Documentation Guidelines for Evaluation and Management Services

Effective 1/1/21

Table of Contents

Note: for the services provided prior to January 1, 2021, and for services Other than Office Outpatient E/M Visits 99202-99215, utilize the Centers for Medicare & Medicaid Services (CMS) 1995 or 1997 Documentation Guidelines. For reference, see the original **Documentation Guidelines for E/M Services** booklet:

- Access the **Provider Resource Center**
- Select **Claims, Payment & Reimbursement**
- Click **Documentation Guidelines for Evaluation And Management Services**
- Select the **Documentation Guidelines for Evaluation and Management Services** manual for services prior to 1/1/21

Documentation Requirements for E/M 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, 2021, the Plan is aligning E/M coding with changes adopted by the American Medical Association (AMA) CPT Editorial Panel for office/outpatient E/M visits 99202 - 99215. These changes allow clinicians to choose the E/M visit level based on either medical decision making (MDM) or time.

For additional information, please refer to Reimbursement Policy 057.

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

Description of History and/or Exam Elements for Office or Other Outpatient E/M 99202-99215

Office or other outpatient services 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 the level of office or other outpatient codes.

Description of Medical Decision Making Element for Office or Other Outpatient E/M 99202-99215

The medical decision-making (MDM) elements associated with codes 99202-99215 will consist of three components: 1) The number and complexity of problems addressed 2) Amount and/or complexity of data to be reviewed and analyzed AND 3) Risk of complications and or morbidity or mortality of patient management. To select a level of E&M service, two of the three elements must be met or exceeded.

1) Number and Complexity of Problems addressed

Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction. Symptoms, comorbidities, and underlying diseases may not be considered in selecting the level of care unless they are addressed, and their presence increases complexity. The final diagnosis for a condition does not solely determine the complexity or risk.

2) 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.

3) 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 that are associated with the patient's problem(s), the diagnostic procedure(s), and/or treatment(s). This includes the possible management options selected and those considered but not selected, after shared MDM with the patient and/or family.

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211. 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.

The Table of Risk (common clinical examples) (Office or Other Outpatient E/M's 99202 - 99215) can be referenced in the 2021 (95 guidelines) E/M Audit tool.

MDM Definitions as Published by AMA:

Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/ surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

Minimal problem: A problem that may not require the presence of the physician or other qualified healthcare 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 one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, in a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic, the risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, noninsulin- dependent diabetes, cataract, or benign prostatic hyperplasia.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

Chronic illness with exacerbation, progression, or side effects of treatment: A 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. An example may be a lump in the breast.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness, or to prevent complications, see the definitions ***for self-limited or minor problem*** or ***acute, uncomplicated illness or injury***. Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.
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. An example may be a head injury with brief loss of consciousness.

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, 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. Examples may include acute myocardial infarction, pulmonary embolus, severe

respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

Analyzed: The process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, 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 (eg, 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 (eg, 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 (eg, 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 (ie, does not need to be in person), but it must be initiated and completed within a short time-period (eg, within a day or two).

Independent historian(s): An individual (eg, 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 (eg, 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 (eg, 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.

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery–Minor or Major:*** The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk." These terms are not defined by a surgical package classification.
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> ***Surgery–Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
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> ***Surgery–Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. Examples may include monitoring for cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples

of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (even if unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Description of Time Element for Office or Other Outpatient E/M 99202-99215

According to American Medical Association Current Procedural Terminology (AMA CPT®), beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Time may be used to select a code level in office or other outpatient services whether counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service.

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.

Physician/other qualified health care professional time includes the following activities, when performed on the date of the encounter:

- 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)

Prior to January 1st 2021	Beginning January 1st 2021
Time may only be used or selected if 50% of the encounter is spent on counseling and/or coordination of care	Time may be used to select an E/M code whether counseling and/or coordination of care dominates the visit or not
Time is based on only face to face activities on the date of service	Time includes both face-to-face and non-face-to-face activities on the date of service
Time criteria is based on a typical time for the level of service	Time is based on defined intervals of time

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) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes*
- *CMS Centers for Medicare & Medicaid Services Evaluation and Management Services Guide*