PARTNERSHIP HEALTHPLAN of CALIFORNIA

4665 Business Center Drive
Fairfield, California 94534

EVALUATION & MANAGEMENT CODING AND DOCUMENTATION

Part I: Six Steps to Improved Evaluation & Management Coding and Documentation:

The AMA defines six (6) steps to selecting the appropriate Evaluation & Management (E&M) code for the services you provided.

Step 1: Identify the Category and Subcategory of Service

There are several categories and subcategories of service. Each category represents a specific type of Evaluation & Management service, such as "Office or Other Outpatient Services."

Within each category there are subcategories that define the type of service provided with more specificity. For example, the subcategories of "Office or Other Outpatient Services" would include "New Patient" and "Established Patient." Understanding these categories and subcategories are the first step to accurate coding.

For your reference, **Table 1** below includes the current categories and subcategories as provided by the AMA. It should be noted that, while all of the codes listed are reportable, reimbursement policies may vary from carrier to carrier.

Table 1

Category/Subcategory	CPT Code(s)
Office or Other Outpatient Services	
• New Patient • Established Patient	99201-99205 99211-99215
Hospital Inpatient Services	
• Initial Hospital Care • Subsequent Hospital Care • Observation or Inpatient Care Services (Including • Admission and Discharge Services) • Hospital Discharge Services	99221-99223 99231-99233 99234-99236 99238-99239
Consultations	
• Office Consultations • Inpatient Consultations	99241-99245 99251-99255
Emergency Department Services	99281-99285
Critical Care Services	
• Adult (over 24 months of age)	99291-99292
Nursing Facility Services	
• Initial Nursing Facility Care • Subsequent Nursing Facility Care • Nursing Facility Discharge Services	99304-99306 99307-99313 99315-99316
• Nursing Facility Assessment	99301-99303

Table 1 (continued)

Category/Subcategory	CPT Code(s)
Domiciliary, Rest Home or Custodial Care Services	
• New Patient • Established Patient	99321-99328 99331-99337
Home Services	
• New Patient • Established Patient	99341-99345 99347-99350
Prolonged Services	
• With Direct Patient Contact • Without Direct Patient Contact	99354-99357 99358
Physician Standby Services	99360
Preventive Medicine Services	
• New Patient • Established Patient • Other Preventive Medicine Services	99381-99387 99391-99397 99420-99429
Newborn Care	99435-99436
Other E&M Services	99499

Step 2: Review the Reporting Instructions for the Selected Category and Subcategory

Once you have selected the appropriate category and subcategory of service, based upon the services and/or care you provided, you should consult the "reporting instructions" for that section in the CPT Coding Manual.

The sections of the CPT Coding Manual will include critical guidance in understanding the appropriate use of the codes, what is included under that code, and proper reporting. In addition, the instructions will advise you if an alternate code should be used.

Reading, understanding, and following the reporting instructions will ensure that you are reporting the appropriate code based upon the services you provided.

Step 3: Review the Level of E&M Service Descriptor Examples

Evaluation & Management (E & M) Services are comprised of seven components and include:

1. History (Key Component)
2. Examination (Key Component)
3. Medical Decision Making (Key Component)
4. Counseling
5. Coordination of Care
6. Nature of Presenting Problem
7. Time

The first three components (history, examination, and medical decision making) are key components. Key components are a controlling factor and are critical to determining the level of service for E & M services.

Exception: The use of "time" as a component for determining the level of service is also relevant, as it pertains to visits where the majority of time is spent on counseling or coordination of care. This is covered more specifically in Step 6.

Step 4: Determine the Extent of History Obtained

The AMA recognizes four (4) types of history that are defined as follows:

Problem Focused
- Chief complaint
- Brief history of present illness or problem

Expanded Problem Focused
- Chief complaint
- Brief history of present illness or problem
- Problem pertinent system review

Detailed
- Chief complaint
- Extended history of present illness
- Problem pertinent system review extended to include a review of a limited number of additional systems
- Pertinent past family and/or social history directly related to the patient's problem

Comprehensive
- Chief complaint
- Extended history of present illness
- Review of systems which directly relate to the problem(s) identified in the history of present illness
- A review of all additional body systems
- Complete past, family and social history

Step 5: Determine the Extent of Examination Performed

The AMA recognizes four (4) types of examinations that are defined as follows:

Problem Focused
- A limited examination of the affected body area or organ system (Table 2).

Expanded Problem Focused
- A limited examination of the affected body area or organ system and other symptomatic or related organ system(s)

Detailed
- An extended examination of the affected body area(s) or organ system and other symptomatic or related organ system(s)

Comprehensive
- A general, multi-system examination or a complete examination of a single organ system

Table 2

Body Areas	Organ Systems
Head	Eyes
Neck	Ears, Nose, Mouth, Throat
Chest, including breast and axilla	Cardiovascular
Abdomen	Respiratory
Genitalia, groin, buttocks	Gastrointestinal
Each Extremity	Genitourinary
Back	Musculoskeletal
	Skin
	Neurologic
	Psychiatric
	Hematologic, Lymphatic, Immunologic

Step 6: Determine the Complexity of Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option. This is measured by:

- The number of possible diagnoses and/or the number of management options that must be considered; or
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; or
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The four specific types of medical decision making are:

1. Straightforward
2. Low Complexity

3. Moderate Complexity
4. High Complexity

To qualify for a given decision-making type, two of the three elements in Table 3 must be met or exceeded.

Table 3

Type of Decision Making	# of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality
Straightforward	Minimal	Minimal or none	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Note: Use of Time as a Controlling Factor

The AMA also provides for an option to bill based upon counseling and coordination of care. If counseling and/or coordination of care accounted for more than 50% of the time spent face-to-face with the patient and/or family, then time may be used as the key or controlling factor. However, how the time was spent and the amount of time must be documented in the medical record.

Part II: Consultations

Sometimes a consultation is billed, yet the actual service provided was not a consultative service. According to the AMA, a "consultation" is defined as a type of service that:

- Is provided by a physician,
- Requires an opinion or advice regarding the evaluation and management of a specific problem, and
- Is requested by another physician or other appropriate source.

The AMA cites several other key important factors when considering the use of a consultation code.

1. The consultant's opinion and any services that are ordered or performed must be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.
2. A consultation initiated by a patient and/or family member, and not requested by a physician or other appropriate source, is not reported using consultation codes but may be reported using the office visit, home services, or domiciliary/rest home care codes.

Part III: Basic E & M Documentation Guidelines

Why Documentation is Important

Medical documentation serves multiple purposes. However, the most important purpose is to establish a chronological record of the patient's care to ensure high-quality care. The medical record helps facilitate the following:

- The ability of the treating physician, as well as other health care professionals, to evaluate and plan the patient's immediate care and treatment, in addition to monitor health status over time,
- Communication and continuity of care among providers involved in the patient's care,
- Accurate and timely claims review and payment,
- Appropriate quality of care evaluations, and
- Protect the provider from legal issues related to allegations of fraud, waste, abuse and medical malpractice.

Basic Principles of Medical Record Documentation

1. There is no specific format required for documenting the components of an E&M service.
2. The medical record should be complete and legible.
3. The documentation of each patient encounter should include:
    a. The patient's name and appropriate demographic information
    b. The chief complaint and/or reason for the encounter and relevant history, physical examination findings and prior diagnostic results,
    c. Assessment, clinical impression or diagnosis,
    d. Plan for care, and
    e. Date and a verifiable legible identity of the health care professional who provided the service.
4. If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.
5. To the greatest extent possible, past and present diagnoses and conditions should be accessible to the treating and/or consulting physician. This should include those diagnoses and conditions from the prenatal and intrapartum period that affect the newborn.
6. Appropriate health risk factors, including allergies, should be identified
7. The patient's progress, response to and changes in treatment, planned follow-up care, and instructions and diagnosis should be documented.
8. The Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes reported on the health insurance claim form (CMS 1500) or billing statement should be supported by the documentation in the medical record.
9. Any addendum to the medical record should be dated the day the information is added to the medical record and not dated for the date the service was provided.
10. Documentation should be timely. A service should be documented during the visit, or soon after it is provided, in order to maintain an accurate medical record.
11. The confidentiality of the medical record should be fully maintained, consistent with the requirements of medical ethics and of law.

Appendix B: Evaluation & Management Documentation Quick Reference

Components	**New Patient**					**Established Patient**				
	Requires 3 components within shaded area					Requires 2 components within shaded area				
History	PF	EPF	D	C	C	May not require presence of a physician	PF	EPF	D	C
Examination	PF	EPF	D	C	C		PF	EPF	D	C
Complexity of Medical Decision Making	SF	SF	L	M	H		SF	L	M	H
Average Time (minutes)	10	20	30	45	60	5	10	15	25	40
Level of Service	**I**	**II**	**III**	**IV**	**V**	**I**	**II**	**III**	**IV**	**V**

KEY

Abbreviation	**Description**
PF	Problem Focused
EPF	Expanded Problem Focused
D	Detailed
C	Comprehensive
SF	Straight Forward
L	Low
M	Moderate
H	High