealth modifier, modifier 93 or 95, should be applied to claim lines that describe services furnished via telehealth. Effective January 1, 2024, for reporting telehealth services to CMS use POS 02 Telehealth to indicate you provided the billed service as a professional telehealth service when the originating site is other than the patient’s home, or POS 10 Telehealth for services when the patient is in their home.

Additional information on POS, originating site, etc. can be found in the telehealth MLN Fact Sheet: https://www.cms.gov/files/document/mln901705-telehealth-services.pdf.

CMS continues to evaluate and make appropriate additions of services to the Medicare telehealth list. This current and evolving list of services is available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. The current list of audio-only services are included in this list.

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Modifiers Used with E/M Codes

The following modifiers apply to E/M codes; other modifiers may apply in some situations.

24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional During a Postoperative Period
The physician or other qualified healthcare professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional on the Same Day of a Procedure or Other Service
It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

Optum Note: This modifier is used to identify the E/M service when provided with another service reported with a CPT or HCPCS code.

Key Point

Modifier 25 is appended to the E/M code and not to codes for other procedures or services performed.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date
For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (eg, hospital emergency department, clinic), see **Evaluation and Management, Emergency Department, or Preventive Medicine Services** codes.

32 Mandated Services
Services related to mandated consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified healthcare professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after

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99214

DOCUMENTATION REQUIREMENTS

Medical Decision Making: Moderate

- Moderate number and complexity of problems addressed
- Moderate amount and complexity of data reviewed and analyzed
- Moderate risk of complications and/or morbidity

History: Medically appropriate

Examination: Medically appropriate

Code Indicators (from the MDM table)

Number and Complexity of Problem(s)

- One or more chronic illnesses with exacerbation, progression, or side effects of treatment
- Two or more stable, chronic illnesses
- One undiagnosed new problem with uncertain prognosis
- One acute illness with systemic symptoms
- One acute, complicated injury

Amount and/or Complexity of Data

**Each unique test, order, or document contributes to the combination of two or combination of three in Category 1 below.*

- Moderate

(Must meet the requirements of at least one of the three categories.)

Category 1: Tests, documents, or independent historian(s)

- Any combination of three from the following:
  - review of prior external note(s) from each unique source*
  - review of the result(s) of each unique test*
  - ordering of each unique test*
  - assessment requiring an independent historian(s)

or

Category 2: Independent interpretation of tests

- Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported)

or

Category 3: Discussion of management or test interpretation

- Discussion of management or test interpretation with external physician/other qualified healthcare professional/appropriate source (not separately reported)

Risk of Complications/Morbidity or Mortality

Moderate risk of morbidity from additional diagnostic testing or treatment.

Examples only:

- Prescription drug management
- Decision regarding minor surgery with identified patient or procedure risk factors
- Decision regarding elective major surgery without identified patient or procedure risk factors
- Diagnosis or treatment significantly limited by social determinants of health

Time Spent on Date of the Encounter

- 30 minutes

KEY POINT

The redefined MDM guidelines were published by the AMA in the 2021 edition of CPT and adopted by CMS in the CY2020 Physician Fee Schedule Final Rule.

KEY POINT

The nature and extent of the patient history and physical examination are determined by the treating provider reporting the service.

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99242

Documentation Requvents

Medical Decision Making: Straightforward
- Minimal number and complexity of problems addressed
- No or minimal amount and complexity of data reviewed and analyzed
- Minimal risk of complications and/or morbidity or mortality

History: Medically appropriate

Examination: Medically appropriate

Code Indicators (from the MDM table)

Number and Complexity of Problem(s)
- One self-limited or minor problem

Amount and/or Complexity of Data
- Minimal or none

Risk of Complications/Morbidity or Mortality
Minimal risk of morbidity from additional diagnostic tests or treatment

Time Spent on Date of the Encounter
- 20 minutes

(See "General Guidelines" for additional documentation considerations.)

Sample Documentation—99242

Level II Office/Outpatient Consultation
TO: Dr. Attending Psychiatrist
FROM: Dr. Consultant
RE: Admitting evaluation
Chief complaint: "They brought me for a checkup."
History: This 24-year-old white male is seen for the first time for medical evaluation at the request of Dr. Attending Psychiatrist at the County Mental Health Facility where he was sent from County Correctional Facility after being charged with assault. He was admitted to CMHF for treatment. He is seen today for an admitting H&P.
Past history: He states that he has had no serious medical problems. His only past illness was chickenpox and occasional upper respiratory infections. He smokes about a pack of cigarettes a day and drinks "some," but would not elaborate further.
Allergies: He states that he was given Haldol while in a reformatory eight years ago which caused him to choke and stutter. No other allergies.
Illicit drug use: He reports using cocaine and smoking marijuana in the past but "none in the past few months." Admitting drug screens at CCF were normal.
Family history: Father is 43, mother 41, both living and well.
Review of systems: No specific complaints on general review but admits to feeling anxious and depressed. Cardiorespiratory: No chest pain, shortness of breath, palpitations or hemoptysis. GI: No nausea, vomiting, diarrhea, constipation. GU: No dysuria, urgency, frequency. Neuromuscular: no myalgia, arthralgia.
Physical exam: This is a well-developed, well nourished, moderately obese white male in no acute distress. Height 5'6", weight 185, temperature 98.3, pulse 72, respirations 20, blood pressure l35/88.
HEENT: Some male pattern alopecia starting; he has a large sebaceous cyst on the scalp, midline, measuring about 2 cm in diameter. He states that this is getting larger and would like it removed because it is sometimes tender. Eyes: EOM intact. PERRLA, Snellen Chart tests reveal vision 20/ 25 on right and 20/20 on the left, uncorrected. Ears: TM's intact; hearing is grossly normal. Nose, mouth and throat: nose patent, tongue midline; pharynx not injected.
Neck: Supple; no bruits; no lymphadenopathy; thyroid normal.
Chest: Symmetrical expansion; lungs clear to auscultation and percussion.

(continued)

Key Point

When determining the amount and/or complexity of data reviewed and analyzed, each unique test ordered is counted once; the review of that test is included within the order.

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).

Key Point

The nature and extent of the patient history and physical examination are determined by the treating provider reporting the service.

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Chapter 10: Nursing Facility Services (99304–99316)

Initial Nursing Facility Care (99304–99306)

QUICK COMPARISON

Nursing Facility Services—Comprehensive Nursing Facility Assessments

E/M Code	Medical Decision Making	History	Exam	Time Spent on Date of Encounter
99304	Straightforward or low covmplexity	Medically appropriate	Medically appropriate	25 min.
99305	Moderate complexity	Medically appropriate	Medically appropriate	35 min.
99306	High complexity	Medically appropriate	Medically appropriate	50 min.

GENERAL GUIDELINES

- Nursing facility and skilled nursing facility care are reported using these codes.
- Use these codes to report initial E/M services provided in a psychiatric residential treatment center and intermediate care facility for individuals with intellectual disabilities.
- 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)
- Comorbidities or other underlying conditions should not be considered when selecting the level of service unless they are addressed during the encounter and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality.

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Chapter 20: Knowledge Assessments with Answers

Chapter 2 Questions and Answers

1. 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. Using a standardized documentation format can help decrease audit liability
   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.

2. Why are E/M services considered the dominant source of revenue for most providers?
   a. They are among the most frequently billed services
   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.

3. What can providers use to assess overall coding patterns?
   a. Reimbursement rates from payers
   b. Coder productivity
   c. Payer requests for documentation
   d. Benchmark data

   Rationale: Using E/M benchmark data can help providers analyze patterns of use for specific E/M codes.

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Glossary

1995 guidelines. Guidelines for determining level and type of evaluation and management services released by the Centers for Medicare and Medicaid Services (CMS) in 1995. These guidelines define levels of history, exam, and medical decision making, and the contributing nature of counseling, coordination of care, nature of presenting problem, as well as time.

1997 guidelines. Guidelines for determining level and type of evaluation and management services released by the Centers for Medicare and Medicaid Services (CMS) in 1997. These guidelines are a more defined measure using bullet points for determining the levels of history, exam, and medical decision making, and the contributing nature of counseling, coordination of care, nature of presenting problem, as well as time.

25. CPT modifier, for use with CPT evaluation and management (E/M) codes, that identifies when the patient's condition requires a significant, separately identifiable E/M service(s) above and beyond other services provided or above and beyond the usual preoperative and postoperative care associated with the procedure that was performed on the same date of service. Medical record documentation must clearly support all necessary criteria required for use of the E/M service being reported, including identifying signs or symptoms of the condition for which the service was rendered. Not all payers require a separate diagnosis when billing for a procedure and E/M service on the same date of service.

57. CPT modifier, for use with CPT evaluation and management (E/M) codes, that identifies an E/M service that resulted in the initial decision to perform surgery. This modifier should be used only with procedure codes considered major surgery (90-day global period).

abstractor. Person who selects and extracts specific data from the medical record and enters the information into computer files.

abuse. Medical reimbursement term that describes an incident that is inconsistent with accepted medical, business, or fiscal practices and directly or indirectly results in unnecessary costs to the Medicare program, improper reimbursement, or reimbursement for services that do not meet professionally recognized standards of care or which are medically unnecessary. Examples of abuse include excessive charges, improper billing practices, billing Medicare as primary instead of other third-party payers that are primary, and increasing charges for Medicare beneficiaries but not to other patients.

accountable care organization. Recognized legal entity under state law comprised of providers of services and suppliers with an established mechanism for shared governance who work together to coordinate care for Medicare fee-for-service beneficiaries. Section 3022 of the Affordable Care Act required CMS to develop a shared savings program to promote coordination and cooperation among providers for the purposes of improving the quality of care for Medicare fee-for-service beneficiaries and minimize costs.

Accredited Standards Committee. Organization accredited by the American National Standards Institute (ANSI) for the development of American national standards.

ACG. 1) Ambulatory care group. **2)** American College of Gastroenterologists. Professional organization for gastroenterology medical specialty.

ACH. Automated clearinghouse. Entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard data content for a receiving entity.

activities of daily living. Self-care activities often used to determine a patient's level of function, such as bathing, dressing, using a toilet, transferring in and out of bed or a chair, continence, eating, and walking.

acute. Sudden, severe. Documentation and reporting of an acute condition is important to establishing medical necessity.

acute care facility. Health care institution primarily engaged in providing treatment to inpatients and diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons who are in an acute phase of illness.

add-on code. CPT code representing a procedure performed in addition to the primary procedure and designated with a + symbol in the CPT book. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure.

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