



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.
 - Residential, 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 the 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 99231-99239

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 (HROS) 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 the 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.
 - Symptoms:** Fever, weight loss, etc.
 - Signs:**
 - Anatomy:** 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:** (extended 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 (drugs, food, inhalant, etc.)**
- Immunization status (age-appropriate)**
- Dietary/nutritional status (breeding, eating, etc.)**

• Family history:

- Health status (or cause of death) of patients, 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:

- 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:
 - Symptoms:** Fever, weight loss, etc.
 - Signs:**
 - Anatomy:** 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:**
- Comprehensive 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—the same implies this is the most complete form of history.
 - Symptoms:** Fever, weight loss, etc.
 - Signs:**
 - Anatomy:** ears, nose, mouth, throat
 - Cardiovascular:**
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Michael Rajnik

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Table of Contents 20evaluation And Management Coding Cheat Sheet

1. Understanding the eBook 20evaluation And Management Coding Cheat Sheet
 - The Rise of Digital Reading 20evaluation And Management Coding Cheat Sheet
 - Advantages of eBooks Over Traditional Books
2. Identifying 20evaluation And Management Coding Cheat Sheet
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an 20evaluation And Management Coding Cheat Sheet
 - User-Friendly Interface
4. Exploring eBook Recommendations from 20evaluation And Management Coding Cheat Sheet
 - Personalized Recommendations
 - 20evaluation And Management Coding Cheat Sheet User Reviews and Ratings
 - 20evaluation And Management Coding Cheat Sheet and Bestseller Lists
5. Accessing 20evaluation And Management Coding Cheat Sheet Free and Paid eBooks
 - 20evaluation And Management Coding Cheat Sheet Public Domain eBooks
 - 20evaluation And Management Coding Cheat Sheet eBook Subscription Services
 - 20evaluation And Management Coding Cheat Sheet Budget-Friendly Options

6. Navigating 20evaluation And Management Coding Cheat Sheet eBook Formats
 - ePUB, PDF, MOBI, and More
 - 20evaluation And Management Coding Cheat Sheet Compatibility with Devices
 - 20evaluation And Management Coding Cheat Sheet Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of 20evaluation And Management Coding Cheat Sheet
 - Highlighting and Note-Taking 20evaluation And Management Coding Cheat Sheet
 - Interactive Elements 20evaluation And Management Coding Cheat Sheet
8. Staying Engaged with 20evaluation And Management Coding Cheat Sheet
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers 20evaluation And Management Coding Cheat Sheet
9. Balancing eBooks and Physical Books 20evaluation And Management Coding Cheat Sheet
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection 20evaluation And Management Coding Cheat Sheet
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine 20evaluation And Management Coding Cheat Sheet
 - Setting Reading Goals 20evaluation And Management Coding Cheat Sheet
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of 20evaluation And Management Coding Cheat Sheet
 - Fact-Checking eBook Content of 20evaluation And Management Coding Cheat Sheet
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements

- Interactive and Gamified eBooks

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