Solving the E/M Conundrum: a Special Report

Evaluation and Management (E/M) codes, introduced in 1992 for reporting physician visit services, are linked to a number of perplexing questions for coders. In different settings, they are used differently and with varying sets of criteria. Given the numerous coding and compliance issues related to these codes and the code level use in today's payment process, the use of E/M codes can be problematic. This special report aims to help solve the conundrum with useful tips concerning the appropriate use of E/M codes for reporting both physician services and outpatient services. Briefly, here are some of the issues:

Currently, E/M codes are based more on documentation than any other element. For physician services, the elements of history, examination, and medical complexity are considered key factors, with the nature of the presenting problem, counseling, and coordination of care and time considered contributing elements.

Although the same CPT codes are used, the way they are used and the criteria used to select them is very different. When a code is assigned for physician services, the code reflects the amount of physician work (cognitive skills) and resources used by a physician in the practice of medicine.

Nonphysician practitioners also use E/M services to report their respective services for patients, although insurance plans may restrict reporting of visit services to physicians or services directly supervised by physicians.

When E/M codes are reported by institutional providers for facility services, the codes are expected to reflect the level of resource usage by the entity reporting the service. Instead of practicing medicine, facilities provide the administrative support, services of technicians and nurses, equipment, and supplies for the patient to be evaluated and treated by a physician or other designated practitioner. Comparing the two services by reviewing the E/M codes each reports (even for the same patient) is not recommended without a clear understanding that the CPT codes do not represent the same thing.

What complicates both sides of the issue is the use of the code levels in today's payment process. Common sense tells us that patients who receive medical visit services that take more time, consume more resources, and are higher risk for morbidity and mortality should be charged a higher fee and that insurance plans should reimburse for these services at higher rates. This makes the coding process open to fraudulent and abusive billing or documentation practices by both physicians and healthcare institutions.

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Navigating the Physician Services Maze

by Margaret A. Skurka, MS, RHIA, CCS

E/M Options in the Outpatient Arena

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