



Medicare and Medicaid

Quick Reference Job Aid – E/M Coverage and Documentation

Medicaid 99214 and 99215 Limitations

Managed Care Organizations (MCOs) operating in Kentucky continue to review complex evaluation and management (E/M) services to ensure that physicians are not paid in excess of two complex E/M visits (CPT Codes 99214 and 99215) per year/per patient/per physician. Kentucky Administrative Regulation – [907 KAR 3:005, Section 4 \(7\)](#) limits the number of such complex office visits – CPT Codes 99214 or 99215 to two per year/per patient/per physician. Not all of the MCOs have utilization (system) edits in place to properly address the limits of this Kentucky Administrative Regulation.

The Centers for Medicare & Medicaid indicate that an overpayment is a payment that a provider receives in excess of amounts properly payable under Federal and State statutes. Because Medicaid receives federal dollars, the law requires Kentucky Medicaid to try and recover *all* identified overpayments; even when the overpayment resulted because of an error made by the MCO.

Physicians should continue to document and bill for the E/M service **that is performed**. If a physician performs more than two high complex visits (99214 or 99215) in a year the MCO has the responsibility to reduce the reimbursement to the payment rate for CPT 99213, *without changing the CPT code or asking the physician to change the CPT code*.

If a reduction occurs the Explanation of Benefits (EOB) message should indicate:

Established Patient Medical Services Limited to two per calendar year reimbursement cut back to rate for procedure code 99213 – pricing adjustment max fee pricing applied

E/M Basics

E/M Introduction

Evaluation and Management services are one of the most commonly billed services to all health payers.

Physicians must consider many factors before selecting an E/M CPT code.

This section provides information about the general principles of evaluation and management (E/M) coding and documentation.

Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and are used to record pertinent facts, findings, and observations about the patient's health history. Medical record documentation assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring 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; and/or
- That services furnished have been accurately reported.

Evaluation and Management (E/M) service requires the selection of a Current Procedural Terminology (CPT) code that best represents:

- Patient type;
- Setting of service; and
- Level of E/M service performed.

What do Payers want and why?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- The site of service;
- the medical necessity and appropriateness of the diagnostic and/or
- therapeutic services provided; and/or that services provided have been accurately reported.
- General Principles of Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status.

The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. 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;
 - plan for care; and
 - date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Signature Guidelines

E/M 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.



A *new patient* is defined as an individual who has not received 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 three years.

An *established patient* is an individual who has received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous three years.

E/M Site or location 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
- Emergency department (ED); and
- Nursing facility (NF).
- [Place of Service Codes](#)

E/M Documentation Guidelines

Select either the 1995 or 1997 E/M Guidelines, use whichever is the most advantageous. Follow one guideline per patient encounter and do not “mix” and “match” 1995 and 1997 guidelines.

Both the [1995](#) and [1997](#) physician E/M service coding guidelines recognize seven components, six of which are used in defining levels of service. These components include:

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of presenting problem
- Time

E/M Medical Necessity

Medical necessity is not listed as a separate component because determining medical necessity and having good documentation are part of compliant coding and billing.

According to Medicare, “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.

It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which specific level of service is billed.

Documentation should support the level of service reported. The service should be documented during, or as soon after as practicable after it is provided in order to maintain an accurate medical record.

E/M 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 the following 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; and;
- 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.

The [chart](#) depicts the elements 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.

E/M Level

The code sets used 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 the physician or NPP may bill within the appropriate category. In order to bill any code, the services furnished must meet the definition of the code. It is the physician’s or NPP’s responsibility to ensure that the codes selected reflect the services furnished.

There are three key components when selecting the appropriate level of E/M service provided: 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.

E/M History

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 the 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).

The elements required for each type of history are depicted in the [table](#).

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 is dependent upon clinical judgment and the nature of the presenting problem.

E/M 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.

E/M 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 three days ago);
- Timing (example: constant or comes and goes);
- Context (example: lifted large object at work);
- Modifying factors (example: better when heat is applied); and
- Associated signs and symptoms (example: numbness in toes)



There are two types of HPIs: brief and extended.

- A brief HPI includes documentation of one to three HPI elements.
- 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

E/M Review of Systems (ROS)

ROS is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced.

The following systems are recognized for ROS purposes:

- Constitutional Symptoms (e.g., fever, weight loss)
- Eyes;
- Ears, Nose, Mouth, Throat,
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Integumentary (skin and breast);
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic; and
- Allergic/Immunologic.

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

- A problem pertinent ROS inquires about the system directly related to the problem identified in the HPI.
- 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.
- 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. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.

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

PFSH consist of a review of three areas:

Past history including experiences with illnesses, operations, injuries, and treatments;

Family history includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk; and Social history including an age appropriate review of past and current activities.

- 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.
- A complete PFSH is a review of two or 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 area is sufficient for other services.

At least one specific item from two of the three history areas must be documented for a complete PFSH for the following 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); and
- Home care, established patient.
- At least one specific item from each of the history areas must be documented for the following categories of E/M services:
 - Office or other outpatient services; new patient:
 - Hospital observation services;
 - Hospital inpatient services, initial care;
 - Comprehensive NF assessments:
 - Domiciliary care, new patient; and
 - Home care, new patient

E/M Notes on the Documentation of History

The CC, ROS, and PFSH may be listed as separate elements of history or they may be included in the description of the history of the present illness.

A ROS and/or PFSH obtained during an earlier encounter do not need to be re-recorded 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. The review and update may be documented by:

- Describing any new ROS and/or PFSH information or noting there has been no change in the information; and
- Noting the date and location of the earlier ROS and/or PFSH

The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

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.

E/M Examination

As stated previously, there are two versions of the documentation guidelines – the 1995 version and the 1997 version. The most substantial differences between the two versions occur in the examination documentation section. Either version of the documentation guidelines, not a combination of the two may be used by the physician for a patient encounter.

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

- Problem Focused – A limited examination of the affected body area or organ system; 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);
- 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); and
- 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 single organ system. The type and extent of the examination performed is based upon 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, as depicted in the [chart](#).

A single organ system examination involves a more extensive examination of a specific organ system, as depicted in the [chart](#).

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

Some important points that should be kept in mind when documenting general multi-system and single organ system examinations (in both the 1995 and 1997 documentation guidelines) are:

- Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is not sufficient.
- Abnormal or unexpected findings of the examination of any asymptomatic body area(s) organ system(s) should be described.
- A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

E/M Resources

[Coding Compliance – E/M Documentation](#)

[Coding Compliance – Medical Necessity – A Key Piece of Any E/M Service](#)

[Coding Compliance – New Patient vs. Established Patient](#)

[Coding Compliance Evaluate your E/M Documentation Webinar](#)

[CMS E/M Guidelines](#)