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Evaluation & Management (E/M) Coding Calculator

Essentials for Determining Evaluation & Management (E/M) Codes

Standard Codes for Evaluation & Management (E/M)

Step 1: Determine Whether Patient Has a Diagnosis or Symptom

- If the patient is not sick, use codes for preventive services (99381–99397), counseling (99401-99412), disability evaluation (99450–99456), or evaluation of newborn (99460–99463)
- If patient is sick, use any E/M codes except those listed above. Follow steps 2–7 to determine the correct code

Step 2: Determine the Location of the Service

- **Office or other outpatient services (99201–99215):** Physician's office, walk-in clinic, ambulatory health-care center, etc.
- **Hospital services (99221–99239):** Inpatient, acute care facility
- **Observation services (99217–99226 and 99234–99236):** Patient admitted to hospital under "observation status"
- **Emergency department services (99281–99285):** A hospital-based facility, open 24 hours a day, providing unplanned services to patients requiring immediate medical attention
  - **Critical care/intensive care services (99291–99292 and 99477-99480):** Direct delivery of medical care for patients with a high likelihood of an impending or life-threatening decline of their condition
- **Nursing facility services (99304–99318):** Skilled nursing facility (SNF); intermediate care facility (ICF); long-term care facility (LTCF); psychiatric residential treatment center
- **Domiciliary, rest home, or custodial care services (99324–99340):** Assisted living facility or any other facility providing room, board, and personal assistance services
- **Home Services (99341–99350):** Physician visited patient at his or her home (private residence)

Step 3: Determine the Relationship Between Physician & Patient

- **New or established:** An established patient has received professional services from this physician, or another physician of the same specialty within the same practice, during the last three years. A new patient has never seen this physician/another physician of the same specialty in this practice or was last seen by this physician/another physician of same specialty in this practice more than three years ago
- **Initial or subsequent:** An initial visit is the first date of service this physician sees this patient and a subsequent visit is one on a later date during this course of treatment
  - These terms are used for services provided for patients in observation care, inpatient care, and nursing facilities
- Services are reported by the completed day (calendar date) of service
- **Consultation services:** These services require a requesting physician and a consulting physician. One physician sends a patient to see another physician with a request for advice or recommendations on the patient's care. The services may be inpatient (99251–99255) or outpatient (99241–99245)

NOTE: Medicare will not pay for any consultation codes. For Medicare patients, use other E/M visit codes (such as outpatient or inpatient codes)

Step 4: Determine the Level of History from Documentation

Remember, if it is not documented, it didn't happen!

- History includes four components (not all levels of service include all four components):
  - **Chief complaint (CC):** The patient's description of why he/she felt the need to see this physician for this visit—could be a sign, symptom, condition, diagnosis, or other health-related concern
  - **History of present illness (HPI):** Series of questions asked by a physician or ancillary staff about the patient's condition. This includes seven elements: location, quality, severity, timing, context, modifying factors, and associated signs and symptoms

NOTE: Medicare includes an eighth element: duration

EX: Location (where is the pain?), quality (is the pain sharp or dull?), severity (is the patient bedridden due to the pain?), timing (is the pain constant?), context (is the pain worse when the patient is lying down?), modifying factors (does the pain lessen when the patient takes over-the-counter drugs?), associated signs and symptoms (is the patient nauseated due to the pain?), and duration (how long has the pain been present?)

  - **Review of systems (ROS):** Series of questions to identify signs and/or symptoms the patient may be experiencing now or has experienced in the past. The systems reviewed may include:
    - Constitutional symptoms (fever, weight loss, etc.)
    - Eyes
    - Ears, nose, mouth, and throat
    - Cardiovascular
    - Respiratory
    - Gastrointestinal
    - Genitourinary
    - Musculoskeletal
    - Integumentary (skin and/or breast)
    - Neurological
    - Psychiatric
    - Endocrine
    - Hematologic/Lymphatic
    - Allergic/Immunologic
  - **Past/Family/Social history (PFSH):** Series of questions concerning the patient's personal and family background. This includes:
    - **Patient's history**
      - Prior major illnesses and injuries, surgical procedures, and hospitalizations
      - Current medications and allergies (drug, food, inhalant, etc.)
      - Immunization status (age-appropriate) and dietary/nutritional status (feeding, eating, etc.)
    - **Family history**
      - Health status (or cause of death) of parents, siblings, and children
      - Specific diseases of family members related to problems identified in the chief complaint, history of present illness (HPI), and/or system review
      - Diseases of family members that may be hereditary or place the patient at risk
    - **Social history**
      - Marital status and/or living arrangements
      - Current employment
      - Occupational, military, and sexual history
      - Use of drugs, alcohol, and/or tobacco
      - Level of education
      - Other relevant social factors
- Histories are often provided by the patient using a form filled out before seeing the physician or by a nurse. The physician must note that the form was reviewed
- A patient's review of systems (ROS) is not the same as an examination
- The physician may indicate that an organ system's history is **unrelated or non-contributory**—these terms (and similar ones) document that the physician addressed or discussed this with the patient or family member. This area can be counted toward the history

The levels of history are:

Problem-Focused History
- **Chief complaint (CC)** required
- **Brief HPI:** Documentation of a limited number (usually 1–3) of elements
- **ROS:** No ROS is required
- **PFSH:** No PFSH is required

Expanded Problem-Focused History
- **Chief complaint (CC)** required
- **Brief HPI:** Documentation of a limited number (usually 1–3) of elements
- **ROS:** Review of system related to the chief complaint
- **PFHS:** No PFSH is required

Detailed History
- **Chief complaint (CC)** required
- **Extended HPI:** Documentation of extended (usually 4 or more) elements
- **ROS:** Review of an extended number (usually 2–9) of systems directly related to the chief complaint or present illness **plus** a limited history of additional related systems
- **PFSH:** One item from past, family, or social history related to patient's current condition

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Neurosurgery Coding Guidelines For Evaluation And Management

Yi-Tong Ma

Neurosurgery Coding Guidelines For Evaluation And Management:

Decoding **Neurosurgery Coding Guidelines For Evaluation And Management**: Revealing the Captivating Potential of Verbal Expression

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