UC DAVIS HEALTH

Evaluation & Management Services Documentation and Coding Requirements 2026

Training Goals

E/M Classifications

E/M Coding Elements- Non-ED E/M

- Use of Time to Level E/M Service
- Use of Medical Decision Making (MDM) to Level E/M Service

ED E/M Coding Element

- Use of MDM to Level E/M Service

Critical Care

Policies

Resources

Classification of Common E/M Services

- Office or Other Outpatient Services
  - New Patient 99202-99205
  - Established Patient 99211-99215

- Consultations (Not recognized by Medicare)
  - Office or Other Outpatient Consultations 99242-99245
  - Initial Inpatient Consultations 99252-99255

- Hospital Inpatient and Observation Services
  - Initial Hospital Inpatient or Observation Care 99221-99223
  - Subsequent Inpatient or Observation Care 99231-99233
  - Hospital Discharge Services 99238-99239

Classification of Other E/M Services

- Emergency Department Services
  - New or Established 99281-99285
- Preventive Medicine
  - Initial Preventive Medicine 99381-99387
  - Established Patient 99391-99397
- Nursing Facility Services 99304-99316
- Home or Residence 99341-99350
- Prolonged Services
  - On date of office or other outpatient service 99417
  - On different date of office or other outpatient service 99358-99359

E/M Services Category

Choosing the right category of E/M depends on:

- Place of Service
  - office, hospital, emergency room, nursing home
- Type of Service
  - consultation, admission, office visit
- Patient Status
  - new patient, established patient, inpatient, outpatient

Each E/M category includes different levels of service.

The levels indicate the wide variations in skill, time, effort, responsibility and knowledge required to diagnose, treat, or prevent an illness or injury.

New vs. Established E/M Services

- New patient – CPT Definition
  - Has not received professional services from the physician or another physician of the same specialty and subspecialty within the same group practice within the past 3 years.

- Established Patient
  - Seen by the same physician within a 3-year period regardless of where the previous professional services were rendered (hospital setting, previous physician practice, etc.) or another physician of the exact same specialty in the same group practice.

New vs. Established E/M Services - Medicare

- Does not recognize subspecialties.
- Physician specialty determined by the 2-digit specialty code listed on the provider's Medicare enrollment application (855I), not the taxonomy codes submitted for their National Provider Identifier (NPI).
- Medicare defines group practices by tax identification number (TIN), not by National Provider Identifier (NPI).

CMS E/M Services – Medicare Update

Medicare Update: January 2010

With the exception of telehealth consultations, all other consultation codes have been eliminated for Medicare.

- Inpatient setting
  - Use Initial Hospital Day and Subsequent Hospital Day codes.

- Outpatient setting
  - Use New or Established Evaluation and Management (E/M) codes.

Consultation vs. Referral

Consultation

- Services rendered to give advice or an opinion to a requesting provider about a patient's diagnosis and/or management of a condition
  - The 4 R's:
    - Request
    - Render opinion
    - Report
    - Reason

Referral

- Transfer of care
- Referring provider transfers the responsibility for managing the patient's complete care for a condition to the receiving physician and the receiving physician documents approval of care

E/M Documentation Guidelines- Excludes ED

History and examination are no longer key components.

- Continue to perform and document medically appropriate history and/or examination.

Components for code selection (may use either)

- MDM level; or
- Total time billing provider spent on the date of the encounter.

Time no longer dependent on counseling and coordination of care dominating visit.

Now includes non-face-to-face time on the same date of the encounter.

Time cannot be used for ED E/M services!

E/M Documentation Guidelines - Excludes Time

- The time defined in the E/M descriptors is used for selecting level.
- Includes face-to-face and non-face-to-face time personally spent by billing provider on the date of encounter.
- Only the teaching physician time counts, resident time does not count, nor does clinical staff time.
- Total time spent by billing provider on the date of encounter must be documented.

E/M Documentation Guidelines - Excludes Other Time

Time

Total time includes:

- 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 health care 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).

E/M Documentation Guidelines – Medical Decision Making

Elements of MDM table for office/outpatient codes:

- Number and complexity of problems addressed at the encounter.
- Amount and/or complexity of data to be reviewed and analyzed.
- Risk of complication and/or morbidity or mortality of patient management.

Level of MDM - based on 2 out of 3 MDM elements.

Medical Decision Making (MDM) Element 1

- Number and complexity of problems addressed at the encounter.

Minimal	Low	Moderate	High
1 self-limited or minor problem	2 or more self-limited or minor problems	1 or more exacerbated chronic illness	1 or more severely exacerbated chronic illnesses
	1 stable chronic condition	2 or more stable chronic illnesses	1 acute or chronic illness that poses a threat to life or bodily function
	1 acute, uncomplicated illness or injury	1 undiagnosed new problem	
		1 acute illness with systemic symptoms	
		1 acute complicated injury	

Medical Decision Making (MDM) Element 2

❖ Amount and/or complexity of data to be reviewed and analyzed.

Limited	Moderate	Extensive
Must meet 1 of the following categories	Must meet 1 of the following categories	Must meet 2 of the following categories
Category 1	**Category 1**	**Category 1**
Any combination of 2 of:	Any combination of 3 of:	Any combination of 3 of:
Review of prior external notes from each unique source	Review of prior external notes from each unique source	Review of prior external notes from each unique source
Review of results of each unique test	Review of results of each unique test	Review of results of each unique test
ordering of each unique test	ordering of each unique test	ordering of each unique test
	Assessment requiring an independent historian(s)	Assessment requiring an independent historian(s)
Category 2	**Category 2**	**Category 2**
Assessment requiring an independent historian(s)	Independent interpretation of a test performed by another	Independent interpretation of a test performed by another
	Category 3	**Category 3**
	Discussion of management or test interpretation with external provider	Discussion of management or test interpretation with external provider

Medical Decision Making (MDM) Element 3

- Risk of complications and/or morbidity or mortality of patient management:
  - Level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.
  - Also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.
  - The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Medical Decision Making (MDM) Element 3 Table

❖ Risk of complications and/or morbidity or mortality of patient management Table

Minimal	Low	Moderate	High
Minimal risk of morbidity from additional diagnostic testing or treatment	Low risk of morbidity from additional diagnostic test or treatment	Moderate risk of morbidity from additional diagnostic test or treatment	High risk of morbidity from additional diagnostic test or treatment
		Examples include: - Rx drug management - Minor surgery with identified risk factors - Major surgery without identified risk factors - Diagnosis or treatment significantly limited by social determinants of health	Examples include: • Drug therapy requiring intensive monitoring for toxicity • Elective surgery with identified risk factors • Emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Critical Care

Definition (AMA CPT):

- Critical care is defined as the direct delivery by a physician(s) or other qualified health care professional(s) medical care for a critically ill or critically injured patient.
- A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition.
- Critical care involves high complexity decision making to assess, manipulate, and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

Critical Care: Documentation Guidelines

Include all of the following when documenting for critical care services:

- Patient's condition - system failure or imminent system failure, life threatening deterioration in the patient's condition.
- Complexity of the plan – highly complex decision making.
- Time spent providing services, activities directly related to individual patient's care -total number of minutes, continuous or intermittent and aggregated in time increments.
  - Teaching time with residents or fellows does not count toward critical care time.
- Activities involved - review of tests and records, conversations with other physicians and staff, telephone calls (in the unit and available to the patient), preparing records, adjusting ventilators, writing orders, and talking with patients or family members.
- Details of family discussion - patient is unable or incompetent to participate in giving history and/or making treatment decisions.

Documentation Guidelines Example

Patient seen and examined with Dr. Resident.

Reviewed and agree with his note:

- and the plan of care we developed together.
- One hour of critical care time personally performed due to patient's hemodynamic
- instability. Patient was resuscitated with 2 units of packed red blood cells. Obtained
- additional studies to determine possible causes for patient's instabilities.

Policies

UC Davis Health has internal policies and procedures for Evaluation & Management Services Documentation and Coding Requirements.

- **1920**: Coding Rules for Evaluation and Management Services and Preventive Services
- **1924**: Evaluation and Management Consultation Guidelines
- **1928**: Teaching Physician Guidelines for Professional Fee Billing
- **2305**: Approved Abbreviations
- **2307**: Medical Record Documentation Standards

Resources

For questions regarding this training, please visit the HIM Centralized Coding Leadership page at https://intranet.ucdmc.ucdavis.edu/emr/projects/him_centralized_coding_leadership/index.shtml

For compliance questions, please submit an Inquiry Form or visit the Compliance website at health.ucdavis.edu/compliance; or contact Compliance via email at compliancehelp@health.ucdavis.edu or phone 916-734-8808.