In this course, you will learn more about the basics of Evaluation and Management Services, to include:

- Basic Overview of Evaluation and Management Services
- Identify Categories and Subcategories of Evaluation and Management CPT® Codes
- Identify Evaluation and Management Modifiers
- Locate Resources for Evaluation and Management Services on the CMS and Cahaba GBA web sites
Medical Necessity of Evaluation and Management Services:

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a Current Procedural Terminology (CPT®) code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation of the History, Physical Exam and Medical Decision Making should support the code billed, however, the extent of the History documented, the extent of the Physical Examination documented and the level of Medical Decision Making should not be greater than the levels required by the patient’s condition.
A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.
Purpose of the CPT book includes, but is not limited to:

• Useful for administrative management purposes such as claims processing and development of medical guidelines.
• Identifies descriptive terms & codes for reporting medical services & procedures performed by physicians.
• Serve a wide variety of important function in the field of medical nomenclature.

CPT Book: Classification of Evaluation & Management Services

The Evaluation and Management Services section of the CPT © book is divided into broad categories. Most of the categories are further divided into two or more subcategories as shown on the next slides.
Evaluation and Management Services: Broad Categories

Categories available for reporting Evaluation and Management Services:

- Office or Other Outpatient Services
- Hospital Observation Services
- Hospital Inpatient Services
- Emergency Department Services
- Critical Care Services
- Nursing Facility Services
- Domiciliary, Rest Home, or Custodial Care & Home Services

Evaluation and Management Services: Subcategories

- Office Visit
  - New Patient
  - Established Patient
- Hospital Visit and Nursing Facility Visit
  - Initial Visit
  - Subsequent Visit

Refer to the Evaluation and Management Services section of the CPT® book for complete service codes.
Level of E&M Service

- The code sets used to bill for E/M services are organized into various categories and levels.
- In general, the more complex the visit, the higher the level of code the physician or non-physician practitioner (NPP) may bill within the appropriate category.
- In order to bill any code, the services furnished must meet the definition of the code.
- It is the provider's responsibility to select and code services appropriately.

Medical Necessity of Services
Social Security Act 1862(a)(1)(A) All billed services must be based only on activities that are reasonable and necessary for the diagnosis or treatment of illness or injury.
E&M Services Subcategories

This Organization Chart further explains the breakdown of Evaluation and Management Services into subcategories.

Office or Other Outpatient Services

- New Patient
  - 99201
  - 99202
  - 99203
  - 99204
  - 99205
  - 99211
  - 99212
  - 99213
  - 99214
  - 99215

- Established Patient

Hospital Inpatient Services

- Initial Hospital Care
  - New or Established Patient
    - 99221
    - 99222
    - 99223
  - Subsequent Hospital Care
    - 99231
    - 99232
    - 99233
  - Hospital Discharge Services
    - 99238
    - 99239
Currently, physicians may use the Evaluation and Management Services 1995 guidelines or 1997 guidelines when determining levels of service to bill. Medical records are reviewed utilizing the guidelines that afford the provider the best opportunity to support the highest appropriate code with the greatest reimbursement.

Refer to the following links for Evaluation and Management guidelines and additional information:

Evaluation and Management Services Information Center:

The 1995 and 1997 Evaluation and Management Services Documentation Guidelines:
There are 3 key components for E&M services:
1. History
2. Physical Exam
3. Medical Decision Making

There are 4 contributing components for E&M services:
1. Counseling
2. Coordination of Care
3. Nature of presenting problem
4. Time
A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. There are five types of presenting problems for E/M codes:

1) Minimal
2) Self-limited or minor
3) Low severity
4) Moderate severity
5) High severity
New Patient:
CPT® 99201-99205
Requires 3 key components
• History
• Physical Examination
• Medical Decision Making

Established Patient:
CPT® 99211-99215
Requires at least 2 of 3 components
• History
• Physical Examination
• Medical Decision Making

Initial Hospital Care:
CPT® 99221-99223
New or Established Patient
Requires 3 components
• History
• Physical Examination
• Medical Decision Making

Subsequent Hospital Care:
CPT® 99231-99233
Requires 2 of 3 components
• History
• Physical Examination
• Medical Decision Making
Evaluation and Management Services Components

- The documentation of the History, Physical Examination, and Medical Decision Making should support the code billed, however, the extent of the History documented, the extent of the Physical Examination documented and the level of Medical Decision Making **should not be greater** than the levels required by the patient's condition.

- **Time** shall be considered the key or controlling factor to qualify for a particular level of E/M service, if counseling and/or coordination of care dominates more than 50% of time devoted to the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility).

- The time includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents, person acting in loco parentis, legal guardian).

- The extent of counseling and/or coordination of care must be documented in the medical record.
History

Four Levels of History:

1. **Problem Focused** – Chief Complaint (CC), brief history of present illness (HPI) or problem

2. **Expanded Problem Focused** – Chief complaint, brief history of present illness; problem pertinent system review

3. **Detailed** – Chief complaint; extended history of present illness; review of problem pertinent systems (ROS), 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 problems*

4. **Comprehensive** – Chief complaint; extended history of present illness; review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems: complete past, family and social history (PFSH)

A chief complaint is indicated at ALL levels.
HPI, ROS and PFSH (all three elements) of the history must be met to qualify for a given type of history.
A **Chief Complaint** is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter and is usually stated in the patient's own words. The medical record should clearly document the chief complaint.

For example: a patient complains of upset stomach, aching joints, and feeling tired. It should be well defined in the note, the reason the patient is in the office.
History of Present Illness (HPI)

The **HPI** is a chronological description of the present illness from the first sign and/or symptom or from the previous encounter to the present. The following elements are included:

- **Location** (right leg)
- **Quality** (pain radiating, burning, aching)
- **Severity** (pain 9 on a scale of 1-10)
- **Duration** (began two days ago)
- **Timing** (sign/symptom comes and goes, constant)
- **Context** (lifted large object at home)
- **Modifying factors** (better when heat is applied)
- **Associated signs and symptoms** (numbness in toes)

HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

- A **brief** HPI consists of **one to three elements** of the HPI
- An **extended** HPI consists of **four or more elements** of the HPI

It is expected that the HPI will be performed by the provider billing the service, and not by ancillary personnel.
Review of Systems (ROS)

- A **problem pertinent** ROS inquires about the system directly related to the problem(s) identified in the HPI.

- An **extended ROS** inquires about the system directly related to the problem(s) identified in the HPI & a limited number of additional systems. **Two to nine systems should be documented.**

- A **complete ROS** inquires about the system(s) directly related to the problem(s) identified in the HPI. **At least ten organ system must be reviewed.** Those with positive or pertinent negative responses must be individually documented. A notation indicating all other systems are negative is permissible.

- In the absence of such a notation, **at least ten systems** must be individually documented.
Past, Family, and/or Social History (PFSH)

PFSH= Past, Family, Social History. A review of three areas is required for Past history; Family history; and Social history.

• A pertinent PFSH is a review of the history area(s) directly related to the problem identified in the HPI. At least one specific item from any of the three history areas must be documented.

• A complete PFSH is a review of two or all three of the PFSH history areas, depending on the level of E/M.

• All three history areas are required for comprehensive assessment or reassessment.
To qualify for a given type of history, all three elements (HPI, ROS, PFSH) in the table must be met.

<table>
<thead>
<tr>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems</th>
<th>Past, Family and/or Social History (PFSH)</th>
<th>Type of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief 1-3 Elements</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>Brief 1-3 Elements</td>
<td>Problem Pertinent</td>
<td>N/A</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>Extended 4 or more elements</td>
<td>Extended 2-9 systems</td>
<td>Pertinent: At least 1 specific area from any of the 3 history areas</td>
<td>Detailed</td>
</tr>
<tr>
<td>Extended 4 or more elements</td>
<td>Complete At least 10 systems</td>
<td>Complete New patient – all 3 PFSH Established patient – 2 of 3 PFSH areas</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

* Number of elements, systems and areas are noted in red
Four Levels of Physical Exam:

1. **Problem Focused** - A limited exam of the affected body area or organ system.
2. **Expanded Problem Focused** - A limited exam of the affected body area or organ system & other symptomatic or related organ systems.
3. **Detailed** - An extended exam of the affected body area(s) & other symptomatic or related organ system(s).
4. **Comprehensive** - A general multi-system exam or complete exam of a single organ system.

**Note:** The comprehensive examination performed as part of the preventive medicine E/M service is multisystem, but its extent is based on age and risk factors identified.

The extent of physical examinations performed and documented is dependent upon clinical judgement and the nature of the presenting problem.
Physical Exam

Body Areas:
- Head, including the face
- Neck
- Chest, including breasts & axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

Organ Systems:
- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/Immunologic
Example: Subsequent Hospital Care

It is reasonable to expect higher levels of history and physical exam may be needed in the **days immediately following**:  
- Hospital admission  
- Following transfer from intensive care  
- Following an acute exacerbation  
- Complication  
- De-compensation of the patient's condition(s)
Four types of medical decision making:
1. Straight-forward
2. Low complexity
3. Moderate complexity
4. High complexity

Medical Decision Making Table:
*Two of three elements in the table must be either met or exceeded to establish the type of decision making.

<table>
<thead>
<tr>
<th>No. of Diagnoses or mgmt. options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of complications morbidity or mortality</th>
<th>Type of Decision Making*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
<td>Moderate</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

Evaluation and Management Services Guidelines
Medical Decision Making (MDM)

For MDM, the complexity of establishing a diagnosis and/or selecting a management option is measured by:

• The number of possible diagnoses and/or management options (the nature of the present illness).

• Amount and/or complexity of medical information that must be obtained, reviewed & analyzed (lab tests reviewed, old records reviewed, x-rays, treatment options).

• Risk of significant complications, morbidity and/or mortality, as well as comorbidities associated with the presenting problem(s), diagnostic procedure and/or management options.

• Refer to the table of Risk in the E/M Guidelines for common clinical examples of risk measures:


The CPT clinical examples list the CPT code, then specialty related examples.


For coding information and ordering American Medical Association (AMA) products, refer to: https://www.ama-assn.org/
The Importance of Medical Record Documentation

What Is Documentation and Why Is It Important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care.

An appropriately documented medical record can reduce errors associated with claims processing and may serve as a legal document to verify the care provided, if necessary.
Medical Record Documentation

Medical record documentation must support:

**Social Security Act 1862(a)(1)(A):**
Reasonable and Necessary Services - All billed services must be based only on activities that are reasonable and necessary for the diagnosis or treatment of Illness or injury.

**Medical Necessity of Services:**
Medical necessity of services must be validated by concise and accurate medical record documentation.

**CMS Signatures Requirements:**
Documentation of services provided/ordered must be authenticated by the author of services.

**Compliance with CMS Manual Regulations and Guidelines:**
The principles of documentation are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status.

To review the general medical record documentation guideline principles for E/M services, refer to The Medicare Learning Network (MLN) Documentation Guidelines for Evaluation and Management Services in the link below:

The Medicare Learning Network (MLN) Documentation Guidelines for E/M Services

E/M Services - Complying with Documentation Requirements:
Providers must ensure that medical record documentation supports the level of service reported to a payer. The volume of documentation should not be used to determine which specific level of E/M service is billed. The medical record must include:

- A complete and legible record
- Documentation for each encounter, and it should include:
  - Reason for the encounter, relevant history, exam and prior diagnostic test results; reports if applicable;
  - Assessment, clinical impression;
  - Plan for care; and
  - Legible identity of the provider; hand written or electronic signature is required – stamp signatures are not acceptable
- Rationale for ordering diagnostic & other ancillary services should be documented or easily inferred
Medical Record Documentation

- Past & present diagnoses should be accessible to the treating and/or consulting physician;
- Identify health risk factors;
- Patient's progress, response to treatment, changes in treatment or revisions in diagnoses should be documented; and
- Document any revisions to the plan of treatment.

- All CPT/ICD-9 codes billed on the insurance claim form should be supported by documentation in the medical record;
- All claims must be coded correctly;
- If an E/M code is billed based upon time for counseling or coordination of care, time may be the primary component used to determine the level of service if more than 50% of the E/M encounter included counseling and/or coordination of care.
- Time must be clearly documented with a brief summary of the counseling and/or coordination of care provided.
<table>
<thead>
<tr>
<th>Modifier AI</th>
<th>Modifier 24</th>
<th>Modifier 25</th>
<th>Modifier 57</th>
</tr>
</thead>
</table>
| Principal Physician of Record. Used by the admitting or attending physician who oversees the patient's care, as distinct from other physicians who may be furnishing specialty care | Unrelated E&M service during a post-op period of a major or minor surgical procedure
- Minor surgery is 0 or 10 days global period
- Major surgery is 90 days global period | Significant, separately identifiable evaluation and management service by same physician on day of procedure
- For codes with "0 day or 10 day" global period* | **Decision for surgery** - Use with E/M codes billed by the surgeon to indicate that the E/M service resulted in the decision for surgery (E/M visit was NOT usual preoperative care). For E/M visits prior to MAJOR surgery (90-day post op period) only. Failure to use this modifier when appropriate may result in denial of the E/M service. |
| Append to E&M codes only. | | | |

*For established patient only
- New illness
- Follow up visit with multiple complaints

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**Navicent Health**
Everything about us is all about you.
CMS Signature Requirements

Transmittal 327: Change Request 6698:
Signature Requirements for Medical Review Purposes
• For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author
  • Hand written or
  • Electronic signature
• Stamp signatures are not acceptable

CMS Signature Requirements Fact Sheet - Complying with Medicare Signature Requirements:

Program Integrity Manual - Publication 100 – 8: Chapter 3, Section 3.3.2.4 Signature Requirements:
Comprehensive Error Rate Testing

The CERT Program
- Measures improper payments in the Medicare fee-for-service (FFS) program.
- Designed to comply with the Improper Payments Elimination and Recovery Act of 2010 (IPERA).
- Calculates the paid claims error rate for Medicare claims submitted to contractors.

The CERT Documentation Contractor
- Responsible for requesting and receiving the medical record documentation from providers.

The CERT Review Contractor
- Review selected claims and associated medical record documentation.

For additional CERT education, refer to:
CMS Resources

• CMS website:  
  https://www.cms.gov/

• Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6: Evaluation and Management Service Codes - General (Codes 99201 - 99499):  

• Evaluation and Management Services Guide:  

• The Medicare Learning Network® (MLN) Educational Web Guides - The 1995 and 1997 Documentation Guidelines for Evaluation and Management (E/M) Services:  
Additional Resources

Cahaba Government Benefit Administrators®, LLC (Cahaba GBA) web site:
https://www.cahabagba.com

Cahaba GBA Evaluation and Management Services Information Center & Education Material Links
https://www.cahabagba.com/part_b/education_and_outreach/evaluation_and_management_services/index.htm#8

Cahaba GBA Listserv
https://www.cahabagba.com/forms/subscribeForm.htm

Click the link below and complete the E&M Training Post-test:

http://w3.mcccg.org/iota/test-EM.asp

When the test is successfully completed, you will be prompted to enter information to record your results.