

Evaluation & Management (E/M) Coding Calculator



Essentials for Determining Evaluation & Management (E/M) Codes

Standard Codes for Evaluation & Management (E/M)

Step 1 – Determine Location of the Service

- Where did this encounter between physician and patient take place?
 - **Office or Other Outpatient Services:** Physician's office; walk-in clinic; ambulatory health-care center; etc.
 - **Hospital Services:** Inpatient, acute care facility
 - **Consultation – Office or Inpatient**
 - **Emergency Department Services:** A hospital-based facility, open 24 hours a day, providing unplanned services to patients requiring immediate medical attention
 - **Critical Care/Intensive Care Services:** Direct delivery of medical care for patients with a high likelihood of impending or life-threatening decline of condition
 - **Nursing Facility Services:** Skilled nursing facility (SNF); intermediate care facility (ICF); long-term care facility (LTCF); psychiatric residential treatment center
 - **Domiciliary, Rest Home or Custodial Care Services:** Assisted living facility; any other facility providing room, board and personal assistance services.
 - **Home Services:** Private residence

Step 2 – Determine Relationship Between Physician & Patient

- The relationship between the physician and the patient is the next thing you must determine:
 - **New or Established:** An established patient is one who has received professional services from this physician, or another physician of the same specialty within the same practice, during the last three years.
 - If this is not stated in the physician's notes for this encounter, you may need to refer back to the patient's chart
 - **Initial or Subsequent:** An initial visit is the first date of service this physician sees this patient and a subsequent visit is one on an additional date, after the first date, during this course of treatment
 - Services are reported by complete day (calendar date) of service
 - **Consultation Services:** Determine who requested the consultation
 - Physician or other health-care professional = use **consultation code** from the range 99241-99255
 - Patient and/or family member = use appropriate **location of service code**, such as: outpatient 99201-99215 or hospital 99217-99239

Step 3 – Determine Level of History from Documentation

Remember, if it is not documented, it didn't happen!

- Histories are usually taken orally—a spoken exchange of questions and answers between the provider and the patient—but there still **MUST** be notes that record what occurred
 - A patient history review of systems (ROS) is not an examination
 - The physician may indicate that a body or 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
 - There are four types of histories: (1) problem-focused, (2) expanded problem-focused, (3) detailed, and (4) comprehensive:
 - **Problem-Focused**
 - **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
 - **Brief history of present illness or concern:** The patient's recounting of the date and time (as accurately as possible) of the onset and progress of the chief complaint, including first sign and/or symptom, as well as anatomical location, severity, timing, circumstances, modifying factors, and related signs and/or symptoms
 - **Expanded Problem-Focused**
 - Chief complaint (same as above)
 - Brief history of present illness or concern (same as above)
 - **System Review:** Pertains **only** to that system directly related to the chief complaint or present illness:
 - signs/symptoms: fever, weight loss, etc.
 - eyes
 - ears, nose, mouth, throat
 - cardiovascular
 - respiratory
 - gastrointestinal
 - genitourinary
 - musculoskeletal
 - integumentary: skin and/or breast
 - neurological
 - psychiatric
 - endocrine
 - hematologic/lymphatic
 - allergic/immunologic
 - **Detailed**
 - Chief complaint (same as above)
 - **Extended history of present illness or concern**—brief history expanded upon to include pertinent **past family** and/or social history directly related to the chief complaint or present illness:

- prior major illnesses and injuries
- prior surgical procedures
- prior hospitalizations
- current medications and/or vitamins/supplements
- allergies (drug, food, inhalant, etc.)
- immunization status (age-appropriate)
- dietary/nutritional status (feeding, eating, etc.)
- **Family history** includes:
 - health status (or cause of death) of parents, siblings and children
 - specific diseases of family members related to problems identified in **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** includes:
 - marital status and/or living arrangements
 - current employment
 - occupational history
 - use of drugs, alcohol and/or tobacco
 - level of education
 - sexual history
 - other relevant social factors
- **System Review:** Review of systems directly related to the chief complaint or present illness **PLUS** a limited history of additional related systems:
 - signs/symptoms: fever, weight loss, etc.
 - eyes
 - ears, nose, mouth, throat
 - cardiovascular
 - respiratory
 - gastrointestinal
 - genitourinary
 - musculoskeletal
 - integumentary: skin and/or breast
 - neurological
 - psychiatric
 - endocrine
 - hematologic/lymphatic
 - allergic/immunologic
- **Comprehensive***
 - Chief complaint
 - Extended history of present illness or concern
 - Complete past, family and/or social history
 - **System Review:** Review of systems directly related to the history of the present illness **PLUS** a history related to **all** body systems—as the name implies, this is the most complete form of history:
 - signs/symptoms: fever, weight loss, etc.
 - eyes
 - ears, nose, mouth, throat
 - cardiovascular
 - respiratory
 - gastrointestinal

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**Paul J. Driscoll, Diane Landers, Jerry G.
Seare**



Evaluation Management Em Coding Calculator Quickstudy Academic:

Evaluation and Management (e/M) Coding Calculator Shelley C. Safian, 2007-12-14 Covers all the evaluation and management codes physicians and their staffs have to know when dealing with patients in the office hospital or at home Ideal for both allied health services students and medical office staff

Evaluation & Management (E & M) Coding Calculator Theresa Tropin, 2017 *Evaluation and Management (e&M) Coding Calculator* BarCharts, Inc, Theresa Tropin, 2017-01-31 Annotation Quick and easy tool for students and professionals Whether studying for class or a coding certification test Use as a quick go to desk reference for the professional starting out or for the guru that has the ultimate coding toolbox of useful resources 6 page laminated guide includes Standard Steps Codes for E M Diagnosis or Symptom Location of the Service Relationship Between Physician Patient Level of History from Documentation Level of Exam from Documentation Level of Medical Decision Making Choose Code Based on Levels of Key Components When Time Determines the E M Code Modifiers Special Types of E M Services HCPCS Level II E M Services Medicare Documentation Guidelines History Physical Examination Medical Decision Making Suggested uses Students handy reference that is compact and easily reviewed on a daily basis Certification great quick review tool for certification testing Coding Professionals a quick reference memory refresher Medical Administration training tool for coding or non coding staff

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E-M Coding Made Easy James B. Davis,1995-01-01 Text is a comprehensive tutorial designed to be a basic introduction to the evaluation and management E M codes of CPT Current Procedural Terminology

E&M Coding Clear & Simple Terri Ann Brame,2013-09-16 This easy to read text breaks these complex codes into manageable bite sized pieces Practice questions and real world case studies help you apply your knowledge and approach any coding situation with confidence

Evaluation and Management Coding Made Easy Terry Tropin,2021-11-29 This book simplifies the language of Current Procedural Terminology CPT for Evaluation and Management coding The book includes the updates for 2022 This book was developed by a coding teacher to help both students and working coders The book is updated every year or as needed The book covers The key components history examination and medical decision making Office or other outpatient services Forms to guide the reader through the step by step process to determine level of service Services to patients who are not sick Non Face to Face Services Services based on time Modifiers Definitions of terms CMS 1997 Documentation Guidelines

E/M Fast Finder Ingenix,2010-11-17 Quickly assign the evaluation and management EM codes from the 99000 series of the CPT code set with the Ingenix E E M FAST FINDER Durable and small enough to be carried in a lab coat pocket this carry along reference allows coders to quickly make level difficulty and other determinations for each E M code

The New Face of Evaluation and Management KELLIE. HALL,2025-04-17 This book evaluates the new guidelines and brings them into prospective so physicians providers coders can easily understand how to document and calculate the level of service for reimbursement

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 prospective 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 *E-M Coding Consultant* Paul J. Driscoll,Diane Landers,Jerry G. Seare,1992 The hilarious adventures of a gang of boys and their friends from Sugar Creek

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