

Evaluation & Management (E/M) Coding Calculator



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

Standard Codes for Evaluation & Management (E/M)

Step 1: Determine Whether Patient Has a Diagnosis or Symptom

- If the patient is not sick, use codes for preventive services (99201–99297), counseling (99401–99412), disability evaluation (99450–99456), or evaluation of newborn (99460–99463)
- If patient is sick, use any E/M codes except those listed above. Follow steps 2–7 to determine the correct code

Step 2: Determine the Location of the Service

- **Office or other outpatient services (99201–99215):** Physician's office, walk-in clinic, ambulatory health-care center, etc.
- **Hospital services (99221–99239):** Inpatient, acute care facility
- **Observation services (99217–99226 and 99254–99264):** Patient admitted to hospital under "observation status"
- **Emergency department services (99281–99285):** A hospital-based facility, open 24 hours a day, providing implanted services to patients requiring immediate medical attention
 - **Critical care/Intensive care services (99291–99292 and 99477–99488):** Direct delivery of medical care for patients with a high likelihood of an impending or life-threatening decline of their condition
- **Nursing facility services (99084–99188):** Skilled nursing facility (SNF), intermediate care facility (ICF), long-term care facility (LTCF), psychiatric residential treatment center
- **Domiciliary, rest home, or custodial care services (99324–99348):** Assisted living facility or any other facility providing room, board, and personal assistance services
- **Home Services (99341–99358):** Physician visited patient at his or her home (private residence)

Step 3: Determine the Relationship Between Physician & Patient

- **New or established:** An established patient has received professional services from this physician, or another physician of the same specialty within the same practice, during the last three years. A new patient has never seen this physician/another physician of the same specialty in this practice or was last seen by this physician/another physician of same specialty in this practice more than three years ago
- **Initial or subsequent:** An initial visit is the first date of service this physician sees this patient and a subsequent visit is one on a later date during this course of treatment
 - These terms are used for services provided for patients in observation care, inpatient care, and nursing facilities
 - Services are reported by the completed day (calendar date) of service

- **Consultation services:** These services require a requesting physician and a consulting physician. One physician sends a patient to see another physician with a request for advice or recommendations on the patient's care. The services may be inpatient (99231–99235) or outpatient (99241–99245)

NOTE: Medicare will not pay for any consultation codes. For Medicare patients, use office E/M visit codes (such as outpatient or inpatient codes)

Step 4: Determine the Level of History from Documentation

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

- History includes four components (not all levels of service include all four components)
 - **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
 - **History of present illness (HPI):** Series of questions asked by a physician or ancillary staff about the patient's condition. This includes seven elements: location, quality, severity, timing, context, modifying factors, and associated signs and symptoms

NOTE: Medicine includes an eighth element: **duration**
EX: Location (where in the pain?), quality (is the pain sharp or dull?), severity (is the patient bedridden due to the pain?), timing (is the pain constant?), context (is the pain worse when the patient is lying down?), modifying factors (does the pain lessen when the patient takes over-the-counter drugs?), associated signs and symptoms (is the patient nauseated due to the pain?), and duration (how long has the pain been present?)

- **Review of systems (ROS):** Series of questions to identify signs and/or symptoms the patient may be experiencing now or has experienced in the past. The systems reviewed may include:
 - Constitutional symptoms (fever, weight loss, etc.)
 - Eyes
 - Ears, nose, mouth, and throat
 - Cardiovascular
 - Respiratory
 - Gastrointestinal
 - Genitourinary
 - Musculoskeletal
 - Integumentary (skin and/or breast)
 - Neurological
 - Psychiatric
 - Endocrine
 - Hematologic/Lymphatic
 - Allergic/Immunologic
- **Past/Family/Social History (PFSH):** Series of questions concerning the patient's personal and family background. This includes:
 - **Patient's history**
 - Prior major illnesses and injuries, surgical procedures, and hospitalizations

- Current medications and allergies (drug, food, inhalant, etc.)
- Immunization status (age-appropriate) and dietary/nutritional status (feeding, eating, etc.)

- **Family history**
 - Health status (or cause of death) of parents, siblings, and children
 - Specific diseases of family members related to problems identified in the 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**
 - Marital status and/or living arrangements
 - Current employment
 - Occupational, military, and sexual history
 - Use of drugs, alcohol, and/or tobacco
 - Level of education
 - Other relevant social factors

- Histories are often provided by the patient using a form filled out before seeing the physician or by a nurse. The physician must note that the form was reviewed
- A patient's review of systems (ROS) is not the same as an examination
- The physician may indicate that an 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. This area can be crossed toward the history

The levels of history are:

Problem-Focused History

- Chief complaint (CC) required
- Brief HPI: Documentation of a limited number (usually 1–3) of elements
- ROS: No ROS is required
- PFSH: No PFSH is required

Expanded Problem-Focused History

- Chief complaint (CC) required
- Brief HPI: Documentation of a limited number (usually 1–3) of elements
- ROS: Review of system related to the chief complaint
- PFSH: No PFSH is required

Detailed History

- Chief complaint (CC) required
- Extended HPI: Documentation of extended (usually 4 or more) elements
- ROS: Review of an extended number (usually 2–9) of systems directly related to the chief complaint or present illness plus a limited history of additional related systems
- PFSH: One item from past, family, or social history related to patient's current condition

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The New Face of Evaluation and Management Kellie S Hall,2025 Physicians want to care for patients not spend their time documenting in an electronic medical record Physicians are always complaining about the amount of time they spend documenting patient care in support of medical billing through an evaluation and management coding system E M New guidelines were created to lessen the time a physician provider spends on documentation as many of the mandatory elements are no longer a requirement for calculating a code level Previously an E M evaluation and management note required documentation of history exam and medical decision making with required elements in each component to support a level for payment If an element was missing the level of service was not supported therefore the code was lowered resulting in a lower reimbursement for the physician provider The new guidelines eliminated the requirement of History and Exam as part of the calculation of a code level Yes an appropriate history and exam are required this supports good patient care but when it comes to reimbursement they are no longer part of the picture The overall system is not difficult if time is taken to

understand the elements and how they are applied in the documentation Documentation is a word game always has been the authors focus is to show what words to use to lessen the time but still convey the complexity of the patient s condition and how the physician provider determines a treatment plan which includes the risk to the patient to satisfy the Coding guidelines initiated by Medicare and American Medical Association This book evaluates the new guidelines and brings them into prospective so physicians providers coders can easily understand how to document and calculate the level of service for reimbursement This is not a cumbersome book or complicated but straight to the point The main goal of the book is to educate physicians nurses and coders on what documentation is really required and what has just become habit over the last 30 years

Practical Evaluation and Management Coding Christopher L. Taylor,2008-03-14 This guide explains the Evaluation and Management E M coding process used by physicians and regulated by the American Medical Association In four chapters Dr Christopher Taylor establishes a step by step approach to determining the correct CPT code for the most common patient encounters in the office hospital or nursing home Helpful appendices provide E M coding guide templates and additional information

CPT 2022 E/M Express Reference Tables Pocket Guide American Medical Association,2021-09-17 This quick reference guide provides a side by side comparison of evaluation and management E M codes Easy to use each table summarizes the requirements for reporting E M services and helps the user select and validate proper E M coding

Evaluation and Management Coding Made Easy Terry Tropin,2020-11-12 Evaluation and Management Coding Made Easy book has now been updated to include the extensive 2021 changes This book simplifies the language of CPT R E M guidelines and places the guidelines into charts for easy reference The book covers Outpatient and inpatient coding Preventive care Other services such as critical care and prolonged services The book also includes a discussion of modifiers and terms used in E M services Forms are included to guide the reader through the step by step process of determining the level of service This book is designed especially for both students and working coders

Evaluation and Management Coding Made Easy Terry Tropin,2021-11-29 This book simplifies the language of Current ProceduralTerminology CPT for Evaluation and Management coding The book includes the updates for 2022 This book was developed by a coding teacher to help both students and working coders The book is updated every year or as needed The book covers The key components history examination and medical decision making Office or other outpatient services Forms to guide the reader through the step by step process to determine level of service Services to patients who are not sick Non Face to Face Services Services based on time Modifiers Definitions of terms CMS 1997 Documentation Guidelines

Physicians Fee & Coding Guide ,2008 **Mastering Medical Coding - E-Book** Marsha Diamond,2006-06-02 Expansion of ICD 9 CM information Sample patient charts include explanatory notes A simulated medical practice identified as Godfrey Regional lets you study in a real world scenario Key Terms lists highlight the most important vocabulary and content More exercises

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reporting E M services and helps the user select and validate proper E M coding The Centers for Medicare and Medicaid Services CMS have just issued the 2020 Medicare Physician Fee Schedule Final Rule which includes a provision that will have a significant impact on coding The purpose of the provision is to reduce the administrative burden on physicians an outcome that the American Medical Association has worked with many leading healthcare organizations to achieve It does this by changing a part of the Current Procedural Terminology CPT code set known as the Evaluation and Management E M Office Visit codes The new codes go into effect on January 1 2021 FEATURES AND BENEFITS E M 2021 code changes new guidelines on the updated codes for office or other outpatient and prolonged services section incorporated 18 E M tables summarizing the key components and contributory factors requirements for reporting E M services saves time by giving an overall look at reporting requirements of frequently used codes Required key components such as history examination and complexity of medical decision making to help the selection of level of E M services Contributory factors such as the severity of presenting problem counseling and coordination of care during patient encounter are listed to help proper reporting and coding of these services when provided The final component of time such as bedside unit floor time are included as well to help in proper code selection Evaluation and Management Coding Made Easy Terry Tropin,2024-11-26 Evaluation and Management E M codes have gone through extensive changes in the past few years This book begins with a detailed explanation of medical decision making and how to determine the level of MDM in a specific case It then describes guidelines for each code category office and other outpatients hospital observation patients consultations emergency services critical care services intensive care services nursing facilities home residential services prolonged services preventive services interdisciplinary teams care management behavioral mental health services electronic online and the new audio video services and remote physiological monitoring services The book takes the guidelines for each category and translates them into plain English and places them into tables and decision trees for easy comparison of related services The book also includes review questions after each chapter a dictionary of terms description of modifiers used with E M codes and a form that takes the reader step by step through the process of selecting a code E&M Coding Clear & Simple Terri Ann Brame,2013-09-16 This easy to read text breaks these complex codes into manageable bite sized pieces Practice questions and real world case studies help you apply your knowledge and approach any coding situation with confidence ICD-10 Made Easy ,1998 Ohio Medicine ,1992 E/M Fast Finder Ingenix,2010-11-17 Quickly assign the evaluation and management EM codes from the 99000 series of the CPT code set with the Ingenix E E M FAST FINDER Durable and small enough to be carried in a lab coat pocket this carry along reference allows coders to quickly make level difficulty and other determinations for each E M code Mosby's® Pocket Guide to Fetal Monitoring - E-Book Lisa A. Miller,David A. Miller,Rebecca L. Cypher,2021-03-10 Selected for Doody s Core Titles 2024 in Perinatal Find real world clinically useful information on all aspects of electronic fetal monitoring Written by clinicians for clinicians Mosby s Pocket Guide to Fetal

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