CALIFORNIA BILLABLES PROJECT

E&M Resource Guide

You have two options in coding your patient encounter: key component and time-based. Different rules apply depending on the coding option you use.

Key Component Coding

The American Medical Association (AMA) has established three key components for Evaluation and Management (E&M) services. These are: **1) the patient's history, 2) the medical exam,** and **3) medical decision-making**—which includes the treatment plan. Your E & M must include all three to be compliant for a new patient.

Key component-based coding for an "established" patient (one you have seen within the past 3 years) follow much along the same rules. The key components are the same, but only need to meet meet any 2 out of the 3 components.

Time-Based Coding

- When **counseling or care coordination** dominates **more that 50% of the billable provider-patient interaction**, you will want to use time-based coding.
- Time counted **begins at the point of the face-to-face encounter**.
- Remember to **document a summary of the topics discussed**, as well as the time spent. Complete coding rules are in E&M Pocket Guide (see below).

Coding a nurse-only visit

A brief interaction between a patient and an ancillary provider.
Common examples include follow-ups, administering a pregnancy test or providing test results, counseling, and education. *In all cases, for these visits use the "nurse only" code of* ***99211***. If you're not sure if a brief encounter applies, check the payer's billing rules, or ask your clinic billing staff. For more information refer to:

E&M Pocket Book published by the AMA: **https://commerce.ama-assn.org/**

Evaluation & Management Coding and Documentation Reference Guide:

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html