

## E&M Billing Guidance

### General Principles

There are general principles of medical record documentation that are applicable to all types of medical and surgical services in all settings. While E/M services vary in several ways, such as the nature and amount of physician work required, the following general principles help ensure that medical record documentation for all E/M services is appropriate:

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
  - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results
  - Assessment, clinical impression or diagnosis
  - Medical plan of care
  - Date and legible signature with credentials (initials if included by agency policy) of the provider.
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

**Chief Complaint (CC):** The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter. The provider seeks to address the client's CC during the course of the evaluation and management visit. The medical record should clearly reflect the chief complaint.

**Chief Complaint Use of 'Follow-Up':** The medical record must clearly reflect the chief complaint. Do not use the term 'Follow-up or F/U' without expanding upon the reason for the follow-up. For example, the provider could write, "Follow-up bilateral Otitis Media".

Completing the documentation of an encounter should be done within two days. However, we strongly encourage all health care providers to enter information into the patient's medical record at the time the service is provided to the patient; that is, contemporaneously. (PHNPD recommends that documentation be completed during the visit or immediately after, or no more than 2 days following a visit.)

Please see CMS Documentation Guidelines for Evaluation and Management Services on the [CMS website](#) for more information.

### Evaluation and Management Guidelines

Two sets of E&M (Evaluation and Management) guidelines are available: 1995 Guidelines for Evaluation and Management Services and 1997 Guidelines for Evaluation and Management Services. Use these guidelines to learn more about the specific steps for determining the levels for the key components and their respective elements.

- Neither set of guidelines is better. A physician or practitioner may use either set of guidelines to determine the appropriate code level for the E&M services provided.
- For each separate E&M service, you must use only one set of E&M guidelines throughout the code determination process. Mixing or combining the two sets of guidelines for a single E&M encounter is not acceptable.

## **E&M Service Components**

An E&M Service recognizes seven components that are used in defining the levels of E&M services. These components are:

1. **History** (History includes HPI, ROS and PFSH)
  - HPI = History of Present Illness
  - ROS = Review of Systems
  - PFSH = Personal, Family and Social History
2. **Examination**
3. **Medical Decision Making**
4. Nature of Presenting Problem
5. Counseling
6. Coordination of Care
7. Time

The first three components (**History, Examination, and Medical Decision Making**) are the components used in setting the level of service. An exception to this rule is the case of visits that consist predominantly (more than 50%) of counseling or coordination of care. For these visits, time is the key controlling factor to qualify for a particular level of E&M services. (Please see, "Documentation by Time" below for specific information about billing by time.)

Only the physician or midlevel provider conducting the E&M service can record the HPI. The HPI, Exam and Medical Decision Making are considered physician/provider work. In some cases the office/clinic nurse may document preliminary information concerning the CC (Chief Complaint) or HPI, but this is to be considered preliminary. The provider must document that he/she reviewed the CC/HPI in greater detail.

If ancillary staff is present while the provider is gathering further information related to the patient's visit (e.g., the three key components), he/she may document (scribe) what is dictated and performed by the physician or non-physician practitioner. The physician or non-physician provider must verify that the transcribed documentation is accurate and complete. Transcribed documentation must contain the provider's signature with credentials and the transcriptionist's signature and credentials. All record entries must be dated.

Medicare and Medicaid require that services provided/ordered must be authenticated by the author. The signature for each entry must be legible, and include the practitioner's first and last name. The practitioner's credentials should follow the signature. Initials are only allowed under the following circumstances:

1. over a typed printed name.
2. accompanied by a signature log or attestation statement.

Each entry to the record for a specific date and chief complaint must be specific to the client for that date of service. Cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. Documentation must support the level of service reported.

When the physician or qualified non-physician practitioner (NPP), provides a significant, separately identifiable medically necessary E/M service in addition to the Initial Preventative Physical Examination (IPPE) or an Annual Wellness Visit (AWV), CPT codes 99201 – 99215 may be reported depending on the clinical appropriateness of the circumstances using the appropriate modifier.

Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the Initial Preventative Physical Examination (IPPE) or an Annual Wellness

Visit (AWV) and should not be included when determining the most appropriate level of E/M service to be submitted for the medically necessary, separately identifiable, E/M service.

### **Documentation by Time:**

If the physician documents total time *and* suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

If the answers to the following three questions are all “yes” then the physician/provider may select the visit level based on time.

1. Does documentation reveal total face to face time of the visit?
2. Does documentation describe the content of the counseling or the coordination of care provided?
3. Does documentation reveal that more than half of the time was used counseling the client or coordination of the client's times?

**When the answer to any of these questions is “no,” then the physician/provider can not use time to set the visit level.**

### **History**

The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented for E/M services is dependent upon clinical judgment and the nature of the presenting problem(s).

The ROS and PFSH can be recorded by ancillary staff, or can be recorded on a form by the patient. There must be a notation supplementing or confirming the information recorded by ancillary staff or the patient to document that the provider reviewed the information. (“Reviewed” and then signed by the provider is NOT adequate. The provider must supplement or confirm the information by adding to, clarifying or verifying the information provided.)

Brief and extended HPI is distinguished by the amount of detail needed to accurately characterize the clinical problems. A brief HPI consists of 1 to 3 elements. An extended HPI consists of at least 4 elements. The CC may be listed as a separate element of the history or it may be included in the HPI description.

**Interval' history:** History refers to the past, family and social history (PFSH) portion of an E/M service. Interval refers to the time between the client's last visit and the current visit. An interval history requires that updates be made to the client's record regarding any additions or changes to the client's previously documented medical, family or social history that occurred between the last and current visits. Updates made must be relevant to the chief complaint for them to be counted toward setting the billing level for the visit.

The Review of Systems (ROS) refers to signs and/or symptoms that the patient may be experiencing or has experienced, not a list of diagnoses (i.e., denies CHF (chronic heart failure), diabetes, etc.). The review of systems must be relevant to the chief complaint.

If the patient can not provide information to complete the history elements the documentation must clearly reflect:

1. Why the HPI, ROS, and PFSH was unobtainable (severely demented, sedated on a vent, etc.).
2. If the provider uses the verbiage, ‘poor’ historian, the documentation must support why (severely demented)
3. No family members were present to provide information
4. Unable to obtain information from medical record (chart, ambulance run sheet, etc.)

If patient or family can provide information at a later time, the provider may add an addendum containing information.

**1997 Guidelines Use of Status of Three Chronic/Inactive Conditions for extended HPI:** Under the 1997 E/M Guidelines , an extended History of Present Illness (HPI) may consist of the status of three chronic/inactive conditions.

## **Examination**

Examination data may be recorded by body area(s) or by organ system(s). In setting the level for the visit the provider may only consider the number of body areas or the number of organ system(s) recorded not both.

**Abnormal Findings:** Specific abnormal and relevant negative examination findings of the affected/symptomatic body area(s) or organ system(s) must be documented. A notation of 'abnormal' without elaboration is not sufficient.

**1995 Guidance regarding Examination-Constitutional:** The measurement of at least three vital signs (sitting or standing blood pressure, supine blood pressure, pulse rate and regularity, respiration, temperature, height and weight) or the patient's general appearance must be documented in order to receive 'credit' for 'constitutional,' under the 1995 'organ systems.'

**Use of “Normal”:** A brief statement or notation indicating 'negative' or 'normal' is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

## **Medical Decision Making**

The levels of evaluation and management (E/M) services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- Number of possible diagnoses and/or the number of management options that must be considered.
- Amount and/or complexity of medical records, diagnostic tests and/or other information that must be obtained, reviewed and analyzed.
- Risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The review of lab, radiology or other diagnostic tests must be documented in order for that review to be considered in establishing the appropriate level of visit for billing. An entry in the progress note such as, “WBC elevated” or “Chest x-ray unremarkable” is acceptable. Alternatively the review may be documented by initialing and dating the report containing the test results.

**Independent Review of Image, Tracing or Specimen:** When a provider 'independently reviews an image, tracing or specimen,' the documentation must clearly indicate you personally performed the service and your specific findings.

**Diagnosis/Management Options:** The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

**If you receive a denial or down code based on medical necessity,** it is important to review the documentation submitted along with the E/M guidelines to determine the reason/cause for the denial. If you do not agree with the denial/down code you may appeal the service(s) within 120 days from the date of the initial determination.

### **Reminder:**

Documentation should not be added to meet billing requirements. For further information regarding entries in medical records (amendments, corrections and addenda) please visit the [CMS Program Integrity Manual \(Pub. 100-08\)](#) (PDF, 458 KB), Chapter 3, Section 3.3.2.5. (See below)

### **A. Amendments, Corrections and Delayed Entries in Medical Documentation**

Providers are encouraged to enter all relevant documents and entries into the medical record at the time they are rendering the service. Occasionally, upon review a provider may discover that certain entries, related to actions that were actually performed at the time of service but not properly documented, need to be amended, corrected, or entered after rendering the service. When amending or correcting an entry to a record, providers must use accepted practices as required by agency policy. Failure to use accepted practices could result in the denial of payment for services rendered. Generally, auditors shall NOT consider any entries that do not comply with the principles listed in section B below, even if such exclusion would lead to a claim denial. For example, they shall not consider undated or unsigned entries handwritten in the margin of a document. Instead, they shall exclude these entries from consideration.

### **B. Recordkeeping Principles**

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted for payment containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such, and
2. Clearly indicate the date and author of any amendment, correction or delayed entry, and
3. Not delete but instead clearly identify all original content.

Paper Medical Records: When correcting a paper medical record, these principles are generally accomplished by using a single line strike through so that the original content is still readable. Further, the author of the alteration must sign and date the revision. Similarly, amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record.

Electronic Health Records (EHR): Medical record keeping within an EHR deserves special considerations; however, the principles above remain fundamental and necessary for document submission for payment of services rendered. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

- a. Distinctly identify any amendment, correction or delayed entry, and
- b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.