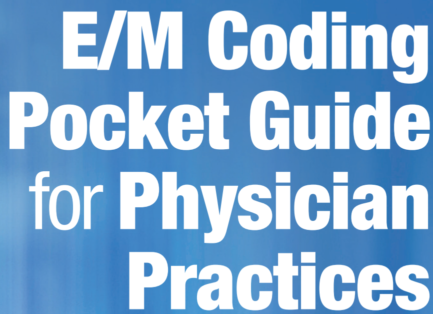

E/M Coding Pocket Guide for Physician Practices

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Importance of E/M coding

For practices large and small, evaluation and management (E/M) coding is an integral part of the revenue cycle. In 2004, the Centers for Medicare & Medicaid Services (CMS) allotted a large portion of the Medicare budget, approximately $29 billion per year, for the payment of E/M services. In 2006, CMS revamped the Medicare Physician Fee Schedule to better reflect the work and time required to furnish E/M services, further increasing payments for many outpatient E/M codes.

However, due to the complexity of assigning E/M codes and the often confusing differences between the 1995 and 1997 documentation guidelines developed by CMS, providers often unintentionally code incorrectly. Billing incorrect E/M codes can result in

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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, and CMS has stated that providers have a responsibility to know the rules and regulations that apply to all services billed to Medicare.

In order 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 versus 1997 guidelines

Your documentation should reflect whether you used the 1995 or 1997 documentation guidelines developed by CMS to select your code. The 1997 guidelines, although similar in most aspects to the 1995

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guidelines, require a more detailed examination and were not well received by the medical community. 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).

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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 page 24 for a complete list.

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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 last 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.

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New-patient—99201
(must satisfy all three components)

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

**Must satisfy two of three documentation elements.*

Time-based billing for level one

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” on p. 42 for more information.

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New-patient—99202
(must satisfy all three components)

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

**Must satisfy two of three documentation elements.*

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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 "Time-based billing" on p. 42 for more information.

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New-patient—99203
(must satisfy all three components)

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

**Must satisfy two of three documentation 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 "Time-based billing" on p. 42 for more information.

New-patient—99204
(must satisfy all three components)

Component	Level	Documentation
History	Comprehensive	HPI: (1995) 4+ elements or (1997) status of 3+ chronic illnesses or inactive conditions ROS: 10 PFSH: 3
Exam	Comprehensive	1995: 8+ systems/organs 1997: 2 bullets from 9 systems/organs*
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 documentation 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 "Time-based billing" on p. 42 for more information.

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New-patient—99205
(must satisfy all three components)

Component	Level	Documentation
History	Comprehensive	HPI: (1995) 4+ elements or (1997) status of 3+ chronic illnesses or inactive conditions ROS: 10 PFSH: 3
Exam	Comprehensive	1995: 8+ systems/organs 1997: 2 bullets from 9 systems/organs*
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 documentation 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 "Time-based billing" on p. 42 for more information.

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Established-patient office visits (codes 99211–99215)

According to the AMA, an established patient is one who has received professional services within the last 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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Established-patient—99211*

Component	Level	Documentation
History	N/A	HPI: CC ROS: N/A PFSH: N/A
Exam	N/A	1995: none–minimal 1997: none–minimal
Medical decision-making	N/A	Diagnosis: minimal Data: none–minimal Risk: none–minimal

** This level is for a minimal problem that may not require the presence of a physician (e.g., a nurse gives a patient an injection or a patient lost their prescription and needs another one written), so many of the typical documentation requirements do not apply. Visits are typically 5 minutes in length.*

Time-based billing for level one

To bill based on time for level one (99211), you must document at least **5 minutes** of face-to-face counseling/coordination of care for the patient. See "Time-based billing" on p. 42 for more information.

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Established-patient—99212
(must satisfy two of the three components)

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

**Must satisfy two of three documentation elements.*

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Time-based billing for level two

To bill based on time for level two (99212), you must document at least **10 minutes** of face-to-face counseling/coordination of care for the patient. See "Time-based billing" on p. 42 for more information.

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Established-patient—99213
(must satisfy two of the three components)

Component	Level	Documentation
History	Expanded problem focused	HPI: (1995) 1+ elements or (1997) status of 1 chronic illness or inactive condition ROS: 1+ PFSH: N/A
Exam	Expanded problem focused	1995: 2-7 systems/organs 1997: 6-11 bullets
Medical decision-making*	Low	Diagnosis: limited Data: limited Risk: low

**Must satisfy two of three documentation elements.*

Time-based billing for level three

To bill based on time for level three (99213), you must document at least **15 minutes** of face-to-face counseling/coordination of care for the patient. See "Time-based billing" on p. 42 for more information.

Established-patient—99214
(must satisfy two of the three components)

Component	Level	Documentation
History	Detailed	HPI: (1995) 4+ elements or (1997) status of 3 chronic illnesses or inactive conditions ROS: 2-9 PFSH: 1
Exam	Detailed	1995: 2-7 systems/organs 1997: 12-17 bullets
Medical decision-making*	Moderate	Diagnosis: multiple Data: moderate Risk: moderate

**Must satisfy two of three documentation elements.*

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Time-based billing for level four

To bill based on time for level four (99214), you must document at least **25 minutes** of face-to-face counseling/coordination of care for the patient. See "Time-based billing" on p. 42 for more information.

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Established-patient—99215
(must satisfy two of the three components)

Component	Level	Documentation
History	Comprehensive	HPI: (1995) 4+ elements or (1997) status of 3 chronic illnesses or inactive conditions ROS: 10 PFSH: 2-3
Exam	Comprehensive	1995: 8+ systems/organs 1997: 2 bullets from 9 systems/organs*
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 documentation elements.*

Time-based billing for level five

To bill based on time for level five (99215), you must document at least **40 minutes** of face-to-face counseling/coordination of care for the patient. See "Time-based billing" on p. 35 for more information.

Consultation office visits (codes 99241–99245)

Codes in this category identify services that consulting providers render to patients after another provider has requested their specialized opinion. The requirements for each component (i.e., history, exam, medical decision-making) in this code category are the same as the criteria for each level of service in the new-patient visit category. However, there are three major differences between the two types of visits:

1. A requesting provider must seek the opinion of the consulting provider and document that request in the patient's medical record. The consulting provider must render a service and send a report back to the requesting provider. If the record is shared between the two providers, it is not necessary to report back.

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2. The amount paid for consultation office visits is higher than that for new-patient visits.
3. The time requirements for consultation office visits are higher than those for new-patient visits.

Coders, auditors, and providers often refer to the following three Rs when discussing consultations:

- **Request.** This refers to a written or verbal request for a consult. The referring provider or other appropriate source makes this request and documents it in the patient's medical record.
- **Render.** The consulting provider must render and document an opinion—as well as any services ordered and performed—in the patient's medical record.
- **Report.** The consulting provider must compose a written report and send it back to the requesting provider or other appropriate source.

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Consultation—99241
(must satisfy all three components)

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

**Must satisfy two of three documentation elements.*

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Time-based billing for level one

To bill based on time for level one (99241), you must document at least **15 minutes** of face-to-face counseling/coordination of care for the patient. See "Time-based billing" on p. 42 for more information.

Consultation—99242
(must satisfy all three components)

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

**Must satisfy two of three documentation elements.*

Time-based billing for level two

To bill based on time for level two (99242), you must document at least **30 minutes** of face-to-face counseling/coordination of care for the patient. See "Time-based billing" on p. 42 for more information.

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Consultation—99243
(must satisfy all three components)

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

**Must satisfy two of three documentation elements.*

Time-based billing for level three

To bill based on time for level three (99243), you must document at least **40 minutes** of face-to-face counseling/coordination of care for the patient. See "Time-based billing" on p. 42 for more information.

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Consultation—99244
(must satisfy all three components)

Component	Level	Documentation
History	Comprehensive	HPI: (1995) 4+ elements or (1997) status of 3 chronic illnesses or inactive conditions ROS: 10 PFSH: 3
Exam	Comprehensive	1995: 8+ systems/organs 1997: 2 bullets from 9 systems/organs*
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 documentation elements.*

Time-based billing for level four

To bill based on time for level four (99244), you must document at least **60 minutes** of face-to-face counseling/coordination of care for the patient. See "Time-based billing" on p. 42 for more information.

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Section 1
Consultation—99244

Consultation—99245
(must satisfy all three components)

Component	Level	Documentation
History	Comprehensive	HPI: (1995) 4+ elements or (1997) status of 3 chronic illnesses or inactive conditions ROS: 10 PFSH: 3
Exam	Comprehensive	1995: 8+ systems/organs 1997: 2 bullets from 9 systems/organs*
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 documentation elements.*

Time-based billing for level five

To bill based on time for level five (99245), you must document at least **80 minutes** of face-to-face counseling/coordination of care for the patient. See "Time-based billing" on p. 42 for more information.

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Section 1
Consultation—99245