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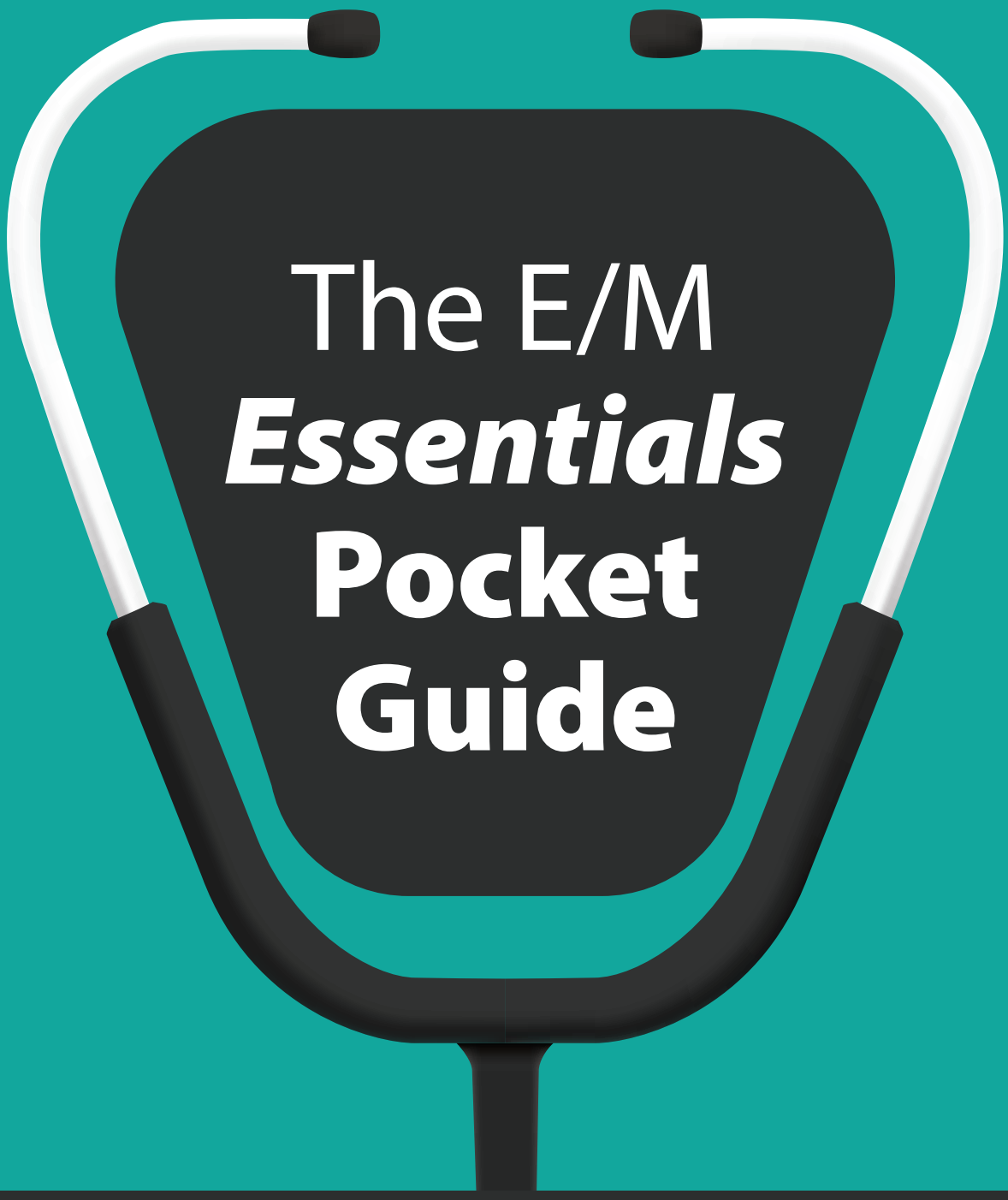

The E/M *Essentials* Pocket Guide

Peggy S. Blue, MPH, CPC, CCS-P, CEMC

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About the Author

Peggy S. Blue, MPH, CPC, CEMC, CCS-P

Peggy S. Blue, MPH, CPC, CEMC, CCS-P, is an instructor for HCPro's Medicare Boot Camp®—Physician Services, the Certified Coder Boot Camp® (live and online), and the Evaluation and Management Boot Camp®. She serves as an instructor for the Certified Coder Boot Camp—ICD-10-CM/PCS. Most recently, she co-developed the Codercise®—CPT Operative Report course. Blue has more than 20 years of experience in the health insurance industry, including extensive

experience in the Medicare and TRICARE government programs.

Blue served as the technical advisor for "The Medicare Update for Physician Services," a bimonthly e-zine to help physicians, physician practice administrators, and those in roles that assist physicians stay up to date on the latest news from CMS and the OIG.

Prior to joining HCPro, Blue participated in the development, implementation, dissemination, and reporting of information related to Medicare professional services training efforts for Highmark Medicare Services. In that capacity, Blue has researched, resolved, and responded to issues and inquiries from the physician community in addition to congressional offices, medical societies, and professional associations. Blue has delivered multiple presentations on Medicare legislation.

Blue is recognized as a Certified Professional Coder and a Certified Evaluation and Management Coder through the American Academy of Professional Coders (AAPC).

She is also certified through the American Health Information Management Association (AHIMA) as a Certified Coding Specialist—Physician Services and is an approved AHIMA ICD-10-CM trainer. She holds a Master's of Public Health from the University of Tennessee in Knoxville and a Bachelor of Arts degree from Purdue University.

Introduction

Importance of E/M Coding

For practices large and small, evaluation and management (E/M) coding is an integral part of the revenue cycle. Medicare paid $32.3 billion for E/M services in 2010, according to the May 2014 Office of Inspector General report "Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010."[1] The report states that "E/M services are 50% more likely to be paid for in error than other Part B services; most improper payments result from errors in coding

and from insufficient documentation." Further, the report found:

> *In total, Medicare inappropriately paid $6.7 billion for claims for E/M services in 2010 that were incorrectly coded and/or lacking documentation, representing 21 percent of Medicare payments for E/M services that year. We found that 42 percent of claims for E/M services in 2010 were incorrectly coded, which included both upcoding and downcoding (i.e., billing at levels higher and lower than warranted, respectively), and 19 percent were lacking documentation. Additionally, we found that claims from high-coding physicians were more likely to be incorrectly coded or insufficiently documented than claims from other physicians.*

CMS continually revamps the Medicare Physician Fee Schedule to better reflect the work and time required to furnish E/M services, changing payments for many outpatient E/M codes.

Due to the complexity of assigning E/M codes and the often confusing differences between the 1995 and 1997 documentation guidelines, providers often unintentionally code incorrectly. Billing incorrect E/M codes can result in underpayments and lost revenue for practices or overpayments, which can make providers targets of the Office of Inspector General (OIG).

The OIG has recently increased its auditing efforts regarding E/M coding and has found a significant error rate. CMS has stated that providers have a responsibility to know the rules and regulations that apply to all services billed to Medicare.

To avoid OIG scrutiny and receive proper reimbursement, providers must not only select the appropriate code for each patient visit but also properly document their reasons for choosing a code.

1995 vs. 1997 Guidelines

The 1997 guidelines, although similar in most aspects to the 1995 guidelines, require a more detailed examination and were not well received by the medical community despite the medical specialty societies' own input in developing the 1997 guidelines. In response, CMS decided to allow practices to use either set of guidelines.

You are not required to use the same set of guidelines for all of your patients. For instance, you may use the 1995 guidelines for one patient and the 1997 guidelines for the next patient. However, you cannot mix and match the guidelines on one encounter to support your E/M level.

How to Use This Guide

This guide is designed to help you choose the appropriate E/M code and determine the proper documentation

requirements during or immediately following a patient visit. Use the tabs on each page to find the set of codes that correspond to the type of patient you are seeing (i.e., new patient, consultation, or established patient).

The easy-to-read tables in Section 1 provide a basic overview of each code level to help you quickly select the appropriate code. In each table, you will find information about the level of history, exam, and medical decision-making needed to bill for a code. However, if you aren't sure whether you've met the documentation requirements for a specific code and would like more information, turn to Section 2 for a detailed breakdown of what each component entails.

For example, if you think an established patient may be eligible for a level five code (99215) but can't remember which systems can be included in the review of systems, turn to the History section for a complete list.

Section 1

E/M Code Quick Reference

New-Patient Office Visits (Codes 99201–99205)

According to the American Medical Association (AMA), a new patient is one who has not received any professional services, defined as face-to-face services reported by a specific Current Procedural Terminology® (CPT) code, within the past three years from his or her physician or from another physician of the same specialty

who belongs to the same group practice. Consider as new an established patient who presents for a visit after three years.

For a patient seen by a physician who is on call or is covering for another physician, classify the patient encounter as though it was with the physician who was unavailable.

Time-based billing for level one

As shown in Figure 1.1, to bill based on time for level one (99201), you must document at least **10 minutes** of face-to-face counseling/coordination of care for the patient. (See "Time-based billing" in Section 2 for more information.)

Figure 1.1 | New Patient—99201
(must satisfy all three components)

Component	Level	Documentation
History	Problem focused	HPI: 1+ elements or status of 1 chronic illness or inactive condition ROS: N/A PFSH: N/A
Exam	Problem focused	1995: 1+ areas/systems 1997: 1–5 bullets
Medical decision-making*	Straightforward	Diagnosis: minimal Data: minimal or low Risk: minimal

*Must satisfy two of three medical decision-making (MDM) elements.

Time-based billing for level two

To bill based on time for level two (99202), you must document at least **20 minutes** of face-to-face counseling/coordination of care for the patient. (See Figure 1.2.)

Figure 1.2 | New Patient—99202
(must satisfy all three components)

Component	Level	Documentation
History	Expanded problem focused	HPI: 1+ element or status of 1 chronic illness or inactive condition ROS: 1+ PFSH: N/A
Exam	Expanded problem focused	1995: 2–7 areas/systems 1997: 6–11 bullets
Medical decision-making*	Straightforward	Diagnosis: minimal Data: minimal or low Risk: minimal

*Must satisfy two of three MDM elements.

Time-based billing for level three

To bill based on time for level three (99203), you must document at least **30 minutes** of face-to-face counseling/coordination of care for the patient. (See Figure 1.3.)

Figure 1.3 | New Patient—99203
(must satisfy all three components)

Component	Level	Documentation
History	Detailed	HPI: 4+ elements or status of 3+ chronic illnesses or inactive conditions ROS: 2–9 PFSH: 1
Exam	Detailed	1995: 2–7 areas/systems 1997: 12–17 bullets
Medical decision-making*	Low	Diagnosis: limited Data: limited Risk: low

*Must satisfy two of three MDM elements.

Time-based billing for level four

To bill based on time for level four (99204), you must document at least **45 minutes** of face-to-face counseling/coordination of care for the patient. (See Figure 1.4.)

Figure 1.4 | New Patient—99204
(must satisfy all three components)

Component	Level	Documentation
History	Comprehensive	HPI: 4+ elements or status of 3+ chronic illnesses or inactive conditions ROS: 10 PFSH: 3
Exam	Comprehensive	1995: 8+ organ systems 1997: 2 bullets from 6 areas or 12+ elements in 2+ areas*
Medical decision-making**	Moderate	Diagnosis: multiple Data: moderate Risk: moderate

*Applies only to general multisystem exams. For exams pertaining to a single organ system, excluding psychiatric and eye exams, perform all bullets from shaded areas in addition to one bullet from each unshaded area in the *1997 Documentation Guidelines for Evaluation and Management Services.*

**Must satisfy two of three MDM elements.

Time-based billing for level five

To bill based on time for level five (99205), you must document at least **60 minutes** of face-to-face counseling/coordination of care for the patient. (See Figure 1.5.)

Figure 1.5 | New Patient—99205
(must satisfy all three components)

Component	Level	Documentation
History	Comprehensive	HPI: 4+ elements or status of 3+ chronic illnesses or inactive conditions ROS: 10 PFSH: 3
Exam	Comprehensive	1995: 8+ organ systems 1997: 2 bullets from 6 areas or 12+ elements in 2+ areas*
Medical decision-making**	High	Diagnosis: extensive Data: extensive Risk: high

*Applies only to general multisystem exams. For exams pertaining to a single organ system, excluding psychiatric and eye exams, perform all bullets from shaded areas in addition to one bullet from each unshaded area in the *1997 Documentation Guidelines for Evaluation and Management Services.*

**Must satisfy two of three MDM elements.

Established-Patient Office Visits (Codes 99211–99215)

According to the AMA, an established patient is one who has received professional services within the past three years from his or her physician or from another physician of the same specialty who belongs to the same group practice.

You typically do not need to redocument the review of symptoms (ROS) and past, family, and social history (PFSH) during each visit of an established patient if you've reviewed previous documentation of the ROS and PFSH and made appropriate updates. Instead, document that you reviewed the previous record and found no changes since the previous visit. If you do find a change, document that change and identify the previous condition from the old record in your new documentation.

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JustCoding's *E/M Essentials Pocket Guide* is the essential resource for every physician practice, perfect for educating coders and billers—as well as physicians themselves.

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