

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.
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