

# 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

**L Cohen**



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## **Table of Contents Evaluation And Management Coding Guidelines 2012**

1. Understanding the eBook Evaluation And Management Coding Guidelines 2012
  - The Rise of Digital Reading Evaluation And Management Coding Guidelines 2012
  - Advantages of eBooks Over Traditional Books
2. Identifying Evaluation And Management Coding Guidelines 2012
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Evaluation And Management Coding Guidelines 2012
  - User-Friendly Interface
4. Exploring eBook Recommendations from Evaluation And Management Coding Guidelines 2012
  - Personalized Recommendations
  - Evaluation And Management Coding Guidelines 2012 User Reviews and Ratings
  - Evaluation And Management Coding Guidelines 2012 and Bestseller Lists
5. Accessing Evaluation And Management Coding Guidelines 2012 Free and Paid eBooks
  - Evaluation And Management Coding Guidelines 2012 Public Domain eBooks
  - Evaluation And Management Coding Guidelines 2012 eBook Subscription Services
  - Evaluation And Management Coding Guidelines 2012 Budget-Friendly Options

6. Navigating Evaluation And Management Coding Guidelines 2012 eBook Formats
  - ePub, PDF, MOBI, and More
  - Evaluation And Management Coding Guidelines 2012 Compatibility with Devices
  - Evaluation And Management Coding Guidelines 2012 Enhanced eBook Features
7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Evaluation And Management Coding Guidelines 2012
  - Highlighting and Note-Taking Evaluation And Management Coding Guidelines 2012
  - Interactive Elements Evaluation And Management Coding Guidelines 2012
8. Staying Engaged with Evaluation And Management Coding Guidelines 2012
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Evaluation And Management Coding Guidelines 2012
9. Balancing eBooks and Physical Books Evaluation And Management Coding Guidelines 2012
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Evaluation And Management Coding Guidelines 2012
10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
11. Cultivating a Reading Routine Evaluation And Management Coding Guidelines 2012
  - Setting Reading Goals Evaluation And Management Coding Guidelines 2012
  - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Evaluation And Management Coding Guidelines 2012
  - Fact-Checking eBook Content of Evaluation And Management Coding Guidelines 2012
  - Distinguishing Credible Sources
13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
14. Embracing eBook Trends
  - Integration of Multimedia Elements

- Interactive and Gamified eBooks

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