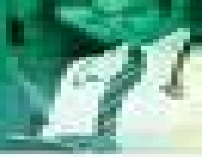
Quick Study ACADEMIC

Evaluation & Management (E/M) Coding Calculator



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

Standard Codes for Evaluation & Management (E/M)

Step 1: Determine Whether Patient Has a Diagnosis or Symptom

- If the patient is not sick, use codes for preventive services (99381–99397), counseling (99401–99412), disability evaluation (99450–99456), or evaluation of newborn (99460–99463)
- If patient is sick, use any E/M codes except those listed above. Follow steps 2–7 to determine the correct code

Step 2: Determine the Location of the Service

- **Office or other outpatient services (99201–99215):** Physician's office, walk-in clinic, ambulatory health-care center, etc.
- **Hospital services (99221–99239):** Inpatient, acute care facility
- **Observation services (99217–99226 and 99234–99236):** Patient admitted to hospital under "observation status"
- **Emergency department services (99281–99285):** A hospital-based facility, open 24 hours a day, providing unplanned services to patients requiring immediate medical attention
  - **Critical care/intensive care services (99291–99292 and 99477–99480):** Direct delivery of medical care for patients with a high likelihood of an impending or life-threatening decline of their condition
- **Nursing facility services (99304–99318):** Skilled nursing facility (SNF), intermediate care facility (ICF), long-term care facility (LTCF), psychiatric residential treatment center
- **Domiciliary, rest home, or custodial care services (99324–99340):** Assisted living facility or any other facility providing room, board, and personal assistance services
- **Home Services (99341–99350):** Physician visited patient at his or her home (private residence)

Step 3: Determine the Relationship Between Physician & Patient

- **New or established:** An established patient has received professional services from this physician, or another physician of the same specialty within the same practice during the last three years. A new patient has never seen this physician/another physician of the same specialty in this practice or was last seen by this physician/another physician of same specialty in this practice more than three years ago
- **Initial or subsequent:** An initial visit is the first date of service the physician sees the patient and a subsequent visit is one on a later date during this course of treatment
  - These terms are used for services provided for patients in observation care, inpatient care, and nursing facilities
  - Services are reported by the completed day (calendar date) of service
- **Consultation services:** These services require a requesting physician and a consulting physician. One physician sends a patient to see another physician with a request for advice or recommendations on the patient's care. The services may be inpatient (99251–99255) or outpatient (99241–99245)

NOTE: Medicare will not pay for any consultation codes. For Medicare patients, use other E/M visit codes (such as outpatient or inpatient codes)

Step 4: Determine the Level of History from Documentation

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

- History includes four components (not all levels of service include all four components):
  - **Chief complaint (CC):** The patient's description of why he/she felt the need to see the physician for this visit—could be a sign, symptom, condition, diagnosis, or other health-related concern
  - **History of present illness (HPI):** Series of questions asked by a physician or ancillary staff about the patient's condition. This includes seven elements: location, quality, severity, timing, context, modifying factors, and associated signs and symptoms

NOTE: Medicare includes an eighth element: duration

EX: Location (where is the pain?), quality (is the pain sharp or dull?), severity (is the patient bedridden due to the pain?), timing (is the pain constant?), context (is the pain worse when the patient is lying down?), modifying factors (does the pain lessen when the patient takes over-the-counter drugs?), associated signs and symptoms (is the patient nauseated due to the pain?), and duration (how long has the pain been present?)

  - **Review of systems (ROS):** Series of questions to identify signs and/or symptoms the patient may be experiencing now or has experienced in the past. The systems reviewed may include:
    - Constitutional symptoms (fever, weight loss, etc.)
    - Eyes
    - Ears, nose, mouth, and throat
    - Cardiovascular
    - Respiratory
    - Gastrointestinal
    - Genitourinary
    - Musculoskeletal
    - Integumentary (skin and/or breast)
    - Neurological
    - Psychiatric
    - Endocrine
    - Hematologic/Lymphatic
    - Allergic/Immunologic
  - **Past/family/social history (PFSH):** Series of questions concerning the patient's personal and family background. This includes:
    - **Patient's history**
      - Prior major illnesses and injuries, surgical procedures, and hospitalizations
      - Current medications and allergies (drug, food, inhalant, etc.)
      - Immunization status (age-appropriate) and dietary/nutritional status (feeding, eating, etc.)
    - **Family history**
      - Health status (or cause of death) of parents, siblings, and children
      - Specific diseases of family members related to problems identified in the 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**
      - Marital status and/or living arrangements
      - Current employment
      - Occupational, military, and sexual history
      - Use of drugs, alcohol, and/or tobacco
      - Level of education
      - Other relevant social factors
- Histories are often provided by the patient using a form filled-out before seeing the physician or by a nurse. The physician must note that the form was reviewed
- A patient's review of systems (ROS) is not the same as an examination
- The physician may indicate that an 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. This area can be counted toward the history

The levels of history are:

Problem-Focused History

- **Chief complaint (CC)** required
- **Brief HPI:** Documentation of a limited number (usually 1–3) of elements
- **ROS:** No ROS is required
- **PFSH:** No PFSH is required

Expanded Problem-Focused History

- **Chief complaint (CC)** required
- **Brief HPI:** Documentation of a limited number (usually 1–3) of elements
- **ROS:** Review of system related to the chief complaint
- **PFSH:** No PFSH is required

Detailed History

- **Chief complaint (CC)** required
- **Extended HPI:** Documentation of extended (usually 4 or more) elements
- **ROS:** Review of an extended number (usually 2–9) of systems directly related to the chief complaint or present illness **plus** a limited history of additional related systems
- **PFSH:** One item from past, family, or social history related to patient's current condition

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Evaluation And Management Coding Pocket Guide:

Evaluation and Management Coding Reference Guide - First Edition AAPC,2020-06-30 Defeat the challenges that threaten your E M claims and compliance success Evaluation and management E M services are the lifeblood of your revenue stream and yet they re the most problematic to report Claim denials remain high E M coding errors in fact rose from 11 9% in 2018 to account for 12 8% of CMS s overall 2019 improper payment rate How much E M revenue are you losing 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 prep for 2021 E M guideline changes overhauling new and established office and outpatient services and walk you through online digital E M services remote physiologic monitoring and more 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 Benefit from expert tutorials covering the spectrum of E M reporting concepts and challenges Prep for 2021 guideline changes and their impact on your organization Master the ins and outs of E M guidelines in CPT Capture the seven components of E M services Sort out medical decision making coding Avoid the pitfalls of time based coding Nail down specifics for critical care E M services Clear up modifier confusion Understand NPPs rules for same day E M services Take the guesswork out of complexity determinations Get the details on coding surgery and E M together Learn the principles of E M documentation *Practical Evaluation and Management Coding* Christopher L. Taylor,2008-03-14 This guide explains the Evaluation and Management E M coding process used by physicians and regulated by the American Medical Association In four chapters Dr Christopher Taylor establishes a step by step approach to determining the correct CPT code for the most common patient encounters in the office hospital or nursing home Helpful appendices provide E M coding guide templates and additional information *CPT 2022 E/M Express Reference Tables Pocket Guide - 10 Pack* American Medical Association,2021-09-17 This quick reference guide 10 pack provides a side by side comparison of evaluation and management E M codes Easy to use each table summarizes the requirements for reporting E M services and helps the user select and validate proper E M coding CPT 2022 E/M Express Reference Tables Pocket Guide American Medical Association,2021-09-17 This quick reference guide provides a side by side comparison of evaluation and management E M codes Easy to use each table summarizes the requirements for reporting E M services and helps the user select and validate proper E M coding **The New Face of Evaluation and Management** KELLIE. HALL,2025-04-17 This book evaluates the new guidelines and brings them into prospective so physicians providers coders can easily understand how to document and calculate the level of service for reimbursement **Evaluation and**

Management Coding Made Easy Terry Tropin,2020-11-12 Evaluation and Management Coding Made Easy book has now been updated to include the extensive 2021 changes This book simplifies the language of CPT R E M guidelines and places the guidelines into charts for easy reference The book covers Outpatient and inpatient coding Preventive care Other services such as critical care and prolonged services The book also includes a discussion of modifiers and terms used in E M services Forms are included to guide the reader through the step by step process of determining the level of service This book is designed especially for both students and working coders Evaluation and Management Coding Made Easy Terry Tropin,2021-11-29 This book simplifies the language of Current ProceduralTerminology CPT for Evaluation and Management coding The book includes the updates for 2022 This book was developed by a coding teacher to help both students and working coders The book is updated every year or as needed The book covers The key components history examination and medical decision making Office or other outpatient services Forms to guide the reader through the step by step process to determine level of service Services to patients who are not sick Non Face to Face Services Services based on time Modifiers Definitions of terms CMS 1997 Documentation Guidelines **Physicians Fee & Coding Guide** ,2008 **2013 HCPCS Level II Professional Edition -- E-Book** Carol J. 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E-Book* Marsha Diamond,2006-06-02 Expansion of ICD 9 CM information Sample patient charts include explanatory notes A simulated medical practice identified as Godfrey Regional lets you study in a real world scenario Key Terms lists highlight the most important vocabulary and content More exercises **Women's Health in Clinical Practice** Amy Lynn Clouse,Katherine Sherif,2010-01-01 This book clearly elucidates many of the key issues found in the disparate literature on sex based differences in health and illness It provides primary care clinicians with a practical up to date source of information that can lead to optimal targeted care for women Among the topics examined in this comprehensive volume are treating and preventing osteoporosis diabetes cervical cancer eating disorders and more *E/M Express Reference Tables Pocket Guide 2021 (Packet of 10)* American Medical Association,2020-09-17 CPT E M Evaluation and Management codes are changing significantly for office visits for the 2021 code set year This quick reference guide provides a side by side comparison of evaluation and management E M codes Easy to use each table summarizes the requirements for reporting E M services and helps the user select and validate proper E M coding The Centers for Medicare and Medicaid Services CMS have just issued the 2020 Medicare Physician Fee Schedule Final Rule which includes a provision that will have a significant impact on coding The purpose of the provision is to reduce the administrative burden on physicians an outcome that the American Medical Association has worked with many leading healthcare organizations to achieve It does this by changing a part of the Current Procedural Terminology CPT code set known as the Evaluation and Management E M Office Visit codes The new codes go into effect on January 1 2021 FEATURES AND BENEFITS E M 2021 code changes new guidelines on the updated codes for office or other outpatient and prolonged services section incorporated 18 E M tables summarizing the key components and contributory factors requirements for reporting E M services saves time by giving an overall look at reporting requirements of frequently used codes Required key components such as history examination and complexity of medical decision making to help the selection of level of E M services Contributory factors such as the severity of presenting problem counseling and coordination of care during patient encounter are listed to help proper reporting and coding of these services when provided The final component of time such as bedside unit floor time are included as well to help in proper code selection Physicians at Teaching Hospitals (PATH) Audits United States. Congress. Senate. Committee on Appropriations. Subcommittee on Departments of Labor, Health and Human Services, Education, and Related Agencies,1998 *Ohio Medicine* ,1992 Evaluation and Management Coding Made Easy Terry Tropin,2024-11-26 Evaluation and Management E M codes have gone through extensive changes in the past few years This book begins with a detailed explanation of medical decision making and how to determine the level of MDM in a specific case It then describes guidelines for each code category office and other outpatients hospital observation patients consultations emergency services critical care services intensive care services nursing facilities home residential services prolonged services preventive services interdisciplinary teams care management behavioral mental health services electronic online and the new audio video services and remote physiological monitoring services The book takes the guidelines for each category and translates them into plain English and places then into tables and decision trees for easy comparison of related services The book also includes review questions after each chapter a dictionary of terms description of modifiers used with E M codes and a form that takes the reader step by step through the process of selecting a code E&M Coding Clear & Simple Terri Ann Brame,2013-09-16 This easy to read text breaks these complex codes into manageable bite sized pieces Practice questions and real world case studies help you apply your knowledge and approach any coding situation with confidence ICD-10 Made Easy ,1998 *Mosby's® Pocket Guide to Fetal Monitoring - E-Book* Lisa A. Miller,David A. Miller,Rebecca L. Cypher,2021-03-10 Selected for Doody s Core Titles 2024 in Perinatal Find real world clinically useful information on all aspects of electronic fetal monitoring Written by clinicians for clinicians Mosby s Pocket Guide to Fetal Monitoring A Multidisciplinary Approach 9th Edition provides an evidence based collaborative approach to fetal heart monitoring during labor and in the antepartum period It covers the physiologic basis for FHR monitoring methods and instrumentation standardized terminology pattern recognition and interpretation and management of care Authored by a nurse midwife a perinatologist and a nurse this compact guide prepares you for success on the EFM certification exam and for success in today s clinical practice Pocket sized format makes this guide ideal to carry and use in the clinical setting and a colorful design makes information easier to find Coverage of fetal heart rate assessment evaluation interpretation and management is supported by evidence based practice and literature helping you prioritize care and make clinical decisions Patient safety and risk management strategies include case studies and legal commentary plus guidelines for providing safe and competent care Information on the relationship between fetal heart rate patterns and neonatal outcomes provides a guide to the correct use of fetal monitoring Illustrations tables and fetal monitor tracings highlight critical information Coverage of innovative practices supports patient safety and improved outcomes through the use of a common language for fetal heart rate patterns a standardized approach to interpretation a discussion of emergency preparedness and a discussion of human factor issues such as improved communication situational awareness no fault just culture and teamwork Practical appendices offer a guide to FHR tracings and interpretation as well as self assessment questions for credentialing and certification exam preparation Expert author team provides clinical insight along with international presence NEW information on Category II tracing management is included NEW Expanded section on common misconceptions and myths includes evidence supporting factual EFM characteristics NEW Detailed information on documentation and legal issues is added NEW EFM tracings with interpretation are added **E/M Coding Pocket Guide for Physician Practices** Joe Rivet,2006-09-29 Do you want to receive proper reimbursement for new and established patients and consultations You use E M codes everyday but are you selecting the appropriate code for the level of the patient visit Are you familiar with the guidelines that will help you pick the most appropriate code If not you could be missing out on revenue that you earned That s why HCPro created a detailed easy to use pocket sized reference to help you select accurate E M codes E M Coding Pocket Guide for Physician Practices Code accurately and avoid OIG audits with one convenient resource Full of coding criteria and documentation requirements for E M codes this pocket guide is small enough to carry with you into the exam room but thorough enough to help you select the appropriate E M code immediately after examining a patient receive proper reimbursement for every evaluation and avoid scrutiny from the OIG The E M Coding Pocket Guide for Physician Practices includes E M documentation requirements for all five levels of new patient established patient and consultation visits in the office setting clarifies differences between the often confusing 1995 and 1997 E M coding guidelines explains in detail how to determine the level for each documentation component splits E M coding into these two easy to follow sections basic requirements for each code detailed explanations of documentation requirements Take a look at the Table of Contents Introduction Importance of E M coding 1995 vs 1997 guidelines How to use this pocket guide Section 1 E M Code Quick Reference New patient office visits codes 99201 99205 Established patient office visits codes 99211 99215 Consultation office visits codes 99241 99245 Section 2 E M Code Components History Exam Medical decision making Time based billing Who should read E M Coding Pocket Guide for

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