EVALUATION AND MANAGEMENT GUIDELINES

The general guidelines and modifiers found in the 2012 CPT®-4 were adopted by reference by the Industrial Commission and are applicable when utilizing Arizona's Fee Schedule. The evaluation and management guidelines adopted by reference may be found in the *Current Procedural Terminology®, Fourth Edition ("CPT® book")* published by the AMA and is reprinted, in part, below with permission. To the extent that a conflict may exist between the adopted portions of the CPT®-4 and a code or guideline unique to Arizona, the Arizona code or guideline shall control. Language unique to Arizona is printed below in italics*.

1. CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES: 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, e.g., office consultation. Third, the content of the service is defined, e.g. 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 following).

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. E/M services may also be reported by other qualified health care professionals who are authorized to perform such services within the scope of their practice.

   - New and Established Patient: *Each new incident that includes the completion of a Worker's and Physician's Initial Report of Injury form should be paid as a new patient visit.*

*Prior editions of this Fee Schedule included a subsection under the E/M Guidelines Section titled "Modifiers", which reprinted language from Appendix A of the CPT® specific to E/M Services. This section is no longer being reprinted in this Fee Schedule.

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, 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.

- Chief Complaint: A chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's words.

- Concurrent Care and Transfer of Care: Concurrent care is the provision of similar services (e.g., 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. Transfer of care is the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

- Counseling: 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.
  (For psychotherapy, see 90804-90857)

- Family History: A review of medical events in the patient's family that includes significant information about:

  - The health status or cause of death of parents, siblings and children;
  - Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review;
  - Diseases of family members which may be hereditary or place the patient at risk.

- History of Present Illness: A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s).

- 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, such as the determination of the need and/or location for appropriate care. Medical screening includes the history, examination, and medical decision-making required to determine the need and/or location for appropriate care and treatment of the patient (e.g., office and other outpatient setting, emergency department, nursing facility). 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.

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 the following pages.

Any specifically identifiable procedure (ie, identified with a specific CPT code) performed on or subsequently to the date of initial or subsequent E/M services should be reported separately.

The actual performance and/or interpretation of diagnostic test/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT® codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code with modifier 26 appended.

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 other services provided or beyond the usual preservice and postservice care associated with the procedure that was performed. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

- 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.

- Past History: A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

    - Prior major illnesses and injuries;
    - Prior operations;
    - Prior hospitalizations;
    - Current medications;
    - Allergies (e.g., drug, food);
    - Age appropriate immunization status;
    - Age appropriate feeding/dietary status.

- Social History: An age appropriate review of past and current activities that includes significant information about:

    - Marital status and/or living arrangements;
    - Current employment;
    - Occupational history;
    - Use of drugs, alcohol, and tobacco;
    - Level of education;
    - Sexual history;
    - Other relevant social factors.

- System Review (Review of Systems): An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. For the purposes of CPT®, the following elements of a system review have been identified:

    - Constitutional symptoms (fever, weight loss, etc.);

- Eyes;
- Ears, Nose, Mouth, Throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Integumentary (skin and/or breast);
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic;
- Allergic/Immunologic.

The review of systems helps define the problem, clarify the differential diagnosis, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

- 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 intraservice time and total time for E/M services. Intraservice 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. When prolonged time occurs in either the office or the inpatient areas, the appropriate add-on code should be reported.

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 (hospital observation services, inpatient hospital care, initial inpatient 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 that 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: 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. The clinical examples are listed in Appendix C. (*Appendix C of the CPT® has not been reprinted in this text.)* 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 examples that were rated consistently have been included in Appendix C.

6. INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE: Identify the category and subcategory of service codes available for reporting E/M services:

   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	99201-99215
New Patient	99201-99205
Established Patient	99211-99215
Hospital Observation Services	99217-99226
Observation Care Discharge Services	99217
Initial Observation Care	99218-99220
New or Established Patient	99218-99220
Subsequent Observation Care	99224-99226
Hospital Inpatient Services	99221-99239

Initial Hospital Care	99221-99226
New or Established Patient	99221-99226
Subsequent Hospital Care	99231-99239
Observation or Inpatient Care Services (including Admission And Discharge Services)	99234-99236
Hospital Discharge Services	99238-99239
Consultations	99241-99255
Office or Other Outpatient Consultations	99241-99245
New or Established Patient	99241-99245
Inpatient Consultations	99251-99255
New or Established Patient	99251-99255
Emergency Department Services	99281-99288
New or Established Patient	99281-99285
Other Emergency Services	99288
Critical Care Services	99291-99292
Nursing Facility Services	99304-99318
Initial Nursing Facility Care	99304-99306
New or Established Patient	99304-99306
Subsequent Nursing Facility Care	99307-99310
Nursing Facility Discharge Services	99315-99316
Other Nursing Facility Services	99318
Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services	99324-99337
New Patient	99324-99328
Established Patient	99334-99337
Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Plan Oversight Services	99339-99340
Home Services	99341-99350
New Patient	99341-99345
Established Patient	99347-99350
Prolonged Services	99354-99360
Prolonged Service With Direct Patient Contact	99354-99357
Prolonged Service Without Direct Patient Contact	99358-99359
Physician Standby Services	99360
Case Management Services	99363-99368
Anticoagulant Management	99363-99364
Medical Team Conferences	99366-99368
Medical Team Conference, Direct (Face-To-Face) Contact With Patient and/or Family	99366
Medical Team Conference, Without Direct (Face-To-Face) Contact with Patient and/or Family	99367-99368

Care Plan Oversight Services	99374-99380
Preventive Medicine Services	99381-99429
New Patient	99381-99387
Established Patient	99391-99397
Counseling Risk Factor Reduction And Behavior Change Intervention	99401-99429
New or Established Patient	99401-99412
Preventive Medicine, Individual Counseling	99401-99404
Behavior Change Interventions, Individual	99406-99409
Preventive Medicine, Group Counseling	99411-99412
Other Preventive Medicine Svcs	99420-99429
Non-Face-to-Face Physician Services	99441-99444
Telephone Services	99441-99443
On-Line Medical Evaluation	99444
Special Evaluation & Management Services	99450-99456
Basic Life and/or Disability Evaluation Services	99450
Work Related or Medical Disability Evaluation Services	99455-99456
Newborn Care Services	99460-99465
Delivery/Birthing Room Attendance And Resuscitation Services	99464-99465
Inpatient Neonatal Intensive Care Services And Pediatric and Neonatal Critical Care Svcs	99466-99480
Pediatric Critical Care Patient Transport	99466-99467
Inpatient Neonatal and Pediatric Critical Care	99468-99476
Initial and Continuing Intensive Care Svcs	99477-99480
Other Evaluation and Management 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, e.g., "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 (i.e., 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 instructions for selecting level of E/M Service).

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 extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). 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; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family and/or social history directly related to the patient's problems.

Comprehensive – chief complaint; extended history of present illness; review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family and social history.

The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.

e. Determine the extent of EXAMINATION performed: The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:

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 other symptomatic or related organ system(s).

Detailed – an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive – a general multisystem examination or a complete examination of a single organ system. Note: The comprehensive examination performed as part of the preventive medicine E/M service is multisystem, but its extent is based on age and risk factors identified.

For the purposes of these CPT® definitions, the following body areas are recognized:

- Head, including the face;
- Neck;
- Chest, including breasts and axilla;
- Abdomen;
- Genitalia, groin, buttocks;
- Back;
- Each extremity;

For the purposes of these CPT® definitions, the following organ systems are recognized:

- Eyes;
- Ears, Nose, Mouth, and Throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Skin;
- Neurologic;
- Psychiatric;
- Hematologic/Lymphatic/Immunologic.

f. Determine the complexity of MEDICAL DECISION MAKING: Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- 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.

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and high complexity. To qualify for a given type of decision making, two of the three elements in the table following must be met or exceeded.

Table 1 – Complexity of Medical Decision Making

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low complexity
Multiple	Moderate	Moderate	Moderate complexity
Extensive	Extensive	High	High complexity

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

g. Select the appropriate level of E/M services based on the following:

1. For the following categories/subcategories, ALL OF THE KEY COMPONENTS (i.e., history, examination, and medical decision making), must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; initial hospital care; office consultations; initial inpatient consultations; emergency department services; initial nursing facility care; domiciliary care, new patient; and home, new patient.

2. For the following categories/subcategories, TWO OF THE THREE KEY COMPONENTS (i.e., history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

3. When counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-

to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then TIME may be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

4. NOTE: The treating physician is required to submit with their level 4 or 5 E & M billings a narrative that justifies the billing for that level of service.

7. In the text of the Fee Schedule, we utilize * and ** to denote "add-on" codes and those codes that are exempt from the multiple procedure rule.

a. * Denotes Add-On Codes

(List separately in addition to code for primary procedure)

Note: This code is an add-on procedure and as such is valued appropriately. Multiple procedure guidelines for reduction of value are not applicable.

b. ** Denotes Codes Exempt from Modifier "-51"

Note: Multiple procedure guidelines for reduction of value are not applicable for this code.