Payment Policy: High Complexity Medical Decision-Making

Reference Number: CC.PP.051
Product Types: ALL
Effective Date: 6/2017
Last Review Date: 3/1/2024

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

There are sections of the Evaluation and Management (E/M) Services that are applicable to all E/M categories, and there are sections that have special significance to a particular category. The AMA Current Procedural Terminology (CPT) book lists categories in addition to subcategories of special services together with section-specific criteria.

In E/M section of CPT includes codes that range from 99202-99499. Each category may have specific guidelines or codes that apply to that area, with specific details to outline requirements for code selection, based on the providers documentation.

The criteria for code selection are not the same as the documentation of E/M service requirements. The reporting physician or any authorized healthcare provider is responsible for using and applying the rules for choosing a code. Documentation in the medical record has two purposes: it supports the patient's care provided by the treating physician and gives other physicians who are treating the patient now or in the future access to the patient's medical history and specifics of their treatment.

The basic format of codes with levels of E/M services are based on Medical Decision Making (MDM) or time will look the same. The place of service type is defined by the location where the face-to-face encounter with the patient and/or family or caregiver occur.

Prior to 2021, the code selection for an E/M service was based upon seven components pertinent to the patient's encounter with the provider: 1) history, 2) examination, 3) medical decision making, 4) counseling, 5) coordination of care, 6) nature of presenting problem, and/or 7) time. Medical decision making is based upon the physician's complexity of establishing a diagnosis and/or selection of options to manage the patient's health.

Starting on Jan. 1, 2021, AMA and CMS updated most E/M visit families to choose the visit level based on the level of MDM or the amount of time spent with the patient. The Health Plan follows the guidance of AMA and CMS for code selection. The purpose of this policy is to discuss the appropriate assignment of moderate to high complexity E/M services, with MDM as the key component of the assignment process. To bill for any code, the services provided must meet the definition of the code. The codes must reflect the services you are providing and documenting.

E/M services are assigned based on the medical appropriateness/necessity of the physician-patient encounter and must meet the specific requirements of the Current Procedural Terminology (CPT) code billed on the claim. Physicians should not submit a CPT code for a

higher intensity E/M service if the circumstances surrounding the physician-patient encounter do not support medical decision making of moderate to high complexity. Medical necessity is the primary reason CMS recommends payment for services.

Application

The policy is to be used and applied by the reporting physician or other qualified healthcare professional for code selection for services that are provided in:

- Office and Other outpatient services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Visits
- Nursing Facility Services
- Domiciliary Services
- Home or Residence Services

Policy Description

In 2012, the Office of Inspector General (OIG) reported in their article, *"OIG, Coding trends of Medicare Evaluation and Management Services"* that from 2001 to 2010, physicians increased billing of higher-level E/M services. Consequently, higher level E/M services are reimbursed at a higher level of reimbursement. Furthermore, the report revealed that E/M services are 50% more likely to be paid in error due to miscoding and/or coding errors.

As a result of this study, the OIG determined that 26% of Medicare claims reviewed were billed with a higher intensity E/M code than supported by the medical documentation.

Medical decision-making is a key component necessary to assign the appropriate level of E/M visit type. There are four acknowledged forms of MDM:

- Straightforward
- Low
- Moderate
- High

Medical decision making is defined by the complexity of a physician's work that is necessary to establish a diagnosis and/or to select a healthcare management option. When determining the level of E/M service to assign, the physician must consider the MDM Elements listed below:

1) The number and complexity of the problem(s) addressed during the encounter
2) The amount and/or complexity of medical records, diagnostic testing or any other information that must be reviewed, evaluated, and analyzed
3) The risk of complications and/or morbidity or mortality of patient management

To qualify for a level of care based on MDM, two of the three elements must be met, or exceeded for that level of MDM selection.

The following chart, used for determination of MDM, includes the four levels of care (straightforward, low, moderate, and high) along with the 3 elements used when code selection is based on MDM.

Table 1.

Number & Complexity of Diagnoses addressed at the encounter	Amount and/or complexity of data to be reviewed & analyzed	Risk of complications and/or morbidity or mortality of Patient Management	Level of Care (MDM) using 2 of the 3 Elements
Minimal	Minimal or None	Minimal	***Straightforward***
Low	Limited	Low	***Low***
Moderate	Moderate	Moderate	***Moderate***
High	Extensive	High	***High***

Level of Care Based on Time

Time is used differently in some time-based E/M code categories (such as Critical Care Services) that do not contain MDM-based service levels in the E/M section. It is crucial to look over the guidelines for every category. When code selection is based on time, the time listed must be met or exceeded for the date of the encounter.

When choosing an E/M service code based on time, the right level of services is chosen using the time specified in the service descriptors. Time for these services is the entire duration on the encounter date for coding purposes.

Time is defined as the total billing practitioner time spent, including non-face-to-face work done on that day. The nature of the work must require practitioner knowledge and expertise. Time includes any of the activities, when provided:

- Preparing to see the patient (review of tests)
- Obtaining and/or reviewing separately obtained history
- Preforming a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not reported separately)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not billed separately) and communicating results to the patient/family/caregiver
- Care coordination (not billed separately)

Time does not include travel, instruction that is broad and does not just focus on the conversation needed to care a particular patient, and services that can be billed separately.

The following chart can be used for determination of coding based on the total time on the date of encounter for New or Established patients.

Table 2.

Code	Time to Meet or Exceed	Code Description
99202	15 minutes	Office or other outpatient visit, New patient, straightforward MDM, 15 min.
99203	30 minutes	Office or other outpatient visit, New patient, low MDM, 30 min.
99204	45 minutes	Office or other outpatient visit, New patient, moderate MDM, 45 min.
99205	60 minutes	Office or other outpatient visit, New patient, high MDM, 60 min.
99212	10 minutes	Office or other outpatient visit, Established patient, straightforward MDM, 10 min.
99213	20 minutes	Office or other outpatient visit, Established patient, low MDM, 20 min.
99214	30 minutes	Office or other outpatient visit, Established patient, moderate MDM, 30 min.
99215	40 minutes	Office or other outpatient visit, Established patient, high MDM, 40 min.

Reimbursement

Payers expect that a provider who bills a high intensity E/M service is either treating a very ill patient or the physician was required to review an extensive amount of clinical data to determine the best health management option. To ensure proper reimbursement when billing high intensity E/M codes, providers must show documentation that supports medical necessity and:

1. An extensive number of diagnoses or management options reviewed
2. An extensive amount and/or complexity of data reviewed
3. High risk of complications and/or morbidity and mortality

Providers who do not adhere to the requirements above may experience a delay in claims payment, a disallowance of payment related to a request for additional information from the provider, and/or a request to review additional medical records for medical necessity or post payment medical record review.

Documentation Requirements

Number of Diagnoses and/or Health Management Options

This is based on the number and types of problems addressed during the patient encounter, the difficulty in establishing a diagnosis and the complexity of health management decisions made by the provider.

For each patient encounter documentation should include:

1. An assessment, clinical impression, or diagnosis

2. If the patient presents with an established diagnosis, documentation must include whether or not the condition is improved, well controlled, resolving, resolved, inadequately controlled, worsening or failing to improve.
3. If the patient presents with a problem without a diagnosis, the provider should document their clinical impression in the form of a "possible," "probable," or "rule out" diagnoses.
4. Initiation of a treatment plan or changes in the treatment plan.
5. If a referral or consultation is sought, the physician should document to whom or where the consultation is made or from whom the consultation was requested.

Document the Amount and/or Complexity of Data to Be Reviewed

Providers should base documentation on the types of diagnostic testing ordered and reviewed. Obtaining old medical records and history from sources other than the patient increase the amount of complexity and data reviewed.

For each patient encounter documentation should include:

1. Diagnostic tests or services that were ordered, performed, planned or scheduled during the E/M encounter.
2. Review of any diagnostic tests or services performed. Medical records should clearly support that the tests were reviewed.
3. Determination to obtain old medical records or seek health information from someone other than the patient.
4. Significant findings from old medical records and/or receipt of additional history from the family
5. The results of discussion diagnostic testing with another physician who performed the testing.
6. Direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician.

Risk of Complications, Morbidity and/or Mortality

When determining the risks of complications, morbidity or mortality, the physician must assess the risks associated with the presenting problems, diagnostic procedures, and the possible health management options.

For each patient encounter, documentation should include:

1. Comorbidities/underlying diseases contribute to the risk of complications, morbidity, and mortality. This increases the complexity of medical decision making.
2. Documentation of provider orders, scheduling or planning a surgical or invasive procedure at the time of the E/M visit, including the type of procedure.
3. Documentation of any surgical or invasive diagnostic procedures performed at the time of the E/M encounter.
4. The referral for or a decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

Provider Documentation

When documenting the medical visit, physicians must ensure that the medical record documentation is:

1. Intelligible - The medical record should include the date and legible identity of the physician who furnished the service.
2. Concise - The care the patient received and related, facts, findings, and observations about the patient's health history.
3. Supports the medical necessity reason for the visit and the level of E/M service billed.
4. The medical record must be complete.

Medical Record Authentication
The health plan requires that services provided to the member must be authenticated by the author of the medical record. Medical records must be signed prior to submission of the claim. The signature must be handwritten or electronically signed.

Providers who do not adhere to the requirements above, may experience a delay in claims payment, a disallowance of payment for a service or claims may be subject to a post payment medical record review.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Definitions

Evaluation and Management (E/M)
Physician-patient encounters that are translated into five-digit CPT codes for billing purposes. Different E/M codes exist for different patient encounters such as office visits, hospital visits, home visits etc. Each patient encounter has different levels of care. For example, Hospital Inpatient and Observation Care Services has three levels of care for this encounter (99221, 99222 and 99223).

Office of Inspector General (OIG)
The largest inspector general's office in the Federal Government dedicated to combating fraud, waste, and abuse.

Additional Information
https://oig.hhs.gov/oei/reports/oei-04-10-00181.pdf

Internal Related Documents and/or Resources

Policy Number	Policy
CC.PP.021	Clean Claims
CC.PP.066	Leveling of Care: Evaluation & Management Over coding

References

1. *Current Procedural Terminology (CPT)®*, 2024
2. *HCPCS Level II*, 2024
3. *https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf*
4. OIG May 2014, "*Improper Payments for Evaluation and Management Services Costs Medicare Billions in 2010*" https://oig.hhs.gov/oei/reports/oei-04-10-00181.pdf
5. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Revision History	
04/26/2017	Initial Policy Draft Created
08/07/2017	Corrected code in levels of care
04/24/209	Conducted review and updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
01/01/2021	Addition of new E/M documentation guidelines for 99202-99215
11/30/2021	Annual review completed; no major updates required
12/01/2022	Annual review completed; code list removed as this information can be referenced in the current CPT manual
11/13/2023	Annual review completed, no major updates to the policy. Reviewed and updated dates from 2022 to 2023
3/1/2024	Annual review completed; updated E/M Guidelines to match new AMA & CMS Guidance; Included AMA & CMS links for reference of policy.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage,

certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.