The Basics of Evaluation and Management (E/M)

Understanding how to bill is essential to practice success.

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Editor's Note: *This article is the first in a series of articles directed at medical students, residents, and new physicians.*

Evaluation and Management (E/M)

The first thing we need to learn are Evaluation and Management services (E/M, pronounced E & M). All physicians use E/M services as a source of revenue. It works like this: a patient seeks medical attention from a doctor. The doctor evaluates, diagnoses, and manages their ailment—whether it be prescribing or modifying their medications, ordering labs, or referring the patient to another specialty. Other than the physical exam, treatment is mostly hands off. Regarding current events, think telemedicine. Primary care and internal medicine doctors bill almost exclusively through E/M. Some doctors such as podiatrists bill through a mixture of E/M and procedures. Sometimes, a patient with plantar fasciitis comes in and we prescribe anti-inflammatories and stretching (E/M). For the same patient, perhaps we give them a corticosteroid injection or cast them for orthotics (procedure).

If a patient were to pay cash for the doctor's time and care, there would be an exchange of money, treatment would be furnished, and that would conclude that transaction. For example: "I'll pay you $200 bucks for this office visit and x-rays," or "I'll pay you $300 bucks to do a matrixectomy on me."

But our healthcare system is not simple. The reason is that healthcare has become ruled and regulated by government and private health insurance companies. Insurance companies are now the middleman. There are still patients who pay cash—but for the most part, patients generally do not pay doctors directly (other than their co-pay). Rather, they pay their health insurance company a monthly fee (known as a premium) and then the insurance company pays the doctor on the patient's behalf.

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In order for the doctor to get paid, the doctor communicates with insurance companies and "bills" them through a five digit code, known as a CPT* code (Common Procedure Terminology). These CPT codes have rules and counter rules on which codes can be submitted, which diagnosis codes they can be submitted with, and how many times a code can be submitted at a time or in a given time frame.

If you, as a doctor, want to get paid, you need to understand the fundamentals of billing and coding. Evaluation & Management coding is the perfect place to start because it is ubiquitous and you will be using it every day. Lucky for you, E/M rules are changing in 2021 for the office/outpatient setting. That means everyone is in the same boat as you in learning the new rules.

E/M Background

There are currently two main guidelines in how to bill Evaluation and Management codes. They were released in 1995 and 1997 and haven't changed since then. There are different levels of service ranking from high to low. The more 'work' that is done to treat a patient, arguably the more the doctor should be paid. A doctor-patient encounter is translated to a code which is billed to the insurance company for fair reimbursement. That code is different depending on where you are (office, hospital, emergency room, assisted living facility, nursing home, etc.), and whether or not that patient is a *new* patient or an *established* patient, or in some cases, an initial encounter versus a subsequent encounter. A new patient is someone that hasn't

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received care from you or anyone in your group of the same specialty in the past three years. A new patient takes more effort to 'work up' and consequently may reimburse at a higher rate. There are nuances. For example, in a hospital, encounters are rated as Initial vs. Subsequent. When they follow up in your office for the first time, they are considered established patients.

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We'll stick with office/outpatient Evaluation and Management codes because these codes are the most relevant to us as podiatrists.

These codes are CPT 99201, 99202, 99203, 99204, 99205 (new office/other outpatient patients) and CPT 99211, 99212, 99213, 99214, 99215 (established office/other outpatient patients). The last digit in the code is what level the visit is. For example, Medicare pays around $77-$92 for a CPT 99202 (level 2, new office patient) vs. $211-$242 for a CPT 99205 (level 5, new office patient). The reimbursement varies depending on your geographic location as the reimbursement reflects the cost to practice in your area. [The Medicare fee schedule can be found at the CMS.gov website]

The code you choose to bill is NOT subjective, e.g., "I feel like the patient was really difficult, and they were giving me a hard time so I'm going to bill a higher code." Rather, it is objective. Meaning: E/M codes have specific criteria that need to be met to qualify for a level of code. If you do not meet these criteria but still decide to bill a higher level than what you are supposed to, this is inappropriate. Third party payers, including The Centers for Medicare & Medicaid Services (CMS), may regulate this. Their goal is aligned with doctors in that they both want a healthcare system that provides affordable, accessible, high-quality healthcare. Plainly speaking, their goal is not to lock you up. They understand that the whole system is difficult to navigate—even for the most seasoned doctors. But since they are paying you, they want to make sure they are paying you correctly. They do this by making sure you are following the rules and billing guidelines. If you aren't, they can fine you, audit you, and reclaim that money back, or in extreme cases impact your licensure.

Billing and coding is important. The rules are overwhelming; many doctors agree on that. But not knowing the rules through negligence is not a defendable answer. So what are the rules for billing correctly?

Historically speaking, you can do two things when billing E/M: 1) bill through the documentation of "Key Components", which are made up of your history, physical exam, and medical decision-making, or 2) bill based on time if counseling and coordinating dominate the visit.

A comprehensive exam requires that you document two bullet points from nine body systems (1997 rules), or a general multi-system examination, or a complete examination of a single organ system (1995 rules).

New E/M Changes for 2021

Big things are coming in 2021 for office & other outpatient E/M billing and coding. Traditionally, those that specialize in one area of the body, like podiatrists, have had a difficult time reaching higher level Evaluation and Management codes in the office and outpatient setting. One reason is because in order to bill a CPT 99204 or 99205 (level 4 & 5 new office patient), a full body comprehensive physical exam is needed. A comprehensive exam requires that you document two bullet points from nine body systems (1997 rules), or a general multi-system examination, or a complete examination of a single organ system (1995 rules). That exam needs to be relevant to the problem that you are treating.

So let's say you have a train wreck of a patient. The patient has gas gangrene and needs to be admitted for an emergent fasciotomy and hospital care. Most of your exam is going to be in the lower extremity. Are you going to do a genitourinary exam or an abdominal exam? Maybe check out their eyes, ears, nose, and throat? Yeah, you can check their lymph nodes; maybe do a respiratory exam—but hitting all the bullet points for a comprehensive physical exam is difficult and can be a stretch.

But things are changing for the office/ other outpatient setting. In 2021, those that specialize in one area of the body, like podiatrists, will have a much clearer path to billing level 5 visits—and rightly so. We deal with a lot of sick patients—sometimes the worst of them.

There are two main changes (for Office & Other Outpatient settings):

1) The History and Physical Exam components will no longer affect the E/M level that is chosen. Rather—more emphasis will be placed on the Medical Decision-Making (MDM)

2) Time, if you decide to bill based on time, this is not only an option if counseling and coordinating dominate the visit. Rather, it is TOTAL time. That means the time it takes to: prep to see your patient, see your patient, coordinate care, and write your note—count toward time spent treating the patient.

Let's go over this in detail:

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There will be four levels of medical decision-making in 2021 (Note, the level one codes are being phased out):

- Straightforward: CPT 99202/99212
- Low: CPT 99203/99213
- Moderate: CPT 99204/99214
- High: CPT 99205/99215

There are three elements in medical decision-making. You need to reach the thresholds of two out of the three to qualify for a level of medical decision-making. The three elements of MDM are:

1) Number and complexity of problems addressed;

2) Amount and/or complexity of data to be reviewed and analyzed;

3) Risk of complications and/or morbidity or mortality of patient management.

Straightforward: CPT 99202/99212

Number and Complexity of Problems Addressed:

- 1 self-limited or minor problem

Amount and/or Complexity of Data to be Reviewed and Analyzed:

- Minimal or none

Risk of Complications and/or Morbidity or Mortality of Patient Management:

- Minimal risk of morbidity from additional diagnostic testing or treatment

Low: CPT 99203/99213

Number and Complexity of Problems Addressed:

- 2 or more self-limited or minor problems;

or

- 1 stable chronic illness;

or

- 1 acute, uncomplicated illness or injury

Amount and/or Complexity of Data to be Reviewed and Analyzed:

(Must meet the requirements of at least 1 of the 2 categories)

- Category 1: Tests and documents. Any combination of 2 from the following:

— Review of prior external note(s) from each unique source*

— Review of the result(s) of each unique test*

— Ordering of each unique test*

(* = can count unique external notes, results, or tests multiple times)

or

- Category 2: Assessment requiring an independent historian(s). An Independent historian is defined as an individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.

Risk of Complications and/or Morbidity or Mortality of Patient Management:

- Low risk of morbidity from additional diagnostic testing or treatment

Moderate: CPT 99204/99214

Number and Complexity of Problems Addressed:

- 1 or more chronic illnesses with exacerbation, progression, or side-effects of treatment;

or

- 2 or more stable chronic illnesses

or

- 1 undiagnosed new problem with uncertain prognosis

or

- 1 acute illness with systemic symptoms

or

- 1 acute complicated injury

Amount and/or Complexity of Data to be Reviewed and Analyzed:

(Must meet the requirements of at least 1 out of 3 categories)

- Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following:

— Review of prior external note(s) from each unique source*

— Review of the result(s) of each unique test*

— Ordering of each unique test*

— Assessment requiring an independent historian(s)

(* = can count unique external notes, results, or tests multiple times)

or

- Category 2: Independent interpretation of tests

— Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported)

or

- Category 3: Discussion of management or test interpretation

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Starting in 2021, for coding purposes, time for office/other outpatient E/M services is the total time on the date of the encounter.

FIGURE 1

Time Chart for Office E/M

E/M CPT Code (Minutes)	Total Time
99202	15-29
99203	30-44
99204	45-59
99205	60-74
99212	10-19
99213	20-29
99214	30-39
99215	40-54

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— Discussion of management or test interpretation with external physician/other qualified healthcare professional/appropriate source (not separately reported)

Risk of Complications and/or Morbidity or Mortality of Patient Management:

• Moderate risk of morbidity from additional diagnostic testing or treatment. Examples:

— Prescription drug management

— Decision regarding minor surgery with identified patient or procedure risk factors

— Decision regarding elective major surgery without identified patient or procedure risk factors

— Diagnosis or treatment significantly limited by social determinants of health

High: CPT 99205/99215

Number and Complexity of Problems Addressed:

• 1 or more chronic illnesses with severe exacerbation, progression, or side-effects of treatment

or

• 1 acute or chronic illness or injury that poses a threat to life or bodily function

Amount and/or Complexity of Data to be Reviewed and Analyzed:

(Must meet the requirements of at least 2 out of 3 categories)

• Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following:

— Review of prior external note(s) from each unique source*

— Review of the result(s) of each unique test*

— Ordering of each unique test*;

— Assessment requiring an independent historian(s)

(* = can count unique external notes, results, or tests multiple times)

or

• Category 2: Independent interpretation of tests

— Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported)

or

• Category 3: Discussion of management or test interpretation

— Discussion of management or test interpretation with external physician/other qualified healthcare professional/appropriate source (not separately reported)

Risk of Complications and/or Morbidity or Mortality of Patient Management:

• High risk of morbidity from additional diagnostic testing or treatment. Examples:

— Drug therapy requiring intensive monitoring for toxicity

— Decision regarding elective major surgery with identified patient or procedure risk factors

— Decision regarding emergency major surgery

— Decision regarding hospitalization

— Decision not to resuscitate or to de-escalate care because of poor prognosis

Billing Based Off Time

Everything so far was billing based upon medical decision-making and the documentation of it. The other way to bill Evaluation and Management encounters is through time. Starting January 1st, 2021, it will be TOTAL TIME (see Figure 1). For coding purposes, time for services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified healthcare professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified healthcare professional and does not include time in activities normally performed by clinical staff).

If the time is longer than 99205/99215 values, you can use the prolonged visit codes.

Physician/other qualified healthcare professional time includes the following activities, when performed:

• Preparing to see the patient (e.g., review of tests)

• Obtaining and/or reviewing separately obtained history

• Performing a medically appropriate examination and/or evaluation

• Counseling and educating the patient/family/caregiver

• Ordering medications, tests, or procedures

• Referring and communicating with other healthcare professionals (when not separately reported)

• Documenting clinical information in the electronic or other health record

• Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver

• Care coordination (not separately reported)

Knowing the fundamentals allows us to jump into practice and bill correctly right away.

If you are going to go this route, you need to document what you spent your time doing. For example, for an established patient: 3 minutes reviewing the patient's chart prior to encounter; 15 minutes obtaining history and performing a physical exam; 4 minutes counseling patient; 4 minutes ordering tests; 5 minutes writing the note. This gives us a total of 31 minutes, which would qualify us for a 99214.

Knowing the fundamentals allows us to jump into practice and bill correctly right away. **PM**

Dr. Huey completed his residency at AMITA Saint Joseph Hospital in Chicago and jumped straight into private practice. He is now the owner of Bay Area Foot & Laser Podiatry Group in the San Francisco Bay Area. Dr. Huey loves the business aspect of medicine and currently sits as a young physician on the Coding Committee of the APMA.