

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 (99241–99246 and 99248–99249):** 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 care. 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
CC: 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

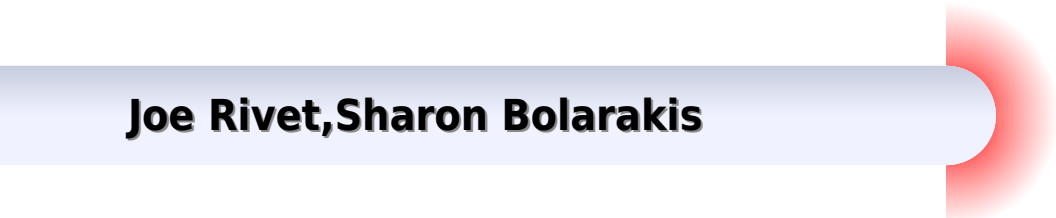
- **Chief complaint (CC)** required
- **Brief HPI:** Documentation of a limited number (usually 1–3) of elements
- **ROS:** Review of system related to the chief complaint
- **PFSH:** No PFSH is required

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

Evaluation And Management Coding Guidelines

Joe Rivet, Sharon Bolarakis



Evaluation And Management Coding Guidelines:

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 perspective 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 **The New Face of Evaluation and Management** KELLIE. HALL, 2025-04-17 This book

evaluates the new guidelines and brings them into perspective so physicians providers coders can easily understand how to document and calculate the level of service for reimbursement *Auditing Evaluation and Management Coding* Joe

Rivet, Sharon Bolarakis, 2006 *Evaluation and Management Coding Reference Guide - First Edition* AAPC, 2020-06-30

Defeat the challenges that threaten your E M claims and compliance success Evaluation and management E M services are the lifeblood of your revenue stream and yet they're the most problematic to report Claim denials remain high E M coding errors in fact rose from 11.9% in 2018 to account for 12.8% of CMS's overall 2019 improper payment rate How much E M revenue are you losing Safeguard your organization from claim denials and audit scrutiny with the Evaluation Management

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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

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This book delves into Evaluation And Management Coding Guidelines. Evaluation And Management Coding Guidelines is a crucial topic that must be grasped by everyone, ranging from students and scholars to the general public. The book will furnish comprehensive and in-depth insights into Evaluation And Management Coding Guidelines, encompassing both the fundamentals and more intricate discussions.

1. This book is structured into several chapters, namely:
 - Chapter 1: Introduction to Evaluation And Management Coding Guidelines
 - Chapter 2: Essential Elements of Evaluation And Management Coding Guidelines
 - Chapter 3: Evaluation And Management Coding Guidelines in Everyday Life
 - Chapter 4: Evaluation And Management Coding Guidelines in Specific Contexts
 - Chapter 5: Conclusion
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 3. In chapter 2, the author will delve into the foundational concepts of Evaluation And Management Coding Guidelines. The second chapter will elucidate the essential principles that need to be understood to grasp Evaluation And Management Coding Guidelines in its entirety.
 4. In chapter 3, the author will examine the practical applications of Evaluation And Management Coding Guidelines in daily life. The third chapter will showcase real-world examples of how Evaluation And Management Coding Guidelines can be effectively utilized in everyday scenarios.
 5. In chapter 4, the author will scrutinize the relevance of Evaluation And Management Coding Guidelines in specific contexts. The fourth chapter will explore how Evaluation And Management Coding Guidelines is applied in specialized fields, such as education, business, and technology.
 6. In chapter 5, this book will draw a conclusion about Evaluation And Management Coding Guidelines. The final chapter will summarize the key points that have been discussed throughout the book.
- The book is crafted in an easy-to-understand language and is complemented by engaging illustrations. This book is highly recommended for anyone seeking to gain a comprehensive understanding of Evaluation And Management Coding Guidelines.

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