# Payment Policy: High Complexity Medical Decision-Making

Reference Number: CC.PP.051
Product Types: ALL
Effective Date: 6/2017
Last Review Date: 07/10/2018

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. That said, physician's should not submit a CPT code for a higher intensity E&M service, when 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 were reviewed
2. An extensive amount and/or complexity of data was reviewed
3. There is a 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, or a disallowance of payment related to a request for additional information from the

provider, the need 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. The review of such diagnostic tests should also be documented. The medical records should clearly support that the tests were reviewed.
3. If the physician decides 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. If the provider orders, schedules or plans a surgical or invasive procedure at the time of the E&M visit, this should be documented and the type of procedure should be included.
3. If the provider performs a surgical or invasive diagnostic procedure at the time of the E&M encounter, this should be documented.
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 medial 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 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current 2017 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 |

| CPT/HCPCS Code | COMPLEXITY LEVEL | Descriptor |
|---|---|---|
| 99214 | Medium-High | Established Patient Office/Outpatient Visit |
| 99215 | High | Established Patient Office/Outpatient Visit |
| 99219 | Medium | Initial Observation Care |
| 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)*®, 2017
2. *HCPCS Level II*, 2017
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 | |
|---|---|
| 04/26/2017 | Initial Policy Draft Created |
| 08/07/2017 | Corrected code in levels of care |
| 07/10/2018 | Conducted Annual review |

**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.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.