

Commercial Reimbursement Policy	
Subject: Documentation and Reporting Guidelines for Evaluation and Management Services - Professional	
Policy Number: C-09007	Policy Section: Administration
Last Approval Date: 12/16/2020	Effective Date: 01/01/2021

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem Blue Cross and Blue Shield (Anthem) benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Our policies apply to both participating and non-participating professionals and facilities as indicated.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, [Anthem] may:

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

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. Anthem reserves the right to review and revise these policies periodically when necessary. When there is an update we will publish the most current policy to the website.

Policy

Anthem allows reimbursement for evaluation and management services under the following circumstances:

- Anthem follows the American Medical Association (AMA) Current Procedural Terminology (CPT) coding and guideline changes for office and outpatient evaluation and management services. Please reference the related coding section for CPT codes that apply.
- Anthem follows the CMS 2019 Final rule for relaxing redundant documentation for all evaluation and management services as follows:
 - For established patients, providers may choose to focus their documentation on what has changed since the last visit, when relevant information is already contained in the medical record, or on pertinent items that have not changed. Providers may choose not to re-record the defined list of required elements, if there is evidence that the practitioner reviewed the previous information and updated it as needed. Providers should still review prior data, update as necessary, and indicate in the medical record that they have done so.
 - For both new and established evaluation and management services, a chief complaint or patient history information, already entered into the record by ancillary staff or by members themselves may be reviewed and verified rather than re-entered. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

- For Other Evaluation and Management service, including Hospital Observation, Hospital Inpatient, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care Home, Anthem 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 other 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, Anthem requires medical records documentation include the signature of the individual who provided/ordered the services. The signature for each entry must be legible and should include the practitioner's first and last names and credentials. Anthem also requires that documentation of the reported service must be complete and legible.

I. History Component:

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

- Chief complaint or reason for the encounter (CC).
- History of Present Illness (HPI).
- Review of Systems (ROS).
- Past, family, and/or social history (PFSH).

II. Chief complaint (CC):

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

III. History of Present Illness (HPI):

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

For the CMS 1995 and 1997 guidelines, at least one of the eight elements must be documented as part of the brief HPI. Detailed and comprehensive history requires 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 guidelines for HPI need to reflect the medical necessity pertaining to the specific encounter throughout the chief complaint, exam, and medical decision-making. The eight elements included in the HPI are:

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

IV. Review of Systems (ROS):

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

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

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

For new patient and consultation visits, the patient’s signs and symptom information (ROS) must be completely documented, including a description of each system that was reviewed during the encounter. Established visits may use reference to a patient questionnaire. The ROS must be supported in the CC and HPI. Documenting “ROS negative” or “ROS noncontributory” is not acceptable. 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.

NOTE: If a provider changes physician group practices and has seen the patient within the past three years, it would NOT be considered a new patient visit. The E/M encounter is considered an established patient visit.

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

Documentation needs to support the medical necessity for the encounter. For example:

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

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

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

VI. Physical Examination:

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

Anthem 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.

B. 1997 Guidelines-Single Organ System Examinations:

Anthem 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.

C. Medical Decision Making (MDM):

Medical decision-making is based on the patient’s clinical condition at the time of the specific visit. The patient’s medical record must include the following:

- For each encounter, an assessment, clinical impression, and/or diagnosis must be documented. The assessment, clinical impression, and/or diagnosis may be explicitly stated or implied in the documented decisions regarding management plans and/or further evaluation.
- The presenting problems need to be addressed in the history, physical examination, and MDM components. For a presenting problem with an established diagnosis, the record should reflect whether:
 - the problem (s) is improved, well controlled, resolving, or resolved; or
 - inadequately controlled, worsening, or failing to change as expected.
 - For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnosis or as a possible, probable, or “rule out” diagnosis.
- The initiation of/or change in treatment must be documented.
- If referrals are made, consultations requested, or advice sought, the record must indicate to whom or where the referral or consultation is made, or from whom advice is requested.
- If diagnostic services (tests or procedures) are ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service (e.g., lab; x-ray) must be documented.
- The review of lab, radiology, and/or diagnostic tests must be documented. A simple notation such as “WBC elevated” or “chest x-ray unremarkable” is acceptable; or the review may be documented by the provider initialing and dating the report containing the test results.
- Relevant findings from the review of old records and/or receipt of additional history from the family, caretaker, or other source to supplement the information obtained from the patient must be documented. If there is no relevant information beyond that already obtained, that fact should be documented; a notation of “old records reviewed” or “additional history obtained from family” without elaboration is insufficient.

Anthem follows CPT coding guidelines for a new patient evaluation and management 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, Anthem’s position is that the complexity of the presenting complaint and medical decision making should generally align with the complexity of the patient history and physical examination. For purposes of medical record audits of E/M coding levels, Anthem expects that the medical records will reflect that the medical decision making component is aligned with the complexity of the patient history and examination. Anthem will consider medical decision making as one of the parameters in determining whether upcoding has occurred when auditing E/M coding outliers.

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

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

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

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

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 describes specific point value information. In order for an E/M service to be assigned a particular medical decision making level, the service must score at or above that level in two out of the three categories.

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

Anthem 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.

Risk Level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal (straight forward)	> One self-limited or minor problem (e.g. cold, insect bite, tinea corporis)	> Lab test requiring: <ul style="list-style-type: none"> • Venipuncture • Chest x-ray • EKG/EEG • Urinalysis • Ultrasound/Echo • KOH prep 	> Rest > Gargles > Elastic Bandages > Superficial dressings
Low	> Two or more self limited or minor problems > One stable chronic condition illness (e.g. HTN, DM, Cataracts, BPH) > Acute uncomplicated illness or injury (e.g. sprain, cystitis, rhinitis)	> Physiological test not under stress (PFT) > Non-cardiovascular imaging studies with contrast (barium enema, CT) > Sleep studies > Superficial needle biopsy arterial puncture > Skin biopsy	> Over the counter drugs > Minor surgery with no identified risk factor > PT/OT,ST > IV fluids without additives > Prescription drug management – maintenance phase (i.e., no change in prescriptions or dosage)
Moderate	> One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment > Two or more stable chronic conditions > Undiagnosed new problem with uncertain prognosis (e.g. lump in breast) > Acute illness with systemic symptoms (e.g. pneumonitis, colitis, pyelonephritis) > Acute complicated injury (e.g. head injury with brief loss of consciousness)	> Physiological tests under stress (eg: cardiac stress test, fetal contraction stress test) > Diagnostic endoscopies with no identified risk factors > Deep needle or incisional biopsy > Cardiovascular imaging studies with contrast and no identified risk factors (eg arteriogram, cardiac catheterization) > Obtain fluids from body cavity (eg L.P), thoracentesis	> Minor surgery with identified risk factors > Elective major surgery (open, percutaneous, or endoscopic) with no risk identified risk factors > Prescription drug management (i.e., new medication prescribed for patient or a change in dosage for an existing medication; takes into account other medications the patient is currently taking) > Therapeutic nuclear medicine > IV fluids with additives > Closed treatment of fracture or dislocation without manipulation

Risk Level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
High	<ul style="list-style-type: none"> > One or more chronic illnesses with severe exacerbation, progression or side effects of treatment > Acute or chronic illnesses or injuries that pose a threat to life or bodily function (e.g. multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, suicidal with potential threat to self or other, peritonitis or acute renal failure) > Abrupt change in neurological status (e.g. seizure, TIA, weakness, sensory loss) 	<ul style="list-style-type: none"> > Cardiovascular imaging studies with contrast with identified risk factors > Cardiac electrophysiological tests > Diagnostic endoscopies with risk factors > Discography 	<ul style="list-style-type: none"> > 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

VII. 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 Anthem 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.

Related Coding

Office and Outpatient Evaluation and Management Codes	Office and Outpatient Evaluation and Management Codes
Standard correct coding applies	

Exemptions

There are no exemptions to this policy.

Policy History

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

12/16/2020	Update approved and effective 01/01/2021: Added language adopting 2021 AMA, CPT code changes; moved section for relaxing CMS documentation requirements to include all E/M services; updated definition section
09/14/2020	Biennial review approved and effective; policy updated with minor administrative changes including language relaxing documentation requirements according to the CMS 2019 Final Rule
06/01/2019	Policy template updated; removed coding section, description section and added definitions
07/13/2018	Policy language updated; Effective 01/01/2019. Language added to describe an established patient when a provider changes group practices.
09/06/2016	Revision under section 3 regarding Medical Decision Making (MDM); we no longer require MDM to be one of the key components of an established E/M but expect the MDM align with the complexity of the history and physical examination (HPE).
10/06/2015	Policy language updated to clarify that our language is based on CPT guidelines
10/07/2014	Annual Review approved; Policy language reformatted
12/03/2013	Annual Review approved; Policy language updated; Minor updates to punctuation and wording and added the definition to define new vs. established patient:
12/04/2012	Policy language updated; Added language regarding signature on medical records top of pg. 3
09/13/2011	Policy language updated; Policy Section II (pg. 4) clarified that documentation of a physical exam is required for an est. visit only if that key component is chosen. Policy Section IV language was also clarified that typically the 2/3 key component are used, but time may be used for visit level.
01/01/2011	Policy language updated; Three new 2011 observation codes (99224-99226) which require key components for determining an E/M level were added to the coding section of this policy; The short coding for time statement on the bottom of Page 2 was deleted and a new policy section IV Counseling and Coordination of Care was added
11/02/2010	Policy language updated; The short coding for time statement on the bottom of Page 2 was deleted and a new policy section IV Counseling and Coordination of Care was added
04/06/2010	Policy language updated Coding section expanded to include all codes requiring 2-3 key components
08/04/2009	Initial policy approval and effective

References and Research Materials

<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> • AMA Current Procedural Terminology (CPT®) 2021 Professional • Centers for Medicare and Medicaid Services (CMS) • CMS 2019 Final Rule • 1995 and 1997 Documentation Guidelines for E&M Services

Definitions

Chief Complaint (CC)	A concise statement describing the symptoms, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s words and documented in the medical record
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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)
Counseling	A conversation with the patient and/or the family/patient's guardian concerning test results, treatment, education, etc.
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
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
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
Medical Decision Making (MDM)	The complexity of establishing a diagnosis and/or selecting a management option, as measured by the following documentation: <ul style="list-style-type: none"> 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. <p>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.</p>
Past History	A review of the patient's past experiences with illnesses, operations, injuries and treatments
Professional Services	Face-to-face services rendered by physicians or other qualified health care professional who may report E/M services within the same group practice and of the exact same specialty and subspecialty
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
General Reimbursement Policy Definitions	

Related Policies and Materials

Documentation Standards For Episodes of Care

Prolonged Services

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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