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Physicians' Current Procedural Terminology

Evaluation & Management Services

Special Supplement

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Physicians' Current Procedural Terminology

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Current Procedural Terminology for
EVALUATION AND MANAGEMENT SERVICES

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SPECIAL SUPPLEMENT TO CPT 1992—CLINICAL EXAMPLES

As described in CPT 1992, clinical examples of the new CPT codes for E/M services are intended to be an important element of the new coding system. The clinical examples, when used with the revised E/M descriptors provide a comprehensive and powerful new tool for physicians to report the services provided to their patients.

The American Medical Association is pleased to provide you with this special supplement to CPT 1992. The clinical examples that are provided in this supplement are limited to Office or Other Outpatient Services, Hospital Inpatient Services and Consultations. The CPT Editorial Panel is in the process of developing and validating other examples for the additional categories and subcategories of E/M codes. These expanded clinical examples will be published as part of CPT 1993; available in December 1992.

It is important to note that these clinical examples do not yet encompass the entire scope of medical practice. The Editorial Panel will be working to ensure that a wide range of examples, applicable to most major specialty areas will be developed, validated and made widely available. Inclusion or exclusion of any particular specialty group does not infer any judgement of importance or lack thereof, nor does it limit the applicability of the example to any particular specialty.

Of utmost importance is the fact that these clinical examples are just that; examples. A particular patient encounter, depending on the specific circumstances must be judged by the services provided by the physician for that particular patient. Simply because the patient's complaints, symptoms or diagnoses match those of a particular clinical example, does not automatically assign that patient encounter to that particular level of service. It is important that the three key components (history, examination and medical decision making, page 3, CPT 1992) be met and documented in the medical record to report a particular level of service.

Contents

Evaluation and Management (E/M) Services

Guidelines

In addition to the information presented in the **INTRODUCTION,** several other items unique to this section are defined or identified here:

1. **CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES:** CPT 1992 includes for the first time, a major section devoted entirely to E/M services. The new codes are more than a clarification of the old definitions; they represent a new way of classifying the work of physicians. In particular, they involve far more clinical detail than the old visit codes. For this reason, it is important to treat the new codes as a new system and not make a one-for-one substitution of a new code number for a code number previously used to report a level of service defined as "brief", "limited", "intermediate", etc.

   The E/M section is divided into broad categories such as office visits, hospital visits and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of physician work varies by type of service, place of service, and the patient's status.

   The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined, eg, comprehensive history and comprehensive examination. (See levels of E/M services following for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified. (A detailed discussion of time is provided on pages 5-7.)

2. **DEFINITIONS OF COMMONLY USED TERMS:** Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties.

   NEW AND ESTABLISHED PATIENT: A new patient is one who has not received any professional services from the physician within the past three years.

   An established patient is one who has received professional services from the physician within the past three years.

   In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.

   No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

   CONCURRENT CARE is the provision of similar services, eg, hospital visits, to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required. Modifier -75 has been deleted.

   COUNSELING is a discussion with a patient and/or family concerning one or more of the following areas:

   - diagnostic results, impressions, and/or recommended diagnostic studies;
   - prognosis;
   - risks and benefits of management (treatment) options;
   - instructions for management (treatment) and/or follow-up;
   - importance of compliance with chosen management (treatment) options;
   - risk factor reduction; and
   - patient and family education.

LEVELS OF E/M SERVICES: Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services. The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians.

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (history, examination and medical decision making) are considered the **key** components in selecting a level of E/M services. (See 6. c., page 11.)

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services,

it is not required that these services be provided at every patient encounter.

Coordination of care with other providers or agencies without a patient encounter on that day is reported using the case management codes.

The final component, time, is discussed in detail following (see pages 5-7).

The actual performance of diagnostic tests/studies for which specific CPT codes are available is **not** included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available should be reported separately, *in addition* to the appropriate E/M code.

NATURE OF PRESENTING PROBLEM: A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- Minimal—A problem that may not require the presence of the physician, but service is provided under the physician's supervision.
- Self-limited or Minor—A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status OR has a good prognosis with management/compliance.
- Low severity—A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- Moderate severity—A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
- High severity—A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

TIME: The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of CPT. The inclusion of time as an explicit factor beginning in CPT 1992 is done to assist physicians in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for physicians to provide accurate estimates of the time spent face-to-face with the patient.

Studies to establish levels of E/M services employed surveys of practicing physicians to obtain data on the amount of time and work associated with typical E/M services. Since "work" is not easily quantifiable, the codes must rely on other objective, verifiable measures that correlate with physicians' estimates of their "work". It has been demonstrated that physicians' estimations of **intra-service time** (as explained below), both within and across specialties, is a variable that is predictive of the "work" of E/M services. This same research has shown there is a strong relationship between intra-service time and total time for E/M services. Intra-service time, rather than total time, was chosen for inclusion with the codes because of its relative ease of measurement and because of its direct correlation with measurements of the total amount of time and work associated with typical E/M services.

Intra-service times are defined as **face-to-face** time for office and other outpatient visits and as **unit/floor** time for hospital and other inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit.

a. **Face-to-face time (office and other outpatient visits and office consultations):** For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.

Physicians also spend time doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

This *non* face-to-face time for office services—also called pre- and post-encounter time—is not included in the time component described in the E/M codes. However, the pre and post face-to-face work associated with an encounter was included in calculating the total work of typical services in physician surveys.

Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.

b. **Unit/floor time (inpatient hospital care, initial and follow-up hospital consultations, nursing facility):** For reporting purposes, intra-service time for these services is defined as unit/floor time, which includes the time that the physician is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the physician establishes and/or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family.

In the hospital, pre- and post-time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital.

This pre- and post-visit time is not included in the time component described in these codes. However, the pre- and

post-work performed during the time spent off the floor or unit was included in calculating the total work of typical services in physician surveys.

Thus, the unit/floor time associated with the services described by any code is a valid proxy for the total work done before, during, and after the visit.

3. **UNLISTED SERVICE:** An E/M service may be provided that is not listed in this section of CPT. When reporting such a service, the appropriate "Unlisted" code may be used to indicate the service, identifying it by "Special Report" as discussed in item 4. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

   99429 Unlisted preventive medicine service
   99499 Unlisted evaluation and management service

4. **SPECIAL REPORT:** An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort and equipment necessary to provide the service. Additional items which may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

5. **CLINICAL EXAMPLES:** of the codes for E/M services are provided to assist physicians in understanding the meaning of the descriptors and selecting the correct code. Each example was developed by physicians in the specialties shown.

   The same problem, when seen by physicians in different specialties, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptors rather than the examples.

   The examples have been tested for validity and approved by the CPT Editorial Panel. Physicians were given the examples and asked to assign a code or assess the amount of time and work involved. Only those examples that were rated consistently have been included.

An eventual goal is to develop suitable, validated examples approved by the CPT Editorial Panel for specialties which will be incorporated in CPT in the future. It is anticipated that examples for Emergency Department services and skilled nursing facilities will be available by May 1992.

6. **MODIFIERS:** Listed services may be modified under certain circumstances. When applicable, the modifying circumstance against general guidelines should be identified by the addition of the appropriate modifier code, which may be reported in either of two ways. The modifier may be reported by a two digit number placed after the usual procedure number from which it is separated by a hyphen. Or, the modifier may be reported by a separate five digit code that is used in addition to the procedure code. Modifiers available in E/M are as follows:

   -21 Prolonged Evaluation and Management Services: When the service(s) provided is prolonged or otherwise greater than that usually required for the highest level of E/M service within a given category, it may be identified by adding modifier '-21' to the E/M code number or by use of the separate five digit modifier code 09921. A report may also be appropriate.

   -24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier '-24' to the appropriate level of E/M service, or the separate five digit modifier 09924 may be used.

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier '-25' to the appropriate level of E/M service, or the separate five digit modifier 09925 may be used.

-32 Mandated Services: Services related to mandated consultation and/or related services (eg, PRO, 3rd party payor) may be identified by adding the modifier '-32' to the basic procedure or the service may be reported by use of the five digit modifier 09932.

-52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '-52,' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Modifier code 09952 may be used as an alternative to modifier '-52.'

-78 Return to the Operating Room for a Related Procedure During the Postoperative Period: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier '-78' to the related procedure, or by using the separate five digit modifier 09978. (For repeat procedures on the same day, see -76).

-79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier '-79' or by using the separate five digit modifier 09979. (For repeat procedures on the same day, see -76).

7. INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE:

a. **Identify the category and subcategory of service:** The categories and subcategories of codes available for reporting E/M services are as follows:

Category/Subcategory	Code Numbers
Office or Other Outpatient Services	
New Patient	99201-99205
Established Patient	99211-99215
Hospital Inpatient Services	
Initial Hospital Care	99221-99223
Subsequent Hospital Care	99231-99233
Hospital Discharge Services	99238
Consultations	
Office Consultations	99241-99245
Initial Inpatient Consultations	99251-99255
Follow-up Inpatient Consultations	99261-99263
Confirmatory Consultations	99271-99275
Emergency Department Services	99281-99288
Critical Care Services	99291-99292
Nursing Facility Services	
Comprehensive Nursing Facility Assessments	99301-99303
Subsequent Nursing Facility Care	99311-99313
Domiciliary, Rest Home or Custodial Care Services	
New Patient	99321-99323
Established Patient	99331-99333
Home Services	
New Patient	99341-99343
Established Patient	99351-99353

Category/Subcategory	Code Numbers
Case Management Services	
Team Conferences	99361-99362
Telephone Calls	99371-99373
Preventive Medicine Services	
New Patient	99381-99387
Established Patient	99391-99397
Individual Counseling	99401-99404
Group Counseling	99411-99412
Other	99420-99429
Newborn Care	99431-99440
Other E/M Services	99499

b. **Review the reporting instructions for the selected category or subcategory**: Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Inpatient Hospital Care", special instructions will be presented preceding the levels of E/M services.

c. **Review the level of E/M service descriptors and examples in the selected category or subcategory:** The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (ie, history, examination and medical decision making) should be considered the **key** components in selecting the level of E/M services. An exception to this rule is in the case of visits which consist predominantly of counseling or coordination of care (See g. 3, page 14.)

The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.

d. **Determine the extent of HISTORY obtained:** The levels of E/M services recognize four types of history that are defined as follows:

- Problem Focused—chief complaint; brief history of present illness or problem.
- Expanded Problem Focused—chief complaint; brief history of present illness; problem pertinent system review.
- Detailed—chief complaint; extended history of present illness; extended system review; **pertinent** past, family and/or social history.
- Comprehensive—chief complaint; extended history of present illness; complete system review; **complete** past, family and social history.

e. **Determine the extent of EXAMINATION performed:** The levels of E/M services recognize four types of examination that are defined as follows:

- Problem Focused—an examination that is limited to the affected body area or organ system.
- Expanded Problem Focused—an examination of the affected body area or organ system and other symptomatic or related organ systems.
- Detailed—an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- Comprehensive—a complete single system specialty examination or a complete multi-system examination.