Evaluation & Management Coding Reference Guide

A comprehensive resource for evaluation and management coding and documentation challenges

SECOND EDITION
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SECOND EDITION
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Evaluation and management (E/M) services represent the bulk of codes reported by many physicians and physician extenders of all medical specialties. The guidelines for E/M services are complex and can be difficult to understand, leading to potential audits and claims denials.

Safeguard your organization from claim denials and audit scrutiny with the **Evaluation & Management Coding Reference Guide**. Our experts break down E/M coding rules and requirements into simple, manageable steps written in everyday language to boost your E/M reporting skills. Learn how to capture the key components of medical history, physical exam, and medical decision making — and capitalize on real-world clinical scenarios to prevent over- or under-coding.

The **Evaluation & Management Coding Reference Guide** will help you adapt to the 2021 E/M guideline changes that overhauled new and established office and outpatient services coding, and walk you through online digital E/M services, remote physiologic monitoring, and more.

**Note:** The information in this guide is provided to use for coding services. It is not a guarantee of payment and not meant to replace an individual coder’s judgment. Check with individual payers for their guidelines on coding, billing, and reimbursement for E/M codes. Note that the code ranges in the table of contents match the AMA CPT® code book; however, not all codes within a specific range will be covered within this guide.

Master the ins and outs of E/M coding — CPT® guidelines, level of service, modifiers, regulations, and documentation guidelines. Put an end to avoidable denials and optimize your E/M claims for full and prompt reimbursement.
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.
Emergency Department Services (99281-99288)

You may report 99281-99285 only for services the physician provides in the ED.

An ED, as defined by the IOM (Publication 100-4, Chapter 12, Section 30.6.11B), is an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention. CPT® defines an ED similarly as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention.

You should not report 99281-99285 Emergency department visit for the evaluation and management of a patient... Counseling and/or coordination of care with other physicians, other qualified healthcare professionals ... for services (even emergency services) the physician provides in the office or outpatient setting other than an emergency department.

You can report 99281-99285 even in nonemergency situations for services provided in the ED. The only requirement for using the emergency department codes is that the patient be seen in the emergency department for an unanticipated service, the IOM states.

Any physician — not only those assigned to the ED — can report 99281-99285. Nothing in the ED service codes definitions limits you to reporting them for physicians assigned to the ED.

Medicare specifically states in the IOM (Publication 100-4, Chapter 12, Section 30.6.11), "Any physician seeing a patient in the ED may use ED visit codes for services matching the code description. It is not required that the physician be assigned to the emergency department to use ED visit codes."

Use Key Components to Choose Service Level

When assigning 99281-99285, you must rely on the key E/M components of history, exam, and MDM, as recorded in the physician’s documentation of the patient encounter. You must meet (or exceed) all three requirements to report a given service level, as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>Problem focused</td>
<td>Problem focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99282</td>
<td>Expanded problem focused</td>
<td>Expanded problem focused</td>
<td>Low complexity</td>
</tr>
<tr>
<td>99283</td>
<td>Expanded problem focused</td>
<td>Expanded problem focused</td>
<td>Moderate complexity</td>
</tr>
<tr>
<td>99284</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate complexity</td>
</tr>
<tr>
<td>99285</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High complexity</td>
</tr>
</tbody>
</table>

Example: A mildly disoriented patient presents to the ED with several lacerations suffered during a fall from a ladder.

The physician examines the patient and records an expanded problem-focused history, a detailed exam, and MDM of moderate complexity.
Initial and Continuing Intensive Care Services (99477-99480)

Initial and continuing intensive care codes 99477-99480 describe services the physician provides to infants who require intensive observation, frequent interventions, and other intensive services. Subsequent intensive care codes are restricted to infants 5,000 grams or less (approximately 11 pounds).

Documentation Needs to Support Services

Documentation must show that the neonate needs intensive care services, including (but not limited to) the following:

- Intensive cardiac and respiratory monitoring
- Continuous and/or frequent vital sign monitoring
- Heat maintenance
- Enteral and/or parenteral nutritional adjustments
- Laboratory and oxygen monitoring
- Constant observation by the healthcare team under direct physician supervision

As long as the patient meets the above requirements and weighs 5,000 grams or less, you can apply the intensive care codes. The patient need not have previously been in critical condition to qualify for continuing intensive care.

The neonatologist doesn’t have to be in constant attendance to report 99477-99480. Instead, they must provide direct supervision of the healthcare team that provides constant observation of the recovering infant.

Translation: The attending physician must provide direct patient contact and be readily available. The doctor doesn’t have to do the procedures or provide 24-hour in-house coverage, but they need to be physically present at some time during that 24-hour period to examine the patient and review the patient’s care and plan with the healthcare team.

Determining What’s Not Normal

Perhaps the trickiest part of coding newborn care services, however, is knowing when a non-critical newborn is very ill. Here’s what to look for in the physician’s documentation: A normal newborn is one who transitions from birth in a normal fashion and subsequently:

- Displays normal vital signs including normal color, respiration, and cardiovascular status
- Begins and continues to feed, stool, and urinate as expected
- Has no significant abnormalities on examination

In contrast, an abnormal newborn may exhibit the following condition(s):

- Abnormal vital signs, such as tachypnea (P22.1), hypothermia (P80.8), environmental hyperthermia of newborn (P81.0), tachycardia (P29.11)
- Abnormal metabolic findings, such as low glucose (P70.4) or cow’s milk hypocalcemia in newborn (P71.0)
Compare the 2020 descriptor for 99203 to the 2021 descriptor below:

<table>
<thead>
<tr>
<th>Code</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.</td>
</tr>
</tbody>
</table>

The descriptors for 2021 codes 99202-99205 all follow the same structure as the 99203 example above. Table 1 shows the requirements for the new patient E/M codes in 2021.

<table>
<thead>
<tr>
<th>Code</th>
<th>History/Exam</th>
<th>MDM</th>
<th>Total Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>Medically appropriate history and/or examination</td>
<td>Straightforward</td>
<td>15-29</td>
</tr>
<tr>
<td>99203</td>
<td>Low</td>
<td></td>
<td>30-44</td>
</tr>
<tr>
<td>99204</td>
<td>Moderate</td>
<td></td>
<td>45-59</td>
</tr>
<tr>
<td>99205</td>
<td>High</td>
<td></td>
<td>60-74</td>
</tr>
</tbody>
</table>

For services longer than 74 minutes, the AMA created a new prolonged services add-on code: +99417 Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services).

**AMA 2021 Office/Outpatient E/M Codes: Established Patient**

The office and other outpatient E/M codes for established patients changed in line with the revisions to the new patient codes in 2021.

**99211**: Level-one established patient E/M code 99211 is still available, but it changed in 2021 with the removal of the time reference crossed out below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified healthcare professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.</td>
</tr>
</tbody>
</table>

**99212-99215**: Established patient E/M codes 99212-99215 look a lot like the new patient codes in 2021. For instance, review the revised descriptor for 99213:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.</td>
</tr>
</tbody>
</table>
CHAPTER 3

Modifiers

The most common modifiers used with evaluation and management services include:

- Modifier 24 Unrelated evaluation and management service by the same physician or other qualified healthcare professional during a postoperative period
- Modifier 25 Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service
- Modifier 32 Mandated services
- Modifier 57 Decision for surgery

To accurately apply many of the modifiers, it is important to understand the concept of the global surgical package.

The Global Surgical Package

The “Surgery Guidelines” within the CPT® code book list services that CPT® includes in the global surgical package, such as one pre-procedure E/M service on the day of and/or the day before, the procedure, local anesthesia, and immediate and typical postoperative care. Medicare’s list of items included in the global package is more extensive.

CPT® does not specify the length of the postoperative period for any individual procedure, whereas CMS defines very precisely in the Physician Fee Schedule Relative Value File, which is updated annually, the number of postoperative days assigned to each code. Minor surgeries are assigned 000 or 010 global days. Major surgeries are assigned 090 global days.

Because the CPT® code book and CMS define the components of the global surgical package differently, and third-party payer guidelines are inconsistent, you should check with your individual payer to determine its rules for the global surgical package.

Modifier 24

Modifier 24 is to be used when a patient is seen by the same provider or another provider of the same specialty who belongs to the same group practice during a postoperative period for an unrelated evaluation and management service. This occurs when a patient develops a symptom unrelated to the surgery. Some non-Medicare payers will allow modifier 24 on an E/M service when it is for a complication related to the surgery; check your payer guidelines.

Modifier 24 tells the payer that the E/M is not related to the surgery and should not be bundled in the global period. Sometimes, even though your provider may not have done the procedure, you can get services bundled due to a global period from a procedure that you don’t even know happened.
### Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| Minimal       | • One self-limited or minor problem, e.g., cold, insect bite, tinea corporis | • Laboratory tests requiring venipuncture  
• Chest X-rays  
• EKG/EEG  
• Urinalysis  
• Ultrasound, e.g., echo  
• KOH prep | • Rest  
• Gargles  
• Elastic bandages  
• Superficial dressings |
| Low           | • Two or more self-limited or minor problems  
• One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH  
• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain | • Physiologic tests not under stress, e.g., pulmonary function tests  
• Non-cardiovascular imaging studies with contrast, e.g., barium enema  
• Superficial needle biopsies  
• Clinical laboratory tests requiring arterial puncture  
• Skin biopsies | • Over-the-counter drugs  
• Minor surgery with no identified risk factors  
• Physical therapy  
• Occupational therapy  
• IV fluids without additives |
| Moderate      | • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment  
• Two or more stable chronic illnesses  
• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast  
• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis  
• Acute complicated injury, e.g., head injury with brief loss of consciousness | • Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test  
• Diagnostic endoscopies with no identified risk factors  
• Deep needle or incisional biopsy  
• Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath  
• Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis | • Minor surgery with identified risk factors  
• Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors  
• Prescription drug management  
• Therapeutic nuclear medicine  
• IV fluids with additives  
• Closed treatment of fracture or dislocation without manipulation |
| High          | • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
• Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure  
• An abrupt change in neurologic status, e.g., seizure, TIA, weakness, or sensory loss | • Cardiovascular imaging studies with contrast with identified risk factors  
• Cardiac electrophysiological tests  
• Diagnostic endoscopies with identified risk factors  
• Discography | • Elective major surgery (open, percutaneous, or endoscopic with identified risk factors)  
• Emergency major surgery (open, percutaneous, or endoscopic)  
• Parenteral controlled substances  
• Drug therapy requiring intensive monitoring for toxicity  
• Decision not to resuscitate or to de-escalate care because of poor prognosis |
<table>
<thead>
<tr>
<th>Acute or Chronic Illness or Injury that Poses a Threat to Life or Bodily Function</th>
<th>An acute illness with systemic symptoms (symptoms affecting one or more organ systems), an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the short term without treatment. Examples may include 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, or an abrupt change in neurologic status.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test</td>
<td>Tests are laboratory services, diagnostic imaging, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT® code set.</td>
</tr>
<tr>
<td>External</td>
<td>External records, communications, and/or test results are from an external provider, facility, or healthcare organization.</td>
</tr>
<tr>
<td>External Physician or Other Qualified Healthcare Professional</td>
<td>An external physician or other qualified healthcare professional is an individual who is in a different group practice or who is of a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health agency.</td>
</tr>
<tr>
<td>Independent Historian(s)</td>
<td>An individual such as a parent, guardian, surrogate, spouse, care giver, or witness, 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 of the patient or another mental condition(s), or because a confirmatory history is determined to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.</td>
</tr>
<tr>
<td>Independent Interpretation</td>
<td>The interpretation of a test for which there is a CPT® code and an interpretation or report is expected. This does not apply when the provider is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented, but need not conform to the usual standards of a complete report for the test.</td>
</tr>
<tr>
<td>Appropriate Source</td>
<td>For the purpose of the Discussion of Management Data Element, an appropriate source includes individuals who are not healthcare professionals, but may be involved in the management of the patient (e.g., lawyer, parole officer, power of attorney, case manager, clergy, teacher). It does not include discussion with family or informal caregivers.</td>
</tr>
<tr>
<td>Risk</td>
<td>The probability and/or consequences of an event (an event is the medical intervention or treatment). The assessment of the level of risk is affected by the nature of the medical intervention or treatment under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a provider in the same specialty. Trained clinicians apply common language usage meanings to terms such as “high,” “medium,” “low,” or “minimal” risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of calculating medical decision making, level of risk is based upon consequences of the problem(s) addressed at the visit when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment, and/or hospitalization.</td>
</tr>
<tr>
<td>Morbidity</td>
<td>A state of illness or functional impairment that is expected to be long-term duration in which function is limited, quality of life is impaired, or there is organ damage that may not be temporary despite treatment.</td>
</tr>
<tr>
<td>Social Determinants of Health</td>
<td>Economic and social conditions that may influence the health of individuals and communities. Examples may include food or housing insecurity, safety and welfare risks, unemployment, inadequate education, etc.</td>
</tr>
<tr>
<td>Drug Therapy Requiring Intensive Monitoring for Toxicity</td>
<td>A drug that requires intensive monitoring is a therapeutic agent which has the potential to cause serious morbidity or death. Monitoring is performed for assessment of potential adverse effects, not primarily for assessment of the therapeutic effect. Monitoring should follow practice that is generally accepted for the drug, but may be patient specific in some cases. Intensive monitoring may be long term or short term. Long-term intensive monitoring is performed not less than quarterly. Monitoring may include a lab test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. Monitoring affects the level of medical decision making in a visit in which it is considered in the management of the patient. Examples may include monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold.</td>
</tr>
<tr>
<td>Total Time on the Date of the Visit (99202-99205, 99212-99215)</td>
<td>For calculation purposes, time for these services is the total time on the date of the visit. It includes both the face-to-face and non-face-to-face time personally spent by the provider(s) on the day of the visit and includes time in activities that require the provider but does not include time in activities normally performed by clinical staff.</td>
</tr>
</tbody>
</table>
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