Master Evaluation and Management Coding Guidelines

Evaluation and management (E/M) encounters remain the most challenging coding areas for physicians and coders alike. If your coding patterns make you an outlier in your specialty and locality, it can be a red flag and may trigger an audit. Therefore, it is imperative that physicians master E/M coding and the documentation needed to support their code selections. Documentation that supports code selection must be present to prevail in an audit.

First, one must decide whether to follow the 1995 or 1997 E/M guidelines (you cannot use both in the same encounter). Many feel the 1997 guidelines are easier to follow and when adhered to, leave less room for an auditor to dispute in an audit as they are less subjective.

Regardless of which guideline is chosen, there are standards and recommendations common to both.

There are three key components in E/M coding: History, Exam, and Medical Decision Making (MDM) (code selection can also be based on time alone as discussed below). While the History and Exam are more objective measures, MDM is subjective, but can be quantified using tools and charts developed by various sources. AAFP's Family Practice Management (FPM) journal has written a series of articles that go into detail and provide tools for these key components:

LEVEL OF CARE CODING KEY COMPONENTS

CPT Code	Presenting problem	Patient history	Examination	Medical decision-making
99201	is self-limited or minor; the physician typically spends 10 minutes face-to-face with the patient and/or family	problem focused	problem focused	straightforward
99202	low to moderate severity; the physician typically spends 20 minutes face-to-face with the patient and/or family	expanded problem focused	expanded problem focused	straightforward
99203	moderate severity; the physician typically spends 30 minutes face-to-face with the patient and/or family	detailed	detailed	low complexity
99204	moderate to high severity; the physician typically spends 45 minutes face-to-face with the patient and/or family	comprehensive	comprehensive	moderate complexity
99205	moderate to high severity; the physician typically spends 60 minutes face-to-face with the patient and/or family	comprehensive	comprehensive	high complexity

Source: Centers for Medicare and Medicaid Services

History: http://www.aafp.org/fpm/2010/0300/p22.html
Exam: http://www.aafp.org/fpm/2010/0500/p24.html
MDM: http://www.aafp.org/fpm/2010/0700/p10.html
Time: http://www.aafp.org/fpm/2008/1100/p17.html
FPM 1997 E/M Coding Tool:
https://www.hcms.org/uploadedFiles/Harris_County_Medical_Society/Practice_Resources/Practice_Operations/Grids/E%20and%20M%20Coding%20Tool.pdf

For established patient encounters, only two of the three key components are required, however, it is best to include MDM as one of the two components in code selection. MDM is often viewed by auditors as the driving force in code selection. Merely checking off boxes to meet the numbers in the Exam and History sections aren't enough to demonstrate the code selected was justified. Also, the services performed must be medically necessary. Performing a complete history and comprehensive exam to get to a higher code for an encounter to remove a splinter is not medically necessary.

Complete, accurate, and detailed documentation is imperative. Always provide enough detail in the documentation to describe all elements of the visit necessary to justify your code selection, much like a SOAP note format. Documentation must support the code selected and it must be of sufficient detail to justify your coding to a third party. Remember, if it's not documented, it didn't happen. Have external audits performed annually, or more frequently if needed, to ensure that your documentation supports your coding. These audits can be an opportunity to improve your coding skills, operations, revenue, and help you avoid, or prevail in, a RAC audit.

Many physicians down-code when uncertain what code to use. However, down-coding has the same consequences as up-coding in an audit. Further, it has an adverse effect on practice revenue. A 2012 study conducted by the American Academy of Professional Coders (AAPC) found that out of 60,000 billing audits, more than a third of the records were down-coded, representing an average of $64,000 in lost annual revenue per physician.

Coding based on time

To code based on time, the physician MUST spend the entire allotted time face-to-face with the patient AND more than HALF of that time must be counseling and coordination of care. Documentation must indicate the total face-to-face time, and the total time spent counseling/coordinating care (greater than 50% of the total face-to-face time). You must also detail the nature of the counseling and the topics discussed in some detail so that the reader/auditor would understand what was discussed with the patient. Example: A total of 15 minutes were spent face-to-face with the patient during this encounter and over half of that time was spent on counseling and coordination of care. We discussed in depth the importance of primary prevention of coronary disease with aggressive treatment of high cholesterol. I also educated the patient about lifestyle modifications which may improve blood pressure.

Other resources

CMS Evaluation and Management Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

Medicare Program Integrity Manual Chapter 3, section 3.3.2: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf

1995 Documentation Guidelines: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf

1997 Documentation Guidelines: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf