Payment Policy: High Complexity Medical Decision-Making

Reference Number: LA.PP.051
Product Types: ALL
Effective Date: 08/2020
Last Review Date: 03/2021

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.

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 2019, 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.

CPT/HCPCS Code	COMPLEXITY LEVEL	Descriptor
99204	Medium-High	New Patient Office/Outpatient Visit
99205	High	New Patient Office/Outpatient Visit
99214	Medium-High	Established Patient Office/Outpatient Visit
99215	High	Established Patient Office/Outpatient Visit
99219	Medium	Initial Observation Care

CPT/HCPCS Code	COMPLEXITY LEVEL	Descriptor
99220	High	Initial Observation Care
99222	Medium	Initial Inpatient Hospital Care
99223	High	Initial Inpatient Hospital Care
99225	Medium	Subsequent Observation Care
99226	High	Subsequent Observation Care
99232	Medium	Subsequent Inpatient Hospital Care
99233	High	Subsequent Inpatient Hospital Care
99235	Medium	Observation or Inpatient Hospital Care
99236	High	Observation or Inpatient Hospital Care
99244	Medium	Office Consultation
99245	High	Office Consultation
99254	Medium	Inpatient Consultation New or Established
99255	High	Inpatient Consultation New or Established
99284	Medium-High	Emergency Department Visit
99285	High	Emergency Department Visit
99305	Medium	Initial Nursing Facility Care
99306	High	Initial Nursing Facility Care
99309	Medium-High	Subsequent Nursing Facility Care
99310	High	Subsequent Nursing Facility Care
99327	Medium-High	Domiciliary, Rest Home or Custodial Care
99328	High	Domiciliary, Rest Home or Custodial Care
99336	Medium-High	Domiciliary, Rest Home or Custodial Care
99337	High	Domiciliary, Rest Home or Custodial Care
99344	Medium-High	Home Services New Patient
99345	High	Home Services New Patient
99349	Medium-High	Home Services Established Patient
99350	High	Home Services Established Patient

Modifier	Descriptor
NA	NA

ICD-10 Codes	Descriptor
NA	NA

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
CC.PP.021	Clean Claims

References
1. *Current Procedural Terminology (CPT)®*, 2019
2. *HCPCS Level II*, 2019
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	
03/21	Converted corporate to local policy.

Important Reminder
This clinical 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 clinical 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 clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical 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 clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical 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 clinical 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 clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical 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 clinical 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 clinical 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.

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