Documentation Guidelines for Evaluation and Management Services

Effective 1/1/24

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Note: for services provided prior to January 1, 2023, see prior versions of Highmark's Documentation Requirements for Evaluation and Management Services (applicable by date of service).

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- Click **Documentation Guidelines for Evaluation and Management Services**
- Select the appropriate **Documentation Guidelines for Evaluation and Management Services** for the date of service

Documentation Requirements for Evaluation and Management Services

The medical record must clearly document the medical care provided to a member. Medical record documentation is necessary to record applicable observations and findings regarding the member's history, examinations, diagnostic tests and procedures, diagnoses, treatments and treatment plan, necessary follow-up care, and outcomes or responses to care per date of service or encounter.

Additionally, the medical record serves as a formal document and a communication tool between providers, vendors, and insurance providers.

All services performed and the diagnosis(es) related to the visit must be documented in the member's medical record.

Effective January 1, 2024, the Office and Outpatient Evaluation and Management (E/M) Coding were updated to remove the time ranges from new and established outpatient codes. The time that needs to be met is now the lowest number of minutes in the current code range.

In addition, the minimum time values for nursing facility care codes increased by 5 minutes each. This change applies to the following codes:

- Office or Outpatient visit 99202-99205 and 99212-99215
- Skilled Nursing 99306 and 99308

Effective January 1, 2023, The Plan is aligning E/M coding with changes adopted by the American Medical Association (AMA) CPT Editorial Panel for all Evaluation and Management visits. These changes allow clinicians to choose the E/M visit level based on either medical decision making (MDM) or time; except for Emergency Department E/M services – these are leveled based on medical decision making (MDM) only.
For additional information, please refer to Reimbursement Policy 057.

- Access the **Provider Resource Center**
- Select **Claims, Payment & Reimbursement**
- Click **Reimbursement Polices**
- Scroll down and select **RP-057**

Description of History and/or Exam Elements

E/M codes that have levels of service include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of level of care.

Description of the Elements for Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211, 99281. MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three components:

- The number and complexity of problem(s) addressed
- Amount and/or complexity of data to be reviewed and analyzed, AND
- Risk of complications and or morbidity or mortality of patient management.

In order to select a level of E&M service, two of the three elements must be met or exceeded.

Number and Complexity of Problems addressed

The number and complexity of the problem(s) addressed during the encounter is an element in selection of the level of evaluation and management services. Symptoms, comorbidities, and underlying diseases may not be considered in selecting the level of care unless they are addressed, and their presence increases complexity. Multiple conditions, new or established, may be addressed at the same time, and may affect the overall medical decision making.
Comorbidities/underlying diseases are not considered in selecting a level of E/M service unless they are addressed, and their presence increases complexity. The final diagnosis for a condition does not solely determine the complexity or risk.

NOTE:

1. For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

2. For a presenting problem with an established diagnosis the record should reflect whether the problem is:
    a. improved, well controlled, resolving or resolved; or,
    b. inadequately controlled, worsening, or failing to change as expected.

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

4. The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.

5. If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.

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

The amount and/or complexity of data to be reviewed and analyzed includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter.

Data is divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)

- Independent interpretation of tests.

- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source.

NOTE:

1. If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service (e.g., lab or x-ray) should be documented.

2. The review of lab, radiology and/or other diagnostic tests should be documented. A simple notation such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.

3. A decision to obtain old records or decision to obtain additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented.

4. Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker, or other source to supplement that obtained from the patient should 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.

5. The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.

6. The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.

Risk of complications and or morbidity or mortality of patient management

The risk of complications and/or morbidity or mortality of patient management is based upon decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment(s). This includes the possible management options selected and those considered but not selected, after shared MDM with the

patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care.

1. Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

2. If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure (e.g., laparoscopy) should be documented.

3. If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.

4. The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281. Shared MDM involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options. MDM may be impacted by role and management responsibility. When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not count toward the MDM when selecting a level of office or other outpatient services. When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of office or other outpatient services.

MDM definitions as Published by AMA:

Minimal problem - A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211).

Self-limited or minor problem - A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Stable, chronic illness - A problem with an expected duration of at least a year or until the death of the patient. Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment - chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.

Undiagnosed new problem with uncertain prognosis - A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms - An illness that causes systemic symptoms and has a high risk of morbidity without treatment.

Acute complicated injury - An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment - The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function - An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment.

Analyzed - The process of using the data as part of the MDM. The data element itself may not be subject to analysis (e.g., glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test - Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique - A unique test is defined by the CPT code set. When multiple results of the same unique test (e.g., serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

Combination of Data Elements - A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or

independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External - External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.

Note: The Plan considers "External" to mean records, communications and/or test results from an external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty.

External physician or other qualified health care professional - An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.

Note: The Plan considers an external physician or other qualified health care professional as an individual who is not in the same group practice or is in a different specialty or subspecialty (including an Advanced Practice Nurse (APN) or Physician's Assistant (PA)). An external provider would not be a Registered Nurse (RN) or Social Worker (SW) that is on your care team.

Discussion - Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (e.g., clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (i.e., does not need to be in person), but it must be initiated and completed within a short time-period (e.g., within a day or two).

Independent historian(s) - An individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent

historian requirement is met. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Note: The Plan considers a parent to be an independent historian if the patient is unable to provide a complete and reliable history due to developmental stage, dementia, or psychosis, and the confirmatory history is necessary for the treatment of the patient. Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source - An appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (e.g., lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers. One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk - The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk 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

A full list of definitions, changes and MDM table can be found:

https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Description of the Time element

Certain categories of time-based E/M codes that do not have levels of services based on MDM (e.g., Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

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.

Effective January 1, 2024, the Office and Outpatient Evaluation and Management (E/M) Coding were updated to remove the time ranges from new and established outpatient codes. The time that needs to be met is now the lowest number of minutes in the current code range.

In addition, the minimum time values for nursing facility care codes increased by 5 minutes each. This change applies to the following codes:

- Office or Outpatient visit 99202-99205 and 99212-99215
- Skilled Nursing 99306 and 99308

When time is used for reporting outpatient E/M service codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services require a face-to-face encounter with the physician or other qualified health care professional. The Plan requires the documentation of time to be recorded with both the start/stop times and the total time treating the patient.

Examples of activities that count towards the documentation of time include:

- Review of tests when preparing to see the patient
- Obtaining and/or reviewing history documentation obtained separately
- Ordering medications, tests, or procedures
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient and/or family/caregiver
- Referring and communicating with other health care professionals (if not being reported separately)
- Documenting clinical information in the health record

- Independently interpreting and communicating results (if not being reported separately)
- Care coordination (if not being reported separately)

Do not count time spent on the following:

- The performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

Consultation Codes (99241-99245 or 99251-99255)

Effective in January of 2021, the Plan no longer recognizes outpatient and inpatient consultation codes as valid codes, and these services should be reported with an appropriate E/M code.

For additional information, please refer to Reimbursement Policy 063.

- Access the **Provider Resource Center**
- Select **Claims, Payment & Reimbursement**
- Click **Reimbursement Policies**
- Scroll down and select **RP-063**

Sources

This document and the information contained is a compilation from various sources including:

- *The Plan's policies and office manual*

- *The American Medical Association (AMA) CPT® Evaluation and Management (E/M) Code and Guideline Changes effective January 1, 2023*

- *CMS Centers for Medicare & Medicaid Services Evaluation and Management Services Guide*