

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 (99381–99397), 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 99234–99236):** Patient admitted to hospital under "observation status"
- **Emergency department services (99281–99285):** A hospital-based facility, open 24 hours a day, providing unplanned services to patients requiring immediate medical attention
 - **Critical care/intensive care services (99291–99292 and 99477–99480):** Direct delivery of medical care for patients with a high likelihood of an impending or life-threatening decline of their condition
- **Nursing facility services (99304–99318):** Skilled nursing facility (SNF); intermediate care facility (ICF); long-term care facility (LTCF); psychiatric residential treatment center
- **Domiciliary, rest home, or custodial care services (99324–99340):** Assisted living facility or any other facility providing room, board, and personal assistance services
- **Home Services (99341–99350):** 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 case. The services may be inpatient (99251–99255) or outpatient (99241–99245)

NOTE: Medicare will not pay for any consultation codes. For Medicare patients, use other 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: Medicare includes an eighth element: duration
EX: Location (where is 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 counted 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

Neurosurgery Coding Guidelines For Evaluation And Management

Alice Covell



Neurosurgery Coding Guidelines For Evaluation And Management:

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ICD 9 CM coding manuals Exercises requiring HCPCS Level II codes are also provided Condition and procedure statements in the exercises reflect the current annual editions of the coding manuals By completing the exercises learners will expand their medical vocabulary and increase their coding skills for the physician s office and will learn to code only what the documentation supports Also included are the Center for Medicare and Medicaid Services CMS guidelines for diagnosis coding and reporting by physicians Learners need current CPT 4 ICD 9 CM and HCPCS coding manuals to complete the exercises

Principles and Practice of Neurocritical Care Hemanshu Prabhakar,Vasudha Singhal,Kapil G Zirpe,Harsh Sapra,2024-05-31 This official textbook of the Society of Neurocritical Care SNCC comprises a comprehensive review of all possible neurologic conditions that one may encounter in the practice of neuro intensive care It covers various topics from the history and origin of neuro intensive care to psychological and nursing care Neurocritical care is the intensive care management of patients with life threatening neurological and neurosurgical illnesses such as massive stroke bleeding in or around the brain subarachnoid hemorrhage intracerebral hemorrhage subdural hemorrhage intraventricular hemorrhage brain tumors brain trauma status epilepticus nerve and muscle diseases myasthenia gravis Guillain Barre Syndrome spinal cord disorders and the cardiopulmonary complications of brain injury Neurocritical care units specialize in managing the unique needs of such critically ill patients The textbook is divided into many sections Chapters discuss issues related to palliative care and describe some of the commonly performed procedures in the neuro intensive care unit as well It provides a straightforward and systematic approach to various clinical problems encountered during intensive care management of neurologic patients It includes a separate section on special considerations in neurocritical care The book includes ample figures flowcharts and algorithms The textbook is a valuable resource for residents fellows and trainees in neuroanesthesia neurointensive care critical care and anesthesia It serves as a quick guide to all intensivists managing neurosurgical patients It is also helpful for general intensivists who occasionally manages neurologic patients

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Neurosurgery Coding Guidelines For Evaluation And Management Book Review: Unveiling the Magic of Language

In an electronic era where connections and knowledge reign supreme, the enchanting power of language has been apparent than ever. Its capability to stir emotions, provoke thought, and instigate transformation is really remarkable. This extraordinary book, aptly titled "**Neurosurgery Coding Guidelines For Evaluation And Management**," published by a highly acclaimed author, immerses readers in a captivating exploration of the significance of language and its profound effect on our existence. Throughout this critique, we will delve into the book's central themes, evaluate its unique writing style, and assess its overall influence on its readership.

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