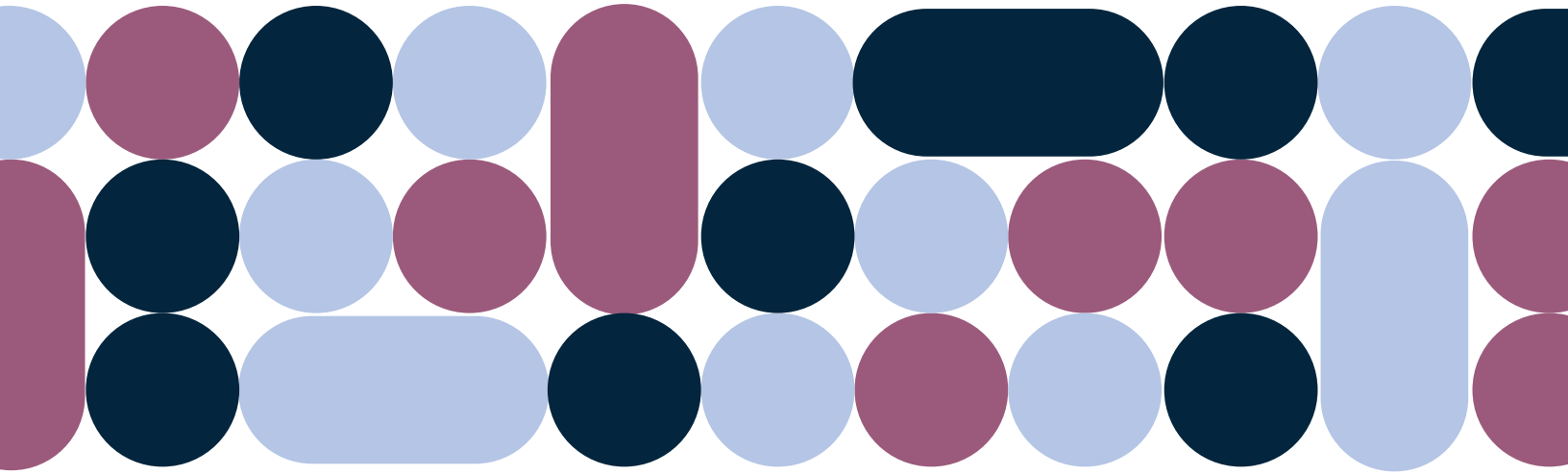
Evaluation & Management Coding Reference Guide

A comprehensive resource for evaluation and management coding and documentation challenges

THIRD EDITION



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Evaluation and Management Subcategories

Evaluation and management (E/M) services are placed prominently at the forefront of the CPT® code book, indicating the importance of these codes. For many providers, E/M services represent the bulk of codes reported. For each E/M service, code selection is based on location, physician work, and the extent of medical decision making demonstrated during the visit. The E/M codes are reported by physicians and physician extenders of all medical specialties.

The E/M codes (99202–99499) describe a provider's service to a patient including evaluating the patient's condition(s) and determining the management of care required to treat the patient. Services based solely on time, such as physician standby services, also may be defined as E/M services.

New vs. Established Patient Status

If you think that the "three-year rule" is all you need to know when you determine whether a patient is new or established in your practice, you might want to think again. You need to consider other factors, such as the kind of services a patient has already received, and what exceptions may come into play, before you make that determination.

So, here's a brief guide that will help you the next time the issue comes up in your practice.

The 3-Year Rule

A close reading of the CPT® guidelines reveals much more than the simple definition that a new patient is one that has not received services from your practice in three years prior to seeing your provider. CPT® also requires that:

1. **The services need to be professional.** Professional means services following the CPT® definition of being performed by a physician or other qualified healthcare professional and being reported by an E/M code.
2. **The services need to be face-to-face.** CMS has determined that services such as EKGs, diagnostic tests, or X-ray interpretations do not affect a patient's status unless they are accompanied by an E/M or other face-to-face service.
3. **The services need to be in the same specialty or subspecialty.** This part of the definition can be significant for large practices that may employ subspecialists, as patients that may be regarded as established in one specialty may be classified as new when they are seen for the first time by a specialist in a different field. As an example, an adolescent patient who has been seen by a pediatrician and graduates into adult care would be regarded as new when seen by an internist or a family practitioner in the same practice for the first time.

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Reserve 57 for Major Procedures

When the physician provides an ED service and, based on that service, performs a major surgical procedure (one with a 90-day global period) on the same or the next date of service, you should append modifier 57 to the ED E/M code.

This tells the payer that the surgery was not scheduled or planned and that the surgeon has not already been paid for the preoperative component of the global surgical package.

Example: A patient presents to the ED with extreme pain in the lower abdomen (R10.30). Upon examination, the ED physician determines the patient has a severely inflamed appendix and performs an immediate appendectomy.

In this case, you should report the appendectomy (44950), along with the ED service level best supported by the physician's documentation. Because 44950 has a 90-day global period, you should append modifier 57 to the ED service code to alert the payer of several things:

1. The physician arrived at the decision to perform surgery during the ED visit.
2. No prior pre-surgical visits have been paid and the ED visit is not bundled with the surgery itself, so the ED visit is separately payable.

Patients in the ED frequently need transfers to or from another venue to receive the care they need. The emergency physician is typically involved in these transfers, but not all of that work is separately reportable from the E/M service. Read on to find out what can and cannot be reported separately.

This has been an area of some confusion over the years. However, an in-depth discussion of ambulance transport codes in the May 2013 *CPT Assistant*® may shed some light.

It is not at all uncommon for a physician in the ED to provide medical direction via radio to EMS personnel in the field. A code exists for this service: 99288 *Physician or other qualified healthcare professional direction of emergency medical systems [EMS] emergency care, advanced life support*. These must be transports of an emergency nature requiring advanced life support rather than a routine transfer, or even transporting a patient from a nursing home to the emergency department for a routine checkup.

CPT® says that the code is intended to cover the direction of necessary medical procedures including but not limited to: telemetry of cardiac rhythm; cardiac or pulmonary resuscitation; endotracheal or esophageal obturator airway intubation; administration of IV fluids and/or administration of intramuscular, intratracheal, or subcutaneous drugs; and electrical cardioversion.

Drawback: Code 99288 has no RVUs assigned and is frequently not covered by payers. They consider it to be part of the preservice work of the E/M service when the patient does arrive in the ED and the physician takes over the patient's care. In the less likely event that the radio direction is for a patient that does not come to the ED where the physician is working, there is no face-to-face encounter so that service has historically not been reportable either.

Peds patient difference: Changes in the regionalization of care have caused an increase in the number of transfers from one facility to another, especially for pediatric and neonatal patients.

There are specific codes in the CPT® code book for transporting critically ill or injured kids under two years of age requiring the physical attendance and direct face-to-face care by a physician during the interfacility transport. These are 99466 *Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; first 30-74 minutes of hands-on care during transport* and +99467 *… each additional 30 minutes (List separately in addition to code for primary service).*

Key: Unlike code 99288, these require face-to-face care, which starts when the physician assumes primary responsibility of the pediatric patient at the referring facility, and ends when the receiving facility accepts responsibility for the pediatric patient's care. You can only report the time the physician spends in direct face-to-face contact with the patient during the transport, so any time spent traveling to the transferring facility to collect the patient cannot be counted toward the minimum time threshold.

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subspecialty. Review of external notes is included in the E/M codes with low to high MDM. Discussion with an external provider is included in codes with moderate and high MDM.

An **independent historian** is a family member, witness, or other individual who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Social determinants of health (SDOH) are economic and social conditions that influence health. SDOH is something you may be familiar with from ICD-10-CM coding, specifically categories Z55.- to Z65.-, Persons with potential health hazards related to socioeconomic and psychosocial circumstances. But the 2021 MDM table references SDOH as an example of moderate risk from additional diagnostic testing or treatment because SDOH, like housing insecurity, may limit those options.

Drug therapy requiring intensive monitoring for toxicity is in the 2021 CPT® MDM table as an example of high risk of morbidity from additional diagnostic testing or treatment. To be sure the case you're coding qualifies as intensive monitoring for toxicity, review these conditions listed in the guidelines:

- The drug can cause serious morbidity or death.
- Monitoring assesses adverse effects, not therapeutic efficacy.
- The type of monitoring used should be the generally accepted kind for that agent, although patient-specific monitoring may be appropriate, too.
- Long-term or short-term monitoring is OK.
- Long-term monitoring occurs at least quarterly.
- Lab, imaging, and physiologic tests are possible monitoring methods. History and exam are not.
- Monitoring affects MDM level when the provider considers the monitoring as part of patient management.
- An example of drug therapy requiring intensive monitoring for toxicity is testing for cytopenia (reduction in the number of mature blood cells) between antineoplastic agent dose cycles.

Morbidity is a "state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment." Morbidity is an important term to understand for the acute and chronic illness definitions below.

Acute and chronic illnesses are referenced in a variety of ways in the "Number and Complexity of Problems Addressed" column of the CPT® level of MDM table. Table 4 will help you compare these terms for acute and chronic illnesses.

Table 4: CPT® E/M Guideline Definitions for Acute and Chronic Illnesses

Term	Description	Examples
Acute, uncomplicated illness or injury	• The problem is recent and short-term. • There is a low risk of morbidity. • There is little to no risk of mortality with treatment. • Full recovery without functional impairment is expected. • The problem may be self-limited or minor, but it is not resolving in line with a definite and prescribed course.	• Cystitis • Allergic rhinitis • Simple sprain
Acute illness with systemic symptoms	• The illness causes systemic symptoms, which may be general or single system. • There is a high risk of morbidity without treatment. • For a minor illness with systemic symptoms like fever or fatigue, consider acute, uncomplicated or self-limited/minor instead.	• Pyelonephritis • Pneumonitis • Colitis
Acute, complicated injury	• Treatment requires evaluation of body systems that aren't part of the injured organ, the injury is extensive, there are multiple treatment options, or there is a risk of morbidity with treatment.	• Head injury with brief loss of consciousness
Stable, chronic illness	• This type of problem is expected to last at least a year or until the patient's death. • A change in stage or severity does not change whether a condition is chronic. • The patient's treatment goals determine whether the illness is stable. A patient who hasn't achieved their treatment goal is not stable, even if the condition hasn't changed and there's no short-term threat to life or function. • The risk of morbidity is significant without treatment.	• Well-controlled hypertension • Non-insulin dependent diabetes • Cataract • Benign prostatic hyperplasia • NOT stable: Asymptomatic but persistently poorly controlled blood pressure (pressures don't change), with a treatment goal of better control
Chronic illness with exacerbation, progression, or side effects of treatment	• The chronic illness is getting worse, is not well controlled, or is progressing "with an intent to control progression." • The condition requires additional care or treatment of the side effects. • Hospital level of care is not required.	• No examples given by CPT® guidelines
Chronic illness with severe exacerbation, progression, or side effects of treatment	• There is a significant risk of morbidity. • The patient may require hospital care.	• No examples given by CPT® guidelines
Acute or chronic illness or injury that poses a threat to life or bodily function	• There is a near-term threat to life or bodily function without treatment. • An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment may be involved.	• Acute myocardial infarction • Pulmonary embolus • Severe respiratory distress • Progressive severe rheumatoid arthritis • Psychiatric illness with potential threat to self or others • Peritonitis • Acute renal failure • Abrupt change in neurologic status

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So, let's say a Medicare patient reports to your practice complaining of shoulder pain on November 21, 20X7. Records indicate that the patient last reported to your practice for pain related to a fractured thumb on April 24, 20X2. This patient is new, for E/M coding purposes.

Established Px parameters: For coding purposes, an established patient "has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years," states WPS Medicare.

Let's say physicians A and B both work for the same group practice. Physician A performs an office E/M in July 20X5 for a patient to check up on a recurring thumb injury. In November 20X7, physician B performs an office E/M for the same patient to address her back pain.

For the 20X7 visit, you should choose an established patient E/M code.

Exceptions: There are a few new and established patient exceptions, which will depend on your practice's scope and the payer. If your practice includes sub-specialists, and the payer allows it, situations might arise in which new patient E/M codes are appropriate for an otherwise established patient.

Best bet: Look before you leap. Contact your payers and ask how they apply new and established patient guidelines specifically with regard to different specialties and sub-specialties in the same group practice.

Specialty: Cardiovascular

Cardiologists typically have specialized equipment, such as electrocardiograms, echocardiography, and Holter monitors, in their office. They use these to perform diagnostic studies on the cardiovascular system.

Electrocardiograms

Electrocardiography (ECG or EKG) is the process of obtaining a graphic depiction of the electrical potentials generated by cardiac activity as recorded from electrodes placed on the body surface and normally refers to standard 12-lead tracing, with or without a rhythm strip or other special leads. Cardiologists typically perform ECGs to evaluate heart rate and rhythm, chest pain and irregular heart rhythms, and inadequate blood flow to the heart muscle. You'll use the following codes for ECG services, depending on the portion of the ECG your provider performs:

- 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* — Report this code for the combined technical and professional components.
- 93005 *Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report* — Report this code for the technical component only.
- 93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only* — Report this code for the professional component only.

Many other services include both a professional and technical component, and you must use modifiers 26 and TC when your provider only performs one part or the other. However, ECG codes separately define the global (93000), professional (93010), and technical (93005) portions of the service and you don't need to attach a modifier.

Remember: An ECG that has been interpreted by a computer alone is not recognized as a properly interpreted ECG. A physician or other qualified healthcare professional must read the results and provide a written or dictated report, not merely sign off on computer interpretations.

Stress Test

A stress test is an ECG your provider performs both before and after stress. The stress can be induced by a treadmill, stationary bicycle, or a pharmacologic agent. Cardiologists can perform stress tests using a treadmill or stationary bicycle in an office setting, whereas they perform stress tests using pharmacologic agents in a facility setting.

Echocardiography

Echocardiography graphically records and depicts the position and motion of the heart walls or the internal structures of the heart and neighboring tissue using echoes obtained from ultrasonic waves directed through the chest wall.

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You report 90792 when your clinician performs an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies. An E/M service will constitute medically appropriate history and examination (which may include mental status) and MDM.

So, you will choose 90792 when your clinician's main focus of evaluation is the "integrated biopsychosocial and medical assessment," while you choose to report an appropriate E/M code when your clinician's evaluation is more medically or physically oriented, although psychosocial issues may also be factored in.

In other words, you will need to report the appropriate code for the initial evaluation based on the components and the focus of the evaluation performed by your clinician.

For the succeeding visits, you have mentioned that 90834 *Psychotherapy, 45 minutes with patient* and 99212 were being reported for the psychotherapy and pharmacological management of the patient.

Since you are reporting an E/M code with psychotherapy, you will need to report an appropriate add-on code for the psychotherapy aspect instead of reporting 90834. If your clinician is typically spending 38-52 minutes in performing psychotherapy for a patient, you will need to report +90836 *Psychotherapy, 45 minutes with patient when performed with an evaluation and management service [List separately in addition to the code for primary procedure]* instead of 90834. If the time component of the psychotherapy session varies, report other add-on codes (based on time) rather than routinely reporting one code for all the patients.

Again, when reporting pharmacological management, you will need to look into what your clinician evaluated and then choose an apt E/M code rather than only reporting 99212 for every situation. You will choose 99212 when your clinician only filled the prescription and did not perform any other assessments of the patient. When your clinician assessed the patient for adverse effects of the medication or performed adjustments to the dosage, you can look at reporting higher levels of the E/M code. In any case, the level of E/M service reported should reflect the level of MDM documented by the clinician.

Gastroenterology

Question: *We reported 99213 as well as the colonoscopy screening code G0121, and we used modifier 25 on the E/M code. Our payer used to reimburse us for this but we're now seeing denials. Should we appeal?*

Answer: Probably not. If your gastroenterologist frequently reports an E/M code (99202-99215) on to their screening colonoscopy services, check the documentation for notes that would support the E/M code — in most cases, this information is insufficient to report both an E/M and a colonoscopy.

For instance, you note that your physician reported 99213 with most of her screening colonoscopies, such as G0121 *Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk.*

How to Avoid Claims Denials

Making sure the right person signs medical documentation in the right way may seem like a trivial component of your job. Yet "signature issues are among the biggest findings in the comprehensive error rate testing (CERT) and medical error rate programs," said National Government Services (NGS) Medicare during the MAC's webinar "Medicare Signature Guidelines."

So, with denials and compliance problems on the line, you might want to refresh your knowledge of Medicare's definitions regarding what constitutes an acceptable signature and take these five steps to satisfy Medicare requirements.

Step 1: Know When the Signature Itself Needs Support

First, some guidelines. Medicare requires that services provided or ordered be authenticated by the author, and the method used for authenticating must be a handwritten or electronic signature. "Medicare's definition of a handwritten signature is a mark or sign by an individual on a document to signify their knowledge, approval, acceptance, or obligation," NGS Medicare noted. Unsigned documentation, or a lack of attestation, will result in a claim denial.

In some cases, the provider will sign a document, but the signature isn't necessarily one that would appear legible to the average reviewer. In these cases, you have the option of creating, maintaining, and submitting additional documentation to demonstrate that the signature actually belongs to the provider in question, which can include a signature log and/or an attestation.

"Providers can sometimes include a signature log in the documentation they submit that lists the type or printed name of the author along with credentials associated with initials for an illegible signature," NGS Medicare said. "A signature log is a typed listing of the providers identifying their names with corresponding handwritten signatures. This may be an individual log or a group log. A signature log may be used to establish signature identity as needed throughout the medical record documentation."

Providers might also include an attestation statement. To be considered valid by Medicare, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.

At any given time, you can submit an attestation statement, signature log, or a document affirming that the signature belongs to the provider if you find the signature to be illegible. "The signature documents can be submitted routinely for all requests for medical records, so in other words, don't wait for us to ask for it, by all means, send it in," NGS Medicare said.

Step 2: Determine Who Must Sign

In most cases, the provider who performed or ordered the service will sign the record, but there are situations when coders have questions about who needs to sign. For instance, it can be confusing to know which provider should enter a

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If you can answer affirmatively to the above question pair, you've likely got a concurrent care claim. If you answer "no" to either question, the service likely falls under the scope of duplicative care.

On concurrent care claims, be diligent in the reporting order of the diagnoses for each claim.

Explanation: Let's say one physician is treating condition A, and the other is treating condition B, but condition C is underlying. When coding for concurrent care, condition C should not be the primary diagnosis for either service. The documentation should clearly illustrate the physician's involvement with the patient as to who is treating what injury or illness.

When a Patient Has Multiple Issues, Focus on Diagnosis Codes

Concurrent care can occur when a patient reports to one physician for an E/M, then that physician directs the patient to another physician for a separate issue. Think about a patient with neoplasm-related colon cancer.

So, let's say an oncologist performs a level-two initial inpatient hospital service for the patient with colon cancer. The oncologist then contacts an acute care pain specialist to treat the patient's neoplasm-related pain. Documentation indicates a level-three consultation service, and includes a note stating that the specialist received a request for opinion from the oncologist.

Oncologist coding: The oncologist would report 99222 *Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making* …. Also, the coder should include a diagnosis code to represent the patient's colon cancer, such as C18.9 *Malignant neoplasm of colon, unspecified*. Make sure you choose this ICD-10-CM code based on the specifics of the encounter.

Pain specialist coding: The acute pain physician would report 99253 *Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making* …. Also, the coder should include a diagnosis code to represent the patient's cancer pain, such as G89.3 *Neoplasm related pain (acute) (chronic).*

For the above scenario, both physicians are treating the patient concurrently for colon cancer, but with a different symptom focus.

Note: Physicians in the same specialty might also provide concurrent care.

For example, a patient with a fractured wrist and ankle is treated by two orthopedic surgeons in the same practice. Surgeon A treats the patient's wrist injury, and Surgeon B, who specializes in ankle injuries, treats the ankle fracture.

This is a potential concurrent care situation, even though the surgeons share both specialty and practice.

Concurrent Can Feature Only 1 Diagnosis

Though the above example highlights concurrent care for two separately diagnosable conditions, different ICD-10-CM codes for each concurrent care provider aren't always necessary. Two physicians can treat a patient for the same condition and bill the same ICD-10-CM code with their E/M service.

Time-Based Coding

Elements of Time	
Provider time includes the following activities, when performed: *Preparing to see the patient, such as reviewing the patient's record *Obtaining and/or reviewing separately obtained history *Performing a medically appropriate history and examination *Counseling and educating the patient, family, and/or caregiver *Ordering medications, tests, or procedures *Referring and communicating with other healthcare providers when not separately reported *Documenting clinical information in the electronic or other health record *Independently interpreting results when not separately reported *Communicating results to the patient/family/caregiver *Coordinating the care of the patient when not separately reported	Do NOT count time on the following: *Time spent on performing any service that is reported separately *Travel *Teaching that is general and not limited to discussion that is required for the management of a specific patient
Total Encounter Time: _____	**E/M Code: _____**

Prolonged Services - Physician or Other Qualified Healthcare Professional					
E/M Code	**Time**	**Report E/M code only**	**99417 x 1**	**99417 x 2**	**99417 x 3 or more for each additional 15 min.**
99205	60-74	Less than 75 minutes	75-89	90-104	105+
99215	40-54	Less than 55 minutes	55-69	70-84	85+
99245	55+	Less than 70 minutes	70-84	85-99	100+
99345	75+	Less than 90 minutes	90-104	105-119	120+
99350	60+	Less than 75 minutes	75-89	90-104	105+
99483	60+	Less than 75 minutes	75-89	90-104	105+

E/M Code	Time	Report E/M code only	99418 x 1	99418 x 2	99418 x 3 or more for each additional 15 min.
99223	75+	Less than 90 minutes	90-104	105-119	120+
99233	50+	Less than 65 minutes	65-79	80-94	95+
99236	85+	Less than 100 minutes	100-114	115-129	130+
99255	80+	Less than 95 minutes	95-109	110-124	125+
99306	45+	Less than 60 minutes	60-74	75-89	90+
99310	45+	Less than 60 minutes	60-74	75-89	90+

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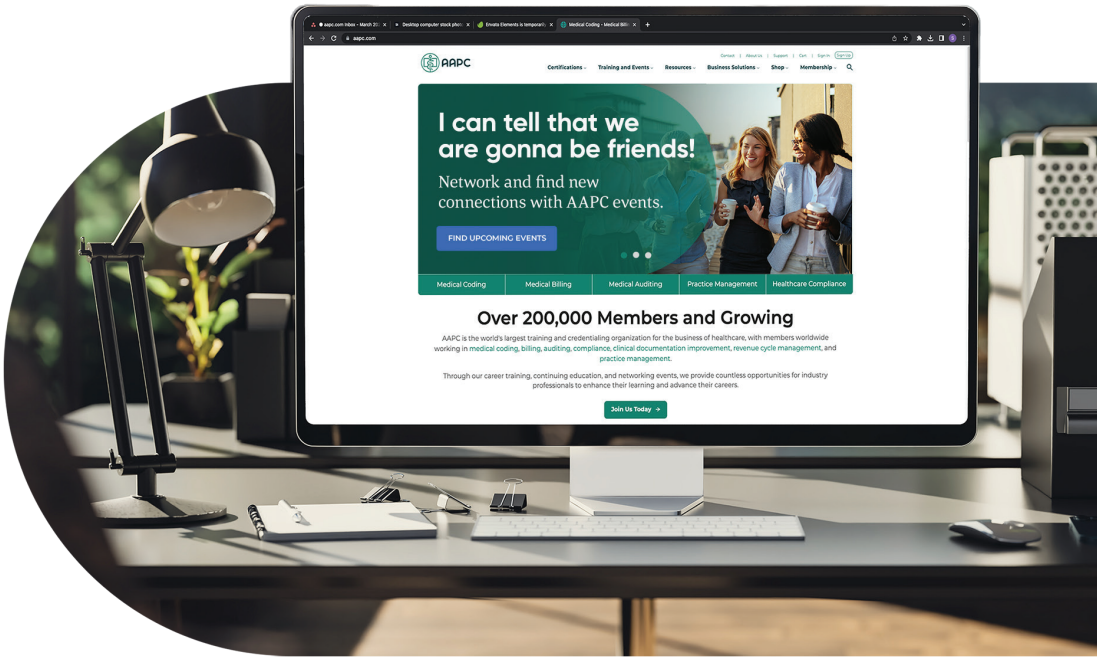

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