

Evaluation & Management (E/M) Coding Calculator



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

Standard Codes for *Evaluation & Management (E/M)*

Step 1 – Determine Location of the Service

Where did this encounter between physician and patient take place?

- **Office or Other Outpatient Services:** Physician's office; walk-in clinic; ambulatory health-care center; etc.
- **Hospital Services:** Inpatient, acute care facility
- **Consultation – Office or Inpatient**
- **Emergency Department Services:** A hospital-based facility, open 24 hours a day, providing unplanned services to patients requiring immediate medical attention
- **Critical Care/Intensive Care Services:** Direct delivery of medical care for patients with a high likelihood of impending or life-threatening decline of condition
- **Nursing Facility Services:** Skilled nursing facility (SNF); intermediate care facility (ICF); long-term care facility (LTCF); psychiatric residential treatment center
- **Domiciliary, Rest Home or Custodial Care Services:** Assisted living facility; any other facility providing room, board and personal assistance services
- **Home Services:** Private residence

Step 2 – Determine Relationship Between Physician & Patient

The relationship between the physician and the patient is the next thing you must determine.

- **New or Established:** An established patient is one who has received professional services from this physician, or another physician of the same specialty within the same practice, during the last three years
 - If this is not stated in the physician's notes for this encounter, you may need to refer back to the patient's chart
- **Initial or Subsequent:** An initial visit is the first date of service this physician sees this patient and a subsequent visit is one on an additional date, after the first date, during this course of treatment
 - Services are reported by complete day (calendar date) of service
- **Consultation Services:** Determine who requested the consultation
 - Physician or other health-care professional = use **consultation code** from the range 99241-99255
 - Patient and/or family member = use appropriate **location of service code**, such as: outpatient 99201-99215 or hospital 99217-99239

Step 3 – Determine Level of History from Documentation

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

Histories are usually taken orally—a spoken exchange of questions and answers between the provider and the patient—but there **MUST** be notes that record what occurred

- A patient history review of systems (ROS) is not an examination
- The physician may indicate that a body or 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
- There are four types of histories: (1) problem-focused, (2) expanded problem-focused, (3) detailed, and (4) comprehensive:

• **Problem-Focused**

- Chief complaint (CC): The patient's description of why he/she felt the need to see this physician for this visit—could be a sign, symptom, condition, diagnosis or other health-related concern
- Brief history of present illness or concern: The patient's recounting of the date and time (as accurately as possible) of the onset and progress of the chief complaint, including first sign and/or symptom, as well as anatomical location, severity, timing, circumstances, modifying factors, and related signs and/or symptoms

• **Expanded Problem-Focused**

- Chief complaint (same as above)
- Brief history of present illness or concern (same as above)
- **System Review:** Pertains only to that system directly related to the chief complaint or present illness:
 - signs/symptoms: fever, weight loss, etc.
 - eyes
 - ears, nose, mouth, throat
 - cardiovascular
 - respiratory
 - gastrointestinal
 - genitourinary
 - musculoskeletal
 - integumentary: skin and/or breast
 - neurological
 - psychiatric
 - endocrine
 - hematologic/lymphatic
 - allergic/immunologic

• **Detailed**

- Chief complaint (same as above)
- **Extended history of present illness or concern**—brief history expanded upon to include pertinent **past** family and/or social history directly related to the chief complaint or present illness:

- prior major illnesses and injuries
- prior surgical procedures
- prior hospitalizations
- current medications and/or vitamin/supplements
- allergies (drug, food, inhalant, etc.)
- immunization status (age-appropriate)
- dietary/nutritional status (feeding, eating, etc.)

• **Family history** includes:

- health status (or cause of death) of parents, siblings and children
- specific diseases of family members related to problems identified in 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** includes:

- marital status and/or living arrangements
- current employment
- occupational history
- use of drugs, alcohol and/or tobacco
- level of education
- sexual history
- other relevant social factors

• **System Review:** Review of systems directly related to the chief complaint or present illness **PLUS** a limited history of additional related systems:

- signs/symptoms: fever, weight loss, etc.
- eyes
- ears, nose, mouth, throat
- cardiovascular
- respiratory
- gastrointestinal
- genitourinary
- musculoskeletal
- integumentary: skin and/or breast
- neurological
- psychiatric
- endocrine
- hematologic/lymphatic
- allergic/immunologic

• **Comprehensive***

- Chief complaint
- Extended history of present illness or concern
- Complete past, family and/or social history
- **System Review:** Review of systems directly related to the history of the present illness **PLUS** a history related to **all** body systems—as the name implies, this is the most complete form of history
 - signs/symptoms: fever, weight loss, etc.
 - eyes
 - ears, nose, mouth, throat
 - cardiovascular
 - respiratory
 - gastrointestinal

Evaluation And Management Coding Guidelines 22

DJ Losen



Evaluation And Management Coding Guidelines 22:

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Answers to Even- Numbered Exercises 9. Experiment with the xman utility to answer the following questions: a. How many man pages are in the Devices section of the manual? Answers to Odd-Numbered Problems CHAPTER 1. Exercises 1.1. 1. (a) ordinary, first order. (c) partial, second order. (e) ordinary, third order. (g) ordinary, second order. Answers to Even-Numbered Exercises How can you keep other users from using write to communicate with you? Why would you want to? Give the command mesg n to keep ordinary users from writing to ... Why do some science or math books only have answers ... Jan 30, 2015 — Some science and math books only provide answers to odd or even numbered questions as a way to encourage students to practice ... MARK G. SOBELL A PRACTICAL GUIDE TO LINUX ... by MG SOBELL · 2013 · Cited by 55 — ... EXERCISES. 1. The following message is displayed when you attempt to log in with an incorrect username or an incorrect password: Page 81. ADVANCED EXERCISES ... ANSWERS TO EVEN-NUMBERED EXERCISES - Sobell Jul 27, 2013 — Answers to Even-numbered Exercises
. 1. Wile?
. 2. What does the /etc/resolv.conf file do? What do the nameserver lines in
. 1 Answers to Chapter 3, Odd-numbered Exercises 1 Answers to Chapter 3, Odd-numbered Exercises. 1) $r(n) = 25r(n - 1) + 3r(n - 2) + 10n - 1$. There are $25r(n - 1)$ identifiers satisfying the first condition, $3r \dots$ Vim Question - Single command to swap words Jan 5, 2012 — Hi, I'm working through Sobell's book Linux Commands, Editors and Shell ... odd-numbered exercises (for which he does not publish the answers). Why do textbooks often include the solutions to odd or ... Jun 18, 2019 — My question is, why do textbooks often include the solutions to odd or even numbered

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