Documentation Guidelines for Evaluation and Management Services

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GENERAL INFORMATION

DOCUMENTATION REQUIREMENTS

What Is Documentation and Why is it Important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.
- Communication and continuity of care among physicians and other health care professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "*hassles*" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

What Do Payers Want and Why?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:

    - reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
    - assessment, clinical impression or diagnosis;

- plan for care; and
- date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

A. Documentation of E/M Services

This publication provides definitions and documentation guidelines for the three ***key*** components of E/M services and for visits which consist predominately of counseling or coordination of care. The three key components—history, examination, and medical decision making—appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. **Documentation guidelines are identified by the symbol • DG.**

The descriptors for the levels of E/M services recognize seven components which 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; and
- time.

The first three of these components (i.e., history, examination and medical decision making) are the ***key*** components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (e.g., examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

B. Documentation of History

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief Complaint (CC); • Review of systems (ROS); and
- History of Present Illness (HPI); • Past, Family and/or Social History (PFSH).

The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The following chart shows the progression of the elements required for each type of history. To qualify for a given type of history **all three elements in the table must be met**. (A chief complaint is indicated at all levels.)

HISTORY REQUIRED ELEMENTS

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	**Problem Focused**
Brief	Problem Pertinent	N/A	**Expanded Problem Focused**
Extended	Extended	Pertinent	**Detailed**
Extended	Complete	Complete	**Comprehensive**

Note:

DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.

DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:

DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.

B1. Description of each History Elements

a. Chief Complaint (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words.

DG: The medical record should clearly reflect the chief complaint.

b. History of Present Illness (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location,
- quality,
- severity,
- duration,
- timing,
- context,
- modifying factors, and
- associated signs and symptoms.

Brief and ***extended*** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A ***brief*** HPI consists of one to three elements of the HPI

DG: The medical record should describe one to three elements of the present illness (HPI).

An ***extended*** HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

DG: The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions.

c. Review of Systems (ROS)

A ROS is 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.

- describing any new ROS and/or PFSH information or noting there has been no change in the information; and
- noting the date and location of the earlier ROS and/or PFSH.

For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

A ***problem pertinent*** ROS inquires about the system directly related to the problem(s) identified in the HPI.

DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.

An ***extended*** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

DG: The patient's positive responses and pertinent negatives for two to nine systems should be documented.

A ***complete*** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.

d. Past, Family and/or Social History (PFSH)

The PFSH consists of a review of three areas:

- past history (the patient's past experiences 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); and
- social history (an age appropriate review of past and current activities).

For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care CPT requires only an "interval history. It is not necessary to record information about the PFSH.

A ***pertinent*** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.

A ***complete*** PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services

DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient.

DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.

C. Documentation of Examination

The levels of E/M services are based on four types of examination that are defined as follows:

- ***Problem Focused*** — a limited examination of the affected body area or organ system.
- ***Expanded Problem Focused*** — a limited examination of the affected body area or organ system and other symptomatic or related body area(s) or organ system(s).
- ***Detailed*** — 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).
- ***Comprehensive*** — a general multi-system examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

A general multi-system examination or a single organ system examination may be performed by any physician regardless of specialty. The extent of examinations performed and documented is dependent upon clinical judgment, the patient's history, and the nature of the presenting problem(s). **Specific requirements for each level of exam are explained in detail on each exam sheet**.

The following single organ system exams are recognized:

- Cardiovascular
- Ears, Nose, Mouth and Throat
- Eyes
- Genitourinary (Female)
- Genitourinary (Male)
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.

DG: Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.

DG: A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

C1. Tools (score sheets) to document the exam

Examples of the score sheets for both the 95 version and the specialty exams for the 97 version are attached or can be found on Highmark's resource center. www.highmarkblueshield.com (click on Provider and then click on provider forms)

D. Documentation of the Complexity of Medical Decision Making

The levels of E/M services recognize four types of medical decision making straightforward, low complexity, moderate complexity and high complexity. Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered; the amount and/or complexity of medical records, diagnostic tests, and/or other
- information that must be obtained, reviewed and analyzed; and the risk of significant complications, morbidity and/or mortality, as well as
- comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The following chart shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded**.

Medical Decision Making Elements

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	**Straightforward**
Limited	Limited	Low	**Low Complexity**
Multiple	Moderate	Moderate	**Moderate Complexity**
Extensive	Extensive	High	**High Complexity**

D1. Description of the Elements for Medical Decision Making

a. Number of Diagnoses or Management Options

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

DG: 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.

- 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.

- 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.

DG: 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.

DG: 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.

b. Amount and/or Complexity of Data to be Reviewed

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

DG: 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.

DG: 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.

DG: 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.

DG: 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.

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

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

c. Risk of Significant Complications; Morbidity and/or Mortality

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

DG: 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.

DG: 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.

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

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

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is ***minimal, low, moderate,*** or ***high***. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. **The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.**

Table of Risk (common clinical examples)			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Options Selected**
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-ray • EKG/EEG • Urinalysis • Ultrasound, e.g., echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated Illness or injury, e.g. cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses. • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast. • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis. • Acute complicated injury, e.g., head injury with brief loss of consciousness.	• Physiologic tests under stress, e.g., 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, e.g., arteriogram, cardiac catheterization. • Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis.	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) no identified risk factors. • Prescription drug management. • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation.
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment. • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure. • An abrupt change in neurologic status, e.g., seizure, TIA, weakness, or sensory loss.	• Cardiovascular imaging studies with contrast with identified risk factors. • Cardiac electrophysiological tests. • Diagnostic Endoscopies with identified 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.

E. Documentation of an Encounter

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital or nursing facility); time is considered the key or controlling factor to qualify for a particular level of E/M service.

DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.

The documentation guidelines presented in this booklet will be used for review purposes and are applicable to all Highmark Blue Shield & Keystone Health Plan West (KHPW) programs.

These guidelines are according to the 1995 Documentation Guidelines for Evaluation and Management Services by Centers for Medicare & Medicaid Services (CMS).