Professional Pricing Policy

Subject: **Documentation and Reporting Guidelines for Evaluation and Management Services**	
Policy Number: HLEM-0001	Policy Section: **Evaluation and Management**
Last Approval Date: September 1, 2020	Effective Date: October 17, 2020

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

HealthLink recognizes the seven components identified by both CPT and CMS that 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
- Time

For the majority of E/M services, depending on the category, either two or three of the first three components listed above provide the sole basis for selecting the level of E/M service.

In addition, according to the American Medical Association, all entries to the medical record should be dated and authenticated. Therefore, HealthLink requires medical records documentation include the signature of the individual who provided/ordered the services. The signature for each entry must be legible and should include the practitioner's first and last names and credentials. HealthLink also requires that documentation of the reported service must be complete and legible.

I. History Component:

HealthLink requires that the medical record include documentation of the history component, which is comprised of the following elements:

- Chief complaint or reason for the encounter (CC).
- History of Present Illness (HPI).

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- Review of systems (ROS).
- Past, family, and/or social history (PFSH).

II. Chief complaint (CC):

The chief complaint is required for every E/M encounter. This is separate from the HPI. It is the first step in establishing the medical necessity for the presenting problem(s) for that specific encounter. It is used to determine to what extent HPI, ROS, and the nature of the physical exam is medically necessary.

III. History of Present Illness (HPI):

There are two levels of HPI (brief and extended) for both the 1995 and 1997 CMS documentation guidelines. Brief and extended HPI are differentiated by the amount of detail documented based on the patient's clinical and/or presenting problem(s). A brief history is taken for problem focused and extended problem focused level of E/M visit codes. A detailed or comprehensive history is required for the middle to upper level E/M visit codes.

For the CMS 1995 and 1997 guidelines, at least one of eight elements must be documented as part of the brief HPI. Detailed and comprehensive HPI require at least four of the eight to be documented as part of the HPI. Alternatively, the 1997 guidelines permit documentation of the status of three or more chronic or inactive conditions in lieu of any elements.

The chronic or inactive conditions stated in the 1997 HPI need to reflect the medical necessity pertaining to the specific encounter throughout the chief complaint, exam, and medical decision making. The eight elements included in the HPI are:

- Location - where problem, pain or symptom occurs
- Quality - description of problem, symptoms or pain
- Severity - description of severity of symptoms or pain
- Duration - description of when the problem, symptom or pain started
- Timing - description of when the problem, symptom or pain occurred
- Context - instances that can be associated with the problem, symptom or pain
- Modifying Factors - actions taken to make the problem, symptom or pain better or worse
- Associated Signs or Symptoms - other problems, symptoms or facts that occur when primary problem, symptom or pain occurs

IV. Review of Systems (ROS):

The level of the ROS needs to be relative to the medical necessity of the presenting problem(s). For example:

- It may be medically necessary to obtain a complete ROS when a patient presents as a new patient.
- It may not be considered medically necessary to repeat a complete ROS on a follow-up visit.

If a provider uses a patient questionnaire to obtain information on the patient's current signs and symptoms, the provider needs to acknowledge the review of the questionnaire as the source of the information, in the office note, along with the provider's signature and date on the questionnaire.

For new patient and consultation visits, the patient's signs and symptom information (ROS) must be completely documented, including a description of each system that was reviewed during the encounter. Established visits may use reference to a patient questionnaire. The ROS must be supported in the CC and HPI. Documenting "ROS negative" or "ROS noncontributory" is not acceptable. A notation indicating "all other systems negative" is acceptable when at least the organ system relating to the reason for the visit is individually documented. The following documentation is required, at a minimum:

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- Brief ROS documentation of positive/negative responses to problem pertinent systems directly related to the chief complaint.
- Extended ROS documentation of positive/negative responses for at least two to nine systems.
- Complete ROS documentation of positive/negative responses for ten or more systems.

V. Past, Family and/or Social History (PFSH): Documentation needs to support the medical necessity For the encounter. For example:

- It may be medically necessary to obtain past medical, family and social history for a new or consult patient.
- It may not be medically necessary for a repeat past medical, family and social history for an established patient encounter.

HealthLink follows the CMS 1995 and 1997 documentation guidelines which both require that the CC, HPI, and ROS support the medical necessity of obtaining PFSH during an established visit for a patient that has been seen within the last three months for the same clinical condition(s).

- Past history - Describes "the patient's past experiences or lack thereof with illnesses, operations, injuries and treatments."
- Family history – "A review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk"
- Social history - Describes "age-appropriate past and current activities. Some examples are marital status, education, tobacco, and alcohol or drug abuse."

VI. Physical Examination:

- HealthLink requires that the medical record include documentation of the physical examination component for all E/M categories that require the three key components.
- For all E/M categories that require two out of the three key components, documentation of the physical examination component is required when the provider selects the physical examination as the second required key component; remove extra space refer to the Medical Decision Making Section for information on the first required key component.
- The extent of the physical examination should correspond to the medical necessity of the presenting problem(s) stated in the chief complaint and history of present illness documentation.
- The nature of the problem and severity of illness defines the intensity of the medical examination required.

HealthLink uses the following guidelines for documentation of the physical examination which are based on the CMS 1995 and 1997 guidelines. They are:

1995 Guidelines:

- Problem Focused examination requires a limited examination of the affected body area or organ system.
- Expanded Problem Focused examination requires a limited examination of between 2 to 7 body areas or organ systems.
- Detailed examination requires an extended examination of between 2 to 7 body areas or organ systems.

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- Comprehensive examination requires a general multi-system examination of at least 8 organ systems or a complete examination of a single organ system.

1997 Guidelines-Single Organ System Examinations:

HealthLink requires the performance and documentation of the indicated elements of the 1997 guidelines for problem focused, expanded problem focused, detailed and comprehensive examinations. Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) must be documented.

- A notation of "abnormal" without elaboration is insufficient.
- Documenting "No change in physical examination" or "no change in condition from last examination" or similar nonspecific reference is not acceptable.

VII. Medical Decision Making (MDM):

Medical decision making is based on the patient's clinical condition at the time of the specific visit. HealthLink follows the requirements for documentation recorded in *Medical Record Auditor*, Grider, Deborah, 2nd edition, ©2008 by the American Medical Association. The patient's medical record must include the following:

- For each encounter, an assessment, clinical impression, and/or diagnosis must be documented. The assessment, clinical impression, and/or diagnosis may be explicitly stated or implied in the documented decisions regarding management plans and/or further evaluation.
- The presenting problems need to be addressed in the history, physical examination, and MDM components. For a presenting problem with an established diagnosis, the record should reflect whether:
    - the problem remove space (s) is improved, well controlled, resolving, or resolved; or
    - inadequately controlled, worsening, or failing to change as expected.

For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnosis or as a possible, probable, or "rule out" diagnosis.

- The initiation of/or change in treatment must be documented.
- If referrals are made, consultations requested, or advice sought, the record must indicate to whom or where the referral or consultation is made, or from whom advice is requested.
- If diagnostic services (tests or procedures) are ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service (e.g., lab; x-ray) must be documented.
- The review of lab, radiology, and/or diagnostic tests must be documented. A simple notation such as "WBC elevated" or "chest x-ray unremarkable" is acceptable; or the review may be documented by the provider initialing and dating the report containing the test results.
- Relevant findings from the review of old records and/or receipt of additional history from the family, caretaker, or other source to supplement the information obtained from the patient must be documented. If there is no relevant information beyond that already obtained, that fact should be documented; a notation of "old records reviewed" or "additional history obtained from family" without elaboration is insufficient.

HealthLink follows CPT coding guidelines for a new patient office visit or consultation and requires that all of the key components, i.e., history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for reporting a particular level of E/M.

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Although CPT coding guidelines do not specify which two out of the three key components must meet or exceed the stated requirements to qualify for reporting a particular level of E/M for an established patient visit, HeathLInk's position is that the complexity of the presenting complaint and medical decision making should generally align with the complexity of the patient history and physical examination. For purposes of medical record audits of E/M coding levels, HealthLink expects that the medical records will reflect that the medical decision making component is aligned with the complexity of the patient history and examination. HealthLink will consider medical decision making as one of the parameters in determining whether upcoding has occurred when auditing E/M coding outliers.

This position is based on HeathLink's interpretation of the 1995 and/or 1997 E/M documentation guidelines found in the Medicare Claims Processing Manual, Chapter 12; section 30.6.1; "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed."

If a clinical note indicates that the MDM level was straight forward and the other components were determined to be low complexity the visit level should be reported as 99212 based on the MDM level.

VIII. Selecting a Level of Medical Decision Making for Coding an E/M Service:

HealthLink uses a point system described in a tool developed by the Marshfield Clinic (tables A and B below) in conjunction with CMS to quantify the presenting problem and the amount of comprehensive data that must be reviewed by the examining provider. This point system is used in conjunction with the CMS Documentation Guidelines Table from 1995 and/or 1997 for determining the appropriate level of E/M service to select. (See the table in Section C below.)

A. Number of Diagnoses/Management Options	Points
Self-limited or minor (stable, improve, or worsened (maximum of 2 points in this category)	1 point
Established problem (to examining MD); stable or improved	1 point
Established problem (to examining MD); worsening	2 points
New problem (to examining MD), no additional work-up planned (maximum of 3 points in this category)	3 points (maximum)
New problem (to examining MD); additional workup (diagnostic test)	4 points

B. Amount and/or Complexity of Data Reviewed	Points
Lab tests ordered and/or reviewed (regardless of number ordered)	1 point
X-rays ordered and/or reviewed (regardless of number ordered)	1 point
Procedures found in the Medicine section of CPT (90281-99199) ordered and/or reviewed	1 point
Discussion of test results with performing physician	1 point
Decision to obtain old record and/or obtain history from someone other than patient	1 point
Review and summary of old records and/or obtaining history from someone other than patient and/or discussion with other health care provider	2 points
Independent visualization of image, tracing, or specimen (not simply review of report)	2 points

Tables A and B (above), in conjunction with the table in section C describes specific point value information. In order for an E/M service to be assigned a particular medical decision making level, the service must score at or above that level in two out of the three categories.

C. Risk Level of Complication and/or Morbidity or Mortality

HealthLink uses the following risk table, which appears in both the 1995 and 1997 CMS published guidelines,

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as a tool for determining the appropriate risk level for a reported E/M visit. The procedures listed below appearing in bolded text within the Low and Moderate Risk Level rows were added by HealthLink for further clarification of these two risk levels.

Risk Level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal (straight forward)	> One self-limited or minor problem (e.g. cold, insect bite, tinea corporis)	> Lab test requiring: • Venipuncture • Chest x-ray • EKG/EEG • Urinalysis • Ultrasound/Echo • KOH prep	> Rest > Gargles > Elastic Bandages > Superficial dressings
Low	> Two or more self-limited or minor problems > One stable chronic condition illness (e.g. HTN, DM, Cataracts, BPH) > Acute uncomplicated illness or injury (e.g. sprain, cystitis, rhinitis)	> Physiological test not under stress (PFT) > Non-cardiovascular imaging studies with contrast (barium enema, CT) > **Sleep studies** > Superficial needle biopsy arterial puncture > **Skin biopsy**	> Over the counter drugs > Minor surgery with no identified risk factor > PT/OT,ST > IV fluids without additives > **Prescription drug management – maintenance phase (i.e., no change in prescriptions or dosage)**
Moderate	> One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment > Two or more stable chronic conditions > Undiagnosed new problem with uncertain prognosis (e.g. lump in breast) > Acute illness with systemic symptoms (e.g. pneumonitis, colitis, pyelonephritis) > Acute complicated injury (e.g. head injury with brief loss of consciousness)	> Physiological tests under stress (eg: cardiac stress test, fetal contraction stress test) > Diagnostic endoscopies with no identified risk factors > Deep needle or incisional biopsy > Cardiovascular imaging studies with contrast and no identified risk factors (eg arteriogram, cardiac catheterization) > Obtain fluids from body cavity (eg L.P), thorancentesis	> Minor surgery with identified risk factors > Elective major surgery (open, percutaneous, or endoscopic) with no risk identified risk factors > Prescription drug management **(i.e., new medication prescribed for patient or a change in dosage for an existing medication; takes into account other medications the patient is currently taking)** > Therapeutic nuclear medicine > IV fluids with additives > Closed treatment of fracture or dislocation without manipulation

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Risk Level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
High	> One or more chronic illnesses with severe exacerbation, progression or side effects of treatment > Acute or chronic illnesses or injuries that pose a threat to life or bodily function (e.g. multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, suicidal with potential threat to self or other, peritonitis or acute renal failure) > Abrupt change in neurological status (e.g. seizure, TIA, weakness, sensory loss)	> Cardiovascular imaging studies with contrast with identified risk factors > Cardiac electrophysiological tests > Diagnostic endoscopies with risk factors > Discography	> Elective major surgery (open, percutaneous or endoscopic) with identified risk factors > Emergency major surgery (open, percutaneous or endoscopic) > Parenteral controlled substances > Drug therapy requiring intensive monitoring for toxicity > Decision not to resuscitate or to de-escalate care because of poor prognosis

IX. Counseling and Coordination of Care:

For the majority of E/M services, depending on the category, either two or three of the first three components (history, examination, and medical decision making) provide the sole basis for selecting the level of E/M service. However, if during an E/M encounter, counseling and/or coordination of care represents more than 50 percent of the time the physician spends face-to-face with the patient and/or family, then HealthLink allows time to be considered the key or controlling factor used to select the E/M visit level to report. HealthLink requires that two different time elements be recorded and documented in sufficient detail:

- One time element is the amount of time spent performing counseling and/or coordination of care.
- The second time element is the total amount of face-to-face time spent with the patient for the entire encounter.

Related Coding

Code	Description	Comments
N/A	N/A	Standard correct coding applies.

Exemptions

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Definitions

Chief Complaint (CC)	A concise statement describing the symptoms, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words and documented in the medical record
Comprehensive Exam	A general multi-system examination or complete examination of a single organ system and other symptomatic or related body areas or organ system(s).
Detailed Exam	An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s)
Expanded Problem Focused Exam	A limited examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s)
Family History	A review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk
Medical Decision Making (MDM)	The complexity of establishing a diagnosis and/or selecting a management option, as measured by the following documentation: 1. "The number of possible diagnoses and/or the number of management options that must be considered 2. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed. The risk of significant complications, morbidity, and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), diagnostic procedures(s), and remove space /or the possible management options.
Past History	A review of the patient's past experiences with illnesses, operations, injuries and treatments
Review of Systems (ROS)	An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For the purpose of ROS, the following systems are recognized: eyes, ear nose, mouth, throat, respiratory, genitourinary, integumentary (skin and/or breast), psychiatric, hematologic/lymphatic, constitutional (e.g. fever, weight loss) cardiovascular, gastrointestinal, musculoskeletal, neurological, endocrine, and allergic/immunologic
Social History	An age appropriate review of past and present activities
Consult	A type of service provided by a physician, or other appropriate source, whose opinion or advice regarding the evaluation and/or management of a specific problem is requested by another physician or other qualified non-physician practitioners. The intent of the requesting provider is not to have the consulting physician treat the patient's condition, but rather to render an opinion and/or working diagnosis to aid the referring provider in formulating a treatment plan.
Counseling	A conversation with the patient and/or the family/patient's guardian concerning test results, treatment, education, etc.
History Present Illness (HPI)	A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present
Time	Face-to-face duration for office and other outpatient visits and unit/floor time for hospital and other inpatient services.
New patient	a patient who has not received any professional services within the past year by the same provider or another provider in the same group with the exact same specialty and subspecialty

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Definitions	
Established patient	a patient who has received professional services within the past three years by the same provider or another provider in the same group with the exact same specialty and subspecialty
Professional Services	Face-to-face services rendered by physicians or other qualified health care professional who may report E/M services within the same group practice and of the exact same specialty and subspecialty.

Related Policies and Materials

References and Research Materials

This policy has been developed through consideration of the following

- CMS
- 1995 and 1997 Documentations Guidelines for E&M Services
- American Medical Association (AMA) Current Procedural Terminology (CPT)

Use of Pricing Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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