Coding for E&M Services: 101

by Barbara Constable, RN, MBA

The Centers for Medicare & Medicaid Services (CMS) wants to compensate physicians for the quality of care they provide to patients. Evaluation and Management (E&M) documentation is the pathway that translates a physician's patient care work into the claims and reimbursement process. Careful documentation of services provided is the foundation for correct coding.

As a result of a five-year review of the Resource-Based Relative Value Scale (RBRVS) for E&M services, the Relative Value Update Committee (RUC) recommended an increase in the work RVUs for 28 E&M services, while the work RVUs for 7 services remained unchanged. For example, in 2007, the work RVUs for CPT code 99204 (mid-level office visit, new patient) increased 15 percent; the work RVUs for 99213 (mid-level office visit, established patient) increased by 37 percent; for 99221 (initial hospital, inpatient) the work RVU increased by 41 percent.

To help ensure that you are coding for *all* the services your physicians provide, coders and billers should refer to the two quick references listed below.

Principles of Documentation

CMS has developed seven general principles of medical documentation:[1]

1. The medical record should be complete and legible.
2. Documentation of each patient encounter should include:
   - Reason for encounter, relevant history, physical examination findings, and prior test results
   - Assessment, clinical impression, or diagnosis
   - Plan for care
   - Date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic tests must be "easily inferred."
4. Past and present diagnoses should be accessible to treating and consulting physicians.
5. Appropriate health risk factors should be identified.
6. The patient's progress, responses to and changes in treatment, and revision of diagnosis should be documented.
7. Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes reported on the health insurance claim form should be supported in the medical record.

Seven Components for E&M

CMS has also identified seven key components for E&M services. When billing for physician services, coders and billers must understand that the first three components: *history*, *examination*, and *medical decision making* are key to selecting the appropriate level of the E&M service.

1. History
2. Examination
3. Medical decision making
4. Counseling
5. Coordination of care
6. Nature of presenting problem
7. Time.

When visits consist primarily of counseling or coordination of care, time is the controlling factor for determining level of service. Keep in mind that performance and documentation of one of these key components at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level.

Documentation of History. In this first of three key components, the level of the E&M services is based on four types of history: chief complaint; history of present illness; review of systems; and past, family and/or social history.

Examination. Under this key component, the levels of E&M services are based on four types of progressively more complex examinations: problem-focused, expanded problem focused, detailed, and comprehensive.

Medical decision making. Coders and billers should use the following four levels of service to describe this third key component: straightforward, low complexity, moderate complexity, and high complexity. Each of the four levels is based on an established progression of elements.

To help coders and billers understand the level of service for each of these three components, CMS has developed definitions and specific documentation guidelines that are available online at: *www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf.*

When coding new patient visits, the three key component areas must be at the same level to bill for that service. In other words, to bill at the highest level of service, the medical record must document that all three key components were carried out at the highest level of service. If the three components are not at the same level, the coders and billers must bill the entire visit at the next lowest service level documented. Established patient visits require two of the three key components to be on the same level to code a visit. In other words, if two of the three components are high-level services and the third is a mid-level service, the entire visit can be coded as a high-level office visit.

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References

[1]Centers for Medicare & Medicaid Services. *1997 Documentation Guidelines for Evaluation and Management Services*. Available online at: *www.cms.hhs.gov/MLNProducts/Downloads/MASTER1. pdf.* Last accessed on Feb. 23, 2007.