EVALUATION AND MANAGEMENT CODE SELECTION OVERVIEW

The purpose of this tool is to give a brief overview of coding and to provide a desk aid for coding decisions related to evaluation and management services.

The Centers for Medicare and Medicaid Services (CMS) 1995 and 1997 *Documentation Guidelines for Evaluation and Management Services* are divided into three key components: history, exam, and medical decision making. For new patients (99201-99205), the minimum of all three components is required for the code (see below for example). For established patients (99211-99215), only two of the three components must meet or exceed criteria to qualify for a specific level of evaluation and management (E/M) service.

Another option for encounters is to use time as your guide. **If counseling or coordination of care account for more than 50 percent of the visit, then you can select your E/M code based on the length of the visit.** In general, the time spent counseling should meet or exceed the typical visit times listed. If you decide to use time-based billing, make sure to document the time in your chart ("9:01-9:18 am— 10 of 17 minutes spent counseling patient on safer sex practices"). For more information, watch the Introduction to Coding webinar, https://vimeo.com/72297075.

Level of history
+ Level of exam
+ Level of medical decision making
= Level of service

OR

Time = Level of service

If counseling or coordination of care account for more than 50% of the visit, then you can select the E/M code based on time.

CODING LEVEL OF SERVICE

New Patient Level of Service

- Level of History, Exam, and Medical Decision Making (MDM) is "3 of 3 Required"
- Overall visit level is the lowest element of History, Exam, and MDM

LEVEL OF SERVICE WORKSHEET: NEW PATIENT

SOAP (subjective, objective, assessment, and plan)
See pages 3 and 4 for scoring criteria

S	**C/C:** Here for urine CT/GC test **HPI:** Unprotected sex 2 weeks ago **ROS/GU:** No vaginal discharge	2
O	NAD	1
A/P	Presumptive treatment for chlamydia **RX:** Azithromycin 1 g orally in a single dose-4	4
TIME		

1 · 2 · 4 = 99201

For new patients, the overall visit level is the lowest element of History, Exam, and MDM

STD TAC

CODING LEVEL OF SERVICE

Established Patient Level of Service

- Of History, Exam, and MDM, 2 of 3 are required to code the level of service
- Level of service is the component score in the middle

LEVEL OF SERVICE WORKSHEET: ESTABLISHED PATIENT

SOAP (subjective, objective, assessment, and plan)
See pages 3 and 4 for scoring criteria

S	**C/C:** Here for urine CT/GC test **HPI:** Unprotected sex 2 weeks ago **ROS/GU:** No vaginal discharge	**3**
O	NAD	**2**
A/P	Results positive for chlamydia **RX:** Azithromycin 1 g orally in a single dose-4	**4**
TIME		
	2 · 3 · 4 = 99213	

For established patients, level of service is the component score in the middle

---

CODING LEVEL OF SERVICE

Using Time to Bill for a New or Established Patient

If counseling OR coordination of care account for more than **50 percent of the visit**, then you may select the E/M code based on the length of the visit. See decision-making chart on pages 3 and 4 to select the appropriate levels for new or established patients.

WORKSHEET: BILLING TIME FOR ESTABLISHED PATIENT

SOAP (subjective, objective, assessment, and plan)
See pages 3 and 4 for scoring criteria

S	**C/C:** follow/up labs (+ herpes culture last visit) **HPI:** Finished Valtrex Rx–"no more sores"	
O	**GU:** no lesions at present	
A/P	New dx of herpes, spent 35/40 minutes discussing HSV 1 & 2, viral transmission, treatment episodic vs suppressive, healthy behaviors to reduce outbreaks & safer sex	**35**
TIME	1/15/13 (9:00– 9:40)	**40**
	35/40 minutes = 99215	

Counseling accounts for more than 50% of the visit so you may select the E/M code based on time.

E&M: NEW PATIENT OFFICE VISIT (99201–99205)

New Patient Office Visits: History, Exam, and MDM must be met. Code based on the score of the lowest element

NOTE: New Patient Definition—patient has not had face-to-face service by a provider of the same specialty within a group practice in three years.

Level	1	2	3	4	5
History	Problem Focused 1-3 History of Present Illness (HPI) No Review of Systems (ROS) No Past, Family and/or Social History (PFSH)	Expanded Problem Focused 1-3 HPI 1 ROS No PFSH	Detailed 4 HPI 2-9 ROS 1 PFSH	Comprehensive 4 HPI 10 ROS 3 PFSH	Comprehensive 4 HPI 10 ROS 3 PFSH
Exam	Problem Focused <1 Body Areas (BA)/Organ System (OS)	Expanded Problem Focused 2-4 BA/OS	Detailed 5-7 BA/OS	Comprehensive 8 Organ Systems	Comprehensive 8 Organ Systems
Medical Decision Making (MDM)	Straightforward	Straightforward	Low Complexity	Moderate Complexity New Problem w/ RX Acute Complicated Illness/ Injury Undx'd, New Problem 1 or more chronic Illness w/mild exacerbation	High Complexity New Problem with work-up planned and high level of acuity
Time	10 minutes	20 minutes	30 minutes	45 minutes	60 minutes

Chief Complaint (CC)
Required for ALL visits
- Reason(s) for visit—not always the primary ICD-10
- Concise statement in patient's own words

History of the Present Illness (HPI)
- Duration, timing, severity, location, modifying factors, associated signs & symptoms, and context

No Appreciable Disease (NAD)

Past Medical, Family & Social History (PFSH)
- Allergies, medication list, other problems, or surgeries
- Sick contacts at home
- Smoker, alcohol use, sexual history

Review of Systems (ROS)
- Signs & symptoms related to the illness or complaint

Body Areas (BA)
- Head (including face)
- Neck
- Chest
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

Organ Systems (OS)
- Constitutional*
- Eyes
- ENMT
- Cardiovascular
- Respiratory
- Genitourinary
- Gastrointestinal
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hem/Lymph/Immune

*1995 Guidelines require only one vital sign vs. three for 1997 Guidelines

STD TAC   WWW.STDTAC.ORG   EVALUATION AND MANAGEMENT CODE SELECTION OVERVIEW | 3

E&M: ESTABLISHED PATIENT OFFICE VISIT (99211–99215)

Established Patient Office Visits: History, Exam, and MDM must be met. Code based on the score of the middle element.

Level	1	2	3	4	5
History	Provider not required, but a provider must be in the building. Patient must have been seen previously and this is just a follow-up, not a new problem.	Problem Focused 1-3 HPI No ROS No PFSH	Expanded Problem Focused 1-3 HPI 2-9 ROS No PFSH	Detailed 4 HPI 2-9 ROS 1 PFSH	Comprehensive 4 HPI 10 ROS 2 PFSH
Exam		Problem Focused <1 BA/OS	Expanded Problem Focused 2-4 BA/O	Detailed 5-7 BA/OS	Comprehensive 8 Organ Systems
Medical Decision Making (MDM)		Straightforward	Low Complexity	Moderate Complexity New Problem w/ RX Acute Complicated Illness Injury Undx'd, New Problem 1 or more chronic Illness w/mild exacerbation	High Complexity New Problem with work-up planned and high level of acuity
Time		10 minutes	15 minutes	25 minutes	40 minutes

Chief Complaint (CC)
Required for ALL visits
- Reason(s) for visit—not always the primary ICD-10
- Concise statement in patient's own words

History of the Present Illness (HPI)
- Duration, timing, severity, location, modifying factors, associated signs & symptoms, and context

No Appreciable Disease (NAD)

Past Medical, Family & Social History (PFSH)
- Allergies, medication list, other problems, or surgeries
- Sick contacts at home
- Smoker, alcohol use, sexual history

Review of Systems (ROS)
- Signs & symptoms related to the illness or complaint

Body Areas (BA)
- Head (including face)
- Neck
- Chest
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

Organ Systems (OS)
- Constitutional*
- Eyes
- ENMT
- Cardiovascular
- Respiratory
- Genitourinary
- Gastrointestinal
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hem/Lymph/Immune

*1995 Guidelines require only one vital sign vs. three for 1997 Guidelines