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KNOWLEDGE • RESOURCES • TRAINING

EVALUATION AND MANAGEMENT SERVICES GUIDE

UPDATES

- Updated for 2021 Medicare Physician Fee Schedule final rule dates and links

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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INTRODUCTION

This guide is intended to educate providers about the general principles of evaluation and management (E/M) documentation, common sets of codes used to bill for E/M services, and E/M services providers

This guide is offered as a reference tool and does not replace content found in the 1995 Documentation Guidelines for Evaluation and Management Services and the 1997 Documentation Guidelines for Evaluation and Management Services. These publications are also available in the Reference Section.

NOTE: For billing Medicare, you may use either version of the documentation guidelines for a patient encounter, not a combination of the two.

For reporting services furnished on and after September 10, 2013, to Medicare, you may use the 1997 documentation guidelines for an extended history of present illness along with other elements from the 1995 documentation guidelines to document an evaluation and management service.

GENERAL PRINCIPLES OF E/M DOCUMENTATION

Clear and concise medical record documentation is critical to providing patients with quality care and is required for you to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history. Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.

Health care payers may require reasonable documentation to ensure that a service is consistent with the patient's insurance coverage and to validate:

- The site of service
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided
- That services furnished were accurately reported

General principles of medical record documentation apply to all types of medical and surgical services in all settings. While E/M services vary in several ways, such as the nature and amount of physician work required, these general principles help ensure that medical record documentation for all E/M services is appropriate:

- The medical record should be complete and legible
- The documentation of each patient encounter should include:
  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
  - Assessment, clinical impression, or diagnosis
  - Medical plan of care
- If date and legible identity of the observer if the rationale for ordering diagnostic and other ancillary services is not documented, it should be easily inferred
- Past and present diagnoses should be accessible to the treating and/or consulting physician
- Appropriate health risk factors should be identified
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented
- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record

To maintain an accurate medical record, document services during the encounter or as soon as practicable after the encounter.

COMMON SETS OF CODES USED TO BILL FOR E/M SERVICES

When billing for a patient's visit, select codes that best represent the services furnished during the visit. A billing specialist or alternate source may review the provider's documented services before submitting the claim to a payer. These reviewers help select codes that best reflect the provider's furnished services. However, the provider must ensure that the submitted claim accurately reflects the services provided.

The provider must also ensure that medical record documentation supports the level of service reported to a payer. You should not use the volume of documentation to determine which specific level of service to bill.

Services must meet specific medical necessity requirements in the statute, regulations, and manuals and specific medical necessity criteria defined by National Coverage Determinations and Local Coverage Determinations (if any exist for the service reported on the claim). For every service billed, you must indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

HCPCS

The HCPCS is the Health Insurance Portability and Accountability Act-compliant code set for providers to report procedures, services, drugs, and devices furnished by physicians and other non-physician practitioners, hospital outpatient facilities, ambulatory surgical centers, and other outpatient facilities. This system includes Current Procedural Terminology Codes, which the American Medical Association developed and maintains.

Effective January 1, 2021 CMS is aligning E/M coding with changes adopted by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel for office/outpatient E/M visits, which:

- Retains 5 levels of coding for established patients, reduces the number of levels to 4 for office/outpatient E/M visits for new patients, and revises the code definitions
- Revises the times and medical decision-making process for all of the codes, and requires performance of history and exam only as medically appropriate
- Allows clinicians to choose the E/M visit level based on either medical decision making or time

For more information, review the CY 2021 Physician Fee Schedule Web Page and the Medicare Learning Network®(MLN) Connects Physician Fee Schedule Final Rule: Understanding 4 Key Topics Call transcript, recording and presentation.

Effective January 1, 2021, CMS is consolidating and increasing payment for the Medicare-specific add-on code, HCPCS code GPC1X, for office/outpatient E/M visits for primary care and non-procedural specialty care into a single code describing the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition.

This code is not intended to reflect a difference in payment by enrollment specialty, but rather a better recognition of differences between kinds of visits.

International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)

ICD-10-CM codes – A code set providers use to report medical diagnoses on all types of claims for services furnished in the United States (U.S.).

ICD-10-PCS codes – A code set facilities use to report inpatient procedures and services furnished in U.S. hospital inpatient health care settings. Use HCPCS codes to report ambulatory services and physician services, including those physician services furnished during an inpatient hospitalization.

E/M SERVICES PROVIDERS

To receive payment from Medicare for E/M services, the Medicare benefit for the relevant type of provider must permit him or her to bill for E/M services. The services must also be within the scope of practice for the relevant type of provider in the State in which they are furnished.

SELECTING THE CODE THAT BEST REPRESENTS THE SERVICE FURNISHED

Billing Medicare for an E/M service requires the selection of a Current Procedural Terminology (CPT) code that best represents:

- Patient type
- Setting of service
- Level of E/M service performed

Patient Type

For purposes of billing for E/M services, patients are identified as either new or established, depending on previous encounters with the provider.

New Patient: An individual who did not receive any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

Established Patient: An individual who receives professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous 3 years.

Setting of Service

E/M services are categorized into different settings depending on where the service is furnished. Examples of settings include:

- Office or other outpatient setting
- Hospital inpatient
- Emergency department (ED)
- Nursing facility (NF)

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Level of E/M Service Performed

The code sets to bill for E/M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code you may bill within the appropriate category. To bill any code, the services furnished must meet the definition of the code. You must ensure that the codes selected reflect the services furnished.

The three key components when selecting the appropriate level of E/M services provided are history, examination, and medical decision making. Visits that consist predominately of counseling and/or coordination of care are an exception to this rule. For these visits, time is the key or controlling factor to qualify for a particular level of E/M services.

History

The Elements Required for Each Type of History table shows the elements required for each type of history. You can find more information on the activities comprising each of these elements on pages 7 and 8. To qualify for a given type of history, all four elements indicated in the row must be met. Note that as the type of history becomes more intensive, the elements required to perform that type of history also increase in intensity.

For example, a problem focused history requires documentation of the chief complaint (CC) and a brief history of present illness (HPI), while a detailed history requires the documentation of a CC, an extended HPI, plus an extended review of systems (ROS), and pertinent past, family, and/or social history (PFSH).

Elements Required for Each Type of History

TYPE OF HISTORY	CC	HPI	ROS	PFSH
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

Table 1: Elements for Each Type of History

While documentation of the CC is required for all levels, the extent of information gathered for the remaining elements related to a patient's history depends on clinical judgment and the nature of the presenting problem.

Chief Complaint (CC)

A CC is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient's own words. For example, patient complains of upset stomach, aching joints, and fatigue. The medical record should clearly reflect the CC.

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History of Present Illness (HPI)

HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI elements are:

- Location (example: left leg)
- Quality (example: aching, burning, radiating pain)
- Severity (example: 10 on a scale of 1 to 10)
- Duration (example: started 3 days ago)
- Timing (example: constant or comes and goes)
- Context (example: lifted large object at work)
- Modifying factors (example: better when heat is applied)
- Associated signs and symptoms (example: numbness in toes)

Effective January 1, 2021, practitioners will have the choice to document office/outpatient E/M visits via medical decision making (MDM) or time. CMS is adopting the CPT's revised guidance, including deletion of CPT code 99201. CMS has also finalized separate payment rates for the remaining nine E/M codes.

For more information, review the CY 2021 Physician Fee Schedule Final Rule, page 301 and the CPT® Evaluation and Management webpage.

The two types of HPIs are brief and extended.

1. A **brief HPI** includes documentation of one to three HPI elements. In this example, three HPI elements – location, quality, and duration – are documented:
   - CC: Patient complains of earache
   - Brief HPI: Dull ache in left ear over the past 24 hours

2. An **extended HPI**:
   - 1995 documentation guidelines – Should describe four or more elements of the present HPI or associated comorbidities
   - 1997 documentation guidelines – Should describe at least four elements of the present HPI or the status of at least three chronic or inactive conditions

For reporting services furnished on and after September 10, 2013, to Medicare, you may use the 1997 documentation guidelines for an extended HPI along with other elements from the 1995 documentation guidelines to document an E/M service.

In this example, five HPI elements – location, quality, duration, context, and modifying factors – are documented:

- CC: Patient complains of earache.
- Extended HPI: Patient complains of dull ache in left ear over the past 24 hours. Patient states he went swimming 2 days ago. Symptoms somewhat relieved by warm compress and ibuprofen.

Review of Systems (ROS)

ROS is an inventory of body systems obtained by asking a series of questions to identify signs and/or symptoms the patient may be experiencing or has experienced. These systems are recognized for ROS purposes:

- Constitutional Symptoms (for example, fever, weight loss)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic

The three types of ROS are problem pertinent, extended, and complete.

1. A **problem pertinent ROS** inquires about the system directly related to the problem identified in the HPI. In this example, one system – the ear – is reviewed:
   - CC: Earache.
   - ROS: Positive for left ear pain. Denies dizziness, tinnitus, fullness, or headache.

2. An **extended ROS** inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems.

   In this example, two systems – cardiovascular and respiratory – are reviewed:
   - CC: Follow-up visit in office after cardiac catheterization. Patient states “I feel great.”
   - ROS: Patient states he feels great and denies chest pain, syncope, palpitations, and shortness of breath. Relates occasional unilateral, asymptomatic edema of left leg.

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3. A **complete ROS** inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of ten) organ systems. You must individually document those systems with positive or pertinent negative responses. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, you must individually document at least ten systems.

   In this example, ten signs and symptoms are reviewed:

   - CC: Patient complains of "fainting spell."
   - ROS:
     - Constitutional: Weight stable, + fatigue.
     - Eyes: + loss of peripheral vision.
     - Ear, nose, mouth, throat: No complaints.
     - Cardiovascular: + palpitations; denies chest pain; denies calf pain, pressure, or edema.
     - Respiratory: + shortness of breath on exertion.
     - Gastrointestinal: Appetite good, denies heartburn and indigestion. + episodes of nausea. Bowel movement daily; denies constipation or loose stools.
     - Urinary: Denies incontinence, frequency, urgency, nocturia, pain, or discomfort.
     - Skin: + clammy, moist skin.
     - Neurological: + fainting; denies numbness, tingling, and tremors.
     - Psychiatric: Denies memory loss or depression. Mood pleasant.

Past, Family, and/or Social History (PFSH)

PFSH consists of a review of three areas:

1. Past history includes experiences with illnesses, operations, injuries, and treatments
2. Family history includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk
3. Social history includes an age appropriate review of past and current activities

The two types of PFSH are pertinent and complete.

A **pertinent PFSH** is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document at least **one** item from any of the three history areas.

In this example, the patient's past surgical history is reviewed as it relates to the identified HPI:

- HPI: Coronary artery disease.
- PFSH: Patient returns to office for follow-up of coronary artery bypass graft in 1992. Recent cardiac catheterization demonstrates 50 percent occlusion of vein graft to obtuse marginal artery.

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A **complete PFSH** is a review of two or all three of the areas, depending on the category of E/M service. A complete PFSH requires a review of all three history areas for services that, by their nature, include a comprehensive assessment or reassessment of the patient. A review of two history areas is sufficient for other services.

You must document at least one specific item from **two** of the three history areas for a complete PFSH for these categories of E/M services:

- Office or other outpatient services, established patient
- ED
- Domiciliary care, established patient
- Subsequent NF care (if following the 1995 documentation guidelines)
- Home care, established patient

You must document at least one specific item from **each** of the history areas for these categories of E/M services:

- Office or other outpatient services, new patient
- Hospital observation services
- Hospital inpatient services, initial care
- Consultations
- Comprehensive NF assessments
- Domiciliary care, new patient
- Home care, new patient

In this example, the patient's genetic history is reviewed as it relates to the current HPI:

- HPI: Coronary artery disease
- PFSH: Family history reveals:
  - Maternal grandparents – Both + for coronary artery disease; grandfather: deceased at age 69; grandmother: still living
  - Paternal grandparents – Grandmother: + diabetes, hypertension; grandfather: + heart attack at age 55
  - Parents – Mother: + obesity, diabetes; father: + heart attack at age 51, deceased at age 57 of heart attack
  - Siblings – Sister: + diabetes, obesity, hypertension, age 39; brother: + heart attack at age 45, living

Notes on the Documentation of History and Exam

- To simplify documentation of history and exam for established patients for office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.

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Any part of the chief complaint or history that is recorded in the medical record by ancillary staff or the beneficiary does not need to be re-documented by the billing practitioner, and may instead review the information, update or supplement it as necessary, and indicate in the medical record that he or she has done so.

(see FAQ posted here): https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/E-M-Visit-FAQs-PFS.pdf

- You may list the CC, ROS, and PFSH as separate elements of history or you may include them in the description of the HPI.
- You do not need to re-record a ROS and/or a PFSH obtained during an earlier encounter if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. You may document the review and update by:
  - Describing any new ROS and/or PFSH information or noting there is no change in the information.
  - Noting the date and location of the earlier ROS and/or PFSH.
- Ancillary staff may record the HPI, ROS and/or PFSH. Alternatively, the patient may complete a form to provide the ROS and/or PFSH. You must provide a notation supplementing or confirming the information recorded by others to document that the physician reviewed the information.
- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.

Examination

The most substantial differences in the 1995 and 1997 versions of the documentation guidelines occur in the examination documentation section. For billing Medicare, you may use either version of the documentation guidelines for a patient encounter, not a combination of the two. For reporting services furnished on and after September 10, 2013, to Medicare, you may use the 1997 documentation guidelines for an extended HPI along with other elements from the 1995 documentation guidelines to document an E/M service.

The levels of E/M services are based on four types of examination:

1. **Problem Focused** – A limited examination of the affected body area or organ system
2. **Expanded Problem Focused** – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s)
3. **Detailed** – An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s)
4. **Comprehensive** – A general multi-system examination or complete examination of a single organ system (and other symptomatic or related body area(s) or organ system(s) – 1997 documentation guidelines)

An examination may involve several organ systems or a single organ system. The type and extent of the examination performed is based on clinical judgment, the patient's history, and nature of the presenting problem(s).

The 1997 documentation guidelines describe two types of comprehensive examinations that can be performed during a patient's visit: general multi-system examination and single organ examination.

A **general multi-system examination** involves the examination of one or more organ systems or body areas.

General Multi-System Examination

TYPE OF EXAMINATION	DESCRIPTION
Problem Focused	Include performance and documentation of one to five elements identified by a bullet in one or more organ system(s) or body area(s).
Expanded Problem Focused	Include performance and documentation of at least six elements identified by a bullet in one or more organ system(s) or body area(s).
Detailed	Include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet is expected. Alternatively, may include performance and documentation of at least twelve elements identified by a bullet in two or more organ systems or body areas.
Comprehensive	Include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by bullet is expected.*

Table 2: General Multi-System Examination

* The 1995 documentation guidelines state that the medical record for a general multi-system examination should include findings about eight or more organ systems.

A **single organ system examination** involves a more extensive examination of a specific organ system.

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Single Organ System Examination

TYPE OF EXAMINATION	DESCRIPTION
Problem Focused	Include performance and documentation of one to five elements identified by a bullet, whether in a box with a shaded or unshaded border.
Expanded Problem Focused	Include performance and documentation of at least six elements identified by a bullet, whether in a box with a shaded or unshaded border.
Detailed	Examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet, whether in a box with a shaded or unshaded border. Eye and psychiatric examinations include the performance and documentation of at least nine elements identified by a bullet, whether in a box with a shaded or unshaded border.
Comprehensive	Include performance of all elements identified by a bullet, whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected.

Table 3: Single Organ System Examination

Both types of examinations may be performed by any physician, regardless of specialty.

Here are some important points to keep in mind when documenting general multi-system and single organ system examinations (in both the 1995 and the 1997 documentation guidelines):

- Document specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s). A notation of “abnormal” without elaboration is not sufficient.
- Describe abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s).
- It is sufficient to provide a brief statement or notation indicating “negative” or “normal” to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

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Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering these factors:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options

This table shows the progression of the elements required for each level of medical decision making. Note that to qualify for a given type of medical decision making, two of the three elements must either be met or exceeded.

Elements for Each Level of Medical Decision Making

TYPE OF DECISION MAKING	NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS	AMOUNT AND/ OR COMPLEXITY OF DATA TO BE REVIEWED	RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Table 4: Elements for Each Level of Medical Decision Making

Number of Diagnoses and/or Management Options

The number of possible diagnoses and/or the number of management options to consider is based on:

- The number and types of problems addressed during the encounter
- The complexity of establishing a diagnosis
- The management decisions made by the physician

In general, decision making for a diagnosed problem is easier than decision making for an identified but undiagnosed problem. The number and type of diagnosed tests performed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those problems that are worsening or failing to change as expected. Another indicator of the complexity of diagnostic or management problems is the need to seek advice from other health care professionals.

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Here are some important points to keep in mind when documenting the number of diagnoses or management options. You should document:

- An assessment, clinical impression, or diagnosis for each encounter, which may be explicitly stated or implied in documented decisions for management plans and/or further evaluation:
  - For a presenting problem with an established diagnosis, the record should reflect whether the problem is:
    - Improved, well controlled, resolving, or resolved
    - Inadequately controlled, worsening, or failing to change as expected
  - For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible," "probable," or "rule out" diagnosis
- The initiation of, or changes in, treatment, which includes a wide range of management options such as patient instructions, nursing instructions, therapies, and medications
- If referrals are made, consultations requested, or advice sought, to whom or where the referral or consultation is made or from whom advice is requested

Amount and/or Complexity of Data to Be Reviewed

The amount and/or complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. Indications of the amount and/or complexity of data being reviewed include:

- A decision to obtain and review old medical records and/or obtain history from sources other than the patient (increases the amount and complexity of data to be reviewed)
- Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test (indicates the complexity of data to be reviewed)
- The physician who ordered a test personally reviews the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation (indicates the complexity of data to be reviewed)

Here are some important points to keep in mind when documenting amount and/or complexity of data to be reviewed. You should document:

- The type of service, if a diagnostic service is ordered, planned, scheduled, or performed at the time of the E/M encounter.
- The review of laboratory, radiology, and/or other diagnostic tests. A simple notation such as "WBC elevated" or "Chest x-ray unremarkable" is acceptable. Alternatively, document the review by initialing and dating the report that contains the test results.
- A decision to obtain old records or additional history from the family, caretaker, or other source to supplement information obtained from the patient.
- Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement information obtained from the patient. You should document that there is no relevant information beyond that already obtained, as appropriate. A notation of "Old records reviewed" or "Additional history obtained from family" without elaboration is not sufficient.

- Discussion about results of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study.
- The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician.

Risk of Significant Complications, Morbidity, and/or Mortality

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with these categories:

- Presenting problem(s)
- Diagnostic procedure(s)
- Possible management options

The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter.

The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category determines the overall risk.

The level of risk of significant complications, morbidity, and/or mortality can be:

- Minimal
- Low
- Moderate
- High

Here are some important points to keep in mind when documenting level of risk. You should document:

- Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality.
- The type of procedure, if a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter.
- The specific procedure, if a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter.
- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis. This point may be implied.

This table can help determine whether the level of risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Because determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk.

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Table of Risk

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	• One self-limited or minor problem (for example, cold, insect bite, tinea corporis)	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound (for example, echocardiography) • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness (for example, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH) • Acute uncomplicated illness or injury (for example, cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress (for example, pulmonary function tests) • Non-cardiovascular imaging studies with contrast (for example, barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives

Table 5: Table of Risk

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (for example, lump in breast) • Acute illness with systemic symptoms (for example, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (for example, head injury with brief loss of consciousness)	• Physiologic tests under stress (for example, cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors (for example, arteriogram, cardiac catheterization) • Obtain fluid from body cavity (for example, lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation

Table 5 (cont.): Table of Risk

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LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function (for example, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) • An abrupt change in neurologic status (for example, seizure, TIA, weakness, sensory loss)	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Table 5 (cont.): Table of Risk

Documentation of an Encounter Dominated by Counseling and/or Coordination of Care

When counseling and/or coordination of care dominates (more than 50 percent of) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital, or NF), time is considered the key or controlling factor to qualify for a particular level of E/M services. If the level of service is reported based on counseling and/or coordination of care, you should document the total length of time of the encounter and the record should describe the counseling and/or activities to coordinate care.

The Level I and Level II CPT® books, available from the American Medical Association, list average time guidelines for a variety of E/M services. These times include work done before, during, and after the encounter. The specific times expressed in the code descriptors are averages and, therefore, represent a range of times that may be higher or lower depending on actual clinical circumstances.

OTHER CONSIDERATIONS

Split/Shared Services

A split/shared service is an encounter where a physician and a NPP each personally perform a portion of an E/M visit. Here are the rules for reporting split/shared E/M services between physicians and NPPs:

- In the office or clinic setting:
  - For encounters with established patients who meet incident to requirements, use either practitioner's National Provider Identifier (NPI)
  - For encounters that do not meet incident to requirements, use the NPP's NPI
- Hospital inpatient, outpatient, and ED setting encounters shared between a physician and a NPP from the same group practice:
  - When the physician provides any face-to-face portion of the encounter, use either provider's NPI
  - When the physician does not provide a face-to-face encounter, use the NPP's NPI

Consultation Services

Effective for services furnished on or after January 1, 2010, Medicare no longer recognizes inpatient consultation codes (CPT codes 99251–99255) and office and other outpatient consultation codes (CPT codes 99241–99245) for Part B payment purposes.

However, Medicare recognizes telehealth consultation codes (HCPCS G0406–G0408 and G0425–G0427) for payment.

Physicians and NPPs who furnish services that, prior to January 1, 2010, would have been reported as CPT consultation codes, should report the appropriate E/M visit code to bill for these services beginning January 1, 2010.

KEY TAKEAWAYS

- While E/M services vary in several ways, such as the nature and amount of physician work required, good general documentation principles help ensure that medical record documentation for all E/M services is appropriate.
- When billing for a patient's visit, select codes that best represent the services furnished during the visit. The provider must also ensure that medical record documentation supports the level of service reported to a payer. You should not use the volume of documentation to determine which specific level of service to bill.
- To receive payment from Medicare for E/M services, the Medicare benefit for the relevant type of provider must permit him or her to bill for E/M services.
- Billing Medicare for an E/M service requires the selection of a Current Procedural Terminology (CPT) code that best represents:
  - Patient type
  - Setting of service
  - Level of E/M service performed

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RESOURCES

This table provides evaluation and management (E/M) services resource information.

E/M Services Resources

FOR MORE INFORMATION ABOUT…	RESOURCE
All Available Medicare Learning Network® (MLN) Products	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo
CPT® Books	https://commerce.ama-assn.org/store
CPT® Evaluation and Management	https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management
Evaluation and Management (E/M) Visit Frequently Asked Questions (FAQs) Physician Fee Schedule (PFS)	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/E-M-Visit-FAQs-PFS.pdf
HCPCS	https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo
ICD-10-CM/PCS	https://www.cms.gov/Medicare/Coding/ICD10
Medicare Benefit Policy Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673
Medicare Claims Processing Manual	https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912
Medicare Information for Patients	https://www.Medicare.gov
1995 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf
Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits	https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf
2020 Physician Fee Schedule Final Rule	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F

HYPERLINK TABLE

EMBEDDED HYPERLINK	COMPLETE URL
CPT® Evaluation and Management	https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management
CY 2020 Physician Fee Schedule Fact Sheet	https://www.cms.gov/newsroom/fact-sheets/finalized-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar
Medicare Learning Network®(MLN) Connects Physician Fee Schedule and OPPS/ASC Final Rules Call	https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2019-11-6-PFS
1995 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf
2020 Physician Fee Schedule Final Rule	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F

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