Anthem Blue Cross and Blue Shield
Professional Reimbursement Policy

Subject: Documentation and Reporting Guidelines for Evaluation and Management Services

IN, KY, MO, OH, WI Policy: 0024  Effective: 12/01/2015 – 09/30/2016

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Description

The Evaluation and Management (E/M) coding section of the Current Procedural Terminology (CPT®) codebook is divided into different types of E/M services. There are broad categories, such as office/outpatient visits, inpatient hospital visits, consultations, etc. Many of these categories are further divided into two or more subcategories appropriate for that service type such as:

- Office visits have new and established patients
- Hospital E/M services are based on the health status of the patient (e.g., critical care or observation)
- Other E/M services may be based on location alone (e.g. emergency department services)

The nature and amount of provider work and documentation required varies by type of service, place of service, the patient’s medical status or other code criteria.

The Centers for Medicare & Medicaid Services (CMS) published E/M documentation guidelines in 1995 and 1997. The Health Plan allows providers to use either the 1995 or 1997 CMS E/M documentation guidelines. Within a single encounter/claim, the two sets of guidelines cannot be mixed. In other words, the provider must follow either the 1995 or the 1997 documentation guidelines for the single encounter/claim. The following information describes the Health Plan’s interpretation of those CMS guidelines.

In addition, this policy addresses the Health Plan's own requirements (which may differ from CMS requirements) for selecting the level of a reported E/M service, and the eligibility for E/M reimbursement based on the fulfillment of the required criteria.

Definitions

The Health Plan uses the following definitions from the 1995 and 1997 editions of CMS’ E/M Services Guidelines:

- 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.”
Anthem Blue Cross and Blue Shield
Professional Reimbursement Policy

- **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.
  3. 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/or the possible management options.”
- **Past History:** “A review of the patient’s past experiences with illnesses, operations, injuries and treatments.”
- **Problem Focused Exam:** “A limited examination of the affected body area or organ system.”
- **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.”

The Health Plan uses the following definitions which are based on the 1995 and 1997 editions of CMS’ E/M Services Guidelines:
- **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.” Usually this information is derived from the patient’s own words and obtained by the provider.
Anthem Blue Cross and Blue Shield
Professional Reimbursement Policy

- **Time:** Face-to-face duration for office and other outpatient visits and unit/floor time for hospital and other inpatient services.

Based on CPT guidelines, the Health Plan uses the following definitions to determine new or established patient:
- **New patient:** a patient who has not received any 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
- **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.

CPT describes “professional services” as 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. The Health Plan considers other qualified health care professionals, including but not limited to, physician assistants or nurse practitioners, to be of the same specialty and subspecialty as the physician(s) in the same group practice location.

Policy
The Health Plan 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 the Health Plan requires medical records documentation include the signature (e.g., handwritten, electronic) 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. The Health Plan also requires that documentation of the reported service must be complete and legible.

1. **History Component:**
   The Health Plan 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).
A. 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.

B. 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 (e.g., leg, chest, back).
- Quality - description of problem, symptoms or pain (e.g., dull, itching, constant).
- Severity - description of severity of symptoms or pain (e.g., 1-10 rating, mild, moderate, severe).
- Duration - description of when the problem, symptom or pain started (e.g., one week, since last night, months).
- Timing - description of when the problem, symptom or pain occurred (e.g., morning, after eating, when lying down, on exacerbation).
- Context - instances that can be associated with the problem, symptom or pain (e.g., while standing for long periods of time, when sitting).
- Modifying Factors - actions taken to make the problem, symptom or pain better or worse (e.g., pain relievers help dull pain, nausea after eating).
- Associated Signs or Symptoms - other problems, symptoms or facts that occur when primary problem, symptom or pain occurs (e.g., stress causes headache, dizziness with exercising).

C. 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.
Anthem Blue Cross and Blue Shield
Professional Reimbursement Policy

- 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. The following documentation is required, at a minimum:

- 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

D. 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

The Health Plan 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, alcohol or drug abuse”

II. Physical Examination:

- The Health Plan 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 (i.e., established or subsequent E/M visit), documentation of the physical examination component is required when the provider selects the physical examination as the second required key component; refer to the Medical Decision Making Section for information on the first required key component
Anthem Blue Cross and Blue Shield
Professional Reimbursement Policy

- 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.

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

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

Complete information on the 1995 CMS guidelines may be found in the following CMS document:

B. 1997 Guidelines-Single Organ System Examinations
The Health Plan 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 non specific reference is not acceptable.

Complete information on the 1997 CMS guidelines may be found in the following CMS document:

III. Medical Decision Making (MDM):
Anthem Blue Cross and Blue Shield
Professional Reimbursement Policy

Medical decision making is based on the patient’s clinical condition at the time of the specific visit. The Health Plan follows the requirements for documentation recorded in Medical Record Auditor, Grider, Deborah, 2nd edition, ©2008. 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:
  a. the problem(s) is improved, well controlled, resolving, or resolved; or
  b. 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.

The Health Plan 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.

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, the Health Plan requires that medical decision making be one of the two key components used to determine the E/M code level selected. The other component can be either patient history or physical examination.

This requirement is based on the Health Plan’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 straightforward (e.g., 99212) and the other components were determined to be low complexity (e.g., 99213), the visit level should be reported as 99212 based on the MDM level.

Selecting a Level of Medical Decision Making for Coding an E/M Service:
The Health Plan 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)

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

| 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 (below), describe 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

The Health Plan uses the following risk table, which appears in both the 1995 and 1997 CMS published guidelines, 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 the Health Plan for further clarification of these two risk levels.

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| 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  
> 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, pycnolephritis) | > Physiological tests under stress (ex 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 | > Minor surgery with identified risk factors  
> Elective major surgery (open, percutaneous, or endoscopic, davinci) with no risk identified risk factors  
> Prescription drug management (i.e., new medication prescribed for patient or a change in  
  prescriptions or dosage) |
<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>&gt; Acute complicated injury (e.g., head injury with brief loss of consciousness) no identified risk factors (ex arteriogram, cardiac catheterization) &gt; Obtain fluids from body cavity (e.g., L.P), thoracentesis</td>
<td>&gt; Cardiovascular imaging studies with contrast with identified risk factors &gt; Cardiac electrophysiological tests &gt; Diagnostic endoscopies with risk factors &gt; Discography</td>
<td>&gt; Elective major surgery (open, percutaneous or endoscopic) with identified risk factors &gt; Emergency major surgery (open, percutaneous or endoscopic) &gt; Parenteral controlled substances &gt; Drug therapy requiring intensive monitoring for toxicity &gt; Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>

**IV 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 the Health Plan allows time to be considered the key or controlling factor used to select the E/M visit level to report. The Health Plan 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.

**Coding**

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All E/M codes requiring at least either two or three components (history; examination; medical decision making) for providing the sole basis for selecting the level of E/M service are subject to this policy. The following list of codes is provided as an informational tool only. The inclusion or exclusion of a specific code does not indicate eligibility for reimbursement and/or coverage in all situations.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99205</td>
<td>Office or other outpatient visit; new patient</td>
</tr>
<tr>
<td>99211-99215</td>
<td>Office or other outpatient visit; established patient</td>
</tr>
<tr>
<td>99218-99220</td>
<td>Initial observation care</td>
</tr>
<tr>
<td>99221-99223</td>
<td>Initial hospital care</td>
</tr>
<tr>
<td>99231-99233</td>
<td>Subsequent hospital care</td>
</tr>
<tr>
<td>99241-99245</td>
<td>Office or other outpatient consultation; new or established patient</td>
</tr>
<tr>
<td>99251-99255</td>
<td>Inpatient consultation; new or established patient</td>
</tr>
<tr>
<td>99281-99285</td>
<td>Emergency department visit</td>
</tr>
<tr>
<td>99304-99306</td>
<td>Initial nursing facility care</td>
</tr>
<tr>
<td>99307-99310</td>
<td>Subsequent nursing facility care</td>
</tr>
<tr>
<td>99318</td>
<td>E/M annual nursing facility assessment</td>
</tr>
<tr>
<td>99324-99328</td>
<td>Domiciliary or rest home visit; new patient</td>
</tr>
<tr>
<td>99334-99337</td>
<td>Domiciliary or rest home visit; established patient</td>
</tr>
<tr>
<td>99341-99345</td>
<td>Home visit; new patient</td>
</tr>
<tr>
<td>99347-99350</td>
<td>Home visit; established patient</td>
</tr>
<tr>
<td>G0380-G0384</td>
<td>Hospital emergency department visit provided in a type B emergency department</td>
</tr>
</tbody>
</table>

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**Use of Reimbursement 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. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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