Payment Policy: High Complexity Medical Decision-Making

Reference Number: LA.PP.051
Product Types: ALL
Effective Date: 08/2020
Date of Last Revision: 7/2023

Coding Implications
Revision Log

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

Policy Overview
The selection of an appropriate Evaluation and Management Service (E&M) is 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 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.

Three of these components-- the patient's history, physical examination and medical decision-making are the most important factors in determining the correct level of E&M service that a provider should bill for any given patient encounter. The remaining four components are considered contributing elements.

The purpose of this policy is to discuss the appropriate assignment of moderate to high complexity E&M services with an emphasis on medical decision making as a key component of the assignment process.

Application
Physician and non-physician practitioners who provide:

- Office and other outpatient services
- Hospital observation
- Inpatient services
- Consultations
- Emergency Department Visits
- Nursing Facility Services
- Domiciliary Services
- Home 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 as a result of miscoding 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 types of medical-decision making:

- Straight-forward
- Low complexity
- Moderate complexity
- High complexity

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 1) the number of possible diagnoses or health management options, 2) the amount or the complexity of medical records, diagnostic testing or any other information that must be reviewed and evaluated, and 3) the risk of complications, morbidity and/or mortality.

The following chart describes each of the four types of medical-decision making listed above:

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*

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.

Beginning 1/1/2021, for office/outpatient visit codes 99202-99205 and 99212-99215 only, the appropriate level of E/M services may be selected based on either of the following:

1. The level of medical decision making as defined for each service; or
2. The total time for E/M services performed on the date of the encounter

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.

Code	Time Range
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes

99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

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/enrollee 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.

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 and etc. Each patient encounter has different levels of care. For example, Initial Hospital Care 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

Related Documents or Resources

Policy Number	Policy
LA.PP.021	Clean Claims

References

1. *Current Procedural Terminology (CPT)*®, 2022
2. *HCPCS Level II*, 2022
3. *Centers for Medicare and Medicaid Services*
4. Levinson, D.R., (2014). Improper payments for evaluation and management services costs Medicare billions in 2010. *Department of Health and Human Services Office of Inspector General.* 1-41. OEI-04-10-00181

Revision History	Revision Date	Approval Date
Converted corporate to local policy.	03/21	
Annual Review; Addition of new E/M documentation guidelines for 99202-99215 Dates updated in the reference section from 2019 to 2021 Removed clinical and added payment policy in "Important Reminder" section"	08/22	
Annual review; code list removed as this information can be referenced in the current CPT manual; reference dates updated. Changed member to member/enrollee	07/2023	9/25/23

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions 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 LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. 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. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical 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/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to an actual signature on paper.