

Evaluation & Management (E/M) Coding Calculator



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

Standard Codes for *Evaluation & Management (E/M)*

Step 1 – Determine Location of the Service

Where did this encounter between physician and patient take place?

- **Office or Other Outpatient Services:** Physician's office; walk-in clinic; ambulatory health-care center; etc.
- **Hospital Services:** Inpatient, acute care facility
- **Consultation – Office or Inpatient**
- **Emergency Department Services:** A hospital-based facility, open 24 hours a day, providing unplanned services to patients requiring immediate medical attention
- **Critical Care/Intensive Care Services:** Direct delivery of medical care for patients with a high likelihood of impending or life-threatening decline of condition
- **Nursing Facility Services:** Skilled nursing facility (SNF); intermediate care facility (ICF); long-term care facility (LTCF); psychiatric residential treatment center
- **Domiciliary, Rest Home or Custodial Care Services:** Assisted living facility; any other facility providing room, board and personal assistance services
- **Home Services:** Private residence

Step 2 – Determine Relationship Between Physician & Patient

The relationship between the physician and the patient is the next thing you must determine.

- **New or Established:** An established patient is one who has received professional services from this physician, or another physician of the same specialty within the same practice, during the last three years
 - If this is not stated in the physician's notes for this encounter, you may need to refer back to the patient's chart
- **Initial or Subsequent:** An initial visit is the first date of service this physician sees this patient and a subsequent visit is one on an additional date, after the first date, during this course of treatment
 - Services are reported by complete day (calendar date) of service
- **Consultation Services:** Determine who requested the consultation
 - Physician or other health-care professional = use **consultation code** from the range 99241-99255
 - Patient and/or family member = use appropriate **location of service code**, such as: outpatient 99201-99215 or hospital 99217-99239

Step 3 – Determine Level of History from Documentation

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

- Histories are usually taken orally—a spoken exchange of questions and answers between the provider and the patient—but there still **MUST** be notes that record what occurred
- A patient history review of systems (ROS) is not an examination
- The physician may indicate that a body or 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
- There are four types of histories: (1) problem-focused, (2) expanded problem-focused, (3) detailed, and (4) comprehensive:

• **Problem-Focused**

- 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
- Brief history of present illness or concern: The patient's recounting of the date and time (as accurately as possible) of the onset and progress of the chief complaint, including first sign and/or symptom, as well as anatomical location, severity, timing, circumstances, modifying factors, and related signs and/or symptoms

• **Expanded Problem-Focused**

- Chief complaint (same as above)
- Brief history of present illness or concern (same as above)
- **System Review:** Pertains only to that system directly related to the chief complaint or present illness:
 - signs/symptoms: fever, weight loss, etc.
 - eyes
 - ears, nose, mouth, throat
 - cardiovascular
 - respiratory
 - gastrointestinal
 - genitourinary
 - musculoskeletal
 - integumentary: skin and/or breast
 - neurological
 - psychiatric
 - endocrine
 - hematologic/lymphatic
 - allergic/immunologic

• **Detailed**

- Chief complaint (same as above)
- **Extended history of present illness or concern**—brief history expanded upon to include pertinent **past** family and/or social history directly related to the chief complaint or present illness:

- prior major illnesses and injuries
- prior surgical procedures
- prior hospitalizations
- current medications and/or vitamin/supplements
- allergies (drug, food, inhalant, etc.)
- immunization status (age-appropriate)
- dietary/nutritional status (feeding, eating, etc.)

• **Family history** includes:

- health status (or cause of death) of parents, siblings and children
- specific diseases of family members related to problems identified in 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** includes:

- marital status and/or living arrangements
- current employment
- occupational history
- use of drugs, alcohol and/or tobacco
- level of education
- sexual history
- other relevant social factors

• **System Review:** Review of systems directly related to the chief complaint or present illness **PLUS** a limited history of additional related systems:

- signs/symptoms: fever, weight loss, etc.
- eyes
- ears, nose, mouth, throat
- cardiovascular
- respiratory
- gastrointestinal
- genitourinary
- musculoskeletal
- integumentary: skin and/or breast
- neurological
- psychiatric
- endocrine
- hematologic/lymphatic
- allergic/immunologic

• **Comprehensive***

- Chief complaint
- Extended history of present illness or concern
- Complete past, family and/or social history
- **System Review:** Review of systems directly related to the history of the present illness **PLUS** a history related to **all** body systems—as the name implies, this is the most complete form of history
 - signs/symptoms: fever, weight loss, etc.
 - eyes
 - ears, nose, mouth, throat
 - cardiovascular
 - respiratory
 - gastrointestinal

Evaluation And Management Coding Guidelines 2012

**Joseph T. DiPiro, Gary C. Yee, L. Michael
Posey**



Evaluation And Management Coding Guidelines 2012:

This book delves into Evaluation And Management Coding Guidelines 2012. Evaluation And Management Coding Guidelines 2012 is an essential topic that must be grasped by everyone, from students and scholars to the general public. The book will furnish comprehensive and in-depth insights into Evaluation And Management Coding Guidelines 2012, encompassing both the fundamentals and more intricate discussions.

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 - Chapter 1: Introduction to Evaluation And Management Coding Guidelines 2012
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