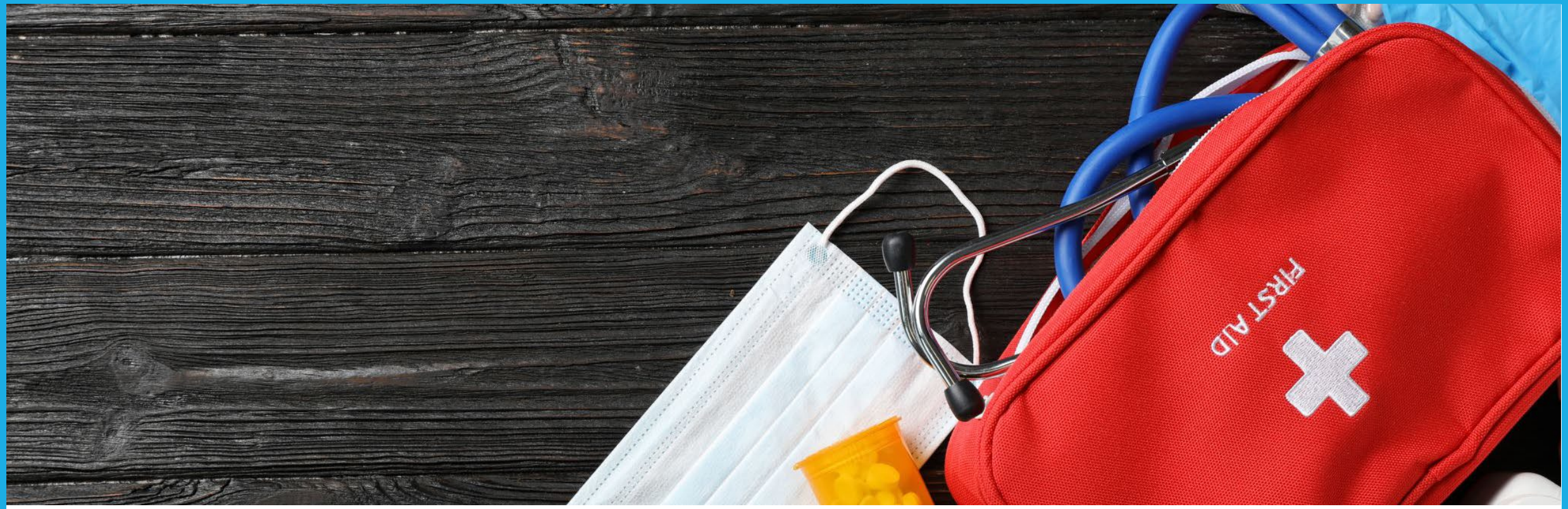


EVALUATION AND MANAGEMENT CODING

CHRISTINE A. PFEIFER, MHA, CPC
SENIOR CONSULTANT
MCMANIS ASSOCIATES

Evaluation and Management Coding

"EM services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (e.g., by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of EM services."

Evaluation and Management Coding

Medicare adopted new CPT® E/M changes effective 1/1/2021, and again 1/1/2023

- The changes are now applicable to all EM services.
- EM Introductory Guidelines have been changed.
- There is no required level of history or exam for visits for all E/M code sets.
  - A Chief Complaint is still required for all encounters.
- Coding based on time is based on the total amount of time spent performing certain activities on the date of the encounter.
- Several Categories of E/M services have been eliminated, most notably is the Observation E/M codes.

MDM Changes Comparison

95/97 MDM

- Number of Diagnoses or Management Options
- Amount and/or Complexity of Data to be Reviewed
- Risk of Complications and/or Morbidity or Mortality

2021/2023 MDM

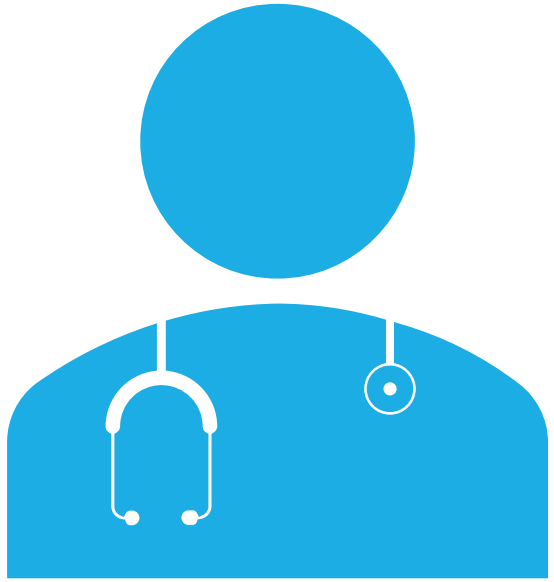
- Number and Complexity of Problems Addressed at the Encounter
- Amount and/or Complexity of Data to be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management

Evaluation and Management Coding

Coding Based on Medical Decision Making

- There are several new definitions within MDM
- The MDM calculation is similar to, but not identical to, the previous MDM calculation.
- CPT® has provided numerous definitions to clarify terms in the current guidelines, such as “chronic illness with exacerbation”, “progression or side effects of treatment”, and “drug therapy requiring intensive monitoring for toxicity.”

Evaluation and Management Coding



- Medical decision making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.
- There are the four levels of medical decision making
  - Straightforward
  - Low
  - Moderate
  - High
- There are three elements of medical decision making
- To qualify for a particular level of medical decision making, two of the three elements for that level of medical decision making must be met or exceeded.

Evaluation and Management Coding

Element 1 - The number and complexity of problem(s) that are addressed during the encounter

- A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.
- A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service.
- This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.
- Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service.
- Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

Evaluation and Management Coding

Self-limited or minor problem

A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Evaluation and Management Coding

Stable Chronic Illness

A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition). 'Stable' for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function.

Examples: Diabetes at A1c goal, well-controlled hypertension, BPH, hyperlipidemia

Evaluation and Management Coding

Acute, Uncomplicated Illness or Injury

A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness.

Examples may include cystitis, allergic rhinitis, or a simple sprain.

Evaluation and Management Coding

Acute, Uncomplicated Illness or Injury Requiring Hospital Inpatient or Observation Level Care

A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Evaluation and Management Coding

Stable, Acute Illness

A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.

Evaluation and Management Coding

Chronic Illness with Exacerbation, Progression, or Side Effects of Treatment

A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Evaluation and Management Coding

Undiagnosed New Problem with Uncertain Prognosis

A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

An example may be a lump in the breast.

Evaluation and Management Coding

Acute Illness with Systemic Symptoms

An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for 'self-limited or minor' or 'acute, uncomplicated.' Systemic symptoms may not be general, but may be single system.

Examples may include pyelonephritis, pneumonitis, or colitis.

Evaluation and Management Coding

Acute, Complicated Injury

An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

An example may be a head injury with brief loss of consciousness.

Evaluation and Management Coding

Chronic Illness with Severe Exacerbation, Progression, or Side Effects of Treatment

The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

Evaluation and Management Coding

Acute or Chronic Illness or Injury that Poses A Threat to Life or Bodily Function

An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment.

Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

Classify the condition!

1. Minimal
2. Self limited or minor
3. Stable, chronic illness
4. Acute, uncomplicated illness or injury
5. Chronic illness with exacerbation, progression or side effects of treatment.
6. Undiagnosed new problem with uncertain prognosis
7. Acute, complicated injury
8. Chronic illness with severe exacerbation, progression or side effects of treatment.
9. Acute or chronic illness or injury that poses a threat to life or bodily function

A. Breast lump
B. Laceration to forehead with brief loss of consciousness.
C. Blood pressure check
D. Type II Diabetes with HgbA1c of 7.0
E. Type II Diabetes with HgbA1c of 16.0
F. Sprained ankle
G. Asymptomatic, uncontrolled hypertension
H. Common cold
I. COVID-19 with O2 saturation of 90%

And the answers are…

1. Minimal
   C. Blood Pressure check

2. Self limited or minor
   H. Common Cold

3. Stable, chronic illness
   D. Type II Diabetes at goal with HgbA1c of 7.0

4. Acute, uncomplicated illness or injury
   F. Sprained ankle

5. Chronic illness with exacerbation, progression or side effects of treatment
   G. Asymptomatic, uncontrolled hypertension

6. Undiagnosed new problem with uncertain prognosis
   A. Breast lump

7. Acute, complicated injury
   B. Laceration to forehead with brief loss of consciousness

8. Chronic illness with severe exacerbation, progression or side effects of treatment
   E. Type II Diabetes with HgbA1c of 16.0

9. Acute or chronic illness or injury that poses a threat to life or bodily function –
   I. COVID-19 with O2 saturation of 90%

Evaluation and Management Coding

Element 2 - The amount and/or complexity of data to be reviewed and analyzed.

- This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter.
- This includes information obtained from multiple sources or interprofessional communications that are not separately reported.
- It includes interpretation of tests that are not separately reported. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter.
  - Data is divided into three categories:
    - Tests, documents, orders, or independent historian(s). (Each unique test, order or document is counted to meet a threshold number)
    - Independent interpretation of tests.
    - Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source

Note: Reviewing of tests previously ordered are not counted separately

Evaluation and Management Coding

Analyzed: The process of using the data as part of the MDM. The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment.

- Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter.
  - Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed.
    - For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter.
- Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Evaluation and Management Coding

- ***Test:*** Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.
- ***External:*** External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.
- ***External physician or other qualified healthcare professional*:** An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency.

Evaluation and Management Coding

Independent historian(s): An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.

- In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.
- It does not include translation services.
- The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Evaluation and Management Coding

Independent Interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: For the purpose of the Discussion of Management data element, an appropriate source includes professionals who are not health care professionals, but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

Evaluation and Management Coding

Element 3 - Risk of Complications and/or Morbidity or Mortality of Patient Management

- One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter.
- This is distinct from the risk of the condition itself.

Evaluation and Management Coding

Risk: **The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration.**

- For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk.
- Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty.
- Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities).
- For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.
- The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter

Evaluation and Management Coding

***Morbidity*:** A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

***Social determinants of health*:** Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Evaluation and Management Coding

Surgery

(minor or major, elective, emergency, procedure or patient risk)

Surgery—Minor or Major:
The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk." These terms are not defined by a surgical package classification.

Surgery—Elective or Emergency:
Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (e.g., scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.

Surgery—Risk Factors, Patient or Procedure:

Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Evaluation and Management Coding

Drug therapy requiring intensive monitoring for toxicity

A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death.

- The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy.
- The monitoring should be that which is generally accepted practice for the agent, but may be patient specific in some cases.
- Intensive monitoring may be long-term or short term.
  - Long-term intensive monitoring is not less than quarterly.
  - The monitoring may be by a lab test, a physiologic test or imaging.
  - Monitoring by history or examination does not qualify.
  - The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient.

- Examples may include monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis.
- Examples of monitoring that does not qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (unless hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold.

Elements of Medical Decision Making			
Level of MDM (based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed**	**Amount and/or Complexity of Data to be Reviewed and Analyzed** *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Straightforward	• 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	• 2 or more self-limited or minor problems; • 1 stable chronic illness; • 1 acute uncomplicated illness or injury; • 1 stable acute illness; • 1 acute, uncomplicated illness or injury requiring hospital IP/OBS level of care	**Limited** (Must meet the requirements of at least 1 of 2 categories) **Category 1: Tests and documents** • Any combination of 2 from the following: o Review of prior external note(s) from each unique source o Review of the result(s) of each unique test o Ordering of each unique test **Category 2: Assessment requiring an independent historian(s)**	**Low risk of morbidity from additional diagnostic testing or treatment**
Moderate	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; • 2 or more stable, chronic illnesses; • 1 undiagnosed new problem with uncertain prognosis; • 1 acute illness with systemic symptoms; • 1 acute, complicated injury	**Moderate** (Must meet the requirements of at least 1 of 3 categories) **Category 1: Tests and documents** • Any combination of 3 from the following: o Review of prior external note(s) from each unique source o Review of the result(s) of each unique test o Ordering of each unique test o Assessment requiring independent historian **Category 2: Independent interpretation of tests** (performed by another physician/other qualified health care professional (not separately reported). **Category 3: Discussion of management or test interpretation** (with external physician/other qualified health care professional/appropriate source (not separately reported).	**Moderate risk of morbidity from additional diagnostic testing or treatment** **Examples:** • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
High	• 1 or more chronic illnesses with severe exacerbation, progression, of side effects of treatment • 1 acute or chronic illness or injury that poses a threat to life or bodily function.	**Extensive** (Must meet the requirements of at least 2 of 3 categories) **Category 1: Tests and documents** • Any combination of 3 from the following: o Review of prior external note(s) from each unique source o Review of the result(s) of each unique test o Ordering of each unique test o Assessment requiring independent historian **Category 2: Independent interpretation of tests** (performed by another physician/other qualified health care professional (not separately reported)). **Category 3: Discussion of management or test interpretation** (with external physician/other qualified health care professional/appropriate source (not separately reported)).	**High risk of morbidity from additional diagnostic testing or treatment** **Examples:** • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances

Evaluation and Management Coding

Total time on the date of the encounter

- When time is used for reporting E/M services codes, the time defined in the service descriptor is used for selecting the appropriate level of service.
- The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional and the patient and/or family/caregiver.
- For coding purposes, time for these services is the total time on the date of the encounter.
  - It includes both the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff).
- It includes time regardless of the location of the physician or other qualified health care professional (e.g., whether on or off the inpatient unit or in or out of the outpatient office).
- It does not include any time spent in the performance of other separately reported service(s), i.e., bedside procedures.
- Do not count time spent on travel, or teaching that is general and not limited to discussion that is required for the management of a specific patient.
- When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Evaluation and Management Coding

Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

Note: time spent with an interpreter does not count

Evaluation and Management Coding

Prolonged Service

- Prolonged total time is time that is 15 minutes beyond the time required to report the highest-level primary service.
- Prolonged service is only used when the primary service has been selected using time alone as the basis and only after the time required to report the highest-level of service has been exceeded by 15 minutes.
- To report a unit of prolonged service, 15 minutes of time must have been attained. Do not report report prolonged service for any time increment of less than 15 minutes.
- Additional units of prolonged service may be added for each full increment of 15 minutes documented.
- Prolonged Service CPT® and HCPCS (**Medicare**)
  - 99417 (G2212, **G0318**) – 98003, 98007, 98011, 98015, 99205, 99215, 99245,**99345, 99350**, 99483
  - 99418 (G0316, **G0317**) – 99223, 99233, 99236, 99255, **99306, 99310**

IN SUMMARY

A chief complaint is required for every encounter

A medically appropriate history and exam should be documented

Document, as appropriate, diagnostic studies ordered, external notes reviewed, conversation(s) with other healthcare providers or appropriate source involved in the care of the patient.

Document the total time spent on an encounter if appropriate.

The level of service may be coded based on MDM or time, whichever is most advantageous to the provider.

Documentation requirements for Critical Care remain the same and were not impacted by the new 2023 documentation guidelines.

Resources

American Medical Association - CPT® Evaluation and Management (E/M) Code and Guideline Changes – Effective January 1, 2023

https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

American Medical Association - CPT® 2025 Professional Edition

CMS – Evaluation and Management Services Guide

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

Thank You!

Christine Pfeifer

cpfeifer@mcmanis-monsalve.com

(814)969-8810