Commercial Reimbursement Policy

Subject: **Documentation and Reporting Guidelines for Evaluation and Management Services – Professional**	
Policy Number: **C-09007**	Policy Section: **Administration**
Last Approval Date: **09/14/2023**	Effective Date: **09/14/2023**

Disclaimer

These reimbursement 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 an Anthem Blue Cross (Anthem) member's 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. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. 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. We reserve the right to review and revise these policies when necessary. When there is an update, Anthem will publish the most current policy to the website.

Policy

The Health Plan allows reimbursement for evaluation and management (E/M) services when properly billed as described in this policy, unless provider, state, or federal contracts and/or mandates indicate otherwise.

For office and other outpatient E/M services and for other E/M services (including inpatient and observation visits, emergency department visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment), The Health Plan follows CMS guidelines for documentation and determination of service level, except:

- for split/shared services and consultation services criteria
- where this or other reimbursement policy differs

Note: All documents are subject to the Documentation Standards for Episodes of Care policy.

I. Documentation Requirements for the Use of Time

As described by CMS, time alone may be used to select a code level for certain E/M services. When time is used for reporting E/M codes, documentation must:

- Provide an exact time of service, rather than an approximate range of time, that is supported in the medical record
- Support the medical appropriateness of the visit
  - The summary should not just be a list of allowed elements, but instead a description of individual activities performed for that specific encounter.
  - A description of activities performed during the stated time must be documented.

Note: if the documentation requirements are not met for the use of time in establishing the level of service, then the claim will be evaluated using Medical Decision-Making (MDM) criteria.

II. Medical Decision-Making (MDM)

For services billed using MDM, documentation should reflect the appropriateness of the billed service code, as described by The Health Plan below.

A. Documentation Requirements

MDM 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.

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

The Health Plan uses the 2021 AMA CPT® Level of MDM Table to quantify the complexity of problems addressed, complexity of data to be reviewed and analyzed, and risk of complications and/or morbidity and mortality to determine the appropriate level of E/M service to select.

Related Coding	
Office-and-Other-Outpatient and Other E/M Codes	Office-and-Other-Outpatient and Other E/M Codes

Policy History	
09/14/2023	Review approved and effective: updated policy language to follow CMS guidelines (including changes detailed in the 2023 CMS Final Rule and selecting a level of MDM based on the 2021 AMA CPT® Level of MDM Table); added language specifying the documentation requirements when using time to determine service level; now allow “other” E/M services to be determined using time; related code list updated to include “other” E/M services
12/16/2020	Review approved 12/16/2020 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	Review approved: policy updated with minor administrative changes including language relaxing documentation requirements according to the CMS 2019 Final Rule
09/01/2019	Policy template updated

06/01/2019	Revised: policy template updated; removed coding section, description section and added definitions
07/13/2018	Review approved 07/13/2018 and effective 01/01/2019: policy language updated; 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	Review approved: policy language updated to clarify that our language is based on CPT® guidelines
10/07/2014	Review approved: policy language reformatted
12/03/2013	Review approved: policy language updated; minor updates to punctuation and wording; added the definition to define new vs. established patient
12/04/2012	Revised: added language regarding signature on medical records
09/13/2011	Revised: policy language updated to clarify that documentation of a physical exam is required for an est. visit only if that key component is chosen; policy language updated to clarify that the 2/3 key components are typically used, but time may be used for visit level
01/01/2011	Revised: 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 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 was deleted and a new policy section 'IV Counseling and Coordination of Care' was added
04/06/2010	Revised: policy language updated; coding section expanded to include all codes requiring 2-3 key components
08/04/2009	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
  - CMS Final Rule, 2023 (87 FR 69404)
  - CMS Medicare Learning Network (MLN)
  - 1995 and 1997 Documentation Guidelines for E/M Services
- Optum EncoderPro, 2022
  - Current Procedural Coding Expert: AMA CPT® Evaluation and Management (E/M) Services Guidelines

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
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)
Encounter	Record of a medically related service (or visit) rendered by a provider to a beneficiary who is enrolled in a participating health plan during the date of service; it includes, but is not limited to, all services for which the health plan incurred any financial responsibility
Episode of care	A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition
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**:** • 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. • 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
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 – Professional
Prolonged Services – Professional

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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